

## **IACAPAP Bulletin - September 1997**

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#### **Presidents' Message**

*The Future of Nations Depends on Their Care of Children*

Fortunate children and families in democratic, industrialized societies are healthier and intellectually better prepared than ever. Good prenatal care, immunizations, diet, treatment of diseases, schools with advanced courses, and stable family life is improving the health, life expectancy, and achievement of large groups of children and youth. At the same time, increasing numbers of children and families are facing grave and life-threatening risks that reduce potential and lead to emotional and intellectual dead-ends. Too often, the lucky children with access to health care, education and social supports are separated only by short geographical distances from those whose lives are burdened by multi-generational

poverty, family dysfunction, and social trauma. More and more, in advanced nations, there are two societies living in close proximity—those who are educated and wealthy, and those who are increasingly alienated. This polarization is not only harmful to both groups of children, it threatens the security of society in their future.

IACAPAP is the international spokes-man for all children, from infants to young adults, and their families, as well as for the professions that serve them. Our special concern is with children who are vulnerable or already suffering from emotional, behavioral, and developmental disorders. Today, the theoretical orientation that guides our work emphasizes the multi-generational nature of developmental psychopathology—the transmission of bio- logical and psychosocial vulnerability and protective factors from one generation to another, and the expression of strengths and impairments in specific communal contexts. For more than fifty years, IACAPAP has been engaged in disseminating advances in clinical and developmental knowledge, helping to support professionals and to train the next generation, encouraging the advancement of the scientific basis of child psychiatry and psychology, and promoting the welfare of children and families. The 14th International IACAPAP Congress in Stockholm in the summer of 1998 will continue this tradition. Focusing on the care of children by mental health clinicians, the Congress will describe new scientific knowledge and emerging mental health systems. The Congress will describe how the science and therapies of the future will draw upon the concepts and skills of many disciplines— including child psychiatry, psychology, pediatrics, epidemiology, public health, nursing, education and neuroscience. Working in collaboration with families and communities, the mental health clinician of the future will be armed with a broadening range of psychological and biological treatments and a widening scope of theory and concepts. The problems we face will remain very difficult, of course, but the work will become more intellectually challenging and hopefully more effective.

Left on their own, children and families mobilize their own modes of adaptation to stress and trauma; when they are successful, the child and parents can move ahead with new competence and with confidence. Failures in adaptation, however, set the stage for a child and parents to move further off the mainstream and along paths leading to increasing dysfunction.

The scientific study of children's development, in the context of family and community, can help provide a rational, empiri- cally testable framework for effective intervention. Biological and behavioral methods already are becoming available to analyze the contributions of specific and general genetic and biological factors to the vulnerability for disorders, and the ways in which environmental adversity interacts with constitution in the emergence of specific conditions. This knowledge will increasingly help to pinpoint the sensitive moments for intervention— from gestation through each phase of development—and the precise blend of psychosocial, behavioral, and pharmacological treatments.

Clinicians need to know when to allow children to right themselves and how to provide well-timed, effective interventions when development becomes derailed. All our treatments must, of course, be humane and ethical; as we learn more, they must also be able to withstand rigorous, scientific examination for effectiveness, efficiency and replicability.

For children and families, strengths generally build upon strengths and risks are compounded by failures. Healthy babies in loving families acquire the preconditions for later achievement in school and community. Small, vulnerable, drug exposed infants who are

raised in chaotic and dysfunctional families fail to thrive as infants and will be two or three years behind in language and social skills by the time they reach school, where they are likely to fail and drop out. Yet, not all vulnerable children in situations of danger become impaired. By studying children who move ahead, in spite of risk, we also can learn about inborn strengths, protective factors, and what helps children cope with adversity, as well as about luck.

Just as in other branches of public health, this knowledge of the normal tasks of development as well as the threats to individuals and groups provides a rational orientation for prevention and treatment. We already know that support at each phase of development and early detection of difficulties are far more caring and efficient—for the child, family, and broader society—than later attempts at remediation when things have gone badly for too long a time. However, no child or group should be written off. Even in situations of persistent and serious psychosocial adversity—such as the clinical situations that confront us when we deal with street children, abused children, children suffering from AIDS, and seriously delinquent children—communities and clinicians can offer opportunities and hope for self-righting and future achievement. Of course, as clinicians we have a special responsibility for the care and treatment of children and adults with the most severe developmental, emotional and behavioral disorders. For many of these children, our greatest contribution may be the advancement of knowledge that can fundamentally alter their prognoses.

There are good reasons for clinicians and researchers to emphasize the first years of life when behavioral and biological templates are being laid down. During the first years, children take in the care they are provided. They metabolize these experiences and make them a part of themselves. This process is both psychological and biological. Children's experiences affect their feelings, thoughts, and the internal emotional portraits of their family. These experiences, we are now learning, also determine how the brain matures, the density of synaptic connections, and the relations among different parts of the brain. All future emotional and cognitive development is built upon these psychological and biological foundations.

The care of the children in loving families is ideally suited to fertilize and mold their emerging competencies. This care facilitates children's intellectual and emotional development, their language and thinking, their sense of personal value and autonomy, and the depth of their inner lives. The cognitive and attentional abilities that emerge from the interactions between inborn endowment and experience prepare children to enter school and make use of what they are taught to acquire the formal academic skills that are necessary for success in technological societies. Yet, there is no single, magic phase of development. Children who have started well require continuing affection, stimulation, protection and education. Some children cope remarkably well with adversity and early strain to become productive, competent adults, especially if they are provided suitable care.

To an increasing degree, children's opportunities for continuity of nurturance by parents and extended families are being eroded. Broad social changes are affecting families of all social classes. One century ago, in the U.S. and Europe, the average family had many children (seven in the U.S.), two parents, and a mother at home to care for the children; divorce was rare. Today, the situation is vastly different. In Europe and the U.S., the average family has two children, both parents work, and infants are placed in day care during the first year or two of life. With many children born out of wedlock and divorce rates of 50%, most children will live with only one parent sometime during childhood.

As families have become smaller and more mobile, many young families can no longer turn to their own parents for help and guidance. Increasingly, there must be social systems to support young families and intervene when there are problems. New models of intervention are available. They emphasize the importance of prevention, family support, and the availability of an integrated spectrum of community-based services for those with serious problems. These models draw upon collaborations among different disciplines and between professionals and parents. The future mental health professionals will require knowledge about these new systems and the skills to work with other professionals and with families and the community.

Child mental health professionals have been immersed in the lives of children in many contexts—in hospitals, clinics, schools, and in the consulting room. Each context calls upon expertise in the understanding of development, as well as new types of knowledge. To work in hospital settings and with severely disturbed children, mental health professionals will require knowledge of clinical neuroscience, genetics, pharmacology, and cognitive and behavioral strategies, while preserving their sense of the child's inner experience and family relationships. To work in the community will require greater understanding of systems and of the methods and goals of other professionals, such as teachers, probation officers, judges, police, and social service agencies. For those who work in the most high risk situations—the impact of urban violence and war, drugs and AIDS; abuse and neglect; child labor and sexual exploitation; and the impact of parental physical and psychiatric illness on children—a range of clinical, advocacy, and political skills are called upon, in addition to broad clinical knowledge.

IACAPAP has special commitments to the most threatened children, such as those who are caught in war and urban violence. Today, millions of children are refugees and live in camps or as undocumented aliens, often separated from their parents. Trauma-tized by war at home, they are then exposed to illness, danger, lack of schooling, and risks of exploitation. In this domain, IACAPAP has been an international spokesman for the rights of children as well as deeply immersed in supporting clinicians and organizations who are directly involved in providing care.

IACAPAP also has an important role in providing leaders in government and international organizations with authentic knowledge that comes from clinical work and from research. The daily, intimate engagement of clinicians with families and communities is a rich source of information about the state of children, of institutions that serve them, and of what is useful for treatment. We need specialists who can integrate all types of epidemiological, biological, and clinical knowledge and provide this information in ways that are useful for legislators who must make the final policy decisions about allocation of resources.

This domain has taken on increasing importance in relation to the future security of nations. Throughout the world, leaders are recognizing that a nation's most critical natural resource are its children. In the United States, President and Mrs. Clinton convened a special working group in the White House to discuss brain and behavior in the first years of life; they, like other leaders, are increasingly concerned about the implications of new scientific knowledge for how society cares for and educates children. To succeed in the future, nations need to optimize the development of children—to launch them down paths that will lead to physical and emotional health and the capacity to deal with the tensions that are arising from the increased polarization within society between those who are prepared for modern society

and those who are pushed further and further to the margins. This polarization will prove to be as great a threat to security as political dangers from without.

At the beginning of the twentieth century, child advocates and government leaders talked about this being the century of the child. At the end of the century, we can see that this has been a grim century indeed for children and nations. The work of IACAPAP is to help assure that mental health professions—child psychiatry, psychology, social work, nursing and the other allied professions—can contribute to knowledge and services that will offer more hope and optimism for the next decade and century.

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### **Editor's Comments**

Modern medicine and more specifically, Child and Adolescent Psychiatry, are and have to be simultaneously tuned to universality and to particularism.

Both the DSM and ICD systems are rooted on worldwide multisite research in order to standardize universal criteria for each disorder. Every child all over the world will be diagnosed by the same way of observation and rating. A Pakistan autistic toddler is supposed to be similar to his age-mate in Argentina. No one has doubt about the necessity for international classification of disorders as a condition for researchers to communicate, compare their results and finally provide to patients well proved treatments, based on strict diagnoses.

This trend for universality stimulates a tremendous exchange of scholars between countries for research, training and also multinational peer consultations. The development of Telemedicine, mainly for somatic illnesses, is a positive consequence of this universal understanding of disorders. This word, Telemedicine, may be the hottest in development of medicine in the next decade or even century!

