THE AFRICAN DIASPORA: PSYCHIATRIC ISSUES

A Proceeding from the Meetings Held
November 17 - 21, 2002
Boston, Massachusetts

The Department of Psychiatry
Massachusetts General Hospital
A Teaching Affiliate of Harvard Medical School

WELCOME

Dear Colleagues and Supporters:

It is a great privilege to invite you to the Inaugural Event of the International Division of the Massachusetts General Hospital Department of Psychiatry. During the time we spend together at this conference on the African Diaspora, we will seek to understand overlays and underlays of the psychiatric issues confronting African descended people dispersed around the earth. Thank you for coming. Special thanks are given to those invitees' commitment to write papers about the issues in their own countries.

In coming years, perhaps these deliberations will lead to new and important cross-national, cross-disciplinary projects designed to serve all people, everywhere. Furthermore, this meeting is one step toward achieving a worldwide organization of Black psychiatrists, which will allow participation with medical, governmental, and non-governmental agencies.

Finally the organizers of this meeting, including our co-sponsor, The Carter Center of Atlanta, Georgia, render special thanks to Janssen Pharmaceutica, Inc., and the Massachusetts General Hospital for their encouragement and financial support in facilitating this meeting. Without their sustained and generous aid, the meeting would not have been realized.

Chester Pierce
Program Chairman

ROSALYNN CARTER

17 November 2002

Dear Chet,

The Carter Center is pleased to join the International Division of the Department of Psychiatry at Massachusetts General Hospital in sponsoring *The African Diaspora: Psychiatric Issues*. This is a wonderful opportunity to understand better how African people have coped and adapted to changing circumstances wherever they live around the world. Bringing together so many noted specialists can build a tremendous network to help alleviate the suffering of those of African descent with mental health concerns.

The Carter Center's *Sixteenth Annual Rosalynn Carter Symposium on Mental Health Policy* in November 2000 focused attention on the U.S. Surgeon General's Supplemental Report on the mental health of racial, ethnic, and cultural minorities. This landmark document raised concerns about disparities in mental health care for minority populations and highlighted the need for more equitable access to treatment. Your meeting today is an important step forward in improving the quality of care for all people with mental illness. We commend you for your efforts and send our warm best wishes for success.

Sincerely,

Rosalynn Carter

Chet Pierce, M.D.
Professor of Education and
Psychiatry, Emeritus
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I Proceedings Overview

Paul G. Organ, M.D. Editor

This volume, the *Proceedings of the Psychiatry and the African Diaspora* International Conference, represents the collective work of forty psychiatrists of African-descent who gathered for five days in Boston, Massachusetts, (November 17-21, 2002) to analyze, discuss and develop an agenda to address the role of psychiatry and psychiatrists in healing the mental health problems of people of African-descent in Africa and throughout the world.

The Proceedings begin with an Executive Summary which briefly describes the format of the conference and the participants. The summary identifies the critical concerns and outlines the consensus recommendations that emerged from the conference.

Following the Dedication and Acknowledgement sections, selected excerpts from each of the nineteen international presentations are included in the Insights and Reflections section. The goal of this section is to provide the reader with an overview of the broad spectrum of clinical issues, pragmatic interventions and theoretical constructs which were addressed and discussed by the conference participants.

The next section, composing the bulk of this volume, International Presentations, includes the edited texts of the papers that were prepared and submitted in advance by conference participants from nineteen countries and five continents. The papers and their presentation, though extremely scholarly in nature and design, were intended to be discussed within the framework of a "think tank" context in which the group discussion and analysis was encouraged. Therefore, much of the original grammar and choice of language of the international participants (many of whom spoke English as a second language), was left intact, thus allowing each presentation to portray the unique cultural and linguistic perspectives of that particular country.

The Proceedings conclude with a set of Appendices which include the agenda and schedule of the conference, biographies of the participants and relevant references and bibliographic materials.

Of note is that the bibliographies and references that were included in the original papers submitted by the international presenters were removed from the edited versions included in the International Presentations section so as to facilitate the reader's enjoyment of the ideas and experiences without the distraction of detailed notations.

II Executive Summary

November 17-21, 2002 an historic conference was convened in Boston, Massachusetts, at the Massachusetts General Hospital by the Department of Psychiatry's Division of International Psychiatry.

At the invitation of Dr. Chester Pierce, tenured Professor of Psychiatry at the Harvard Medical School and the conference chairman, psychiatrists of African-descent from twenty countries around the world gathered to discuss, analyze and seek solutions for "Psychiatric Issues in the African Diaspora".

For five days, psychiatrists from Africa, the Caribbean, Central and South America, the South Pacific, Canada, the United Kingdom and the United States engaged in a wide-ranging dialogue and analysis of the myriad of mental health issues and challenges facing people of African descent, while also searching for mutual solutions to common problems.

The international conference participants prepared and presented vivid descriptions of the mental health concerns, services, human and material resources currently available within their home countries along with specific examples of clinical issues that they as individual clinicians confront on a daily basis.

In addition, many of the international presenters defined, outlined and elaborated upon theoretical and empirical constructs which attempted to understand the current clinical manifestations and etiologies of mental illnesses among people of African-descent, within a historical framework that included (and still includes), the genocide, colonization, enslavement and oppression of people of African-descent by people of European-descent.

As psychiatrists, trained in traditional western schools of medical and scientific thought, much of the dialogue and analysis by the conference participants focused on identifying and distinguishing the general and universal aspects of mental illness and disorders found in all human beings, utilizing the specific and unique clinical manifestations found among people of African-descent around the world.

The nineteen presentations by the international conference participants, occupied much of the time during the first three days of the conference and were accompanied by daily small and large group discussions which were facilitated by the co-convenors, tenured professors Dr. Felton Earls from Harvard and Dr. Ezra Griffith from Yale,
and included the twenty five members of the host national committee from the United States.

The host national committee included psychiatrists of African-descent living in the United

States and practicing psychiatry in a wide variety of clinical, academic, research and administrative settings. In addition, international advisors and consultants attended the large and small group discussions.

The diverse and complex topics presented by the international conference participants covered the full gamut of mental illness and mental health, ranging from primary clinical issues such as diagnosing and treating homeless and immigrant populations, victims of mass trauma, domestic violence and substance abuse, to addressing systemic issues of governmental health policies, resource allocation and the training/support of mental health care professionals.

Two recurrent topics of particular concern and discussion were:

1. The pervasive need for relevant and accurate evidence-based, empirical research and clinical intervention projects related to the mental health issues of African-descended people.
2. The need to diagnose and treat the insidious and destructive role that racism, through its local and global manifestations, continues to have upon the mental health and well-being of people of African descent.

By the end of the five day conference, the participants had identified, discussed, analyzed and prioritized a wide variety of mental health issues and concerns resulting in several recommendations including:

1. Creating and developing the infrastructure, organizational framework and financial support for short and long term, international collaborative research and intervention projects focused on the mental health needs of people of African-descent throughout the world, with the goal of "thinking globally, acting locally".
2. Creation of a short and long term research agenda which addresses the immediate and ongoing needs of African-descended people around the world, primarily in the areas of community-based, culturally relevant research; and interventions that address the mental health issues and problems of displaced and disadvantaged populations, particularly elders, children and adolescents, the homeless, immigrants and those suffering from HIV/AIDS and other preventable infectious and medical diseases.
3. The creation and maintenance of an international organization of psychiatrists of African descent that will embrace the issues and challenges identified at this initial conference and expeditiously develop and implement the appropriate policy initiatives, public education and outreach efforts, research and intervention projects necessary to address and resolve the devastating mental health problems and issues that affect people of African-descent, over one quarter of the world's population.

III Dedication

We, as psychiatrists of African-descent, representing people of African-descent in Africa and throughout the African Diaspora, first and foremost, dedicate this volume to the Divine Creative Force, that inspired our Ancestors to evolve the first human societies, originate the sciences, mathematics and medicine and spread civilization to all corners of the earth; *"We can never forget the bridge that brought us across".*

These Proceedings are dedicated to people of African-descent in Africa and throughout the African Diaspora, our families, friends, colleagues and patients; We, as a group and as individuals, understand the truth and wisdom of the African proverb; *" I am because we are, and because we are, I am".*

These Proceedings are dedicated to all of the traditional healers, physicians and psychiatrists of African-descent, past and present, who have preceded us and continue to guide us; We acknowledge that; *" If we have seen farther, it is because we are standing on the shoulders of giants".*

These proceedings are dedicated to the children and adolescents of African-descent throughout Africa and the African Diaspora, who are looking to our generation of elders for guidance and wisdom in these difficult times, *" May the ancestors be proud and may our children speak well of us".*

And finally, the Proceedings of the Psychiatry and the African Diaspora Conference are dedicated to Chester M. Pierce, M.D., Professor Emeritus of Education and Psychiatry at Harvard University; a psychiatrist, researcher, scholar, mentor, friend and gentleman extraordinaire, who has planted this powerful seed in fertile ground and nurtured it into creation; *"May our efforts be worthy of your vision and may the results resound throughout the millenia".*

IV

Acknowledgements

On behalf of the participants of the "Psychiatric Issues in the African Diaspora" Conference we would like to thank the following individuals and institutions:

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Itsuko Mino

Robert Fowler

Delia Hodge

Loretta Holliday

In particular, we would like to extend our sincere gratitude and appreciation to Kathy Pike, an organizing force, logistical wizard and beacon of warmth and enthusiasm, without whom this conference would not have come to fruition.

V Editor's Insights and Reflections

Editor's Note: In this section the reader will find selected excerpts from each of the nineteen treatises included in this volume, "The Proceedings of the Psychiatry and the African Diaspora Conference". These excerpts cannot (and are not intended) to substitute for the brilliant analysis and remarkable eloquence that characterized all of the conference presentations, but are included here as a brief introduction to the issues and ideas discussed, and as an enticement to the reader to delve into the collective experience and wisdom of the psychiatrists of African descent who participated in this conference.

Reflections

Augusto Costa Conceição, M.D. Brazil

On behalf of my colleagues, I would first like to welcome all those attending this event, with a sense of dignity and autonomy that reflects our spirit and our struggle, on many continents, for full citizenship and the affirmation of the values of our ancestors.

I would also like to state that this meeting is a gathering that I consider special, as it asks for the exercise of solidarity, a fundamental value in our culture and one that was so well expressed in the pre-conference outline that was suggested as the reference point for the organization of the presentations made at this conference.

Despite the various forms of violence, prejudice and discrimination of which he (the African) was a victim throughout his history, he is now conquering spaces which, no matter how limited they may be, affirm with dignity, the force of his culture and civilization.

The phenomenon of *social exclusion* deepens among us on a scale that surpasses the alternatives offered by the traditional social and cultural network of support. Families live a daily life of deprivation, humiliation and aggression. Young people are prevented from working due to the lack of employment or because of their physical appearance. A feeling of frustration and of uselessness is developing in the face of daily obstacles to the realization of opportunities to improve one's life. The ideology and notion of "having nothing to lose" is gaining status. Unproductive laziness becomes established as a routine. Public education is precarious. New stereotypes associated with the same image emerge, those of being poor, black and marginal.

Prolonged unemployment, the dispersal of the family, the liability of gender and of childhood, the absence of alternative perspectives, feelings of fatality and inferiority, lack of knowledge, downward geographic and social mobility, malnutrition and violent behavior form the core of psychosocial factors that we in the mental health arena have come to call the *Psychopathology Of Exclusion*.

In particular, referring to my own actions in these last years, according to my values and my public consciousness, I have dedicated myself to the understanding of the living conditions of my community in a broad sense, and simultaneously valuing and empowering Afro-descendant institutions to confront what I consider to be the primary challenge in the context of the new millennium: the broadening of our models of solidarity and the spread of the pedagogy of positive self-esteem beyond the territorial limits and the circle of its followers.

Finally, I believe this to be an historic event with great significance for the Afro-descendant community. Belonging to the countries of the African Diaspora, this organization, an association represents persons who are breaking down the barriers of discrimination, conquering

and reclaiming certain real and psychological spaces in their countries; and today has become united as a professional body, making a statement of commitment to embracing our similarities in different regions of the world, to stand together in our *Drive to the Black Atlantic*, under the value that I think is most expressive of our culture: SOLIDARITY.

George Mahy, M.D. Barbados

We often talk of the inability's of White psychiatrists to diagnose people of African origin but one never stops to think of the need for understanding African people with different cultural backgrounds.

This increased rate of suicide is not unique to the Caribbean region, but it is of special significance because we are dealing with countries with small populations and small size where there are few secrets. One is always aware that the community monitoring process is excellent and the neighbors are as concerned with happenings in the home as they are with the activities in the village and district. The stigma of mental health issues are thus magnified in when living in a small society.

If we accept a feeling of hopelessness as a major factor that drives one to suicide, then the degree of insecurity and frustration of the African Caribbean must be considered as a possible factor for the increase in the suicide rate. The increase in suicide behavior reported in the region among African Caribbean people should be a main focus of mental health efforts.

There are few studies that have been conducted in this Region on the norms of behavior among our people. We do not have any idea of some of the basic facts on psychopathology. We make statements about our people with no scientific evidence e.g.

> "People of African origin have more somatization as part of depression"
>
> "People of African origin have more hysterical reactions but much less obsessive compulsive disorder"

A research foundation should be set up to establish appropriate behavior and psychological norms for Caribbean people. From the account given above, one sees clearly that there are different issues and preoccupations in different Caribbean territories based on history, size, economic situation and ethnic mix. Any research done regarding the diverse African people of the Caribbean should take this into account.

Ghislaine Adrien, M.D. Haiti

What was striking about the recently immigrated Haitians, was that they wanted their children

to behave just like true American citizens (including the spoken language, the dress codes, etc.). At the same time, they expected them to keep their Haitian identity.

Those children born in the USA or in Canada speak English or French. Most of the time, they are unable to communicate with their own parents, whose language is Creole with a minimal knowledge of English. Parental exclusion in that situation has many consequences because role models for the young people do not exist. For these and other reasons, the parents were frequently ridiculed by their children who insisted on keeping their American identity.

In fact however, these "Haitian Americans" are living with a permanent ambivalence: *Am I an American or not?*.

In response, negative commentaries and attitudes emerge from the local society, which usually does not readily accept those with "cultural differences". The local residents are usually afraid of foreigners. Moreover, in some countries, strangers, foreigners and black people are synonymous with "danger and insecurity". Generally, the native is afraid of the "other one", and if the "other one" is very dissimilar, the fear gets worse and promotes rejection. Frequently, withdrawal and/or violence become psychological responses to this situation. Clinical manifestations of psychosocial pathology like delinquency, drug abuse and aggressive behaviors become more frequent and extensive.

The situation is complicated for immigrants because each individual who enters a specific culture or society, by birth or by immigration, learns to act in accordance with the basic beliefs, values and norms of the existent culture. Each individual has a number of roles that he is expected to play and these role(s) may or may not be in harmony with the roles played in their native culture.

Deviation from the norm, especially in regard to the majority norms, is symptomatic of feelings of inferiority or marginality.

Fred Hickling, M.D. Jamaica

The mental health challenge for African people in the Diaspora at this time is to make sense of the psychology of racism and colonization, to challenge the psycho-sociological constructs of slavery and underdevelopment, and to catalyse the transformation process that will move the African Diaspora into freedom, prosperity, and psychological stability. The challenge for African mental health professionals at home and abroad is to create a blueprint for mental health in the African Diaspora. This presentation attempts to meet this objective, by revisiting the developmental history of the world using a psycho-political analysis with race as the primary dialectic construct.

This paper argues that African mental health must incorporate the phenomenological

perspective of psychiatry within the prism of the psychological, political and philosophical experiences of African people. This paper posits a thesis that demands the rethinking of the African epistemology from an interdisciplinary and philosophical repositioning, and the fusion of such thought with the dream of a united Africa, and the Pan-Africanist vision of cooperation and justice.

This thesis negates these analyses using a historical and political methodology called psychohistoriography developed on the Caribbean island of Jamaica, and grounded within a post-colonial philosophical perspective. It concludes that historical events of the past five hundred years have systematically confronted the European imperative to own the world and the people and resources contained therein. These challenges to world history have forced the systematic transformation of world mental health systems, based upon the negation of the Eurocentric concept of white supremacy and the confrontation of the European delusion of world ownership by Divine Right.

Oye Gureje, M.D. Nigeria

The story of colonial legacy vis-à-vis the place of traditional African religions in present day Nigeria is a good example of the way colonialism has affected the psychology of our people and has literally left them in a psychological limbo: unsure of where they are and uncomfortable with where they have come from.

Even though there is little research, there is certainly no deficit of pathology. The little research that does exist and the considerable clinical experience available suggest that virtually every psychiatric disorder described or encountered in North America or western Europe is also present in Nigeria. Claims of the absence of depression or of obsessions, for example, as made by expatriate psychiatrists working in Africa several decades ago, have been shown to be mistaken. Of course, rates may vary, and when they do, may present opportunities for not only learning about the nature of the disorders but also about their possible etiological factors.

The availability and affordability of effective medications are the other principal reasons that mental illness constitutes a double jeopardy for its sufferers in our environment. With the cost implications accompanying the presence of patent on newly developed medications for psychiatric disorders, our patients are virtually untouched by the recent remarkable developments in the treatment of depressive and psychotic disorders.

There is a need to expand training facilities for producing mental health professionals. This should be done in a way that does not engender a brain drain that results when trainees are sent to institutions abroad but fail to return home after the completion of their training.

International collaborations need not end with research. A network of black mental health

professionals may provide the political pressure necessary for a re-examination of international trade agreements that have negative impact on African people living in the poorer sections of the world. By having a voice in places where these agreements and decisions could be influenced, i.e. the rich and influential countries around the world, blacks may be able to lend their voices on behalf of their sisters and brothers who are otherwise voiceless. We have seen how the political pressure mounted by concerned citizens around the world has positively affected the availability of antiretroviral drugs for HIV.

This coming together of black psychiatrists is of great potential significance. First, we are better placed to understand the peculiar nature of the black experience over the past two centuries and the problems and strengths that have been the consequence of such experience. Second, while we should not deny the role of ethnicity and culture in both the origin and manifestations of psychiatric disorders, we have the opportunity to work together to provide sound evidence that challenges the poor science that often lends itself to the propagation of racial prejudice and stereotypes. Third, spread across such a diverse terrain in terms of geography, culture, and economy, we can contribute to the advancement of the science of psychiatry by studying the relationships of such attributes to diversity, psychopathology, coping, and well-being.

Granville da Costa, M.D. Canada

In many West Indian immigrant families the children are reunited with their biological parents, most often their biological mother, after being in the care of surrogate parents for substantial portions of their childhood. The tasks of the parents and children at reunion are formidable and complex and are met with a rich array of adaptive behaviours. Some of these adaptive strategies are often unrecognized, misunderstood, misdiagnosed, untreated or harmfully treated. There is little appreciation of the relevance of these adaptive strategies to the processes and natural history of reunion, and to the diagnostic assessment of these families and children.

Some results of these attitudes are: unconscious punitive reactions and blockage of empathic understanding; moralistic judgments about child rearing practices, thereby casting the parents as offenders or scapegoats; over-identification and collusion with the reunited children who are perceived as victims; disparagement of the kinship systems and disinterest in learning about their cultural contexts; all of which are the prelude for insensitive and incomplete evaluations, imprecise diagnoses and improper therapeutic interventions.

Some knowledge of West Indian extended family systems and their cultural contexts is necessary to appreciate the backgrounds of the reunited children and the crosscurrents of relationships in the different family systems. It is easier to label the family as chaotic, broken etc., than to pursue the collection and understanding of this data.

Peni Moi Biukoto, M.D. Fiji

Man is a complex creature whose character is moulded by biopsychosocial forces. I believe that the major influences on a person are the social forces (eg. culture, religion, community laws, etc.) exerted on the individual during development. The perceptions and psyche of a person can be an outgrowth of these social forces. The native Fijian is not an exception.

The culture is closely interwoven with the religion and each has meaning only when viewed in the context of its counterpart.

The pressures of urban life, the diminishing influence of chiefs and clans, and the increasing dependence on a money economy has greatly encouraged the spirit of individualism amongst Fijians. The individualism may have been encouraged from a personal need for economic survival and deterioration in social support networks that were inherent in the communal way of life.

There is so much intermixing of experiences and beliefs within a community that it can be difficult to separate odd or abnormal experiences from an accepted belief. Also, the native Fijian also is reticent about discussing their beliefs in the face of a "scientist". It is especially so when their beliefs face the risk of classification as delusions, figments of the imagination or products of an overactive mind.

I also find myself at times having to adhere to criteria set forth in ICD-10 for the purpose of obtaining a diagnosis, but personally retain doubts about the stated beliefs of the patient being truly delusional or hallucinatory in nature. These conflicts are evident within the population by their persistent habit of resorting to traditional methods of healing, sometimes to the detriment of the mentally ill. They generally adopt the explanation of biopsychosocial causes with varying degrees of acceptance, but ultimately consider cultural and religious causes as being of greater or similar import.

We operate often times on assumptions based on research done in other communities with different socio-cultural and religious backgrounds and genetic make-up.

We are generally ignorant of the underlying general perceptions of our own communities towards their environment and their coping strategies in the face of rapid change.

We need to understand the mechanism or the association between the community's perception, its coping strategies and the symptomatology manifested when the community or individual fails to cope.

I wish to see local psychiatrists become less dependent on anecdotal experiences and more reliant on data collected from community-based studies in their own country to formulate relevant management strategies and improve the diagnosis and treatment of psychosis.

Uma Ambi Siva, M.D. New Guinea

Historical precursors of psychiatry in the territory of Papua New Guinea are primarily anthropological. The contribution of social anthropology to psychiatry in Papua New Guinea lies mainly in the areas of customs, language and social structure.

Culture stems from and is molded by language, with each one giving rise to and characterizing a distinct cultural-linguistic group of people. Each cultural-linguistic group has its own pattern of psychiatry and its own traditional nosology. In Papua New Guinea, the "Tok Pisin" (Melanesian pidgin) word "long long" is used to refer to all forms of mental disorder. The word "kava kava" is used by Hiri Motu speakers to refer to mentally ill people in the Papua Region of New Guinea.

The methods used for the diagnosis and treatment of illness invariably reflect the individual, communal and traditional views of the causation of sickness. Common ailments are usually treated symptomatically with various plant products or simple surgery. In the rural areas, a fair proportion of people often seek the help of traditional healers first, but when the sickness becomes serious or persistent, they turn to the western medical services.

In the past, the emphasis was on research directed towards theory, with minimal interest in addressing practical medical aspects and providing genuine psychiatric help for the people.

David M. Ndetei, M.D. Kenya

Over the past decade, Kenyans have become increasingly aware of multiple fatality disasters. Kenyans have lost lives in a number of incidents, some of which have been alluded to earlier. These various forms of psychotrauma have brought a sense of fear and insecurity. In general terms, a sense of insecurity pervades the country in homes, in schools and in our routine duties. There is a foreboding sense of vulnerability. Fearfulness and vigilance have increased.

To be effective, psychological interventions following disasters of all forms require understanding of the traumatic elements of the events. The severity of trauma is measured by, among other factors, the duration of the event, the number of people killed, the age of the victims and the defenselessness of victims.

Traumatic impact is also magnified by the fact that some of these events occur by human design. They are deliberate, planned, sudden and completely unpredictable and are aimed at people in defenseless positions. The threat is that anyone irrespective of age, sex or status could be a victim. The intent in some of these incidences is to demoralize the people targeted and undermine their sense of confidence and security. When groups of people begin to think of themselves as potential victims, you have the ultimate hostage situation. A traumatic atmosphere is created when people feel that anyone can be a victim. Killing people in the course of their

day-to-day lives as they carry out the most ordinary of tasks and responsibilities including learning in schools creates a sense of vulnerability and fearfulness that may persist for a lifetime. It may also put a person at a risk for long term psychological difficulties. For the victims and rescue workers this atmosphere of trauma needs to be addressed with, among others, a psychological intervention.

Therefore, there is the need to fund the critical work of the researchers, allowing science and practice to work together as a refined team and maximizing the value obtained for the funds expended in these efforts. Without research-based evidence for our clinical practices, there is a high risk of institutionalizing non-effective or even dangerous interventions, no matter how many resources are expended on unevaluated interventions.

Omar Ndoye, M.D. Senegal

Throughout the ages, the majority of Senegalese people sought and received mental health care from traditional therapists. During colonial times, several small health care facilities opened up, and the major hospitals took charge of mental health care. Mental trouble "in the native" was usually explained as demons or other religious delirium of a xenophobic nature, or *"furious madness*...an expression of diencephalatic predominance in the functioning of the brain in the African"

The "notion of illness" must be undertaken within the large sense of the culture that gives birth to different interpretations of reality. Representations of illness particularly the mentally ill vary from culture to culture. Mental illness cannot be cured if one does not take into consideration its wider cultural meaning.

In Africa and since the beginning of time, causality lies embedded within its cultural context. Collomb rightly affirmed that "mental illness is a disruption of the established order, a modification of relationships between individuals and spirits. Mental illness is not only a problem of an individual or the individual's family, but is also a threat to the cohesion and relations within the entire group."

When mental trouble is noted, the first thing the family usually does is hide the problem because mental illness is considered by many to be a shameful illness. When the trouble becomes intolerable, the family might secretly visit the healer. When the problems continue, the family might then come to the hospital.

For families, the most disturbing thing about hospital care is the inability to control or even get a grasp on the total costs of treatment and hospitalization. Families often have the impression that doctors try many different treatments before they find the one that works. The treatment, and whether it is continued or not, is more often than not, influenced by economic problems.

Today in Senegal, the psychiatrists, with the exception of a French military co-operant, are Senegalese and share the same cultural background as their patients. Practitioners learn western medicine and use concept and instruments that are foreign to their own culture. As a result, conceptions of mental illness and treatment are essentially occidental. Many psychiatrists do not seem to be at ease facing this position of being "between two cultures." They subscribe more and more to western logic and use an imported psychiatry.

If we accept the hypothesis that this cultural heritage helped the African slave survive, stay alive, and "continually renew himself and draw upon the myths, gods, rhythms, and values," we may infer that this cultural heritage is still alive and well in the diaspora.

If one considers psychiatry to be a science that treats everyone in a systematic and invariable way, regardless of the origine and the itinerary of the individual, will this not mean the programmed disappearance of one of the historically most powerful coping mechanisms of the African diaspora?

Whereas the hospital today seeks profitability, the traditional therapist, because he lives among the people, looks for recognition, respect, and notoriety.

Emilio Ovuga, M.D. Uganda

Because of the inadequacy of modern health care both in terms of quantity and quality, the public seeks care from traditional healers, and churches. Unfortunately those who seek help from churches in pre-psychotic states develop frank psychotic disorders necessitating hospitalization. Human sacrifice in the treatment and prevention of mental illness has been reported. The level of stigmatization and discrimination against the mentally ill is high; those who are psychotic not infrequently get killed for minor misdeeds that they might commit.

Psychiatry's response has been to promote the discipline in medical education at Makerere University. The purpose of this has been to portray psychiatry as an integral part of every other medical specialty, and that psychiatry is at the heart of every branch of clinical medicine. Psychiatry is not concerned with teaching madness, but with teaching the art of allaying human suffering and promoting human health through health promotive activities, and early recognition, diagnosis, and appropriate management in primary care.

Outstanding issues for psychiatric care in Uganda concern the most basic needs of human beings who suffer from mental disorder. Facilities are inadequate in quantity as well as in quality. The public lacks awareness that mental ill health is a medical condition, just like any other health problem, and can be treated. The human rights of those who suffer from mental illness are frequently violated in all spheres of life, including employment, security, custody, care and protection from harm. Laws regarding the care of the mentally ill are outdated and policies

targeting the needs of the mentally sick do not exist. Investment in mental health is inadequate, and stands at less than 1%.

A most pertinent area in point is the fact that African-descended psychiatrists are currently being trained using texts written for non-African patients using concepts, which are culturally not relevant to Africans. This is not to say that psychiatric disorders among Africans are different in nature. *The argument being advanced is that the same disorders, as they afflict members of the human race, do present in different ways in different locations, environments, cultures and social groups.*

Psychiatry for Africans scattered throughout the world is obviously an area in which psychiatrists of African descent can influence the future development and practice of psychiatry to the benefit of African-descended patients worldwide. The establishment of collaborative linkages between African universities and those in the western world will provide opportunities for students from the developed world to gain experience in African psychiatry. This should enable the student to understand the presentation and origins of psychopathology in patients of African descent living in the western world, and hopefully improve the quality of care provided for African-descended patients.

Sammy Ohene, M.D. Ghana

Psychiatric illness is strongly stigmatized in Ghana. This may be because of the recurrent or chronic course of most disorders and the belief that there is no satisfactory "cure". Besides, the ideas people have their own ideas about causation of mental illness.

A popular adage in Ghana translates loosely as: "No matter how well a mentally ill person may be, he still retains the few symptoms that will scare children".

The absence of a tangible "cause" intrinsic or extraneous for a mental illness (e.g. underlying physical illness, head injury or heartbreak) is considered highly unsatisfactory. Thus if the doctor does not "know the cause" he's not considered fully capable of curing it.

It common for unaculturated psychiatrists to assume that a patient expressing the belief that his symptoms are caused by a witch is paranoid. In fact many patients with somatic symptoms that cannot be explained as due to a physical illness fall into this category. Belief in the supernatural in Ghana is common and not necessarily delusional.

Africans tend to take a holistic view about the causes and therefore the treatment of mental disorders. Physical, genetic, emotional, spiritual and environmental causes are all important. Intrinsic and extraneous dimensions are believed to be involved, and the spiritual is thought to come from within as well as without, in the form of physical and psychic "assaults" initiated by people that an individual has wronged. It would be interesting to find out if these beliefs hold true across the oceans.

Carlos Smith-Fray, M.D. Panama

Despite this history of discriminatory attitudes and some of our own people trying to put our colour to the side, our presence is now so strong that we ARE the cultural expression of the Panamanian nationality and pride. We are found in the music with our drums and songs, in the foods, the arts, literature, science and sports. We are easily identified but never evenly recognized.

From my point of view as a black psychiatrist, black people in Panama are not affected by mental illnesses differently than the rest of the population, however poverty does play a significant and devastating role. A great part of the black population are in a perpetual situation of unemployment. There is, therefore, a great need to raise their self esteem by assisting them in completing their education, enhancing their knowledge of our historical and cultural roots and helping them to feel proud of our race

Transcultural psychiatric research in the areas or chemical dependency, mental illness and migration, the use of cultural institutions such as museums and theatre to enhance mental wellness and the impact of racism upon self-esteem and the "sense of belonging" would also be areas of great interest in which to pursue further research.

Miguel Valdés Mier, M.D. Cuba

An analysis of the high incidence of mental problems found among those who are most discriminated against; immigrants, individuals with low income level and poor health, and those with fewer opportunities for intellectual development and optimal health care and attention, there is no doubt that it is critically important that psychiatry value the enormous importance of socio-economic factors in mental illnesses.

Referring to the etiological, diagnostic and treatment problems related to the stress suffered by minority and discriminated against groups, it is not possible to see the patient as separate from his origins, value system, hopes, beliefs, achievements and frustrations. Family traditions and the beliefs of our ancestors are powerful social and psychological factors that pave the way for the development of individual and group personality patterns.

To exercise its profession, psychiatry in our milieu cannot ignore the transcultural elements and must value the clinical manifestations generated by the many social, cultural and political factors; the influences of family, geographical region, environmental and mythical-religious components that can play a role in the pathological profiles manifested in different clinical states.

The possibility to motivate psychiatrists of African descent to unite and organize for fraternal and scientific aims, would, in my opinion, be an excellent initiative that merits assistance. While among the colleagues from the different countries that approved this idea there exist different economics, politics and languages, in addition to our identification as medical professionals and

psychiatrists, we are united by powerful similarities from our common African origin. At the start of this new millennium it is impossible to turn our backs on understanding, respect, tolerance and altruism.

In relationship to our daily psychiatric work linked with practice and science, we must help ourselves develop and nurture sensitivity and generosity towards the most needy in order to guarantee everyone the access to quality mental health services.

Ongoing clinical work and research, exchanges through visits, conferences and workshops, publication of our ideas and dissemination of current and accurate information about these topics, offer us the double possibility of bettering ourselves scientifically and strengthening our legitimate pride in our race.

Mohamed Zitouni, M.D. Morocco

To be born is to be born into the discourse of the parents, of the nuclear family, of the extended family and therefore of the social corpus. To be born into the life of parents living in extreme circumstances is, (as in the case of colonized parents), at the very least, a source of discordance, of division, of vexation for the child. So the child, from the start has the alternative of being born to fulfill his life, or to stray towards survival, living a lesser life , in short to accept himself as an inferior being, a lesser being, different from the masters, the colonizers. Such was the case of our coming to existence in North Africa.

So from the start we were put into an in-between existence: between two worlds, two injunctions, between here and there, between the ancient (ours) and the modern (theirs), between them and us. What marked us most was that we had come out of a lesser world, poor, filthy, without light or glasses. We felt that we were behind from where they seemed to be, in short we were objectively lacking in our daily lives. To our envy of the rich and dominating whites was added hatred for our own, developing in ourselves a vague feeling of insufficiency, trouble with self image and dissatisfaction with oneself, and even lacking in an understanding of our place in the world.

Claudina E. Cayetano M.D. Belize

The dreadfulness of the chronically and severely mentally ill living on the streets, in constant danger, without the basic necessities of life, let alone treatment, is almost too incredible to contemplate, and too difficult to live with.

Homeless mentally ill, perhaps are found worldwide, but this is not an excuse not to take the time to understand and jointly assist each other in providing decent services to this population,

and strive to minimize the frustration of providing treatment and appropriate services to this vulnerable population.

As psychiatrists, we have special expertise in dealing with these disorders. If we can help to better their lives, live a healthier life, become self-sufficient and have an identity of their own, we would have made a great and significant contribution.

The question I pose to you is what is our role as psychiatrists? The role of psychiatry is impartial and detached if it only provides medications, and does not assist in the understanding of the phenomena of the homeless mentally ill and address the issue of poverty alleviation.

The lack of human resources in a country like ours that does not provide the necessary resources and tools, or the time needed to develop the appropriate research, limits the ability of the clinicians to effectively deal with the problems facing them on a daily basis.

Kwame McKenzie, M.D. United Kingdom

The treatment of African-Caribbean people with mental health problems is at best patchy. Contested diagnostic rubrics, poor compliance with medication and treatment plans, higher levels of imprisonment, and more coercive treatment are all testament to the failures of the system.

Black children are the only racial/ethnic group to have significantly different rates of school exclusion, and of this group, the excess is mainly due to Black Caribbean origin children. The Government Home Office concluded that there were high levels of tension in the classroom with teachers complaining about troublesome black pupils and criticizing them, and black pupils responding to expectations of low ability with disruptive behavior. Few black youngsters get to University and there are a negligible number of black doctors or medical students. There is a relative over-representation in nursing but few in allied professions such as psychology. There is a concentration of black professionals in relatively junior positions.

The challenge for the future must be in some way to re-invent black community and black identity in a way that is acceptable and sustainable. The challenge will be to produce internal and external sources of resilience to the effects of racism. A movement to produce such a change may need to be international but any such movement would also need to be bottom up instead of top down. It would have to reflect the varied aspirations of our geographically dispersed people, while reflecting the singular position of black people in the world today. It will need to be focused on the future but will need to be anchored in the past.

Pamela Collins, M.D. United States

Stigma has been identified as a stressor that is pervasive. African Americans are "at risk" of experiencing discrimination in a variety of social contexts. The ambiguity of prejudice adds additional stress as it often leaves its targets guessing at the meaning of events that may or may not be a result of discrimination. A number of studies have found positive associations between the experience of discrimination and psychological distress or specific psychiatric symptoms, such as depression. What seems particularly critical is to enable African Americans to address feelings of powerlessness, depression, and anger that can result from these dehumanizing insults.

The constant struggle to prove oneself a fully capable human being may eventually take a physical and emotional toll; thus, one priority is to examine existing coping styles and facilitate the maintenance or development of adaptive coping styles.

Although at first glance HIV/AIDS may not appear to be a mental health problem, the AIDS epidemic is the most devastating health crisis facing people of African descent throughout the world. AIDS is a disease that is disproportionately affecting people of African descent. While taking the lives of millions of African people each year, it decimates communities and takes a tremendous social and emotional toll on those infected and affected by the virus. As such a monumental issue, it is critical that psychiatrists of Africa and the African Diaspora actively seek a role in combating the AIDS epidemic, be it through research, clinical care, prevention, or advocacy.

Aimé Charles Nicolas, M.D., Ph.D. French West Indies

More than 80% of the present population are African descended people. References to slavery are numerous in public life and the abolition of slavery, attained through sheer force, is fervently commemorated every year. The importance that we have to give today to the story of slavery is an object of controversy. So is the question of our identity: what relative importance should we attach to our African roots and to our European heritage? Nevertheless, there is no doubt about our pride of being what we are.

Most of these behaviours are not psychotic but linked to changes in the way of life and with the loss of cultural references. Psychological suffering seems to be more painful than it was when group life prevailed, maybe because the support of the extended family has disappeared Today families do not take into account anxiety and depression ("you must not coddle yourself"). People do not consult psychiatrists easily because of this disregard for psychological suffering and the stigma of psychiatric disorders. Loss of cultural references is frequently one of the key explanations given by the man in the street about the spread of violence and substance abuse.

People are brought up in an insecure context. The meaning of life is increasingly founded on

personal material success and less and less sculpted by the tenets of uprightness and honesty. On the contrary, these values represent impediments to the success of a professional career. Psychiatric patients no longer enjoy their traditional status and their cultural niche, instead, they have become a real hindrance, particularly in small public housing flats. Western individualism infiltrates into child rearing practices without the history and the background of western countries.

African-Descended People and Psychiatry: Views from Nigeria

Oye Gureje, M.D. Nigeria

The Country: Nigeria

Nigeria is the most populous country in Africa. Indeed, with a population of about 120 million people, one in five of every African-descended person alive is Nigerian. The country was a British colony until 1960 when it obtained its independence. A resource-rich country, Nigeria is a major producer of petroleum and also has large deposits of tin, gold, and steel. Endowed with extremely arable land, it used to be a major agricultural country until about two decades ago when oil became a major revenue earner and young people deserted the farms in the towns and villages and migrated to the cities in search of both blue and white-collar jobs. The country is highly diverse in language and culture: there are more than two hundred spoken languages but three of them account for probably 65% of the population.

Broadly speaking, there are three major religions: Islam, Christianity, and various traditional faiths. Even though the northern part of the country is predominantly Muslim, and the south-east is predominantly Christian, there is indeed a large admixture of religions in all of the sections of the country. This is perhaps better exemplified in the southwest where virtually every extended family will have among its members Christians, Muslims, and traditional religion adherents. Of course, both Islam and Christianity are imported religions and in some way, are the enduring legacies of colonialism. They are nevertheless firmly rooted in the lives of Nigerians now and can hardly be perceived as alien religions, partly because various traditional influences have been brought to bear on their practice.

The paradox of traditional religious practices these days is that they are probably more dynamically alive among the African-descended people in Brazil than among those still residing in Nigeria in Africa. The story of colonial legacy vis-à-vis the place of traditional African religions in present day Nigeria is a good example of the way colonialism has affected the psychology of our people and has literally left them in a psychological limbo: unsure of where they are and uncomfortable with where they have come from.

The Problems

Nigeria as a country has gone through circles of trauma, almost always man-made. At the departure of the colonialists, the country was in a politically untenable situation: central power was in the hands of a conservative elite, predominantly from the Muslim north. At the same time, a gaping educational imbalance, with the north at a gross disadvantage relative to the south, was in existence. The tension within the political system, principally resulting from the reluctance of those with the reins of power to let go democratically, soon led to the first military coup. Other than a short interregnum of civilian governance, the country was under one form

of military dictatorship or the other for the best part of 1966 until 1999. With a military command political structure and massive corruption, civil life deteriorated in every sphere during those years.

When the re-institution of civil rule came about in 1999, the pent-up frustration resulting from years of repression and the denial of basic human rights now finds its outlet in violent clashes in most parts of the country. With such violence has come the attendant worsening of security and quality of life. The harsh economic situation has left more than one half of the population living in poverty.

Poor governance has left a trail of illiteracy, poverty, and poor health among the populace. Despite the real and potential wealth of Nigeria, its health statistics are among the worst in the world. Life expectancy is about 47 years for males and 48 years for females. More than 170 of every 1000 children will die before they reach the age of 5 years (compared with, for example, 8/1000 in the US). The neglect of its health service by successive governments is exemplified by the fact that, of the 191 member states of the World Health Organization, Nigeria is rated 184th in terms of the overall attainment of its health system.

Given the traditional neglect that mental health services often face from governments, it is no wonder that the statistics for mental health would be even worse. Thus, with a population of about 120 million, the country has less than 100 psychiatrists working in both its public and private health services. The situation is no less stark for other mental health professionals such as psychologists, social workers, and occupational therapists and other allied health professionals.

What really is the level of psychological problems in Nigeria? The answer is we do not know.

Wouldn't it be very important to know? Of course, it would.

Given the social and economic circumstances of the country and the level of traumatic events occurring almost on a daily basis, the impact on the psychological health of the people is likely to be profound. If on the other hand, the impact were not remarkable, it would of course be interesting to learn about the coping mechanism that provides such protection against adverse life events. We do not have answers to these questions because the level of research in Nigeria is low. Research is low because there is no institutionalized support for research. There is no equivalent agency such as the National Institutes of Health or the Medical Research Council with a government mandate and support to fund research in Nigeria. Research is of course a low priority for the few mental health professionals available because they are overburdened with clinical (and depending on where they work), teaching and administrative duties, leaving them with little or no time to address research questions.

The relative paucity of research in the mental health field in Nigeria is a particularly painful paradox because this is an area in which Nigeria showed early promise, and where, despite the odds, her academic psychiatrists have continued to offer a credible voice internationally. The

first Nigerian to qualify as a psychiatrist, Thomas Adeoye Lambo, not only became a university professor but subsequently the deputy director general of the World Health Organization. His pioneering work in the integration of orthodox psychiatric care into the traditional village support system blazed a trail in community psychiatry. His legacy and those of others like Professor Tolani Asuni have been sustained by a strong academic interest among most Nigerian psychiatrists. Without a doubt, Nigerian psychiatry would be a strong force in international psychiatric research if the necessary support and nurturing can be made available at the governmental level.

Even though there is little research, there is certainly no deficit of pathology. The little research that does exist and the considerable clinical experience available suggest that virtually every psychiatric disorder described or encountered in North America or western Europe is also present in Nigeria. Claims of the absence of depression or of obsessions, for example, as made by expatriate psychiatrists working in Africa several decades ago, have been shown to be mistaken. Of course, rates may vary, and when they do, may present opportunities for not only learning about the nature of the disorders but also about their possible etiological factors.

If the profile of pathology present in Nigeria is not too dissimilar from that existing in North America and western Europe, what is clearly dissimilar is the care available to those suffering from mental illness. As mentioned before, the level of professional help available is grossly inadequate and so also are the available non-human resources. The availability and affordability of effective medications are the other principal reasons that mental illness constitutes a double jeopardy for its sufferers in our environment. With the cost implications accompanying the presence of patent on newly developed medications for psychiatric disorders, our patients are virtually untouched by the recent remarkable developments in the treatment of depressive and psychotic disorders.

Unfortunately, this situation is not likely to change for the better as the trade relationships between developing and developed countries become more and more skewed under new international trade agreements that make no exemptions for medications for the less privileged. So, as supportive traditional social and family networks break down under the influence of poverty, urbanization and the adoption of western values, the number of vagrant psychotics on the streets in Nigeria is unlikely to grow less. With no formal care system to provide for their needs, and with tired families unable or unwilling to cope, the severely mentally ill have nowhere else to gravitate to but to the streets.

Social changes have other implications for the mental health of the people. Along with major changes in demography, the profile of mental health needs will undergo significant changes. For example, the proportion of persons aged 65 years and older is projected to triple in the next 50 years or so in developing countries. For these elderly persons, informal care will become less and less available as would-be caregivers migrate to urban areas and abandon traditional extended

family structure. Loneliness, loss of self-worth and depression are likely to increase among the elderly. Whether that is likely to lead to increased substance abuse among the elderly is not known. But what is known is that the traditional restraint on excessive use of alcohol is unlikely to be available to the city-dwelling youths. With few opportunities for legitimate health-promoting leisure activities in our overcrowded cities, substance abuse among the youths is already a growing problem. If the spread of HIV goes unchecked, not only will the number of orphans increase with its attendant social and psychological consequences, but the direct psychiatric sequelae of this infection will also increase the mental health burden of the populace.

Suggestions for Solutions

So, what is needed in Nigeria?

There is a need to expand training facilities for producing mental health professionals.

This should be done in a way that does not engender a brain drain that results when trainees are sent to institutions abroad but fail to return home after the completion of their training. There are more than 2,000 Nigerian doctors in North America and western Europe that have gone abroad for specialist training after completing their basic medical training at home, but have failed to return. The best arrangement is probably one that offers help in developing resources within the country to make it possible for the delivery of qualitative training locally. Short-term fellowships in centers abroad remain useful and desirable as well since exposure to mental health service delivery in countries with better service than Nigeria can have a lasting positive influence on participating fellows.

Research capacity in mental health needs to be developed to a sustainable level.

Of course, the training of mental health professionals in the conduct of clinical and epidemiological research is a basic necessity. However, beyond training in basic research techniques, opportunities for using the acquired skills require the availability of research support in the form of grants. Opportunities abound in collaborative research endeavors between mental health professionals working in different cultural settings. The notion that schizophrenia may have a better short-term outcome in some developing societies arose as a result of such collaborative work. Collaborations involving studies of blacks currently residing in different socio-cultural settings may offer even more rewarding results, and provide invaluable insight into possible etiological factors for mental disorders.

An example is our on-going collaboration in Ibadan with colleagues at Indiana University comparing the occurrence and risk factors for Alzheimer's disease among Yoruba Nigerians and African Americans living in Indianapolis. By demonstrating that the prevalence and incidence rates of Alzheimer's disease are significantly less in our elderly Nigerian sample than the elderly sample of African Americans, we have set the stage for a potentially rewarding search for environmental factors that may account for these differences and so provide possible clues to some etiological factors for this disease.

International collaborations need not end with research. A network of black mental health professionals may provide the political pressure necessary for a re-examination of international trade agreements that have negative impact on African people living in the poorer sections of the world. By having a voice in places where these agreements and decisions could be influenced, i.e. the rich and influential countries around the world, blacks may be able to lend their voices on behalf of their sisters and brothers who are otherwise voiceless. We have seen how the political pressure mounted by concerned citizens around the world has positively affected the availability of antiretroviral drugs for HIV.

Conclusion

This coming together of black psychiatrists is of great potential significance.

First, we are better placed to understand the peculiar nature of the black experience over the past two centuries and the problems and strengths that have been the consequence of such experience.

Second, while we should not deny the role of ethnicity and culture in both the origin and manifestations of psychiatric disorders, we have the opportunity to work together to provide sound evidence that challenges the poor science that often lends itself to the propagation of racial prejudice and stereotypes.

Third, spread across such a diverse terrain in terms of geography, culture, and economy, we can contribute to the advancement of the science of psychiatry by studying the relationships of such attributes to diversity, psychopathology, coping, and well-being.

Nigeria is a well-endowed country and should not only be doing well but should be helping her neighbors to do well. Personally, given the valuable medical training, clinical experiences and wide opportunities for networking with colleagues around the world that I have had, I would be very delighted indeed to be part of all of these ongoing efforts.

Which Psychiatry for Sub-Saharan Africa? The Example of Senegal

Omar Ndoye, M.D. Senegal

Demographics

Located in West Africa, Senegal has a population of approximately 9 million people and an area of 196,722 km. Senegal shares a border with Mauritania in the north, Mali to the east, Guinea Bissau and Guinea Conakry to the south, and the Atlantic Ocean to the west. The Gambia is an enclave that separates the southern Casamance region from the northern part of Senegal.

Since 1960, Senegal has been an independent democratic state. The official language of Senegal is French, and the most widely spoken national language in Senegal is Wolof. This singular national identity is shared by people of many different ethnic groups who live within Senegal's borders.

There are over 20 different ethnic groups represented in Senegal; each has its own language, culture, and belief system. Many of these ethnic groups are not bounded by national borders and it is not rare to see a single ethnic group represented in several different countries. For example, the Senegal River forms a natural border between Senegal and Mauritania, but to both the north and the south of the river, the Peul comprise the largest ethnic group. There are therefore people of the same (Peul) ethnicity who speak the same language, share the same traditions, and may be able to trace their ancestry to the same lineages, but are of differing nationalities. The struggle for independence that is currently taking place in the Casamance region of in southern Senegal, which is separated from the rest of Senegal by another country (The Gambia) is of ethnic origin.

People and Ethnicity

The twenty or so different ethnicities of Senegal are made up of seven main groups:

1. The Wolof traditionally occupy the northwest part of Senegal, but today can be found all over and especially in urban areas. The Lébou, who are closely related to the Wolof and also speak Wolof, occupy the area around the Cap-Vert peninsula (the region in which Dakar is located) and live often in fishing villages. Wolof is the national language and is spoken by about 80% of the Senegalese population.
2. The Sereer, excellent cultivators, live in the "petite côte" region (Mbour, Joal, Fadiouth) near the Sine and the Saloum rivers. Although the majority of Sereer are Catholic, they keep alive many beliefs, rites, and customs that come out of their animist past.
3. The Peul and the Tukulor are of the same origin and share the same language. They live along the Senegal river in the north of the country.
4. The Saraholay are located in the northeast, between Matam and Bakel.

5. The Bassari live in the hills of Niokolo-Koba, which are located along the southeast border shared with Guinea, a country they once fled.
6. The Mandinka, descendents of the founders of the Mali Empire, came from the Gambian Valley to settle the southern part of Senegal.
7. The Jola are the dominant ethnic group in the Basse-Casamance region and are connected to the Bainouk, the Manjack, and the Ballantays. The social organization of the Jola differs greatly from that of the other ethnic groups in Senegal, and it is in this area, (Casamance) that the civil war has been going on for a number of years.

Religion

Islam came to Senegal in the 11th Century, but did not spread widely until the 19th Century. During that period, Islam was represented by several strong, charismatic leaders such most notably Lat Dior and El Hadji Omar. These two opposed French colonialism and strengthened the autonomous cultural identity of a nation that needed it.

These two personalities, almost deified, founded two religious brotherhoods. They worked as intermediaries, like priests, between their followers and Allah. This relationship was more comforting to many of the people than the direct and solitary confrontation with Allah that was proscribed by the Koran. Today, over 90% of the population is Muslim.

Mental Health

Today in Senegal, we have:

1. A psychiatric hospital located 20 km outside of Dakar
2. A clinic of psychiatry and medical psychology in the University Hospital Center of Fann in Dakar
3. A psychiatric service in the Principal Hospital (military)
4. Three public psychiatric villages that are almost obsolete
5. A private Catholic center about 70 km from Dakar
6. A private psychiatric village about 55 km from Dakar
7. Five schools for traditional therapists
8. Five associations of traditional therapists

Background

Throughout the ages, the majority of Senegalese people sought and received mental health care from traditional therapists. During colonial times, several small health care facilities opened up, and the major hospitals took charge of mental health care. Mental trouble “in the native” was

usually explained as demons or other religious delirium of a xenophobic nature, or "*furious madness*. . .an expression of diencephalatic predominance in the functioning of the brain in the African" (Sanon 1961).

Sarr and Gueye (1987) explain that until 1938, the only mental hospital or asylum existing in French West Africa was in Bingerville. No mention of traditional therapy was made whatsoever. The mentally ill "native" was seen as little more than a nuisance to colonial public order. The authors comment that the silence in the national archives indicates that there was lack of interest among colonial doctors regarding mental disorders. Mentally ill patients were instead often transported to asylums in the metropole. The report of the 22nd Conference held in Tunis in 1912 indicates that there was a push toward training colonial psychiatrists and constructing psychiatric institutions in order to end the transportation of mentally ill persons from the colonies to France, but these recommendations were not heeded. In 1917, persons deemed mentally ill were actually being imprisoned in St. Louis. Although plans were actually proposed for the construction of a psychiatric hospital in the city of Thies around 1922, nothing ever came of these.

After the first World War, there were construction projects proposed for asylums that would treat European and "native" persons deemed mentally ill. In a way, these projects offered segregation as a viable option and also sought to put "natives" to work in agricultural camp asylums "because agricultural work [was seen as] an excellent way to keep the native busy and treat his mental problems" (Casenove 1927).

