

# World Association for Psychosocial Rehabilitation

# BULLETIN

Association Mondiale Pour La Réadaptation Psychosociale

## Volume 14 (3) October 2002

### **PRESIDENT'S REPORT** by Zebulon Taintor

The Japanese, Korean, and Shanghai branches of WAPR reaffirmed their relationships with the rest of us during my trip to the World Psychiatric Association (WPA) conference in Japan and Korea. The WPA meeting also provided a chance to recruit more national secretaries. Meeting so many fine, dedicated people, learning from them, and developing ways we can help each other is one of the delights of travel. The WPA meeting brought about a closer relationship between the WPA and WAPR, which will be providing the administrative services the Section on Rehabilitation needs. The Section is cosponsoring the 2003 WAPR World Congress in New York City. More on these points:

WAPR in Japan, Korea, and Shanghai: Our Asian friends were concerned about the constitutional requirement to send half the dues money to WAPR. Some were unaware that that the constitution was changed at the Paris World Assembly to place this requirement in the bylaws (amendable by the Board) according to a formula of 50% only for the first 100 members, decreasing thereafter by 10% per 100 members down to 5%. At the Board meeting in Rome in June it was agreed that keeping WAPR together was more important than quibbling over money. Despite a unanimous vote for the constitutional change, only a few of the 36 national branches have followed the route of seeking the annual recertification and dues structure approval required by the change. Two national groups (Austria, Philippines) do not collect dues. Also, WAPR has become less dependent on dues income. We do not pay for anyone's travel, we generate some earnings from meetings despite our low fees, the American chapter subsidizes the *Bulletin*, we have received a few donations, etc. In fact, the Board felt too little money was being expended and authorized the *Bulletin* translations into French and Spanish and direct delivery of the *Bulletin* from abroad to countries that have paid dues. Until the Board (April 2003) and Assembly (August 2003) have a chance to discuss this more fully, the formula will be regarded as a guideline rather than requirement. Aside from the dues issue, our Asian friends wanted to feel personally in touch with WAPR and have informal discussions with its leadership to ensure our goals and methods are congruent. The WPA program offered many chances for such discussions – "rehabilitation" was mentioned in 137 abstracts, including many presented by WAPR members. The Japanese association has about 700 members, the Korean about 350, and the Shanghai about 150. I continued from Yokohama to Seoul and the Rongin Hospital for a tour of impressive facilities and great hospitality.

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The WPA-WAPR relationship: this was approved by the Section on Rehabilitation and in the meeting of sections. It would result in no dues for being a member of the WPA section nor in a requirement that a WPA rehabilitation section member be a member of WAPR (although there would be urgings to that effect and WPA section members would receive WAPR mailings unless they asked not to do so). There is no problem with having nonpsychiatrist members. A WPA section chief need not be a psychiatrist. However, some WAPR members may still not want to be WPA rehabilitation section members. The WPA does mandate section elections every three years and conceivably the section may have other votes for which a quorum is required, so joining the WPA section carries some responsibility to be in Cairo, September 10-15, 2005. There are at least three other WPA sections that operate this way. The WPA's finances are similar to WAPR's, with a surprisingly low central office salary load and an expectation that the sections will be autonomous, self-supporting, and productive.

**New National Secretaries:** The WPA meeting provided a chance to recruit and orient colleagues who will work in Barbados, Guatemala, Indonesia, Papua, Switzerland and Vietnam. Their contact information is included with those recently appointed for Bosnia and Palestine. Their charge is simple: try to convene a multidisciplinary group to promote community-based psychosocial rehabilitation in their countries.