Amazing technologies in the field of telecommunication enable exchange of data and knowledge in real time between people living thousands of miles apart.

X-rays, CT scans, MRIs, ultrasound pictures are viewed, analyzed and discussed through video conference between an isolated general practitioner in the African savane and the best specialist in France. A surgeon operating in China can listen to the recommendations and advice of the head of the surgery department at UCSF who is looking right into the operation field and even can maximize it, when the surgeon himself cannot!

These techniques also have been developed for supervising medical treatment of isolated persons who can stay in their homes. The home care nurse "visits" the needy person through his/her TV receiver and is seen by the nurse through two video cameras. The nurse can check the pills the person has to take, show her how to measure her blood pressure

and according to the results, fix the dosage, check her general state, discuss her feelings, have a small talk that is a kind of psychotherapy. If the "visited" person is a child, the nurse or any other caregiver can advise the parents how to cope with difficult behaviors or other disturbances.

Teaching is one of the most important fields of application of these techniques. Every trainee, wherever he lives, can link himself with a teacher giving a lecture, ask questions and receive answers on the spot, discuss with students who attend the same lecture all over the world.

In our field, Child and Adolescent Mental Health, this application can be the first and easiest to promote. We can also imagine, and then organize, a video international conference, where a child psychiatrist proceeds to an evaluation of a child and his family dispatched to several centers around the world. Before concluding he can receive the impressions of all the participants, integrate them, and then conclude with the family and the child. Such a video camera can be installed in a kindergarten somewhere and clinicians and researchers in various parts of the world will observe the same developmental phenomena and influence the course of the observation. That is the difference between telemedicine and viewing of videotapes sent to colleagues. Such experience will increase critical observations, stressing cultural differences, rearing customs, parental functioning, and educational values.

These techniques can be very helpful to differentiate cultural issues with emigrant patients, with controversial diagnoses, with subtle symptoms. Who can imagine assessing a child in front of his mentors and teachers and then debate the issues with him/her. Supervising isolated professionals who work in remote areas will be essential to cover populations in need of mental health support. DSM V and ICD 11 elaborations will be tremendously simplified by this method.

Promoters emphasize the financial interests of telemedicine even though the investment in material and infrastructure is quite high. We see in it an improvement in quality of services and hopefully, more health and accuracy of treatment for all. Your ideas about how to use and develop these techniques will be welcomed in these columns.

We ask ourselves about confidentiality, about patient–doctor relationships, about the psychic aspects in every somatic disease. Our role is to be aware of these dangers and supportive of the advantages. Our role is to initiate acceptable solutions that protect the patient's rights including the right to the highest level of diagnosis and treatment, and the right to confidentiality and choice of physician. These methods can be used only after informed consent. Counselors cannot retain for themselves material broadcast but by specific authorization of patients. In any case, the first line physician remains the only responsible person, juridically and ethically vis à vis of the patient. This topic of confidentiality and its relevance in child and adolescent mental health will be the theme of the permanent symposium on ethics at the IACAPAP Congress in Stockholm. Colleagues who are interested in presenting a paper at this symposium should contact Jocelyn Yosse Hattab who will organize this symposium.

This commitment to universality is the rationale for international organizations like IACAPAP and its International Congresses, and this BULLETIN, too. We dedicate this issue to reports of residents trained in other countries than their own. These reports emphasize the inherent

problem of universality. The tremendous advantages of universality cannot minimize the commitment to particularism and cultural specificity.

Looking closer at ICD and DSM criteria shows us that most of these criteria are highly subjective and even vague. What is a "gross impairment in social skills" or "suicidal ideation" for an adolescent? What is the limit between an energetic child and hyperactivity. The hyperactive child living on a farm in central Australia will be a blessing for his parents through his ability to be aware of every stimulus at the same moment, and a mildly active child is a problem for older intellectual and carrieristic parents. Considering "conduct disorders," street kids of Rio and their families can survive only if they behave as well-diagnosed "conduct disorder." An adolescent who throws stones and participates in riots and the liberation of his country is not necessarily "disordered." Obsessive and compulsive traits are also highly conditioned by culture and social adjustment. Psychotic disorders or features are approached in differently ways in the western world and in so-called "primitive" societies. Respect for differences is even more required in treatment. No one can efficiently and ethically treat every similarly diagnosed patient in the same way without paying attention to his language, culture, and beliefs, in addition to informed consent.

IACAPAP and this BULLETIN are profoundly dedicated to national and cultural specificities. In each issue, we bring a description of child and adolescent mental health services in a specific country. In this issue, Dr. Yanki Yazgan invites us to know more about Turkey. We open in this issue, a new column where colleagues who trained or worked in a country other than his/her own describe their experiences and feelings. We call on those who had such an experience to report it in our next issues. As an international tool of communication, that is the role of our BULLETIN. We call for more such descriptions and discussions on cultural aspects of psychopathology. Toward the Stockholm Congress, and considering debates about the role of our Association, we interviewed our three Honorary Presidents. Their answers must be understood by all child psychiatrists.

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**Trauma and Psychic Development: Perspectives from Risk Studies and  
Developmental Psychopathology**  
**John B. Sikorski, M.D.**

This review of trauma and psychic development was meant to highlight some of the important dimensions in the development of this field and reflect the state-of-the-art of developmental

psychopathology conceptualization in this important and increasing area of distress and emotional disturbance. It is meant to provide a preview of coming attractions in stimulating our curiosity and mobilizing our professional efforts in the clinical work that lies ahead. It is also meant to provide an inducement for participation in the Fourteenth International Congress of the International Association of Child & Adolescent Psychiatry and Allied Professions (IACAPAP) which will be held in Stockholm in the first week of August, 1998. The organizing theme for that Congress is: "Trauma and Recovery; Care of Children by 21st Century Clinicians."

In September 1990, Dr. Irving Philips, then the newly-elected president of the International Association for Child & Adolescent Psychiatry and Allied Professions, and our Director of Child & Adolescent Psychiatry at the University of California San Francisco, appointed the organizing committee for the Thirteenth International Congress which was to be held in San Francisco in July 1994.

As he was my mentor, I could not refuse when he asked me to chair the Organizing Committee. This parenthetically was my own personal experience with chronic traumatic stress within the context of my academic development.

I remember our discussions about an organizing theme for that Congress. We began to examine broad academic and clinical themes and prognosticated about issues that would be most important to our professional work in academic training centers during the decades of the 90s and into the turn of the century.

Finally, the theme emerged and struck our organizing committee with its preemptive relevance as well as dread about its implications for children, families, society, and our professional work and responsibilities.

As you know, the theme of the Thirteenth International Congress was "Violence and the Vulnerable Child," and the monograph for that Congress was titled, "Children and Violence," exploring that theme in its multiple developmental dynamic and cross-cultural perspectives.

During the decade of the 1990s, violence in some form is the everyday experience of peoples around the world, whether in the form of "news" or "entertainment" through the mass media, or through more direct experience as in urban conflict and violence, economic dislocation, racism and ethnic strife, civil warfare, or the seemingly more frequent man-made accidents or natural disasters.

At the same time, the personal experience of victimization through family conflict and neglect, domestic violence, physical and sexual abuse often intensified by alcohol and substance abuse and addiction, provide the context in which the unexpected and overpowering event or incident impinges upon the subjectivity of the individual, overwhelming their psychic defense structure. This, in turn, may lead to some regression, or some forms of re-experiencing the trauma, along with further cognitive, emotional, and behavioral adaptations, or mal-adaptations which further impact upon their sense of self and distort the fragile developmental trajectory.

In the literary tradition, there has long been some recognition that psychic trauma may adversely affect the child's development, as reflected in mythology, folk lore and children's fairy tales. It is of interest to note that the 20th Century was called "The Century of the Child" by the progressive reformers of the turn of the century, who were dedicated to the improvement of the social conditions and education, particularly of those children who were in the charge of public responsibility. It has been during this century that a more scientific study of the effect of trauma on psychic development and symptom formation has occurred. This interest was initially stimulated and informed by psycho-analytic and psychodynamic considerations as reflected in Freud's early formulation of a "stimulus barrier" which could be overwhelmed by an event. Once this stimulus barrier was breached, and the psychic structure overwhelmed, there followed intra-psychic consequences including the triggering of anxieties, memories, and other defensive mechanisms including repression which then may lead to further symptom formation and adverse consequences for development. In the classic study by René Spitz of children deprived of maternal care and affection, he noted that they developed what was called "anaclytic depression" suggesting that the traumatic impact of loss and neglect had disastrous consequences for their development.

During the catastrophe of World War II with large numbers of terrorized, physically sick and injured, displaced and orphaned children, a new dimension of interest in traumatized children was seen focusing on the nature of the traumatic events, the social and environmental conditions, and the parental and caretaker responses to these traumatized children. After World War II, public health concepts, including primary prevention through mental health education and therapeutic intervention for children at risk, began to be developed, to eliminate or minimize the detrimental effects of neglect and trauma.

In the 1970s, the monumental work of John Bowlby on the attachment, separation, and loss, synthesizing psychoanalytic theory and psychodynamic clinical perspectives, was combined with the new understanding of human development, derived from modern biology, ethology, and cybernetics and information theory. This led to a new-found interest in child development research. In the areas of psychic trauma, this research effort led to an exploration of the complex relationships of various traumatic risk factors, and resilient or stress resistant factors, related to either outcome, risk, or symptomatic behaviors. It also led to a more complex understanding of the critical significance which the subjective experience of the traumatic event has upon the individual at the time that they experience the trauma. This subjective experience includes such factors as the degree of intensity, the subjective experience of the stress and helplessness, the cognitive, affective, and behavioral reactions to the subjective recollections, as well as to external events which may be reminders of the traumatic experience.