The Algerian Conference of 1938 led to the creation of the Psychiatric Association of French West Africa. In 1952, a French psychiatrist was assigned to work in Senegal, and four years later, a clinic of neuropsychiatry was put in place by the French colonial regime. The ideological foundation of the French colonial regime, however, based itself on such ideas as primitivism, organicism, and the general subordination of African culture.

In 1958, Professor Henri Collomb was named the director of the Clinic of Neuropsychiatry at the University Hospital Center of Fann in Dakar. Collomb took an interest in African psychopathology, approached traditional healers, and became a chief contributor in the theoretical and clinical fields of ethnopsychiatry. Some of the key concepts that came from his work were the notion of the collective phallus, the idea of incomparable ancestors (the fantasy of the death of the father), and the idea that fraternal rivalry displaces Oedipal father-son rivalry in many non-western settings.

The methodological approaches that referred to occidental models were not always adequate. Collomb and his team also sought to understand and describe traditional representations and exegeses of mental illness in Senegal, and look closely at traditional therapeutic practices of healers. Many studies and inquiries were carried out that allowed research on mental illness in Africa to flourish. Collomb and his team, in order to treat psychosomatic illnesses, for example,

put into place dynamic forms of group therapy that were inspired by traditional treatments and therapies. This was the birth of the famous "Fann School."

In terms of the clinical model of Fann, there was no parallel between the typology set forth by Georges Devereux (1970); classical nosography was still applied. Collomb did however hypothesize that temporary delusional states and delusions of persecution masked other forms of depression and depressive anxiety, yet often lacking the usually more noticeable element of auto-accusation.

The Notion of Illness

This notion must be undertaken within the large sense of the culture that gives birth to different interpretations of reality. Representations of illness particularly the mentally ill vary from culture to culture. Mental illness cannot be cured if one does not take into consideration its wider cultural meaning.

The traditional therapist Tekheye Diouf explained, during the First Pan-African Conference of Mental Health, that psychiatrists view illness in terms of a syndrome, while traditional healers speak of a fault or mistake (offending another person, society, or the ancestors, or doing something forbidden).

In Sereer society, for example, mental illness is linked to:

1. Abnormal morphology of the head,
2. Inheritance: a mentally ill ancestor, who was either wronged or unjustly denounced for an act such as murder, is reincarnated in one of his or her descendants,
3. Depression (sudden or violent) or a critical state linked to anthropophagy (the mystical soul-eating sorcery that manifests itself)

In the first issue of the journal Psychpathologie Africaine (1965), Henri Collomb wrote that illness is never simply fortuitous, that it is not a natural state or an accident, but is instead "the result of a bad relation to or with one or many members of the group, or with the rules that govern the community (rules that involve the ancestors and dictate prohibitions)." Mental disorder is explained as either stemming from troubling encounters with spirits (possession by spirits called "jinns" or "rabs"), or as coming from sorcerers, marabouts, or fetishists utilizing magical or religious means.

In Africa and since the beginning of time, causality lies embedded within its cultural context. Collomb rightly affirmed that "mental illness is a disruption of the established order, a modification of relationships between individuals and spirits. Mental illness is not only a problem of an individual or the individual's family, but is also a threat to the cohesion and relations within the entire group."

The complexity of symptomatology is directly related to cultural specificities. The vast majority of patients consider their illness to be an "evil action coming from the exterior, an aggression aimed to take vengeance or to punish due to the transgression of certain social rules" (Gueye, D'Almeida, and Sarr 1993).

In traditional therapies, the group naturally takes the patient into its care and accompanies him in the treatment of his illness in order to restore not only the patient's health, but the social order that has been transgressed.

Pathology has concerned adults for a very long time; children may be born sick but it is the adult who is responsible. This explains the fact that the adult was the only guarantor of normalcy and balance of the human system and of the pantheon. And, in that mental disorder was the result of troubled relationships, only the adult could be implicated.

Today, because of a rising birth rate and a progressive decline in the infant mortality rate, the population in Senegal is growing. Children and adolescents are present in the therapeutic sphere. During the last few years, a child psychiatric clinic has been established, as well as several children's day centers, and even counseling centers for adolescents. The adolescent population, until now silent, has emerged over these last few years and can be seen as a reflection of the changes taking place in today's society.

When mental trouble is noted, the first thing the family usually does is hide the problem because mental illness is considered by many to be a shameful illness. When the trouble becomes intolerable, the family might secretly visit the healer. When the problems continue, the family might then come to the hospital.

Hospital Care

A study conducted in 1993 found that psychiatric medication prescribed is usually bought only once; prescriptions are rarely renewed and treatment is often abandoned, due in part to the alarming economic situation in which many Senegalese find themselves.

Since January 2000, the hospitals have been managed by a centralized administration council by way of an intermediary team of directors. In our psychiatric clinic, the administration council of the hospital has recently doubled the price of consultations (from $2.50 to $5.00) and stated that this same amount must be paid for each day the patient stays in the hospital, up to the 10th day (for a total of $50.00). The cost of medication at the beginning of the treatment varies, but is usually between $12.00 and $21.00). As a result, if a patient stays only 10 days in the psychiatric clinic (which is a very short stay), his or her stay will cost (not counting the transportation costs for those who will come to visit the patient or the cost of the meals prepared and brought to the patient) about $70.00. This is more than the average person makes each month in Senegal. Most professionals, for example, including workers, manufacturers, maids and house workers, guards, etc. make about $30.00 per month.

We also should not forget that hospitalization is not only accompanied by medication; there are also such things as EEGs and brain scans that may cost an additional $12.00 and $65.00, respectively. We thus see that psychiatric treatment may easily cost $160 or more, that is to say 8 times the average monthly salary of a guard who keeps watch over someone else's house each night.

Commentary

For families, the most disturbing thing about hospital care is the inability to control or even get a grasp on the total costs of treatment and hospitalization. Families often have the impression that doctors try many different treatments before they find the one that works. "We are obliged to buy medicine and pay for EEGs or brain scans that seem necessary to the doctors, but not as necessary to us, the family. But if we do not do what the psychiatrists say, we will be blamed if our relative does not get better."

The treatment, and whether it is continued or not, is more often than not, influenced by economic problems. A woman once told us, "I am scared before each of the bi-monthly visits from the health care team because each time there is something else to buy or to do, and therefore more money to pay." In reality, it ends up being painful for families to have to continuously knock on the same doors to ask for money to finance the patient's care.

The fact that the families do not know how much the treatment will end up costing often keeps them from approaching the hospital. The foreseeable financial difficulties often lead people to look to:

1. Traditional therapy and medicine, which is in actuality are very sought after for mental problems and which offers a variety of different interpretations (jinn, rabs, possession, maraboutage, sorcery, etc.)
2. Street markets where prescription medication may be found and bought. This constitutes a real problem for the state. "Kër Serigne Bi" (The Marabout's House) is a clandestine, but somewhat official part of a bustling Dakar market where prescription medications may be bought. One even finds there medicines that have not yet become available to pharmacies. These drugs, like those sold in train and car stations, street markets, on the beaches, and in other public places are much more affordable and thus better adapted to fill the needs within the Senegalese economic and social context.

The politico-religious implications of this, and the incapacity of health services and establishments to assure the distribution of quality medication at affordable prices make the illegal selling and buying of medication necessary. Without any medical inspection, these products are sold to people one by one, without instructions, and are frequently exposed to light, dust, and humidity.

Psychiatric Practice: Western or Occidental?

Today in Senegal, the psychiatrists, with the exception of a French military co-operant, are Senegalese and share the same cultural background as their patients. Practitioners learn western medicine and use concept and instruments that are foreign to their own culture. As a result, conceptions of mental illness and treatment are essentially occidental. Many psychiatrists do not seem to be at ease facing this position of being "between two cultures." They subscribe more and more to western logic and use an imported psychiatry. A recent study (Ndoye, et.al.) affirms that patients come to the hospital to see a doctor, not a traditional healer.

Psychiatric clinics receive many patients each day; a doctor may consult a dozen patients in one morning. Today, interns and specializing students work regularly with psychologists and devote more time listening to their patients. The hospitalized patient is guaranteed that he or she will see the doctor in charge of his or her case at least once each week, and those who are seen as outpatients are assured that they will see their doctor at least once every three weeks.

The illnesses most frequently encountered are depression, paranoia, schizophrenia, states of anxiety, temporary delusional states, substance abuse, epilepsy, manic depression, chronic hallucinatory psychosis, etc. The principle symptoms that bring people to consultation are insomnia, anxiety, troubles in the night, visual and auditory hallucinations, psychomotor agitation, withdrawal from social situations, mystico-religious delirium, delusions of persecution, mutism, physical asthenia, aggressivity, drug use, suicide attempts, etc.

The team of psychotherapists stands behind all psychological and psychotherapeutic consultations. They guide the ethnopsychiatric endeavor and work to bring western medicine and traditional healing together.

Traditional

It must be kept in mind that over 90% o the population in Senegal first go to a doctor or psychiatrist, quit treatment spontaneously and then consult a traditional therapist.

Well before the arrival of Islam, and the arrival of western medicine, Senegalese interpreted and cared for mental troubles through various cultural and religious approaches.

For instance, one traditional Sengalese religious perspective states that God permits certain beings to be reborn. Their life-death cycle remains a constant process of coming and going. The beings, who are "dead but not really dead" are believed to protect the families to which they are linked from natural catastrophes and ill wishes. LÈbou and Sereer beliefs take into consideration this coming and going. These cultural beings were once considered to be divine, but imported religions put a stop to that. There were once believed to be gods that one would ask for rain, peace, more fish, fewer deaths, or no snake bites. One did not recite verses from the Koran, but used "jutt," permanent words and sayings that kept people in direct relationship with the cultural being. Since Islamization, Arab words have replaced these ancient "jutt".

Ceremonies of initiation and possession are very much a part of the field of mental health. The Lébou organize curing therapies called "ndëpp" around "rab" spirits, and the Sereer organize "pangols." These African belief systems insist that the cultural being (the rab, the pangol, the foley of Niger, the spirits of Benin, Brazil, and Haiti) takes hold of their "fit" (ego) and take it away on a trajectory that is not natural. Incomprehensible gestures and speeches are the result. The healer fixes the "fit" in the ground, at the roots, from where the spirit has come. This preserves the ego and the therapy will permit the person to recover and return thanks to their "calabash (personal carriage) being turned in the right direction". The traditional ceremonies usually take place over the course of several days and follow several steps including the sacrifices, trances, dances, songs and chants, baths, etc.

The Psychopathology of Slavery

Many African people of different ethnicities passed through Gorée, the "famous island" in the Atlantic Ocean off of the coast of Dakar. These Africans, in chains, waited there, in tiny cells for boats that they would be forced to take to the Americas and to the Caribbean. To understand the origin of the psychopathology of slavery we may start from the hypothesis of Doudou Diène, the Director of the Division of Intercultural Projects at UNESCO, which states that many centuries of slavery have not erased the African cultural heritage of the slaves or their descendents because it was *"a fountain of life, the invisible motor and the dynamic force that accompanied the slave and made him feel more powerful than the physical violence he was forced to endure."*

If we accept the hypothesis that this cultural heritage helped the African slave survive, stay alive, and "continually renew himself and draw upon the myths, gods, rhythms, and values," we may infer that this cultural heritage is still alive and well in the diaspora.

If one considers psychiatry to be a science that treats everyone in a systematic and invariable way, regardless of the origine and the itinerary of the individual, will this not mean the programmed disappearance of one of the historically most powerful coping mechanisms of the African diaspora?

Conclusion

Senegalese doctors are confronted with the difficult question of taking cultural elements into consideration when trying to read symptoms. A delusional patient who evokes a "rab" spirit is not considered to be sick by members of is own group.

How can one distinguish the normal from the pathological? Must one rely upon modern nosography and all of the weight it carries with it, or might there be cultural criteria that are specifically African? If we consider that "normal" and "pathological" are categories given from within each culture and differing from place to place, we can then deduce the necessity to

explain the cultural construction of these terms.

Hospital care remains difficult in Africa due to greater and great economic restrictions on families. Payment is important in therapeutic processes, and in our opinion must happen even if patients have no money, because one always has something to exchange. To not make patients pay has implications in the symbolic dimension. When Sigmund Freud took on patients from struggling social classes for no charge, he thought of ways besides money by which services could be paid for. In many cases he asked patients to provide services for him. That is what traditional therapists understood long before Freud, and their methods worked and continue to be effective both on the level of the cure, as well as on the level of payment that can be money or a boubou, an animal, jewelry, etc.

The conclusions and recommendations that stemmed out of the First Pan-African Conference on Mental Health that I organized in March 2002 in Dakar stressed the indispensable and necessary cooperation between western and traditional therapies.

Since the time of Collomb, a patient's family and visitors have played an integral part in the therapeutic process in "pÎnc" (traditional healing) ceremonies. Whereas the hospital today seeks profitability, the traditional therapist, because he lives among the people, looks for recognition, respect, and notoriety.

Which should be chosen?

Traditional psychiatry, if it incorporates traditional healing has many good years ahead of it!

The African Diaspora: Psychiatric Issues in Ghana

Sammy Ohene, M.D. Ghana

Background

Ghana is a tropical country of 18.5 million people (2000 Census) on the West Coast of Africa. The almost exclusively black population consists of different ethnic groups, languages and cultures. The official language however is English. Economically it is relatively poor with a per capital income of about $400/annum. Gold, cocoa and timber exports constitute the main sources of income. Agriculture provides employment for most people living in rural areas. Ghana is a multiparty presidential democracy and runs a liberal free market economy. The people are generally very friendly to foreigners.

Introduction

Like virtually every human community, psychiatric disorders are prevalent in Ghana. A Lunatic Asylums Act was enacted by the colonial administration in 1888 to provide guidelines for custodial care of the mentally ill. Margaret Field in her classic "Search for Security" in the Gold Coast described the role of traditional healers in treatment of mental illness in pre-independence Ghana. Osei A. (1999) - studied traditional healing practices and found psychiatric cases to be among the commonly treated ailments.

The Accra Psychiatric Hospital (A.P.H.) started as a Lunatic Asylum in 1906 with 110 patients, 16 untrained nurses and 1 visiting prison doctor. Modern psychiatric services have been available since then. The Annual Report 2001 of Accra Psychiatric Hospital shows a range of diagnostic categories rather like would be seen in similar hospitals elsewhere. There are no reliable data available on prevalence of Mental Disorders in Ghana generated from public surveys. The closest estimates come from hospital data.

A few observations can be made however:

1. Virtually every DSM IV disorder occurs and can be diagnosed among Ghanaians.
2. A relatively small proportion of people use formal psychiatric services.
3. A considerable proportion including those who have access to formal services go for other forms of therapy - traditional and spiritual.
4. Many people use a combination of all the treatment modalities available.
5. Somatic complaints are the most common presentations of minor psychiatric disorders.
6. Psychotic illnesses are more likely to be seen in psychiatric hospitals than minor or non-psychotic disorders.

Psychiatric illness is strongly stigmatized in Ghana. This may be because of the recurrent or

chronic course of most disorders and the belief that there is no satisfactory "cure". Besides, the ideas people have their own ideas about causation of mental illness.

A popular adage in Ghana translates loosely as: "No matter how well a mentally ill person may be, he still retains the few symptoms that will scare children".

Public Perceptions of Psychiatry

Causation of Mental Illness: Among the commonly ascribed causes are:

1. Evil spirits: brought on by others via witchcraft, ancestral curses etc.
2. Stress: significant 'negative' life events like bereavement or loss marital disharmony, lack of (sexual) partner and "thinking too much"
3. Heredity (genetic): may people recognize the fact that some illnesses are familial.
4. Substance Abuse - There is an overemphasis on abuse of drugs especially marijuana as the cause of mental illness among young people. The media frequently depicts drug abuse as the main reason people develop psychotic disorders.
5. Psychiatric illness is often considered to be synonymous with psychosis.
6. Minor psychiatric disorders are assumed to be due to physical ailments.
7. Many patients with anxiety disorders attribute their symptoms initially to hypertension or heart disease.
8. Similarly somatization disorders and minor depressive disorder are presumed to due to physical conditions like malaria or worm infestation because the patients focus on their somatic symptoms.

The absence of a tangible "cause" intrinsic or extraneous for a mental illness (e.g. underlying physical illness, head injury or heartbreak) is considered highly unsatisfactory. Thus if the doctor does not "know the cause" he's not considered fully capable of curing it.

Treatment Facilities

Three general types of treatment are available.

1. Traditional: Herbal or spiritual via sorcery, exorcism etc.
2. Religious: Christian or Islamic
3. Modern/Orthodox: The available facilities are few and consist of:
    a. Three large public psychiatric hospitals with a total of less than 2000 Beds
    b. Small psychiatric units in the ten regional hospitals and also in a few other hospitals
    c. Two small private psychiatric hospitals with less than 30 beds each

Traditional and Religious healing centers are widespread. Some of their methods are unfortunately primitive and inhumane. Physical restraints with chains, instillation of corrosive chemicals and oral administration of toxic preparations as well as physical beating still characterize their practices.

Religious healers of the Christian faith prescribe fasting, prayers and "deliverance" (from evil spirits) for all types of psychiatric ailments. Islamic healers may prescribe talismans worn on the body or drinking solutions of chalk writings of Quoranic verses washed off a slate.

The location of all three major public psychiatric hospitals, on the coast, two in Accra and one in Ankaful, limits accessibility to people living elsewhere in the country. Many very disturbed patients have to travel very many miles to get to these hospitals. For many people the first port of call is the priest or traditional healer. This is a consequence of:

1. Their beliefs in what causes mental illness
2. Belief in a holistic approach to treatment i.e. covering physical, psychological and spiritual dimensions.
3. Poor accessibility to modern care facilities.

It is not uncommon for well patients discharged from hospital to seek spiritual help for completeness of cure.

Treatment offered at the psychiatric hospitals is based on standard modern practices. The main limitation to quality care is the lack of material and even more so, human resources.

Lack Of Human Resources

There is a severe lack of staff even in the few psychiatric facilities available. Worse still there is continuous migration of the few qualified psychiatrists to countries that offer better rewards.

Ghana has a population of 18.5 million (2000 Census) and has thirteen practicing Psychiatrists. Eight of these are over sixty years old. An ongoing effort to compile a directory of Ghanaian mental health workers indicates at least thirty psychiatrists working outside Ghana, mostly in North America.

The Accra Psychiatric Hospital (A.P.H.) – by far the biggest facility of its kind in the country – best summarizes the manpower situation in its 2001 Annual Report:

Total No. of Doctors	12	(Psychiatrists - 7)
Nurses	261	(Professionals - 143)
Clinical Psychologists	4	
Psychiatric Social Worker	0	
Total out-patient visits:	New - 8,237	
	Old - 26,969	

Diagnostic and Treatment Issues

Many patients manifest stress through somatic symptoms. The commonest ones include:

Headaches

Heat sensation in head

Crawling sensation

Sleep disturbances

Anxiety symptoms - palpitations, sweating, tremors etc.

"Thinking too much" usually implying obsessive rumination.

There is no precise word for " depression" in any Ghanaian language. Perhaps 'sadness' is the closest. Spontaneous expression of depression or sadness as a complaint is uncommon, though many patients will admit to feeling sad when asked directly.

A word common to many Ghanaian languages "Basaa" which loosely translates as 'confused' or "out of sorts", is the frequently used expression by many depressive patients. It appears that there are cultural or religious inhibitions to acceptance of depression or sadness, without reason for many people in Ghana. The answer to the question "Are you sad?" is often "Yes, but only because of these persistent headaches,"

Diagnosis of psychotic disorders does not usually pose a problem as far as signs and symptoms are concern. Patients however tend to present rather late. It is common to see people with florid psychotic symptoms and overt behavioral problems that have been ongoing for many months or years.

It common for unaculturated psychiatrists to assume that a patient expressing the belief that his symptoms are caused by a witch is paranoid. In fact many patients with somatic symptoms that cannot be explained as due to a physical illness fall into this category. Belief in the supernatural in Ghana is common and not necessarily delusional.

Medication

Generally patients who come to hospitals expect to be given drugs for their symptoms. There is also the expectation that the drugs will effect a "total cure". Long term preventive medication is unpopular or unacceptable to many who need it by the recurrent nature or their illnesses. Even in the light of statistical evidence most patients like to believe that their illness will not recur. This view is usually reinforced by religious beliefs and spiritual healers. Ghana is full of traditional healers claiming to offer "cures" for hypertension, asthma, HIV-AIDS, impotence, infertility and mental illness.

The actual response of most patient's signs and symptoms to medications follow predicted

patterns. There appears however to be a peculiarity in how Ghanaians (? Africans) handle tricyclic antidepressants. Most patients seem unable to tolerate anything beyond a maximum of 150mg of Imipramine or Amitryptiline. Majority still respond well to doses between 75 - 100mg, even for severe Depressive illness.

Psychological Treatments

Psychological therapies must take the following into account:

1. The peculiar beliefs in what are considered to be the origins of most illnesses,
2. The expectation of an outright stop to symptoms, and the fact that many minor disorders may manifest with complains rather different from ordinary description.
3. Long term psychotherapy is not a practical option for the great majority since clinical psychologists are very few anyway.

Mental Health Services: Organization and Funding

Public Mental Health Services are currently part of the Ghana Health Services. The Ministry of Health is the policy making department of the Ghana government responsible for all health matters. There is a relative lack of interest of officialdom in dealing with mental health issues. The Mental Health Act of 1972 - N.R.C. Decree 30 is the law that governs mental health practice in Ghana.

Funding Issues

The official policy regarding psychiatric cure has always been to offer fully state-funded treatment to all patients in public psychiatric institution. Admissions are free for any length of stay. Outpatients only pay a token fee for drugs. The amount of money provided is however grossly inadequate and possibly used inefficiently. This is reflected in the availability of medications for example, clinicians being limited to only a few options usually relatively cheaper, older drugs.

Research

Research suffers from a severe lack of funding whilst the service requirements paced upon the very few psychiatrists actually in academic departments put a greater strain. The Department of Psychiatry at the University of Ghana Medical School, located at the Accra Psychiatric Hospital, is the only department of all the clinical departments that is located outside the main teaching hospital.

Drug companies currently do not contribute much money, even for local drug trials, apparently because they cannot guarantee big enough sales for their newer products.

A World Health Organization (WHO) - demonstration project - Nations for Mental Health has however been going on for the past three years in two small semi-rural communities. It focuses on training lay-people, community health workers and a few nurses and doctors in mental health issues. They are taught to recognize psychiatric problems, educate the public and deal with those they can whilst referring others.

Approaches to Solving the Problems

Research Collaboration

Possible areas of interest may include:

1. Effectiveness of traditional and spiritual healing methods in minor psychiatric disorders. Do they apply to Africans in the Diaspora?
2. The epidemiology of psychiatric disorders in Ghana.
3. Why is epilepsy so prevalent in parts of Ghana? (For various reasons epilepsy is largely dealt with by psychiatrists in Ghana).
4. Ethnopsychoharmacology: Drug distribution, metabolism, excretion, etc.
5. Pharmacogenetics

Training Support for Psychiatrists

1. Creation and support of Fellowships for faculty and residents in psychiatric training.
2. Development of appropriate mental health teaching materials (e.g. videos etc. and funding for development of similar local materials).
3. Faculty support in teaching, research and service provision in Ghana
4. Networking with Ghanaian Psychiatrists and other mental health professionals in the USA and other countries, via e-mail, conferences etc.
5. Assistance with procurement of new medications at affordable cost through pharmaceutical industry support.

Conclusion

Africans tend to take a holistic view about the causes and therefore the treatment of mental disorders. Physical, genetic, emotional, spiritual and environmental causes are all important. Intrinsic and extraneous dimensions are believed to be involved, and the spiritual is thought to come from within as well as without, in the form of physical and psychic “assaults” initiated by people that an individual has wronged. (It would be interesting to find out if these beliefs hold true across the oceans).

Significantly, there are numerous issues holding back progress of psychiatry in Ghana. Lack of

resources is the core problem. Collaboration and support from outside will contribute to solving some of these problems and may prove beneficial to all.

The African Diaspora: Psychiatric Issues in Uganda

Emilio Ovuga, M.D. Uganda

Background

Uganda has been brutally traumatized for over 30 years as a result of political unrest, civil war, and continuing armed rebellion. The HIV/AIDS pandemic has imposed its own toll on the population, leaving more than 1.5 million dead. More than 800,000 children have been orphaned by HIV/AIDS in Uganda. Many of the children are poor, cannot afford education and survive on their own as some of them have lost both parents and the traditional family support system has been overstretched. Poverty levels are high, and per capita income of some households is less than the equivalent of US $10, particularly in the rural areas where 90% of the population lives. The national literacy rate averages 67% but this figure is as low as 5% in some parts of the country such as the Karamoja region in the northeast of the country. Levels of malnutrition are high and 32% of the children are stunted. Life expectancy currently stands at 49 years of age.

It is amazing to note how many people in rural areas cope with multiple stressors, difficulties and challenges. The reality, though, is that they cope and survive.

Psychiatry's Problems in Uganda

Against this background, it would appear as though psychiatric problems are not an issue. After all the leading causes of mortality in Uganda are AIDS, measles, diarrhea, acute respiratory diseases, cardiovascular diseases, tuberculosis, cancer, complications of malnutrition and pregnancy related conditions. Thus mental health is lumped together with tropical diseases such as bilharziasis, sleeping sickness, and river blindness disease. No specific budget item is allocated to mental health even within this category. Mental health does not exist in the health management information systems of the Ministry of Health. This is in sharp contrast to the fact that mental health is a component of the country's minimum health care package1,2.

Situation Analysis

The prevalence of severe mental illness in Uganda has been documented. Results from the most recent surveys using the Beck Depression Inventory (BDI) indicate that 14.8% of adult rural populations in two districts of Uganda suffered from moderate to severe depressive disorder. The BDI was interpreted and back interpreted into the local languages of the communities that took part in the study, and pre-tested. A cut-off point of 19 was considered to determine the probable prevalence of clinically significant depression in the community. Eight hundred twenty-two residents of 36 villages in two separate districts took part in the study designed to validate a screening instrument, the Response Inventory for Stressful Life Events (R.I.S.L.E.), which is being developed for use in Uganda. The BDI was used as the gold

standard in the exercise. Fifteen percent (14.6%) of the population reported having attempted suicide at least once in the past five years. Twenty six percent believed that they might attempt to end their own lives in the future. A recent study of 104 police officers in two barracks in Kampala revealed that 20% of the officers were dependent on alcohol with significant impairments on their health, work, social functioning and personal development. Another study of 126 patients aged 60 years and older admitted on non-psychiatric wards of Mulago National Referral Hospital revealed that 48% had psychiatric disorder, notably depression, dementia, and delirium.

The full range of psychiatric disorders as described by DSM-IV are seen, but the most common are affective disorders; unipolar major depressive disorder; anxiety states including panic disorder, social phobia, and obsessive-compulsive disorder; organic mental disorders; alcohol and substance use disorders and schizophrenia. Dissociative disorders frequently occur among girls in girls' boarding schools. HIV-related mental disorders pose special ethical and clinical management challenges. Learning disability is prevalent due to high levels of malnutrition and malaria fever, which are often complicated by convulsions in early childhood. Morbidity due to post-traumatic stress disorder, often masked in physical complaints is prevalent in areas affected by armed rebellion. River blindness disease and sleeping sickness are also associated with significant psychosocial morbidity in affected areas. The existence of dual diagnosis in alcohol and substance abuse has also been documented with 53% of individuals who abuse alcohol and meet diagnostic criteria for schizophrenia, mania, depression or unipolar major depressive disorder.

Therapeutic approaches, which seem to work, include brief focused psychotherapy, cognitive behavior therapy, and group activities such as singing, dance and prayers that help patients to express themselves and experience emotional relief. Unpublished results of an audit of a private psychiatric clinic in Kampala, aimed at improving the quality of care, indicated that the outcome of psychiatric care was good in 80% of patients at six months follow-up.

Factors that predicted good outcome were family involvement in care at home, patient and family being provided information about the psychiatric disorder, its management and expected outcome, and the patient being involved in gainful occupation at work or at home. Factors that were associated with poor outcome included severe neurological disorder, lack of family involvement in care provision, poverty, language and cultural barriers.

Services for the mentally sick are inadequate. There are only eight practicing psychiatrists in the country with a population of twenty two million, and all of the psychiatrists live in Kampala in the south of the country. There are twenty two physician assistants in mental health, but they serve a disproportionately small section of the population.

Because of the inadequacy of modern health care both in terms of quantity and quality, the public seeks care from traditional healers, and churches. Unfortunately those who seek help from churches in pre-psychotic states develop frank psychotic disorders necessitating

hospitalization. Human sacrifice in the treatment and prevention of mental illness has been reported. The level of stigmatization and discrimination against the mentally ill is high; those who are psychotic not infrequently get killed for minor misdeeds that they might commit.

Government Response

Mental health is now an essential component of the country's minimum health care package. An official health policy has been established, and laws regarding the provision of basic mental health care are being included in the country's new Health Services Act, which is being formulated. Within the new arrangement, mental health services will be integrated within the general health care delivery system at district level.

Psychiatry's Response

Psychiatry's response has been to promote the discipline in medical education at Makerere University. The purpose of this has been to portray psychiatry as an integral part of every other medical specialty, and that psychiatry is at the heart of every branch of clinical medicine. Psychiatry is not concerned with teaching madness, but with teaching the art of allaying human suffering and promoting human health through health promotive activities, and early recognition, diagnosis, and appropriate management in primary care.

In line with this thinking, I pursued a vigorous course of action that resulted in psychiatry being taught and examined as a separate discipline from internal medicine from year three of the medical curriculum through year five. The relevance of psychiatry in other branches of clinical medicine is repeatedly illustrated in the course of teaching with many instances in which psychiatric knowledge could be applied in an integrated and comprehensive clinical care. We are lucky in Uganda that these instances are not rare. The numerous cases of HIV/AIDS presenting with frank psychotic disorders, the cases of alcohol and cannabis abuse, epilepsy presenting with psychotic features, sickle cell being complicated by psychiatric illness, and social cultural factors that complicate clinical management are all too common to escape the attention of the medical student.

Over the last one year, the department, under my team leadership, has been involved in a feasibility study to decentralize psychiatric services at district level. The program will involve the training of primary health care providers at a district hospital in each of four districts. The trainers will thereafter be expected to train their colleagues at lower levels of the district health care service. The role of psychiatry will then be to provide support supervision. If successful, the department intends to recommend the development of several levels of mental health service provision from the district level to the village level. It is anticipated that households will be taught skills to recognize the early signs of common mental disorders, and strategies to seek help from the nearest health unit available. Where help for a given problem is not available, the individual will be referred to the next level higher up the referral system where treatment will be

provided. The cornerstone in this approach will be the involvement of families and communities in planning, choice of personnel for training, and the management of individuals who develop mental illness at an early stage. The pay-off from this strategy is the expected demonstration that mental illness is treatable using modern approaches to care, and that the mentally ill can be rehabilitated to resume normal life.

District Response

The districts, which participated in the pilot study have recognized the importance of mental health and have expressed optimism about the future impact of this program. In one example, the civic leadership in one district in northern Uganda plans to promote mental health and prevent mental illness using the following strategies:

1. Train existing health workers in mental health.
2. Establish a separate budget item for mental health.
3. Establish mental health clinics throughout the district.
4. Enact by-laws to curb the uncontrolled sale and consumption of alcohol.
5. Address social factors in domestic violence.
6. Establish a network of community counselors at the parish level to help families and individuals cope with the stresses of daily living, and to prevent suicide in the district.

Psychiatric Issues

Outstanding issues for psychiatric care in Uganda concern the most basic needs of human beings who suffer from mental disorder. Facilities are inadequate in quantity as well as in quality. The public lacks awareness that mental ill health is a medical condition, just like any other health problem, and can be treated. The human rights of those who suffer from mental illness are frequently violated in all spheres of life, including employment, security, custody, care and protection from harm. Laws regarding the care of the mentally ill are outdated and policies targeting the needs of the mentally sick do not exist. Investment in mental health is inadequate, and stands at less than 1%. To address these most basic issues, the following suggestions are made.

Suggestions

1. Training at Makerere University has targeted medical and other undergraduate health sciences students. The aim of this approach has been to enable students to recognize that the management of common mental disorders is their future responsibility, and this management is within their capability.
2. Psychiatrists have been involved in the process of policy reform and development in mental health. There is no aspect of policy, which is not relevant to mental health.

3. Research has aimed to show that mental health is an critical health issue. The issues here include; the impact of mental illness on social functioning, on the ability of an individual for free choices, on the individual's ability to enjoy life fully, on the nation's economy, on lifelong morbidity, and mortality, however small this may be. Further research needs to show that mental illness is treatable, and individuals can become useful members of their communities after an episode of mental illness. Research needs to evaluate the potential usefulness of preserving and harnessing the extensive social support in the African extended family system in the provision of care for those with severe mental illness. Particularly relevant here is the need to elucidate how the disadvantaged peoples of African descent cope with multiple stressors. Research should also aim to identify policy issues relevant to mental health care development.
4. Human rights issues will be high on the agenda in Uganda to ensure that those who suffer from any form of mental illness receive appropriate and high quality clinical care. The living conditions of patients in hospital should be habitable, human, and comfortable. All efforts will be made to reduce mortality from psychiatric illness among hospitalized patients. Avenues will be created to allow patients to raise questions concerning their care and welfare. The role of psychiatry will be to advocate for government commitment to improve accessibility and quality of services and care for the mentally ill.
5. Advocacy for the regular review of laws and regulations concerning the admission, care and treatment of people with mental illness will be a priority. Laws for the protection of the rights of vulnerable groups, such as children, women, prisoners and refugees will be recommended, as these are not in place at the current time.
6. There is need to establish a network of African Researchers and Academicians in Mental Health to address wide ranging problems and challenges facing psychiatry for African descended peoples worldwide. A most pertinent area in point is the fact that African-descended psychiatrists are currently being trained using texts written for non-African patients using concepts, which are culturally not relevant to Africans. *This is not to say that psychiatric disorders among Africans are different in nature. The argument being advanced is that the same disorders, as they afflict members of the human race, do present in different ways in different locations, environments, cultures and social groups.*

   Psychiatry for Africans scattered throughout the world is obviously an area in which psychiatrists of African descent can influence the future development and practice of psychiatry to the benefit of African-descended patients worldwide. The establishment of collaborative linkages between African universities and those in the western world will provide opportunities for students from the developed world to gain experience in African psychiatry. This should enable the student to understand the presentation and origins of psychopathology in patients of African descent living in the western world, and hopefully improve the quality of care provided for African-descended patients.

7. Their respective ministries of Health employ most psychiatrists. This should not interfere with psychiatrists contributing to the development of mental health in their private capacities. For example in Uganda, I have helped found a non-governmental organization, The Mental Healthcare Organization of Uganda (MHOU), to help members of the general public who are interested in mental health, to contribute to the development of mental health services. We have sponsored research to highlight the magnitude of suicide behavior in Adjumani district, and of the burden of alcohol abuse in the police force. We were instrumental in government establishing a Judicial Commission of Inquiry into the causes of the world's second largest mass suicide that took place at Kanungu, southwestern Uganda on 17 March 2000. In addition we have petitioned government to explicitly include a clause in Uganda's new constitution to provide for the rights and protection of people who suffer from mental ill health.

Personal Dream

I would wish to work toward the establishment of a model community-based mental health program with community involvement in Uganda, or wherever the opportunity and feasibility exists, so as to make basic psychosocial services accessible to communities. Strategies for achieving this will include community needs assessment, training of primary health care providers, activities aimed at reducing stigma associated with mental illness, a program for training lay counselors, incorporation of rehabilitative activities to empower patients who have recovered from mental illness to achieve economic independence, and to enhance monitoring and evaluation.

A Fire Tragedy in Kenya: Mental Health Response and Lessons Learnt

David M. Ndetei, M.D. Kenya

Introduction

Many tragedies have afflicted Kenya in its brief history. These include road accidents (over 2000 lives are lost annually on road accidents), air, ferry and train accidents, fires, floods, mudslides, tribal and religious clashes, terrorist and bandit attacks, violent cattle rustling, violence of all forms including armed robberies both in urban and rural areas and also domestic violence, famines etc. More related to this presentation are institutional unrests. There have been many strikes in our state universities and at times lives have been lost in these events. More recently, secondary schools have joined this pattern of behaviour at an alarming rate. This reached a climax in 2000 and 2001, with over 200 strikes reported. Among notable events, are the St. Kizito tragedy in which 19 girls died, in July, 1991, the Bombolulu fire disaster in which 23 girls died.

On the international arena, there have been a number of mass fatality disasters, which have included both natural and human disasters. Recent examples include the Rwandan genocide in which nearly one million people were killed in an attempted ethnic cleansing, multiple mass killings in the Balkans, many terrorist attacks including the infamous September 11, attack on the World Trade Centre and the AP Murrah Federal building in Oklahoma City in the USA among others. Similarly, natural disasters including typhoons, land slides and even volcanic eruptions have resulted in many fatalities. The most recent of these disasters include the volcanic eruption at Goma in the Democratic Republic of Congo, floods in Mozambique etc.

Psychological Impact of Disasters

Over the past decade, Kenyans have become increasingly aware of multiple fatality disasters. Kenyans have lost lives in a number of incidents, some of which have been alluded to earlier. These various forms of psychotrauma have brought a sense of fear and insecurity. In general terms, a sense of insecurity pervades the country in homes, in schools and in our routine duties. There is a foreboding sense of vulnerability. Fearfulness and vigilance have increased.

To be effective, psychological interventions following disasters of all forms require understanding of the traumatic elements of the events. The severity of trauma is measured by, among other factors, the duration of the event, the number of people killed, the age of the victims and the defenselessness of victims. Traumatic impact is also magnified by the fact that some of these events occur by human design. They are deliberate, planned, sudden and completely unpredictable and are aimed at people in defenseless positions. The threat is that anyone irrespective of age, sex or status could be a victim.

The intent in some of these incidences is to demoralize the people targeted and undermine their sense of confidence and security. When groups of people begin to think of themselves as potential victims, you have the ultimate hostage situation. A traumatic atmosphere is created when people feel that anyone can be a victim. Killing people in the course of their day-to-day lives as they carry out the most ordinary of tasks and responsibilities including learning in schools, creates a sense of vulnerability and fearfulness that may persist for a lifetime. It may also put a person at a risk for long term psychological difficulties. For the victims and rescue workers this atmosphere of trauma needs to be addressed with, among others, a psychological intervention. This study and report on a school fire at Kyanguli Secondary School is therefore a pioneering landmark in the study of the phenomena of psycho-trauma and the damage it inflicts on individuals and society, in an African setting.

On the night of March 25/26, 2001, at around 1.00a.m., a fierce fire razed down a dormitory at Kyanguli Mixed Secondary School in which over 130 students were sleeping at that time. The fire killed 67 of the occupants, 58 of whom were burned beyond recognition while the remaining died on their way to hospital or at the hospitals. Others had variable degrees of burns among other physical injuries sustained while either escaping or attempting to help out the others.

The injured were taken to hospitals immediately by the police and volunteers. The bulk of the victims were admitted at the local Machakos district hospital. Due to the severity of the burns, some were eventually transferred to the Kenyatta National Hospital for more specialized treatment. Also involved in the rescue efforts were personnel from the Red Cross Society. When the fire had burned to its own extinction, it was time to take stock of the loss. Parents and students made efforts to recover whatever they could of their lost ones under the dying embers.

Rescue Efforts

The police cordoned off the scene of the fire immediately at dawn and commenced investigations. This was to reveal a lot that was not previously known. Led by the local District Commissioner, and Ministry of Education officials, they began taking stock of the losses incurred. Soon it became apparent that there was poor record keeping; the exact number of students in the affected dormitory could not be established until two days after the incident, and this only happened after a tedious process that included a head count for all the students. Even identifying the dead by names was only possible through a process of elimination; those who survived assisted in identifying the dead. Meanwhile, anguished parents and relatives made the rounds between the Machakos District Hospital, Kenyatta National Hospital, their respective mortuaries, the city mortuary in Nairobi and the school grounds seeking to establish the whereabouts of their children. Meanwhile, the charred remains of the dead were packed into body bags and removed to the city mortuary.

Burial

In the meantime, burial arrangements had to be made. Every parent wanted to have the remains of their children for burial in accordance with their cultural practice. The futility of this wish was soon apparent. Fifty eight of the dead could not be identified positively by any means locally available. They were to be buried in a mass grave within the school compound after prolonged discussions. Ten days after the incident, the remains were laid in a mass grave at a funeral service attended by high-ranking government officials including the Head of State, President Daniel Arap Moi. His presence, by all means, was a great consolation to the community and a source of inspiration and strength to the parents, students and teachers in the school.

Community Response

Soon after the burial and even immediately after the fire, speculations on the cause of the fire were rampant in the grapevine; a number of disingenuous issues surfaced within the community. The fire raged under a torrential downpour; students in the neighbouring dormitories and homes only twenty metres from the burning dormitory somehow did not hear the screams of the afflicted. This opened doors for speculation and to many local people these were interpreted as significant factors concerning the cause and nature of the fire. Some speculated that the fire was the work of unhappy spirits taking revenge on the community for unspecified sins while others thought it was the work of a local businessman who tends "jinis" (evil spirits), viewing it as a blood sacrifice to enhance his business. The fact that the funeral service was interrupted by a swarm of grasshoppers that many of the mourners mistook for bees only served to fuel the speculations further.

General Mental Health Response Strategy

The mental health response following the tragedy was initially scanty and inadequately organized. Only two groups of mental health personnel were available to offer any form of assistance namely; Nairobi Psychotherapy Services and Institute and postgraduate students from the University of Nairobi's Department of Psychiatry and Amani Counseling Centre. The principal author of this report, a professor of psychiatry, visited the school immediately and commenced a mental health management plan for the school community including the parents of the deceased. The plan was three-fold as follows:

I. Debriefing

This followed critical incident management and was done mainly by a group of volunteers from Amani Counseling Centre. This intervention was for the surviving students, the teachers and other staff members and the parents of the deceased students. This and other interventions were aimed at helping them cope with the reality of what

had happened and to give them hope and support to face the reality of the events and focus on the future. Details are given in later sections of this report.

II. Documentation and Collection of Scientific Data

This followed immediately after the debriefing and was part of the counseling provided for the individuals affected in the process. The data was collected using internationally used instruments for measuring stress and grief as well as the level of substance abuse. They were administered to the subjects in three groups and included the following:

1. Children/Students, Teachers and Other Staff:
    a. Incident of Events Scale (IES-R)
    b. SCL 90-R (Hopkins Symptom Check List)
    c. CDI (Children Depression Inventory)
    d. BDI (Beck's Depression Inventory)
    e. SRQ (Self-Rating Questionnaire)
    f. NOK (Ndetei-Othieno-Kathuku)
2. Grieved Parents/Guardians and Relatives:
    a. Prigerson et al instrument for traumatic grief
    b. NOK (Ndetei-Othieno-Kathuku)
    c. SRQ (Self-rating questionnaire)

The team from Nairobi Psychotherapy Services & Institute headed by the principal author, Prof. David M. Ndetei, compiled and prepared the instruments listed above. It involved adequate and thorough preparation including interpretation of all concepts to local language equivalents for those unable to understand English well. The data was later analyzed and the insights gained from the findings are included in later sections of this report. The data was also factor-analyzed in an attempt to come up with short versions that are culturally sensitive and can be used in the future with greater ease and flexibility, while still maintaining validity.

III. Longitudinal Follow-up

Often, people attended to after disasters are left to suffer psychopathology alone and in silence, sometime without hope of ever recovering. Having already established baseline data, it is expected that all those involved in this study will be followed up in the future and any psychopathology noted managed in good time. These longitudinal studies should last for at least 5 years, with yearly cross-sectional documentation of psychotrauma, in order to monitor progress.

Recommendations on Child Mental Health Services in Disasters

1. There is need to encourage more teacher-student communication and vice-versa to avert such tragedies.
2. The number of teachers on night duty in boarding schools should possibly be increased to be able to attend to the large student numbers effectively.
3. More studies are needed to find out the major causes of school unrest and conduct disorders in schools and how to manage them.
4. Presence of child specialists at psychological first aid centers and availability to death notification teams: It is recommended that child mental health specialists be available on site at counseling centers established following mass casualty events involving children.
5. Involvement of child mental health specialists in planning and response: There should be active involvement of local professionals in developing mental health disaster plans, and in all aspects of assessment and service delivery planning for children's services and program evaluation.
6. Preparation of school mental health disaster plans: Clearly a large number of children are exposed to mental health stress other than during disasters. These include academic and family stress and drugs/substance abuse. These children will require counseling and support from people they trust. It is important to organize workshops and equip schools with the basic knowledge and skills in order to implement a counseling/mental health response.
7. Crisis counseling grants: Government-funded or donor-funded crisis counseling projects need to make appropriate provisions for services to children both in the schools and in the community at large. Staff should not only include professionals, but also child specialists skilled in both the planning and execution of the programs. Schools play a critical role in helping children recover from disaster and community - wide trauma.

   Mental health clinicians can work with entire classrooms at a time, individual students, parents, school officials, teachers and school counselors. Teachers and counselors can be provided with brief training on how to conduct classroom exercises and how to identify children that should be evaluated to determine the need for further professional mental health services.
8. Long-Term Care: The exceptional psychological impact on children experiencing mass casualty and terror events needs to be better recognized and provided for through effective interventions. The death of children increases the incident's impact on children and adults alike. There is a need for well-planned, adequately funded, long-term, developmentally appropriate mental health disaster services for children. Substantial efforts are needed to provide for the long-term needs of the children affected.

9. Links between research and services: The scientist/practitioner model, which lies at the heart of much of psychology, recognizes the need for linkage between research and the provision of services.

   Needs assessment studies provide information on the numbers and locations of people needing services and the nature of the services they may require. Program evaluation provides information regarding the quality of services provided. Treatment-based research has the capacity to evaluate the relative merits of different techniques for the provision of services. These types of research are critical to the service provider to ensure that those in need receive the most effective treatment possible in an efficient manner. The government of Kenya and donor- funded crisis intervention programmes need to communicate actively with researchers studying the aftermath of the disasters that necessitate the crisis intervention program, learning from researchers in the immediacy of the moment.

   Therefore, there is the need to fund the critical work of the researchers, allowing science and practice to work together as a refined team and maximizing the value obtained for the funds expended in these efforts. Without research-based evidence for our clinical practices, there is a high risk of institutionalizing non-effective or even dangerous interventions, no matter how many resources are expended on unevaluated interventions.

Recommendations for Services to Teachers and Support Staff

1. The curriculum for teacher training should be reviewed with a goal of having it include management of disasters. Teachers should be well versed with basic knowledge and understanding of counseling principles would go a long way in assisting them handle their students' minor psychological problems. At the minimum, there should be a trained counselor permanently attached to every school.
2. The Ministry of Education should introduce ongoing in-service training programmes for the teachers and professional school counselors.
3. The Ministry of Education should formulate and enforce minimum requirements for teachers, especially insisting that teachers reside in school especially during the period they are on duty.
4. Taking into account the stresses experienced by teachers, their employers should make counseling services available for them at all times, if they are to remain useful, efficient and productive. Mental health services of all forms should similarly be offered to them on a continuous basis.
5. Efforts should be made to improve teacher-student relationships and to resolve conflicts at their inception through open dialogue. Kenya has, at its disposal, a model in one of the world's top most schools, located not so far from the city center of Nairobi. This model works!

Recommendations for Providing Services to the Bereaved Parents and Guardians

1. Well-wishers could provide funds for the parents to enable them be attended to and assisted to overcome their psychological difficulties in forums and ways sensitive to their special needs, and therefore acceptable to them. At the moment, there are professionals willing to help them, but there is a general lack of coordination and lack of funds available to assist the parents. NPSI, which has voluntarily provided this service so far, cannot continue much longer, except to provide token support.
2. It is also important that the number of available mental health personnel be increased. This would be achieved mainly through the training of volunteers to offer limited assistance to the parents and identify those requiring referral to more professionally trained personnel.
3. There should be a well-organized way in which the parents will be followed up and assisted as a group to overcome the subsequent psychopathology arising from the tragedy.
4. These parents also need some form of self-help support groups to at least boost their hopes that their children did not just die in vain, and to assist them in their own recovery as well. They could organize themselves for income generating activities. This is perhaps their greatest hope for a healthy recovery.

Recommendations on the Role of the Government

1. There is a great need for a clear and focused national mental health services response to mass casualty and disaster situations. It is essential for the government to have an integrated national mental health disaster plan to coordinate mental health response efforts with available emergency response organizations and local volunteers in time of disaster. The plan should ensure efficient, coordinated, effective response to the mental health needs of the affected population.
2. There is a need for local/regional disaster mental health plans: It is strongly recommended that each administrative district establish a Department of Mental Health with a disaster response plan that is an essential component of their overall district emergency management plan. They should identify points of contact (individuals by position) and develop procedures and protocol and train mental health personnel in disaster management.
3. There is a need to develop a comprehensive disaster mental health plan: The plan should include all government departments at every administrative level. It should be a well-integrated component of a comprehensive emergency management plan. The mental health plan must also specify roles, responsibilities and relationships within a mental health emergency framework.
4. There is a need to create an awareness of the existence of disaster mental health plans

within the general population: The services should be available at the site/scene of the disaster, hospital, first aid centers and any other place where the victims may be taken.

5. There is a need for ongoing training of mental health personnel in disaster preparedness, coordination of resources, policies and procedures: The knowledge of existing resources and their coordination should be taught and frequently rehearsed in earnest. Though disasters cannot be planned, the aftermath and destiny of survivors victims can be planned. Lives can be saved and given a semblance of normalcy only if planning and coordination are well done; prior planning prevents poor performance.

Recommendations for Mental Health Personnel in Disasters

1. The mental health personnel should come up with a formula on how to handle disasters. They should emphasize appropriate steps in the mental health response with clear details of each step to be followed in situations that may arise. Above all, the plans should emphasize teamwork with a clear hierarchy of needs and activities to be carried out.
2. All volunteers should be screened before being allowed to offer any mental health services. They should be asked to show proof of relevant training and have proper legal identification documents. All unqualified persons should be barred from offering any services and even accessing the survivors. Their interventions could have negative effects.
3. The mental health professionals should liaise with the government and have all the relevant groups of professional registered with the relevant government agency. They should also formulate a clear policy of association/cooperation with the government to avoid any conflict of interest between them, as well as rid themselves of any quack agencies.
4. Mental health professionals should lead the way in training the relevant personnel at the institutions of learning, including teachers, to offer limited basic counseling services. They should similarly offer refresher courses in times when there are no current emergencies. This will reduce the sole dependency on the few qualified personnel without compromising the standards of services offered.
5. Basic tools for research and psychotrauma assessment should be availed to all mental health workers. They should be adequately trained on their application and interpretation including follow-up of the patients.
6. Avenues should be opened for adequate funding of all genuine mental health programmes. They should be equipped with relevant resources including computers and relevant data analyzing packages.
7. Mental health workers and volunteers in times of disaster should remain professional and leave press liaisons to administrators. It impacts negatively when they appear to seek the limelight.

Recommendations on the Role of Clergy in Disasters

There should be a clergy organization, training and disaster plan: They should be able to organize a response team with guidelines for membership, screening, mobilization, training and establish parameters for delivery of appropriate ministry services in time of disasters. The clergy disaster plan should try to align itself to the emergency response plans of the local districts, nationally and with other responding agencies.

The Role of Volunteers in Disaster Mental Health

The large number of volunteers that simply show up should be screened using a standardized format. Such a form should include basic demographic information, e.g. name, address, phone numbers, gender and language spoken. Additional information would be the highest qualification and experience in the field of practice, employment and address of employers etc. including trauma related and clinical experience where applicable.

The Role of Media in Disaster Mental Health

The media, including both print and electronic were instrumental in dispatching the information to the rest of the country and therefore summoning help that was needed at the time. The information was broadcast on the local radio and TV stations and appeared in all the local daily newspapers. While the media did an excellent job of informing, the same cannot be said about allaying of fears among the members of the public. While some reporters were giving good and informative coverage, others formed alliances with the rumour mills peddling falsehoods bordering on superstition and probably ended up creating greater psychological anguish to the bereaved persons.

The Role of Documentation and Research in Disasters

This cannot be over-emphasized. Documentation and research enable future follow-up and evaluation. The need for appropriate instruments is vital. NPSI is in the process of refining such instruments.

Transition from Immediate To Long-Term Disaster Mental Health Services

The transition from immediate to long-term care during and following large scale disasters is a complex process, usually involving different groups of providers with different levels of expertise, training and preparedness.