## REGIONAL REPORTS

### Africa

#### **Vice-President: Paul Sidandi**

I attended the WHO World Health Assembly in Geneva, Switzerland in May 2001 as part of the Botswana Government delegation, the report of which appeared in a recent WAPR *Bulletin*. Also in 2001, a Global Campaign Against Epilepsy initiative was summarized and circulated to some psychiatrists in Africa. The Botswana Association for Psychosocial Rehabilitation received a grant of US\$37,000 to establish a Model Project for the rehabilitation of mentally ill patients with HIV/AIDS with an emphasis on Women and Children from Bristol-Myers Squibb Foundation Education and Community Outreach Fund. Professor Kelvin Mwaba of the University of the North West, South Africa, audited the BAPR Project and it received a high commendation. The Project has generated a lot of interest and the Kaiser Family Foundation of the USA sponsored a group of Journalists to visit the project. The Project has succeeded in helping to establish a Community Based Psychiatric Rehabilitation service, which was hitherto absent in the Botswana Mental Health Services. The next step is to replicate the Project in another part of the country and start a Half Way house. This will help with the tertiary rehabilitation and relapse prevention for patients at the large Lobatse Mental Hospital.

**Deputy Tolani Asuni:** Recently visited New York, has been in touch with Nigerian psychiatrists to start an organization there; no other recent activities, spends half his year in London.

### Americas

By Rosalba Bueno-Osawa

This is a joint report for the President of the WAPR Mexican Chapter, the WAPR Mexican National Secretary and the WAPR Regional Vice president. The president of the Mexican Chapter and all its members in October of 2001 coordinated a meeting of various directors of government and private institutions all related with mental health with Dr. Benedetto Saraceno. It was a very valuable exchange of ideas and experiences. Two members of our Chapter are working with 400 persons that are now in a Safe House and used to be in a psychiatric hospital and lost contact with the family. The plan is to recover as many of the families as possible. Some of our members have been working with the Institute of Mental Health (an official Institution of the Department of Health) collaborating with their programs.

In November 2001 the National Secretary Maria Eugenia Ruiz Velasco organized a follow-up workshop with Dr. Ramon Blasi. "Psychosocial Rehabilitation in the Community and with the Community." The previous workshop had been in 1998. The attendance consisted mostly of persons from psychiatric institutions and penal Institutions. The national secretary organized the attendance of many members of our chapter and from psychiatric institutions to the ARAPDIS WAPR congress in Barcelona May 2002. 11 papers were presented and 60 persons in total attended. The National Secretary participated in a series of lectures regarding the Psychiatric Reform Social Assistance and Mental Health issues. This was organized at the San Luis Potosi University, Mexico. The National Secretary gave a lecture on psychosocial rehabilitation for the long-term consumer residents in the psychiatric Samuel Ramirez Moreno Hospital. Several members of the Mexican Chapter participated in the third week on mental health issues. "Psychiatry and Psychosocial Rehabilitation." The participants were: Maria Eugenia Ruiz Velasco, Lidia Fernandez, Aura Silvia Valdés and Rosalba Bueno Osawa. Lectures in the Psychology Department of the Metropolitan University to discuss the treatment of psychosis in the psychiatric institutions. We continued to make sure that mental health professionals are informed of the changes that are taking place in México with the new rehabilitation programs, particularly the new structures in the state of Hidalgo. Villas, halfway houses and independent apartment facilities substituted for the very old and dilapidated Psychiatric Hospital Ocaranza. The National Secretary has been instrumental in taking students from the Metropolitan University to visit this new facility. The Vice president has participated in numerous lectures and press conferences in which the purpose is to promote the knowledge of the possibilities and options for psychiatric rehabilitation. The Vice presidents and other members of the Mexican Chapter are actively participating in a psychiatric rehabilitation network that was promoted by Virginia Gonzalez Torres through the Foundation for the Rehabilitation of the Mentally Ill.

Countries: Zebulon Taintor (English language countries): Barbados: new National Secretary George Mahy; Canada: continuing some activities under co-national secretaries; Dominica, St. Vincent, St. Lucia: inactive; Grenada: Peter Bourne active; Jamaica: Lorraine Barnaby appointed National Secretary; United States: 100+ members, monthly meetings in NY and Hawaii, rebuilding in NJ, WA, CO, CA; looking forward to hosting 8th World Congress.

**[MORE REGIONAL REPORTS TO FOLLOW IN NEXT *BULLETIN*]**

**“Recovery from ‘Chronicity’: Some Life Experiences”**

By Marit Borg, Norway and Alain Topor, Sweden.