With the formulation of the concept of Post Traumatic Stress Disorder, derived primarily from studies of adult reactions to stress, particularly in warfare or combat conditions, and the codification of Post Traumatic Stress Disorder in the Diagnostic and Statistical Manual of the American Psychiatric Association in 1980, a further research effort on the effects of trauma on life course and adaptation was stimulated. The DSM-III curiously did not refer to specific diagnostic criteria in children. This omission was not neglected by child psychiatrists and child development researchers who began a burgeoning literature on the effects of various types of trauma on child development and psychopathology.

The early work of my UCSF faculty colleague, Dr. Lenore Terr, focusing on a group kidnapping of grade-school children, as well as clinical case studies of other traumatic

experiences in early childhood, began to highlight some particular differences between children and adults in the subjective experience of psychic trauma and its longer term consequences for development and symptom formation. In 1981 Dr. Terr reported that children tended to experience their trauma in the context of their developmental stage and history of previous experiences. Children also express that traumatic experience in post-traumatic play, re-enactment behaviors, specific fears, time and perceptual distortions, and omen formation symptoms.

These child-specific manifestations of traumatic experience have been included in the 1994 edition of the Diagnostic and Statistical Manual IV, for Post Traumatic Stress Disorder as follows:

A. Exposure to a traumatic event, which;

1. the person experienced, witnessed or was confronted with an event or events that included actual or threatened death or serious injury or a threat to the physical integrity of the self or others;
2. the person's response included fear, helplessness or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently re-experienced in one or more of the following ways:

1. Recurrent and intrusive distressing recollections, etc. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
2. Recurrent distressing dreams of the event. Note: In children, there might be frightening dreams without recognizable content.
3. Acting or feeling as if the traumatic event were recurring, etc. Note: In young children, trauma-specific

re-enactment may occur.

C. Persistent avoidance of stimuli associated with the trauma and the numbing of general responsiveness.

D. Persistent symptoms of increased arousal not present before the trauma.

E. Duration of the disturbance is more than one month.

F. Disturbance causes clinical distress or impairment in social, occupational or other important areas of functioning.

While criteria C, D, E, and F are not child-specific, their manifestations must be present in the child in order to meet the criteria for the diagnosis.

The central importance of the DSM-IV official terminology and classification is necessary not only in providing accurate and reliable clinical diagnosis, treatment, and research, but also

has implications in the forensic area for the legal attribution of negligence, responsibility and compensation in civil liability litigation.

Retrospective as well as longitudinal prospective studies of various traumatic experiences during the course of childhood have, by this time in our knowledge base, clearly established a causal relationship between the experience of childhood psychic trauma, and longer term detrimental effects on personality development, symptom formation and psychopathology, for many symptomatic adolescents and adults. A recent overview of the field of traumatic stress (Freedy and Donkervoet, *Traumatic Stress: From Theory to Practice*, Plenum Press, New York, 1995) noted that in a national probability sample of adult women, the lifetime PTSD rates were 12.3% overall, but rose to 25.8% for adult women who had been victims of abuse or violence at some time in their development. Moreover, post traumatic stress disorder is not the only downstream diagnostic consequence, as significantly higher rates for other diagnostic categories and co-morbid conditions include major depression, anxiety and phobic disorders, alcohol and drug abuse disorders, and personality disorders including borderline and antisocial personality disorder. In addition, the more intermediate term consequences of childhood trauma on adolescence have demonstrated higher rates of risk for the development of borderline psychopathology, aggressive conduct disorders, vulnerability to substance abuse and addiction, higher rates of teenage pregnancy, school dropout, welfare dependency and involvement with the juvenile court jurisdiction for law violations.

Recent studies (Haviland, Sonne, and Woods, *Journal of the American Academy of Child and Adolescent Psychiatry*, 34:8, August 1995) have demonstrated that in addition to post traumatic stress disorder, significant disturbances in object relations, including insecure attachment and egocentricity, and in reality testing, including uncertainty of perception, reality distortion, and delusions and hallucinations, were experienced by adolescents who had been physically or sexually abused. It was also noted that adolescents whose abuse involved sexual abuse generally showed more severe symptomatology than adolescents whose abuse was physical, and that symptoms of alienation and social incompetence were correlated with abuse at an earlier age and by a family member.

In a recent monograph on child abuse trauma, Briere (J. M. Briere, Sage Publications, London, 1992) summarizes the long-term impact of various types of child abuse along three stages:

1. Initial reaction to victimization;
2. Accommodation to on-going abuse;
3. Long-term elaboration and secondary accommodation including abuse-related dysphoria.

Briere also explores major clusters of psychological disturbance experienced by adolescents and adults who had been abused in childhood. These include:

1. Post Traumatic Stress
2. Cognitive Distortion
3. Altered Emotionality

4. Dissociation
5. Impaired self-reference
6. Disturbed relatedness
7. Avoidance

In the past decade, work in the area of infant psychiatry and early child development has highlighted the effects of child mal-treatment on infant development, including the impaired social relatedness and emotional dysregulation which is experienced by the traumatized infant (Osofsky). The impact of trauma and violence on the reciprocal processes of attachment and bonding between mother and infant, and on the attribution and projective identification of disturbed relatedness, along with the disturbed development of sense of self, has been described by, among others, my UCSF colleagues Lieberman and Pawl.

Perhaps the most important contribution to the study of the complexity of human development during the past two decades has been the evolution of the conceptual framework of developmental psychopathology, defined in 1984 by Sroufe and Rutter as, "The Study of the Origins and Course of Individual Patterns of Behavioral Mal-Adaptation." I refer here specifically to the two volume reference text by this title, *Developmental Psycho-pathology*, edited by Dante Cicchetti and Donald J. Cohen, a Wiley-Interscience publication, 1995. Within this larger multi-disciplinary bio-psycho-social evolutionary model, the particular effects of one or more stressors or traumatic events can be delineated and assessed vis-a-vie the child's developmental history, comprehensive social-environmental context, and adaptation efforts and experiences, throughout the developmental trajectory. This framework highlights the interplay of vulnerability and resistance in assessing the impact and consequences of the traumatic experience, and creates the opportunity for more specific rational, preventive and treatment interventions along the developmental lines, appropriate to the specific needs of the traumatized individual at any point in time.

### **Child Mental Health and Child Psychiatry in the Arab World** **Myron Belfer, M.D.**

The International Association for Child and Adolescent Psychiatry and Allied Professions was invited to collaborate with the Faculty of Medicine of Alexandria University to provide the First Academic Seminar on Child Mental Health and Child Psychiatry in the Arab World, October 29 to November 3, 1996. Amira Seif El Din, M.D., Professor of Community Medicine (Mental Health), Department of Community Medicine, Alexandria University, was the moving force behind the development of the course. It was coordinated with her colleagues in Egypt, notably Professor Ahmed Okasha, President of the Egyptian Psychiatric Association and Professor of Psychiatry at Cairo University. The Academic Seminar was supported by the World Health Organization through Dr. Ahmad Mohit, Regional Advisor, Mental Health, Eastern Mediterranean Regional Office, WHO. The Dean of the Medical Faculty, Dr. Ehab

El-Mansy and Professor of Psychiatry, Dr. Adel El Sheshai, provided great support and hospitality.

The academic seminar faculty included Gordon Harper, John Sikorski, Phyllis Cohen, Kyle Pruett, Marsha Kline, Tony Jaffa and Myron Belfer. The seminar took place in a beautiful setting in Alexandria overlooking the Mediterranean Ocean. The course was attended by a broadly representative audience of physicians including pediatricians and psychiatrists, psychologists, social workers, nurses, and school personnel. It was particularly gratifying to have a number of students in attendance.

The course embraced a developmental perspective and covered mental health related issues from infancy to adolescence. Each morning there were one or more didactic presentations followed by questions from the attendees. In the afternoons there was a presentation that focussed on an aspect of the Egyptian experience with child mental health which was followed by group discussions. The faculty served as resource persons for the groups made up of conference attendees. At the conclusion of each afternoon, the groups reported on their prioritization of concerns relevant to fostering Egyptian child mental health training and services. These group sessions served as a mutual learning experience. Course faculty gained a greater appreciation of the most prominent mental health issues faced in Egypt and the Arab world. Among the concerns facing those wanting to develop child mental health services in Egypt are the development of a cadre of trained professionals, access to current literature in a timely fashion, work with cultural differences in the region, and the fear of stigmatization in seeking help. On the other hand, we heard of excellent school consultation and substance abuse treatment programs that were already in place and functioning that could serve as models in any venue.

The faculty and course attendees enjoyed a wonderful graduation celebration at which certificates with signatures from the Regional Director of WHO, the Dean of the Faculty of Medicine and IACAPAP representative were awarded to the attendees. There was a general sense that much had been accomplished both educationally and personally in the five days that the course ran. It was hoped by all that this was the beginning of ongoing dialogue.

The feedback from the course was very instructive for the development of future course offerings in international settings. It was felt that future efforts could benefit from more audiovisual presentations, clinical interviews, and a series of more focussed topics for differing levels of sophistication regarding child mental health. With adequate time for preparation, learning at least the rudiments of the local language would be helpful to both faculty and attendees.

One possible outcome from the course is the establishment of a regional resource center for child mental health at the Faculty of Medicine of the University of Alexandria. Such a resource center would serve as a repository of training materials on child mental health, sponsor future trainings, and search out and establish collaborations in the Arab world to promote child mental health. A formal proposal for such a center has been sent to the WHO and Her Excellency Mrs. Susan Mubarak, the wife of the President of Egypt. It is hoped that IACAPAP can serve a supportive role in the establishment of such a center and in the promotion of child mental health throughout the region.