Helping survivors is best understood in the context of when, where and with whom interventions took place. The temporal dimension may be broken down into emergency phase, the post-impact phase and the recovery phase. Different groups are involved at the different phases. The post-impact and recovery phases are usually served by the community, private agencies and independent practitioners in organized societies. There is therefore a transition period in which the delivery of mental health services transfers from one provider to another.

Following the Kyanguli tragedy, there was a lack of organized mental health response on the part of the government. For follow-up care, those affected depended on the Amani Counseling Center and Nairobi Psychotherapy Services and Institute (NPSI) which mobilized volunteers and undertook documentation.

As indicated in earlier parts of this report, all groups of persons seen were assessed using standardized questionnaires and the extent of their trauma noted. This form of approach is best since the same instruments could be used in the future to assess the effectiveness of the services offered. It is worth noting that prior to this initiative of the NPSI, no organized forms of mental health assessments had ever been carried out in Kenya following any of the many disasters that we have witnessed with the exception of the Nairobi American Embassy bombing four years ago. And so far no public reports have been availed from their documentation.

This is therefore a ground-breaking effort. The future of interventions of this nature will surely be sharpened by the outcome of this effort. Frequent reports of this nature will be important in the education of both mental health personnel and the public on the importance of a mental health response following disasters.

The only river between us and these noble objectives is dire lack of funding; a *"bridge of hope"* must be built across this river and only people of good will and intentions can do this.

The future lies on shaky grounds without timely and adequate resources in terms of both personnel and funding. If funds had been available, this report and other scientific reports would have been ready 12 months before now.

Conclusions

Following the Kyanguli fire tragedy, mental health response was immediate but scanty and poorly coordinated. Different groups of people availed themselves with good intentions of helping, but only few were of genuine value to the survivors of the tragedy. While the volunteers need to be commended along with members of the media, it must be pointed out that some of them may have unintentionally worsened the situation.

Several of the recommendations made cut across the board:

1. Mass fatality disasters are different from other disasters with a more extreme psychological impact. The severity leads to more immediate and long term traumatic stress reactions. Disaster plans need to provide for all the probable consequences.
2. Immediate response crisis programs are essential to help survivors through the period following a disaster. It is important to have qualified and available personnel doing this job for it to serve the appropriate purpose. There should be a clear and precise line of supervision for inexperienced volunteers.

3. Long-term response needs to be planned for and implemented. It is capital intensive and adequate funds must be availed for this. Failure to follow-up clients would be a failure of the whole mental health response plan.
4. Research is an important aspect of any response. Scientific methods must be used to create proper linkage between research and service provision. Need assessment studies provide information regarding the numbers and locations of those needing services and the nature of services required. Program evaluation provides information regarding the quality of services provided. Research evaluates the relative merits of different techniques for the provision of services. This type of research ensures that those in need receive the most effective treatment possible as efficiently as possible.

For example, from this study we were able to make evidence-based reports as follows:-

1. It was wise not to relocate the school or the students.
2. There was a need to evaluate critically the effectiveness of intervention methods routinely used.
3. Drugs were not a significant factor in Kyanguli School Fire Tragedy, but other problem issues emerged.
4. It is possible to effectively document psychotrauma. The research instruments adopted and adapted in this study can be used easily in other parts of Africa.
5. The people most hurting were the bereaved parents/guardians, followed by the teachers and staff, and finally the children.
6. There was a very high level of psychotrauma in the general population, before and after the fire tragedy.
7. Our traditional social support system is our biggest resource.
8. There is merit following up of with all of the subjects included in this study, plus others not initially included (siblings of the deceased children and parents of the surviving children) for the following reasons:
    a. This is the first reported study of its kind in Kenya and is representative of other tragedies.
    b. The study has baseline data.
    c. The study forms an excellent study case cohorts whose findings could be used in other tragedy situations.
    d. Most importantly, this report forms an initial effort and merely suggests a basis for a structured approach to future discussions and improvements on the mental health aspects of dealing with tragedy.

The Psychopathology of Acculturation
Mohamed Zitouni, M.D. Morocco

To be born is to be born into the discourse of the parents, of the nuclear family, of the extended family and therefore of the social corpus. To be born into the life of parents living in extreme circumstances is, (as in the case of colonized parents), at the very least, a source of discordance, of division, of vexation for the child. So the child, from the start has the alternative of being born to fulfill his life, or to stray towards survival, living a lesser life , in short to accept himself as an inferior being, a lesser being, different from the masters, the colonizers. Such was the case of our coming to existence in North Africa.

So being born threw us into a split world, comprehending on one hand the Arab town, ours, on the other hand, the European town. Our houses built on stilts, generally not whitewashed, narrow and small, did not allow for children playing and blossoming. Right in front of us, the vision of luxurious European houses with sophisticated and exotic layouts, green and flowered spaces, left us frustrated and devoured by envy.

At night the difference was even more noticeable: our streets and our houses sank into darkness for lack of electricity. Evil spirits called 'jins' co-habitated with us in the dark corners and recesses of our homes. Across on the other side, the new modern town, the European town, was lit up and was often the place of elaborate celebrations. Our insomnias and our fears led us to dream of going there, to switch places with the "one across", without ever knowing that their place was indeed ours.

Eating is a word that changes meaning and taste, according to where we were born. At home, mint tea, stale bread occasionally dipped in olive oil, tomatoes, eggplants and wheat flour soup constituted our culinary program. Meat was reserved for the days of the 'Souk' (weekly market) and especially for the lamb holiday commemorating Abraham's sacrifice. The majority of inhabitants were Moslem. Jews shared the same nutritional conditions as the Moslems with the exception that they had access to 'eau de vie' (home made liquor prepared with figs).

No allowance was made for sport or leisure. At an early age, the male child was put into Koranic school where classes started at dawn. The 'Fquih' (teacher) hastened our awakening with lashing strokes of long flexible reeds, which whistled pass our ears when they didn't coil around them causing a sharp pain. We had to learn by heart what we had written on a polished wooden board under the Fquih's dictation. Errors of memory brought upon us the 'Fakala' (several strokes on the soles of the feet held in the air by our school mates).

Modern school was considered mandatory, wherever one could find it. School was for us the first living experience of immigration. It was a real place of exile. Everything was different: the white-washed classrooms, the chairs, the tables, the windows, the big black plank called black board and especially electricity.

There, at the school, one spoke French, a different language than the one spoken at home and at the Koranic school. And moreover, one wrote from left to right whereas until now it was from right to left. French words had a strange ring to them. It was a real phonetic and linguistic trauma. I have used the words psychic trauma, exile and migration, because going to school threw us into a new, different, strange and threatening world, that was also compelling and even fascinating.

And when one is fascinated one doesn't see anything for what it really is. We were fascinated by the different way of dressing of our teachers. Our parents and ourselves often walked barefoot and wore the djellaba or gandoura and our skulls were shaven, (preferable because of lice), whereas our teachers wore pants, shirts and shoes. We discovered a different way to be in the world through the clothes of our teachers. We often stared at their shoes, their ties and (goodness!) at their eyeglasses. At home there were no eye glasses.

So from the start we were put into an in-between existence: between two worlds, two injunctions, between here and there, between the ancient (ours) and the modern (theirs), between them and us. What marked us most was that we had come out of a lesser world, poor, filthy, without light or glasses. We felt that we were behind from where they seemed to be, in short we were objectively lacking in our daily lives. To our envy of the rich and dominating whites was added hatred for our own, developing in ourselves a vague feeling of insufficiency, trouble with self image and dissatisfaction with oneself, and even lacking in an understanding of our place in the world.

Lack of adult role models being available to the child leaves him prey to an identity crisis, with narcissist wounds and compensatory inflation, with feelings of frustration and dissatisfaction with oneself. In daily life this is manifested by difficulties in learning, school failures, behavioral troubles, paranoia and leads to a life experience based upon persecution, permanently unfulfilled desires, hypersensitivity, aggression, excessive behaviors, criminality, inhibition, withdrawal and, self- confinement in religion as a result. The quest for identity frequently turns towards the archaic.

At the psychiatric level and from our experience (20 years of practice) we can outline certain characteristics:

Frequent types of reactive psychopathology:

1. Depressive and often chronic reactive states (note the importance of accumulated frustrations transmitted generationally from mothers to children).
2. Acute anxiety and panic attacks in response to events experienced as frustrating, resulting in chronic anxiety states.
3. Relapsing acute psychotic decompensation.

4. Sleep disorders with nightmares, insomnia, aggressiveness and hypersensitivity reminiscent of the typical case of PTSD.
5. Use of the body as means of expressing psychic tensions and conflicts, with expresso-emotive crises, conversion and somatization and behavioral troubles with addictive behaviors (alcoholism, drug abuse, compulsive shopping and the strong need to consume for those who can afford it).

Treatment of this level and variety of psychpathology requires an efficient approach to psychotherapeutic care (which necessitates specific training), and demands full acknowledgement and appreciation of the traumatic effects of cultural invasion and acculturation. To be geographically deported, or to be colonized and therefore "deported at home", and deprived of one's freedom, produces in different degrees a narcissistic wound and an identity crisis.

Psychiatrists having cultural ties with deported or colonized Africans have a lot to gain from exchanges and comparison of the results of their clinical and research work. To get organized, to meet and exchange knowledge and experiences drawn from their practice with people of their own background, is not just a narcissistic desire but rather a genuine need in order to increase the efficiency of their daily clinical activities. Similar suffering unites mankind and puts us as psychiatrists at risk for approaching the experience of the patient through projective identification. To talk about these transference and counter-transference issues with experienced colleagues will enable us to keep some therapeutic distance and be better able to manage these tendencies, and hence to preserve professional neutrality. This "opening of the frontiers of knowledge" for those who have acquired it in a cultural context different from theirs own, will have the goal and the intention of helping them to adapt to the socio-cultural reality of the patient.

In summary, let's work towards a sharing of knowledge and its development from within, while avoiding its management from the outside.

The African Diaspora and Psychiatric Issues: The Fiji Perspective

Peni Moi Biukoto, M.D. Fiji Islands

Introduction

Man is a complex creature whose character is moulded by biopsychosocial forces. I believe that the major influences on a person are the social forces (eg. culture, religion, community laws, etc.) exerted on the individual during development. The perceptions and psyche of a person can be an outgrowth of these social forces. The native Fijian is not an exception.

Geographically Fiji lies at the border of the Polynesian, Micronesian and Melanesian regions of the Pacific. The culture, language and physical characteristics of the Fijian reflect in part those of its Pacific neighbours. Early historians mention an increasing Polynesian influence and a decreasing Melanesian influence as one traveled from west to east across the Fiji Group. They also mention the differences in physical build and skin texture between natives living on coastal or small islands with highland tribes. These differences are not as distinct now due to increased intermarriages between natives and other racial groups making a home in Fiji.

About Fiji

Fiji has a population of about 800,000 people. It consists of 332 islands of which a third are populated. It has a landmass of 18,333 square kilometres including two main islands Viti Levu (10, 249 square kilometers) and Vanua Levu (51,559 square kilometers). Current GDP per capita is around US $1,700 per annum. Over 90% of adults can read and write. Life expectancy at birth is 68 years, infant mortality is 22 per thousand, crude birth rate is 24 per 1,000 and crude death rate is 5 per 1,000.

Fiji is a multiracial and multicultural society. Native Fijians and Indo-Fijians (descendants of Indian immigrants) form 50.8% and 43.7% of the population respectively (1996 census).

History of the Fijians

Fragments obtained from 'meke' (dances) and poetry recount a convoy of immigrants led by three chiefs; Lutunasobasoba, Waicalanavanua and Degei landing on the west coast of Viti Levu at Vuda (our beginning, our source), after traveling from a land in the far West.

These were remnants of the sea migration after members of the party had settled in unnamed lands to the west on their journey eastwards.

A cyclone at sea scattered the remaining vessels and blew for thirty days. During the cyclone a treasure chart 'kato ni mana' (literary meaning "chest of miracles" or "chest of blessings") was lost overboard near an island now called Mana Island situated along the west coast of Viti Levu.

The party beached at Vuda on the west coast of Viti Levu near Nadi (the current site of the International Airport) and made their voyages along the coast and overland towards the eastern end of the group.

Old pottery and artifacts excavated by archaeologists in Fiji (on Viti Levu) have been dated back to 1290 B.C.

These are speculations of the original departure point of the migrants being located in the African subcontinent. The current President of Fiji, Ratu Iloilo the Tui Vuda, has been quoted at the recent ACP summit meeting (July 2002) held in Fiji as referring to Africa as the land of departure.

About Fijian Religion

The Fijian settlers believed in ancestor gods 'kalou vu' and in the spirit world. They believed that gods could reside in inanimate and animate objects and revered such objects. They believed that the gods communicated with men through anointed priests (hereditary), animals (or totems) and other aspects of nature.

They believed that spirits and man co-exist on a daily basis and an that afterworld 'bulu' existed for spirits of dead persons. The wives, servants and appointed warriors and personal articles are buried with the chiefs to accompany them to 'bulu'. A violent death in life ensured quick passage to paradise 'burotu'. A natural death meant having to undergo tortures from evil spirits on the journey to 'burotu'.

A Fijian's way of life was guided by his fear of the spirits, his fear of the chief and his status in the society. His behavior was also guided by his perceived need to satisfy the demands of the spirits and the clan or chief.

About Fijian Culture

The traditional Fijian society is an autocratic society with the basic unit being the clan ('mataqali'), an extended family with paternal links to a common male ancestor. Each clan had a designated duty towards the paramount chief. For example, the warrior clans ('bati', literally "teeth"), the spokesmen ('matanivanua', literally "face of the land")

It was a communal system with the Fijians loyalty first to his clan and his chief.

The interaction between members of the clan and outsiders were determined by customary codes of conduct. The conduct displayed towards another depended on:

(1) Common ancestry or gods ("tauvu")

(2) Maternal linkages ("vasu")

(3) Tribal functions (eg. "bati")

(4) Blood kinships (conduct differed towards maternal and paternal relatives)

(5) Social status (chief or commoner, tributary or paramount)

(6) Seniority in age

The culture is closely interwoven with the religion and each has meaning only when viewed in the context of its counterpart.

Arrival of Christianity

The first major influence on the Fijian psyche, individually and as a community, can be traced to the arrival of Methodist missionaries heralding the arrival of Christianity in 1835. The conversions occurred individually but mostly on a communal basis. For example, whole villages and provinces were converted to Christianity on the conversion of the chief, Ratu Cakobau, in 1854.

The adoption of Christianity saw the disappearance of the old religions in parts of Fiji. Some Fijians formed cults composed of a synthesis of their religions and Christianity eg. the Tuka cult. The adoption of Christian beliefs necessitated changes in the thinking and attitudes of Fijians. Wars and cannibalism ceased, and temples, totems, etc. were abandoned over time.

Some clans lost their functions (eg. warrior clans, priest clans) and maintained the functions in name only. Early historians record a low prevalence of law breaking in the early history of the new colony of Fiji (i.e. from the late 1800's to the early 1900's).

The advent of Christianity though causing changes in the Fijian way of life helped preserve the communal structure in the society. Christian fellowship programs simply strengthened or latched onto links already pre-existing in Fijian villages and provinces.

Arrival of Industrialization, Physical Science and Capitalism

As the need for the benefits of western civilization increased (eg. clothes, housing, electricity, medical care), the Fijian increasingly turned to formal education in the sciences and human arts studies.

The arrival of Indian indentured laborers (Girmityas) in the late 1800's and early 1900's also necessitated changes in the general attitude of the Fijian in order to adapt to the presence of a foreign culture and religion.Industrialization and need for formal education produced the effect of increased urbanization and increased prevalence of urban squatter settlements (see Table 1).

The pressures of urban life, the diminishing influence of chiefs and clans, and the increasing dependence on a money economy has greatly encouraged the spirit of individualism amongst Fijians. The individualism may have been encouraged from a personal need for economic survival and deterioration in social support networks that were inherent in the communal way of life.

TABLE 1: URBAN POPULATION / YEAR

YEAR	URBAN	RURAL
1966	33.4	66.6
1976	37.2	62.8
1986	38.7	61.3
1996	46.4	53.6

Source: 1996 Population Census, Bureau of Statistics

The Psychological Makeup of the Modern Fijian

The modern Fijian native is a product of the pre-Christian beliefs and customs, the Christian influence and the age of capitalism, industrialization and science. It is not unusual for a university graduate in science to acknowledge and express beliefs in old customs and religious beliefs with conviction.

The early literature about the character of native Fijians was written by colonialists. The observations were often based on their anecdotal experiences with natives within their employ. Thus these early observations though useful for posterity were limited by several factors: (1) lack of scientific technique, (2) cultural bias of the observer, (3) very small sample size, and (4) pre-existing preconceptions of the mentality of native Fijians.

The recent studies in mental health done in Fiji over the past 30 years are limited in sample size, and focused mainly on clearly delineated clinical outcomes like suicide. No study has attempted to explore the effect on the Fijian as an individual and a community of the changes that accompanied the above stated socio-cultural shifts.

Advent of Mental Health Services

The Fijian originally viewed the mentally ill as being: (1) either cursed through infringement of taboos by ancestors or a personal infringement, (2) possessed by
a spirit being, (3) individuals with lost spirits. Unfortunately, there is a dearth of statistics and studies on the symptoms prevalent amongst the mentally ill during the colonial periods.

The historical literature says little about suicide and institutionalized mental disorder among indigenous Fijians (Leckie, 2001). It was assumed that problems were handled at the tribal level.

Fiji was ceded by the chiefs to Great Britain in 1874. In 1884 the colonial government founded the Lunatic Asylum (see Appendix for complete history) now called Saint Giles Psychiatric Hospital. Native Fijians were sent to the Lunatic Asylum as a last resort when their families or communities refused or could not provide care (Leckie, 2001).

Supporting evidence of insanity in the early history of St. Giles Hospital were transgressions of

the local codes of morality, toleration of violence and defiance of customary codes (Leckie, 2001). For example, a male Fijian villager was committed in 1903 and his transgressions included having "walked upright and spoke freely in defiance of Fijian etiquette before the Roko. . .entering stores and helping himself to goods, entered before bulis and eating food prepared for them".

Introduction of Universal Diagnostic Criteria

The use of the International Classification of Diseases (ICD-10) was started in 1996 at the St. Giles Hospital. The DSM Criteria was used prior to 1996. Problems were often encountered by the clinician when interpreting expressed beliefs and perceptions as "delusions" and "hallucinations" according to the criteria.

This problem is compounded by the current situation where Fijians by virtue of their educational background, religious beliefs and developmental influences etc. have begun to form subcultures of beliefs. For example the current generation, raised mostly under western influence, have begun to look at old beliefs still adopted by age peers raised in the villages as delusions. There is so much intermixing of experiences and beliefs within a community that it can be difficult to separate odd or abnormal experiences from an accepted belief. Also, the native Fijian also is reticent about discussing their beliefs in the face of a "scientist". It is especially so when their beliefs face the risk of classification as delusions, figments of the imagination or products of an overactive mind.

Problems Facing a Practicing Doctor in Psychiatry

As a Fijian doctor working in a mental hospital, a common problem frequently encountered in defining symptoms as delusions and hallucinations is the presence of a significant overlap between clinical symptoms and culturally accepted beliefs.

1. For example, passivity phenomenon may be diagnostic of schizophrenia, but it can also be part of the psyche of a spiritual or religious person. There may also be claims of being controlled by the Spirit of God or a demon.
2. My own cultural and religious background engenders a personal belief in the existence of a world of spirit beings. I believe that a God who is spirit exists and that a devil spirit also exists. I believe that a human by choice can be under the control of demons or under the control of God. I believe that demonized persons can be "normal", or exhibit abnormal behaviors that may lie within the field of psychiatry.
3. I also find myself at times having to adhere to criteria set forth in ICD-10 for the purpose of obtaining a diagnosis, but personally retain doubts about the stated beliefs of the patient being truly delusional or hallucinatory in nature.

These conflicts are evident within the population by their persistent habit of resorting to

traditional methods of healing, sometimes to the detriment of the mentally ill. They generally adopt the explanation of biopsychosocial causes with varying degrees of acceptance, but ultimately consider cultural and religious causes as being of greater or similar import.

Recommendations

1. The conduct of research to assess the dominant beliefs within a culture or people and their prevalence. The research data may be reviewed at regular intervals, say intervals of ten years, to keep pace with shifts in community beliefs. In a world where mental health professionals are pursuing careers outside their home countries, such data would aid with further research and in clinical work.
2. The exchange of ideas on ways to improve patient compliance and management when religious and cultural beliefs appear to be the major hurdles to management.
3. The conduct of research to assess the general perceptions of a community or people and their relationship to the symptomatology of psychiatric disorders.
4. The conduct of research to assess the general perceptions of a community or people and the associated coping strategies to internal/ external stresses placed on the community, either individually or as a group.

Conclusion

1. Psychiatry in Fiji and associated research is still in its infancy. The country suffers from a lack of research often due to the unavailability of funds. We depend on research done in other countries with different populations and cultures to formulate management strategies in our country.
2. We need local research data on the cost-effectiveness and cost-efficacy of management strategies.
3. We operate often times on assumptions based on research done in other communities with different socio-cultural and religious backgrounds and genetic make-up.
4. We are generally ignorant of the underlying general perceptions of our own communities towards their environment and their coping strategies in the face of rapid change.
5. We need to understand the mechanism or the association between the community's perception, its coping strategies and the symptomatology manifested when the community or individual fails to cope.
6. I wish to see local psychiatrists become less dependent on anecdotal experiences and more reliant on data collected from community-based studies in their own country to formulate relevant management strategies and improve the diagnosis and treatment of psychosis.

Psychiatry in Papua, New Guinea
Uma Ambi Siva, M.D. New Guinea

Introduction

Papua New Guinea (PNG) is an independent nation in the Pacific region. It is located due north of Australia. It is made up of a main island and about one hundred smaller islands in the Bismarck and Solomon Seas, to the north and east of the main island.

The projected population of PNG is about 5.1 million in 2002. The total land area is approximately 463,840 square km and population density is eight persons per square kilometer. Only about fifteen of the population is urban, the average household size is 5.4 persons and 45.1% of the population are literate. There are approximately eight hundred and fifty native languages spoken.

Politically and administratively, Papau New Guinea is divided into 19 provinces and a National Capital District. Since 85% of the population live in rural areas, the provision of services to the rural areas is constrained by difficult terrain, poor infrastructure and the geographic dispersion of the rural population.

PNG is a developing Pacific nation with an economy largely based on primary agriculture and the mining industries. According to the 1993 World Bank estimates, more than 30% of the Gross Domestic Product (GDP) is derived from agriculture.

Healthcare Delivery Systems in PNG

In PNG, disease patterns are still dominated by communicable disease. The Government emphasizes promotion of healthcare and preventive measures while attempting to ensure an adequate provision of curative services to the scattered population.

As we have seen, the overwhelming majority of PNG people live in rural areas. The health services to these people are provided by both the government as well as church mission agencies. The government provides most of the health services, although the churches are an important partner, particularly in the provision of rural health services. Churches administer almost half of all rural health services. They employ 16% of the health workers in Papua New Guinea. They also are important contributors to the training of rural health workers.

Health services in PNG are comprised of three (3) distinct systems:

1. Public Healthcare System
2. Private Healthcare System
3. Traditional Healthcare System

As in other developing countries, these systems complement each other. In a developing country such as PNG, this is a desirable situation.

Public Health System

This system refers to those services which the Government and the churches provide and which address the main health problems of the community. It includes promotive, preventive and curative services. This system aims to be as close to the community as possible and as universally available as possible. This system is characterized by the following services:

Health Centres: These centers are the bases from which a fairly comprehensive health service is delivered to the population of a specific health district. The average population served in each Health Centre is 10,000 persons, with approximately 500 inpatients and 20,000 outpatients seen per year.

Health Sub-Centres: These are institutions which provide service to approximately 7,000 people, with approximately 400 inpatients and 15,000 outpatients seen per year.

Aid-Posts: The aid-posts provide a basic level of health care for an identified population of approximately 3,000 persons.

Urban Clinics: The urban clinics offer outpatient care for adults, children and pregnant mothers. The services of urban clinics are closely linked with the outpatient departments of the local hospitals.

Secondary Health Services: These are hospital based services; services that are primarily responsible for the provision of comprehensive diagnostic and curative services, in support of the primary healthcare services.

In 1989, PNG had the following facilities:

19 Hospitals

32 Urban Clinics

192 Health Centres

279 Health Sub-Centres

2,325 Aid-Posts

These facilities reflect the genuine attempt of the nation, to provide services which effectively address the main health problems of the community.

Church Health Services

Historically, the missions and the churches have always played an important role in health work of most nations – especially in rural areas. In PNG they have trained nurses since 1894 and have played an important role in the provision of health care, particularly in the areas of curative medicine, maternal health and child health.

The Private Healthcare System

The private healthcare sector is small, but growing. This growth reflects the increasing number of citizens who are able to pay for services and choose between the quality of service in the public and private sectors.

In 1989, there were sixty one medical practitioners in private practice which is approximately 25% of all medical practitioners in PNG. The medical practitioners in the private sector provide mostly general medical and obstetric services. They may also sell prescription drugs if there is no general pharmacy close by, and conduct simple laboratory tests.

Private doctors refer patients requiring specialist care to public hospitals. The growth of private sector sources of health care and insurance are, to an extent, driven by the expectations of high income earners who demand "luxury" medical services.

Traditional Healthcare System

The methods used for the diagnosis and treatment of illness invariably reflect the individual, communal and traditional views of the causation of sickness. Common ailments are usually treated symptomatically with various plant products or simple surgery. In the rural areas, a fair proportion of people often seek the help of traditional healers first, but when the sickness becomes serious or persistent, they turn to the western medical services.

Historical Notes on Trans-Cultural Psychiatry

Historical precursors of psychiatry in the territory of Papua New Guinea are primarily anthropological. The contribution of social anthropology to psychiatry in Papua New Guinea lies mainly in the areas of customs, language and social structure. Given the anthropological influence alluded to above, the first full length, primarily psychiatric article from New Guinea to appear in reference European psychiatric journals was "Temperament, Conflict and Psychosis in a Stone Age Population" in which Seligman summarized his theories and observations arising from several visits to PNG at the turn of the century. In the past, the emphasis was on research directed towards theory, with minimal interest in addressing practical medical aspects and providing genuine psychiatric help for the people.

In 1959, a service based on clinical and trans-cultural principles was established for the first time by Dr. Burton-Bradley. Previously, anthropologists had contributed and reported on empirical observations that were also of considerable psychiatric interest, but rarely was there adequate or sustained communication between the two disciplines.

Dr. Burton-Bradley however, was the man who single-handedly, and in geographical isolation, based upon his dual training in anthropology and psychiatry, made outstanding contributions to the field of cultural and trans-cultural psychiatry. He lived in Papua New Guinea and carried out many systematic psychiatric researches in Papua New Guinea from 1959-1994.

Cultural Background

On the Papua New Guinea mainland and adjacent islands, we find one thousand discrete languages. In the independent state of Papua New Guinea, with a population of approximately 5.1 million, there are 800 languages spoken. This is 29% of the world's total. This is a unique situation by any standard.

Culture stems from and is molded by language, with each one giving rise to and characterizing a distinct cultural-linguistic group of people. Each cultural-linguistic group has its own pattern of psychiatry and its own traditional nosology. In Papua New Guinea, the "Tok Pisin" (Melanesian pidgin) word "long long" is used to refer to all forms of mental disorder. The word "kava kava" is used by Hiri Motu speakers to refer to mentally ill people in the Papua Region of New Guinea.

Though there are variations in the details of social life between different linguistic and cultural groups of our country, certain generalizations may perhaps be made. For example, the people all live in settled communities, though in some localities, the settlements are moved fairly frequently. The communities are small and the typical coastal village would include not more than four to five hundred people. Port Moresby's Hanuabada (village) is an exception with a population of more than 3,000 persons with two distinct linguistic groups. The majority of people in this village belong to the Motu group and a small sector to the Koitabu group. Culturally, there is little difference between the Motu and Koitabu speaking groups.

In general, agricultural activities are similar in all the groups of people and supernatural beliefs significantly influence the lives and thoughts of most of the people of Papau New Guinea. The belief in the supernatural is the same whether the stated aim is the achievement of success in some desirable activity such as fishing or whether the motive is to harm or kill an enemy. Consequently, most illnesses are thought to be the result of the actions of sorcery ("Puri Puri" in the Motu language) or displeased spiritual forces. Most deaths are similarly explained. Attempted remedies are also generally based on the belief that supernatural forces existing either in the field of magic or religion can assist in the achievements of desired ends.

The common psychiatric diagnoses in PNG are:

1. Schizophrenia, Schizo-affective Disorder, Bipolar Disorder, Organic Psychosis, 2° to Typhoid and Malaria are common;
2. Substance Abuse - (especially cannabis), triggering psychosis, is a great concern to our society
3. Anxiety Disorder, Depressive Disorder, Stress-related Disorder, Somatization;
4. Childhood Disorder;
5. Sexual and Physical Abuse and Violence also common.

Our current treatment facilities include:

1. One psychiatric hospital - "Laloki Psychiatric Hospital" with 80 beds".
2. Five psychiatrists for 5.1 million people.
3. Each province provides psychiatric services provided by trained psychiatric nurses and primary healthcare workers who are trained in mental health.
4. Psychiatric units provide services at general hospitals in every province.
5. Rehabilitation services are provided for chronic mentally ill patients.
6. Most anti-psychotic drugs are available including Olanzapine.

The following training support exists for psychiatrists:

1. Master of Medicine Program for Psychiatrists
2. University supported teaching, research and service provision
3. The PNG Psychiatric Association networks with the World Psychiatric Association
4. There are overseas fellowships with the Masters program at the New South Wales Institute of Psychiatry
5. A national network of PNG psychiatrists with other mental health professionals in Australia including attending joint conferences.

Mental Health Services in PNG

Recognizing the tremendous need, we in Papua New Guinea have developed a 2001 - 2010 National Health Plan. The mental health component has adopted the strategies and goals listed below:

1. Review and update the Public Health (Mental Disorders) Regulations.
2. Increase staffing and improve the training of Psychiatric Nurses.
3. Establish psychiatric Units at all Public Hospitals.
4. Establish four regional referral hospitals and provide supervision units at level two hospitals.
5. Upgrade Laloki Psychiatric Hospital.
6. Improve intersectional collaboration in forensic psychiatry, the control and prevention of substance abuse and the prevention of domestic violence.
7. Improve community knowledge and skills to support community based patient care.
8. Expand community mental health program.
9. Improve monitoring and reporting.

10. Support and improve the effectiveness of mental health services in Primary Care are:
11. The policy paper reviewing the Public Health Regulation is ready for NEC submission
12. Recent achievements include:
    a. The training of Medical Officers from 19 Provinces - 22 trained in 1999;
    b. Sponsoring a national mental health conference in 2000 - 200 participants; the mental health conference in 2002 had 150 - 200 participants;
    c. Primary Health Care workers training - 260 trained in 2001
    d. Creation of mental health awareness promotional materials including pamphlets posters, radio commercial, street programs at market places at the national and provincial levels and community awareness programs on videos.
13. Long term goals include:
    a. Greater support for HEO training/diploma in Mental Health for Nursing Officers;
    b. Conducting and supervising under-graduate and post-graduate training in Psychiatry for Medical Officers
    c. Establishment of a National Rehabilitation Centre;
    d. Facilitating intersectional collaboration between church groups, the Social and Welfare Departments, Lifeline, Department of Defense, local police, the Narcotics Bureau, Universities, etc;
14. Improving community knowledge of mental health issues through a radio talk-back show featuring the Mental Health Foundation, Mental Health Association and Family Support Group
15. Increase specialists' visit to provinces and training mental health workers in rehabilitation services to be provided as a service at the provincial levels
16. Expand community-based patient care and strengthen the private sector service providers thereby complementing the public sector.

Mental Health and the Afro-Descendant Community: Notes on the Journey in the Black Atlantic

Augusto Conceição, M.D. Brazil

(Translated by Linda Denning)

Introduction

On behalf of my colleagues, I would first like to welcome all those attending this event, with a sense of dignity and autonomy that reflects our spirit and our struggle, on many continents, for full citizenship and the affirmation of the values of our ancestors.

I would also like to state that this meeting is a gathering that I consider special, as it asks for the exercise of *solidarity*, a fundamental value in our culture and one that was so well expressed in the pre-conference outline that was suggested as the reference point for the organization of the presentations made at this conference.

Prelude

I feel obligated to briefly review the characteristics and condition of the people in my own city as an introduction to the theme proposed by the conference organizers.

Today, in the twenty-first century, a visitor, upon arriving in Salvador, Brazil and seeing its 365 churches, its monuments, convents and its oldest neighborhoods, will be a witness to the opulence and beauty of our colonial past, a source of pride for the Bahians. The visitor will also see evidence of the grueling work and wretched living conditions that our ancestors were subjected to, as displayed in the quantity and quality of the monuments that were built under a brutal system of exploitation: Slavery.

The experience of our visitor will be broadened with the images that emanate from our urban atmosphere, modern hotel complexes, large commercial facilities, shopping centers, supermarkets, commercial buildings, banking and financial institutions, surrounded by a government center and airport, that stand as living testimony to the work and lifestyle of the descendants of the Africans brought here centuries ago.

Today, as a result of forces and factors starting in the 1970s and 1980s, we are subjected to a system that is equally exploitative: *Monopolistic Capitalism*, in its globalization stage, as it expands into the northeast of Brazil.

Nevertheless, in striving for a more complete understanding, our visitor will encounter a different picture: the 2500 communities of African culture and religion located in Salvador, (also known as the Land of CandomblÈ) amongst the AfoxÈ blocks, the old CandomblÈ streets, which are currently being recovered and used by Afro-descendants during Carnaval.

The Carnaval Blocks with their African roots, contain the cultural centers, the neighborhoods and the zones of the city considered to be the space belonging to the Afro-descendant culture and include their music, their food, their linguistic expressions and the capoeira circle.

In this aspect, the image of the black man in Salvador is spotlighted, no longer as "construction material", but rather as a cultural articulator and active agent in the formation of permanent values and symbols. Despite the various forms of violence, prejudice and discrimination of which he was a victim throughout his history, he is conquering spaces which, no matter how limited they may be, affirm with dignity, the force of his culture and civilization.

With these considerations, I have two objectives:

First, to reject the image that focuses on Afro-descendants simply as victims of the socio-politico-economic system and of its dominant class.

And, as a corollary to that, to also reject the ideological concepts that try to make my city an expression of a double democracy: the cultural and the racial.

Yet, alluding to verifiable criteria, such as the demographic hegemony of the black and mulatto population (80%), and the expressive variety of the black culture in Salvador, such an ideology is deceptive: the creation of a cultural industry, articulated at the level of governmental politics, that is, the tourism industry, the inspiration for which is the *control of cultural manifestations* through the use of mechanisms that favor forms of assimilation consistent with globalization patterns. This policy of cultural control is also associated with a policy of co-opting individuals and groups. Thus we reject both the dislocation and the obscuring of the fundamentals of our city's true social and historical relationships, as the suppression of *creative resistance* in the history of our people.

Starting in the 1960s and 1970s, with the beginning of the late modernization of Bahia (in Brazil's northeast), its population has experienced a set of transformations that have changed its economic structure and social physiognomy substantially. The local economy, went through a long period of stagnation from the end of the 19th Century to the 1950s, based upon the decline of export activities (cacao) and on the incipient rise of the textile, tobacco, metallurgic and public services sectors.

With the opening of the Rio-Bahia Highway, and with investments made by Petrobras through a policy of incentives and subsidies, officials and financiers appointed by the federal government were able to assist in the establishment of the Petrochemical plant, the creation of the Aratu Industrial Center, the Annealing Plant of Bahia, and the Port of Aratu, among others.

Soon thereafter - characterized by fluid movement and spasmodic investments - there came the widening and modernizing of the financial sector, the energy sector, the establishment of big business, and most recently, the establishment of the computerization of businesses and services. This "industrial revolution" however, has had a limited effect on the generation of new

employment, since it will mainly impact the modernization of business, services and home construction.

Currently, Salvador is experiencing a demographic expansion on the order of around 1000%, evolving from two hundred thousand inhabitants in 1940 to more than 2.4 million presently.

The most impressive rates occurred during the period from 1940 to 1970 with the recent slowing (1990-2000) being mainly a result of the decline in the fecundity rates and the distribution of the migratory flow away from those cities that compose its metropolitan region. At the same time, there has been a rise in life expectancy at birth, promoting a rise in the number of juveniles and the elderly.

At the level of the social structure in Salvador, it is moving from a stratification model to the formation, on a large scale, of social classes. This process initially translates into a certain upward mobility for a small portion of Afro-descendants, who will comprise the new middle class and the working class linked to the modern sectors of the economy.

For the great majority, however, being poor and illiterate, the alternative continues to be the informal economy, government employment, domestic employment, small businesses and service industries. Thus begins the period of the intensification of inequalities, of the concentration of wealth, with the by-product being social and spatial segregation. This leads to the formation of neighborhoods marked by the absence of services, homogenization, poverty, and a miserable existence, accompanied by marginalization associated with criminality.

Meanwhile the middle class sectors individualize themselves socially and spatially believing in the theory of upward social mobility. This however, is at an imaginary social level, especially among the youth, so that the new model, in terms of its ideology, exerts an exceptional gravitational force, transforming itself into diverse aspirations, conduct and life expectations.

Beginning in the decade from 1970 to 1980, some leaders developed initiatives, trying to affirm the identity of the Afro-descendant community on the local political scene. The results were modest, and only recently was there any tangible expression at the legislative level (the election of two congressmen) and at the union level. The problem at this level seems to reside, (according to the consensus of opinion among the intellectuals consulted), in the differentiation and separation of the “chosen” group, and in the polarizing manner with which this ethnic question is handled.

The alternative for the Afro-descended community facing the changes that have occurred over the past decades, continues to have as its primary support, the original model that lasted through slavery and defeated republican repression. That is, *self-affirmation based upon culture*, using as its reference CandomblÈ religiosity, which, since the end of the 19th Century, has produced a number of leaders with the ability to negotiate the intransigent affirmation of their culture, and to address the question of the insertion of itself into society without losing its specific nature, even during republican intolerance and authoritarianism.

Overcoming the feelings of rejection, (promoted by the repression of the black community), and the adoption of firm negotiation strategies, were considered to be the principal interventions that made fundamental conquests possible during the republican period. This is when the religious communities numerically multiplied and won (in 1976), the right to carry out their rituals without the supervision of the local police. Subsequently, as of the decade 1970-80, there has been an authentic re-Africanization of Carnaval, with the rescue of the afoxÈs, the African blocks (neighborhoods). This rejuvenation has included a re-invention of "black" music and the redefinition of the popular festivals and the "largo", the cycle of parties that stretches from the beginning of December through March. This revitalization has also included the renewal of the customs of young Afro-descendants (clothing, hair, jewelry,etc.), a surge of rock, hip-hop and reggae music groups and theater, and most importantly, an enlargement of the spaces designed for African culture (Pelourinho).

With a powerful force of attraction, the cultural heritage of the Bantos and Yorubas that arrived here from Africa continues to be the foundation of racial identity and behavior for youths, women and adults, even becoming an important economic activity (the sale of food, drinks, artisan wares, fabrics, typical products and activities related to tourism) in the composition of the family income.

Despite the speed and extent of the progressive social processes in the last decades, a social crisis has emerged, which is prolonged and unresolved within the framework of the current model of economic development, due the following factors:

1. A significant rise in the city's population base
2. A prolonged housing crisis
3. An increase in the number of invasions
4. Dislocation of the low income population to the periphery
5. Lack of employment opportunities
6. The ongoing financial crisis of the industrial park, and of international capitalism itself
7. A decrease in government employment
8. Stagnation in the supply of essential services to the population, particularly in the areas of education and health
9. Absence of compensatory policies

The phenomenon of *social exclusion* deepens among us on a scale that surpasses the alternatives offered by the traditional social and cultural network of support. Families live a daily life of deprivation, humiliation and aggression. Young people are prevented from working due to the lack of employment or because of their physical appearance. A feeling of frustration and of uselessness is developing in the face of daily obstacles to the realization of opportunities to

improve one's life. The ideology and notion of "having nothing to lose" is gaining status. Unproductive laziness becomes established as a routine. Public education is precarious. New stereotypes associated with the same image emerge, those of being poor, black and marginal.

In our context, then, a subculture emerges that is incapable of generating processes for a positive identity. This leads people to develop reactive social behaviors, molded by fury and personal affliction, making possible the formation of subgroups whose ties are based on the condition of being excluded and ultimately, making the use of violence a way of life.

Schools in conflict areas are transformed, there is an increase in the mother-centered family, and religion begins to function as a stronghold in conflict resolution. The problem of child abandonment worsens. A population of street children is formed, constituting stratification, with its own language and values, expressing a primordial failure.

Local health system records show and verify the increase in the incidence of neurosis, in particular anxiety and depression in women, alcohol abuse and dependency among men and more recently, women and juveniles, accompanied by a rise in the sale and use of drugs among street children and adolescents.

In a similar way, we see the emergence of significant problems facing the individual sufferer with chronic mental illness, the mentally deficient, the physically and psychologically handicapped, those with dementia and residual schizophrenics, who are in need of shelter, social and health care but are being cared for in an assistance network that was formed in the 1950s and that was based on hospitalization.

Prolonged unemployment, the dispersal of the family, the liability of gender and of childhood, the absence of alternative perspectives, feelings of fatality and inferiority, lack of knowledge, downward geographic and social mobility, malnutrition and violent behavior form the core of psychosocial factors that we in the mental health arena have come to call the *Psychopathology Of Exclusion*.

We are not trying with this term to characterize a new syndrome, which becomes reduced to a dimension of clinical therapy. In reality, we are not at the level of dealing with illness at all. The dimensions reached by the many new challenges faced by mental health professionals throughout the last decades, and in particular the Afro-descendant community in Salvador are, the manifestation in individuals or in groups of pathological processes produced by social and economic inequalities and violent discrimination based on differences. These illnesses acquire a representative status in our statistics, being expressed especially through the events designated by the rubric of "accident by external causes". In Salvador, there were 3,369 murders between 1996 and 1999. The highest rate of violence and victims of such acts were concentrated in the poorest neighborhoods, where the majority of the city's black population resides.

We understand that situations like these can be controlled through the development of public

policies that prioritize the investment in and expansion of social services, as well as by a better use and redirection of existing resources.

It is perceived that in the minds of many health officials, there is little or nothing we can do in terms of the prevention of such events. Yet the biggest challenge consists of using the epidemiological concept of risk in determining the etiological factors and translating these into "prophylactic" actions. The question becomes more complex when we consider the cases of persons suffering from chronic illness or incapacitation, when social and health needs are convergent and juxtaposed.

We should, however, recognize that we are living within a perverse local and global short term economic trend that compromises one of the fundamentals for equalizing the social question and as a consequence, developing models of health care that are socially oriented: namely, the existence of a social state, capable of ensuring an active public presence, and social policies, in the areas of education, nutrition, employment, health, safety, housing and culture. What also helps is the affirmation of a tendency towards the progressive restriction of governmental presence in the social arena, transferring that function instead, to Non-Governmental Organizations (NGOs) and/or to privately funded groups, through the implementation of outsourcing policies.

The difficulties at every turn reach to the very heart of psychiatry, particularly the compartmentalized form it has taken in the last decades. The version of psychiatry that exclusively favors the use of medications (association with the pharmaceutical industry) and the biological determination of mental illness is becoming more and more influential. As a direct consequence to the currently available clinical services, a technical culture prevails, based upon an individual approach to collective problems, and on the medicalization of all types of events.

I ask, can psychiatry be exclusively biological?

However, despite the bleak outlook for the development of ongoing work that requires social ties of solidarity, supportive government policies and a spirit of initiative among professionals, some positive movements can be detected. In the social environment and the environment of cultural institutions in our city, there have been some positive moves in support of the struggle for affirmation in our community:

1. There is an increase in the understanding of the diverse segments of our community and of the fundamental role of our culture within Brazilian society, with the goal of helping our youth avoid entering into the world of marginalization and criminality.
2. There is a broadening of positions among local leaders in terms of understanding the necessity of creating a culture as an articulated social item and challenge, and not created by government policies, which overtly link culture to tourism, carrying with it the concepts of products and sale.

3. In some of the more traditional African communities and blocks, social activities are increasing, mainly in the area of basic education, building schools that are open to the community with a pedagogy oriented toward the development of self-esteem and valuing the Afro-descendant culture. Recently, at the initiative of the Eugenia Anna dos Santos school in Ilê Axé Ôo Afonja, an Education Forum was established at the municipal level, for the primary purpose of expressing these experiences.
4. At the university level, the Center for Afro-Oriental Studies was created as an instrument for the legitimization of the black culture in Bahia, especially in the CandomblÈ communities, and for contributing to the re-Africanization of our culture's customs and developing local talents and intelligence in diverse areas.
5. The documentation of social and cultural experiences developed by Non-Governmental Organizations that were successful and of proven credibility with the local community,.
6. The emergence of people committed to the Afro-descendant community, in leadership roles that result in African-descendants being acknowledged and represented in different public and private social arenas and political institutions.

At the mental health level, as a consequence of the psychiatric reform movement developed by us beginning in 1990 (and currently under review), several positive movements have been recorded in the understanding of the mechanisms of mental illness and the organization of psychiatric services:

1. A decrease has been registered in asylum beds and in the loss of effectiveness of psychiatric hospitals.
2. In some sectors, the culture of mental health assistance has been consolidated, based on a multi-professional team and on a community model.
3. A modification in the attitude of rejection and discrimination against persons suffering from mental disturbances.
4. Better integration with general health services; the development in some cases of psychiatric services in general hospitals.
5. The development of specific techniques, focused on the rehabilitation of chronic illnesses and the socio-cultural reinsertion of the patients.
6. The selection by the Ministry of Health of a whole health assistance strategy, based on the Family Health program, as the instrument favored by the national health promotion policy, which creates the possibility of a broadening of actions in the area of mental health.

I am currently contributing to the process of modernizing and updating mental health, both at the level of assistance and of teaching. In this sense, I would like to point out the following

initiatives that I believe can supply some references for the development of partnerships and cooperative projects:

1. The establishment of the Center for Alcoholism and Treatment of Alcoholics (Centro de Acolhimento e Tratamento de Alcoolistas - CATA), with services would developed in partnership with the Secretary of Health of the State of Bahia and the Santo Antonio Hospital (Irmã Dulce), consisting of a Detoxification Unit, designed for a regime of short term hospitalization that ensures detoxification, staffed by a multi-professional team (psychiatrist, general clinic, psychology, occupational therapy and nurses), and by different specialties that are found in a general hospital. This is complemented by a Center for Psychosocial Attention (Centro de Atenção Psicossocial - CAPS), developed from a therapeutic approach model for users and their family members. The services offered by CAPS are provided by a multi-professional staff and includes various activities like walk-in triage, individual and group consultations in psychiatry, psychology, psychotherapy, social services, nursing and nutrition, besides the various activities in the therapists' offices. In this way, the user is guaranteed an integral service, since the treatment follows the elaboration of a therapy program that is individualized and in which the user participates.
2. The establishment of the Center for Psychosocial Attention at the Professor Aristides Novis Center for Mental Health, with services provided at the unit that housed the State Secretary of Health for Bahia, which is now municipalized, designed as a long term treatment program for chronic psychotics and seriously neurotic persons, based upon promoting the prevention of unnecessary hospitalization and the socio-familiar reintegration of the patients and their families. These activities are conducted by a multi-professional staff (psychiatrist, general clinic, psychology, occupational therapy, social assistance and therapeutic assistants), and are based upon individualized therapy plans. In this project we have emphasize the constitution of an Association of Patients and Family Members, properly legalized and registered as a civil agency.
3. The re-taking of cultural and social psychiatry, through the creation of the Brazilian Association for Ethno-psychiatry and Social Psychiatry. Considering the traditions in this field in our country and the relevance of the socio-cultural question for us, I believe there is a serious prejudice against psychiatry in Bahia, and as of 1990, an interruption of this in the process of educating professionals who practice in the area of mental health. Initially acting through holding workshops, seminars and courses, the Association has added institutions and professionals of undeniable competence and respectability to the scientific and Afro-descendant communities. At the same time, it serves as a means for the sharing and exchange of work done in the university departments at local universities and at universities in other states, and is progressively establishing the bases for an interdisciplinary methodology for the treatment of today's cultural question. I also

contributed, along with other professionals in the area, to the examination of issues such as ethno-psychopharmacology and the relationships between mental health and culture.

4. At the academic level, we are beginning to develop a project that promotes a better understanding and treatment of mental health within the family medicine program at the medical school, and conduct regular teaching activities, particularly regarding the presentation and treatment of psychosomatic illnesses.

Also in the university arena, using the Ufba editor, we are editing the papers on trans-cultural psychiatry written by Professor ¡lvaro Rubim de Pinho, head of Psychiatry at Ufba, who died in 1994, as a part of the critical rescue of the Bahian School of Mental Health.

4- Through Ilê Axé Ôpo Afonja, the most traditional Candomblé-ist area in the state, founded in 1903 and belonging to the Keto nation, today managed by Oxossi's daughter, Yalorixa Maria Stella de Ázevedo, a project has been developed in the area of health and teaching called "Taking care of the caretakers". This foresees the construction of a general teaching hospital with 120 beds, having a center for the education of health professionals other than doctors, a walk-in section, a community activities section, with staffing from the Family Medicine program and a Center for Research and Studies. Developed in partnership with the City of Salvador, the project is designed for the care of the local community and has a specific program for health care in the areas of geriatrics, pediatrics and youth care in Afro-descendant communities, initially those located on the perimeter of the metropolitan region of Salvador. At the moment, we are in the phase of finalizing the donation of land by the local municipality.

At this point in the presentation, I would like to emphasize the areas that I consider to be possible for collaboration with other countries:

1. The development of preventive actions in the area of chemical dependence, in particular the use of alcohol.
2. Projects involving the development of mental health activities in the Afro-descendant communities, in collaboration with the family medicine training programs.
3. The establishment of a referral center for the city of Salvador providing specialized psychiatric services for children and adolescents.
4. The identification of mobiliation of resources for the financing of research and intervention projects in the areas of psychiatry for children and adolescents and the construction and staffing of age appropriate mental health hospital units.
5. Development of research studies of Afro-descendant populations and their most common diseases, in particular chronic degenerative diseases (hypertension, cardiopathy, diabetes, myoma, sickle cell anemia) and those diseases classified as psychosomatic.
6. The development of research and studies of the health difficulties related to social suppression, racial discrimination and negative stereotyping in the mass media.

7. The development of exchanges in the areas of teaching and specialization (bachelor, masters, doctorate, post-doctorate degrees), in the areas of cultural and social psychiatry, particularly in the areas of public health and development of the Afro-descendant community.

We are in a period that demands an increase in action in the area of mental health, through flexible programs carried out with integral actions, that take into account the socio-cultural dimension of our community. This demand can be partially handled through the existing family health programs. We are proposing the constitution of a national referral service that provides assistance, teaching and research that is both aimed at the child-juvenile population and is capable of working in conjunction with the Afro-descendant community, in particular, the Candomblé areas, which are in great need of this type of effort and collaboration.

In conclusion, I would like to highlight the central point of my professional program of activities for the upcoming years. I will try to concentrate my work on compiling the resources that will be need to be mobilized in order for Salvador and its population to have mental health services that permanently involve professionals who are committed to the Afro-descendant community and who are up-to-date on the situation in their area.

Considering the current situation on the African continent, particularly in Sub-Saharan Africa, I propose that a working group be formed to:

1. Examine the question of migratory flow between our countries and produce institutions that can ensure resources and references for those who need and seek them, and
2. Come up with suggestions for the development of projects of technical cooperation between our regions.

I think, not without sadness and restraint, that one of the critical points of convergence for our attention as psychiatrists, at this moment of time, on this planet, should be the study and confrontation of the rise and renewal of intolerance, contempt and the xenophobic protectionism by the white citizenry in some countries against foreign (black) immigrants, which once again will create more adverse conditions that eventually will lead to more war, hunger and epidemics.

In particular, referring to my own actions in these last years and according to my values and my public consciousness, I have dedicated myself to the understanding of the living conditions of my community in a broad sense, and simultaneously valuing and empowering Afro-descendant institutions to confront; what I consider to be the primary challenge in the context of the new millennium; the broadening of our models of solidarity and the spread of the pedagogy of positive self-esteem beyond the territorial limits and the circle of its followers.

Finally, I believe this to be an historic event with great significance for the Afro-descendant community.