Severe mental illness is often thought of as having a long-term course with limited benefit from treatment. People who suffer from various kinds of mental illnesses often find themselves identified with the illness and find that helpers offer little hope for improvement and recovery. Schizophrenia, for example, has long been thought of as an incurable disease. However, there is reason to be optimistic. Recent research as well as an increasing interest in patients' own experiences and coping strategies, show us that many patients do recover (Harding et al 1994, Strauss 1992, Strauss 1996, Harrison et al 2001). Improvement as well as total recovery is seen in many patients. Still, there are many dilemmas facing us in studying such processes of human development and we need to look closer into concepts like "chronicity" and "recovery."

### **"chronicity"**

Are we using the term "chronic" less frequent when referring to certain mental illnesses? Or do we speak more about *long-term* illnesses having a *long-term* course, demanding *long-term* treatment? Whether or not this is the case, many patients are still referred to as "chronics" and schizophrenia is often spoken of as being a "chronic illness". The term "chronic" comes from Greek meaning "time." Thus, "chronicity" indicates a long period of time. Time is not the only factor, however. Schizophrenia, as many know, was originally called dementia praecox, meaning early dementia. Back then, "chronic" was thought of as something constant, persistent and life-long, getting progressively worse over time. Episodes of improvement were of no relevance. "Chronic" was also associated with a natural course, therapy-resistance, the demand of long-term care, and finally being incurable. In psychiatry the various aspects of chronicity have often been identified through four criteria that are applied singly or in various combinations: diagnosis, duration, hospitalisation and disability. However, these criteria are far from valid predictors of a person's potentials. They cannot alone be related to the persons' condition, but as much to his or her situation in general – and especially the treatment and rehabilitation services available. These so called "chronic conditions" must be understood and seen in an individual perspective, with attention to the social and psychological aspects of life. The stigma and pessimism associated with them also need to be given consideration.

People who have experienced severe mental illness do recover. Most of us have seen or experienced this. Several research results have proven it over many years (Deegan 1988, Deegan 1997, Harding et al 1987, Tooth et al 1997, DeSisto et al 1995 a & b, Topor 2001, Warner 1994). However, such research is often met with the following arguments:

1. The patients studied were misdiagnosed and did not have any of the severe diagnoses.
2. Recovery was spontaneous which means it cannot be analysed, much less reproduced. When something is spontaneous, it is not planned and cannot be controlled. It is therefore impossible to learn from such spontaneous improvement.

### **"recovery"**

There are many ways of defining and understanding recovery. The following captures some elements that seem to be central. Recovery is:

*"The uniquely personal and ongoing act of claiming and gaining the capacity to take control of life, feel a part of community life that is personally meaningful and satisfying, with opportunities to perceive him/herself as a valued person. The person may develop and use their self determination to grow beyond and thrive, despite the presence of limitations and challenges invited and imposed by the illness, it's treatment and the personal and environmental understanding of them."* ( Glover 2002).

Recovery processes involve several factors in addition to the person and his or her condition.

These include available services in the community, the financial situation, housing and job opportunities. The attitudes of professionals and society in general plays a central role, and there is reason to wonder why the knowledge developed through recovery research is not more clearly present in mental health practises and why pessimism still has such a strong grasp on helpers' attitudes.

We do not know enough about which factors lead to recovery. Furthermore, the relationship between treatment, rehabilitation and recovery is not clear. In order to acquire more knowledge, a Norwegian-Swedish research team turned to former patients for help (Borg et al 1998 & 2001, Topor 2001). Through interviews, fifteen persons were invited to tell their stories. We had one major question. What was helpful in *your* process of recovery? The idea was to learn more about various ways of dealing with problems and challenges and about experiences with services and other situations that were considered supportive.