Editors' Note: IACAPAP grieves the loss of Joseph Noshpitz, MD, a beloved teacher, scholar,

humanitarian and advocate for child and adolescent psychiatry and allied professions

## **A Recognition of Joseph D. Noshpitz, M.D.**

Alan Apter, M.D.  
Chairman, Dept. of Psychiatry  
Sackler School of Medicine, University of Tel Aviv

Sam Tyano, M.D.  
Chairman, Section of Child and Adolescent Psychiatry  
Sackler School of Medicine, University of Tel Aviv

It was with great shock and sorrow that we heard of the untimely passing away of Joe Noshpitz at his home on Tuesday, January 28th.

Prof. Noshpitz was born in New York City and attended the University of Louisville, Kentucky, graduating in 1945 with a medical degree. He served as a medical officer at the 118th Station Hospital, Kyushu, Japan just after World War II, working with patients suffering from radiation illness. This experience and later work with leukemic children deepened his commitment to work in psychiatry and to his belief that "an informed and caring heart could make the difference in human suffering."

Joe Noshpitz received his training at the Meninger School of Psychiatry in Topeka, Kansas. His child and adult psychoanalytic training took place at the Baltimore–D.C. Psychoanalytic Institute where he served on the faculty.

He was chief of the Children's Service at the National Institute of Mental Health where he worked with Fritz Reidel on the residential treatment of aggressive children. Subsequently he was Director of Training at the Children's National Medical Center in Washington, D.C.

Prof. Noshpitz has published papers on subjects as wide ranging as self destructiveness in adolescence, ethics and child development, teenage group pressure, Shakespeare's *Loves Labors Lost*, *Richard the Third*, *King Lear*, *Teenage Mutant Ninja Turtles*, the history of children and mental health in the twentieth century, music, art, dance and poetry, model after school programs and *they Dybbuk*. He also had a fascination with sexual identity in girls and the so-called Tomboy phenomenon.

Joe is widely regarded as the founder of modern child and adolescent psychiatry in Israel. Although other great teachers tried to set up programs here, they were not successful, and it is interesting to speculate as to why Joe was able to put his ideas into practice where others had failed. One obvious reason was complete identification with the task at hand with no concern for his own personal glorification. The first day he came here, he said, "OK, now tell me what you want me to do." He never let us feel patronized or in the shadow of a great physician and teacher (which he actually was). Little by little, however, almost by osmosis, the message sank in; people became inspired and today the profession in Israel thrives as a living monument to his work. All five (!) fellowship programs which he set up in the Tel Aviv area are still going strong. The academic program at Sackler School of Medicine at the University of Tel Aviv founded by Joe in the mid 1970s has expanded by leaps and bounds. The division of child and adolescent psychiatry at the university boasts four full professors of psychiatry—all of whom were students of Joe Noshpitz.

Modern child and adolescent psychiatry has tended to become polarized between the biological–empirical and the psychodynamic understanding of childhood suffering and development. Joe made it his job to integrate these lines of thought and to bridge gaps. This philosophy still remains on the masthead of Joe's followers in Israel. The most popular textbook here is still the two-volumed work, Pathways to Growth: Essentials of Child Psychiatry authored by Joe and Bob King. This book is a model of integrative and authoritative scholarship and just about the only one which still gives the psychiatric fellow the basis for making dynamic formulations while allowing him to keep abreast of the advances in the basic neurobiological and empirical social sciences. In addition, he was editor-in-chief of the encyclopedic and magisterial work, The Handbook of Child Psychiatry. The second edition, The Handbook of Child and Adolescent Psychiatry, published in March 1997 (four volumes) and in January 1998 (three volumes) by John Wiley and Sons.

Fortunately, only a few months ago, Joe was able to make a triumphal tour of child psychiatry in Israel and to see the fruits of his labor planted by him nearly twenty years ago. Professional children and grandchildren now leaders of a profession fully on the mental health map in Israel came to applaud him and marvel at his continued creativity and productivity.

Israel being a Jewish country is a child-oriented society and as such, owes a great deal to the leadership, scholarship, enthusiasm and friendship of this great child and adolescent psychiatrist.

### **Conditions of Psycho-Neurological Help to the Children of Latvia Jewgeni J. Zaltsman, M.D.**

Out of the 538,760 children of the Republic (up to the age of 14 included) 10,991, that is 2.04% of the total number of children, are registered as psychiatric cases as of 1995.

Out of the total number of registered children, 4,111 are children with retarded mental development. Out of the whole number of children with mental backwardness, 3,232 make up the group of children with retardation to the extent of debility. But 879 children are even more mentally handicapped.

Now about other psychical disorders of non-psychotical nature, including the delay in mental development.

To this category of children belong 6,790; that is 61.8% of the whole number of registered children. Children with disturbances in their behavior, with different neurotic symptoms, are included in this group, besides children with delayed mental development.

The number of children registered with a diagnosis of schizophrenia is decreasing. For 1995, we had only 90 children diagnosed with schizophrenia.

The children's ambulatory psychiatric service is provided by 28 children's psychiatrists in the Latvian Republic. They have centers in towns and districts of the Republic.

In the Latvian Republic, there are two departments containing 140 beds for children with psychiatric disorders. These two departments are at the Republican Psychoneurological Hospital in the town of Yelgava. We have also one department containing 30 beds in Riga at

the Child General Hospital, and one department containing 20 beds at the Psychoneurological Hospital in the town of Liepaya. Besides that, there are two more independent children's psychiatric hospitals with 175 beds for children with chronic psychical disorders. The above-mentioned children's departments and the hospitals accommodate patients from the age of three up to the age of 15 inclusive.

Three schools of a sanatorium-type situated in a woodland countryside with accommodation for 400 children function in Latvia. These schools are assigned to children with various psychic disorders. They are all provided with children's psychiatrists. In addition to those schools, we have three schools for children with speech disturbances with accommodations for 420 children. These schools are under the close supervision of the local child psychiatrists. A total of 3,232 children who are mentally backward receive instruction in 42 special schools, at present. We are waging a constant war against the hyperdiagnosis of mental backwardness in children.

There are a lot of specialized establishments for children under school age, among them six children's homes accommodating 940 children in Latvia. There are kids among them from newborn to the age of four with various psychoneurological disorders. The selection of children to specialized preschool institutions and schools is made by committee consisting of children's psychiatrists, defectologists, teachers and pediatricists, and in some cases, psychologists. Before the selection, most children are observed more than once by children's psychiatrists, pedagogues, psychologists to present errors in the directing of children to these institutions.

Latvia also has three homes with accommodation for 505 children from the ages of four to 15 inclusive. These homes are for children with obvious psychic disturbances and mental backwardness.

At the sanatoria at the Riga seaside, we have special children's departments which can accommodate 30 children suffering from logoneurosis and various other neurotic conditions.

What is wrong with us:

1. We have almost no children's psychotherapeutical services because it was not encouraged in the former USSR;
2. every children's psychiatrist has only a minimum of knowledge in children's psychotherapy;
3. neither have we enough children's psychologists and sociologists;
4. we are in dire need of medicines now. We have practically no medicines for curing psychosis.

But we are optimistic and look forward with hope for the future.

Jewgeni J. Zaltsman, M.D., is Chief Child Psychiatrist of the Latvian Mental Health Care Centre.

## **Student Perspective on Anorexia Nervosa and Bulimia Nervosa**

Editors' Note: We welcome articles from students on relevant issues of psychological development and mental health as provided in the present article by a 12-year-old child.

Tassie Hajal

I chose anorexia and bulimia for my report because I thought it would be interesting to learn about. Anorexia and bulimia are two eating disorders, mostly affecting adolescent girls. However, it does affect boys, but a much smaller quantity. It also affects some adults. In the following report I have included information on what parts of the body these disorders affect, what can be done to prevent them, what is the cure or ways to deal with them, who can help, and how the family of an anorectic or bulimic is affected. I have learned a lot by doing this report and hope you learn from it.

What Is Anorexia Nervosa? Anorexia nervosa, an eating disorder, is when a girl gets such an incredible fear of becoming fat that she diets herself until she becomes less than the minimal weight for her height and age. Anorectics can become very depressed. Some of the anorectics who do die, die of committing suicide. The rest of them who unluckily do die, die of malnutrition.

What Is Bulimia Nervosa? Bulimia is also caused by a girl who is concerned about her weight. The girl will binge, or eat a lot and then vomit everything she ate. Some bulimics overuse laxatives, something that loosens your stools, or, bowels. Bulimics do their bingeing or purging in secret. They can become very depressed after bingeing and purging. They will starve themselves inbetween binges.

How Does Anorexia and Bulimia Affect the Body? Anorexia has a major affect on the body. Obviously, the anorectic loses an incredible amount of nutrition. Many of the anorectics who do die, die of malnutrition. With anorectic girls, menstruation usually stops when they get to about over 10% of what they should weigh. After a normal weight is back, it can take 1-72 months for a girl to start menstruating again.

An anorectic's bones also become very breakable. The heart and blood system can be affected, causing the anorectic to startle and shock easily. It is also easy for an anorectic to faint.

Bulimia also has major effects on the body. Bingeing (eating a lot of food and then vomiting) and purging (the overuse of laxatives) can tear the esophagus and enlarge the stomach. Acid in vomit takes away the white part (enamel) of the teeth. The acid in the vomit also causes gum damage. Purging can change the sodium, chloride, potassium levels in the blood. It also decreases women's bone density, which puts the person at a risk to have osteoporosis when they later reach their middle age.

What Can Be Done to Prevent These Eating Disorders? The parents of children have a big role in trying to prevent bulimia and anorexia. It is important to promote healthy eating habits, starting early in life. They must also give their child a good, strong sense of their individual importance and worth. They must give their children high self-confidence and especially high self-esteem.

What is the Treatment for Anorexia and Bulimia? First, when someone's parents think their child is anorexic, they should take the child to a physician or doctor. There, if they are definitely anorexic, they will be hospitalized. In the hospital, their weight will be brought up by special liquids (one kind called Sustecal). They will also be given appetite pills, and anti-depressants. In the hospital, the patient would have four different kinds of therapy. Individual therapy (the patient alone), group therapy (with other anorectics), family therapy (therapy with the family), and behavior therapy. Behavior therapy is when if the patient reaches a certain weight, they will get a special reward or privilege. If they do not get to that certain weight by a certain time, they will get something taken away, like use of the phone, allowance, or going out with friends.