Belonging to the countries of the African Diaspora, this organization, an association represents persons who are breaking down the barriers of discrimination, conquering and reclaiming certain real and psychological spaces in their countries; has today, become united as a professional body, making a statement of commitment to embracing our similarities in different regions of the world, to stand together in our Drive to the Black Atlantic, under the value that I think is most expressive of our culture: SOLIDARITY.

Psychiatric Issues of African-Descended People in Panama

Carlos Smith-Fray, M.D. Panama

History describes two main moments of arrival of black people to the isthmus of Panama, as part of the great diasporan events from Africa. The first moment was formed by a huge group of slaves in the earliest part of the 16th century brought by the Spaniards conqueror. They can be recognized today not only by their colour, but also by their surnames which are related to their former owners.

The second great moment is represented by the migration of black workers from the West Indies that came to work on the banana plantations and work on the construction of the Panama Canal. The majority of them came from the British colonies, predominantly from Barbados. They can be identified by their surnames, almost all English. This forced migration took place during the later years of the 19th century and the first decade of the 20th century.

There was a coincidence of the construction of the Panama Canal and the occurrence of an economical crisis in many of the islands in the Caribbean, that led to a major unemployment problem. This situation led to a large availability and cheap manual labour. The recruitment of the Africans took place with so many promises and wishes, that were never fulfilled.

These men from the West Indies were forced to leave their home islands without wives or children. For long periods of time they were alone, with their prayers, religious songs, and their great solidarity with each other. Of course, many of them became “homesick”. In addition to making a way of living they also became survivors, despite all of the environmental hazardous to their health. Many of the brave men died of various tropical infectious diseases such as yellow fever, malaria, tuberculosis. Due to treatment with ototoxic medication such as quinine, many of the workers experienced deafness or a significant reduction in their hearing capacity. In other cases the African laborers were unable to hear the warning whistle prior to the triggering of the dynamite explosions, and as a consequence of the huge unexpected noise, experienced permanent injury to the auditive nerve.

There was also a cruel myth that said that black people were stronger than other races. This concept drove the Americans supervising the building of the canal to expose the African workers to the toughest environments, where bacteria and virus invaded their bodies, killing many of them. Many of the Africans were used as human guinea pigs to try new medications.

Beside all I have previously expressed, the American government created an opprobrious segregational social system based upon a clearly racial and discriminatory concept. Instead of calling it apartheid, it was labeled the “gold and silver roles”. Under this apartheid system black people were all placed in the “silver role” and were paid in different offices than the white people who were placed in the “gold roles”. The restrooms were different for white and blacks. The housing and the schools were also separate. The end of that oppressive system occurred in

the late fifties of the past century. It is of note that many of the changes came as repercussion or consequences of the Africans national struggle for equal opportunities through the civil rights movement that occurred in the United States.

Despite this history of discriminatory attitudes and some of our own people trying to put our colour to the side, our presence is now so strong that we are the cultural expression of the Panamanian nationality and pride. We are found in the music with our drums and songs, in the foods, the arts, literature, science and sports. We are easily identified but never evenly recognized.

Many of the economic ruling class try to hide the nation's black heritage but they can't fight against genetics. DNA research studies done by the Institute of National Studies of the University of Panama, indicate that more than 50% of the population have black components in their genetic configuration.

From my point of view as a black psychiatrist, black people in Panama are not affected by mental illnesses differently than the rest of the population, however poverty does play a significant and devastating role. A great part of the black population are in a perpetual situation of unemployment. There is, therefore, a great need to raise their self esteem by assisting them in completing their education, enhancing their knowledge of our historical and cultural roots and helping them to feel proud of our race. There is a need for more scholarships, drug prevention programs and encouragement of our people to create small and large businesses by making "soft" loans available.

Lastly, there needs to be a genuine recognition of the African participation in the evolution of the nation called Panama, the narrowest territory in Central America, where in an hour or less, you can drive from the east coast to the west coast, take a dive in the Atlantic Ocean and sixty minutes later you are swimming in the Pacific Ocean.

Final Comments and Suggestions

There is strong academic support for the presence of black people in the North American continent and in Panama, extensively detailed in the research done by the anthropologist Dr. Ivan Van Sertima and discussed in his books, "They Came before Columbus" and "The African Presence in Early America".

It could be interesting undertake research projects that would provide evidence and support for how African-descended people used song and music to adapt to and cope with the stress and hard, tough work they were forced to withstand during the slavery and post-slavery periods.

Transcultural psychiatric research in the areas or chemical dependency, mental illness and migration, the use of cultural institutions such as museums and theater to enhance mental wellness and the impact of racism upon self-esteem and the "sense of belonging" would also be areas of great interest in which to pursue further research. Of note is that next year, during

Panma's centennial celebration of Independence, there will be an international conference of African-descended anthropologists that would present an excellent opportunity for a joint meeting with psychiatrists of African descent.

The Challenges of Treating the Homeless Mentally Ill in Belize

Claudina E. Cayetano M.D. Belize

Introduction

"As black psychiatrists we have the opportunity to help our people better negotiate the future..." (Diasporan conference introductory letter by Chester Pierce, M.D. 2002).

The dreadfulness of the chronically and severely mentally ill living on the streets, in constant danger, without the basic necessities of life, let alone treatment, is almost too incredible to contemplate, and too difficult to live with.

These are the thoughts that drive me to present this paper in this conference.

Homeless mentally ill, perhaps are found worldwide, but this is not an excuse not to take the time to understand and jointly assist each other in providing decent services to this population, and strive to minimize the frustration of providing treatment and appropriate services to this vulnerable population.

Preamble

The context of this work can best be understood against the backdrop of my country, its historical background, the current mental health services and human resources available for these services, as well as a brief presentation of common psychiatric disorders, and consultation pattern. After setting the context, my focus will be on the homeless mentally ill, their characteristics and associated problems, and the difficulties of managing and treating them. I explore possible solutions and the possibility of forming outside collaborations to alleviate this situation.

Belize, Geographic and Socio- Demographic Information

Belize (formerly British Honduras) is an independent nation in the heart of Central America. This tiny English speaking country boasts the second-largest barrier reef in the world, which is also the largest living reef. The countries that are our neighbors are Mexico to the north and northwest, Guatemala to the west and south, and the Gulf of Honduras and Caribbean Sea to the east.

It is a country with a diversity of peoples and cultures and physical and natural attractions, including the coastal Cayes, (over 200 small offshore islands) that dot the turquoise Caribbean waters. Geographically it consists of 8,876 square miles, broken into 6 districts. The largest population center is the Belize district.

Map of Central America

The People of Belize

The total population of Belize in 2001 was approximately 250,000 people. Truly exotic and fascinating mixes of cultures, many different kinds of people, with many different racial or ethnic mixes make up today's Belizeans. The Mestizos, a mixture of Spanish ancestry and the Maya constitute 49 % of the population. Belizean Creoles are mixture of European and African ancestry; represent 25 % of the population. These are the two largest racial groups. The others are the Indigenous Mayas 11 %, Garifuna (black Carib Indians) 6 %, Mennonites 4 %, East Indians 3 % and Other 2 % (Chinese, British etc, etc). During slavery, the majority of Belize's population was African and Creole. Mestizos became the largest ethnic group when many refugees came from Central America.

The first people known to live in Belize were the Mayas, from before 2500 B.C. In the early 1700s the Europeans brought African slaves to do the hard logging work. In 1802 the Garifuna came to Belize via Honduras having been exiled from St. Vincent.

The demographic profile is one of a young population with 44 % below the age of 15 years, and 4.2 % above the age of 65 years. The male/female ratio is almost equal at 1:1. 49.6 % of the populations are Roman Catholic.

Poverty

33 % of the population is described as poor and 13 % regarded as extremely poor - income below US $1/day. Poverty is prevalent in both urban and rural areas.

Overview of the Psychiatric Services

The main provider of psychiatric services in Belize is the government. The Mental Health Program falls under the Ministry of Health. The staff consists of two psychiatrists; both with multiple roles, eight psychiatric nurse practitioners and four practical nurses. The rest of the Mental Health Program staff have only received in-service training.

There is an inpatient service, the Rockview Hospital, with an average of sixty patients a day, of whom 70 % are chronic patients, with no family support. This hospital is isolated from the city, which has added to the stigma of psychiatry. Recently, an acute psychiatric unit was added to the general hospital in Belmopan. Ongoing staffing limitations have affected the ability of this unit to fulfill its role.

There is an outpatient clinic in every district town. In Belize City, an average of one thousand patient are serviced by the clinic per year. The psychiatrists are based at the clinic in Belize City. They do rounds at the hospital and serve as consultant to the psychiatric nurse practitioners that run the outpatient clinics. There are no day hospitals, no shelter housing, and no welfare programs.

Epidemiological Picture

At present, no psychiatric epidemiological research has been conducted in Belize with the exception of a survey of treated disorders conducted in 1993 by Khon, and in 2001 reports by Cayetano. There is no formal mental health policy; the mental health national plan is currently under development. Management protocols for common disorders are being documented. The last revision of the substantive laws of Belize occurred in 2000, however the Mental Health legislation's last revision was 1959.

Common Psychiatric Diagnosis

Anxiety Disorders, Depressive Disorders, and Stress-related Disorders

Patients tend to seek psychiatric consultation either because their physician or relatives referred them, or they come on their own. When they are in a crisis, they tend to attend the consultations and most of the time prefer to take medications, rather than participate in some form of psychotherapy. Some patients are comfortable with counseling in a face to face setting with a more supportive or guided approach. Others are comfortable being treated by their physicians but maintaining a contact with the psychiatrist, especially if they fear a relapse. What I find interesting is the crisis consultation; regardless of the amount of psycho-education provided, many of the patients seem to return only when there is a crisis. The course of illness becomes very difficult to determine in situations like these.

Schizophrenia, Schizoaffective Disorder, Bipolar Disorder and Major Depression with Psychotic features:

In most of the cases with these types of disorders the patients are brought by their relatives, friends or police. The availability of laboratory testing, the accessibility of the mental health facilities and most importantly, the family understanding of the illness causation, play an important role in the diagnosis of these disorders.

Due to this cultural understanding, the treatment of psychotic disorders is very challenging; especially first episodes. The family tends to explore alternative medicines within their own environment before taking the patient to the psychiatrist. Depending how much they buy into the psychiatrist or nurse's explanation, they may or may not continue the treatment.

The stigma of mental illness frequently deters patients from seeking appropriate treatment at the right time in the right place. This is a deeply rooted problem in the country of Belize, but it is not the intention of this paper to discuss this issue.

Sexual and Physical Abuse, Domestic and Community Violence and Suicide

The escalation of violence in our society has become alarming with significant increases in incidents of sexual and physical abuse and domestic violence. There are management and treatment protocols in place to deal with these issues. Suicide rates continue to rise slowly. In particular, suicide attempts have increased in the 16-20 year old age group, primarily due to conflicts in relationships. (Cleopatra Clinic 2000)

Substance Use

The results of two surveys on substance use (Pride Belize, 1992, 1993) conducted locally, have been compared with similar studies done in neighboring Guatemala and the United States. While Belize appears to have lower rates of tobacco use, the usage rates of alcohol, marijuana and cocaine seem to be comparable with those in the U.S., and considerably higher than in the two neighboring countries.

Certainly, the high usage has contributed to an increase of substance use disorders in the country. Unfortunately, there is no treatment facility for this population. They end up being admitted to the psychiatric hospital if their psychiatric condition dominates the picture, but no treatment is given specifically for the substance abuse. This is a very common problem among the homeless.

Homeless Mentally Ill

Over the years of practice, I have seen an increase in services and in the awareness of the importance of mental health, but there has also been an increase in the homeless mentally ill. Concurrent with the growth in the general population we have seen a significant growth in the number of homeless people in the communities. People sleeping in public places, living on the streets, begging and wandering day in day out, are appearing in districts and communities that did not have homeless people in the past. Many of the homeless people suffer from personality

disorders, schizophrenia, bipolar disorder, mood disorder with psychotic features and drug induce disorders.

As psychiatrists, we have special expertise in dealing with these disorders. If we can help to better their lives, live a healthier life, become self-sufficient and have an identity of their own, we would have made a great and significant contribution.

The question I pose to you is what is our role as psychiatrists? The role of psychiatry is impartial and detached if it only provides medications, and does not assist in the understanding of the phenomena of the homeless mentally ill and address the issue of poverty alleviation.

Another dilemma that is faced on a daily basis is the diagnosis and management of the mental health problems of the homeless. After living in the streets, the psychopathology of the individual seems somewhat disturbed, without necessarily having a specific diagnosis described in the DSM- IV. Given the political and social characteristics of this country, the authorities will insist that homeless people wandering on the streets be taken to the psychiatric hospital. In addition if someone has been admitted into the psychiatric hospital (Rockview Hospital) they are deemed to have a mental disorder even if they have not been diagnosed with one.

Characteristics of the Homeless

The presence of the homeless on the streets of Belize is a serious and challenging situation for the Government and the community. Part of the community service of the mental health program has been the creation of a mobile clinic. The objective of the mobile clinic is to treat mentally ill patients who do not attend the regular outpatient clinics. This approach only target patients that are known to the program with documented deterioration of their psychiatric disorders due to non-compliance with medications. These patients usually only receive a monthly injection of depot neuroleptic. Again providing medication treatment is not the only need of this neglected population.

In 2001, a multidisciplinary team was mandated from the Cabinet to determine the extent of the homeless problem. A task force was created, formed by professionals from the Ministry of Health, the Police Department and the Human Services Department. Due to lack of statistics on this population, a team was formed to conduct a visual survey assessment. Engaging these individuals was a difficult task. Some of them did not answer the questions or gave misleading information.

In spite of the difficulties, the team was able to document one hundred and thirty four individuals sleeping in various public places throughout Belize City, (a population of 50,000 people). In addition to that, there are currently two homeless shelters with a capacity for fifty four people, which are always full to capacity. 35 % of these individual were considered to have a significant mental illness with many of them having been on the streets for over three years.

A table was created that included name, age, gender, family contact, location where the

individual was found, and remarks. When possible the information collected under remarks included the reason for homelessness, amount of time living on the streets, whether they maintained contact with their family, and had any other support.

No children were found in the survey. It was difficult in some instances to determine their age since the data collected was missing information about the date of birth, or as in some cases they simply did not know their age.

The ages recorded were between 17 and 74. The majority of them are between the ages of 35 and 50, followed by 51 to 75, then 17 to 34. These represent sensitive periods in the life cycle, when people are most productive, especially considering that the retirement age is 55. There were notable gender differences, with males outnumbering females, (24 of 134 were female), by a ratio of almost of 5:1.

Problems Associated with the Mentally Ill Homeless

HIV /AIDS

In reviewing the available profile information of the homeless (received from the head of the Government AIDS department), patients were identified that had tested positive for HIV. Many of these patients have homes and family; however some patients have chosen to be on the streets, begging for money, not working nor being involved in any structured activities, leading an irresponsible life and refuse to engage in counseling. They often have been abandoned by their families because of the stigma attached to this disease. HIV positive homeless people are a serious public health concern. Such patients endanger themselves and others, by living on the streets without proper protection or treatment. No treatment is currently available for HIV positive patients in Belize.

Violence and Victimization

This homeless population has an extremely high rate of victimization, especially women. They seem to be more vulnerable. One of our female patients who was used to doing domestic work was working for a local man, and instead of paying her for her services, he battered and raped her. This is not a rare story. Few of our female patients have been hospitalized after experiencing severe injuries and broken bones from being assaulted. These patients tend to wander the streets exposing themselves to more violence and victimization.

Incarceration

Almost all of the homeless people on the street have histories of incarceration, most of the time for minor offenses. They are continually in an out of jail. They get into trouble for minor drug possession, trespassing, and theft. Sometimes instead of sending them to jail, the police will bring them to the hospital for treatment and care. At times, some of the homeless people intentionally commit minor offenses just to be taken to an institution, jail or the psychiatric hospital.

Deportees

Most of these people have been deported from the United States to Belize, because they have been in trouble with the law. These people frequently have no family in Belize, and most of the time do not possess skills or jobs. To exacerbate the situation, they often have antisocial behaviors and drug problems. Deportation itself has its own psychological stressors, especially when the deportees left Belize as children, and have no social network. This deportees many times come with the double baggage of antisocial and psychopathological problems.

Physical Health

Chronic and infections diseases tend to be common among the homeless. Hypertension diabetes are also common disorders among the homeless. We have not been able to eradicate tuberculosis in this country, and it continues to threaten our vulnerable population. It has become a common infectious disease among the homeless population.

Their nutritional condition tends to deteriorate also because of their eating habits. There is a public kitchen which provides daily meals. Due to distance, many patients do not always go to the public kitchen to get their meals, and prefer to beg for money on the streets, not necessarily for food, but sometimes for drugs. Patients who are mentally ill, and have limited insight, usually do not care about their physical health, and do not consult the clinics in time to solve their medical problems.

Abandoned Elderly

The family or relatives of this vulnerable population are sometimes abroad, and do not continue to take care of them. Others don't have the space and refuse to keep them. (During a recent emergency evacuation of Belize City due to a hurricane threat, an elderly patient was left abandoned right at the door of the hospital for the state to care for!). Many times, the elderly patients are confused and demented and cannot give proper information about themselves. Many of the patients who remain at the psychiatric institutions are elderly and have been there since the 1960's.

Conclusions

There are real and challenging issues in managing this population. It can be frustrating and disheartening facing these dilemmas. For a developing country like Belize, poverty and unemployment rank first as contributing factors in this population. Moreover, there are key questions that need to be addressed to ameliorate this problem.

1. What are the prevalence and incidence of psychiatric disorders in the population?
2. How much of the homeless population suffers from chronic mental illness?
3. Has mental illness precipitated an increase in homelessness?

4. What kinds of programs and specific services should homeless mentally ill individuals receive?

The first question is epidemiological. It is extremely important to research the prevalence and incidence of psychiatric disorders in the population. Once we have a diagnosis of the situation, it can be a door to developing appropriate programs, treatment approaches and improve the prognosis of the mental health issues.

The second question is statistical in nature. No research has been done to determine the percentage of the homeless population that is mentally ill. We have empirical answers based only patients treated or patients released from the psychiatric hospital, but this data is not necessarily accurate or adequate. The current profile that is available resulted from a visual assessment. There has never been an organized and systematic plan to diagnose this sub-population properly. Having proper diagnoses will definitely give us a better picture and understanding of the situation.

The third question deals with the fact that having a mental illness can be a factor of becoming homeless. The nature of the mental illness is an important element. Patients become delusional, paranoid, and very suspicious and can't trust their family members, due to their false beliefs. Having an illness that affects thinking, behavior and feelings impairs the ability to have and sustain a job. Families find it very hard to cope with this situation. Being in the hospital and taking medication can help them to recover; however, the stigma of the illness itself makes it very hard for them to be incorporated back into the community. Answering the third question will help us to become more efficient in treating this population, by developing services that are sensitive to their needs. The absence of housing is one part of the equation. The lack of sufficient resources and strong community ties, that is, the lack of a social safety margin is the other part.

Possible Joint Solutions

1. Provide technical support in the development of a much needed epidemiological research
2. Assistance in the training of mental health care providers, specifically in the management of the homeless mentally ill.
3. Training and sensitizing the general health care providers, to assist in treating homeless mentally ill.
4. Assist in the design of outreach interventions that are culturally sensitive and that are feasible to implement

The lack of human resources in a country like ours that does not provide the necessary resources and tools, or the time needed to develop the appropriate research, limits the ability of the clinicians to effectively deal with the problems facing them on a daily basis.

The homeless in Belize *are not the product of deinstitutionalization*, a consequence that has been experienced in other developed countries. Belize still has a psychiatric institution and many people continue to believe that the best way to treat the mentally ill is by keeping them in such institutions. Poverty and the lack of human and material resources are the social plagues that perpetuate this view. Keeping or closing down the institution without the appropriate community resources is a disservices to the mentally ill. The most meaningful therapeutic approach is to provide those services that satisfy the patient's specific needs.

Engaging the homeless population within a therapeutic setting is a tremendous challenge to psychiatrists and healthcare providers in Belize and worldwide.

The African Diaspora and Psychiatry in Cuba
Miguel Valdés Mier, M.D. Cuba

The 42,800 square mile Cuban archipelago, situated in the Caribbean, or Antilles, Sea, is made up of the island of Cuba, the Isle of Youth and 4,010 keys dispersed among four distinct groups. There are more than 11 million inhabitants that are distributed ethnically into 66 percent white, 22 percent mulatto and 12 percent black.(see annex 1)

The Cuban nationality springs principally from the Spanish conquistadors and colonizers, who imposed their customs, language and religion (Catholic), and the African slaves, mainly from the Gulf of Guinea who by the mid 19th century were more than half the population, one million of them working in the developing sugar industry. At the beginning of the 20th century there were also important migrations, 25 percent of which came from the neighboring Antilles islands of Jamaica and Haiti. This mixture generated an ample blend of races and a social-political-ethnic mosaic with each group contributing its culture and traditions. The principal African-origin religions not only greatly influenced the psyche of the black population, but also much of the Creole population (Cubans of Spanish descent born in Cuba).

Prohibition of free expression of African religious beliefs generated an interesting transculturation process in the Negro Diaspora, with adaptation of their deities to the permitted Catholic saints, producing a syncretism exemplified by Catholic Santeria.

Santeria, the most significant of these religions, is characterized by the syncretism of Catholic saints and Yoruba deities, that persists today, for example, Chango with Saint Barbara, Yemaya with the Virgin of Regla, Ochun with the Virgin of Charity of Cobre, patron saint of Cuba.

The Congo religion of Palo-Mayombe has its roots in the Bantu region's ancient monarchies, and incorporates concepts of vegetation animated by spirits, water as the representation of ancestors, and uses graphic symbols with a sacred character.

Participation in the secret Abakua Society, or gÒaÒiga, (the only one of its type in the American hemisphere), surged at the dawn of the 19th century, primarily as a response to severe discrimination, and the rivalry between free blacks and slaves. Membership in the secret society was based upon the social sects of the Calabar region of Nigeria, which only admitted males, and possessed a beautiful ethical-moral code, admitting only those who were a good friend, good son, good father, worker, neighbor and a rebel against any injustice.

Voodoo came from Haiti with the migration provoked by that country's revolution. Upon arrival in Cuba, voodoo acquired special characteristics. As such, it has influenced the perceived etiologies and clinical presentations of some psychiatric illnesses in Cuba, which still produce repercussions for those suffering from mental disorders today. Above all, voodoo propagated the popular belief that psychotic states occurred due to retaliation by real enemies for a previous injury, or were exacted as punishment from those having developed a congenital predisposition

that the sick person then continues to possess. In the eastern province of Santiago de Cuba, Cuban psychiatrist Alberto Cutie studied 200 people chosen at random, and found that 46% of those surveyed believed that magical religious systems could influence the course of a mental illness. Many delusions and hallucinatory states are related to the fear of the "evil eye from the dead" for violations of prohibitions or the failure to fulfill promises. These beliefs that have been inherited from our forebearers form a significant part of the cultural background of many Cuban families.

An analysis of the high incidence of mental problems found among those who are most discriminated against; immigrants, individuals with low income level and poor health, and those with fewer opportunities for intellectual development and optimal health care and attention, there is no doubt that it is critically important that psychiatry value the enormous importance of socio-economic factors in mental illnesses.

In Cuba, first as a consequence of slavery, and later as result of of marginalization and great racial discrimination, many of the Afro-Cubans have experienced reduced access to opportunities for individual and group development and advancement. Although many of these aspects were modified later by the socio-political process occurring after 1959, the historic roots and their subsequent consequences have molded a situation of chronic and constant stress which has left deep psychic traces on the human beings who suffered from this oppression and trauma. In some countries, ignorance or rejection of the consequence of the different histories, language, cultures and religions of these minorities, aggravates the conflicts, intensifies the tension of non-acceptance, contributes to the lack of developmental opportunities and reinforces in the people living in poverty that they certainly are "out of the game".

Referring to the etiological, diagnostic and treatment problems related to the stress suffered by minority and discriminated against groups, it is not possible to see the patient as separate from his origins, value system, hopes, beliefs, achievements and frustrations. Family traditions and the beliefs of our ancestors are powerful social and psychological factors that pave the way for the development of individual and group personality patterns.

Though independently possessing a political-social system different from other Caribbean nations, Cuba does share the common characteristics of multi-national ethnic origin, and the indisputable influence of popular beliefs evolved from different African-origin religions and traditions. Dissimilar cultures have evolved which nevertheless share more in common than their antagonistic elements

To exercise its profession, psychiatry in our milieu cannot ignore the transcultural elements and must value the clinical manifestations generated by the many social, cultural and political factors; the influences of family, geographical region, environmental and mythical-religious components that can play a role in the pathological profiles manifested in different clinical states.

Although specifically in my country there is no detectable discrimination now that could engender stress in the minority African-origin population, we can appreciate evidence of problems of this nature in some countries in the Caribbean. Our doctors who have worked internationally in Central American countries, such as Honduras and Nicaragua, have interacted with marginalized and discriminated blacks, like those who live on the Nicaraguan Atlantic Coast (the Miskita population). Many execrable illnesses in these groups are connected with dietary disorders, poverty, poor sanitation and lack of social-medical help. These negative health risk factors increase vulnerability and facilitate the appearance of psychiatric symptoms, principally depression and delusions.

Considering the difficulties minorities face in accessing healthcare services, and the ignorance of many professionals about their specific characteristics; if foreign collaboration or assistance becomes available, ongoing projects should be organized to:

1. To provide better training of health field personnel in the principal cultural manifestations influential in determining the psychiatric profile of the clinical presentation of minority races.
2. To increase and disseminate information about the social and anthropological aspects of minority groups to help majority group members to better understand their behavior, worries and needs.
3. Increase sensitivity to these aspects using the communication media and enlisting the cooperation and support of community leaders, formally and informally.
4. Augment pride in the minority groups themselves by facilitating expression in culture, education, art and sports.
5. Increase the self-esteem of members of the Diaspora by facilitating their access to the material means to excel in work and culture, to possess more resources and to create better living conditions.

Cubans are disposed to, and in fact have provided collaboration and aid to countries with fewer resources (fundamentally human resources), to increase the level of health of the less favored groups. It has the accumulated experience garnered over several decades of sending thousands of doctors to nearly fifty Latin American, African and Asian countries. Cuba has also trained professionals, technicians, athletes, and artists from other latitudes, who in many cases were from the African-origin Diaspora, to prepare these individuals to return to their countries of origin to help the most needy population.

While congresses, workshops conferences, and meetings, such as we are attending, can enormously facilitate collaboration, comprehension and help among human beings of diverse cultural origins and levels of development, there also exist other means such as bibliography interchange, diffusion of cultural expressions, expositions, museums, music, literature, dance

and other artistic manifestations that can increase understanding and acceptance. It is very important to learn about the characteristics of people near you and to understand their problems. An example of this are the "Casa de Africa" in Old Havana neighborhood and the Guanabacoa Museum where Cubans can appreciate objects, photos, dress and cultural expressions of diverse African ethnicities, many of which were important factors in forming our nationality.

I am pleased and happy as a psychiatric professional and equally as well on a personal level, and particularly as a descendant of African forebearers, to have the opportunity to participate in this historic forum where hopefully the outlines to how to proceed in the next years to minimize the consequences of the trauma, stress and tensions generated by historical discrimination and the social isolation of many African-descended people in the Diasporas, are analyzed, discussed, and most importantly, valued.

The possibility to motivate psychiatrists of African descent to unite and organize for fraternal and scientific aims, would, in my opinion, be an excellent initiative that merits assistance. While among the colleagues from the different countries that approved this idea there exist different economics, politics and languages, in addition to our identification as medical professionals and psychiatrists, we are united by powerful similarities from our common African origin. At the start of this new millennium it is impossible to turn our backs on understanding, respect, tolerance and altruism.

I am convinced that through this Association we could facilitate the interchange of national and regional experiences, discover and develop the forms and ways necessary to conquer our common problems, and offer our solidarity to those who need it most.

In relationship to our daily psychiatric work linked with practice and science, we must help ourselves develop and nurture sensitivity and generosity towards the most needy in order to guarantee everyone the access to quality mental health services.

Ongoing clinical work and research, exchanges through visits, conferences and workshops, publication of our ideas and dissemination of current and accurate information about these topics, offer us the double possibility of bettering ourselves scientifically and strengthening our legitimate pride in our race.

The African Mix in the Caribbean Basin
George Mahy, M.D. Barbados

Historical Perspective

The Caribbean is geographically a very small area between the Americas and the Atlantic Ocean. The countries are mainly a chain of islands, but a few of the countries are part of the Central and South America mainland with some of their coastal areas bathed by the Caribbean Sea. This Caribbean Basin, as it was called by a former US President, is multilingual, multicultural, multinational and multiracial.

In this paper I will focus on the English speaking Caribbean countries that were either formally under British rule, and those that are still British, now called British Dependent Territories (BDT). The Caribbean countries that will be excluded are the French, Spanish and Dutch countries and the United States Virgin Islands. I will also exclude Jamaica and Belize since these countries have representatives presenting at this conference

There are eleven main islands in the eastern chain, with the Caribbean Sea on the western side and the vast Atlantic Ocean separating our eastern coasts from the west coast of Africa.

The eleven islands are: Anguilla, Antigua-Barbuda, Barbados, British Virgin Islands, Dominica, Grenada, Montserrat, St. Kitts- Nevis, St. Lucia, St. Vincent and Trinidad-Tobago

The physical size and geographic position are of little significance in this presentation, but the ethnic distribution, population size and density and the affiliations with Europe and USA play a major part in how our people behave and respond to stressors.

These eleven major islands can be divided into four categories.

Category A includes countries with a very strong uninterrupted history of British traditions. Barbados is a good example of such a country with uninterrupted British rule for over 350 years until Independence thirty-four years ago

Category B includes the group of islands that continue to be under British rule and are classified as BDT - British Dependent Territories.

Category C includes countries like the twin island state of Trinidad & Tobago, with Spanish and British influence, but not existing as a sovereign state.

Category D includes the remaining six islands that gained their Independence over the past twenty five years, but their affiliations with Britain are much less than categories A, B and C.

An examination of some of the dynamics of the islands in each of the four categories will demonstrate that the issues and needs are different, and that different “defense mechanisms” are used by people in the different islands.

Barbados (Category A)

This small island has a very high population density, over 96% of its people have obvious African features, with about 2% White and a very tiny Asian and Oriental group. Barbados was under British rule for over 350 uninterrupted years until Independence in 1966. There remains a small pocket of white people who dominate the private sector, are seen as the wealthy minority and are labeled Barbadian White.

The African Barbadian has made full use of the tertiary education available and occupy all of the top paying jobs within governmental organizations, but are underrepresented in the private sector and hence see themselves as not in economic control.

The people of Barbados can be seen as a very conservative group of people with British standards and the African Barbadian has a frustration about having knowledge, but the money being still in the hands of the Barbadian White minority. One might conclude that the African Barbadian, though in the numerical majority, still feels insecure. The White Barbadian also feels insecure in his or her own country because of their very small numbers and being less economically secure than in previous years.

Anguilla, British Virgin Islands and Montserrat (Category B)

These three island chains have smaller populations and again contain predominantly people of African origin. These islands are for all practical purposes colonies with a white governor sent by Britain with the Governor having broad administrative powers. Some of the legislation approved in the UK is imposed upon the people in these islands. Hence, Britain is still very much the mother country.

There is a strong possibility that the people in these colonies might be given British passports. There is some ambivalence about accepting this offer and automatically becoming even more dependent. To complicate the issue further, because of the proximity of these islands to USA, United States currency is accepted in business places not the British pound, even though the British flag flies. Due to the geographical proximity to Puerto Rico, a significant percentage of the population is white British and white American citizens who are found primarily in the private sector and in the marine industry.

It is obvious that the African people of these islands have a different thinking process from those in the other categories.

Trinidad & Tobago (Category C)

This twin island state has a relatively large population (1.3 million). It is a republic and does not follow the Westminster model of having a governor, so it is not a Sovereign State. It does not have the strong British tradition of Barbados nor the affiliation with the British as the British Dependent Territories. There is strong East Indian presence (40.0%) and a comparable figure of

40.3% for those of African origin, with only 1% of the population identified as White Trinidadian.

Ethnicity is a major problem and the two major political parties follow the same pattern of ethnic polarity. In the most recent general elections the voting was equally polarized with 18 seats to each party, forcing the President of the republic to make a decision between choosing an African Prime Minister or an East Indian Prime Minister.

Antigua, Dominica, Grenada, St. Kitts, St. Lucia & St. Vincent (Category D)

These remaining six islands have a similar cultural style. The people are predominantly of African origin in countries with a British background but with Spanish and French influence. There is far less loyalty to the British when compared with Barbados and the British Dependent Territories. The US dollar and the British pound are both accepted as foreign currencies, unlike those islands mentioned above and classified as British Dependent Territories.

Socio-cultural Summary

The Caribbean countries described above have relatively small populations and manifest a wide variation in size. Except for the island state of Trinidad & Tobago, the vast majority of the people are of obvious African descent but with very different backgrounds culturally. Little effort has been made to see in what way this would affect their abilities to adapt to stressors.

The Afro-Barbadian is over 90% of the population but seems no more secure than the Afro-Trinidadian with less than 50% of the population.

We often talk of the inabilities of white psychiatrists to diagnose people of African origin, but one never stops to think of the need for understanding African people with different cultural backgrounds.

Current Problems

The major problem facing the African Caribbean person is coming to some common agreement on how to express their Africanism. There is the radical group that concentrates on appearance and embraces the philosophy of the need to return to Africa. The appearance involves African dress and sometimes, uncombed long hair. This group would highlight the historical contributions of individuals like Emperor Haile Selassie of Ethiopia and Marcus Mosiah Garvey, founder of the United Negro Improvement Association.

The conservative type, labeled by some as Euro-centric, speaks less of the continent of Africa, but concentrates on getting economically strong and taking away dominance from the small minority of whites. This group unfortunately is sensitive to the degree of skin pigmentation and hair texture. The degree of pigmentation of people of the African Caribbean has a meaning

whether economic, social or as an indicator of the stage at which the male White British slave masters got into sexual relationships with the local people. Hence there are sub-groups who say they are not Black but Colored, not African but a mixed race. These differences in how African Caribbean people identify themselves has resulted in major conflicts that still exist.

Problems Facing African Caribbean People

Problem 1: Adolescent Defiance

Many males (and females to a lesser extent), in late adolescence and early adulthood have an significant identity problems, and in an effort to deal with this, many have ended up in an institution such as a correctional center like a government industrial school prison, or the mental hospital. As described above, their parents and grand parents still have a strong European influence whereas the adolescents are identifying with Africa, in defiance of their parents.

They often choose to identify with the Rastafarian group and become anti-establishment. The Rastafarians often dress in African colors with long, uncombed hair. They "meditate" with the help of Cannabis and would like to return to Africa, specifically Ethiopia. They are easily identified because of their matted hair known as, dread locks. Marihuana usage is the norm for this group and hence it is easy for them to be picked up by the police. The magistrate in the Court might use either the prison or the mental hospital in an effort to reverse this form of defiance. In an effort to identify with Africa many adolescents are ending up in custody.

The international success of the Rastafarian Bob Marley and his African rhythm are a very strong force and become a route to identifying with Africa. The Rastafarian sees marihuana as a facilitating agent in worship and in meditation and they think it is better than using alcohol. Some of the ideas expressed during cannabis use have been interpreted as delusions and frequently the adolescents are given anti-psychotic medication against their will.

The adolescent male, who, in defiance, chooses marihuana and not alcohol; vegetarian food not meat; long hair rather than the low cut; Africa rather than Europe; a black rather than white Jesus, is making a cultural and lifestyle choice, and should not be diagnosed as borderline personality disorder with marihuana addiction. If mental health workers can be made sensitive to these cultural issues, and the magistrates in the Court can be advised accordingly, then many of our young men would be saved from early institutional life.

In addition, there is a group of persons of both genders, in mid and late adulthood, who are also in conflict with the traditional British values and culture. Long, uncombed hair, refusal to eat meat and refusal to go to traditional Christian worship are some of the areas of conflict.

Problem 2: Expressing *Africanism*

Nearly all African Caribbean people are aware of their African roots in terms of physical features, rhythm, motor coordination, to mention a few. There is however, some doubt as to the best way

of expressing these feelings. The more radical approach is to express this through dress, hairstyle and the preference for an African prophet like Haile Selassie rather than Jesus. There are Pan-Africanists who feel that this should be done by providing full-fledged and all-embracing courses in African history throughout secondary and tertiary education centers. The Director of the Commission for Pan-African Affairs in Barbados recently stated that colonial education left out vital areas, and in his words, "we learnt everything else, Adam and Eve, Jack and Gill. . .except our roots".

The less radical group assert that they too feel very strongly about their African heritage, but they do not want to associate with African dress, uncombed hair or the "Back to Africa" sentiment. The situation is more complex since our African ancestry has been thoroughly diluted by European influences, yet is far easier to trace the more recent European elements.

Problem 3 Suicide

There is an increase in the number of suicides reported in the Caribbean region, and has been particularly documented for the twin island state of Trinidad and Tobago. (Of note is that studies done in the USA report that suicide rates are lower for African American males than White males and that African American females had the lowest rates). This increased rate of suicide is not unique to the Caribbean region, but it is of special significance because we are dealing with countries with small populations and small size where there are few secrets. One is always aware that the community monitoring process is excellent and the neighbors are as concerned with happenings in the home as they are with the activities in the village and district. The stigma of mental health issues are thus magnified in when living in a small society.

If we accept a feeling of hopelessness as a major factor that drives one to suicide, then the degree of insecurity and frustration of the African Caribbean must be considered as a possible factor for the increase in the suicide rate. The increase in suicide behavior reported in the region among African Caribbean people should be a main focus of mental health efforts.

Problem 4: Relevance of Psychiatric Diagnoses

Common diagnostic terms used in psychiatric practice like Major Depressive Disorder, Borderline Personality Disorder, Adolescent Crisis, Anti-Social Personality Disorder, Paranoid Personality Disorder, Marihuana Psychosis etc should be revisited. The criteria recommended by the DSM IV will need alterations in order to be more relevant to the populations discussed above.

Problem 5: Lack of Accurate and Relevant Research

There are few studies that have been conducted in the Caribbean on the norms of behavior among our people. We do not have any idea of some of the basic facts on psychopathology. We make statements about our people with no scientific evidence, for example:

"People of African origin have more somatization as part of their depression"

"People of African origin have more hysterical reactions but much less obsessive-compulsive symptomatology"

A research foundation should be set up to establish appropriate behavior and psychological norms for Caribbean people. From the account given above, one sees clearly that there are different issues and preoccupations in different Caribbean territories based on history, size, economic situation and ethnic mix. Any research done regarding the diverse African people of the Caribbean should take this into account.

The African Renaissance and the Struggle for Mental Health in the African Diaspora

Frederick W. Hickling, M.D. Jamaica

The mental health challenge for African people in the Diaspora at this time is to make sense of the psychology of racism and colonization, to challenge the psycho-sociological constructs of slavery and underdevelopment, and to catalyse the transformation process that will move the African Diaspora into freedom, prosperity, and psychological stability. The challenge for African mental health professionals at home and abroad is to create a blueprint for mental health in the African Diaspora. This presentation attempts to meet this objective, by revisiting the developmental history of the world using a psycho-political analysis with race as the primary dialectic construct. This challenges the conventional political analysis of Karl Marx, which uses class as the primary dialectic construct, and rejects the post-modern constructs of Foucault (1) and others as the latest form of western philosophical orthodoxy, which facilitate globalization.

This thesis negates these analyses using a historical and political methodology called psychohistoriography developed on the Caribbean island of Jamaica, and grounded within a post-colonial philosophical perspective. It concludes that historical events of the past five hundred years have systematically confronted the European imperative to own the world and the people and resources contained therein. These challenges to world history have forced the systematic transformation of world mental health systems, based upon the negation of the Eurocentric concept of white supremacy and the confrontation of the European delusion of world ownership by Divine Right.

The concept and praxis of the African Renaissance, which has emerged since the fall of apartheid in South Africa, represents a recent phase of the historiographic negation of the racist European social system that has dominated the history of the world for the past five hundred years. Makgoba (2) defines the African renaissance:

> "The African renaissance is a unique opportunity for Africans to redefine ourselves and our agenda according to our own realities and taking into account the realities of the world around us. It is about Africans being agents of our own history and masters of our own destiny" (Makgoba 1999, xii).

The African Renaissance and the struggle for mental health in the African Diaspora must also be seen within the context of Pan Africanism and the great Pan-Africanists of the recent century. Frederick Douglas, Harriet Tubman, W.E.B Dubois in the United States, Marcus Garvey, George Padmore and CLR James from the Caribbean, join Jomo Kenyata, Kwame Nkrumah and Nelson Mandela to represent some of the great Pan-Africanists of the 20th century, who have helped to chart the emergence of the African Renaissance and the necessity for African people to redefine ourselves.

This paper argues that the African Renaissance must be seen in the context of mental health in the African Diaspora. This paper argues that African mental health must incorporate the phenomenological perspective of psychiatry within the prism of the psychological, political and philosophical experiences of African people. This paper posits a thesis that demands the rethinking of the African epistemology from an interdisciplinary and philosophical repositioning, and the fusion of such thought with the dream of a united Africa, and the Pan-Africanist vision of cooperation and justice. The thesis takes off from the writings of another Caribbean psychiatrist, Frantz Fanon (3) using race as the primary dialectic for analysis, and repositioning class as the secondary dialectic antipode.

Method

The ideas and concepts in this paper have come from a number of psychohistoriographic large group experiences over the past twenty-five years. The technique of psychohistoriography (4) was developed at Bellevue Mental Hospital, Jamaica in the late 1970's. The process was developed in response to the major changes that were taking place in that mental institution as a result of the intense de-colonization process that had been triggered by the political climate in Jamaica in that decade (5). The technique was adapted from the concept of historiography which is a method of analysis of historical documents which had been described initially by Thomas Becker (6) and by the Caribbean historian Elsa Goveia (7). Historiography is a method of analysis of historical documents to determine a given society's outlook, ideology and beliefs and to identify dynamics and social forces that compel change.

Historians have used historiography to analyze the writings of the period in a particular region to identify the vectors of change in a given society. Often, there have existed conflicting views between historians and psychiatrists as psychiatrists have tended to make exclusively causal (biological) explorations, whereas historians have tended to address themselves exclusively to the understanding of actual experiences in all their detail. The time has now come for both sciences to include, within both fields of enquiry, the evidence from psychopathology to work for their mutual advancement.

The investigation of psychopathological phenomena in society and in history must be of prime importance to the development of a realistic perspective on our total human reality. In order for therapy to progress, and for change to take place, the patient must internalize the insights in order to facilitate transformation by dealing with forces that block action. The marriage of psychiatry and history through the investigation of psychopathology must promote problem solving and reality testing and facilitate the mastering of anxieties. The process must reinvest normal life goals within the acceptance of personal limitations and handicaps while fulfilling the development of the highest degree of human creative potential.

Thus the technique of historiography was incorporated in a graphic technique called *psychohistoriography*; an analytic methodology designed to produce insight in a group situation

by the examination of psychopathology within the historical perspective of that group. The method incorporates historical material garnered from anecdotes and knowledge within the oral tradition and presents this material in a graphic form within a dialectic perspective; to identify reality based themes and trends; and to facilitate productivity and change for the individuals and group. Psychohistoriography was developed in the mental hospital in Jamaica within the context of helping people from various socio-economic and educational backgrounds with under-developed political and psychological constructs, to debunk the myths of colonization and to establish reality as a framework for future action.

Psychohistoriography uses group psychological dynamics in the collective analysis of the group's history and behaviour as recorded in the person's memories, exemplified in the oral tradition that is so common in the culture of the African Diaspora (8). A major contributor to the components of the process has been the Martiniquan psychiatrist Frantz Fanon, one of the first psychiatrists to recognize the importance of politics in the understanding of the psychopathology of human beings and in particular, black people. Fanon demanded that the historical perceptions of the world be seen within a dialectical framework and that psychological analysis is incomplete without this component. The analytic work of Fanon has given us a platform for contemporary analysis, and locates this work firmly on the shoulders of the ancestors who have gone before.

The psychohistoriographic analysis occurs in a large group setting with a designated chairperson and analyst. Using blackboard or a large flip chart, the analyst begins by drawing a horizontal line across the centre of the chart, constituting the time line or time continuum. The group decides collectively the period of history under consideration and the analyst charts the initial year of that period on the extreme left edge of the time line. The present year is charted at the extreme right hand edge of the time line and the line between these two points is subdivided with equidistant points each representing equal time periods.

A dialectical matrix is then established above and below the time line. The conventional dialectical continuum used in the context of Marxist dialectic materialism is the social class continuum. This dialectic continuum is charted on the extreme left-hand side of the graph and the dialectical antipodes of the class are placed on the top and the bottom left hand corner of the chart respectively. In this context, the primary dialectical matrix identified was the racial dialectic, with the anecdotal historical material serving the interests of the white and the black people involved being charted. The social class dialectic, those of the rich and the poor, was also charted, but as the secondary dialectic antipode. Central to this understanding of the separation of these dialectic analytic continua, was the identification of the coterminous relationship between race and class (9). The third matrix, which is important for the analysis, is the dialectical matrix of the mad and the bad. Once the psychohistoriographic matrix is completed, it is then ready to receive historical data either from anecdotal materials within the group or the reports of written work characterized in particular times on the graph.

Using conventional group dynamic techniques, the group discusses its history by eliciting the individuals' free associations. Each historical fact is verified by the group and is referenced wherever possible or necessary. Once consensus is achieved regarding each historical datum, the group establishes its class relationship. The datum is then entered on the chart at the point corresponding to the time when the datum occurs and which has been collectively agreed upon as the racial/class position. As many historical facts as possible are discussed by the group and recorded in the manner stated. Very soon the chart becomes filled with consensual historical material.

The analysis continues by the process of visual inspection by the analyst and the group, identifying specific clusters of charted historical data. Around these clusters vertical theme lines are drawn and horizontal trend lines are established again by group consensus. The theme and the trend lines are then labeled by the group using single words or single phrases which express the group's perception or insight of the theme or the trend. The theme lines represent a cross-sectional analysis at a particular point in time, and are represented by labels at both dialectical ends of the chart, either at the top or the bottom, respectively representing the race/class/psychopathologic perceptions of the historical themes. The labeled themes are then listed on separate sheets of paper and are used within the process of "insight bringing", in order that the group can understand the development of their attitudes and behaviours through this particular analysis of the dialectical perspective of their history.

This paper will now identify specific and repetitive theme lines that have emerged from a number of different collective analytic processes in different group settings over the past twenty-five years.

Results

1. 'The Discovery Grande-Invaders: "come outta mi land" (circa 1492)

The European encounter with the New World began as an accident with Christopher Columbus endeavoring to find passageway to the Far East. Instead of finding that pathway, he encountered millions and millions of human beings, unknown to the European world, who inhabited North and South America and the Caribbean. The dialectic perception of this discovery by the Europeans is strongly contested from the perceptions of the indigenous Caribbean and American people who regarded the European "discovery" more as an intrusion, and in reality an invasion of their personal, social and geographic space by marauding White pirates. The early sixteenth century writings of the Spanish monk, Las Casas (10), identify the dialectical processes involved in this period. The Europeans were particularly interested in plunder and the exploitation of the mineral resources and other treasures of the lands that they had "found".

The principal insight of this theme line was the recognition that the Eurocentric concept of

white supremacy, which identified European ownership of the world, the indigenous people and resources therein by Divine Right, were elements of a collective delusion which we have called the *European psychosis*. Essential to this delusion was that people of color, the indigenous inhabitants of the rest of the world, were sub-human, only slightly superior to domestic animals.

2. Ethnic Cleansing: Genocide: "dem a kill we" (circa 1520)

By definition, a delusion is a fixed, false belief, contrary to rational argument, which is out of keeping with the cultural beliefs of the time. Clearly, the delusional ideas of owning the land and the people of the world were out of keeping with the belief systems of every culture in the world, with the exception of the European culture. By the systematic eradication of all opposition of the indigenous people by mindless and ferocious genocide, and by systems of cultural imperialism, the European was able to impose the madness of European colonization on the world. Las Casas describes the voracious genocide of the native Arawak and Carib Indians of the Caribbean by Spanish Europeans. Millions of people were wiped out not only by diseases brought to the New World by the Spaniards, but also through the systematic genocidal destruction of these people who were hunted down by bounty hunters paid for by the state. The Spanish were excited by the prospect of gold and other mineral riches to be found in the New World. By the middle of the 17th century, the Taino Indians of the Caribbean had been virtually decimated. Thornton (11) estimates that there were 72 million native people in the western hemisphere but that they were reduced to less than six percent of that number, slightly more than four million people, in the following two centuries. The European delusion had been dragged into reality by the genocidal negation of the cultural opposition. The gun had become the midwife of the madness.

3. The Rights of Europeans: "Dem wipe de slate clean" (circa 1655)

The Americas and the Caribbean represent a slate wiped clean by Europe - a template for European social engineering. Having removed the original inhabitants, Europe proceeded to re-engineer these countries and populate them with Europeans, and then with Black people enslaved from the continent of Africa.

Millions of African people from West Africa and Southwest Africa were brought across the Atlantic in the Middle Passage to feed the plantation system developed by the Europeans. The British Merchant Navy was the main agent of transportation of the African slaves, who were sold on auction blocks from Barbados in the East to Jamaica in the West, Charleston, North Carolina in the North to Palmares, Brazil in the South. The physical and mental cruelty of the process of enslavement, the period of enforced labor and the passage across the Caribbean is a story that has not been completely told. The dis-membering of Africa and the Holocaust of African slavery certainly does not impinge upon the memory of European people in the same way as the Jewish Holocaust of Nazi Germany has impinged upon the collective psyche of white people at this time.

4. 'Fuelling the Plantation-The Birth of Capitalism, Forced Migration, African Slavery: "dem tek we from we lan" (circa 1700)

The horror of the imposition of the European psychosis on the New World and the African people has recently been summarized

> "The suffering and mental illness of the enslaved African people at that time must have been untold and horrendous, but whoever heard of a mad slave? Slaves who had physical and mental disability would no doubt have been swiftly executed and exterminated by the European slave owners and slave masters, leaving the perception that mental illness was something which was not known in African people. This lie was clearly expressed by Halliday in his writings in 1824, which declared that mental illness was rare in the slaves of the West Indies, in the heathens and pagans of Africa, and in Welsh and Irish peasants. Suicide by hanging and dirt eating at an individual and a group level was common among slaves on their way from Africa and within the Caribbean plantation system. But the horrors of the African experience in the New World did nothing to diminish the African cunning for survival, wisdom for regeneration and reinvention of self, penchant for adaptation, and courage to resist the enslavement".
>
> (Hickling 2002, p114)

The ferocity with which the ideas of white supremacy and European ownership of the world were imposed can only be likened unto the irrational violence of psychosis. The essence of this psychohistoriographic theme underlines the epiphany that the collective delusion of a race, a psychosis of racism, can be imposed on whole nations of people, if the lunatic enslaver holds the instruments of superior military power.

5. Emancipation from Slavery: "fight down de white oppressor" (circa 1830's)

European colonization of the New World virtually wiped out the indigenous populations of North and South America, but the stubborn ferocity with which African slaves in the Americas resisted the slavery imposed by the European madness soon triggered the emancipation of African slaves. This retreat by the European slave-mongers to concede emancipation in essence represented the first major collective *psychological encapsulation* of these delusional ideas within the sweep of history. A new modified form of the European psychosis called colonialism, which produced a new layer of European exploitation, replaced slavery in 1834 in the New World.

The incisive analysis of Trinidadian African scholar Eric Williams identified that this period heralded the birth of the capitalist system by fuelled by the Industrial Revolution in Europe. From the perspective of this psychohistoriographic analysis, the capitalist system must be seen as a psychopathological construct, the material economic manifestation of the delusional greed of the colonizing European.

6. 'Treaty of Berlin: The Scramble for Africa: "dem tief we lan" (circa 1884)

By the end of the 19th century, the European nations were engaged in a frenzied scramble for control of Africa , as their attention was shifted from the exploitation of the New World to the under-development of Africa during this period of time. Walter Rodney, the Guyanese African historian, in his book *How Europe Under-Developed Africa*, made clear the processes that were used by Europe to continue the ruthless rape of the African continent and the African people.

Psychohistoriographic analysis has illustrated the cunning and Machiavellian strategies used by the European colonizer in the maintenance of the enslavement and exploitation process. As the development of the capitalist system ensured the sharpening of the class forces in Europe and around the rest of the world, this also formed the basis for the persistent poverty, described so eloquently by Jamaican African economist George Beckford, and the dire economic situation of African and Caribbean people.