Seven women and eight men from the ages of 29 to 63 were interviewed. All except one had been admitted to psychiatric hospitals several times, some for long periods. At the time of the interviews, the persons considered themselves as recovered. They all had a permanent place to live, functioned well in everyday life, had a stable economy and were satisfied by having reached so far. Although some experienced problems at times and certain limitations in their lives, they described their situation as fairly satisfactory, and none of them had been inpatients during the past two years. The former patients let us in on their experiences, both good and bad ones. Some of them say that despite of it all, they value all they have learned in the process of recovery. One man says he feels as though he has got "a deeper personality." Another says she has become "a better, kinder person." They wanted to stress that having a severe mental illness is not just misery and pain and something merely "bad." Nevertheless, the journey towards a better life has been long and tough. Many sacrifices have been made and they speak of fear, chaos, disturbing voices, pain, loneliness, feeling of hopelessness and anxiety. As we read these stories, we get to know the person behind the diagnosis. These patients are often talked about as "chronics." Here we can see capable and competent persons doing hard work to help themselves. They appear as creative and resilient individuals, committed to their projected of recovery. They are so much more than just the illness itself, so much more than "the schizophrenic."

The persons we met talked about themselves as being active and capable rather than passive victims of an illness. Through the interviews, it becomes clear that they have much in common:

- They knew a lot about themselves, about what was helpful and made them feel better
- They had done a lot to help themselves and their role in treatment and rehabilitation had been active, showing both courage and endurance
- They had developed various ways of dealing with day-to-day challenges
- They had developed important relationships
- They could see what their helpers were good at and made use of them in their individual ways

All in all, they wanted to be treated as adults – as people who had difficulties but who also knew about things. Their intention had been to get on with their lives in their own way, without having people making decisions or doing things for them. At the same time, it was

important to be taken care of in certain periods - when *they* felt it was necessary. One of the women we met was Bodil. Her problems started in her youth long before she got in touch with professional help. For her it all began when the Great Reaper came into her life. He lived in the back of her head and demanded her to do bad things. He was often vicious and tortured her. The first time he appeared Bodil really got scared. She did not understand what was happening, what she ought to do and to whom to turn. Like many others, she described getting scared and confused when symptoms appear. Throughout time, however, she finds ways of dealing with the everyday challenges and finds helpers who are understanding and useful.

*"I got so scared that I sometimes banged my head against the wall to make him go away. And then he disappeared, because it hurt him. It's so weird."... It made it better, but then I started crying and called the crisis team. In the beginning, before I knew about them, I was all by myself. There was no one I could call."*

At times, Bodil felt small and weak, and needed people around her. Sometimes she wanted her therapist to show concern for her and comfort her. Other times she could call her voluntary worker just to talk. She did not always call to discuss problems. The most important thing was to have someone to talk to, about anything. The presence of the Great Reaper often made it necessary to call for helpers. She was afraid – and really wanted him to leave her alone. Other times she slashed her arm with a knife. The pain drove him away. Slashing her arm, banging her head against the wall and calling the crisis team, were Bodil's ways of dealing with the Reaper for many years. In similar ways, the other informants talked about ways of overcoming the problems that various symptoms or other consequences of the illness had given them. They wanted relief from a chaotic and intolerable situation. Calling for professionals was not always a good solution. They just wanted to talk and someone who would listen and explain. Psychiatry's answer was often medication alone. Bodil had experiences like this – she was just sent home with a lot of pills in her pocket.

*"They said I should go to the acute admission ward. I went there anyway, at night. I talked to a guy who gave me Rohypnol and said to me with a sharp tone of voice: 'Don't take both tablets at the same time...' Then I went home – and took both pills because I really wanted to sleep. I had never taken those kinds of medication before so I got absolutely wiped out... But I didn't get any help at that place, you could say... In the morning I couldn't wake up, I was in a daze..."*

People with mental health problems find ways of dealing with everyday life's challenges. They do not just sit there helplessly. This becomes very clear through the interviews. We talked with fifteen people who all together had more than 260 years of experience with illness and being a psychiatric patient. One comment came up in many of the talks we had: *"Why hasn't anyone asked me about this before? All the things I do to help myself?"*

The elements of time and energy were important in Bodil's as in many of the other stories. They highlight structural issues, where *time* can play an important role.