When a parent thinks their child is bulimic, they would take him or her to a doctor or physician first. If it is a very severe case of bulimia, they may be hospitalized, but bulimics are usually cured at home. Laxatives would be taken away from the bulimics and thrown out. A bulimic would also go to a therapist. They would have the same kind of therapy as an anorexic would have, family, group, behavior and individual. Bulimics are also given anti-depressants.

Who Can Help With These Eating Disorders? Many different people can help cure an anorectic or bulimic. All different kinds of doctors: physicians, psychiatrists, psychologists and therapists. Nutritionists also help. Support groups and hotlines can help very much. And, of course, loyal friends and family members help tremendously.

How is the Family of an Anorectic or Bulimic Affected? The family of an anorectic or bulimic is definitely affected. Families are incredibly worried about the anorectic or bulimic. They become obsessed and controlled by the child. All attention goes to the bulimic or anorectic, and other siblings begin to feel neglected and resentful to the other child.

Conclusion. I have learned so much from doing this report on anorexia and bulimia. I never knew how much it could affect the family, and how dangerous and damaging these disorders really are. I think that it is good there are so many people who can help, but I hate the fact that more adolescents are dieting and so concerned about their weight and appearances.

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#### **Honorary Presidents' Remarks**

Editors' Note:

Honorary Presidents of IACAPAP were asked to comment on their past and current ideas about our association as noted below. Questions that we asked focused on their goals and dreams when IACAPAP was in its early stages; the role of IACAPAP as a scientific, professional, and advocacy group; the relations between child and adolescent psychiatrists, neurologists and pediatricians; the role of IACAPAP in training mental health professionals; and future dreams and expectations of IACAPAP.

Gerald Caplan, M.D.

I wanted to found our International Association as a mutual-help group of national child psychiatry societies that would help each other promote the development of child psychiatry training and organization in their own countries. We hoped that at our four-yearly congresses we might share information from which our members might profit in stimulating research and program development. Some of us were promoting the philosophy of involving members of other professions, such as psychology, social work, pediatrics, and nursing, in our work in taking care of psychologically disturbed children, and we wished to persuade our colleagues in other countries to accept these other professionals into their institutions and societies as equals, despite the emphasis on "psychiatry" in our name. Our international association provided a forum for discussion on this issue. We hoped that it would also offer guidance and support to colleagues in countries where there was no organized child psychiatry, to develop along multidisciplinary lines. I feel that these goals have been amply realized.

The present leaders of our Association are indeed developing it as an advocacy group pushing for changes in line with their understanding of system similarities among services that differ in their details from country to country, as in the recent Venice Declaration. This is a natural development in a well organized international group, once its primary goals have been achieved and leaders realize the political potential of access to data coming from a large membership that allows comparisons in widely differing settings. I have no personal experience in working at this level, and I continue to devote myself to working in the primary field of dealing directly with the needs of disturbed children, which includes working as a clinician not only in treating those who have become sick but also in trying to remedy those factors in their families, schools, communities, and service networks that increase the risk that currently healthy children will become disturbed. It is important that the cross-system programs being advocated should be based on validated practice at the local level rather than on theoretical abstractions or ideological fashions, so I hope that our Association will continue to foster both types of activity.

Despite the obvious overlap, I feel that the primary concerns of psychiatry and neurology are sufficiently different that there is merit in continuing them as separate professions. We should continue to devote a lot of effort to strengthening our relationships and in building working partnerships with these other professions. Particularly, those of us who are interested in the field of preventive child psychiatry, may well work within the framework of pediatric, educational, child welfare, or family law courts, rather than inside our own clinical base, in order to build partnerships with our colleagues that aim to achieve a professional amalgam that would be hard to obtain by each restricting ourselves to our separate traditional setting. We will never have enough specialists in Child Psychiatry to satisfy all our needs. We should bring our work to the attention of medical students and young health professionals by working in teaching hospitals.

In 1990 I was invited to lecture at the Annual Meeting of the American Psycho-

logical Association, and the following year, I was honored by a similar invitation to give a guest lecture at the Annual Meeting of the American Psychiatric Association. At these meetings I was surprised and tremendously gratified to discover that my writings over the years have had a great influence in molding the practice of many psychologists, adult psychiatrists, and community mental health professionals, in addition to the child psychiatrists who were my intended readers. I hope that over the coming years I will succeed in completing my study of the techniques of primary preventive child psychiatry in our Jerusalem program that focuses on children of divorced parents as an example of intervention in a high risk population.

I hope that many of you will become committed to pioneering in the clinical practice of child psychiatry. I hope that some of you will, after you have learned your profession, venture forth and spend part of your time in schools, in pediatric, orthopedic, and general medicine departments of hospitals, in public health centers, in child welfare agencies, and in law courts, where the vast majority of the child population are to be found, and not spend all your time in the safety of your child psychiatry clinic or department, where you feel comfortable because you are in control.

Serge Lebovici, M.D.

I was not a member of the first International Association of Child Psychiatry, before WWII, but I was present at each congress after London in 1948. My first Congress at that time was joining with Congress of Mental Health. I was very happy because after Toronto, our Congress became independent. In Lisbonne, I began to be involved in the working groups and lucky enough to work with Gerald Caplan, our eternal treasurer, but in fact, the real animator of IACAPAP (Cf. the book we edited; G. Caplan & S. Lebovici "l'abord psychaitrique de l'adolescence"; "Psychiatric Approaches to Adolescence", 1966, Amsterdam, Excerpta Medica).

In Edinborough, after having been Chairman of the program committee, when John Bowlby was President, I was elected as the new president and Professor Didier Duche as the general secretary. We had in charge the organization of the Jerusalem Congress (1970).

It was a realized dream to be a president of IACAPAP: I was helped a lot by Gerald Caplan, but unfortunately not without conflicts with university professors and himself. I remember the time when I was elected as vice president and my boss, Georges Heuyer, climbed on the platform to announce that I was not representing the Chair of La Salpetriere.

That is how I learned that a president was meant to keep the international community interested. It did spoil my dreams a little, but I was able to play a fair part in the administration of IACAPAP, in accomplishing my task as a president, in organizing a good congress, and leaving my seat in a reasonable state to my successor, James Anthony. I did, amongst other things, initiate the biannual book which came before the present monographies: every other year, a book was published in English and in French. It either reported the meeting of the executive committee, or special articles initiated by a special meeting or in a specific region of the world, or was dedicated to the various papers

presented at the congresses. Let me remind you that the first editors were James Anthony and Cyril Koupernik (who was later replaced by Colette Chiland).

My dreams were eventually fulfilled, and I have been able to supervise at IACAPAP the follow-up of the work I had initiated.

I consider the future in child and adolescent psychiatry as defined by the problems concerning the infant and the adolescent. IACAPAP is, by the way, the only international organization able to follow the children from their conception up to adolescence in a developmental process. The infant is obviously an important element in the psychiatric options of mental health, considering that they are the victims of the socio-cultural conditions deriving in most cases from the mother's migrations and loneliness. The same conditions apply to the adolescents who, in the large cities' ghettos associate with bad people in order to eliminate etiologic conditions.

I consider the role of IACAPAP as mainly scientific and professional. However, cases may happen such as wars and genocides, which influence the fate of children as victims of the facts or as witnesses to murders, even the murders of their own parents. These conditions call for a recording of the facts and for helping the populations concerned: the ONG must partly reconsider their program and make more use of local resources. The CEDRATE unit of the CIDEF has recently organized a symposium on "The Child and the War Stories." Donald Cohen took part and was extremely interested, as far as I know, by what he saw and heard there.

The contribution of neurobiological and psychobiological sciences to the psychopathology of the child is unquestionably of great importance. But man cannot be reduced to the functioning of his brain. My personal experience is totally in favor of the psychopathological approach and cannot tolerate the hegemonical tendencies of the neuro-pediatricians.

One must take account of the dynamic psychology. The notion of handicap, leaned upon by too many families who try to avoid contact with the psychiatrist, must be revised. As proposed by the OMS, the handicap is the disadvantage which comes with every disability or injury, and it must be submitted to a precise evaluation, in order to limit as much as possible the consequences of the bad luck linked to the happening of the troubles.

Finally, how could one accept the idea of the child psychiatrist's task reduced to filling questionnaires defining the "scales"... This method is interesting by its epidemiological aspect and if one wants to measure the effectiveness of on-going treatments, but it does not reduce the importance of psychopathology.

The relationship with pediatricians is very important, mainly as far as the mental health of the infant is concerned. There are psychiatrists who have no somatic knowledge of an infant or a young child. It would be good for them to work with pediatricians. The latter have interesting methods of observation, namely in the families, and it is therefore quite obvious that child psychiatrists have a better knowledge of pediatrics.

It is therefore important to establish a modus of cooperation with the pediatricians, under the condition that the tasks have been clearly specified. This does not prevent a psychiatric formation of the pediatrician. As the psychiatrist has to intervene under worse conditions than the pediatrician, it may happen that the consultation of the pediatrician may end up with

the proposal of a consultation at the psychiatrist. Not only can the pediatrician give useful advice, but he should, together with the general practitioner and the gynecologist, play a role in the development of parenthood.

In child psychiatry, the team has to hold together quite tightly, but without anyone feeling condemned to a too limited role. We must all talk a language understood by all, and the psychiatrist, especially if he is a psychoanalyst, should not misuse his superiority in the field of the language.