7. The European Wars: "fighting over our treasures" (circa 1914)

The scramble for Africa by European nations at the Treaty of Berlin in 1884 was the precursor of the two European wars, commonly referred to as 'World Wars". These ferocious battles represented a struggle between the European nations over world hegemony. The contempt with which Europe simply divided up the African continent, is a reflection of the lunacy with which Europe mid-wifed modern Africa through the creation of boundaries that served their grandiose and delusional interests in their frenzied quest for African land, labor and raw materials. Magubane points out how Lord Salisbury the British Prime Minister, in a speech on 6th May 1898, divided the nations of the world into the living and the dying with the relegation of African nations into the category of the dying nations.

Magubane asks the question whether we can dismiss the callousness of the actions of the Europeans as characteristic of their time and of no interest to us in the present. This psychohistoriographic analysis provides an answer to the question, by forcing us to apply the thinking and actions of the time into a psychopathological continuum of the European delusion, which has existed for five centuries and is most certainly still alive at present

8. White on White Racism: "Dem ah kill dem one anoder"

In the sweep of the history of the latter half of the millennium, certain critical historical events can be identified which at first glance might not fit easily into the psychohistoriographic analysis which has identified the European psychopathology. These events are the American Revolution in 1776, the French Revolution of 1795 and the Bolshevik Revolution of 1917. However, on the contrary, these events merely buttress the conclusion of the existence of the European psychosis, as they underscore the reality that the delusion has and continues to exist, as evidenced by the hostility of one white ethnic group for another.

The early European settlers in America were themselves escaping from the racial and ethnic

cleansing of their own kith and kin in Europe, who were attempting to perpetuate their tyranny across the Atlantic. The white French aristocracy treated the French peasants who stormed the Bastille with the same contempt and oppression that they meted out to their African slaves. This truth is revealed in the increased violent expression of the virulent European delusional system directed by the white American revolutionaries towards their own African slaves. Unlike the African slaves however, the French peasants were subsequently absorbed into the French racial tapestry following the revolution. Liberty, equality and fraternity were the watchwords of the French revolution, but only for white French people, not for their Black African and Caribbean slaves.

The Soviet Revolution contained within it similar expressions of the virulence of the European psychosis. In spite of proletarian platitudes of comradeship with people of colour, the harsh expression of racism by Soviet people to blacks at home and abroad has often been reported. Numerous examples of white on white racism insert themselves into the psychohistoriographic analysis but receive the same analysis and treatment. The English attempt to subjugate the Irish, and more recently the Serb genocide against the ethnic Albanians serve as other examples.

In this regard, we must not forget the atrocities and the mental suffering of the Jewish holocaust in Nazi Germany in the twentieth century. Again, this is another example of white on white racism within the context of the European delusional system. But as with the other examples of white on white racism, once the problem has been resolved with the oppressor, the victims of this type of racism become the perpetrators of an even more virulent form of racism against Black people. The behavior of the Jewish State of Israel to the Palestinian people in the latter half of the twentieth century and the early twenty-first century illustrates this complicity with the European madness.

9. Independence from the Empire: "gimmie back mi lan" (circa 1955)

Emancipation represented the first watershed defeat of the European psychosis and its retreat into its new form of colonialism. The independence period in the decades of the 1950's and 1960's represents the next major historical defeat of this psychopathology, the dissolution of the "empire" and the birth of the next phase, now known as neo-colonialism and subsequently as globalization.

Crippling racism was experienced by the soldiers of colour from India, Africa, the Caribbean and America who fought for the west in the trenches against the Kaiser in the First European War. The racism that was meted out by their colonial masters acted as a catalyst for revolutionary anti-colonial fervour on their return home. By the early 1930's, political discontent and rebellion were springing up all around the British, Spanish and French empires. By the end of the Second European War, the colonized people of the Caribbean, India and Africa had pushed Europe against the wall and forced the political break-up of their empires and the creation of politically independent nation-states.

Once again the racist psychosis had been confronted, had been pushed against the wall by the struggles of Black people around the world. Once again the most virulent elements of the delusion were pushed back and encapsulated. Once again the resultant compromise with Europe allowed the psychosis to survive in exchange for major political concessions to the people of colour. However, the fundamental mainstay of the psychopathological European social system, the economic control of the resources of their former colonies, remained intact. The European psychosis metamorphosed and survived, to reform itself again. With each defeat, more of the psychosis was forced to encapsulate while the struggle for survival of the remnants of the delusion became more desperate.

10. Defeat of Apartheid: The African Renaissance (circa 1993)

The thirty-year period from 1960 to 1990 saw the turbulent realignment of political and strategic forces around the world as the European psychosis was pushed back and forced to encapsulate further. The Civil Rights Movement in the United States of America forced the ruling centre of the European psychosis to check its more virulent elements. The escalation of racial tension in the United Kingdom forced the "mother" of the European psychosis to admit that institutional racism was alive and well in Britain. The recent McPherson Report which looked into the death of African Caribbean teenager Stephen Lawrence, substantiates the numerous previous reports of racism by the police force in Britain. Most blacks living in Britain know, as a daily reality, that race is the basis of social barriers that are endemic in modern British society. The perception of many black people living in the UK (challenging the postmodern orthodoxy), is the presence of a pervasive racist conspiracy which riddles British society and makes the daily living for most black people in Britain a living hell.

The stupendous victory of the African people against Afrikaner Apartheid System in South Africa is seen by some as being nothing short of a miracle. The victory represented decades of struggle and courageous valour by the African masses in the face of the most vicious expression of the European psychosis witnessed on earth. The fact that this virulent form of the European psychopathology was allowed to flourish by the rest of the western world reflects a paradox. Even in the face of significant encapsulation of the white delusional system around the globe, evidenced by emancipation and the independence movements, bizarre, grandiose delusions and psychotic thoughts were allowed to flourish in a raw and unexpurgated form in apartheid South Africa, in many respects nurtured by the west. The victory over apartheid in 1993 represents the next major world historical victory against the European psychosis, and has itself given birth to the fledgling epiphany of the African Renaissance.

Jamaican African visionary leader Marcus Mosiah Garvey articulated the concept of Pan-Africanism at the turn of the twentieth century. His newspaper The Negro World was translated into 25 languages, and long before the telephone or the Internet, was being read and studied by African people in every corner of the globe. In 1945, at the 1st Pan-African Conference held in

Manchester, England, the vision of that movement was given flesh by the African Founding Fathers. Ghanaian African Kwame Nkrumah, Kenyan African Jomo Kenyata, Trinidadian African George Padmore and American African William E B Dubois, and Peter Abrahams, a South African who was later exiled in Jamaica, were the major players.

By 1963, the Organization of African Unity came into being at the Founding Conference held in Addis Ababa. Soon after that conference H.I.M. Emperor Haile Sellasie gave his famous address to the United Nations in California on Feb. 28 1968, which has been immortalized by the song of Bob Marley "War":

> *Until the philosophy which holds one race superior and*
> *another inferior is finally and permanently*
> *discredited and abandoned...*
> *everywhere is war*
> *mi sey war...*
>
> *we Africans will fight we find it necessary*
> *we know that we shall win, as we are confident in the*
> *victory of good over evil*

The relentless battle of people of colour against delusional European racism in this historical period was undoubtedly the cause of the eventual defeat of the Afrikaner Apartheid system in South Africa. The recent declaration of the formation of the African Union in July 2002, fashioned on the European Union represents the most recent advance of this encapsulation process. From the perspective of psychohistoriographic analysis this victory represents the latest in the escalating historical negation of the European racist delusional system. As with the other watershed periods described, the victory was not final, was not complete, but represented a compromise formulation with the European delusion. The victory forced a further negation of the delusion, placing political power in the hands of the African masses, but still leaving the ownership of the commanding heights of the economy in the hands of the Whites.

It is very simple for the seasoned observer, the insightful historian, the grounded psychologist to recognize the similar components of institutionalized racism, whether it exists in postcolonial Jamaica, the deep southern United States, in Stephen Lawrence's Britain or in post apartheid South Africa. White people still own the commanding heights of the economy, and blacks are forced to scrape out a meager survival in a social reality that relegates them to an economic second class. Even in the countries where Blacks are in the majority and are in political control of the society, the tangible elements of the racist delusional system still control the reality for black people.

From the perspective of this analysis, the insights gained have revealed that the birth of the capitalist economic system represented a psychopathological manifestation of the insane European social system. The surplus generated by theft, exploitation and slavery imposed by this

lunacy has formed the material basis for the birth and growth of the capitalist economic system and has left Black people with a Catch 22 situation. Without control of the commanding heights of the economy, black people are destined to eke out an existence in the ghettos of the canefields and the copper mines, in the inner cities and the townships.

The profound importance of the insight that the capitalist system is a psychopathological mushroom of European madness being imposed on the rest of the world will be of the greatest importance in our consideration of the African Renaissance. The psychohistoriographic analysis predicts that the next watershed points in human history must confront this lunatic economic construction. In Thabo Mbeki's words, ". . .we are subjected to the strange situation that the process of the further reproduction of wealth by the countries of the North has led to poverty in the countries of the South". Without the confrontation and defeat of this capitalistic madness there can be no African Renaissance, and the historic defeats of the past will simply have dashed the struggles of the African people at home and abroad against the treacherous reefs of European psychopathology. But the compelling and relentless defeats of the European delusional system provide a historic comfort that human life on this globe will not tolerate the continued existence of this lunacy.

The African Renaissance and Mental Health

Many will find the perception of racism in this account as a reduction to the level of psychopathology, and will consider this to be problematic. However, this is the essence of this analysis, and is the principal insight from the process of psychohistoriography. No doubt this perception will challenge thinkers from Africa and elsewhere, and will at the very least be controversial. Few can deny however, that much of the time and resources of the world for the second half of the millennium have been devoted to the irrational European desire to own the world.

The greatest challenge to the mental pathology of European colonialism and enslavement has come from black popular revolt. Stuart Hall and his colleagues have picked up the psychic challenge of the black revolt of the period, and begun to articulate the intellectual and philosophical challenge to postmodernism. The western dominated paradigm of postmodernism assumes the ability to explain all and to apply meaning to peoples of all cultures in a unitary way. Hall has posited the antithetical construct to postmodernism, which has become known as post colonialism. Postcolonial theory describes how the processes of colonization and decolonization have been indelibly branded within the cultures of the colonizers as well as within those of the colonized, thus displacing the "story" of capitalist modernity from its European centering to its dispersed global peripheries; from peaceful evolution to imposed violence; redirecting the focus of the transition from feudalism to capitalism and replacing this with the formation of a world market controlled essentially by Europe.

Most importantly, Hall and his colleagues have constructed an intellectual and philosophical

platform in Britain for black people to redefine issues of their own mental health. It is hard to comprehend how European society successfully renders people with black skins 'invisible'. Melba Wilson argues that " In mental health terms, the invisibility engendered by the image, when combined with the overall tendency to portray people with mental health problems outside the bounds of normality compound the disadvantage experienced by black people in both the mental health and criminal justice systems". The stereotypical images of black men as violent rapists, black people as lazy and unproductive, and black families as unstable and pathological are clearly rooted in the experience of racism

At a recent conference on Pan African Mental Health held in Dakar in Senegal in April 2000 a call was made for the establishment of a Pan African Association of Mental Health Professionals. Such an Association would certainly facilitate a blueprint for mental health in the African Diaspora. I suggest that the blueprint should include the following elements:

1. A vehicle for African Unity across the Diaspora
2. Development of psychological processes designed for the negation of the effects of racism and colonization in people of colour in the Diaspora.
3. The training of culturally sensitive mental health workers for every community of black people in the African Diaspora
4. The creation of community based mental health services across the African Diaspora
5. The deinstitutionalization of European colonial custodial mental hospitals in the African Diaspora.
6. The establishment of rehabilitation facilities across the Diaspora that places work as therapy and the use of art, dance, music and drama as the vehicles for African mental health
7. The use of evidence-based mental health methodologies for Africans at home and abroad

Perhaps the most important mental health imperative for African people in the world today is to find strategies for navigating capitalism, and the encapsulation of the European psychosis. African people have as much right as any ethnic group to be in all parts of the world and to claim ownership of the world community which we have helped to build by our labour and our blood. Once there are white Africans, there will certainly be black Europeans. Our navigation maps must include creating safe places where African people can be culturally safe and secure. We must restore the driving ambition of our people, which has tended to be erased by this pervasive delusional system. We have to continue our process of stepping out of being the underclass and being our own masters as we create economic wealth across the globe, which will teach us how to live with ourselves in a harmonious and unified way.

This must be the focus and the vision for all black people - The Unity of Africans at Home and Abroad!

The French West Indies: Mental Health and Westernization

Aimé Charles Nicolas, M.D., Ph.D. French West Indies

Out of deference for our Chairman's namesake, I propose to take a pragmatic stance and I will interpret the meaning and justification of my beliefs in terms of their "practical" effects.

Just like Julius Caesar's Gaul, France is divided into departments. There are four French Overseas Departments: Martinique and Guadeloupe (which form "les Antilles" or French West Indies, with 400,000 and 480,000 inhabitants respectively), French Guyana , with 200,000 inhabitants (the three form the French Departments of America, or FDA) and La Reunion in the Indian Ocean, near Madagascar. All of the people understand French and speak Creole except for those from France. Law, rules and regulations are the same in the FDA as in France.

In terms of patterns of settlement the situation was similar in the different French Departments of America: in addition to White settlers who have remained few, the slave trade brought over the majority of black people from Africa. The abolition of slavery (1848) made the slave owners fall back on indentured workers: Indians from the south of India between 1852 and 1863, Africans (1857-1862) and Chinese (1859-1860). Syrian and Lebanese traders came in the 30's followed by a few Italian tailors.

After exporting people to France in the 70's, Martinique, Guadeloupe and French Guyana (FDA) have been the recipients of immigration since the end of the 1980's, mainly from Haiti and from the nearby English speaking islands. Recent migrations have particularly modified the population of French Guyana with African-descended immigrants from Haiti, Surinam, and Brazil.

Despite the békés (white Creoles) who form a powerful, closely knit endogamous financial elite, the society of FDA is deeply interracial with intimate relationships between whites, "colored" and blacks, including sexual ones, continuing to be formed. There is an important black / "colored" middle class of civil servants (and clerical waiters) and a rich upper class of mulattos .

More than 80% of the present population are African descended people. References to slavery are numerous in public life and the abolition of slavery, attained through sheer force, is fervently commemorated every year. The importance that we have to give *today* to the story of slavery is an object of controversy. So is the question of our identity: what relative importance should we attach to our African roots and to our European heritage? Nevertheless, there is no doubt about our pride of being what we are.

In France, in order to avoid stigmatization and discrimination, identity documents do not include ethnic or religious data. For the same reasons the census is not allowed to include data on the ethnic composition of the general population, so it is not possible to give statistics about it.

Mental Health Issues in the French West Indies (FWI)

In the field of mental health, the main issues are not related to poverty or discrimination in the

FDA, as opposed to metropolitan France. In spite of pockets of deprivation, the standard of living in the French West Indies is not low. Social security (Universal Medical Insurance) provides ready access to medications.

There is one psychiatrist for every 10,000 inhabitants, that is to say, about forty psychiatrists on each island. The number of black psychiatrists has been decreasing for the past eight years. The white psychiatrists come from France and do not speak Creole. Since the situations of white psychiatrists working with black patients there is an ongoing need for transcultural sensitization programs or seminars to facilitate the therapeutic relationships.

Nevertheless, the mental health issues are worrisome. Five major areas of concern emerge:

1. Lack of Family support
2. Dysfunctional Parents and Families
3. Violence
4. Substance Abuse
5. Immigration Related Mental Disorders

1. Lack of Family Support

Changes in the family structure: the extended family in the rural areas with a devoted grandmother and a lot of aunties (even the neighbours were part of the family) is disappearing. Country people go to the cities. Single parent families are as numerous as before and the link with the fathers is just as fragile. In the two-parent families the marital link is weakened, separations and divorces are more and more frequent.

People are brought up in an insecure context. The meaning of life is increasingly founded on personal material success and less and less sculpted by the tenets of uprightness and honesty. On the contrary, these values represent impediments to the success of a professional career. Psychiatric patients no longer enjoy their traditional status and their cultural niche, instead, they have become a real hindrance, particularly in small public housing flats. Western individualism infiltrates into child rearing practices without the history and the background of western countries.

2. Dysfunctional Families and Parents

Parenting in early childhood seems to be easy, compared to the management of adolescence, which is often difficult and sometimes devastating. Mothers seem to be able to lead the child to 12 years age without any major difficulty but many experience helplessness in the face of adolescent rebelliousness. Drug abuse is the number one problem for the Public Health Service, above high blood pressure and diabetes. The increasing number of adolescent suicide attempts is a matter of concern even if it has not (yet) reached the rate of European countries. Antisocial behavior (petty crime is growing) increasingly takes a violent form. The media publish repeated reports about incest cases. Male chauvinistic violence is a persistent fact.

Parent-Child relationships are nowadays more complex and unstable. Profound and rapid cultural changes have widened the gap between parents and their children. Traditionally, the child must be at his/her parent's beck and call and the parents tend to try to subdue him/her instead of enlisting the child's cooperation.

The omnipresence of the ideological background of the TV and the permissive context of child-rearing and education has transformed corporal punishment into persecution from the child's point of view. He/she grows up without basic guidelines. In addition classic types of child neglect are a major concern.

3. Violence

More than the murders that hit the headlines, the multiplicity of daily, unnoticed petty crime, corrodes the social fabric. The tacit acceptance of the petty crime is a just cause for concern. The media are indeed full of anxious questions from readers, listeners and viewers regarding rape, incest, paedophilia, corruption, school violence, "road rage", the lack of a sense of civic responsibility, the crisis of authority and justice, and the "feeling of impunity demonstrated by these juvenile delinquents".

All of these disparate topics simultaneously stem from a central reference: transgression. Public opinion reflect worries about the non-observance of the rules of the moral game. The multiplication of petty crimes trivializes transgression. The burglars of service stations and jewelleries no longer hesitate to attack the employee. The immorality of the transgression is no restraint: one swindles a blind man, the ram-raid replaces the screwdriver, and they do not refrain from striking old people. Acting out has become easy.

Relationships with others have changed. To be approached by an unknown person increasingly involves a reaction of mistrust. Drivers' discourtesy increases the tension between people. From this point of view there is probably more violence today.

Most of these behaviors are not psychotic but linked to changes in the way of life and with the loss of cultural references. Psychological suffering seems to be more painful than it was when group life prevailed, maybe because the support of the extended family has disappeared Today families do not take into account anxiety and depression ("you must not coddle yourself"). People do not consult psychiatrists easily because of this disregard for psychological suffering and the stigma of psychiatric disorders. Loss of cultural references is frequently one of the key explanations given by the man in the street about the spread of violence and substance abuse.

4. Substance Abuse

For almost twenty years, crack has been destroying social integration. Before 1970 there were very few drug abusers in the FDA. Cannabis use began in the 70s followed by crack use since 1986. Crack has rapidly become the main drug problem although cannabis smoking can facilitate acute psychotic reactions. The "gateway drugs" are marihuana and alcohol. They are

used to calm "crack-wired nerves". The social complications of crack abuse, included family violence, crime and burglary are, today, the number one concern of the people of the FDA.

Crack abuse is an exclusive problem of African-descended people. We must make special efforts in this field. We have to make special efforts to involve the community and the political leaders to implement our propositions. Studies must be conducted to identify protective factors. Factors that seem to be protective and reduce the risk of substance abuse are:

1. Effective and consistent child-rearing practices
2. Cohesive family structure
3. Traditional solidarity in the countryside
4. The presence of craftsmen and small traders, and small scale production
5. Geographical or architectural structures that permit the visual control of the comings and goings of individuals involves with drugs
6. The stability of the settlement
7. Maintenance of the traditional way of life.

5. Immigration, Migration and Psychosis

Since the publication of "Aliens and Alienists" in 1987, several studies have been devoted to the question of the excessive rate of psychosis among the African-Caribbean population living in England. Three studies have reported that this high rate of psychosis is not found among African-Caribbean natives who remained in their country of origin.

Comparison of the data showed that the migration factor had to be taken into account in order to explain why the African-Caribbean population, when living in England, present with a higher rate of psychosis than the white English population, but don't manifest a significant difference when remaining in their native countries.

How migration might increase the rate of psychosis among African-Caribbean immigrants, remains quite unclear. Various hypotheses have been proposed:

1. Predisposition to psychosis of the first migrant generation
2. Intermarriage among predisposed former generations
3. Social disadvantage
4. Racism

Areas of Potential Research

We have carried out a study that showed a higher rate of psychosis among a French West Indian sample than in the French metropolitan sample. All of this research however compares a

Caribbean site with a European site. I propose that we launch research studies comparing English speaking West Indians with French speaking ones in the West Indies, and comparing them with the descendants of migrants to France and Britain. These comparison comparison studies would be very interesting in many respects.

We must use the same methodology: the rate of psychosis has to be evaluated by the same means at each site. We could then compare West Indians with African-Americans, or with a Spanish West Indian sample where African-descended people are in a minority.

It would also be possible then to study several hypotheses including migration factors, misdiagnosis, mood disorders, genetic predisposition, cannabis and crack use, and the magical interpretations of life events.

To bring an effective response to transgressive violence and substance abuse in terms of changing individual and group behavior, we propose a collaborative process with an international management committee. On a local basis, five working groups would collect data, statistics and information about violence and substance abuse in their country and conduct interviews with the victims and perpetrators of violence, substance abusers and clinicians.

The five groups would work on:

Violence and substance abuse in the school

Violence and substance abuse in the family

Violence and substance abuse in the city

Violence and substance abuse in the work place

Violence and substance abuse the media

These groups would make proposals for concrete actions in their countries. An international management committee (IMC) would work as a superordinate pilot group that would keep an eye on the focus to avoid dissipation and give sense to the results. The IMC members would give information to the different national groups about the initiatives already taken in their respective country and about international data. On an ongoing basis the work of the groups would be reported to a forum/congress which would operate as an "agora" by facilitating and increasing the interaction between the professionals and the population. A symbolic dimension would be introduced by proposing to every participant a charter of several governing principles. In every site, a campaign of signatures could be entrusted to the school children that would enhance their education in civics. The mobilization of a majority of the people is one of the essential conditions for success. The IMC would supervise an evaluation procedure.

Conclusion

In other respects we probably need a permanent structure a sort of High Committee to

coordinate all these initiatives. Pragmatically, by organizing many exchanges of psychiatrists, we will get closer to our aim of better understanding the ways that African- descended people have adapted their psychology, emotions and behaviour wherever they have dispersed. Short and long stays of African descended psychiatrists in Brazil, the Caribbean, the USA etc. could produce interesting reports, books and projects and help in the practical implementation of our recommendations.

The goals and design of all of these collaborative projects are in keeping with the general pattern of what could be an African Diasporan policy: think regionally, act locally.

Psychiatric Issues of Haitians in the African Diaspora

Ghislaine L. Adrien, M.D. Haiti

"Haitians Deported from the United States of America Arrive in Port-au-Prince."
"Young Haitians Expelled from Canada"
"Young Haitians and Street Gangs in Montreal"
"Haitian Violence Group in France"
"Mass Deportation of Haitians Living in the Dominican Republic"

Unfortunately, and too often, these declarations constitute the headlines of newspapers published in Haiti, in Montreal and many other cities around the world. But what do these kinds of expressions mean for the local Haitian communities and those across the Diaspora? Let us analyze the problem for a better understanding. Our analysis should not be limited to only the many different reactions described above, but should include facts and factors older than the past ten years, and should be placed within the context of our concerns as a psychiatrists.

Haiti, as the poorest country of the American hemisphere, has been confronted for many years with very serious political problems, which are far from improving the economical situation. Haitian migration, which was relatively small during the first sixty years of the past century, has progressed massively around the middle of 1970's to reach an alarming number at the beginning of the 1990's.

Keep in mind that in spite of the dictatorial regime of that time, Haiti was not as criticized as it is now. The "French elitist education" which was praised and appreciated during those early years of increased migration, allowed the Haitian citizens in the Diaspora to establish a certain anchorage for their social norms. That anchorage dictated and insured the direction of their behaviors and their social relationships in their foreign environments.

The USA did not yet attract the Haitian elite who were not interested in migrating until the past twenty years. During that that time, many countries did not require entrance visas, and many of our compatriots were rather moree attracted to the "petroleum boom" that enriched Venezuela. However, a second flow of immigrants began to be directed towards North America, mainly towards the United States, which was known as "the land of opportunity" and was perceived as a synonym for money. Coming to America meant become rich in a few years.

Among those people there were some professionals, however, the majority of them lacked educational background and basic skills, and had serious economic problems. In addition, for most of them, the United States represented a liberal country where they could freely express their opinions; whereas in Haiti they could not do so, because of the dictatorship. Hence, their social integration was realized in a way that was completely different from the earlier immigrants, reflecting their different backgrounds and perceptions .

Haitian Population in USA in 1999

The more recent immigrant parents were obligated to work long hours daily to support their family as well as other relatives still living in Haiti. Thus, they could not devote enough time to their offspring. What was striking about the recently immigrated Haitians, was that they wanted their children to behave just like true American citizens (including the spoken language, the dress codes, etc.). At the same time, they expected them to keep their Haitian identity.

Those children born in the USA or in Canada speak English or French. Most of the time, they are unable to communicate with their own parents, whose language is Creole with a minimal knowledge of English. Parental exclusion in that situation has many consequences because role models for the young people do not exist. For these and other reasons, the parents were frequently ridiculed by their children who insisted on keeping their American identity.

In fact however, these "Haitian Americans" are living with a permanent ambivalence: *Am I an American or not?*.

Since the 1980's, the phenomena of the "Boat People" in Florida has caused a negative reaction against Haitians returning to Haiti (who more often than not are returned back to their native country) and those who eventually arrived in America. Most of the time, they are tolerated in their work environments but are socially excluded. As a marginalized community, they then turned inwards and recreated numerous aspects of home, such as "Little Haiti" in Miami in their own neighborhood ghettoes. Naturally, the young ones feel uncomfortable in such situations where they have been left behind or excluded. They react with violence and adopt violence as their way of acting out and turning their backs on society. They reproduce unhealthy "ghettoes" and begin to ruin themselves.

In response, negative commentaries and attitudes emerge from the local society, which usually does not readily accept those with "cultural differences". The local residents are usually afraid of foreigners. Moreover, in some countries, strangers, foreigners and black people are synonymous with "danger and insecurity". Generally, the native is afraid of the "other one", and if the "other one" is very dissimilar, the fear gets worse and promotes rejection. Frequently, withdrawal and/or violence become psychological responses to this situation. Clinical manifestations of psychosocial pathology like delinquency, drug abuse and aggressive behaviors become more frequent and extensive.

The situation is complicated for immigrants because each individual who enters a specific culture or society, by birth or by immigration, learns to act in accordance with the basic beliefs, values and norms of the existent culture. Each individual has a number of roles that he is expected to play and these role(s) may or may not be in harmony with the roles played in their native culture.

For most of the immigrant people there is also a gap between their home education, school

education and social life. The children of immigrant families are exposed to one set of customs at home relating to food, gestures, family organization, while at the same time, they are exposed to a different set of customs outside of the home, that of the dominant culture.

Most Haitians feel that cultural and social differences are not as important in the United States as in Europe, so they often do not recognize that behavior patterns differ for members of different social class. Because they have problems with the differing social norms, they frequently experience difficulties in communicating with the people around them. They automatically and unconsciously create interpersonal barriers by transgressing the common social norms of the majority group.

Deviation from the norm, especially in regard to the majority norms, is symptomatic of feelings of inferiority or marginality. It is therefore, very important for the immigrants to integrate all aspect the positive aspects of their native culture, since the majority of "excluded" people living in the urban ghetto, end up consuming drugs, joining street gangs or engaging in illicit activities with the resultant negative consequences, sentencing and imprisonment or deportation.

Over the past decade, many Haitians have been deported back to Haiti from France, North America, the Dominican Republic and some of the other Caribbean Islands.

What are the consequences of these returning deportees for the native Haitian population?

How should they be viewed and treated? Are they deported immigrants? Are they deported native Haitians? Are they illegals? Are they violents criminals or were their illegal behaviors related to being excluded from the local society?

The problems of deportees are complex. Most of them have either lived in the foreign country for many years or were born in the foreign country, and do not really know Haiti and do not speak creole. They have no link with the country.

Excluded from the host country, they are also excluded from Haiti. They are members of the "Diaspora" from their native country and they remain in the "Diaspora" in the foreign country. Being in the diaspora in both places, there are seen as a feared group and expected to have more criminality and violence. Frequently, with black immigrants, the criminality is used an excuse by some countries to export their criminals somewhere else, i.e. deportation back to Haiti and thereby contributing to the crimality problems in the receiving country. Many of the deportees also present with behavior disorders problems and mental disorders such as depression, personality disorders, schizophrenia and suicide.

The problems of immigrants in the Diaspora have many aspects: political, economical, psychological and social. To understand and help their patients, the psychiatrist has to address these aspects.

We also understand that the problems of the diaspora have a direct impact on our society,

particularly on the future of our teenagers and on the short and long term development and growth of the country. These answers to these problems will involve everyone, the psychiatrist, the social worker, the educator, the state and every concerned member of the society.

Separation and Reunion in West Indian Immigrant Populations in Canada

Granville da Costa, M.D. Canada

West Indian Immigrants in Canada

After the Immigration Act was changed in 1967, to remove its racially discriminatory provisions, West Indians began arriving in Canada in relatively large numbers. The new Act contained qualifications for immigrants, so it continued to be discriminatory at the bureaucratic level, since entry was based on the individual decisions of immigration officers at points of entry. Before that, under the Domestic Scheme which began in 1956, women from certain countries were allowed in as potential immigrants if they agreed to work for several years in homes as maids or child-minders.

In many West Indian immigrant families the children are reunited with their biological parents, most often their biological mother, after being in the care of surrogate parents for substantial portions of their childhood. The tasks of the parents and children at reunion are formidable and complex and are met with a rich array of adaptive behaviours. Some of these adaptive strategies, are often unrecognized, misunderstood, misdiagnosed, untreated or harmfully treated. There is little appreciation of the relevance of these adaptive strategies to the processes and natural history of reunion, and to the diagnostic assessment of these families and children. Unfortunately, physical and sexual abuse are frequently the only public faces of these reunions.

The separation of children from their parents in infancy and early childhood and their placement with surrogate parents is a common aspect of child-rearing practices, particularly in Afro-Caribbean populations. Review of published studies indicate that this practice is also reflected by a characteristic pattern of emigration. In a typical family an unmarried parent, usually the mother emigrates and leaves her children in the care of a surrogate, a grandparent or relative. There may be return visits to see the children or, years later, they rejoin the parents. These reunited Afro-Caribbean families are usually female headed and of low socioeconomic status.

Typically the parents had their first child in their teen years and parent-child separation occurred during the first three years of life. Siblings may not all have the same surrogate parent and parents may have started a new family after emigrating. Siblings usually rejoined each other in their parent's family at varying intervals with some parent-child reunions occurring up to 13 years later, with most of the children being in the 8 - 11 year old age range at reunion.

Most families are "matricentral" and are based on unions and not on formal marriages. In Jamaica, two out of three mothers are not married. Marriage tends to occur late in life when the partners are economically stable. More than 70% of children born are in these unions.

As children grow older, the likelihood of their remaining with their biological parent(s)

decreases. In one study at age four, 88% lived with one or both parents, and by age fifteen only 44% were still with their biological parent(s).

Recent studies indicate that mental health facilities are seeing an increasing number of these families, with referrals to the mental health or children's welfare systems occurring on average about three years after reunion. In one child clinic population, 25% of the families presented with pathological behaviours related to parent-child separation.

Studies that examined patterns of immigration in West Indian families also revealed the following:

1. Staggered arrival of immigrant children was the norm.
2. In some instances 18 years separated the arrival of the first and last child in a family. In 50% of the families, parents and children were apart more than five years, and in 17% more than ten years of separation occurred.
3. Parent(s) usually migrated first
4. 38% of children arrived later to join both of their parents, while 59% were rejoining their own fathers.
5. 47% of children came into a new family constellation.
6. 26% of children born in Canada, were returned to the West Indies, and later rejoined their parent(s) in Canada.

Reunion Behaviors

Reunion and separation issues seem to be inseparable, since reunion with the biological parent(s) must mean separation from the surrogate parent(s). Sadness and related affects can be the emotional responses to the disruption of either of these bonds and the the associated social and physical contexts.

For many parents their wishes for a better life for their children gave them optimism and allowed them to rehearse, through mental imagery, making the accommodations and arrangements that would be needed once the children rejoined them. It appears that in some instances the anticipation of the reunion gave the biological parents a sense of being consummated, as they sought to define a different reality for themselves in managing their sense of incompleteness and estrangements due to the loss of their parenting roles. Their roles as mothers or fathers were ascribed on the basis of the responsibilities of kinship, in which certain kinds of parenting behaviors were carried out as a celebration of the coming together of an idealized family. Their anticipation of reunion sustained them through their vicissitudes as immigrants, and it gave new meanings to their lives through the enactment of their fantasies as good parents and successful people. Their absence from the direct care of their children had diminished their opportunity, and perhaps compromised their capacity for love, while what persevered was the observance of faithfulness.

In another aspect of the reunions, both parent and child shared a positive sense of a formal induction into their real family. In these situations, they were with surrogate parents who maintained the distinction between the surrogate family and the family of the child's parents. They did not actively seek to replace the biological parents for example, by not referring to their lives abroad, or by belittling them as deserters of their children, or as bad parents.

For some children it seemed that when there was some contact between the biological parents and the child, the reunion was less turbulent. For other children the smoothness of their attachment during the early phases of reunion was related to relief from what they perceived as a difficult and deprived situation, or one in which they received indifferent care from surrogate parents. Another contributing factor to smooth reunions, was if the children did not feel as if they had been dumped, and where they perceived the care taking by the surrogate parent as a task that was shared with their biological parent. If, (especially with younger children), their surrogate parent kept it in the child's mind that the time with the surrogate parent would end with a definite event, that is the return to the biological parent, the reunion was smoother.

Those parents who tended to blame the surrogate parents for what they perceived as faulty upbringing of their child, were more likely to elicit feelings of resentment, especially from older children and adolescents. However, this strategy by the biological parent may be seen as an effort to gain control of the loyalty and allegiance of the child, while at the same time moving the child more directly to a disengagement from the surrogate parent.

Dysphoric Mood

Depression is present in most of these reunited children, and this is not surprising, since depression appears to be a direct response to the disruption of attachment bonds (7.8).

One of the tasks of biological parents is to reaffirm their children's attachment to them, and their drive to do so demands certain filial behaviours, such as expressed joy at the reunion, dependent and proximity-seeking behaviours and relinquishment of their primary loyalty to their surrogate parent.

Children's distress as evidenced in their depressive moods and anxieties, often tends to be seen by the parents as ingratitude or disrespect, leading to more coercive parental tactics for displays of attachment and affection, sometimes with physical abuse as the outcome.

The children's main defenses are withdrawal and increased fantasy life, associated with a state of solitary mourning. In this condition there may be little or no commiseration from their parents, and as well, variable but usually minimal support from their reunited or other siblings, whose anxieties about being abandoned are aroused by the conflicts and affective tone of the family system.

The children may come to doubt the correctness of their own feelings and the appropriateness of their desires. Oppositional passivity at home and school, avoidant behaviors expressed as a

phobic avoidance of the home, and low level communicative compliant behaviors tend to be features of those in their middle childhood years.

In younger children, depressive states which are frequently expressed as withdrawal and uncommunicative behavior, go unrecognized by many parents as sadness, partly because most of these behaviors are synonymous with culturally valued attributes of the well behaved child.

In pre-pubertal children and adolescents, their dysphoria is associated with more openly aggressive behaviors, in keeping with their developmental drives. Indeed, there often is a vengeful, relentless rage towards the parents with whom they have reunited, that may be expressed in manipulation and in physically aggressive acts towards others.

Suicidal threats or acts are uncommon. The persistence of depressive states and other psychopathology in many of the children for years after the reunion seems to be due to the failure to form secure attachment bonds with their biological parents.

Developmental Adjustments

Part of the process of reclaiming ownership of the children includes varying degrees of parental resistance to facets of the child's developmental march. From these parents there is a steady insistent reminder, part plea, part coercion, that the pace of the children's age appropriate behaviors is too hurried for the parents. One result can be the slowing of their progression to age appropriate autonomy. These efforts to gain control and direction of the children can become part of a protective empathy, that restrains the children's efforts at planning and goal completion, introduces delays in the acquisition of socialization skills, and fosters symbiotic entanglements.

The restraints on the range of the children's self-directed behaviors inhibit individuation and those children who resist this are seen by some parents as lacking attachment to them. This regressive pull is strengthened by gaps in the parents' experiences with the children, and a lack of information about what has gone into shaping the children during their time apart. Some parents resent the fact that the children know more about their own past than they do, and are more up to date and familiar with their surrogate parents or grandparents and extended family systems. Thus the children become synthesizers of the parents' updated reformulation of their identity as a father or mother, and also to some extent an organizer of the new family's identity. These families may seem to the uninformed observer to be dysfunctional.

Regressive behaviors are seen at all ages in which the children's expressions of dependent needs occur in a context of partial or total unfamiliarity with the biological parents, and with the way the family functions. At the same time the biological parents are seeking to begin again the direct or symbolic care at the level of the phase of the children's development at which it was interrupted by separation. It is not unusual for parents to be approached by children of all ages to be given care more appropriate for an infant (eg: bathing, suckling at the breast, being spoon-fed,) and some parents intuitively recognize and reinforce these approaches as mutual

attachment behaviors, whilst for others it is abhorrent or frightening, particularly in older children. These behaviors are sometimes associated with panic states and short-lived aggressive outbursts that can lead to physical aggression by the children or by the biological parents. This is more likely in adolescents where self-object boundaries remain uncertain, emancipation is not yet securely realized, thus permitting fusion and proximity-seeking types of behaviors hold sway.

Abuse

Reference has been made to the parental coercion of affection as a prelude to physical abuse when there is a perceived lack of spontaneous and recognizable attachment behaviors from the reunited children. Some children engage in intense proximity-seeking behaviors such as clinging, following, frequent demands for comfort, staying indoors etc., while others display an intense need for sensual experiences, some of which are perceived by the parents as being frankly sexual. These experiences range from playing with food, (ruminative chewing, smelling, fingering), to close and frequent physical contacts with their parents, or seeking to be physically looked after in ways not ordinarily appropriate for their age, (being bathed, suckled or spoon fed). Some pre-pubertal and adolescent children tend to seek long embraces, during which they sniff their parents or find ways of sitting or lying on or with them to obtain skin to skin contact. Most parents are threatened by these behaviors, while others intuitively respond to these stimuli for nurture. For some parents and older siblings, the cues for affectional connections are misread, and other factors in this fluid relational system lead to incest between parents and reunited children and between reunited siblings.

Identity

Initial physical impressions of each other when reunited are powerful determinants of the quality of attachment that develops, and often determines the ways in which the reunited children deal with the pressures to redefine themselves as belonging to their parents. Difficult early reunion relationships occur when the biological parents experience the children as not belonging to them, as strangers, or in situations in which the physical characteristics of the children differ from parental expectations, as contrasted to the parents feeling that they know them, but are not very familiar with them. Examples are; disappointments in the tone of skin color, or in the degree of physical development of the child.

Mothers who look younger than their age are prone to avoidant reactions from adolescents, and especially so from daughters. Children who were with their biological parents up to the first four or five years of life are more likely to be seen at reunion as bearing a resemblance to their parents if not physically, then in certain traits.

Some children up to age eight, and a few as old as eleven years, who have been with surrogate mothers from infancy, define their surrogate mothers as their birth-mothers, even after being reunited with their biological mothers for more than a year. Some older children and

adolescents doubt their birth by their biological parents when there is only thirteen or fourteen years difference in age between them. Some of the children deal with this doubt by denial, retaliatory rejection, or see it as a bewitching illusion of nature. Their internal conflicts about their births may be expressed in richly detailed reproductive fantasies, intrusive interests in their parent's sexual functions and sexual behaviors, such that their behavior is akin to being the peers of their parents.

Professional Issues

These reunited families tend to evoke powerful counter-transferences among professionals. The most common reaction is the attitude that these parents were opportunistic or callous in the way the children are conceived out, based on what is perceived as uninhibited sexual life styles. The parents are then seen as having treated the children like possessions to be given into safekeeping then collected by the parents some years later when it suits them, and eventually to be discarded when the reunion fails.

In another vein, professionals tend to be daunted by the seeming complexity of the family systems. A wife may have two or three children from different fathers, who are raised by two different sets of grandparents and other caretakers. Her husband may have children of his own raised similarly and then reunited with the family. Finally, the couple may have children of their own to complete a more fulsome description of a "blended family" than is usually meant by that term.

Some results of these attitudes are: unconscious punitive reactions and blockage of empathic understanding; moralistic judgments about child rearing practices, thereby casting the parents as offenders or scapegoats; over-identification and collusion with the reunited children who are perceived as victims; disparagement of the kinship systems and disinterest in learning about their cultural contexts; all of which are the prelude for insensitive and incomplete evaluations, imprecise diagnoses and improper therapeutic interventions.

Some knowledge of West Indian extended family systems and their cultural contexts is necessary to appreciate the backgrounds of the reunited children, and the crosscurrents of relationships in the different family systems. It is easier to label the family as chaotic, broken etc., than to pursue the collection and understanding of this data.

Possible Interventions to Facilitate Immigration

1. Education of prospective immigrants about emigrating as a whole family unit
2. Financial assistance at point of departure for families, i.e. long term, no interest loans to facilitate the resettlement of the whole family
3. Changes in admission criteria to include a broader definition of family, i.e. to recognize extended systems of kinship and cultural arrangements for caring for children.

4. Core funds for non-governmental organizations to provide services for resettlement of immigrants. Short-term funding fosters multiple short-term programs which are inimical to developing and implementing long term plans, intervention programs with depth, retention of skilled staff, training programs for out-reach workers, and documenting meaningful evaluations of the outcomes.
5. Establishment of research centers for the study of patterns of emigration and domestic migration, with particular reference to the impact on families and children
6. Establishment of a central data base as a repository for research programs, services, prevention, rehabilitation, and training programs.

Countries of Origin

Sociologists and anthropologists have studied kinship systems among Afro Caribbean populations. Various labels were coined or borrowed from indigenous populations in attempts to capture and categorize the different styles of kinship. However the children's psychological issues in their various care taking systems have yet to be addressed.

The patterns of immigration of children, in many ways mirrors the child rearing styles in their West Indian countries of origin. Shared parenting in a communal system, such as in a West Indian "yard", can offer economic, social, general health and psychological well-being to children whose parent(s) cannot sustain an independent nuclear family unit. (We are reminded of the African proverb, that "it takes a village to raise a child".) These care-taking arrangements can also be noxious and exploitative with significant deleterious effects on the development and socialization of the children and on their personalities and functioning as adults.

The data for murders in Jamaica was 1100 plus in 2.3 million people in 2001 versus 94 murders in Toronto's 3.2 million people in 2001. Pundits, commentators, and professionals in sociology and related fields have for years attributed this carnage mostly to dysfunctional child rearing. Belief in this relationship is widespread but the empirical data is not on the table. Other factors contribute to this problem, such as the bankrupt economy, high rates of unemployment, and gang warfare in the illicit drug economy. Research is needed to decipher any causal linkage between the prevalence of parent-child separation and reunions, and the relationships if any, to the level of aggression among young people in this society.

These countries of origin cannot afford to fund this massive kind of research. Pilot studies, prospective and retrospective, in targeted communities may discern trends in the flair for violence among youth and young adults. Such trends could then be translated into public education and preventive programs aimed at enhancing positive holding environments for children and their care-givers.

The Mental Health of African and African-Caribbean People in the United Kingdom

Kwame McKenzie, M.D. United Kingdom

History and Demography

African and African Caribbean people have been present in the United Kingdom (UK) in small numbers for at least 500 years. Knowledge and indeed stereotypes of African people were wide enough in the 17th century for Shakespeare to write Othello.

High profile, but relatively low level, forced migration continued through the slave trade with thousands of young Africans, mainly boys, being brought to work in domestic settings in the UK until it petered out when slavery was abolished. It was not until the 1950s that there was any sizeable migration of African or African-Caribbean people to the UK. This followed a concerted campaign from the UK Government to persuade people from their colonies to come to England to service a booming post-war economy which was labour poor. There was also a significant migration from the Indian sub-continent. The African, African-Caribbean and South Asian origin population of the UK grew from a few thousand to two million between 1950 and 1980.

The majority of African-Caribbean migrants came to England with the idea that they could make money and return home. However, work opportunities were strictly limited, with the vast majority working in non-skilled or semi-skilled labour despite the high percentage of professional migrants. The high cost of living and extreme fluctuations in the job market during the 1970s trapped much of the population in poverty, so that only a minority were able to realize their dreams.

Changes in immigration law and the independence of a number of British colonies in the 1970s led to migration from the Caribbean and Africa to decrease to a trickle. New migrants are now almost entirely refugees and asylum seekers from African nations. Successive governments have attempted to limit the number of refugees allowed the enter the UK and the current government plans are to build internment camps in which asylum seekers would be kept until a decision is made as to whether their claim for asylum is granted.

Demographics

Accurate historical demographic information is difficult to obtain because the 1991 census was the first to measure the ethnic composition of the UK by individual self-report. Previously, country of birth of the head of household was the only measure. Of a population of 55 million just under 1 million defined themselves as “Black-Caribbean, Black African or Black other”. Other possible choices were Bangladeshi, Pakistani, Indian, White, Chinese and Other. The 2001 census is soon to report officially. Unofficial statements have said that the population will

are excluded. Black children are the only racial/ethnic group to have significantly different rates of school exclusion, and of this group, the excess is mainly due to Black Caribbean origin children. The Government Home Office concluded that there were high levels of tension in the classroom with teachers complaining about troublesome black pupils and criticizing them, and black pupils responding to expectations of low ability with disruptive behaviour.

Few black youngsters get to University and there are a negligible number of black doctors or medical students. There is a relative over-representation in nursing but few in allied professions such as psychology. There is a concentration of black professionals in relatively junior positions.

Social Services

40% of black people in the UK live in local authority owned housing. However, the housing stock that they inhabit is worse than those which white local authority tenants reside in. 9% of the under sixteen years old population in this country are from ethnic minorities but 20% of children living in foster care come from such families.

Police

Racist incidents are significant, widespread and under-reported. In 1995 there were an estimated 382,000 racist incidents in England and Wales with the number decreasing to 282,000 by 1999. Only 12,220 of these were reported and recorded by the police. 93% of all racial attacks are committed by White people.

In one UK national study 25-40% of white people said they would discriminate against ethnic minorities. 11% of people from ethnic minority communities in one national study said that they had been the target of racist attacks, threats or serious abuse in the last year. Over 65% of people from ethnic minorities in the UK believe employers discriminate because of race and over 50% of ethnic minorities recall micro-aggressions in the past year when asked by white interviewers. Most ethnic minority group members however, over 70%, believe that race relations are improving in the UK.

There are significant and well documented problems with the police. Despite comprising less than 2% of the population black men make up 12% of the prison population and black women 18% of the prison population. Black people in the UK are six times more likely to be stopped and searched by the police and four and a half times more likely to be arrested for a serious offense. Once arrested black suspects are more likely to be charged instead of cautioned and let go and they are more likely to be refused bail. However, they are more likely to have their charges dropped before they come to trial and the most common reason for charges being dropped is that there is insufficient evidence. Those who do go to court get stiffer sentences, 63% of black defendants get prison sentences of greater than four years compared with 47% of white defendants.

be over 58 million and that 7.1% of the UK population will be ethnic minorities, with about 2% being Black Caribbean, Black African or Black other. 50% of the ethnic minority population were born in the UK and less than 50% of the black population live with both of their biological parents.

I will use the term black to mean people who have chosen Black Caribbean, Black African or Black other in the census. African-Caribbean and Black of Caribbean origin are used interchangeably. African origin or African includes those who were born in and African country and those born in the UK who are the children of those born in African countries. Over half of the black UK population lives in London. The rest live in other UK cities, with almost no rural presence. A third of the population are under sixteen and only 6% are older than sixty five.

Employment

The unemployment rate is four times the national average at about 12%. The unemployment rate for black graduates is four times the rate for white graduates. For those in work 23% of white men are managers and 13% of black men. The figures for women differ with 14% of white and 12% of black women working as managers. However, these figures do not take into account the fact that black women have consistently out-performed white women in UK national school examinations.

UK studies have demonstrated that white job applicants are five times more likely to get an interview than Black applicants with similar qualifications.

Economic

40% of Black households have less than half the national average income. The average expenditure per person is £344 if you are white and £263 if you are Black. 70% of Whites are (home) owner occupiers compared with 40% of black adults. Three times as many white people own their house outright than Black people. 82% of black people in the UK have less than £1,500 ($2160) in savings.

Education

Expected average scores for educational achievement are set by the government. 38% of white children of manual workers hit this average target and 34% of black children of manual workers. However, it should be remembered that black manual workers have higher educational achievements than white manual workers. The biggest disparities are found in the children of non-manual workers where 64% of white but only 39% of black children score at the national average. Black females consistently out perform white females when school type and parental social class are controlled for.

Permanent exclusion from school is rare in the UK at 0.2%. However, 0.8% of black children

Police problems are exacerbated by perceived racial/ethnic differences in illicit drug use and abuse. There has not been, however, any good evidence that drug use is higher among black children than white children.

Health

There is surprisingly little data on the physical health of black people in the UK. Mortality statistics are difficult to interpret because place of birth is entered on the death certificate from which most statistics are produced, rather than ethnic group. There is little current evidence of decreased life expectancy in first generation immigrants. However, there is evidence of increased rates of morbidity. In a national survey black people were thirty more likely to rate their health as poor than other groups. Those of Caribbean origin have three times the rate of diabetes and African-Caribbean women have an eighty increased risk of hypertension. There is an increased rate of stroke among those of Caribbean origin. A specific health problem, as elsewhere, is sickle cell disease.

The infant mortality rate in the black UK population is double that of the white as is the risk of low birth weight babies. The latter is particularly concerning given the long term trajectory of low birth weight babies with regards to physical and psychological morbidity.

Mental Health

Studies of mental health of people of Caribbean origin in the UK have been mainly epidemiological.

Diagnosis

There has been debate about whether diagnoses are accurate and whether treatment modalities are culturally appropriate. Differences in the symptomatic profile and outcome from psychosis has led some to believe that black people in the UK are being diagnosed as suffering from schizophrenia when they are actually suffering from affective psychoses. Professor Jim van Os has postulated a psychotic spectrum in which those with biological risk factors produce more "schizophrenic" while those with social precipitants experience more "affective" psychoses. He and others have argued for a fundamental review regarding the way that diagnoses are made. Whether this is a rewrite of the diagnostic system along cultural lines or a move away from categorical to more descriptive and community based diagnoses is currently under debate.

Little specific work has been done on culturally sensitive services though some culturally specific services do now exist and are funded by the government. These services are rarely sustained and their funding is often curtailed. There has been no systematic investigation of their efficacy.

Common Mental Disorders

Compared to whites, African-Caribbean women in the UK are more than two times more likely

to suffer depression. Though there is no increased rate of depression reported in community samples, African-Caribbean men are more likely to suffer from depressive ideas and worry. The higher rates of depression are linked to socio-economic status. There is no increase in the rates of depression in manual workers, the observed increase across the whole group is driven by the higher rates in non-manual workers.

Depression is often missed. London general medical practice surveys report that depression is neither diagnosed nor treated in most of the 15-20% of black surgery attendees with this condition. The rates of depression reported in African and African-Caribbean hospitalized patients is half that of whites, though they are more likely to suffer from depression as outpatients.

Suicide

National surveys describe higher rates of suicidal ideation in African-Caribbeans but not black Africans in the United Kingdom. Rates of suicide were lower for people of Caribbean origin in the UK when studies were done in the 1980s and early 1990s. Rates of suicide then were less than half of those recorded for the white population, but now the rates of suicide for blacks under 35 are no different from the white population.

There are geographic differences in the rates of presentation to emergency rooms with suicide attempts. The rates of presentation for black people are highest in areas where they are in the lowest population concentration. The reasons for this are unknown. It is postulated that this higher inidence reflects increased vulnerability due to racial discrimination, social isolation and decreased social support and buffering.