It takes time to:

- understand what is happening
- reorganise you life and dreams
- find out what you want and need

- find help
- establish helpful relationships
- find and try out different arenas
- learn about and accept problems and find ways of dealing with them
- accept what it takes get through the day

Energy is another central aspect in recovery. Having massive anxiety, hearing voices and taking medication saps your energy. Many felt that they could not get around to do things in periods, small things they used to do in no time, like writing minutes from a meeting or making a phone call. Dealing with the Reaper was a great challenge for Bodil. He more or less took over her life in periods. Still, she did not experience this situation as all bad. At points she described him as a friend, even if he was cruel. They could talk about things and she could take him with her to town or anywhere. When he went away for good, she felt sad. He took her time and energy – but he was someone to spend time with. He was company.

### **Helpful relations with professionals**

Relationships with helpers that are characterised by commitment and co-operation seem to be of great value. It was valuable to have just a few helpers that are there for them over time. These relationships were described as both unique and powerful. They have little in common with helpers concerned with keeping professional distance by carrying out standard programs and models. In many ways they may be seen as a contrast, as a variety of interactions and common activities are described as important and useful to the informants (Borg 1999). For some it was their psychotherapist that mattered most. For others it was their everyday- helpers, those who gave them support and practical help. It can be difficult getting through the day when you are on lots of medications, being tormented by voices and not able to sleep at night. Many of the informants spoke of the importance of getting help at the right time and with what *they* needed. It was important that their agenda was in focus, rather than the helpers.'

For Bodil it was vital to have a variety of helpers and arenas that she used in different ways.

*"I am here (at the work-unit) Monday, Tuesday and Thursday between 08:00 and 10:00. I work in the café. Then I go to see B., my case manager, on Tuesday and Thursday. We eat together. Or we talk about this and that or go to a museum – or to town and do some window-shopping... I even have a voluntary worker, P. I've had him for 11 years. I met him at the acute ward when I was admitted. He was studying to become a nurse. I got his phone number and asked him if he wanted to be my voluntary worker. And he said yes. I see him after work, to put it that way."*

Bodil also had her therapist at the outpatient's clinic, as well as the night team.

*"They came to me at home and we talked, and then I felt better. We were talking about everyday stuff. The night-team was really great. In the beginning they said I had to be admitted in the acute ward, but I told them I only wanted to talk. And then we talked, sometimes about a problem and sometimes just ordinary talk."*

Helpful relationships seem to develop in situations where professionals can be trusted, where a common "project" is established and where both parts agree on the aims and the agenda. In

these relationships it may be easier for the patients themselves to become more active and engaged. Many mentioned how useful it was to know helpers well over time. Bodil chose P. herself and appreciated the fact that he wanted to be her voluntary worker. Bodil also valued the fact that she was the one who decided things -- her choices were important. Furthermore, she could get help throughout the day. Bodil's first meeting with P. was special as he was the one releasing her from the belt. He was nice, humane, and they had breakfast together after she was out of the straps. P. showed interest in how she felt. Bodil experienced that she was made a priority. Many of the informants focus more on the things helpers do, rather than what they say. Professional methods and activities are less relevant in the stories – the helper as a person is the key. It is the personal relationships and not professional merits seem to be what matters. They valued helpers who dared to reveal who they are as a person, who give of themselves, in addition to using their knowledge as, a voluntary worker, an occupational therapist or a doctor. The informants spoke of their helpers in friendly terms, even though they clearly knew that they were not real friends. In various ways they described that they knew where to draw the line.

In these helpful relationships, the patients appear more like partners rather than passive objects. Maybe we need to give the concept of professionalism some consideration? In our eagerness of being competent and successful – of being “professional,” could it be that we are losing some of the curiosity and open-mindedness about patients with whom we are dealing? Are we as professionals too concerned with doing the “right thing “ – as described in textbooks or guidelines or by the norms of the medical community? And are we too worried about what our colleagues may say? On the other hand, perhaps helpers are actually doing a lot of “good things,” but only writing and talking about the “professionally right things?”

It is not enough, of course, just to be just kind and friendly. The challenge is to combine knowledge and methods with the development of collaborative relationships. Perhaps such relationships need to be given more significance and value in treatment models and guidelines and in policy documents? Maybe we need to value them as important as a bed or medication? It is through getting to know and work together with the person we can support him or her in taking control over their situation and living a meaningful life in their community. And - in whatever way we see these matters – it is worth remembering that relationships are built on strengths and weaknesses, on opportunities and limits in both parts.