This is implied in the very name of the IACAPAP, which concerns the affiliated professions as well. The teamwork has, however, received so many praises that it must be criticized somewhere. If everyone keeps a purely professional attitude, and does not get out of it, things begin to be dangerous and too hierarchical. Some people want to do everything, and it is very hard on the families. Martine Lamour and I have realized a film on teamwork in cases where the child was a victim of his own family and where justice had to interfere. This film reminds that protagonists have a tendency to identify too often with the parents or the child and cease, therefore, to play their role.

The importance of child psychiatry in the future is that psychiatrists have to give a hand to pediatricians and many other specialists have to help the family who suffers from the presence of ailing children, or of children who are about to die. The training of accompanying persons is absolutely necessary.

It is my hope to be able to follow, during the coming years, my research on the psychopathology of the infant, thus maintaining the presence of a "French-style" psychopathology: in this spirit, multimedia documents and a CD-ROM are being produced and their translation should be realized under the aegis of the association, "A l'aube de la vie."

I remember that at a meeting of the executive committee of IACAPAP, I met for the first time Donald Cohen in Dakar. I was impressed by the use he made of the word "stress" when expounding his research on the traumatic character of certain circumcisions. "Stress" is a word too vague to cover everything. To wit: the notion of post-traumatic neurosis after stress is a notion that cannot be used in practice. Every case needs a precise psychopathological description. This has been clearly seen in the answer to the question about genocide.

I hope that IACAPAP will carry on its positive action, as it has done for many, many years, without forgetting underprivileged countries or countries which have provided such an outstanding contribution to the progress of the psychopathology of the infant and the adolescent.

Albert Solnit, M.D.

Although I was not a founding member, I became active in IACAPAP in 1970 when I participated in the Jerusalem Congress. At that time James Anthony asked me to be the Secretary-General and Chairman of the Program Committee for the 1974 Congress in Philadelphia. My dreams and goals were and have been the achievement of an international scientific and collegial forum by child psychiatrists and the allied professions in the service of

advancing our knowledge and our understanding of and priorities for children of all ages and cultures.

The necessities for Child and Adolescent Mental Health are to find a process that will increasingly assure each child of: the continuity of affectionate care; of being protected and insulated from violence; and of establishing an international authority that has sufficient capacity and authority to be able to use information and financial grants to persuade national groups to guarantee each child adequate food, health care, education, and their fair share of each state's economic resources. To my mind, seeking better knowledge and priorities for children requires IACAPAP to work as an advocacy group for peace and the goals I have outlined above.

The unification of Child Psychiatry and Child Neurology is not desirable at this time for many reasons, including: (a) we are an organization of child psychiatry and the allied professions, most of which are not involved in the domains of brain research and clinical neurology; and (b) the two fields can continue to advance their own areas of interest while collaborating selectively by remaining where they are now in their missions, priorities and training activities. Furthermore, pediatricians have always been welcomed and helpful to IACAPAP. They are one of the significant allied professions. The same is valid for family physicians and other physicians who are directly or indirectly interested in children. Nurses are especially important.

Each country could benefit from putting more emphasis on training medical students in child development and in exposure to children during the clinical years. It is my impression that there are not a sufficient number of medical students aiming for child psychiatry training. This question again raises the powerful and important question about how child psychiatry and the allied professions constitute in aggregate our mental health or behavioral health resources in the service of children. If we focus only on child psychiatry vis a vis person power, are we sending the right message? Also, this questions cannot be approached without taking into account the needs and priorities of children's physical as well as developmental and mental health. They are interdependent.

From a personal perspective, the most important or central accomplishment in my career has been to help prepare two generations of leaders in child psychiatry and the allied professions; to increase our awareness and understanding of crises throughout the life cycle; and to call attention to the importance of understanding health as well as illness. Knowing that our work will never be finished, it is important to me that our efforts be sustained in good and in bad times by the vitality and strength of the younger leadership and membership.

**A Brief Memory of Professor  
Joseph D. Noshpitz, M.D.  
Natalia Trenchi y  
Miguel Cherro Aguerre  
Atlántida, Canelonca, Uruguay**

We had known him for many years. We had read his books and articles since studying to become child and adolescent psychiatrists.

In 1994, during the IACAPAP Congress in San Francisco, when we were attending a pre-congress activity organized by WAIMH, a conspicuous white-haired man sat beside us. We noticed that everybody heard his opinions with evident respect. As all of us, he was wearing a badge with his last name written in large letters.

Natalia read it and asked me, "Could he be 'our' Noshpitz?" She meant the Noshpitz we had read so many times: the one of the books and articles. In fact, we had just read his "Pathways of Growth."

Precisely, he was "our" Noshpitz.

When we introduced ourselves, he showed great surprise of being read so much in our country. Being so polite and friendly, he became interested in Uruguay, our work, and us personally. We asked him to visit us and he accepted right away.

During the IACAPAP Congress, we kept talking as we shared different events. It was during the farewell party at the Museum of Asian Art that we had the chance to meet Charlotte, his wife. They made a charming couple, lively and joyful.

We met again in 1995, at the ISAP Congress in Athens. A few days later, Joseph and Charlotte came to our country as guests to the Psychiatry Congress. "The Uruguayan Adventure" had it all, even annoying misfortunes that were overcome with an excellent sense of humor on his part.

We spent unforgettable moments with them and Aida and Floreal Loy, both in Montevideo and Punta del Este. Joe loved life and took pleasure in what it offered him every moment. He made us stop to enjoy a sky full of stars in spite of the cold all of us but him felt at the Yacht Club deck. And he dared to touch the sand with his feet, defying the severe Uruguayan winter. We all appreciated his joviality, his fine sense of humor, his culture, his fraternity.

We became friends sharing stories, confidences, and jokes in English, French, and Yiddish, the language he rescued from his memory in order to communicate with Floreal. We were so close that we could even call him "Pepe," the way all Josés are called in Spanish.

After this nice visit, we corresponded extensively. We really enjoyed every letter we received. Due to his great management of the language, he communicated in a spontaneous and simple way, with a fine poetic register full of precision, warmth and humanity.

We were really happy when we met again in 1996 in Tampere, Finland at the WAIMH Congress. That would be our last time together. Joseph participated with us in the ISAP Symposium, and modest as usual, presented his topic, "Idealization." He was so kind that he gave it to us to be published in Spanish in one of our scientific journals.

The Noshpitzes invited us to have dinner with them, and we left our agendas aside to share that moment with which they were honoring us. We met at the door of Tampere Hall, and we videorecorded them, Joseph sending an enjoyable greeting in Yiddish for the Loys in Montevideo.

We walked together to the Lutheran Cathedral where we appreciated the decoration and enjoyed an organ concert. After the concert, while we were looking for a restaurant, Joseph perceived that Charlotte was cold. He automatically took off his coat and offered it to his sweetheart, who accepted it knowing she was well cared for.

That last dinner, we could rejoice once again with Joseph's great stories. As usual, there was good humor, the pleasure of being together, and Joseph's wise remarks.

In the midst of anecdotes, jokes and laughter, he made this reflection about infant psychiatry, "It is the most relevant of all the sciences. What would all advances of other sciences, computers, and space travels be worth without the human being? Our discipline deals with obtaining better human beings...and we are closer to achieving that goal each day."

After dinner, we walked with them to their hotel. When we arrived, they insisted on walking with us to the corner so they could see us get to ours. We laughed at the absurd idea of accompanying each other forever. We said goodbye, with fraternal love.

Today, February 5, 1997, we are on vacation some miles away from Montevideo. We almost never go back to our home town, but as if it had been predetermined, we had to return to find out, through a fax from Michael Kalogerakis, of the sad news. Joseph had died some days before.

The Noshpitzes had invited us to Washington, their beloved home town. We were excited about the idea and tried to make arrangements to take the trip. But reality changed our plans abruptly. However, love and memories bring us the hope that in some blooming spring, we will be there and meet Joseph again, "our" dear Noshpitz, "our" dear Pepe, to continue a dialog that should never be interrupted.

### **Child and Adolescent Psychiatric Day Care and Inpatient Treatment in the Netherlands**

Editors' Note: In planning for coverage of issues about psychiatric and health care services at our IACAPAP meeting in Stockholm, we feature articles on this topic such as the following:

F. Verheij

Psychiatric inpatient treatment has evolved in part out of the necessity to remove the most severely disturbed children from their families and community. Until the 1930s, there were no real treatment possibilities and treatment strategies. Diagnostic frameworks didn't appear until the 1960s and 70s.

Until the 1960s, the child psychiatric diagnostic and treatment practice had been widely differing. In the late 1970s and 80s, the balance could be made because of: better assessment and diagnostics; a biopsychosocial or multi-axial framework in which biology and environment in an interactional unit; knowledge about an effective multidisciplinary working model in which the disciplines are equal, but not the same; models for cooperation with parents, families, schools and outpatient colleagues; indications for psycho-pharmaceutical intervention; and (first) methods of evaluation.

These alternations, together with a period of great economic welfare, produced a rapid rise in child psychiatric inpatient services in countries like the United States, Great Britain and the Netherlands.

An overview of the professional literature of the 1990s shows many inconsistent and contradictory points of view about inpatient and residential treatment. One of the reasons behind this diversity are the radical choices, made by the governments of the United States and Great Britain. In a period of economic decline, these governments withdrew funds, with a crumbling infrastructure of care and a decline of the non-profit agency as results. In these countries, inpatient child and adolescent psychiatry has been limited to crisis-oriented diagnostics and treatment.

In the Netherlands, since the early 1980s a different development took place. Although there was an economic decline, fortunately, the government saved a place for mental health. She started a dialogue with the management of the child and adolescent psychiatric inpatient institutions.