Suicide and suicide attempts in those with psychosis have been investigated by the author. They follow the trends seen in the general population in that Black Caribbean people were four times less likely than their white British peers to either commit suicide or attempt suicide in a four year follow-up study from the late 1980s. However, a study conducted 10 years later showed no difference between people of Caribbean origin and the white British. This was due to a cohort effect; those of Caribbean origin over 35 years old were still less likely to commit suicide, but there was no difference in the rates of suicide in those under the age of 35. A confidential inquiry of deaths of people in psychiatric care commented that doctors were more likely to state that suicide in black patients in their care was more preventable than in any other group. There is currently no national initiative to specifically decrease deaths from suicide in the UK black population.

Psychosis

The incidence rates of schizophrenia and bipolar disorder diagnosed in the Black population in the UK are two to four times the rate of the white population. The rates in Barbados, Trinidad

and Jamaica however, where the majority of migrants came from, are the same as the UK white population. These rates are increased even when socio-economic factors are taken into account and when difficulties in enumeration of the black population are taken into account. No differences in biological risk factors have been found. In fact, people of Caribbean origin with psychosis are less likely to have obstetric complications or neurological problems which pre-date their illness. The risk of developing schizophrenia if you are black and have a first degree relative with schizophrenia is 2-4 times higher in the UK than in the Caribbean. Patients of Caribbean origin have a better symptomatic outcome.

Patient samples demonstrate a higher rate of affective symptoms in Black patients compared to White patients. Work on the outcome of psychotic illness has shown a mixed picture. They are less likely to have a chronic non-remitting illness.

One theory which unites these findings is that the excess of psychosis in the Black population in the UK is due to social factors operating in the UK . This would explain the fact that the rates are higher in the UK than in the countries of origin and the increased risk of psychosis in first-degree relatives. Psychotic illnesses with identifiable social precipitants have a better outcome, have more affective symptoms and are less likely to have biological risk factors.

Racism is a major cause of mental illness in the UK. It is unclear what initiatives in the NHS there are to counter this but as one of the largest employers in the UK a specific anti-racism initiative could have a major impact. The UK Department of Health could take a lead in this. Such a move would move racism from being a political to a health issue in the UK.

If there were widespread social risk factors rather than biological risk factors one may expect them to have an influence at a population level. Studies have demonstrated higher rates of paranoid ideation (but not delusions) and higher rates of hallucinatory experiences in a community sample. There is also evidence of an ethnic density effect, much like that found in suicide attempts. One study investigated rates of psychosis in South London. It looked at the rate of psychosis in electoral wards (areas of about 10,000 people used in local elections). Incident rates of psychosis in ethnic minorities by ward (adjusted for age, gender and economic deprivation) were:

a. 2.4 times higher than the white population in areas where the ethnic minority population was 28-60%,

b. 3.6 times higher in areas where the ethnic minority population was 13-28%

c. 4.4 times here in areas where the ethnic minority population was 8-12%.

Such an ethnic density effect has been demonstrated in the US.

Investigations of possible social factors contributing to mental illness is in its infancy. A community study has shown a 3-5 times increased prevalence of psychosis in those who

experienced racial abuse or attack in the previous year. Those who believed that "most employers would discriminate" had a 50% increased risk of psychosis and common mental disorder. The theory that discrimination is important in the genesis of psychosis is supported by an unpublished Netherlands study in which baseline discrimination predicted new onset psychosis at year 3 after adjustment for age, sex, minority status, urban residence, level of CIDI paranoid symptoms at baseline, level of education, unemployment and single marital status.

Parental loss and life events have also been proffered as possible aetiological factors. There is a higher rate of parental separation in people of Caribbean and African origin with psychosis in the UK but studies on the influence of life events have not been fruitful. Studies are now underway to investigate social capital, income inequality and the role of identity and alternative cultures in mental disorders.

Prison

Because of the failings of the mental health system and social care system troubled African and African-Caribbeans are less likely to get the services they need and are diverted into the prison system where they do not get the care they need.

African-Caribbean Elders

The African-Caribbean elder population in London alone is projected to increase by 29,000 by the year 2011. There are few specific services and little specific data on this group. National studies has suggested that there are increased rates of depression and possibly dementia in African-Caribbean elders and that service usage is half that of white groups. There is no data on the incidence or prevalence of anxiety disorders, psychosis, alcohol misuse or other mental illness in African-Caribbean elders.

Child Psychiatry

There is surprisingly little epidemiological evidence available. That which is available shows an increased rate of psychosis in young blacks referred to child psychiatry clinics and an increased rate of the diagnosis of autism spectrum disorder. The reasons for this are unclear. Rates of cannabis misuse are not higher in black compared to white teenagers.

Treatment

African and African-Caribbean patients are just as likely to consult their GP about psychological problems as British Whites. However, their problems are less likely to be recognized and less likely to be treated. African and African-Caribbean patients are also twice as likely to be referred to a psychiatrist rather than having their problems treated by their GP.

African and African-Caribbeans in London are more likely to be admitted to the hospital with

mental health problems than other ethnic groups. 4% of the adult population of London and the home counties are of African or African-Caribbean origin yet they make up 16% of the admissions, twice the rate of admission as whites. They are twice as likely to be involuntarily admitted to hospital under a section of the mental health act. In some surveys 60% of African and African-Caribbean patients in hospital were on a section.

African and African-Caribbean patients are more likely to be treated with antipsychotic medication. They are also more likely to receive this by injection. Recent studies in London have shown that they are less likely to be offered psychotherapy and to be involved in rehabilitation. African/African-Caribbeans in the system in London are 2.5 times more likely to be treated in secure units and locked wards.

Not surprisingly, surveys in Haringey and in Camberwell have shown that African-Caribbean patients are less satisfied with mental health services than their white peers.

Different ethnic groups have different rates of side effects from the drugs used in the treatment of mental disorder. Some of these are serious and irreversible. Despite this pharmaceutical companies do not have to prove that a drug is safe on all the major UK ethnic groups before it is licensed.

Possible Solutions

Prevention

The high rates of mental illness, psychosis as well as depression and anxiety disorders call for action to decrease their incidence. There is need for a major initiative involving both social services and healthcare services to support black families in crisis, and to offer education and parenting advice to prevent crisis. The aim of such an intervention would be to decrease the number of black children in foster care.

There is a need for better support for black children in schools to decrease the level of school exclusion. The school curriculum in the UK could be more culture affirming for black youngsters. This may increase pupil retention and also decrease identity development difficulties that can produce mental distress. In school there is also a need for education about mental health. This could include information on how to deal with stress, on getting help early when you are in experiencing difficulties and on where to find advice, support and counselling locally.

The high rates of mental illness among certain ethnic groups in certain geographical areas, the need for linkages between different sectors and the clear impact of economic development on the rates of mental illness argues for a specific all-embracing initiative such as mental health action zones. These could be specified by geographical area or community identity. Their aim would be to develop joined coordinated approaches so that existing services can be used more effectively to counter the social causes of mental illness. They could also ensure that mental health impact assessment is considered at a local level when policy is implemented.

Secondary prevention aims to decrease the severity of a disease. This is usually done by early detection of the initial illness or relapses. African-Caribbeans with depression see their General Practitioner (GP) as often as whites but their depression is less likely to be detected or treated. Better training for GPs is imperative if depression is to be appropriately diagnosed and effectively treated. Improved community services are important for decreasing the severity of relapse.

Tertiary prevention is concerned with decreasing the disability caused by an illness. Decreased disability will depend on improving services and targeting the causes of disability such as the poor management of negative symptoms of schizophrenia and other psychotic symptoms and the lack of attention to housing, employment, occupational therapy, spirituality and the other social needs of patients and their families.

The treatment of African-Caribbean people with mental health problems is at best patchy. Contested diagnostic rubrics, poor compliance with medication and treatment plans, higher levels of imprisonment, and more coercive treatment are all testament to the failures of the system.

Treatment

There are a legion of possible interventions including increased use of religious support groups, cognitive behavioural therapy, compliance therapy, cultural psychotherapy, culturally affirming services, culturally specific assertive outreach, use of adjunctive mood stabilizers and alternative therapies, more career support, development of diagnostic systems built on prognosis and the development of specific research paradigms. The efficacy of these treatment interventions has not yet been properly assessed.

Training

The diversity of populations and the increased rates of mental illness in minority communities argues for all health service professionals in inner city areas to be culturally aware. It also argues against the possibility of individuals having expertise and knowledge of all ethnic minority groups. Moreover, the changing profile of ethnic minority communities and the development of different identities over time, makes the ascertainment of contemporary and relevant information an important issue. Cultural competence, coupled with anti-racism training, should be mandatory in all training schemes for clinical personnel and oversight groups should be created to ensure that this mandate is implemented and updated, including the training of non-clinical employees.

The initial work on cultural competence was specifically not geared towards the training needs of individuals, but instead towards institutions that needed to be culturally competent. It was understood that there needed to be learning institutions nested in the communities that were able to adapt to the needs of their communities. This was a much more dynamic model in

which an institution's systems were specifically set up to assess new knowledge and changes in the community so that it did not continue to discriminate. Such a dynamic model was thought to be needed in order to make sure that institutional discrimination did not take hold.

The new UK Race Relations Bill states that institutions are liable if there is inequitable practice and they fail to audit this or set in motion ways of dealing with it. The need to complete the audit loop puts NHS Trusts in particular difficulty. This is an area that can be exploited and used as leverage though it is not completely clear how specific policies can be set up. One model would be that a new oversight body could be set up to advise on training, research and assessment. This type of institution could occur be within existing structures but would have the specific remit for ethnic minority mental health. Such a unit could be the custodians of data from different NHS providers and could ensure that the audit loop is completed in keeping with the statutory requirement.

Research

There are no dedicated research monies for studying ethnic minority mental health issues. There is also no existing organizations of researchers that deal with this issue. There are a handful of academics working in this field and only two are black. It is difficult to move forward a research (i.e. non-service) agenda without significant support from outside the UK. Research to date has used epidemiological methods, but it is unclear whether these methodologies are the most applicable. More in depth work using social sciences models is required and larger cross-national comparisons would be useful. Capacity building is important as is setting up specific support networks.

The Future

Children are the future of the black population in the UK. Racism is producing problems in the development of communities that should sustain and nurture them. Our children are truly multi-cultural, with influences and allegiances in the UK, influences from the United States and from their parent's countries of origin. Few young people without direct links to Africa consider this continent as their spiritual home. There is a 30-40% inter-marriage between the black and white populations in the UK.

The investment that the young have in the UK produces a sense of entitlement which serves to heighten the frustration of thwarted aspirations due to racial discrimination. The pressure to achieve and the flux of new arrivals into traditionally black areas is causing communities to disperse. Hence the safety-net and social support that is needed for the young is disappearing. Added to this, church attendance is also decreasing.

The challenge for the future must be in some way to re-invent black community and black identity in a way that is acceptable and sustainable. The challenge will be to produce internal and external sources of resilience to the effects of racism. A movement to produce such a change

may need to be international but any such movement would also need to be bottom up instead of top down. It would have to reflect the varied aspirations of our geographically dispersed people, while reflecting the singular position of black people in the world today. It will need to be focused on the future but will need to be anchored in the past. The UK does not have such a movement that is of widespread appeal. The development of such a consciousness and voice may well do more in the long term for the mental health of the UK black youth than the efforts of mental health and public health clinicians.

Possible Collaboration

I have outlined above the mental health and social problems that exist for blacks in the UK. However, it should be noted that the national nature of the health service means that change is possible, with the right leverage. Black people in the UK have little political power and many do not vote. This leads to problems in changing and improving existing services. For instance, current mental health legislation concentrates on "dangerousness" because the so called "floating voters", who change their allegiance from election to election, think that this is important. Hence for any changes to come about there needs to be significant political effort. External help and assistance from an international group could help facilitate change in the UK and could help with leveraging the national and local governments.

The high rates of mental illness in black people in the UK is a national scandal. Though, some work is being done on service delivery, unless services are targeted at the causes of mental illness one would not expect these to have much impact on the rates and morbidity of mental illnesses. With few known cures for mental illness, prevention should be a much higher priority on the government agenda.

Specific assistance in the development of a considered position on prevention combined with relevant data on effective intervention strategies would be extremely helpful. Agreement and statement of the primacy of preventive strategies and their evaluation would be a useful collaborative effort for the UK. There is a need for a rigorous and cross-national (including basic and social sciences, policy and health services research) effort into understanding problems and developing solutions. There is some evidence that young Black people in the UK follow cultural changes set in the UK. Information on such trends and how mental health services could be organized to cope with them, would be of significant use, particularly because the capacity and expertise to conduct sociological and socio-epidemiological research in better developed in the United States than in the United Kingdom.

There is also a need for sharing evidence-based treatment modalities that may be of use for the black populations in the UK and elsewhere in the African Diaspora. There is a need for proper documentation of international expertise and professional contacts that could be available for consultation. This effort at documentation could start by way of an international description of psychiatry of the African Diaspora, both in print and through the website that can be accessed

from anywhere. Such documentation and liaison could also form the basis of a training package. Such a training package could be used to facilitate genuine change through teaching current service providers and by teaching medical students or psychiatrists in training. I would personally be interested to produce a directory of African descended psychiatrists.

Mental Health Priorities of African Americans
Pamela Y. Collins, M.D., M.P.H. United States of America

Introduction

African Americans occupy a unique space in the history of the United States. Africans were enslaved and denial of their human rights was legislated until relatively recently. Needless to say, the history of black enslavement and the century of legislated oppression following emancipation continue to shape the life experiences of African Americans.

Historical Context

In 1619, a group of Africans arrived to the first permanent English settlement at Jamestown, in what was to become the colony of Virginia. These laborers were, many believe, indentured servants who would eventually work for their freedom, accumulate property, and live as free members of the colony's society. However, by the 1660's, the same colony of Virginia had enacted laws revoking the rights of African residents, forbidding intermarriage with Blacks and making Black people slaves for life.

Slavery was immediately met with opposition, and this tension between the expanding denial of rights and opposition to these abuses persisted throughout. In the North, the emancipation struggle began in 1777 in tandem with the revolutionary struggle, when Vermont became the first state to abolish slavery. Nearly one century later, in 1863, President Lincoln signed the Emancipation Proclamation, freeing slaves in selected Southern states. The 13th Amendment to the Constitution, abolishing slavery, was passed in 1865, and three years later, the 14th Amendment extended citizenship to African Americans.

By the 1890's Jim Crow laws that legislated segregation in many Southern states were in full swing, and persisted into the 1960s. The civil rights movement would ultimately see the dismantling of segregation in schools with the 1954 Brown v Board of Education ruling that declared school segregation unconstitutional and the passage of the Civil Rights Act of 1964 prohibiting segregation in public accommodation and discrimination in employment and education.

These critical achievements did not, however, eradicate racism and discrimination directed toward African Americans. Andrew Hacker writes in his book *Two Nations; Black, White, Separate, Hostile, Unequal*:

> "There remains an unarticulated suspicion: might there be something about the black race that suited them for slavery?. . .white Americans, who both grant and impose racial memberships, show little inclination toward giving full nationality to the descendants of African slaves."

This paper discusses some of the implications of enduring racism and discrimination for the mental health of African Americans.

In preparation for this presentation, I asked colleagues in psychiatry who subscribe to any of four professional e-mail list-serves (Black Psychiatrists of America, the American Psychiatric Association's [APA] Black Psychiatrists Network, the APA Minority Fellowship Listserve, and the American Association of Community Psychiatrists) to comment on what they viewed as mental health priorities for African Americans. The topics they reported are presented in Table 1. I also spoke to a small number of lay people, asking them to respond to the same question. Their priorities are presented in Table 2.

A comprehensive review of mental health issues and psychiatric epidemiology relevant to African Americans can be found in the Surgeon General's supplement, *Mental Health: Culture, Race, and Ethnicity-A Supplement to Mental Health: A Report of the Surgeon General* (2001). The issues presented below, stigma and HIV/AIDS, are those that I consider priorities based professional and personal experiences of race in this country.

Mental Health Priorities for African Americans

The Stigma of Being Black

> "It does not matter how educationally prepared we are, how wide and deep our experience in our chosen field may be, or how hard we work, historical and current assumptions about our ability to perform creep into our personal interpretation of our worthiness to assume leadership positions in the work place."
>
> 36 year-old Black female administrator, 2002

African Americans comprise a stigmatized group in the United States.. Using Link and Phelan's (2001) components of stigma, stigma related to being black can be understood as follows. African Americans are first *labeled as* different. Societies select those differences that are particularly important to them, eg. skin color in the U.S., and groups are created based on labeled differences. These differences are linked to stereotypes. The dominant group ("us") separates itself from black people ("them"). Black people, as a labeled, set-apart group, experience status loss and discrimination (Link & Phelan, 2001). That discrimination may be individual and/or structural. Finally, according to Link and Phelan, power plays a central role: "Stigma is entirely dependent on social, economic, and political power-it takes power to stigmatize."

The challenges that African Americans face as a result of these mechanisms include 1) coping with economic implications of discrimination, including "restricted socioeconomic mobility" (Williams & Williams-Morris, 2000). Approximately 12% of the U.S. population is black according to the U.S. census, but African Americans are over-represented among the very poor,

the homeless, the incarcerated, and other high need groups (U.S. Department of Health and Human Services, 2001). The effects of discrimination are also manifest in living conditions associated with poverty and violence (Williams & Williams-Morris, 2000). 2) Coping with stereotypes and discrimination, i.e. the reality of being assessed by others negatively because of skin color: being perceived as people who are violent, less intelligent, lazy, or promiscuous. The comment in quotes at the start of this section, from one of the lay respondents to my informal survey, conveys the damaging effects of stigma and discrimination experienced by many African Americans.

Stigma has been identified as a stressor that is pervasive. African Americans are "at risk" of experiencing discrimination in a variety of social contexts (Miller & Kaiser). The ambiguity of prejudice adds additional stress as it often leaves its targets guessing at the meaning of events that may or may not be a result of discrimination (Crocker et al., 1998; Crocker & Major, 1989). A number of studies have found positive associations between the experience of discrimination and psychological distress or specific psychiatric symptoms, such as depression (Williams & Williams-Morris, 2000). What seems particularly critical is to enable African Americans to address feelings of powerlessness, depression, and anger that can result from these dehumanizing insults.

African Americans, depending on social and emotional resources, may respond to the need to establish themselves as equals to the dominant group in a number of ways. Some channel their efforts to working twice as hard as others in order to be recognized as capable. Others invest energies and resources into education or status-raising activities seeking to gain power in the society. There is a risk that our humanity is then defined by what we can achieve, as we rely on these achievements to make us acceptable. Alternatively, people may respond to experiences of discrimination with less socially acceptable forms of resistance, choosing to redefine success. The vast economy of the illegal drug industry is an example. Philippe Bourgois (1995) writes of young men in East Harlem who have found a "viable" way to maintain themselves economically and to maintain a sense of self-efficacy through selling crack.

The constant struggle to prove oneself a fully capable human being may eventually take a physical and emotional toll; thus, one priority is to examine existing coping styles and facilitate the maintenance or development of adaptive coping styles.

HIV/AIDS

Although at first glance HIV/AIDS may not appear to be a mental health problem, the AIDS epidemic is the most devastating health crisis facing people of African descent throughout the world. AIDS is a disease that is disproportionately affecting people of African descent. While taking the lives of millions of African people each year, it decimates communities and takes a tremendous social and emotional toll on those infected and affected by the virus. As such a monumental issue, it is critical that psychiatrists of Africa and the African Diaspora actively seek

a role in combating the AIDS epidemic, be it through research, clinical care, prevention, or advocacy.

The Centers for Disease Control gives the following statistics for the year 2000 in the United States:

- 19,890 cases were reported among African Americans, representing nearly half (47%) of the 42,156 AIDS cases reported that year.
- Almost two-thirds (63%) of all women reported with AIDS were African American. African American children also represented almost two-thirds (65%) of all reported pediatric AIDS cases.
- The 2000 rate of reported AIDS cases among African Americans was more than 2 times the rate for Hispanics and 8 times the rate for whites.

The AIDS epidemic is propelled by a combination of biological factors, social factors, and individual behaviors. Margaret Connors (1996), in *Women, Poverty, and AIDS*, explains the rising prevalence among women:

Structural factors–social class and economic status–far more than individual decisions and aspirations, explain why HIV increasingly affects women in the United States and elsewhere. . . Poverty is the condition which puts women at greater and greater risk of contracting the AIDS virus."

African American women, disproportionately represented among the poor in this nation, exemplify this connection.

What is the role of the psychiatrist in such a complex epidemic? Psychiatrists can play a role in educating patients about HIV by discussing sexual behavior and sexual risk. Psychiatrists can facilitate discussion of HIV risk, sexuality and relationship issues in black communities. We can provide psychosocial support to those living with AIDS, enable men and women to cope with the diagnosis, treat associated depression and anxiety, provide guidance in disclosure of their HIV status to relevant people in their social networks, promote adherence to treatment, treat the neuropsychiatric manifestations of HIV/AIDS, and address the trauma of multiple losses due AIDS.

Tackling the epidemic further requires that psychiatrists as clinicians and researchers function as advocates for people with AIDS, working to reduce the stigma experienced by men and women living with HIV/AIDS.

Finally, among people with severe mental illness in the urban United States, HIV prevalence rates are disproportionately high. Within this population, also, African Americans are over-represented among the infected. Psychiatrists are uniquely equipped to provide prevention (see Collins et al., 2001) and care for this frequently over-looked population (Cournos and Bakalar, 1996).

Questions/Issues for Collaboration

Investigators in the United States have studied some of the questions posed below; however, collaborations established from this conference provide a unique opportunity to do comparative studies or simply to learn from the experiences of other cultural settings.

Coping with stigma/racism/discrimination/poverty

1. Explore the literature on resilience
2. What can we learn from approaches that focus on resilience?
3. How do the effects of colonialism impact the experiences/perceptions of racism in Africa and populations throughout the Diaspora?
4. What cultural strengths exist in communities beset by poverty and discrimination to protect against psychological distress?
5. How do these differ in settings where people of African descent are in the majority versus the minority?
6. How do community mobilization and increasing sociopolitical power work to improve well-being in impoverished settings in industrialized and less developed countries?

HIV/AIDS

Given the scope of the AIDS pandemic, clinical and research issues are relevant.

Clinical issues:

1. Are there sufficient mental health resources to provide the care and support that people affected or infected with HIV require?
2. How do we insure that these provisions are made?
3. Are mental health needs for children orphaned by AIDS and/or infected by AIDS being met?

Research issues:

1. How do we understand the emotional impact of this disaster on the societies most affected?
2. How do we work to understand and diminish the stigma around AIDS?
3. Are there lessons to be learned from experience with stigma and mental illness?
4. How do we understand the experiences of those with multiple stigmas and their vulnerability to the epidemic?
5. What is the role of community mobilization in this epidemic?

Topics of Special Interest

I would be particularly interested in contributing to

1. Efforts to increase mental health clinical and research resources in settings where research is limited by a lack of human resources.
2. Investigating stigma related to ethnicity, gender, and or HIV/AIDS
3. Developing research and training around the psychosocial issues related to HIV/AIDS

Table 1. Mental Health Priorities for African Americans-Psychiatrists' Perspectives

Social
Experiencing Racism/Discrimination
Poverty
Unemployment
Incarcerated Men
Economic empowerment
Violence (exposure to/impact of)
Education
Over-representation of African Americans in homeless populations
Criminalization of behavior of people of color

Community
Dislocation/Disintegration of communities
Stigma related to mental illness and use mental health services
Community education to address stigma
Mentoring Programs
Education of clergy to address stigma
Psychiatrists need to partner with African American leaders to end social exclusion
Restore healthy problem-solving capacities

Family
Loss of extended families
Disruption of families
Marital and parenting problems
Child abuse

Mental Health Services
Access to a full range of quality/cutting edge mental health services
Access to full range of psychotherapy interventions
Access to comprehensive substance abuse services and dual diagnosis services
Access to new psychopharmacologic interventions
Access to culturally competent treatment for adults, children, families
Liaison with other ethnic groups who can benefit from culturally competent care
Need for African American psychiatrists
Recruitment of African American service providers into the public sector
Discrimination/Bias/Stereotyping in diagnosis, hospitalization
Service availability in African American communities (adults and children)
Funneling of African American men into correctional mental health services rather than community services

Research
Understanding of ethnic differences in response to psychotropic meds (metabolism, etc.)
Impact of discrimination and racism on service need and delivery
African American community-focused research
Comorbid medical and psychiatric and substance abuse
Long term effects of racism/its impact on self-esteem
Understanding how relative affluence may or may not affect experiences of racism
Understanding how illnesses are expressed and experienced differently
Effects of stigma-both of mental illness and of being a minority

Training
Training in evaluation, diagnosis, communication, and treatment of African American patients
Teaching residents and faculty to understand the particular needs of African Americans and the context in which they live
Skills for MH professionals to network into the African American community

Clinical Concerns
Trauma
Alcohol/Substance abuse
Depression
Obesity
Chronic post traumatic stress disorder
Communication between doctor's and AA patients
Early Identification of mental health issues
Understanding the roles of religion/spirituality /prayer in the lives of African Americans

Needs for Women
Economic security
Family integrity

Education
Relationship issues with African American men
Needs for Men
Respect
Jobs

VII Historical Documents

African-Descended, Tenured Professors of Psychiatry

Conference Participants

Conference Participants

Chester Pierce
Chairman

Conference Participants

Conference Participants

VIII

Biographies of Conference Participants

Speakers

Barbados/Carribean Basin	George Mahy
Belize	Claudina Cayetano
Brazil	Augusto Costa Conceição
Canada	Granville A. da Costa
Cuba	Miguel Valdés Mier
Fiji	Peni Moi Biukoto
Ghana	Sammy Ohene
Haiti	Marie Ghislaine Adrien
Jamaica	Fred Hickling
Kenya	David Ndetei
Martinique	Aimé Charles-Nicolas
Morocco	Mohamed Zitouni
Nigeria	Oyewusi Gureje
Panama	Carlos Smith-Fray
Papua New Guinea	Uma Ambi Siva
Senegal	Omar Ndyoe
Uganda	Emilio Ovuga
United Kingdom	Kwame McKenzie
USA	Pamela Collins

George Evelyn Mahy

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George Mahy is a 1964 graduate of the University College of The West Indies and did his training in Psychiatry in the Caribbean and in Edinburgh, Scotland. He is now Deputy Dean at the School of Clinical Medicine & Research of the University of the West Indies on the Cave Hill Campus in Barbados. He has been with the Faculty for over twenty years and he is the chief psychiatrist and in charge of undergraduate and postgraduate training in Psychiatry. He is also the Head of the Department of Psychiatry at the Queen Elizabeth Hospital. He was formerly Medical Superintendent of Richmond Hill Hospital in Grenada and later held a similar position at the State mental hospital on the island of Barbados.

He has Fellowship Status with the Royal College of Psychiatrists of the UK, the American Psychiatric Association and the American College of Psychiatrists. His main area of research has been in suicide behavior in the Caribbean. He is known for his services in the neighboring islands of the Caribbean chain through consultancies with international organizations like Pan American Health Organization, Project Hope, CARICOM and special projects funded by national governmental agencies. He is President of the Barbados Association of Psychiatrists and for years has been President of the Caribbean Psychiatric Association.

In 1992, he was named International Scholar by the American Psychiatric Association and five years later was awarded by Howard University School of Social Work through their International Linkage program. Four years ago he was given an award by the government of the British Virgin Islands for 25 years of service in developing the mental health services. He is Past President of the Barbados Association of Medical Practitioners (BAMP) and has recently received the 2002 BAMP Award for his contribution to Psychiatry in the Caribbean Region.

Recent Publications

"Mental Health in the Caribbean". Health Conditions in the Caribbean. Washington DC. Pan American Health Organization 1997. Scientific Publications No.561. pp204-220.

"Mental Health in the Caribbean: An Overview. Caribbean Health vol 1, No 3, 1998

"First-contact incidence rate of schizophrenia on Barbados" British Journal of Psychiatry, (1999), 175, pp 28-33.

"A drug utilization review on mental disorders in St. Lucia and Dominica"- Burnett, Fraser & Mahy. Abstract in West Indian Medical J., vol 49, (Suppl) 21-22, April 2000.

Augusto Costa Conceição

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Augusto Costa Conceição, a Brazilian, native of Salvador/Ba, graduated Medicine, then graduated in Social Medicine and Homeopathy, with research developed in the areas of Anthropology, Medications and Rational Medicine. He participated in the development and implementation of courses and services in the specialties of Homeopathy, Acupuncture, and Natural Medicine. He participated in the Sanitary Reform movement, and recently in the psychiatric reform movement. He developed and implemented Centers of Atenáo Psicossocial (CAPS) and Hospital-Dia, and the Center for Treatment and Shelter of Alcoholics (SEARCH), of the Hospital Saint Antonio, Salvador/Bahia. Presently as co-founder and regional president of the Ethnopsychiatric Association of Brazil, he is giving lectures, symposia and extension courses in collaboration with affiliated institutions.

Among subjects of concern are geographic mobility and mental distress in foreigners in Bahia; religion and mental health; and mental health and culture. Professor Conceição works, also, as editor of publications about culture by Bahain psychiatrists. These focus on culture of people of African descent. Dr. Conceição is professor and chair of Psychopathology in the Department of Psychology at the Federal University of Bahia.

Suggestions for the Conference

Study of African descended people in various parts of the diaspora represented at the seminar.

Examination of how exclusion and segregation is expressed in socio-economic, cultural and ethnic interrelationships.

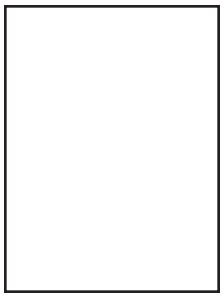
Identification of possible variations of mental distress resulting from exclusion related to problems around diverse areas such as drug use and marginalization during infancy and adolescence.

Study the possibility of getting issues of exclusion put into the diagnostic statistical manual.

Develop strategies in mental health practice in regards to such areas as:
- relationship of mental health to physical health
- how to educate about and promote mental health
- the distribution of resources for the public health
- self esteem in Black communities

Create a journal about psychiatric issues in the African Diaspora

Claudina E. Cayetano



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Claudina E. Cayetano is a medical doctor who has been practicing medicine in Belize since 1986. After graduating from San Carlos University in Guatemala City, she joined the Ministry of Health and worked in various departments of the Belize City Hospital. During her four years at the Belize City Hospital, she worked as a General practitioner, and provided medical support to the only psychiatric Hospital in the country.

In 1990, Dr. Cayetano went to McGill University in Montreal, Canada where she did a residency in Psychiatry. In September of 1994, she returned to Belize and conducted an emergency room study on alcohol related injuries and in 1995, she resumed work with the Ministry of Health. This time she worked as a psychiatrist in the Mental Health Program based at the Cleopatra White Health Center. In 1997, Dr. Cayetano took over as the Director of the Mental Health Program, a position that she still holds.

Dr. Cayetano is well known in the field of Psychiatry. In addition to her work for the Ministry of Health, Dr. Cayetano has maintained an active private practice and has often served as a consultant and technical advisor to the Pan American Health Organization and the World Health Organization. Her recent work with the World Health Organization, Mental Health Division was completed this year 2002, reviewing the manual on mental health Legislation, human resources and training, and essential psychotropics. She is a member of the American Psychiatric Association and the Canadian Psychiatric Association.

Dr. Cayetano has also gained experience in medical training. For over a year she was a professor at two Caribbean Medical schools. At St. Matthew's University, School of Medicine, she taught behavioral science, abnormal psychology, and psychopathology. At St. Luke's University, School of Medicine, she taught behavioral science and abnormal psychology.

Dr. Cayetano's experience includes patient care, health planning, health education, supervision, project management, health administration, and community leadership. She enjoys her clinical role and has been very innovative and creative in the management of the Belize Mental Health Program.

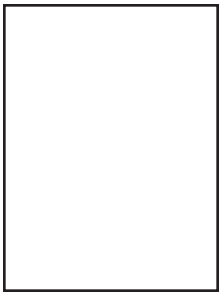
Dr. Cayetano's work in mental health has taken the program to another level. Some of her achievements over the years, have been the decriminalization of suicide attempts, the creation of counseling clinics within the referral hospitals, founder of the first consumer Association in

Belize, creator of the Mental Health Association, facilitating the building of an Acute Psychiatric Unit, within a general hospital.

She is also a member of various community organizations, and serves as a board member to organizations such as the prison parole board.

Dr. Cayetano speaks 3 languages, and is very fluent in English. She is married and lives with her family in Belize.

Granville A. da Costa



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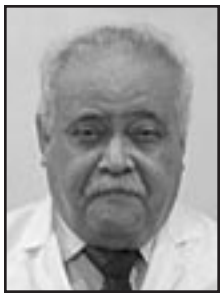
Born in Kingston, Jamaica, West Indies, residing in Toronto, Ontario, Canada, and in private practice, since 1996, as a child and adult psychiatrist. He attended medical school at the University of British Columbia, started his studies in psychiatry at that university, continued in London, UK, where he obtained the specialty degree in psychiatry, DPM, and completed his specialty degree in child and adult psychiatry at the University of Toronto in 1967. He is a Fellow of the American Psychiatric Association since 1977. From 1977 to 1996, he was a staff psychiatrist at the Centre for Addiction and Mental Health-Clarke Institute, and a Professor from 1977 in the Department of Psychiatry, University of Toronto. He has been a member of national, provincial and municipal commissions on issues affecting the mental health of children, immigrants, and refugees. Research interests include child sexual abuse, depression, mental health of immigrants and refugees. His current clinical activities are the treatment of refugees who have been tortured, as well as therapy for their families. He holds memberships in several national and international professional organizations.



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Professor Miguel Angel Valdés Mier was born August 2nd 1938 in Havana City. He graduated from teaching school in 1952 and from Havana University Medical School in 1962. He became Head Director of the Rural Hospital Guinea de Miranda in Santa Clara Province from 1962- 63. His Special Residence in Psychiatry was in Calixto Garcia Hospital from 1963-65. He was Instructor Professor from the First Faculty of Havana from 1965-77, Titular Professor of Psychiatry from 1977-02, Head of the Social Welfare Department of the Minister of Public Health of Cuba from 1977-83, Head of the Cuban Delegation at the Aging World Assembly in Vienna 1982, Head of the Psychiatric Service of Ameijeiras Hospital 1982, and Head of The Natural Group of Gerontology Advisors of the Minister of Public Health of Cuba from1980 -02.

Professor Valdés Mier was vice president and treasurer of the Cuban Psychiatric Society. He is author of the book "Psychogeriatrics for the General Practitioner", author of the Chapter of Psychogeriatrics in another four books and author of 54 published medical papers.

He has participated in 42 International Geriatric Congresses in the last twenty years and has worked in Cuba in the Specialty of Geriatric Psychiatry. Professor Valdés Mier is Head of the Geriatric Advisory group of Clinical Psychologists, Sociologists and other disciplines. He graduated more than 50 specialists in Psychiatry from Calixto Garcia Hospital, Ameijeiras Hospital, and from various Latin American countries. He headed the Cuban delegation to five Psychiatric World Congresses and to other meetings. He has also been an advisor for the Pan-American Health Organization (PAHO).

He worked in Argelia as a Doctor in 1969; was a member of the Tribunal of specialists in Santiago de Compostela University 1968; advisor of the Minister of health of Guyana 1984; and he is now professor advisor of Ameijeiras Hospital in Havana (the highest category of medical teaching in Cuba).

International Experience

Head of Cuban Delegation at the International Aging Assembly, Four International Congresses of Psychiatry, Three International Congresses of Geriatrics.

References

Author of the book "Psychogeriatry for the General Practitioner."

Author of the chapter of Psychogeriatrics in another four books.

Author of 54 published medical papers.

Participant in the 42nd International Congress of Geriatrics.

Head of the Advisory Group of Geriatrics, Psychology, Sociology and other disciplines.

Conferences

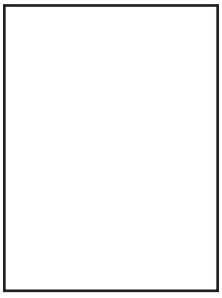
Psychiatry in developed and subdeveloped countries.

Social aspects in mental health.

Quality of elderly home residences among French people in Cuba, 2000

Other

Issues about Psychogeriatrics and Transcultural Psychiatry



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Dr. Biukoto was born in Richmond on Kadavu Island in 1969 and is currently a Medical Officer at the Saint Giles Psychiatric Hospital in Suva, the capital of the Republic of the Fiji Islands. Dr. Biukoto studied Medicine and Surgery at the Fiji School of Medicine in Suva and graduated in 1995 with an MBBS Degree. He did his Internship at Lautoka Hospital in Lautoka and at the Colonial War Memorial Hospital in Suva. [1996 - 1997]. He has worked in various Health Centers and District Hospitals in outlying areas of the Fiji Islands [1997 - 2000]. Dr. Biukoto started work as Medical Officer at the Saint Giles Psychiatric Hospital [2000 - to date] and he is involved in Community Mental Health Awareness Activities [National Mental Health Awareness Week, World Mental Health Day, Annual Saint Giles Hospital Open Day].

Sammy Ohene

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Degrees: MB. ChB., F.W.A.C.P.

Affiliations

University of Ghana Medical School, Accra Psychiatric Hospital.

International Experience

6 Month Internship in Substance abuse in Cleveland, Ohio; Member of International Advisory Board of Editors American Psychiatric Press Textbook of Psychiatry [1998] , 3rd Ed

Dr. Ohene was born in Ghana. He was educated in Ghana and went on to the University of Ghana Medical School Graduating in 1980 at the age of 24 years, winning honor as the top student in Psychiatry. He went on to specialize in Psychiatry working in the University of Benin Teaching Hospital, Nigeria. Dr. Ohene holds the Fellowship of the West African College of Physicians (WACP) (Psychiatry) and has since 1990 been on the Faculty of the Ghana Medical School Department of Psychiatry. He studied Substance Abuse in Cleveland, Ohio, USA for 6 months in 1992. He is an Examiner in Psychiatry to the WACP and a Consultant Psychiatrist to the Korle Bu Teaching Hospital - Ghana's leading hospital and the Accra Psychiatric Hospital. He is a member of the American Psychiatric Association among other national and international professional associations. His research interests include general adult psychiatry, human rights, and psychiatry. Dr. Ohene is married to Sally-Ann a pediatrician currently doing a fellowship in Minnesota. They have two sons.

Ghislaine Adrien

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Ghislaine Louis Adrien, born in Port-au-Prince, Haiti, Psychiatrist.

From 1993 to present, Medical Director of Psychiatric Hospital (Port-au-Prince, Haiti), Professor of Psychiatry at Haiti State University and at "Notre Dame" Catholic University; Hospital Management teacher for the Ministry of Health.

Dr. Adrien graduated from Autonomous National University of Mexico and received her psychiatric degree in 1984 from the University of Los Andes in Venezuela. She has another degree from Switzerland. She has participated for many years in Continuing Medical Education at Miami Children's Hospital.

She also participated in various seminars such as:

Violence and Human Rights, Harvard Public Health School, 1997; Mental Health in the Caribbean country, 1998

Publications

Thesis: Cultural Influence in mental health in Merida, Venezuela, 1983. More than 100 articles on mental health.

"Influencias de la cultura en la enfermedad mental in Venezuela" (Cultural influence in Mental illness in Merida Venezuela); Management of human resources in Psychiatric Hospital; Influences of Culture in Mental Illness in Haiti.

Research

Convulsive crisis in infants in Haiti, 1987; Cultural Influence in mental health in Haiti, 1997.

She participated at the Caribbean Festival of Mental health movie in Martinique. In 1999 she made an award winning film "Children in Domesticity in Haiti".

She has been president of the Haitian Mental Health Association. Her professional Societies and Consultantships include Haitian Medical Association, International Psychology Association, Human Rights and Caribbean Mental Health Association.

International Experience

I have worked as a psychiatrist at MERIDA's psychiatric Hospital in Merida Venezuela

I have worked as a Psychiatrist at GENEVA's Psychiatric Hospital in Geneva Switzerland

Since 1997 I am a Master trainer of trainers in Hospital Management for The National School of Public Health, Rennes FRANCE

Fred Hickling

Head, Section of Psychiatry
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Degree(s) MBBS, BSC, DPM, DM, MRCPsych(UK)
Title: Professor

Dr. Hickling was born in Jamaica and educated in medicine and psychiatry at the University of the West Indies, Mona Jamaica. He received specialist training in Anatomy at St. Thomas' Hospital Medical School, University of London, and postgraduate training in psychiatry at the Royal Edinburgh Hospital, University of Edinburgh. He holds the degree of Doctor of Medicine (Psychiatry) from the University of the West Indies and Membership of the Royal College of Psychiatrists (UK). He has worked at the Bellevue Mental Hospital in Kingston, Jamaica first as a Consultant Psychiatrist and then as Senior Medical Officer, and helped to establish a unique community psychiatric service and to pioneer cultural therapy in that country. He established Psychotherapy Associates as a private psychiatric research and clinical service in Kingston in 1980, and Connolley House, a private community mental health and development center in 1985. Between 1995 and 2000 he was a Consultant Psychiatrist for the North Birmingham Mental Health Trust in Birmingham England. During that time, he established Psychotherapy Associates International Limited and the Bond Hickling Bartley Institute in the UK. Both these organizations have been instrumental in helping to shape policy for African Caribbean Mental Health in that country. In September 2000, he was appointed Professor of Psychiatry and Head, Section of Psychiatry in the Department of Community Health and Psychiatry at the University of the West Indies, Mona, Kingston, Jamaica. His research interests are in African-Caribbean mental health, schizophrenia, community psychiatry, and psychotherapy. He has authored over 60 medical publications in academic journals and book chapters, and has presented widely at academic conferences around the world, with over 50 published abstracts at peer-reviewed academic conferences. He has had numerous psychiatric

consultations and lecture tours in the Caribbean, the USA, Europe, Africa and New Zealand. He has been a Member of the Royal College of Psychiatrists (UK) since 1973, a Member of the American Psychiatric Association since 1977, and the Founding President of the Jamaica Psychiatric Association in 1978. He has been the President of the Jamaica Psychiatric Association from January 2001 to the present. He is married to social psychologist and Lecturer in Organizational Theory and Behavior in the Department of Management Studies at the Mona Campus of the University of the West Indies, Hilary Robertson-Hickling. He has three children. His eldest daughter Deborah is a publicist and television/radio personality in Jamaica; his second daughter, Daniella teaches at Florida State University in Tallahassee, USA, and his son Akindele is an architect in New York. He has also written 12 plays and numerous poems and is an active dramatist and musician.

Affiliations

President, Jamaica Psychiatric Association, Fellow, Royal Society of Medicine, Member, American Psychiatric Association, Member, Royal College of Psychiatrists(UK).

International Experience

Consultant psychiatrist, Mid Central Mental Health, Palmerston North, New Zealand April-October 1993 Specialist work with Maori Mental Health.

Honorary Consultant, Institute of Psychiatry, Maudsley Hospital October - December 1993 Special research project on misdiagnosis of schizophrenia in African Caribbean people in the UK.

Honorary Consultant, North Birmingham Mental Health Trust, Birmingham West Midlands UK, October - December 1995 Specialist consultation on the development of culturally appropriate mental health services for African Caribbean patients in the UK.

Consultant Psychiatrist, Aston Community Mental Health Center, North Birmingham Mental Health Trust, Birmingham West Midlands UK, August 1997 - August 2000. Specialist consultation in the development of public culturally appropriate mental health services for African Caribbean patients in Birmingham.

Medical Director, Psychotherapy Associates International Ltd, Haverstock House, 81-83 Villa Road, Handsworth Birmingham, UK. August 1997 - August 2000. Specialist consultation in the development of private culturally appropriate mental health services for African Caribbean patients in Birmingham.

References

With Griffith, EEH "Clinical Perspectives on the Rastafari Movement". Hospital and Community Psychiatry. 45, 49-52. 1994

"Community psychiatry and Deinstitutionalization in Jamaica". Hospital and Community Psychiatry. 45,1122-1126 (1995)

With Pamela Rodgers-Johnson "The incidence of first onset schizophrenia in Jamaica". British Journal of Psychiatry, 167, 193-196, (1995)

"Psychopathology of White Mentally Ill Migrants to Jamaica" Journal of Molecular and Chemical Neuropathology 28, 261-267, (1996)

"Mental Health in the Caribbean" In "Health and disease in the Caribbean" Ed. RA. Halberstein, Journal of Caribbean Studies, University of Kentucky 57-71, 1997

With Gerard Hutchinson, "The Roast breadfruit psychosis - Disturbed Racial Identification in African Caribbeans" Psychiatric Bulletin, 23, 1-3 (1999) "Postcolonialism and Mental Health: Understanding the roast breadfruit. Psychiatric Bulletin (2000) 24; 94-95

With K. McKenzie, R, Mullen and Robin Murray "A Jamaican psychiatrist diagnoses schizophrenia in a London Hospital" British Journal of Psychiatry (1999) 175; 283 - 285

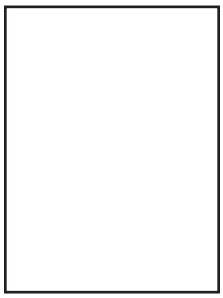
The Political Misuse of Psychiatry: An African Caribbean Perspective. J. Am Acad Psychiatry Law (2002) 30: 112-119

Other

With, Pamela Rodgers-Johnson et al "Retroviruses and Schizophrenia in Jamaica" Journal of Molecular and Chemical Neuropathology 28, 237-248 (1996).

With Gerard Hutchinson Problems in Society, Problem in Psychiatry. International Review of Psychiatry 11; 162-167 (1999).

With Pamela Rodgers-Johnson et al "The treatment of Acute Schizophrenia in Open General Medical Wards in Jamaica" Psychiatric Services (2000) 51(5), 659 - 663.



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I completed my medical education in 1975 at the University of Nairobi when I obtained the medical qualification Bachelor of Medicine and Bachelor of Surgery (equivalent of MD in the American system). I obtained a Diploma in Psychological Medicine at the University of London in 1979 and was elected to Membership of the Royal College of Psychiatrists of the United Kingdom in 1981.

While still in the U.K. I registered for Doctor of Medicine (MD - equivalent of Ph.D in the American system) and I immediately embarked on data collection. I was awarded the degree in 1985 by the University of Nairobi.

I have since rose through the academic ranks at the University of Nairobi and I now hold the Chair of Psychiatry of the University of Nairobi. During this period I was Chairman of the Department of Psychiatry from 1988 to 2000.

I have, for the past 22 years, been involved in various academic activities:

Have published extensively in both local and international journals some of which include the British Journal of Psychiatry, British Journal of Medical Psychology, Acta Psychiatric Scandinavica, Archives of General Psychiatry, East African Medical Journal and the Central African Medical Journal.

I have served in various organizations. I have been visiting Professor in the United Kingdom, Germany and South Africa and also external examiner in Psychiatry in East, Central and South Africa.

Research has always been my interest and I have done it individually and in collaboration with local and international organizations; one of which I am currently involved in is a United Nations Drug Control Programme survey to collect data, analyze and report on the trend of drugs of abuse.

The experience in relation to response to disasters in this part of the world has been very inadequate and to fill this lacuna I conceptualized and developed five postgraduate curricula at the Department of Psychiatry, University of Nairobi namely; Master of Science in Clinical Psychology, Postgraduate Diplomas in Clinical Psychiatry, Substance Abuse, Psychotrauma Management and Psychiatric Social Work. I have also been very instrumental in ensuring Psychiatry is an examinable subject at undergraduate level and the first such class was examined early this year.

I have supervised several M.Med dissertations in East, and South Africa and two Ph.D dissertations.

I have been involved in several psychotrauma related activities in Kenya and outside Kenya, and attended many related seminars all over the world. I am a member of numerous professional bodies in Kenya and outside Kenya. I serve as a member of the Scientific Committee of the World Psychiatry Congress.

International Experience

Have attended numerous international conferences all over the world, such as World Psychiatry Association Meetings, Psychotrauma Conferences (two in USA-2001 and August 2002.

References

Kyanguli Secondary School Fire Tragedy - Mental Health and Psychosocial Response and Lessos Learnt.

The Psychosocial Sequelae Among the Survivors of the Nairobi United States Embassy Terrorist Bomb Blast.

Stress in Refugees in the Kenyan Situation - Development of a Training Manual.

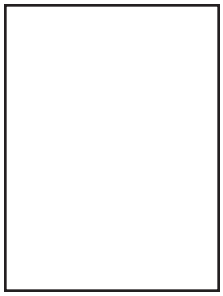
Development of Training Manual on Mental Health for Rwanda following the Genocide in 1994.

Supervision of Masters Degree dissertations in Psychotrauma in Kenya.

Development of University Curriculum for Graduate students in Psychotrauma.

The Effect of Psychotrauma on Babies in-Utero - a research project.

The training on psychotrauma for lay people in Kenya.



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International Experience

Member of the World Association of Psychiatry (World Psychiatric Association: WPA) - Member of the World Section of Military Psychiatry and Catastrophes (1996) - Member of the Reciprocal Association of Psychoanalysis of Paris - Vice-president of the. Association of Early Childhood and Psychoanalysis, Paris - Member of Association Franco-Maghrèbine de Psychiatrie of Ille de France (Paris 1998) - Secretary-general and Arab Founder member of the. Association of Psychotherapy - Member of the Group of Research and Application of Psychoanalytical Concepts with African French-speaking persons (GRAPAF), Paris - Vice-president and Founder member of the. Institute for the Extension of the Psychoanalysis in Francophonie (EPF), Paris - Member of the office of the African Section of the World Council of Psychotherapy.

Founder member and President of the Moroccan Association of Psychoanalysis - Member of the Moroccan Association of Psychiatry - Vice-president of the Moroccan Association of Psychotherapy - Coordinator of the Commission of "Psychotherapy and Culture" - Member of Northern Association for the Development of Psychiatry - Member of the Moroccan Association of the Study of Pain - Vice President of the National commission of Mental Hygiene in the Royal Army Forces - Member of the Scientific Committee of The Military Hospital Moulay Ismail (Meknës, Morocco) - International Correspondent in Morocco of: Review of "Clinic psychology", University Paris VII Edition Harmattan - Review Migration and Santè. Paris - Member of the editorial board of books under Review by the Moroccan Association of Psychotherapy.

Oyewusi Gureje

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Oyewusi Gureje is a Professor of Psychiatry and Head of Department of Psychiatry, University of Ibadan, Nigeria. He is also an Honorary Consultant

Psychiatrist at the University College Hospital, Ibadan.

He had his undergraduate medical education in Nigeria and his post-graduate training in Nigeria and England. He was a Senior Consultant Psychiatrist at the Royal Melbourne Hospital in Australia between 1995 and 1999. He has, for many years served as an Adviser to the World Health Organization and is currently a member of its Alcohol Policy and Strategy Advisory Committee.

Professor Gureje has also served as a Consultant to the National Institute of Medicine. He is currently an Honorary Senior Fellow in Psychiatry at the University of Melbourne and an Ex-Officio Member of the Executive of the Section on Epidemiology and Public Health of the World Psychiatric Association.

Dr. Gureje has conducted studies in schizophrenia, movement disorders, soma to form and pain disorders, and in epidemiology of common mental disorders, particularly in primary care. A number of his research activities have addressed cross-cultural issues

and involved collaborative work with researchers from USA, Western Europe, Asia, Australia, and South Africa. He was a co-investigator in a recent national survey of psychotic disorders in Australia. Widely traveled, he has presented papers in all of the continents of the world.

He is currently conducting a major household survey of mental disorders in Nigeria and is also a co-investigator in the Ibadan-Indianapolis Dementia Project, a comparative longitudinal study of the epidemiology of Alzheimer's disease and of dementia among the Yoruba living in Nigeria and African Americans living in Indianapolis. He has published about 100 papers in peer-reviewed journals and as chapters in books and has served as a reviewer to many international journals in psychiatry and in medicine.

Carlos Smith-Fray

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Bachelor in Science - National Institute Panama - Dec. 1970, Medical Doctor - Faculty of Medicine, University of Panama - Sep. 1977, Psychiatry in Academic Residence, H.P.N. 1979 - 1972., Psychiatry Specialist in Forensic Residential Programs, H.P.N. 1982- 1984, Specialist in Advance Teaching Techniques - University of Panama - 1985 - 1986, Training in Drugs, Narcotics, Alcoholism: Course and Seminars - Miami, Trinidad - Tobago,

Salvador, Venezuela, Costa Rica, Mexico. Psychiatry Forensic Officer of the Public Ministry Ad Honour - 1985 - 1987, National Director Of Mental Health - 1989 - 1990, Consultant of the Juvenile Court of Justice 1985 - 1989, Member of the Psychiatric Panamanian Society. Member of the American Society of Addiction Medicine (ASAM) Washington D. C., Voluntary member of the Panamanian White Cross. Member of the Panamanian Society of Addiction. Member of the Panamanian Society of Legal Medicine. Member of the Physicians Society for the Prevention of Nuclear War. Member of the Panamanian Association for the prevention and Treatment of Obesity. Member of the Society of Friends of the West Indian Museum of Panama. (SAMAAP)., Member of the Lions Club of Parque Lefevre.