A clear message from the informants in this study, is the fact that patients are different from one another even if they have the same diagnosis. Some of the fifteen persons in our study wanted a close relationship with the same helpers over time – other wished to change. Some wanted independence and an active role where things could be sorted out at their pace. Others felt in periods it was important to follow the professional's agenda.

Often it was the little things that mattered, such as going to a café together, having the opportunity to borrow money from one's therapist, learning algebra, listening to music, receiving a rose or some poetry. Little things like these are not often mentioned in the professional agenda. As professionals, we are likely to be more concerned about looking for the bigger events and for what we think is important. We think about what fits in and makes life easy for us.

### **Helpful arenas**

These arenas are places where the informants found help. Examples of good ones were

flexible hospital wards where you could come for dinner after discharge or keep your external therapist during the stay, work-units where the job was adapted to you – and not the opposite situation, leisure-centers where you could be “normal” but also be accepted with your difficulties, and user organisations where you could meet others having problems or your therapists office where you could feel safe and welcomed. What seemed to be important is the open and flexible way these arenas were structured and organised, the warm atmosphere and the opportunities to meet other people, feel welcomed and be of some use.

Work, or something to do, was as crucial to the informants as for most people; getting out of the house and meeting other people was highlighted. Doing something useful and being recognised for that was also noted as important. Finding a suitable situation, however, was not always easy, as Bodil experienced:

*“I had a job in the work-centers café. They gave me a hard time about it, arguing that I would feel better if I had something to do. I was thinking that: ‘Don’t they understand I’m afraid of going to work because I am scared of all the people...’ They frighten me. Everybody were eating at the same time and I was supposed to just stand there... That just didn’t work ... They didn’t understand that I was ill, and found it difficult to get things done. That I was worn out from all the medication.”*

After a while, she came to an agreement with her employer. She would work in the morning, when the place was less busy.

*“I am a morning- hostess and that works out well. I bake too. I am alone then, but that doesn’t bother me. Now I like it at work.”*

Helpful arenas allow for diversity and can be used in various ways. Helpful arenas often have flexible people there, who make it possible to turn this space into “greenhouses,” giving room for nurturing, growth and development. In the opposite way, arenas can have an adverse effect and being experienced as humiliating and oppressive. Work and activity can then be seen as something degrading and negative. The informants talked about a great variety of ways of finding these arenas. Some were determined to locate such good places - others simply stumbled over them. Helpful arenas seem to have the following in common:

- They give meaning to the individual – they serve a purpose
- They allow for personal growth and the chance to try things out
- They allow you to meet other people; they are social places
- They are made up of a diversity of activities and approaches rather than follow one specific model

Rather than a conclusion...

**Women and men who have been treated for severe mental illness have shared their experiences. The study of these recovery-stories brings up certain paradoxes.**

*Subjectivity* is often described in psychiatry as disturbed or completely dissolved in conditions like schizophrenia. It is regarded as disturbances and damages in the ability to receive, integrate and give information in addition to emotional disturbances. Furthermore it is claimed that such illnesses disturbs the experience of individuality and meaning.

The informants of this study saw themselves as both active and goal-directed in dealing with symptoms and everyday challenges. They are getting on with their lives, which have been threatened by extraordinary and unbelievable experiences - and at times even threatened by

the services. Persons who have severe mental illness are often regarded as being unable to develop *mutual relationships* with others. In our stories we learned that it actually was in these relationships the process of recovery started or continued. Another paradox is a challenge for specialised and program orientated services. It seems as if the person's opportunity to be 'both – and' – not 'either – or' is central for recovery. They wanted the chance to be both healthy and ill at the same time, rather than well at certain periods (and being supported in the community) and ill at other times (admitted to hospitals or closed units). The importance of having the right to be 'both – and' is a very concrete experience in the stories. Sometimes it is conveyed through others, who seemed to accept having to deal with a fellow human being's totality, both through suffering, capabilities and opportunities. It was also conveyed through arenas where it was all right to be 'both – and', and where people with or without professional experience were present. They were not segregated. These plain stories about the richness and opportunities in human life are placed up against psychiatry's categorisation and classification. We can look at them in contrast to the logic of natural sciences and hope for finding one answer to every diagnosis, human and social sciences are placed – where medical knowledge is only one knowledge among many others. In this way the end of this study is merely a beginning.