In my country, since three decades, the Department of Health and Welfare legislates which institutes or parts of institutes are child and adolescent psychiatric hospitals. Also, for other kinds of institutions, like the ones for mentally retarded, such legitimations exist. In the Netherlands there is a clear distinction between child and adolescent psychiatric units and hospitals, and the explicit non-psychiatric treatment centers. The just mentioned dialogue has created a national professionalization of the field:

Each health region (with one to one and a half million inhabitants) ought to have one institution or several institutions which intensively cooperate to fulfill six basic functions: outpatient diagnostics and treatment; day care observation and treatment; inpatient observation; crisis intervention; short-term patient treatment; and long-term inpatient treatment.

Specific functions will be distinguished. The functions are too specialized to be organized for just one health region, and ought to be organized for several regions or national: long-term care and treatment of autistic youth; psychiatric treatment of mentally retarded children and adolescents; psychiatric treatment of deaf children and adolescents; treatment in accordance with the therapeutic community principles.

Capacity for children and capacity for adolescents have been redivided. False rations have been removed, while a new capacity for infants was created (especially in day care). At the end of the 1980s and in the middle of the 1990s, limited growth of the capacity has been permitted with circumscribed goals: to complete the basic functions in each health region; to start child and adolescent psychiatric institutions in the three regions without such care; to start day treatment in psychiatric centers without this function; and to create treatment facilities for adolescents who, because of their aggressive behavior in combination with several other problems, are difficult to treat, and facilities for the involuntary treatment of adolescents.

At this moment, a small but differentiated network of psychiatric services for children and adolescents is the result of the aforementioned policy. The following illustrates these issues for: four million children and adolescents; when all the permitted capacity is operative: approximately 1100 inpatient places (children:adolescents = 6:4) and 300 day care places

(infants and children:adolescents = 2:1); 28 institutions, there are health regions with one child and adolescent psychiatric center; also there are regions with two, three or four centers which complement each other, and which cooperate intensively.

A differentiated network with a limited capacity, as a consequence encompasses the need for selective use of this capacity. Worldwide, we are about to understand that diagnoses and diagnostic categories are not the key to child or adolescent psychiatric treatment. A combination of factors creates the child or adolescent psychiatric patient. Recently, I have tried to formulate my view on these factors: the degree of problems within each of the life domains, like individual functioning, functioning as a family member, as a peer, at school, and in sports and free time; the degree of problems within each of the developmental domains, within the biological, cognitive, emotional and social domain or (in case of a part of the adolescents) the severity of the (adult) psychiatric disease.

Children or adolescents who need psychiatric day care or inpatient observation or treatment are most times difficult because of combinations of problems within all or nearly all of the just mentioned domains. Turning around the places of observation and treatment can be formulated if: there exists an indication for day care or inpatient psychiatric observation if longitudinal diagnostics throughout the life and developmental domains is an urge; there exists an indication for day care or inpatient psychiatric treatment if there is a multiproblem child or adolescent with treatment perspective, which treatment needs a highly professionalized multidisciplinary team coordinated by a child and adolescent psychiatrist, because of the need to structure the treatment from a biopsychosocial perspective.

Until now, I have written more about the different psychiatric functions than about the differentiation of care because of age. The capacity is subdifferentiated as follows:

Infants: The favorite programs are outpatient diagnostic and treatment, and day care observation and treatment. At some places, family day care or residential observation and/or treatment is possible. Inpatient observation and treatment is scarcely needed.

School Aged Children: Emphasis is on day care and residential treatment of children with severe developmental multi problems. Inpatient observation of maltreated children and there is rarely a need for psychiatric crisis intervention. There is limited indication for day care or inpatient observation only.

Adolescents: The emphasis is on (day care and inpatient) observation, on crisis intervention and on short-term treatment. There is limited long-term inpatient capacity for (chronic) psychotic adolescents and severely behavior-disturbed adolescents and limited long-term inpatient capacity for neurotic adolescents who are motivated to explore their problems.

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**Child Psychiatrists in Turkey: only 35 for ten million children and adolescents  
M. Yanki Yazgan, M.D.**

More than one-third of Turkey's sixty million population is "child and adolescent." Turkey may be known to many as a tourist destination or a country caught in an escalating

political/economic turmoil. Beyond these impressions, life for ordinary people in Turkey has its own twists. It is "like a Turkish film." An Israeli friend told me that this expression is used in Israel when life seems to be an infinite series of coincidental and accidental sufferings and miseries, and recoveries from these miseries. In the films, misfortune seems never to end for ordinary people, lovers love each other from a distance, and things become stable only after long, chaotic times. Most of the children and adults survive through all these "sufferings" with a hard to imagine capacity for adaptation and resilience. Real life is much like these films.

Turkey experienced significant changes in its social texture in the last 75 years. Following an expedited Westernization in the 1920s, rapid social and economic changes starting in the 1950s have forced migration from the rural areas to urban areas, changing the nation's urban/rural population ratio upside down (i.e., 70 vs 30 percent). Health care systems, traditionally divided between government-owned hospitals and private offices, did not match the needs of the society and became increasingly disabled and inadequate. Despite increasing efforts since the 1960s to improve the health care system, especially for children and mothers, frequent policy changes as well as growing economic and social problems have taken away gains made in child and mother health. By the 1980s, infant mortality rates dropped to 63 per thousand babies (from 154 in the 1970s); immunization rates rose to 90%. The number of medical schools (29 in 1994) and the number of medical school graduates (~5000/year) also increased significantly. However, gross national product increase and its distribution could not yet match these numeric goals, and the numbers may not fully represent what is delivered. Health care services are still unevenly distributed among different social sectors.

Mental health needs of children have not been addressed in official health plans at all. Consequently, child psychiatry has remained as a low priority field. A vast majority of children and adolescents do not receive any mental health services at all. Is child psychiatry and child mental health unknown to policy makers? Child psychiatry in Turkey, at least as a concept, may be dated back to the establishment of the first child protection agency in 1911. At that time, clinical care for children with behavioral and emotional disorders existed as a field of interest among neuropsychiatrists (the official title for combined training in both disciplines). One can see the name of a historic Turkish figure of those times (Dr. F. K. Gökay) among the IACAPAP founders. Despite that relatively long "practical" history, it was not until the 1960s that child psychiatry was considered for recognition as a psychiatric subspecialty and an academic discipline. A few child psychiatrists including Drs. M. Öztürk, A. Yörüko?glu, R. Cebiro?glu, who had received their training in the USA in the 1950s and organized academic divisions in Ankara and Istanbul, led these efforts. Increased public awareness of child mental health paved the way for official recognition while child psychiatrists could make an impact on public opinion about children's behavioral and emotional problems. Dr. A. Yörüko?glu, one of the leading figures of child psychiatry in Turkey, was so popular in urban households, his books sold hundred of thousands of copies and his face on TV screens was known to many children as the "behavior doctor."

Child psychiatrists have almost exclusively worked in medical schools and teaching hospitals (i.e., public sector), and despite the official recognition which came almost three decades ago, the number of trainees in child psychiatry remained negligible. The total number of child psychiatrists who are affiliated with the Turkish Association of Child and Adolescent Mental Health is reported to be 35 (as of 1/1995), including trainees. Currently, there are ten academic divisions of child psychiatry in medical schools. The leaders of child

psychiatry have been concerned about not having full access to personnel and financial resources. Until recently, child psychiatry trainees were recruited from a pool of psychiatrists who have completed at least four years of training in general psychiatry (which includes a six-month child psychiatry rotation). As a result of complex interactions between the academic and government regulations of residency training regulations, child psychiatry programs have started selecting their trainees directly among medical school graduates through the national matching examination. Child psychiatry residency training currently consists of 24 months in child and adolescent psychiatry, 18 months in general psychiatry, and six months in child neurology. A certification examination takes place at the end of the training period. This pathway is expected to shorten the total training time from at least six years to four years, and increase the appeal of child psychiatry. Psychiatry's popularity has increased among medical graduates during the past decade. Psycho-dynamic concepts as well as social approaches to mental illness have attracted significant interest among the new generations of psychiatrists. Child psychiatry with its wide ranging treatment repertoire represents the "other" aspect of psychiatry to many psychiatry residents who admit disappointment with underemphasis of psychodynamic approaches in their training programs. Thus, child psychiatry, not necessarily by choice, has come to represent a more "balanced" understanding of mental disorder, and become an attractive specialty.

These positive perceptions of child psychiatry in Turkey have not helped it grow faster, and reasons similar to elsewhere might well have played a role in its being held back. A few significant specific problems exist in Turkey. First, child psychiatrists are almost alone in dealing with problems. The number of clinical child psychologists, social workers, school psychologists, special education teachers, and child therapists is very small. Second, the existing potential is not used to its full extent: service systems are not connected with each other, collaboration between different care providers is hard to establish and maintain, mostly due to bureaucratic obstacles. Third, and perhaps most importantly, child mental health is not on the immediate agenda of health care policy makers.

Thus, a child psychiatrist in Turkey usually, if not always, has to assume a wide range of responsibilities in clinical work. These may range from being a patient advocate to being a teacher, in addition to the classical role of physician. A child psychiatrist works as a close ally to a patient's family, although not always a potent one. Family systems which play a significant role in clinical work with children appear to remain relatively intact despite profound changes in the social texture. The planning of health services for a huge majority of people in Turkey will depend on public resources allocated by government policies, at least in the foreseeable future. Children's mental health needs still do not have high priority in those policies, and a child psychiatrist shares the patient's and their familie's status on those priority lists. The child psychiatrist also shares with them a taste of "Turkish films," in which things come to a happy resolution by their "internal dynamics," i.e., spontaneously or beyond the individual's control, allowing the viewer to leave the theater in an optimistic mood. The belief in resilient and adaptive capacities of individuals is still there. The next step appears to be going beyond what they and their patients are offered.

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The Influence of Athletic Involvement on Psychosocial Development

Editors Note: Medical students' perspectives on health and illness provide fresh insights about promoting psychological development of children and adolescents as the following outline illustrates.