He is the founder of the Chemical Dependency Treatment Program at the National Psychiatric Hospital. He is a well known Lecturer on Chemical Dependency Themes. He has directed conferences in local Universities, Schools, Civic Groups. Hospitals, Medical Societies and others., Dr. Smith has over 15 years of experience in the field of alcohol, drugs and delinquency. He has participated in scientific events in his specialized field in other countries. Dr. Smith-Fray was born in Panama, R. P. He obtained his primary education at Escuela El Salvador in El Chorrillo, his medical education at the University of Panama and additional training in Miami, Trinidad-Tobago, Salvador, Venezuela, Costa Rica and Mexico.

Dr. Smith has over 8 years of experience in the field of alcohol, drugs and delinquency. He has participated in scientific events in his specialized field in other countries.

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Dr. Uma Ambi is a 1990 graduate from the University of Papua New Guinea (PNG) and did her training in Psychiatry from the University of Papua New Guinea. She had one (1) year training in New South Wales with the Institute of Psychiatry.

She is now the Principal Advisor for Mental Health Services in the Department of Health, Papua New Guinea. She currently holds positions as Chief Psychiatrist, President of PNG Psychiatric Association, Affiliate to World Psychiatric Association, Honorary Lecturer in Psychiatry with University of Papua New Guinea and as the head for undergraduate and

postgraduate training in Psychiatry.

She is currently responsible for the overseeing of the National Mental Health program in PNG and is also entrusted with the preparation of the PNG Mental Health Policy and the Ten-Year Mental Health Plan which is a component to the PNG National Health Plan 2001 - 2010.

She has successfully seen the establishment of Mental Health Services both at district and community levels. She has been responsible for the development of an appropriate mental health monitoring and information system; a standard treatment manual for mental health; and other guidelines with study materials for the in-service training of mental health workers.

She has also been actively involved in the development of community based support and rehabilitation, along with community awareness and education.

She has extensive clinical experience with the developing Pacific countries and currently conducts her own clinical practice in Papua New Guinea. She has been fully involved with the organization and has contributed to the conduct of training, supervision and monitoring of mental health staffs at all levels in Papua New Guinea. This includes advanced training for Psychiatric Registrars, Medical Officers, Health Extension Officers and Nurses.

She has provided Mental Health consultancy work and training services in the Solomon Islands. In this role, she has gracefully combined her experience and professional acumen in PNG thus making her uniquely qualified to be a Specialist Psychiatrist in the South Pacific Region.

Affiliations

PNG Psychiatric Association, Medical Society of Papua New Guinea, World Psychiatric Association, World Federation for Mental Health.

International Experience

Presenting papers at World Federation for Mental Health Congress (Japan, Finland, Dublin, South Africa).

Presenting Papers at World Psychiatric Association Congress.

Chairing and contributing to Scientific Sessions.

References

Up-date on Transcultural Psychiatry in PNG.

Are we sitting on a time bomb?

Medical Insurance/Schemes in PNG.

Depression in PNG.

Impact of Psycho-Social Modernization in PNG.

Somatoform Disorder in PNG.

Neuro-Psychiatric Manifestation of Typhoid Fever.

Mental Health is an integral part of Health System.

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Doctor Omar Ndoye, is a teacher in the University of Dakar (UCAD). He is also a senior researcher. In addition, he was recently been named to head the DASS (Direction Sanitaire et sociale) in the city of Dakar, Capital of Sènègal. This initiative brings together a number of different health care professionals from various domains and also oversees plans for social action in the city.

He is a member of several organization and structures like “Evolution Psychiatric” “Institute de Psychanalyse d’enfants et d’adolescents” all based in Paris (France).

Doctor Ndoye is author of several studies about ethnopsychiatry and psychotherapy. He had also written a book on the topic of the intervention of foreigners in Europe.

In December 2002, his latest book will appear (“Sexualité Africaine, Présence Africaine”).

Doctor NDOYE manages the Dual Research Institute in Dakar (IREP).

He is also the Head Master of Institute Ethnopsy. Afrique based in Paris, France.

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I have worked in Kenya and South Africa before I joined the university teaching service. I have participated in multicenter international field research on riverblindness (onchocerciasis) sponsored by TDR, the special program for training and research on tropical diseases, of the World Health Organization. Currently I am involved in research collaborative study on depression with Professor Danuta Wasserman and Professor Hans Agren, both of Karolinska Institute, Sweden.

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Ovuga EBL & Mugisha RX (1990). Attitudes and psychological characteristics of self-destructive individuals. Crisis, 11:60-72.

Mugisha RX & Ovuga EBL (1991). The use of electroconvulsive therapy in the treatment of psychiatric patients at Umzimkulu Hospital in Transkei. A prospective study. South African Medical Journal, 79: 391-393.

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Other

Because depression is one of the commonest chronic disorders in primary care, and because it is

difficult for the condition to be recognized by primary health care providers, I have been involved in developing a short screening instrument for use at primary care settings in Uganda. I believe I am close to accomplishing my work. A copy of the instrument, to be known as the Response Inventory for Stressful Life Events (R.I.S.L.E.), will be available at the conference. I shall come with details of the work should this be considered useful for conference proceedings.

The instrument aims to help detect depression and high-risk suicide ideation by using indirect clues in depression and suicide behavior. The assumption is that depressed and suicidal individuals have an enduring and inherent propensity to these states, and that such individuals can be detected even if they have no psychopathology. Currently, the RISLE consists of 11 items each of which is scored on a three-point scale: "0" for I disagree, "1" for I agree" and "2" for I strongly agree. The minimum score is zero, and the maximum, 22. A score of 11 and higher requires interview and probable intervention.

Kwame McKenzie

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Dr. McKenzie is a Senior Lecturer in Transcultural Psychiatry at the Royal Free and University College Medical Schools London UK. He also runs an Assertive Outreach Service solely for African and African-Caribbean 16-25 year olds in North London. He is a member of the Black Mental Health Commission of the Greater London Authority, Secretary to Blackliners, (a charity offering care and education for Black people in the UK suffering from HIV); he is part of the editorial board of Culture Medicine and Psychiatry and has an honorary Lectureship at the Institute of Psychiatry London. His expert areas are mental illness in people of Caribbean origin in the UK and social capital and mental health. Dr. McKenzie was born in London; his parents went to London from Cariaccou and Dominica in the Caribbean in the late 1950s and returned to live in Dominica in the 1980s. He was educated in London before reading Medicine at Southampton University. Dr. McKenzie trained in psychiatry at the Maudsley Hospital and Institute of Psychiatry, London. Dr. McKenzie is the past managing editor of the Practitioner, the Medical News Editor of GP and a Visiting Associate Editor of the British Medical Journal. During his period at the British Medical Journal, he wrote the guidelines for the use of race, ethnicity, and cultural terminology in UK publications. He was a founder member of the Board of Trustees of Brixton Circle project, a voluntary sector mental health provider of culturally sensitive services in London and has continued work supporting this sector.

Dr. McKenzie is a trained journalist and his sell-through book, Understanding Depression, has sold over 60,000 copies. While a Lecturer at the Institute of Psychiatry, D.r McKenzie wrote and presented a series of documentaries on psychology for a UK national television station, which have been broadcast worldwide. He continues to act as a consultant to the media in the field of mental health.

International Experience

International work has included work with the European Union in Brussels and University of Kortenberg (he described and published the only account of Belgium community psychiatric services). In the Caribbean, Dr. McKenzie set up the Dominica Case Register of Mental Illness, which was funded by the Stanley Foundation. Dr. McKenzie also studied African-American mental health services as a Harkness Fellow in International Health Policy at the Department of Social Medicine, Harvard Medical School.

His current research portfolio is diverse. Notable projects include, the role of racism in the outcome of psychiatric illness, the impact of social capital on the rates of psychosis in London and an investigation of the increased rate of suicidal behavior in African and African-Caribbean's with psychosis in the UK. Dr. McKenzie envisaged and set up Circles of Fear, the largest ever survey of attitudes to mental health and services receipt among Black users in the UK.

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Dr. Pamela Collins is an Assistant Professor at Columbia University in the College of Physicians and Surgeons, Department of Psychiatry and the Mailman School of Public Health, Department of Epidemiology. She is an attending psychiatrist at the New York State Psychiatric Institute. She completed her medical training at Cornell University Medical College and subsequently trained in psychiatry at Columbia University /New York State Psychiatric Institute. She completed graduate work in public health and an NIMH post-doctoral fellowship at Columbia University. Dr. Collins studied cultural psychiatry as a research fellow in the Department of Social Medicine at Harvard Medical School. She is the principal investigator on grants funded by the NIMH and the Robert Wood Johnson Foundation focusing on sexuality, stigma and HIV risk for women with severe mental illness (SMI). Along with colleagues at the HIV Center for Clinical and Behavioral Studies at Columbia, she has developed an HIV

prevention intervention targeting the specific needs of women with SMI. Dr. Collins' work targets impoverished women of color in New York City. Dr. Collins has long maintained an interest in international health. Early projects took her to Haiti and Nigeria. Later work extended to India, Argentina, and South Africa. She has worked in rural Argentina for several years training primary care doctors in mental health. Dr. Collins has conducted research in South Africa with mental health care providers, studying their perceptions of HIV risk among people with mental illness. She is currently directing a study of HIV prevention intervention development in psychiatric settings in South Africa. She continues to work with the Mental Health Directorate in South Africa as a member of the task team for policy guidelines on HIV/AIDS in psychiatric institutions.

Dr. Collins serves on the Secretariat of the MTCTPlus Initiative at the Mailman School of Public Health. She is a member of the research, training, and clinical working groups, where her focus is on psychosocial issues. This Initiative will provide family-centered HIV/AIDS primary care and antiretroviral therapy in several countries in Sub-Saharan Africa and in Thailand.

Host National Committee

Chester Pierce *Program Chairman*	Boston, MA, USA
Felton Earls *Co-Convenor*	Cambridge, MA, USA
Ezra Griffith *Co-Convenor*	New Haven, CT, USA
Rahn Bailey	Houston, TX, USA
Carl Bell	Chicago, IL, USA
Michelle Clark	San Francisco, CA,USA
Valerie Smith-Gamble	Indianapolis, IN, USA
Patrice Harris	Atlanta, GA, USA
David Henderson	Boston, MA
William Lawson	Washington, DC, USA
Shirley Marks	Lubbock, TX, USA
Gail Mattox	Atlanta, GA, USA
Paul Organ *Proceeding Editor*	Atlanta, GA, USA
Gilbert Parks	Topeka, KS, USA
Robert Phillips	Annapolis, MD, USA
Donald Vereen	Washington, D.C., USA

Other Invitees

Carlotta Arthur	Boston, MA, USA
Beverlee Bruce	New York, NY, USA
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Chester Pierce

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Chester M. Pierce is Professor of Education and Psychiatry, Emeritus in the Medical School, the Graduate School of Education, and the School of Public Health at Harvard University. Dr. Pierce is Senior Psychiatrist at Massachusetts General Hospital in Boston, MA.

For nearly twenty-five years he was also Psychiatrist at Massachusetts Institute of Technology. He is a past president of the American Board of Psychiatry and Neurology and the American Orthopsychiatric Association. He was Founding President of the Black Psychiatrists of America and was National Chairperson of the Child Development Associate Consortium. He held the rank of Commander in the U.S. Navy and has served on twenty-two editorial boards. Prof. Pierce has been Senior Consultant to the Peace Corps; National Consultant to the Surgeon General of the U.S. Air Force; advisor to the Children's Television Workshop (Sesame Street, Electric Company); and advisor to the U.S. Arctic Research Commission.

He has published over 180 books, articles and reviews, chiefly on extreme environments, racism, media and sports medicine. Professional service has included chairing committees for the National Institute of Mental Health; the National Research Council; the National Science Foundation and the National Aeronautics and Space Administration. Awards include those from the National Medical Association, American Psychiatric Association, Black Psychiatrists of America and the World Psychiatric Association. In addition, he has won national and international awards for film production. Dr. Pierce has been invited to lecture on all seven continents and has spoken at over one hundred colleges and universities in the USA. Honors include Pierce Peak in Antarctica; honorary degrees; Honorary Fellowship in the Royal Australian and New Zealand College of Psychiatrists; Honorary Fellowship in the British Royal College of Psychiatrists. He is a member of both the Institute of Medicine at the National Academy of Sciences and the American Academy of Arts and Sciences.

Dr. Pierce has been on the board of the World Association of Social Psychiatry as well as on the boards of local and national voluntary organizations concerned with youth, human rights and conservation. He received an A.B. in 1948 and M.D. in 1952 from Harvard University.

International Experience

Worked as a psychiatrist in numerous countries over all 7 continents of the earth.

Performed research in Antarctica, especially at the geographic South Pole, often with international collaboration.

Chaired international, multi-disciplinary committees dealing with research missions in the Arctic, the Antarctic and Space.

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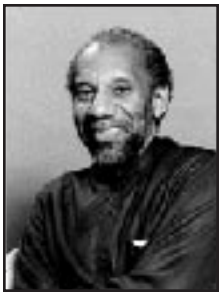

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Felton Earls is Professor of Social Medicine and Child Psychiatry at Harvard Medical School and Professor of Human Behavior and Development at the Harvard School of Public Health. His undergraduate and medical school education was completed at Howard University. Before turning to pediatrics and psychiatry, he trained in neurophysiology at the University of Wisconsin. He completed residency in general psychiatry at Massachusetts General Hospital in 1973 and pursued advanced training in epidemiology and child psychiatry at the London School of Hygiene and tropical Medicine and the Hospital for Sick Children in London. He joined the Faculty of Harvard Medical School in 1974. From 1981 to 1989, he was Director of the Division of Child Psychiatry and Blanche F. Ittleson Professor of Child Psychiatry at Washington University School of Medicine in St. Louis. He returned to his present positions at Harvard in 1989.

Dr. Earls has conducted research in child mental health throughout the world. This work ranges from studies of preschool children of West Indian origin in London to street children in Brazil and institutionalized infants in Romania. Beginning in 1990, he became Principal Investigator of the Project on Human Development in Chicago Neighborhoods. This project is investigating the causes and consequences of children's exposure to violence by combining a detailed study of neighborhoods and families with an accelerated longitudinal study of children from birth to adulthood. Over the past decade, this work has emerged as one of the most influential social science projects of this era. More recently, he has turned his attention to HIV/AIDS and its impact on children in sub-Saharan Africa.

His record of publications includes over 100 original papers, 75 chapters, and 7 books. He was elected to the American Academy of Arts and Sciences in 1993 and the Institute of Medicine in 1995. He has received many other honors and invited lectureships, including the Distinguished Psychiatrist Award (1991) and the Blanche Ittleson Award for Research in Child Psychiatry (1994) from the American Orthopsychiatric Association. He was awarded an Honorary Doctor of Science from Northwestern University (1997), and earned honorary membership in the Gamma Chapter of Alpha Omega Alpha (2001). He currently serves on the Board of Directors of Physicians for Human Rights and serves on the Committee on Human Rights at the National Academy of Science.

He lives with his wife, Maya Carlson, in Cambridge, Massachusetts and he has two daughters and two grandchildren, all of whom live, in the Boston area.

Affiliation

Harvard Medical School

International Experience

With regard to the Diaspora, I have conducted research on child psychopathology and child development in the United States, Great Britain, Brazil, South Africa and Tanzania.

References

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Dr. Griffith is Deputy Chairman for Clinical Affairs in the Department of Psychiatry, Yale University School of Medicine and holds the rank of Professor in Yale's Department of Psychiatry and in its Department of African-American Studies. As deputy chairman of Yale's psychiatry department, he coordinates policy for the department's clinical practice at its different facilities. In the Department of African-American Studies, Dr. Griffith teaches two courses on different approaches to the use of narrative in portraying the individual black life.

He has broad consultation experience in mental health service systems and has written extensively in the areas of cultural and forensic psychiatry. From 1987 to 1996, Dr. Griffith directed the Connecticut Mental Health Center, a joint endeavor of the Yale University School of Medicine and Connecticut's Department of Mental Health and Addiction Services. Dr. Griffith is board certified in general psychiatry as well as in forensic psychiatry. His most recent book, Race and Excellence: My Dialogue with Chester Pierce was published by the University of Iowa Press in February, 1998. He was named Editor of the Journal of the American Academy of Psychiatry and the Law in 1999.

Dr. Griffith has consulted to several universities, to Project HOPE, and to the Pan American Health Organization, as well as to the Robert Wood Johnson Foundation and to the MacArthur Foundation Research Network on Mental Health and the Law. He has, on three occasions, been designated as External Examiner in Psychiatry for the Faculty of Medicine, University of the West Indies. He has been the Mossell Lecturer at the University of Pennsylvania, the Dana African-American Visiting Professor at the University of Maryland, and the Earline Houston Memorial Lecturer in Public Psychiatry at Hahnemann University. In 1994, he was a Distinguished Lecturer at the Annual Meeting of the American Psychiatric Association and in 1997 he presented the Lundbeck Lecture to the Forensic Psychiatry Section of The Royal College of Psychiatrists in England. In 1999, he delivered the Roy Cooke Memorial Lecture in Kingston, Jamaica and was also a special invited Lecturer at the Annual Meeting of the Society of Legal Psychiatry in Madrid, Spain. In May 2001, Dr. Griffith delivered the Solomon Carter Fuller Lecture, at the Annual Meeting of the American Psychiatric Association, on Authentic Representation, Belonging, and the Narrative of Self-Identification.

A former president of the Connecticut Psychiatric Society, Dr. Griffith chairs that Society's

Ethics Committee. He has served on several components of the American Psychiatric Association: Committee on Black Psychiatrists; Council on Psychiatry and Law; Commission on Judicial Action; Task Force on Consent to Voluntary Hospitalization; Council on International Affairs; Ethics Committee; Task Force on Strategic Planning; Committee on Standards and Survey Procedures. He also served as President of the American Board of Forensic Psychiatry and the Black Psychiatrists of America. He was Program Chairman for the 1993 Annual Meeting of the American Academy of Psychiatry and the Law and has served as that organization's President. He completed his presidency of the American Orthopsychiatric Association in 1998.

Affiliation

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International Experience

I have done research in the Caribbean and have provided consultations to several Caribbean governments and to the Pan American Health Organization.

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Dr. Bailey is a double board certified forensic psychiatrist. He completed his general psychiatric training at the University of Texas Medical School in June 1994. Thereafter, he completed his forensic psychiatric fellowship at Yale University in June 1995. He became board certified in general psychiatry in March 1998. In April 1999 he achieved board certification in Forensic Psychiatry. He currently holds a position of assistant clinical professor of psychiatry at the University of Texas Medical School in Houston. Dr. Bailey has served in this capacity since July 1, 1997. Prior to that date, Dr. Bailey served as a tenure track assistant professor on the medical faculty of Louisiana State University in New Orleans. He has clinical appointments at Tulane and Baylor Colleges of Medicine.

Dr. Bailey is the Director of the Program of Law and Psychiatry at the University of Texas at Houston Medical School. In that capacity, he directs a monthly lecture series, a monthly citywide journal club, and coordinates a one-month senior medical student elective. In addition, Dr. Bailey teaches the basic forensics lectures within the second and third year didactic program, these include Legal Issues in Psychiatry, Confidentiality, Ethics, Violence and Suicide/Homicide, and Civil Commitment. He is a member of the Administrative Council of the American Academy of Psychiatry and Law (AAPL). He was recently appointed as chairman of the AAPL Committee on Correctional and Institutional Psychiatry. From 1998-2000, he served as the Corporate Medical Director of Continuum Healthcare, Inc. In that capacity he managed the clinical responsibilities of four physicians.

Dr. Bailey is currently a staff physician at Harris County Psychiatric Center in Houston. He was the Director of Consultation and Liaison Services at Lyndon B. Johnson Hospital within the Harris County Hospital District in 1998. Dr. Bailey was also the Director of Consultation Services at Hermann Hospital from July 1997 through July 1998. Dr. Bailey is the Medical Director/CEO of Bailey Psychiatric and Forensic Associates. In this active private practice, he treats an average of 250 clinical outpatients each month. He oversees the clinical and forensic responsibilities of one physician, and three therapists. Previously, Dr. Bailey served as Correctional Psychiatrist for the Garner State Prison for the Mentally Ill in Newton, CT 1994-1995.

Dr. Bailey is currently the director of the division of Law and Psychiatry at the University of

Texas Medical School Department of Psychiatry. He is a national forensic expert, who has testified and participated in both civil and criminal cases both locally and nationally. Of particular note, he is a psychiatrist for the state of Texas who performs the Sexually Violent Predator (SVP) evaluations. He has done evaluations and provides treatment for United States Probation office and the Texas Rehabilitation Commission. Also, he is an expert for the Federal Social Security Office of Disability Hearings and Appeals. He has been qualified as an expert and testified in five states (Texas, Louisiana, Kansas, Indiana, and Connecticut). He has written and lectured on various forensic topics including Confidentiality, Insanity Defense, Ethnic Differences in Psychopharmacology, Competency and Medical Student Education. He has also written various articles on Post Traumatic Stress Disorder, Sexual Offenders, Ethics in Forensic Practice, Juvenile Crime, Capital Punishment, Atypical Antipsychotic Treatment and Efficacy, Cocaine Dependence and Clinical Treatment, and Stalking.

Dr. Bailey has been featured live on MSNBC Television, as well as on CNN, and local TV/Radio discussing Psychiatric Treatment, the Insanity defense and Violent Criminal Behavior.

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Dr. Bell is President & C.E.O., Community Mental Health Council & Foundation, Inc. He is also the Director of Public and Community Psychiatry and a Clinical Professor of Psychiatry and Public Health, University of Illinois. Dr. Bell is the Principle Investigator of a study in a South African Township using the CHAMP program to Prevent HIV Risk in South African youth; a co-Principle Investigator of the Chicago African-American Youth Health Behavior Project; and a collaborator of the Chicago HIV Prevention and Adolescent Mental Health Project (CHAMP) at the University of Illinois.

He is a member and Former Chairman of the National Medical Association's Section on Psychiatry; a Fellow of the American College of Psychiatrists; a Fellow of the American Psychiatric Association, a Founding Member and Past Board Chairman of the National

Commission on Correctional Health Care. During 30 years, Dr. Bell has published over 200 articles on mental health. He is editor of Psychiatric Perspectives on Violence: Understanding Causes and Issues in Prevention and Treatment; author of Getting Rid of Rats: Perspectives of a Black Community Psychiatrists; co-author of Suicide and Homicide Among Adolescents and chapters on: "Black Psychiatry" in Mental Health and People of Color; "Black-on-Black Homicide" in Mental Health and Mental Illness Among Black Americans; "Isolated Sleep Paralysis" & "Violence Exposure, Psychological Distress and High Risk Behaviors Among Inner-City High School Students" in Anxiety Disorders in African-Americans; "Is psychoanalytic therapy relevant for public mental health programs" in Controversial Issues in Mental Health; and "Prevention of Black Homicide" in The State of Black America 1995.

Dr. Bell was the E.Y. Williams Distinguished Senior Clinical Scholar Award of the Section on Psychiatry of the National Medical Association in 1992. He received the American Psychiatric Association President's Commendation - Violence in 1997. He was appointed to the Violence Against Women Advisory Council by Janet Reno the Attorney General Department of Justice and Donna Shalala Secretary Department of Health and Human Services - 1995-2000, and was a participant - White House's Strategy Session on Children, Violence, and Responsibility. He was appointed to the working group for Dr. David Satcher's Surgeon General's Report on Mental Health - Culture, Race, and Ethnicity and appointed to the Planning Board for the Surgeon General's Report on Youth Violence.

International Experience

I am currently doing HIV prevention research in Durban, South Africa. I have done some international collaboration on the study of Isolated Sleep Paralysis and I have a few international contacts.

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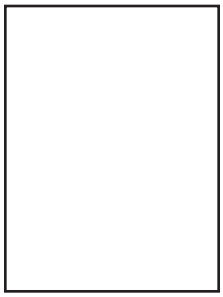

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Dr. Clark is a physician specializing in Psychiatry for the last twenty-five years. She attended Hunter College of the City University of New York for undergraduate studies and received her degree in medicine from Columbia University College of Physicians and Surgeons also in New York City. Her postdoctoral training included a rotating internship at the Charles R. Drew Medical University, Martin Luther King, Jr. General Hospital in Southeast Los Angeles. She trained as a resident at the Neuropsychiatric Institute, University of California at Los Angeles.

Following completion of her training Dr. Clark served for five years as the founding Chief of the Division of Consultation and Liaison Psychiatry at the Augustus F. Hawkins Mental Health Center of the MLK, Jr. Medical Center, part of Los Angeles County Mental Health Services. She was appointed to the faculty of the Charles R. Drew Medical University and served on several faculty committees including the medical school admissions and awards program committees.

In 1985, Dr. Clark relocated to San Francisco to join the faculty of the University of California at San Francisco. She was recruited to develop the Black Focus Program. This special program was created to provide expert treatment, training, consultation, and research for persons of African descent. She served as the founding Director of the program and Unit Chief of the acute inpatient unit, 6B, where the program was housed. She has advanced to Associate Clinical

Professor, Step III and served several departmental and school-wide committees including the Diversity Committee, the Medical School Admissions Committee and the Dean's Committee on Culturally Competent Curriculum. Dr. Clark specializes in cross-cultural issues in psychiatry particularly in populations of African descent. She has interest in treatment of depression in special populations such as U.S. Africans, women and the elderly.

Dr. Clark ended her experience as full time compensated faculty in 1998. She joined the Traditions Behavioral Health group and has consulted through them for various clinical assignments in Northern California. She also spent one year as a psychiatrist for the California Department of Corrections assigned to the Solano State Prison, a men's facility.

Beginning in 2001 Dr. Clark joined the Barbour Floyd Medical Associates to become the Program Psychiatrist for their South Central Health and Rehabilitation Services (S.C.H.A.R.P.) AB 2034 Program. This is a specialized program for treatment of mentally ill ex-offenders toward prevention of homelessness, substance abuse and recidivism.

Outside of her work at the University and in clinical services Dr. Clark has been an active member of several guild organizations. She has served the Black Psychiatrists of America (BPA) most recently as Program Director and Chair of the 23rd Annual Transcultural Conference in Bermuda. She is a member of the National Medical Association (NMA) and has been a regional representative. She has remained active in the American Psychiatric Association (APA) and is currently the Chair of the Committee of Black Psychiatrists and President of the Caucus of Black Psychiatrists. She represents these groups on the APA Board of Trustees.

Dr. Clark's community volunteerism included participation as a charter member of the Grandparents Who Care Advisory Board and the Northern California Episcopal Diocese African American Commission. She was also a member of the Board of Directors of the Girls After School Academy (GASA).

Honors and awards to Dr. Clark include an APA/NIMH Fellowship throughout her psychiatric residency. She was recognized by the city of San Francisco as one of the first group of awardees to receive the Women Who make a Difference Awards in 1995. In 1996 the Black Psychiatrists of America honored her with the first annual Dr. Issac M. Slaughter Memorial Award for leadership in Psychiatry. Dr. Clark was inducted as a Fellow of the American Psychiatric Association in 1999.

Dr. Clark has authored case reports, articles and a book chapter on subjects related to cross cultural psychiatry. She also contributes to the lay press on various subjects in psychiatry. She lectures locally, nationally and internationally.

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Dr. Harris is a graduate of the West Virginia University School of Medicine and completed residency and fellowship training at the Emory University School of Medicine. In addition to her general psychiatry training, she completed fellowships in Child and Adolescent Psychiatry and Forensic Psychiatry. She is currently in private practice in the Atlanta metropolitan area and serves as a consulting psychiatrist for gender specific treatment for two substance abuse treatment facilities. Since January she has worked as a Senior Policy Fellow for the Barton Child Law and Policy Clinic at the Emory University School of Law. In this capacity she is part of a multi-disciplinary team addressing public policy for abused and neglected children, and her responsibilities include legislative advocacy and education. Dr. Harris lectures nationally on the topics of children's mental health, juvenile law, addiction, and abused and neglected children. She is immediate past chair of the Committee of Black Psychiatrists of the American Psychiatric Association (APA) and was recently elected to the APA Board of Trustees. Dr. Harris is a member of the Board of Trustees and the Legislative Committee of the Georgia Psychiatric Physicians Association, a District Branch of the APA and was selected as the 2000-2001 Psychiatrist of the Year in Georgia.

Affiliation

Emory University

International Experience

Traveled on Africa and several Caribbean countries to attend the BPA Transcultural Meetings.

Traveled to Italy for a joint meeting with the APA and the Italian Psychiatric Association.

David C. Henderson

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Affiliations

Massachusetts General Hospital; Harvard Program in Refugee Trauma; Harvard Medical School

International Experience

Dr. Henderson is the Medical Director of the Harvard Program in Refugee Trauma and has been involved in field studies, research, training programs, and policy development in countries that have experienced mass violence. These countries include Rwanda, Cambodia, Bosnia, and East Timor. He also lectures on topics of ethnopsychopharmacology, schizophrenia, and psychopharmacology internationally.

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Dr. Lawson is currently Professor and Chairman of the Department of Psychiatry at Howard University School of Medicine. He is also the residency training director. Dr. Lawson is currently the Chair of the Section of Psychiatry and Behavioral Sciences of the National Medical Association. He is a past president of the Black Psychiatrists of America. He has over seventy five publications involving severe mental illness and its relationship to psychopharmacology, substance abuse, and racial and ethnic issues.

He has a long standing concern about ethnic disparities in mental health treatment, and has been an outspoken advocate for access to services of the severely mentally ill. Dr. Lawson was named as one of "America's Leading Black Doctors" by Black Enterprise Magazine, received the Jeanne Spurlock Award from the American Psychiatric Association, and received the E.Y. Williams Clinical Scholar of Distinction Award from the Psychiatry and Behavioral Sciences Section of the National Medical Association, a Multicultural Workplace Award from the Veterans Administration for his outstanding contributions to the advancement of diversity and multicultural understanding, named as a national mentor by the National Alliance of the Mentally Ill and received numerous awards for excellent teaching. He has received state, federal, and foundation support for pharmacological research and to develop new and effective treatments.

Dr. Lawson received his Bachelor's degree from Howard University, Master's degree from the

University of Virginia, and Ph.D. in Psychology from the University of New Hampshire. He received his M.D. degree from the University of Chicago, and did his residency at Stanford University Medical Center. He completed a fellowship in clinical psychopharmacology at the National Institute of Mental Health intramural program. He is boarded in psychiatry and neurology and has added qualifications in drug and alcohol addiction. He is also a fellow of the American Psychiatric Association.

He currently is a Member of the Scientific Advisory Committee, National Depression and Manic Depressive Society, and serves on the boards of the DC Mental Health Association and the DC Alliance for the Mentally Ill. He currently is directing a $14 million contract with the National Institute of Mental Health intramural program to research mood and anxiety disorders in African Americans and other ethnic minorities.

Shirley F. Marks

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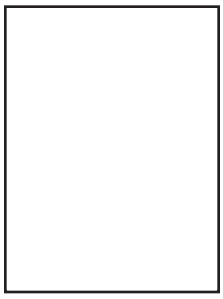
Dr. Marks graduated from Harvard Medical School in Boston in 1973 and became its second African American female medical school graduate. She later completed her psychiatry residency at Harvard Affiliated Mclean Hospital in Belmont, Massachusetts. She furthered her studies in mental health by receiving a psychiatric epidemiology fellowship and Masters of Public Health in Behavioral Sciences from the Harvard School of Public Health in 1976.

Her leadership qualities began while attending public schools in Tyler, Texas. She went on to graduate valedictorian of her graduating class. She attended Spelman College in Atlanta, Georgia and spent a year abroad in Vienna, Austria on a Charles Merrill Scholarship. She later became a member of the Board of Trustees of her alma mater.
On April 11, 2002, Dr. Marks was awarded an Honorary Doctor of Science degree from Spelman.

Dr. Marks was in private practice in Houston, Texas for 17 years. For 9 years she was a medical consultant on "Good Morning Houston" Talk Show KTRK-TV, an ABC affiliate. She has made numerous presentations on women's issues, eating disorders, forensic issues, and domestic and family violence. She returned to her hometown of Tyler in 1993 and continued solo private practice. In addition to her more than 20-year experience in private practice, she has worked in the public sector for 17 years with the Veterans Affairs Medical Center and in the state and federal prison systems.

She has been a board-certified psychiatrist since 1979. She was on the faculty of Baylor College of Medicine as Assistant Professor of Psychiatry from 1976 to 1993. She has been a fellow of the American Psychiatric Association since 1989. Dr. Marks has been active with organized medicine at local, state and national levels. Her active participation in the Texas Society of Psychiatric Physicians as its public affairs chairman for 6 years resulted in an increase in coalition building between TSPP and state mental health advocacy groups. She has held various offices in the National Medical Association including Trustee at Large, Chairperson of the Psychiatry and Behavioral Sciences Section, and Speaker of the House of Delegates. She has chaired the NMA Task Force on Violence Prevention since 1993. Dr. Marks is the National President of the Black Psychiatrists of America, Inc.

Dr. Marks is currently a member of the Covenant Psychiatric Group of the Covenant Health System in Lubbock, Texas which has more than 220 physicians. In addition, she is Clinical Assistant Professor of Psychiatry at the Texas Tech University Health Sciences Center Department of Neuropsychiatry. Her special interests are trauma recovery, violence prevention, women's issues and eating disorders. It is because of her personal history, her professional achievements and her dedication to medicine and mental health that Dr. Shirley Marks has earned the recognition that she has in local and national communities.



Gail Mattox

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Gail Arie Mattox, M.D., is Chairperson and Professor of Clinical Psychiatry, in the Department of Psychiatry and Behavioral Sciences at Morehouse School of Medicine.

Dr. Mattox received her BS degree with honors from Elmhurst College in Illinois and her MD degree with honors from Meharry Medical College in Nashville, TN. She completed a Pediatrics Residency at Meharry, a Child Psychiatry Fellowship at Children's Memorial Hospital of Northwestern University in Chicago, IL and Psychiatry Residency at Northwestern University Memorial Hospital. Dr. Mattox is a Diplomate of the American Board of Psychiatry and Neurology with additional sub-specialty certification in Child and Adolescent Psychiatry.

Dr. Mattox has worked in the public sector of Psychiatry for 15 years. She has served in numerous medical directorship roles and serves as a consultant to numerous organizations. She

is a member of Alpha Omega Alpha Medical Honor Society and has received numerous awards for leadership, teaching and community service.

Affiliations

Professor of Clinical Psychiatry and Chairperson for the Department of Psychiatry and Behavioral Sciences Morehouse School of Medicine

References

Cultural issues related to diagnosis & treatment of AD/HD and co-morbid mental health disorders: CHADD Children's Mental Health Forum, Salvation Army Workshop Center, Atlanta, Georgia, August 2002.

Workshop on Youth Violence: Emory University Child and Adolescent Grand Rounds, Georgia Council on Child and Adolescent Psychiatry, Inc., Atlanta, GA October 2001.

Starting Psychiatric Research at Historical Black Colleges and Universities, Invited Panelist, National Medical Association 2001 Annual Convention and Scientific, August 2001.

Assembly, Washington, D.C. - ADHD and Psychostimulant Prescribing Practices, Black Psychiatrists of America, Inc., April 2001.

30th Anniversary Psychiatric Conference, Atlanta, GA - Addressing the Mental Health Needs of the Poor: J Medical Association of Georgia, 2000 spring;89(1):8-9.

Addressing the Mental Health Needs of the Underserved, Grand Rounds Speaker at the University of Michigan, Ann Arbor, January 2001.

University of Michigan, Ann Arbor - Assisting Primary Care Providers in Addressing the Mental Health Needs of Children & October 2000.

Adolescents, Workshop Presentation, Clinical Interventions Within a System of Care Conference, Atlanta, GA, Managing ADHD in the Primary Care Setting, National Medical Association, Annual Convention, Washington, D.C., August 2000.

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Paul G. Organ, M.D. is board certified in general, child and adolescent psychiatry and has been in clinical practice in public sector psychiatry since 1982. Dr. Organ attended Washington University School of Medicine (WUMS) from 1978-82 where he was elected the first African American class president all four years. After graduating from WUMS, Dr. Organ completed a residency in General Psychiatry at Stanford University School of Medicine in Palo Alto, California (1982-86) and a fellowship in Child and Adolescent Psychiatry at the Cambridge Hospital Division of the Harvard Medical School (1986-88).

After completing his training Dr. Organ worked at the Children's Hospital of Northern California in Oakland, California and with the Indian Health Services in Phoenix, AZ. Since 1999 Dr. Organ has worked as a mental health consultant with the Atlanta Public Schools and founded Therapeutic Educational Consultants in 2001.

Dr. Organ's ongoing clinical and research interests include the use/misuse/abuse of psychotropic medications in children and adolescents and the impact of racism upon the mental and physical health of African and Native American children, adolescents, adults and communities.

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Affiliation

Solo Private Practice

National Interest and Involvement

Black Psychiatrist of America 24th Annual Trans-Cultural Psychiatry Conference November 13-

16, 2001 "Celebrating our Roots & Honoring our Diversity and Mental Health Consequences in Diaspora" Recognized, Gilbert R. Parks, MD BPA Lifetime Achievement Award Accra, Ghana (West Africa).

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Dr. Phillips is currently Medical Director of Forensic Consultation Associates, Inc., a national firm that specializes in psychiatric consultations in civil and criminal litigation. Dr. Phillips holds academic appointments as Assistant Clinical Professor of Psychiatry in the Law and Psychiatry Division of the Yale University School of Medicine, as Adjunct Clinical Professor of Correctional Mental Health at the New York Medical College Graduate School of Health Sciences, and as Associate Clinical Professor at the University of Maryland Schools of Medicine and Law. Possessing considerable expertise in the field of forensic psychiatry, Dr. Phillips has extensive experience in capital sentencing proceedings at the trial and appellate level and has been qualified as an expert witness throughout the country.

Dr. Phillips currently serves as Secretary of the United Nations Working Party on Crime Prevention Among Juveniles and as Councilor, American Academy of Psychiatry and the Law. He is a former psychiatric editor of the Journal of the National Medical Association and of Lifetime Medical Television. Dr. Phillips is also a member of the Advisory Council of the National Television Violence Study and has been actively engaged in research and writing on the effects of media violence on children and adolescents. Dr. Phillips is a consultant to the National Center for State Courts, the U.S. Justice Department, the National Institute of Mental Health, and the Center for Mental Health Services, and serves as psychiatric consultant to the Washington Field Office of the United States Secret Service. Dr. Phillips was Deputy Medical Director of the American Psychiatric Association where he served as Director of the APA Offices of Psychiatric Services, Minority and National Affairs, and as Clinical Director of the Office of Economic Affairs and Practice Management.

Affiliation

University of Maryland Schools of Medicine & Law

International Experience

Dr. Phillips has presented internationally on such topics as "Dangerousness and the Disclosure of

Presidential Threats", "The Impact of Race on the Criminal Justice System", "Psychiatrists and the Death Penalty: Ethical Issues", "Violence: Cultural Phenomenon or Institutional Genocide?", "Violence in the Media and its Effect on African Americans", and "Race and Clinical Decision Making."

References: Book Chapters

Violence in America: Social and Environmental Factors in Medical Management of the Violent Patient: Clinical Assessment and Therapy, Marcel Decker, New York, New York (1999).

Administrative and Staffing Problems for Psychiatric Services in Correctional and Forensic Settings, Phillips, R.T.M., and Caplan, C., in Forensic Psychiatry: A Complete Textbook, Van Nostrand Reinhold, New York, New York, 1994.

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Norko, M.A., Zonana, H.V., and Phillips, R.T.M.: Prosecuting Assaultive Psychiatric Patients. Hospital and Community Psychiatry, 42:2, 1991, 193-195.

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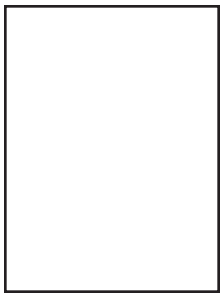

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Donald R. Vereen, Jr., M.D., M.P.H. is the Special Assistant to the Director of the National Institute on Drug Abuse at the National Institutes of Health. He also serves as the Acting Chief of the Office for Special Populations.

During his tenure at NIH, Dr. Vereen worked on the development of new research strategies to address public health issues such as violence, drug abuse, and addiction. From 1992 to 1994 while at the National Institute of Mental Health, he was charged with the development of community-based research projects on violence. Dr. Vereen carried this interest over to NIDA in 1994, where he worked on interdisciplinary research projects dealing with the causes and consequences of drug abuse. This work led to the development of research partnerships between the NIH, the U.S. Department of Health and Human Services, other departments such as Justice and Education, and other non-governmental institutions. Dr. Vereen was appointed to represent NIH on the District of Columbia Task Force on Health Affairs and advised the District of Columbia Mayor's Health Policy Council.

From 1998 to 2001, Dr. Vereen served as Deputy "Drug Czar." As the Deputy Director of the Office of National Drug Control Policy at the White House, Dr. Vereen applied science-based principles to the formation and execution of drug policy. Duties included overseeing National Youth Anti-Drug Media Campaign, overseeing the development and adoption of new methadone treatment regulations, testifying to the U.S. Congress on drug policy issues, contributing to and representing the U.S. in international demand reduction activities. The latter activity included work on anti-doping in sports. Dr. Vereen worked with numerous states, municipalities and counties to introduce and apply the science of drug abuse and addiction to the development of comprehensive drug strategies.

Dr. Vereen graduated from Harvard College in 1980 with an A.B. degree in biology, Tufts University School of Medicine with an M.D. degree, and the Harvard School of Public Health with a Masters in Public Health degree. He completed an internship in internal medicine at Salem Hospital, followed by a residency in psychiatry at Massachusetts General Hospital, where he was appointed Chief Resident. He has completed fellowships in services research at Johns Hopkins School of Public Health and Hygiene and in clinically relevant medical anthropology at the Department of Social Medicine at Harvard Medical School.

Dr. Vereen has held membership and leadership positions in several professional societies and serves on the board of directors of a number of District of Columbia health organizations.

Dr. Vereen is married to Susan Collins, Professor of Economics at Georgetown University and Senior Fellow in Economic Studies at the Brookings Institute. They have two children: Ana, eight and Alec, five.

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Internship and Residencies

1946-1947 - Rotating Intern, Mt. Sinai, Hospital, New York City, 1950-1952 - Psychiatric Resident, Sheppard Pratt Hospital, Towson, MD., 1952-1954 - Fellow in Child Psychiatry, Johns Hopkins Hospital, Baltimore, MD

Affiliation

Harvard Medical School, Department of Social Medicine

International Experience

For 20 years a mental health expert for the World Health Organization (WHO) of the United Nations.

Part of a program to teach social sciences to academic colleagues in Kenya and Tanzania.

Dr. Eisenberg received his M.D. from the University of Pennsylvania (1946) and took his internship at the Mount Sinai Hospital in New York City. He served for two years as Captain in the Army Medical Corps and then completed a residency in psychiatry at the Sheppard and Enoch Pratt Hospital (1952) and a Fellowship in Child Psychiatry at the Johns Hopkins Hospital under Professor Leo Kanner (1954). He became Chief of Child Psychiatry at Hopkins in 1961 and moved to Harvard in 1967 as Chief of Psychiatry at the Massachusetts General Hospital. In 1980, he became Chair of the Department of Social Medicine and Health Policy. In July of 1993, Dr. Leon Eisenberg reached Emeritus status at Harvard Medical School but continues to work full time.

He has served as consultant to the Division of Mental Health at the World Health Organization in Geneva in multiple capacities since 1964 and to the Pan American Health Organization since 1988. He chaired the Scientific Group on Stress, Lifestyle and the Prevention of Disease in

Sophia, Bulgaria (1981), the Working Group on Human Ecology and Health in Metepec, Mexico, (1982), and the Scientific Group on the Treatment of Psychiatric Disorders, Geneva, (1989). He participated in the Consultation Group for the Formulation of an Action Plan for Child Mental Health in Montevideo, Uruguay (1991), a Joint Meeting with the International School of Neurological Sciences in Venice, Italy (1993), the Task Force on Global Action for the Improvement of Mental Health Care, Geneva (1994), and in planning the World Mental Health Report, Geneva (2000).

He is the recipient of honorary Doctor of Science degrees from the University of Manchester in the UK (1973) and the University of Massachusetts in the U.S. (1991). He has received the Theobald Smith Award of Albany Medical College (1979), the Aldrich (1980) and Dale Richmond (1989) Awards from the American Academy of Pediatrics, the Samuel T. Orton Award (1980) of Orton Society, the American Psychiatric Association Agnes Purcell McGavin Award for Prevention (1994), the distinguished Alumnus Award of the University of Pennsylvania (1992), the Camille Cosby Award of the Judge Baker Children's Center (1994), the Thomas W. Salmon Medal of the New York Academy of Medicine (1995), the Blanche F. Ittleson Memorial Award of the American Orthopsychiatric Association (1996), and the Mumford Award of the School of Public Health at Columbia University (1996). He was awarded the 1996 Rhoda and Bernard Sarnat prize for outstanding contributions to mental health from the Institute of Medicine of the National Academy of Sciences. He is an Honorary Fellow of the Greek Society of Neurology and Psychiatry, of the Ecuadorian Academy of Neuroscience, and of the Royal College of Psychiatrists (UK).

He has published widely: more than 230 articles in refereed journals, 130 chapters in books, and eleven edited books. Recent books he edited or co-edited are World Mental Health: Problems and Priorities in Low-Income Countries (Oxford University Press, 1995); The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families (National Academy Press, 1995); The Implications of Genetics for Health Professional Education (Macy Foundation, 1999); and Bridging Disciplines in the Brain, Behavioral and Clinical Sciences (National Academy Press, 2000).

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Dr. Fricchione joined The Carter Center on January 20, 2000 in the position of Director of the Mental Health Program. In July, 2002, he became Associate Chief of

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Dr. Fricchione had been at Harvard University where he was Director of the Medical Psychiatry Service at Brigham and Women's Hospital and also Director of Research for the Mind/ Body Medical Institute. He remains an Associate Professor of Psychiatry at the Harvard Medical School.

Dr. Fricchione was born in the Bronx, New York and received his Bachelor of Science from Iona College, New York. He received his M.D. from New York University School of Medicine. He completed his internship in medicine and psychiatry at New York University-Bellevue and Manhattan Veterans Administration Hospitals. He also did his residency in Psychiatry and was Chief Resident at New York University's Bellevue Hospital. He also was a Fellow in Psychosomatic Medicine at Harvard Medical School and Massachusetts General Hospital's Department of Psychiatry.

Since then his hospital appointments have included: Massachusetts General Hospital as a psychiatrist in the Psychopharmacology Unit and as a project psychiatrist and physician in the Cardiac Rehabilitation Unit; the State University of New York at Stony Brook as Director for the Psychiatry Consultation Division Health Science Center. In 1987-88, he was in New Zealand as a psychiatric consultant at Auckland Hospital. Since 1993, he has worked at Brigham and Women's Hospital.

Besides a wealth of clinical experience, Dr. Fricchione is committed to education. He has taught at the New York University School of Medicine and the State University of New York at Stony Brook. He has been an Associate Professor of Psychiatry at Harvard Medical School since 1993. Among many other honors and awards, he was nominated for Harvard Medical School's "Excellence in Mentoring."

Dr. Fricchione has been an active researcher and has published over fifty journal articles since 1983. Most recently, he has been involved in basic research on neuroimmune mechanisms underlying diseases that connect mind and body. He also has been a reviewer for many major medical journals.

As Director of the Medical Psychiatry Service at Brigham and Women's Hospital, Dr. Fricchione has extensive experience with budget management and with medical economics. He also has experience with fundraising from Federal sources as well as public and private foundations in his role as Director of Research at the Mind/Body Medical Institute.

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Dr. Herman grew up in Wisconsin, and graduated U. of Wisconsin Medical School in 1980. His medical internship was at Brown University Medical School and his residency in Psychiatry at Massachusetts General Hospital, which he completed in 1984. He has been on the staff of the MGH Psychopharmacology clinic since 1984. Between 1991-2000 he was Director of Psychiatry Residency Training at MGH. Currently Dr. Herman is Director of Clinical Services in and of PostGraduate Education in the Department of Psychiatry at MGH and Medical Director for Partners HealthCare Employee Assistance Program. Dr. Herman is co-editor (with Ted Stern, MD) of the popular MGH Guide to Psychiatry in Primary Care (McGraw Hill, 1998) . Dr. Herman is immediate past President of the American Association of Directors of Psychiatry Residency Training. His primary interest is in teaching current psychiatry practice to primary care clinicians.

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My interests are primarily focused on Community Psychiatry programs at the local and national level in the USA.

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In the field of Psychological medicine in Malaysia, one name that is eminent and renowned is none other than that of Tan Sri Dato' Seri Dr. M. Mahadevan. Born on 9th of September, 1929, Dr. Mahadevan still garners a youthful vigor belying his age of 72 and is still one of Malaysia's most eligible bachelors. Having had his early education in Malaysia and a nominee of Sir George Maxwell Scholar, Dr. Mahadevan furthered his education in India and obtained his B.Sc in 1954. With his outstanding results, he was nominated as Cultural Scholar under the Government of India's Technical and Co-operation Scheme of the Colombo Plan in 1955 and pursued his MBBS at Government Medical College in Mysore, India. He emerged as the top student in Psychiatry at the National Institute of Mental Health and Neurological Sciences in Banglore, India winning himself a scholarship to a postgraduate course in Psychiatry at University College in Dublin, Eire. While pursuing his post-graduate studies in UK, he hypnotized a crash victim who underwent an operation under hypnosis at the crash site thus saving the life of the victim. Subsequently, Dr. Mahadevan obtained an anonymous grant of US2,500 monthly for 2 years to be utilized for his further studies and research in the United States at UCLA, Berkeley and Harvard University. At Harvard and UCLA, he had the opportunity to work with great names in Psychiatry like Prof. Chester Pierce, Prof. Jolly West to name but just a few. The former director of Malaysia's biggest mental hospital, he rose to the ranks of Government Chief Psychiatrist and Head of the Department of Psychological medicine at Tunku Abdul Rahman Institute of Neurological Sciences (TARINS) at the Kuala Lumpur General Hospital prior to his retirement

in 1984. The dynamic and ambitious Dr. Mahadevan brought in new concepts and therapy which was unheard of in Malaysia to rehabilitate the mentally ill. Half-Way House, Foster Homes, Day Care Centre, Pet Oriented Therapy, are just some of his enormous contributions to the Malaysian mental health service. A philosopher at heart, Dr. Mahadevan is widely regarded today, as one of Malaysia's foremost authorities on psychosomatic medicine.

Dr. Mahadevan is far from bereft of credit. He has a string of local and international acronyms thus indicating the recognition accorded by the local and international mental health community for his tireless contributions. As the founder of the Malaysian Psychiatric Association, Perak Society for the Promotion of Mental Health and The Re-Entry Association for the Emotionally Disabled, he stands proud to be the 1st. Malaysian and Founding Fellow of Pacific Rim College of Psychiatrists and the 1st. Malaysian to be the president of The Asian Chapter of International College of Psychosomatic Medicine. He was made a member of the prestigious SIGMA Xi The Scientific Research Society of Harvard/Radcliffe Chapter in 1996 and Honorary Founder Fellow and Life Member of Pacific Rim College of Psychiatrists in 1999.

Besides his passion for psychiatry, seemingly into his twilight years, he is the oldest and most senior Polo player in Malaysia and in the region of Asia at the moment. An ardent believer of therapeutic riding, and a great lover of animals (horses and dogs), he operates "Madhuban Stables", a Spelling Station and rehabilitation centre for psycho-socially disabled persons in Malaysia.

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F.A.M.M.(Mal), FICPM (UK), FR.A.N.Z.C.P (Aus), F.R.C. Psych. (Lon), FAPA (USA); Founder President of Asian Chapter of The International College of Psychosomatic Medicine; Founder & Clinical Advisor of Re-Entry Association For Psycho & Socially Disabled (Malaysia).

International Experience

Consultant & Advisor of WHO For Drug Abuse, Public Health Problems and Psychotropic Substances.

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Dr. Richard Martinez, M.D., was Director of CNS Medical Affairs at Janssen Pharmaceutica from 1998 to 2000, and Associate Director of the Janssen Research Foundation from 1997 to 1998. He is currently Director of Medical Affairs at Johnson & Johnson. Dr. Martinez' areas of research include: Research with human subjects; Pharmaceutical development; Mental health and late life mental disorders; Aging and long-term care; Health policy; Academic medical career development; and Corporate Philanthropy.