In this recovery context, rehabilitation cannot be something that experts do to patients according to some preconceived models or plans. Instead it has to be understood as a concrete and practical joint venture, where professionals and patients create new roles to fit a new context where they appear as more than just professionals and patients.

## NEW NATIONAL SECRETARIES

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## CALENDAR

2002

**November 21-22: WAPR Spain\***

**Annual Rehabilitation Meeting. Bilbao, Spain. Contact Jose Uriarte at: [juriarte@thzam](mailto:juriarte@thzam).**

**osakidetza.net**

**November 28-30: WAPR Philippines**

**Manila, Philippines. Contact Lourdes Ignacio at ignacio@ibahn.net**

**December 9-10: WAPR Brazil\***

**Sao Paulo, Brazil. Themes: therapeutic housing, psychosocial rehabilitation community centers (CAPS), and other community programs for people with severe and persistent mental problems. Contact Ana Pitta at: anapitta@usp.br**

**2003**

**April 1-3: WAPR France\*\***

**20<sup>th</sup> Annual Congress. Angers, France. Visit [www.rehabilité.org](http://www.rehabilité.org)**

**May 8-10: Forum zur psychosozialen Praventio, Therapie, Rehabilitation.\*\*\* Hamburg, Germany. Email [info@deltacom-hamburg.de](mailto:info@deltacom-hamburg.de), or visit [www.forumrehabilitation.info](http://www.forumrehabilitation.info)**

**August 3-5: Eighth World Congress of WAPR\*\***

**New York City, United States. Contact Murray Itzkowitz at: [mitzkowitz1@aol.com](mailto:mitzkowitz1@aol.com) or visit [www.wapr.net](http://www.wapr.net)**

**\*WAPR president will participate \*\*WAPR International Board meeting \*\*\*WAPR is cosponsor**

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**E-mail:** \_\_\_\_\_

**Position or Occupation/Profession ou fonction/Profesion o ocupacion** \_\_\_\_\_

**Check type of membership for which you are applying**

**Cochez la classe d'adhesion appropriee**

**Marque que tipo de miembro desea usted ser:**

**Regular/Ordinaire/Ordinario (\$50. US)**

**Sponsoring/Parrainage/Padrinazgo (\$1,000. US)**

**Students, Consumers, Families/Etudiants, Usagers, Families/Estudiantes, Consumidores, Familias (\$25. US)**

**Reduced Fee/Cotisation reduite/Cuoto reducida (enclose letter with rationale/inclure lettre d'explication/inclure carta explicitiva) Amount/Montant/Cantidad (US\$):** \_\_\_\_\_

**Donation/Don/Donacion (Amount/Montant/Cantidad) (US\$):** \_\_\_\_\_

**Interest in Psychosocial Rehabilitation:** \_\_\_\_\_

**Centre d'interets en readaption psychosociale:** \_\_\_\_\_

**Area de interes en rehabilitacion psicossocial:** \_\_\_\_\_

**Committee interest:**

**Committee choices:**

**Advanced Institute**

**Advocacy and Policy**

**Aging**

**Cognitive Rehabilitation**

**Culture**

**Developing Countries**

**Editorial**

**Education**

**Epidemiology**

**Housing**

**Human Rights**

**Liaisons**

**Mental Illness, Work & Employment**

**Models & Best Practices**

**Neurological Disorders**

**Psychiatric Hospitals**

- \_\_ Psychoeducation**
- \_\_ Psychotherapies**
- \_\_ Quality of Life**
- \_\_ Quality Assurance**
- \_\_ Rehabilitation & Law**
- \_\_ Rehabilitation & Economics**
- \_\_ Scientific & Research**
- \_\_ Social Security & other support**
- \_\_ Telerehabilitation**