Past professional experience includes: Chief of Geriatric Psychopharmacology Research at the National Institute of Mental Health in Bethesda, Maryland; Fellow for the U.S. Senate, Special Committee on Aging in Washington, D.C.; Issue expert for The Ad Council's Public Issues Committee in New York, NY; and Technical Advisor for the Federal City Shelter Infirmary in Washington, D.C.

Dr. Martinez is Adjunct Associate Professor at the University of Pennsylvania School of Medicine in Philadelphia and Medical Advisor for the Greater Washington Area Alzheimer's Association in Washington, D.C.

Publications

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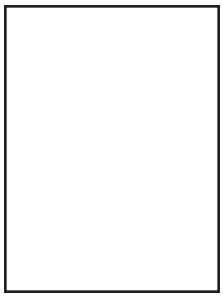

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Wesley Profit, Ph.D., J.D., is a clinically trained psychologist who has long been interested in the problems of social change for minority and disenfranchised populations, including the impact of the mental health and criminal justice systems on poor communities. Dr. Profit has worked in a variety of settings and circumstances to raise issues of fundamental fairness in the workings of public institutions. He has been both a community organizer and a consultant to many grass-root organizations. Recently, Dr. Profit completed an intensive, two year course of legal training leading to a Juris Doctorate. Prior to entering law school, Dr. Profit worked in the criminal justice system. He is credited with establishing a comprehensive program for the delivery of mental health services which substantially increased the ability of mentally disordered offenders to take advantage of other rehabilitative opportunities within the prison system. As the Director of Forensic Services at a maximum security forensic facility, Dr. Profit was frequently involved with the assessment and treatment of extremely violent individuals. Dr. Profit has consulted on numerous occasions on issues of extreme and unusual aggression. Dr. Profit plans to continue to work on issues of mental health and the law in private practice. Among other projects, Dr. Profit is currently helping to design and secure funding for an innovative health care information delivery system utilizing indigenous African American small businesses as service centers.

International Experience

Traveled throughout Europe; lived in Japan for a year.

References

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Dr. Rosenbaum, Chief of Psychiatry at the Massachusetts General Hospital (MGH) and Professor of Psychiatry at Harvard Medical School, is recognized as one of the world's foremost authorities on mood and anxiety disorders, with a special emphasis on pharmacotherapy of those conditions. His research contributions include extensive participation in the design and conduct of clinical trials of new therapies, the design and implementation of trials to develop innovative treatments for major depression, treatment resistant depression, and panic disorder, studies of psychopathology including comorbidity and subtypes, and studies of longitudinal course and outcomes of those disorders.

Dr. Rosenbaum has authored more than 300 original articles and reviews and has published 12 books. He currently serves on 12 editorial boards of professional journals or newsletters. A particular research interest has been ongoing studies of children at risk for anxiety disorders and depression which addresses early temperamental differences, such as the profile known as Behavioral Inhibition to the Unfamiliar, as an identifiable early marker of risk for later psychopathology in children at risk.

At MGH, he directs a department of over 500 clinicians and researchers, ranked by U.S. News and World Report to be the #1 Department of Psychiatry in the United States for the past six years in a row. Dr. Rosenbaum's clinical and consulting practice specializes in treatment resistant mood and anxiety disorders, and he consults extensively to colleagues on management of these conditions. He lectures widely on related topics, addressing thousands of practitioners annually in a variety of postgraduate educational venues.

Dr. Rosenbaum is President and Executive Director of the MGH Mood and Anxiety Disorders Institute, established with a primary mission to enhance the recognition, understanding and treatment of those disorders. Together with his colleagues, he developed the MGH outpatient service into a world leading clinical and clinical research center, with specialty programs including the Depression Clinical and Research Program, the Harvard-MGH Bipolar Program, the Anxiety Disorders Program, the Perinatal and Reproductive Psychiatry Program, and the Psychiatric Genetics Program in Mood and Anxiety Disorders, each of which has extensive portfolios of funded research.

Dr. Rosenbaum received his undergraduate degree from Yale College and his medical degree

from Yale School of Medicine. He completed his residency and fellowship in Psychiatry at Massachusetts General Hospital, Harvard Medical School.

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Dr. Sorel's expertise includes: Health systems planning, implementation, and management; Integration of primary care and psychiatric medicine; Mood disorders and disorders related to traumatic events; Conflict management, violence prevention, the healing of trauma; Health care quality, financing, and patients' rights; Health care policy; and Medical Education. Dr. Sorel has published more than 50 scholarly papers, books, and book chapters. His recent publications include: "Reflections on September 11, 2001", International Medical Journal, volume 9, number 1, pp. 3-5, March 2002, "Early Life Experiences, Later Life Health Consequences" in Psychiatry and Ecology (Roma: Edizioni Internazionali 2001) pp. 134-139 and "Economic Models," in Mental Health Consequences of Torture and Related Violence and Trauma (New York: Plenum Press 2001) pp. 89-107.

Dr. Sorel has provided professional leadership as follows: President, Medical Society of the District of Columbia; Founder, The Health Group, Cosmos Club, Washington, D.C.; Practicing Physicians' Advisory Council, United States NCQA; Commission on Global Psychiatry, American Psychiatric Association; Chairman of the Board, World Association for Social Psychiatry; Founder and Chairman, Violence Task Force and Conflict Management and Conflict Resolution Section, World Psychiatric Association; and Clinical Professor, Psychiatry and Behavioral Sciences, G.W.U., School of Medicine.

He was given the Exemplary Psychiatrist Award 2000, U.S. National Alliance for the Mentally Ill. He has served as Commissioner, Commission on Violence Against Women, The District of Columbia. Dr. Sorel is well versed in several languages: English, French, Romanian (fluent); Italian, Spanish (qualified fluency).

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Mary lou Sudders was appointed Commissioner of Mental Health for the Commonwealth of Massachusetts in February 1996 by Governor William F. Weld. In this capacity, she serves as the Commonwealth's chief spokesperson on mental health issues. With an annual budget in excess of $600 million, the Commissioner oversees a public mental health system that provides services to more than 24,500 adults with serious mental illness and children with serious emotional disturbance. Key legislative successes during her tenure include passage of: mental health parity insurance; five fundamental rights for mental health consumers; civil commitment reform; children's mental health commission; and, the hospital interpreter law. In May 1999, Commissioner Sudders was honored as one of the selected invitees to the first White House Conference on Mental Health. In June, 2002, Commissioner Sudders testified before Congress on the issue of criminal justice and mental illness.

Prior to this appointment, Ms. Sudders served as both Deputy Director and Director of the Division of Mental Health and Developmental Services for the State of New Hampshire for three years. She directed the Division's services for individuals with developmental disabilities, serious mental illness, traumatic brain injury and the homeless.

Before working in New Hampshire, Ms. Sudders held key positions within the Massachusetts public mental health system, including serving as the last Superintendent of Metropolitan State Hospital and managed the closure of the 400 bed facility.

During a respite from public service, Ms. Sudders managed a federal homeless grant for the Massachusetts Association for Mental Health and served as administrator of Tri-City Mental Health Services in Malden. Commissioner Sudders holds a Master's Degree in Social Work and a Bachelor's Degree with honors from Boston University. She is on the Board of Directors of the National Association of State Mental Health Program Directors. She is a member of the National Association of Social Work, the Academy of Certified Social Workers, and the American College of Mental Health Administrators. She has received many awards and is a featured speaker at many academic and professional conferences.

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Augustus A. White, III, MD, PhD, is Professor of Orthopaedic Surgery at Harvard Medical School and Harvard-MIT Division of Health Sciences and Technology and is Orthopaedic Surgeon-in-Chief, Emeritus, Beth Israel Deaconess Medical Center, Boston.

Born in Memphis, Tennessee in 1936, Dr. White received his premedical education at Brown University, where he went on to serve as both Trustee and member of the Board of Fellows, and his medical education at Stanford University, San Francisco, receiving his MD degree in 1961. He completed an assistant residency in surgery in 1963 at Presbyterian Medial Center in San Francisco and in 1965 completed an assistant residency in orthopaedic surgery at Yale-New Haven Hospital in Connecticut.

Dr. White's residency training was completed in 1966 following his completion of programs at Connecticut's Newington Children's Hospital in 1965, Yale-New Haven Hospital, where he was chief orthopaedic surgery resident in 1965, and New Haven's Veterans Administration Hospital, where he also served as chief orthopaedic surgery resident the following year. In addition, Dr. White received his PhD from the Karolinska Institute in Stockholm, Sweden in 1970 and completed Harvard Business School's advanced management program in 1984.

He began his career at Yale-New Haven Hospital where he was an attending orthopaedic surgeon beginning in 1968 and continuing until 1979 when he relocated to Boston. In Boston, Dr. White held clinical appointments at Massachusetts General Hospital, Children's Hospital Medical Center, Brigham & Women's Hospital and Beth Israel Hospital where he was named Orthopaedic Surgeon-in-Chief from 1978 to 1991.

White began his career in academic medicine at Yale University School of Medicine, where he went on to become professor of Orthopaedic Surgery. He joined the faculty of Harvard Medical School in Boston as Professor of Orthopaedic Surgery in 1978 and was appointed the Ellen and Melvin Gordon Professor of Medical Education and Master of the Oliver Wendell Holmes Student Society in 2001.

Dr. White is the author or co-author of more than 100 scientific articles and reviews and, in

addition, has authored or co-authored several books. He has served on the editorial boards of Spine, Annals of Sports Medicine, and Clinical Sports Medicine. He is a member of the Academic Orthopaedic Society, American Academy of Orthopaedic Surgeons, American Orthopaedic Association, American Orthopaedic Society for Sports Medicine, National Medical Association, and is a founding member and past president of both the Cervical Spine Research Society and the J. Robert Gladden Orthopaedic Society.

Dr. White and his wife, Anita, are parents of three daughters.

Affiliations

Beth Israel Deaconess Medical Center, Harvard Medical School

International Experience

1999 - Visited Hanoi, Vietnam to attend a Binational Conference which reviewed key issues involving engagement and disengagement in the US-Vietnamese War.

1996-1997 - Served as a military surgeon in the US Army, Quinon, Vietnam.

1978 - Visited and toured China on a good will orthopaedic information exchange with a group of orthopaedic surgeons and bioengineers.

1975 - American British Canadian Traveling Fellow, visited and lectured at orthopaedic centers in England, Scotland, and Wales.

1972 - Worked in Tunis, Tunisia for a volunteer service in a large orthopaedic hospital.

1968-1969 - National Institute of Health Post-Doctoral Research Fellow at University of Gotheburg in Gotheburg, Sweden and Karolinska Institute in Stockholm, Sweden.

References

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Kathy Pike, MSW, LCSW received her Master's degree in social work from Columbia University and her Bachelor's degrees in French and Psychology from Tufts University. She spent a summer semester studying in Talloires, France and living with a French family. After graduate school Ms. Pike returned to Europe to live and work in Florence, Italy.

Ms. Pike has worked in private industry as a technology specialist for Boston law firms and in the public sector as a social worker for various agencies including Travelers Aid, D.E.A.F., Inc. and the Boston International Institute. She now works for the Department of Psychiatry, Continuing Education Division, at Massachusetts General Hospital, providing administrative support for post-graduate courses and special projects. When not working on the Diaspora project, she volunteers her time with new mothers.

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Ms. Hodge works in the Cardiac Department at MGH as a Medical Assistant and provides both clinic and administrative support. She also provides administrative support to Dr. Chester Pierce in the Department of Psychiatry.

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Itsuko Mino is an Associate in Research at the E. O. Reischauer Institute of Japanese Studies at Harvard University. After twelve years as an on-air radio and television news and feature journalist for Japanese networks, she came to the United States to undertake studies in communications. Subsequently she pursued advanced studies in developmental psychology at the Harvard Graduate School of Education, obtaining first a Masters degree and then a Doctorate in 1986. Since then, she has worked in research at the McLean Hospital, Harvard Medical School Department of Psychiatry, and as a Consultant for Merck and Company.

Her independent investigations have related to cross-national gender issues (e.g., kitchen drinking, gambling, eating disorders), family stress (e.g., intrafamilial violence, runaway housewives) and racism. Among papers she has presented in various countries in Europe, Asia and North America are her studies based on comparative content analyses of German, Japanese and American newspaper articles. Dr. Mino has published scientific translations from English into Japanese. She is also translating into English a series of Japanese novellas involving psychological observations. She is a member of the American Psychological Association and has been a member of international mental health organizations.

Loretta Holliday

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Ms. Holliday came to Massachusetts General Hospital (MGH) in July of 1989 after a ten-year career in the banking industry. At MGH she was working in the Internal Medicine Associates group practice as an office secretary. In 1991 she returned to full-time studies at Northeastern University, were she earned a B.S. in Health Sciences and certificate in Health Information Administration in 1995.

Ms. Holliday, who has worked for MGH Public Affairs Office and the Department of Psychiatry, is presently the Administrative Assistant for Dr. Thomas F. Holovacs of the MGH Orthopaedic Shoulder and Sports Medicine Service.

The Association of Multicultural Members of Partners (AMMP) awarded "Member of the Year" to Ms. Holliday in 2001 for her outstanding achievements and dedication to the organization. She was elected Chairperson of AMMP in June 2002.

AMMP is a volunteer organization made up of employees in the Partners Health Care System, which includes MGH, Brigham and Women's Hospital and Spaulding Rehabilitation Hospital. Its mission is to support the advancement, retention, recruitment and development of multicultural professionals into leadership roles at all levels and areas of the Partners organization.

Student Assistants

Professor Robert Selman of Harvard Medical School and Harvard School of Education, kindly made funds available to obtain student services for the week of the meeting.

Robert J. Fowler, Ph.D., Educational Researcher, Postdoctoral student at Harvard University Graduate school of Education in risk and prevention/human development and psychology. Emphasis on risk and resilience factors of the African American male adolescent.
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Graphic Design Assistance

We thank Joan Smith for her creative and thoughtful attention to the layout and design of this Proceeding.

IX Bibliographies and References from the International Presentations

Editor's Note: *In this section the reader will find references and bibliographies that were included in the original drafts of the papers presented at the conference. These references and bibliographies were removed from the versions of the papers included in the section entitled "International Presentations" in order to facilitate easier reading in their entirety. Many of the international presenters chose not to include references and bibliographies in the drafts of their papers as they were presented at the conference, though they utilized a broad spectrum of books and articles in the preparation of their presentations.*

Adrien References

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Appendix

History of St. Giles Psychiatric Hospital in Suva, Fiji (Brief Overview)

Founded in 1884 and named the Lunatic Asylum.

First patients consisted of four Europeans, four Indians and two natives.

Mechanical restraints consisting of handcuffs and leg irons were used.

In 1901, a European warden was appointed and the Colony's Chief Medical Officer was named the Superintendent.

A Board of Visitors looked after the affairs of the Asylum, scrutinized committal orders of patients and determined who should be discharged.

In 1903, the Attorney General, the Colony Chief Medical Officer and a prominent public member comprised the Board.

In 1909, separate wards were built for the natives. Europeans were separated from all other patients.

In 1915, there were forty-five patients and by 1930 the patient number had doubled.

In 1935, the name of the institution was changed from Lunatic to Mental Asylum.

In 1954, patient number had increased to one hundred and forty.

In 1950, electro-convulsive treatment was introduced and formed the focus of therapy.

By 1959, patient numbers had increased to two hundred and twenty seven patients.

In 1960, treatment in the form of phenothiazines was introduced.

In 1962, a full time medical officer was posted to the hospital. The Superintendency of the hospital remained a part-time function of one of the doctors from the national Medical Headquarters.

In 1964, a psychiatrist was appointed and became the first full time superintendent of the hospital.

In 1968, the formal teaching of psychiatry was started for medical students of the Central Medical School (now the Fiji School of Medicine).

In 1970, the first qualified psychiatry nurse was appointed.

In 1971 the occupational therapy department was set up.

The hospital currently has 190 beds, four wards and an average occupancy of 120-160 patients. It provides inpatient services for the whole of Fiji and some regional countries and outpatient services.

The hospital currently has a complement of seven doctors (four local doctors, and three expatriate doctors). Psychiatric services are also provided by a psychiatrist based at the Fiji School of Medicine.

Services Provided by the Hospital

The hospital provides services to manage a wide range of disorders:
Functional Psychoses
Organic Brain Syndrome
Drug and alcohol related disorders.
Mental retardation
Neurological disorders eg. epilepsy and dementia
Forensic services

The services provided by the St. Giles Hospital include the following:

Inpatient care
Outpatient care
Occupational therapy
Community Psychiatric Nursing (CPN)
Day Care Centre (DCC)
Liaison Psychiatry
Tele-psychiatry
Teaching hospital
Domiciliary treatment
Counseling services.
Community Awareness Programmes on Mental Health and Substance Abuse

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Zitouni References

We need to create spaces where all this is possible: here is what we have done so far:

Creation of the Moroccan Association of Psychoanalysis.

Creation of the Institute for the Extension of Psychoanalysis in Francophony (Paris)

Organizing colloquia in Morocco: first international colloquium of Psychoanalysis in April 2002.

Active participation to African congresses: 1st Panafrican Congress of Mental Health (Senegal in march 2002)

Participation in psychoanalytical workshops: Morocco, Senegal, Burkina Fasso.

Possible Deliverables to Consider

1. Produce a Proceeding of this event.
2. Publish a position paper on whether or not Black psychiatrists should advocate to organized medicine, that racism is an illness.
3. Outline a cross-national study of the depth and variety of burdens of illness in African descended people (including catalogues of available human and non-human resources and data on how Black psychiatrists distribute their time).
4. Disseminate lists of needs and opportunities for African descended psychiatrists in terms of research and education.
5. Recommend steps required to establish a world organization of African descended psychiatrists.
6. Designate psychiatrists to try to obtain liaison status with specific organizations in order to help attend to underserved African descended patients.
7. Present a chart of overlaps and underlaps of problem issues discussed in this meeting.
8. Implement a data bank for African descended psychiatrists, after deciding upon initial content material.
9. Inaugurate cross-national, cross-racial, collaborations between African descended psychiatrists and colleagues in multiple disciplines.
10. Make a mission statement for a Secretariat of African descended psychiatrists and suggest possible revenue sources for establishing it and sustaining it.

Submitted by C. Pierce
17 November 2002

Meeting Overview

	Sunday 17th	Monday 18th	Tuesday 19th	Wednesday 20th	Thursday 21st	Friday 22nd
8:15 - 9:00	Breakfast ***Hotel***	Breakfast ***East Garden Room***	Breakfast ***Hotel***	Breakfast ***Hotel***	Breakfast ***East Garden Room***	Breakfast ***Hotel*** *(15th floor)*
9:15 - 12:00	Participant Arrival (Bus to Church - optional)	AM Presentations ***O'Keefe*** **T**	AM Presentations ***Hotel*** **T**	AM Presentations ***Hotel*** **E**	AM Wrap Up ***Trustees***	Check Out at noon
	Lunch 1:00 - 2:30	Lunch ***Hotel*** 12:00 - 1:00	Lunch ***Hotel*** 12:00 - 1:30	Lunch ***Hotel*** 12:00 - 1:30	Lunch ***BURR 5 & 6*** 12:00 - 1:30	
1:00 - 1:30		Photos				
1:45 - 4:30 5:30	Bus to HMS	PM Presentations ***O'Keefe*** **E**	OPEN or Bus/Guide for Tours then on to	PM Presentations ***Hotel*** **E**	PM Wrap Up ***BURR 5 & 6*** Bus to Academy	
6:00 - 7:00	Opening Reception and Dinner 6:00 - 9:00 pm	Dinner ***East Garden Room*** 6:00 - 7:30	Reception at Harvard Faculty Club	Dinner ***East Garden Room*** 6:00 - 7:30	Close Out Reception and Dinner 6:00 - 9:00 pm	
7:30 - 9:30	**Chester Pierce** Speaker Ben Waterhouse Faculty Room	Break-Out Sessions (see rooms below)	dinner 6:00 - 9:00 pm	Break-Out Sessions (see rooms below)	**Ezra Griffith** Speaker Bus to Am. Academy (Atrium & Blue Dining Room)	

1. Trustees Room, Bulfinch 2
2. Claflin Library, Bulfinch 2
3. Hackett Room, Bulfinch 3
4. Bulfinch 220, Bulfinch 2
5. Lounge Area, Bulfinch 2

T = Felton Earls, Moderator

E = Ezra Griffith, Moderator

Dear [Participant]:

Please do us the honor of being a guest-participant at the inaugural event of the International Division of the Department of Psychiatry at The Massachusetts General Hospital, in Boston, USA. The Massachusetts General is a major teaching hospital of Harvard University. The meeting, "The African Diaspora: Psychiatric Issues" will be held from 17-21 November 2002. Depending on our arrangements you may be asked to arrive as early as 15 November in order to allow you to overcome jet lag prior to the meeting. The conference will be co-sponsored by the Carter Center of Atlanta, Georgia, USA. The co-convenors are Professor Ezra Griffith of Yale University and Professor Felton Earls of Harvard University. English is the official language of the meeting. We expect people from twenty countries.

The aim of the meeting is to elaborate ways that African descended people have adapted their psychology, emotions and behavior wherever they have dispersed. As psychiatrists our focus will be on the diagnosis, treatment and etiology of illness and the management of stress.

Success in the meeting will be measured in terms of the vitality and usefulness of collaborative service, educative and research endeavors that Black psychiatrists will be conducting all over the world, in the next five to ten years. To reach that goal will mean we will have networked successfully with many people from many disciplines. It will mean the benefits may help people of all racial persuasions to live better and longer. A secondary aim is to consider how to organize and unite African-descended psychiatrists from around the world so that they may begin fruitful, on-going communications and interactions.

If you are able to join this historic venture your chief obligation would be to produce a needs assessment paper which could be read in no longer than fifteen minutes (about 8-10 typed pages including Powerpoint slides or charts). As a sample guideline you may wish to construct your paper as follows:

1) Six minutes on your opinion)perhaps including any compelling data) on what you see as the issues, needs or problems in your country or region relative to adaptation by our people; problems in their diagnosis and treatment; concerns about the stress they suffer, etc.;
2) Six minutes on possible approaches or solutions to the issues needs or problems you stated, especially with outside collaborations and assistance;
3) One minute on any ideas you have about what you yourself would be able/willing to pursue with helpers from other places, either in your country or somewhere else.
4) Two minutes on what issues you think would galvanize and motivate African-descended psychiatrists to unite and organize.

As you can see, most of the effort is toward assessing obstacles and reckoning resources that could be mobilized. It is assumed that no one at the meeting knows more about the needs in your country than yourself. We are interested in your views, opinions and experience more than a dry, cautious, academic composition.

We would expect the paper 3 months from the date you agree to do it. In this way, we could circularize all the papers to each participant prior to the meeting. At the meeting, each person would speak for 15 minutes, using the paper produced or speaking on whatever issues you think critical or helpful. The written papers would be used, however, as the basis for a published proceeding. You could add on or modify your paper after the meeting with the knowledge that the editor might ask you to make revisions. Your talk at the meeting would be used in establishing joint activities in our plenary and break-out groups.

Should you be able to accept this request for submission, please let me know as soon as possible. Then between that time and November you would have constant communication from us about a variety of things such as information for the directory we'd like to circulate prior to the meeting, the format of the meeting, your opinions about whom we should be considering contact with after 21 November, any possible international experience you have had, facts about weather in Boston in November, logistical and parietal arrangements and so on.

I hope to hear from you soon. I hope too to see you in Boston in November. If you are unable to accept this invitation, please be so kind as to recommend people in your country or region whom we could invite. Thank you for whatever consideration you can give to this request. As Black psychiatrists we have the opportunity to help our people better negotiate the future.

Sincerely,

Chester M. Pierce, M.D.
Program Chairman
eMail: AfricanDiaspora@partners.org

Schematic Analysis and Redactions of Conference Presentations:

21 November 2002

Three participants, Dr. Zitouni of Morocco, Dr. Ambi Siva of Papua New Guinea and Dr. Valdés Mier of Cuba were not able to attend this conference due to unexpected and unforeseen circumstances. Their papers will be in our Proceedings.

Dr. Ndetei of Kenya was invited late to attend the meeting. His paper also will be in the Proceedings. This paper doesn't focus on Psychiatric Issues of the Diaspora. Instead, it presents an important distillate from Dr. Ndetei's vast experience with the clinical and research aspects of managing disaster. Since one possible hope from this conference was to establish disaster teams, which could be mobilized for world-wide service, the organizers were most pleased that he could participate. All of us can benefit from his insights.

Only Dr. Dr. Ndetei's paper is not included (for reasons stated) in the summarization of papers done by Drs. Mino and Pierce. These summaries are highly selected redactions, attempting to categorize, in a very arbitrary way, the reactions of two readers. Perhaps they can serve to give some overview of where speakers converged or diverged in their focus on psychiatric issues in the African Diaspora.

Chester M. Pierce, M.D.
Itsuko Mino, Ed.D.

The African Diaspora: Speakers

Dr. Oyewusi Gureje - Nigeria	History/Society/Geography	Major Issues	Policy Issues	Recommendations	Author's Preference	Research Suggestions	Cross Diaspora Suggestions	Miscellanous
Title: African Desended People and Psychiatry: Views From Nigeria								
	1/5 Blacks are Nigerian	Effect of slavery colonialism (especially via religion) on self-image	Need for cheaper generic drugs	Increase at home training opportunities without increasing brain drain	Willingness to participate in cross Diaspora projects			
	Resource rich country–minerals, land	Effect of religious struggles in terms of civil war, dictatorship, political instability, e.g., violence, poverty, low/poor education, poor health	Without changes there will be more intensification of psychiatric illnesses	Gather data about brain drain issues				
	Rapid urbanization	One psychiatrist for every 1.2 million people (in a resource rich country)	Need to anticipate high/increasing drug and alcohol abuse, high / Increasing geriatric abuse	Promote Interdisciplinary, cross-cultural research (especially in socio-political settings)				
	Legacy of Colonialism e.g., in imported Christianity, Islam	No institutional support for research	Need for Black mental health professionals to organize	Without changes there will be more intensification of psychiatric illnesss				
	Diverse culture, e.g., religions, languages(over 200);traditional religion may be more alive in Brazil	How does psychological trauma protect or destroy individuals?	Need for evidence-based practice					
	Had a head start in academic psychiatry but was unable to sustain leadership	Do Blacks universally have same illnesses and same burdens of illness?						
	1/2 population lives in poverty	Lack of human & non-human resources						
		Issues of HIV, including the high/increasing numbers of orphans						

Dr. Mohamed Zitouni - Morocco	History/Society/Geography	Major Issues	Policy Issues	Recommendations	Author's Preference	Research Suggestions	Cross Diaspora Suggestions	Miscellanous
Title: Psychopathology of Acculturation								
	Acculturation of colonized people is stressful, conflictful and at a sub-life level			The antidote to cultural confusion & identity confusion depends on some organization & exchange among the oppressed: Use psychotherapy, Educate the oppressors about how they cause damage	Work with organized psychiatry			
	Opressed are enraged and stifled by ubiquitous inequities				Educate individuals about thinking of the oppressor & themselves			
	There is an unfair distribution of resources							
	The oppressor always has more							
	Sharp differences in educational styles, e.g., Muslim strict education; harsh methods; education is strange and traumatic in terms of language, clothes, surroundings, methods; culture-->feelings of identity confusion, self-doubt, dissatis-faction, cultural conflict (immi-grant in one's own country); learning difficulties and "normal pananoia"							
	Acculturation conflicts --> all manner psychiatric disturbances							

The African Diaspora: Speakers

Dr.Carlos Smith Fray - Panama	History/Society/Geography	Major Issues	Policy Issues	Recommendations	Author's Preference	Research Suggestions	Cross Diaspora Suggestions	Miscellanous
	Slaves brought to the New World from 16th century	Racism and its effect on esteem --> risk factors for illness						
	Black West Indians came in late 19th - early 20th century when Panama Canal was built			Need to increse self-esteem				
	Economic ills in Caribbean led to labor for the canal			Need for Blacks to increase their knowledge of their history and culture				
	The Black West Indians suffered harsh physical conditions and emotional deprivation but were sustained on the strength of their culture			Need for increased/increasing entrepereneurship and social action				
	White science theorized that Blacks could withstand climatic conditions			Drug prevention programs				
	Blacks were used in experimentation			Scholarships				
	Rampant racism			Museum exhibits about African descended cultural adapation				
	Nowadays 1/2 of the population in Panama has Black genes			Work toward organizing Black mental health				
	Blacks have participated in the development of the country			Cross-disciplinary, cross-cultural projects				
Dr. Pamela Collins - USA	**History/Society/Geography**	**Major Issues**	**Policy Issues**	**Recommendations**	**Author's Preference**	**Research Suggestions**	**Cross Diaspora Suggestions**	**Miscellanous**
Title: Mental Health Priorities of African Americans								
	Slavery	Black Skin color is a stigma --> negative stereotypes, discrimination		Address Black powerlessness, anger, depression to dehumanization	To study why Blacks have barriers to mental health services			
	Legislated oppression	How can Blacks become 1st-class citizens?		Study the development and maintenance of adaptive coping styles	To work in problem areas of HIV/AIDS: Psychoeducation, Increasing mental health resources in places of great need			
	2nd-Class citizenship	How do psychiatrists educate Blacks in coping skills?		Quantify resources to handle AIDS				
				Psychoeducation programs for AIDS				
				Collaborative cross-diaspora studies on : Resilience, Cultural strengths and Community political action				
				Study diverse therapy techniques, e.g.,spiritual, pharmacological				
				Study what is egodystonic for Blacks seeking or maintaining treatment				
				Study emotional impact of disasters				

The African Diaspora: Speakers

Dr. Miguel Valdes Mier - Cuba	History/Society/Geography	Major Issues	Policy Issues	Recommendations	Author's Preference	Research Suggestions	Cross Diaspora Suggestions	Miscellanous
Title: African Diaspora: Psychiatric Issues								
	Clinical impact of transcultural values				To help less fortunate Blacks avoid/overcome effects of discrimination and isolation			
	Clinical impact of socioeconomic factors, e.g., discrimination, migration, low income, poor education, poor health.	In other countries – clinical impact of poor diet, poverty, poor sanitation, lack of medical help		Training in transcultural psychiatry				
	1/3 population is colored thanks to colonization and intermixing with slaves and more recent Caribbean immigrants	In other countries -- Blacks suffer from inequities		Training in transcultural psychotherapy				
	Multiethnic, multinational, multicultural			Establish mental helath systems				
	Religion blends African & White systems			Cross-diaspora organizing of psychiatrists				
	Role of secretive social (?and religious) organizations, e.g., ABAKUA gnaniga and voodoo			Cross-Cultural exchanges				
	Clinical impact of religious and magical systems			Establish mental health systems				
	Cubans now help the less fortunate in other countries							
	No detectable discrimination which could cause African descended people to have stress (unlike in neighboring countries)							

The African Diaspora: Speakers

Dr. Ghislaine Adrien - Haiti	History/Society/Geography	Major Issues	Policy Issues	Recommendations	Author's Preference	Research Suggestions	Cross Diaspora Suggestions	Miscellanous
The African Diaspora: Psychiatric Issues								
	By 60's - 70's –migration back to Africa, Canada – they were welcomed and allowed to integrate		What is fair & supportive for immigrants (i.e., a "diaspora" back to Haiti), returning because they were unwanted in the foreign country					
	Very poor country	Many immigrants had to overcome many difficult obstacles (adjusting to host countries), especially feelings of being marginial/peripheral	Deported immigrant has many complex problems in home country					
	Many emigrants (over many years)	Impact of emigrants on (citizens in) their country of origin	What is fair for the individual and the 2 countries involved, politically, economical, psychologically?					
	Value / importance of tradition of French elitist educaton	Conflicted, confused, ambivalent cultural identity, e.g.,customs, language, dress, foods, music, etc., accounts for intergenerational stresses and problems of having desired adult role models	In a diapora whole society in sending & receiving country must be concerned					
	New wave of emigrants, many less educated, to South America, then to USA, where they sought a better political and economic life (without much education)	Cultural identity conflicts also result in clashes with society –>cycle of rejection by the host society-->psychopathology - whether to do as the host country does or not-->possible distance - no link with Haiti. - If returned, it is to a Diaspora in Haiti; - returned deportee makes problems for home country	In both countries interrelated political, economic and psychological problems					
	As immigrants they were hard working (worked toward assimilation but kept their culture)		Differential treatment of Black immigrants compared to others					
	Migration is an ongoing, complex problem for sending and receiving country.							

The African Diaspora: Speakers

Dr. Peni Moi Biukoto - Fiji	History/Society/Geography	Major Issues	Policy Issues	Recommendations	Author's Preference	Research Suggestions	Cross Diaspora Suggestions	Miscellanous
Title: African Diaspora: Psychiatric Issues The Fiji Perspecitive								
	Culture & genetic pool influenced by Pacific neighbours		International classification of Diseases(ICD) has been used since 1966, but with problems because of confusion about clinical intrepretation of beliefs/preceptions vs. delusion/hallucinations					
	A Country of dozens of islands	Cultural differences about what constitues mental illness		Need to do longitudinal psycho-anthropological studies on the interaction of religion & psychiatry including perceptions & coping strategies				
	High literacy rate, multi-cultural, multi-racial	Medical caregivers' own belief system relative to western & traditional codes may or may not be relatively synchronous / empathetic / sympathetic to those of patients--this would require special training & awareness by the caregivers		Need to do research on Fijian populations without great reliance on studies on foreign populations				
	Fijians believe they made a sea migration from the West -->by cultural history they came from Africa	In colonial times, there was discrimination in institutional systems		Need to do more objective studies in the Fijian community concening the diagnosis and management of psychosis				
	Religion cherishes animate and inanimate things			Need to study socio-cultural shifts since colonization				
	Fijians believe in spirits & an afterworld, with different ways of getting there							
	Code of living depended largely on religious vaules							
	Conduct code is prescribed in terms of religious values							
	Clan oriented, with some (clan) division specialties							
	Christianity has had major impact since 1835 (and concurrent westernization), including blending traditional and Christian religions & alteration of (many) cultural behaviors							
	Large impact of Indian immigrants, who first arrived in late 19th century (to work sugar plantations)							
	Move towards urbanization, especially since late 1980's has brought new values/expectation around materialism, self-image--Fijian=pre-Christian & Christian (Western) codes - cultural identity confusion and conflict							
	Early written history, by whites, must be viewed warily							
	Little record of mental health before or after colonization							
	In late 19th century, British set up an asylum that per-mitted native lore to be part of the medical domain (in terms of definitions of illness)							
	Much more of the population, include-ing educated segments, retain traditional beliefs							

The African Diaspora: Speakers

Dr. Frederick Hickling - Jamaica	History/Society/Geography	Major Issues	Policy Issues	Recommendations	Author's Preference	Research Suggestions	Cross Diaspora Suggestions	Miscellanous
Title: The African Resaissance and The struggle for Mental Health in the African Diaspora								
	Psychohistoriography grounded post colonial philosophy		In last 1000 years large amounts of time & resource has been devoted to inrrational European desire to own the world				Next confrontation will be for Blacks to confront economics of capitalism	
	Importance to Blacks of last 500 years of European imperative	To make sense of racism & colonization		Find stratgies to navigate capitalism			Organize Blacks	
	Need for Blacks to define themselves & their agenda	Psychopathology must be investigated in society and history					Study how to negate racism,colonization effects	
	F. Fanon used primary dialectic for analysis	Need to identify reality based themes & trends					Culturally sensitve training	
	Need for Black defined outreach, ideology, beliefs & identity	Need to synthesize theory about rich, poor, race, class, mad and bad					Community based mental health service	
	Only Europeans credit themselves as "discovering" new world	Resistance to European madness led to emancipation of slaves					Deinstitution-alization of custodial hospitals	
	Europe was most interested in plunder, exploitation	Europeans continued economic control over former colonies					Use evidence based mental health methods	
	Europeans systematically eradicated all opposition	In both criminal justice system & mental health system Blacks are disadvantageed by being "invisible" to Europeans						
	After eliminating natives, Europeans engaged in re-engineering of the country							
	Imposed cruel slavery							
	European ideas of white supremacy & ownership can be likened to a violent psychosis							
	By end of 19th century, Europe was subjugating Africa for exploitation							
	WWI was a struggle over which Europeans would have world hegemony							
	From earliest days Europeans also attempted to control other whites, also							
	Emancipation of Slavery, led Europeans to new form of colonialism (imperialism)							
	After WWI coloreds all over the world fought against European imperial colonialism							
	Since US civil rights movement, more dilation of European human rights violence							
	Black leaders pushed Pan-Africanism							
	African Apartheid system was defeated by people of color							
	Institutional racism is wide-spread around the world							
	Europe had profit from theft exploitation of slavery & colonization							
	Largest challenge to European colonialism & enslavement has been from Blacks							

The African Diaspora: Speakers

Dr. Claudina Cayetano - Belize	History/Society/Geography	Major Issues	Policy Issues	Recommendations	Author's Preference	Research Suggestions	Cross Diaspora Suggestions	Miscellanous
Title: The Challenges of Treating The Homeless Mentally Ill In Belize								
	Diverse people and culture		Antiquated mental health laws		Provide treatment for homeless mentally ill	Epidemiology of mental illness in the homeless		
	¾ Creole or mestizo	Service to the homeless	Homelessness for 0.4 % of population, secondary to poverty and unemployment			Relationship of mental illness to homelessness		
	Forty- four percent under ages 15; only 4% over age 65	Increasing numbers of homeless mentally ill-not from deinstitutionalization	Technical support for culturally appropriate research, psycho-education for homeless mentally ill			Elaborating specific programs to help homeless		
	Two psychiatrists in government service(population 250.000)	Need to provide societal understanding as well as medicines						
		Homeless mentally ill sent to psychiatric institutions in prisons						
		Homeless mentally ill stigmatized & isolated						
		Social as opposed to medical issues leads to staff demoralization and dissatisfactions						
		Lack of mental health personnel and resources						
		No available epidemiological data						
		Most patients do not see psychiatrists- when seen by a psychiatrist it is usually under crisis condition						
		Most patients do not seem inclined to psychotherapy						
		Patients often first seek alternative treatment						
		Escalation of violence, suicide, drug abuse						
		One-third homeless are mentally ill- mostly males, no children but ages range from 17-74						
		Special problems in treating homeless HIV positive, who often have been abandoned and become homeless						
		Female homeless vulnerable to violence						
		Deportees, especially from USA, become homeless						
		Homeless inflicted with infections and chronic disease, as well as lack of food						
		Abandoned elderly						
		Houselessnss versus homelessness						

The African Diaspora: Speakers

Ghana: Dr. Sammy Ohene	History/Society/Geography	Major Issues	Policy Issues	Recommendations	Author's Preference	Research Suggestions	Cross Diaspora Suggestions	Miscellanous
Title: The African Diaspora: Psychiatric Issues in Ghana								
	18.5 million people with much diversity	Diverse etiology beliefs e.g. evil spirits, stress, genetics, substance abuse, physical ailments.	Little official interest in mental illness	Increase support from drug companies		Study use of traditional and spiritual healing across the Diaspora		Treatment & Diaspora Issues– No word for depression – how indispensable is this and what are the advantages and disadvantages.
	Poor, tropical country	If there is no definite cause for illness, there is a stigma	Little support for mental illness yet circularization of the notion of available care	Training for professionals		Study epidemiology of mental illness		
	Lunatic Asylum Act passed in 1888	One psychiatrist per 1.4 million people; most psychiatrists over age 60		Training lay people and other professionals in mental health care		Research on epilepsy and psychogenetico-pharmacology		
	Traditional healers have treated "psychiatric" cases	Braindrain of psychiatrists		Development of teaching materials				
	All DSM-IV illnesses are seen			Cross Diaspora networking				
	Few people use psychiatric services			Increase support for faculty.				
	Often people use western, traditional spiritual treatment							
	Somatic presentations are common							
	Psychosis treated in hospitals							
	Psychiatric illnesses stigmatized							
	Lack of material medical resources and personnel related to limited accessibility							
	People expect drugs to give quick and complete, cure, with no relapse							
	Long-term psychotherapy usually not available							
	There may be ethnopharmocogenetic differences.							

The African Diaspora: Speakers

Dr. Aime Charles Nicolas - Martinique	History/Society/Geography	Major Issues	Policy Issues	Recommendations	Author's Preference	Research Suggestions	Predictor across Diaspora	Miscellanous
Title: Mental Health & Westernization								
	There are three French Departments in the Americas- with French language, rules and law	Cultural conflict: traditionalism versus assimilation	Closer contact with policy makers	Exchange expertise and community experience with other West Indian countries	Study British, Spanish, and French West Indians at home and abroad about such subjects as migration, diagnosis, genetic predisposition, drug abuse, traditionalism etc.			
	Blacks came as slaves; then indentured coloreds came	Lack of family support and decay of family values related to child neglect, adolescent rebellion (with increase in suicide, anti-social behavior) domestic violence and permissive parenting style.		Identify preventive factors against crack cocaine, a major factor in social disintegration				
	Recent immigrants from all races	Cultural disintegration		International committee with wide representation of local workers in five areas(school, family, city, work place, media). Local recommendations made to the international group to collate experience and suggest actions.				
	Eighty percent of people are African descended	Substance abuse, especially "crack," secondary to use of gateway drugs such as marijuana, alcohol		Study British, Spanish, and French West Indians at home and abroad about such subjects as migration, diagnosis, genetic predisposition, drug abuse, traditionalism etc.				
	Slavery abolishment is celebrated							
	One psychiatrist per 10,000 people	Differences in susceptibility to mental illness after migration						

Dr. Kwame McKenzie - UK	History/Society/Geography	Major Issues	Policy Issues	Recommendations	Author's Preference	Research Suggestions	Predictor across Diaspora	Miscellanous
The Mental Health of African And African-Caribbean People In The UK								
	Blacks long time in United Kingdom		Need to strengthen culturally sensitive services					
	Slave trade	Disparities in employment, education, health, mental health, control by police.–(disparities demand research especially epidemiology)--diagnosis, treatment, rehabilitation	Drs. more likely to say Black killed himself - Blacks have more psychosis than whites in the U.K. but the same rate as U.K whites in their home countries	Educate about culture, stress, mental health, available services				
	Migration in the 1950's (with other coloreds)	Appropriateness of diagnosis -Blacks: two times more depression, even though diagnosis is often missed - No difference in suicide in Blacks under thirty-five years - Probable increase in Black suicide since 1950's - Probable increase in schizophrenia in U.K compared to home country - the higher the Black population percentage, the lower the psychosis - incident rate	Need to do research on Blacks, especially in psycho-pharmacology	Government anti-racism initiative, with interventions				

The African Diaspora: Speakers

Dr. Kwame McKenzie - UK continued	History/Society/Geography	Major Issues	Policy Issues	Recommendations	Author's Preference	Research Suggestions	Predictor across Diaspora	Miscellanous
	Migrants failed to return home	A racial attack or abuse in previous year increases three - five times the likelihood of psychosis	Need to enforce available laws (e.g. UK race relation law)	Mental health action zones				
	Immigration law changed in 1970's	The perception of employment discrimination increases the likelihood of mental illness	Increase Blacks' voting	Better training in mental health for GP;s				
	Government making plans for Black African asylum seekers	Almost all Blacks have a family doctor – yet: - less likely to have diagnosis and treatment for depression - more likely to get diagnosis of psychosis and referral to psychiatrist		Pursue a wider array of treatments and assess them				
	One million Blacks of a 55 million population	Blacks have increased admission for mental health problems		Dedicate efforts to decrease disability including targeting poor housing, unemployment				
	One-half of Blacks are in London	When admitted, Blacks more likely to get antipsychotics		Increase training in cultural competence				
	One third of Blacks under age 16	Blacks are four percent of population but sixteen percent of hospital admissions		Establish an advisory body on mental health				
	Two-fifths of Blacks have less than average income	When admitted, Blacks less likely to get psychotherapy		Establish statutory funds for mental health	Make a directory of Black psychiatrists			
	Blacks 3 times less likely to own home and house is qualitatively inferior	Blacks twice more likely to be admitted without their consent		Promote cross- disciplinary, cross- national research				
	Black females outperform while females on national test, but are 5 less times likely to get job interviews	Blacks over diverted into prisons, where they fail to get care		Do more refined studies on racism				
	Few Blacks in inner city	Black children have increase in autism		Make international description of Black psychiatry for training,therapy,research				
	Blacks have increased exclusion from school	Black children have increased referral for psychosis						
	Ninety-three percent of racial attacks are by whites	Racism is a major cause of mental illness						
	Blacks are two percent of population but twelve percent of prison population - also have heavier charges and longer sentences	Blacks get poorer quality of care						
	Blacks have increased morbidity	Blacks have higher rates of mental illness						
	Blacks in U.K. have increased psychosis from social factors	The higher the Black population percentage, the lower the psychosis incident rate						

The African Diaspora: Speakers

Dr. Omar Ndoye -Senegal	History/Society/Geography	Major Issues	Policy Issues	Recommendations	Author's Preference	Research Suggestions	Predictons across Diaspora	Miscellanous
Title: Which Psychiatry for Sub-Saharan Africa? The Example of Senegal								
	9 Million people		Financial support for mentally ill		Continue work of Pan-African conference		Study the survival value of traditional practices	
	French is the offical language with many different ethnic groups (some cross borders, some in civil war)	Need to consider cultural contribution to mental illness, including traditional view e.,g illness is never simply fortuitous	Control of market prescriptions, many of which may pose dangers					
	90% Muslim	Mental illness often relates to planned or community interpersonal troubles						
	Have hospitals, traditional healers	Mental health theory is partial to and protective of children						
	From colonial times mental health trouble was thought to be caused by demons, religious turmoil	Conflict for doctors between western and traditonal treatments						
	After WWI mental health treatment was "work"	Mental health issues stigmatized and shameful						
	French mental health authorities operated with the idea that Africans were inferior	Treatment is abandoned; prescriptions often not filled						
	In 1958 advances in ethno-psychiatry	Cost of treatment						
		Suspicion of doctors' motives and effectiveness especially when treatment is so costly						
		People stop treatment due to lack of money						
		To have western and traditional healer work together						
		90% of people who see a western doctor quit and go to traditional sources						
		Distinguishing normal from pathological in terms of cultural references						
		Cost of hospital care						

The African Diaspora: Speakers

Dr. George Mahy - Barbados	History/Society/Geography	Major Issues	Policy Issues	Recommendations	Author's Preference	Research Suggestions	Cross Diaspora Suggestions	Miscellanous
Title: The African mix in the Caribbean Basin								
	Carribean Basin chain of islands is multilingual, multinational, multiracial	Category A - Black frustration over lack of economic control despite abundant education, talent --Whites are threatened by being small minority with decreasing economic security – Ambivalence about accepting British passports if offered	To make mental health workers and courts aware of and sensitive to cultural issues	Establish norm for Caribbean people in general				
	Focus here is on 11 English speaking countries and does not include Jamaica	Category B - Britian rules but US, not British, currency is accepted						
	Importance of ethnic distibution, size and diversity, affiliations with Europe and USA	Category C - Ethnicity polarizes politics - Need to understand African people with different cultural backgrounds - Many complications about how to express Africanism and how to label oneself - Identity conflicts both inside and outside of one's generation - Many adolescents end up in custody - Some adolescents given antipsychotics against their will - Increase in suicide -The meaning and significance of the degree of pigmentation as a socioeconomic indicator - Need to alter DSM - Relationship of feelings of hopelessness with hopelessness with frustration and insecurity						
		Intra ethnic conflicts						
	These 11 countries can be divided into 4 categories: Category A (1) Uninter-rupted history of British traditions e.g. Barbados (2) 96% Black (3)High density population (4) Weathy minorities of Barbadian White control the economy Category B (1) British defended territories e.g. Montserrat (2) Predominately Black (3) White govenor sent from Britian Category C (1) No longer a soverigh state e.g. Trinidad and Tobago (2) Strong East Indian presence (about same number as Blacks) Category D Independent with much less British affiliation e.g. Antigua both dollar and pound foreign currency. All Categories Countries have heterogeneous cultures							

The African Diaspora: Speakers

Dr. Granville da Costa - Canada	History/Society/Geography	Major Issues	Policy Issues	Recommendations	Author's Preference	Research Suggestions	Cross Diaspora Suggestions	Miscellanous
Title: Separation and Reunion in West Indian Immigrant Children								
	Increasing West Indian Immigrants after 1967	Reunion & separation issues for children, parents and surrogate parents		Educate immigrants prior to departure				
	If parents and children had a separation, often the reunion was very complicated	Depression present in most reunited children intensifies complicated child parent relationships		Provide financial assistance both at departure and resettlement				
	In the West Indies families often are multicultural	In adjusting to the reunion there are many strains and distortions in the parent-child relationship		Increase research on migration				
	Half of immigrant West Indian children have been separated over 5 years	Caregivers may exhibit powerful and negative counter-transference to complicated, often atypical families.		Advocate culturally sensitive immigration policies				
	Nearly 1/2 of children came into new family constellations			Search for any relationship between separation and the development of levels of aggression				

The African Diaspora: Speakers

Dr. Emilio Ovuga - Uganda	History/Society/Geography	Major Issues	Policy Issues	Recommendations	Author's Preference	Research Suggestions	Cross Diaspora Suggestions	Miscellanous
Title: The African Diaspora: Psychiatric Issues in Uganda								
	30 years of violence	Documented prevalence of severe illness e.g. depression, alcoholism dementia, PTSD, and HIV related	Educate the public about value of psychiatry	Research in using extended family	To teach psychiatry in medical school as a separate discipline			
	HIV/AIDS toll is 1.5 million dead, 800,000 children orphaned	Overwhelming problems with few resources but often times very fine treatment results	Mental health as a separate budget is not recognized by Ministry of Health	Research in how Blacks around the world cope with stressors	To train Primary Care providers who can train others			
	Literacy rate is 67%	About 1 psychiatrist per 2.7 million people	Integration of mental health services in the local general health care system	Organize academic researchers	Public mental health NGO			
	High malnutrition	Mental Illness is stigmatized	Promote the value of psychiatry	Link African and Western medical centers	Community mental health programs			
	Traditional healers are valued	30 years of conflict, suffering	Train existing health workers in mental health	Advocacy: - The right and interests of patients - Policy reform - Law reform - Community involvement				
		15% of the population depressed(BDI>18)	Establish a separate budget item for mental health	Establish network and collaborative linkages with African universities - Influence governments - Research to adduce evidence, guide policy reform, plan, monitor - Share experiences - Promote African psychiatry				
		15% life time suicide attempt	Establish mental health clinics throughout the district					
		26% planning suicide	Enact bylaws to curb the uncontrolled sale and consumption of alcohol					
		Budget for mental health <1%	Address social factors in domestic violence					
		Human rights of people with mental illness violated	Establish a network of community counselors at parish level to help families and individuals cope with the stresses of daily living, and to prevent suicide in the district					
		Treatment is effective with combination of approaches	Make laws for the needs of the mentally ill					
			Advocate for more help from the government					
			Train existing health care providers					
			Train community counselors					
			Establish clinics for mental health					
			Enact bylaws and establish policies to support mental health					

The African Diaspora: Speakers

Dr. Augusto Costa Conceicao - Brazil	History/Society/Geography	Major Issues	Policy Issues	Recommendations	Author's Preference	Research Suggestions	Cross Diaspora Suggestions	Miscellanous
Title: Mental Health and the Afro-Descendant Community: Notes on the Journey in the Black Atlantic								
	Past history of brutal slavery	Rejecting government's contol of culture in the service of tourism	Need for public policy to provide more resources to battle psychopathology of exclusion		Work on the pedagogy of self-esteem			
	Past history of brutal slavery	Rejecting government's contol of culture in the service of tourism	To develop a government which is attentive to the health of its citizens					
	Other evidences of African culture in music, dress, food, language, carnival etc.							
	4/5 Black descended in Salvador							
	Modern financial and commercial center							
	Bahia grew 1000% since 1940 to 2.4 million							
	Increasing numbers of elderly and juveniles							
	Many poor, illiterate associated with inequality, segregation and concentration of wealth							
	After a long fight Candomble religions won in 1976 a human rights struggle permitting them to conduct rituals without police supervision							
	Renewal of African customs and culture							
	Economic woes worsen							
	Social exclusion intensifies							
	Hopelessness, frustration, lack of education leads to negative self-images and stereotypes							
	Increasing violence, fury, mental illness including child abandonment and substance abuse							
	Understanding of the role of culture and social actions to increase individual self esteem; enhancing the value of Afro-culture; academic recognition of the importance of re-Africanization							
	In mental health recent services, unite mental health, integration with general health services; focuses on rehabilitation, collaboration with family health and reduction in stigma							