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Emphasis on sports in American culture is easily appreciated. Buy a daily newspaper, watch the evening news, turn on the television on a Sunday afternoon, or visit a local high school to witness sports obsession first-hand. Children receive early exposure and opportunities to join athletic teams are available as soon as walking is mastered. How does this influence psychosocial development? The answer remains unclear, as the field of sports psychiatry is in its infancy. Personal experience and observation, however, have shown me that athletic involvement in childhood and adolescence can positively impact normal psychosocial development.

According to Erik Erikson, children experience "Autonomy Versus Shame and Doubt" (Erikson, p. 251) during the first years of life. They learn the extent of their physical capacity in the environment and rapidly develop coordination through play. "From birth to approximately three years...the future athlete discovers the body's potential as an instrument of pleasure, experiment, and discovery." (Begel, p. 607) Caregivers seek activities to channel the physical energy and curiosity which characterizes this phase. My mother regularly takes my two-year-old nephew to a playground where he has been climbing ladders, swinging, crawling through tubes, and sliding for a year now, becoming more steady in his execution of these tasks each day and loving every minute of it. This "athletic" activity is establishing a foundation of confidence in his body that will enable him to expand exploration of the environment for years to come.

In the next developmental stage which is characterized by "Initiative Versus Guilt" (Erikson, p. 255) competitive drives emerge. With motor coordination now established, sporting events are the ideal arena for their healthy expression. A home movie of a race between my brother and me around our swimming pool is a perfect illustration. I was four and riding a tricycle, and my three-year-old brother was peddling a toy motorcycle. My brother was the faster competitor but stopped and waited for me each time he discovered himself in the lead, only to resume peddling once we were together again. In the end, he fatigued from the starting and stopping, and I raced to reach the finish line first, never looking back. My brother was happy simply sharing an activity and practicing his skills while I with my competitive striving desperately needed to vent aggressive feelings toward my sibling rival. I was able to do so constructively through healthy competition, avoiding the guilt which may have arisen had my aggression been expressed with my fist. (Kaplan and Sadock, p. 262)

During elementary school when the conflict to be resolved is "Industry Versus Inferiority," (Erikson, p. 258) participation in organized sports encourages continuation of healthy psychosocial development. "Industry [is] the ability to work and acquire adult skills," (Kaplan & Sadock, p. 262) most of which can be mastered playing on an athletic team. Taking part in sports requires a work ethic similar to that needed in the adult workplace: practices and competitions are scheduled regularly, attendance is required to remain on the team, and teammates and coaches expect maximum effort from each player, leading to a sense of loyalty and responsibility. Interpersonal conflict resolution is also learned as rivalries inevitably arise, and the child eventually becomes a "team player." Finally, the

importance of goal-setting is appreciated, and the gratification of achieving as well as the pain of falling short of goals is experienced. Similar events occur in the adult workplace; early lessons in dealing with them can only help.

As a former competitive swimmer I learned all of these lessons, and I continue to apply them in my career in medicine. Friends who are former athletes report similar appreciation for the psychosocial growth which occurred through youth athletics. And in a Pennsylvania town called Burwick which was recently reported in the New York Times for its football record of 272–52–4 in 26 seasons, "football is family...a tough game played by touch boys who have been taught by their fathers and grandfathers the value of hard work." (Longman, p.B23) A teacher elaborated, explaining that in Burwick, "kids were instilled with the work ethic of their parents...they knew that if they were going to succeed, they had to work hard and that if [they] put in a good day's work, [they]'d be rewarded whether it was on the job or on the football field."(Longman, p. B23)

The final state of development which athletics influences is adolescence when "Identity Versus Role Confusion" (Erikson, p. 261) is the central conflict. Erikson explains in his book Childhood and Society, that

The growing and developing youths, faced with this physiological revolution within them, and with tangible adults tasks ahead of them are now primarily concerned with what they appear to be in the eyes of others as compared with what they feel they are, and with the question of how to connect the roles and skills cultivated earlier with the occupational prototypes of the day. In their search for a new sense of continuity and sameness, adolescents have to refight many of the battles of earlier years, even though to do so they must artificially appoint perfectly well-meaning people to play the roles of adversaries; and they are every ready to install lasting idols and ideals as guardians of a final identify...It is an ideological mind—and, indeed, it is the ideological outlook of a society that speaks most clearly to the adolescent who is eager to be affirmed by his peers, which is ready to be confirmed by rituals, creeds, and programs which at the same time define what is evil, uncanny, and inimical. (Erikson, pp. 261, 263)

Participation on an athletic team can provide healthy identification and ideology as well as adult guidance during this tumultuous stage. My idols in high school were Olympic swimmers, and the people with whom I identified were teammates. We wore the same clothing most of the time (team uniform), followed the same rigorous practice and competition schedule, and attended social events together. This support from like-minded peers enabled me to feel secure in my identity yet content to feel unique among high school friends not involved in swimming during this time of great need for sameness. In fact, I enjoyed feeling special as a part of a winning team which was idolized by peers not on the team.

Coaches are also commonly idolized by their adolescent players, and they can be a valuable source of adult guidance at a time when parental rebellion is at its peak. For example, the Berwick football coach is described in the New York Times as "a bulldog of a man, profane, religious, given to strict rules and no nonsense. Players have a 10 o'clock curfew on school nights. When they score a touchdown, they are expected to hand the ball to the referee or set it on the ground. A sign in the weight room says: 'No earrings are allowed in here. This is a men's locker room.'" (Longman, p. B23) This enormously successful coach is a hero in the eyes of the Berwick football players, and as a result, he is

able to provide his teen players with the ideology they seek as well as some structure to potentially chaotic lives.

Furthermore, involvement in athletics in adolescence can keep substance abuse to a minimum. Often the group of identification during adolescence revolves around drugs and/or alcohol with potentially devastating ramifications. Athletics requires devotion of a great deal of time which might otherwise be used experimenting with substances. Athletes fear the impairment of performance which can result from substance use, leading to abstinence for many. And the support provided by coaches and team peers decreases the need for bonding over substances for peer identification. Substance use was much less common among my friends on the swim team as compared to other friends at school who were not involved in sports.

Personal experience aside, do studies support my assertion that athletics enhances psychosocial development? Results are conflicting. In one study a physical education curriculum was developed for third-graders to teach "positive social skills including leadership and conflict-resolution behaviors." The results were "immediate increase in student leadership and conflict-resolution behaviors [and] an increase in percentage of class time devoted to activity participation [with]... similar changes in student behavior...in the regular classroom settings."(Sharpe, p. 401) This implies lessons learned through sports may be applied in other life activities such as academics or a job.

With regard to athletics and adolescent development, several studies have shown "among high school students...a negative relationship between sport participation and delinquent behavior." (Spreitzer, p. 370) And in the area of self-esteem, studies have revealed that self-esteem can be enhanced by a favorable assessment of athletic ability by the coach and "desire to have fun" as the primary motivating factor for participation in the sport. (Hines, p. 869)

On the other hand, Elmer Spreitzer's 1994 article on a study of the "Effects of Athletics on Adulthood" pointed out that "the social scientific literature provides little support for the conventional wisdom... that athletic participation is conducive to the overall development of adolescents and to subsequent levels of achievement as an adult."(Spreitzer, p. 369) The author explains that:

Because of the selectivity factor, the relationship between athletic participation and well-being is fraught with ambiguity. Some observers suggest that youth with higher levels of overall endowment are selected into athletic participation...For example, disciplined and compliance youths may find that the structure inherent in athletics is attractive, whereas nonconventional youths may have been filtered out of sports due to self-selection, eligibility rules, coaching proclivities, and opportunity structures. (Spreitzer, pp. 369, 384)

Spreitzer's study also found "no clear association between athletic participation as a high school senior and psychological well-being six years later."(Spreitzer, p. 385) The author concluded that "arguments concerning transfer effects from the playing field to the larger game of life receive little support from the data of national surveys."(Spreitzer, p. 385)

What does all of this mean for parents seeking advice on child rearing? Should athletics be encouraged? Can athletics be therapeutic in some cases of psycho-pathology? Should schools increase or decrease emphasis on athletics? The jury is still out regarding such

questions. I certainly would not trade my experience as a competitive swimmer for the world, and there will always be children with similar inclination. For now, encouragement of athletic involvement in children with genuine interest will most likely not do any harm. Most important, however, is to place the emphasis on fun no matter what a child chooses to pursue.

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## Unique Challenges Facing Iranian Children and Adolescents Growing Up

Javad Alaghband-Rad, M.D.

I am writing as an Iranian child psychiatrist with the Department of Child and Adolescent Psychiatry, Tehran University of Medical Sciences. I have established a research program, having just finished a three-year fellowship at the Child Psychiatry Branch/ NIMH, Bethesda, Maryland.

Much has been said about Iran and the Iranians in the media after the 1979 revolution, mainly by outsiders and typically picturing them as troublemakers. These negative remarks, however, seek political ambitions and overlooked lives of normal people involved in ordinary day-to-day activities. There is less attention toward challenges facing Iranians, particularly

for the most vulnerable age group, namely children and adolescents. There is a whole range of such challenges, many of them unique to the rapidly changing Iranian society, such as the impact of long-lasting war with Iraq and the way it shaped the structure and function of today's Iranian society. As clinical impression of myself and colleagues would suggest, there is also various forms of psychopathology, ranging from subclinical to full-blown DSM diagnosis, unrecognized in many cases; confounded and colored by cultural variables. Further, Iranian children's unique suffering is contributed by somewhat cognitive overgeneralization and distortion as by and large, stereotypes shape the way they are perceived by media.

There is also a whole range of developmental issues, specific to cultures like Iran's. For example, it is unclear whether social development stages as described in classic studies (done mostly in western cultures) would be applicable to youngsters in cultures like Iran, as for instance, interaction with the opposite sex as expected in western cultures is being considered against the norms. Therefore, it is an open question as to what the normal social development would be like and more important what is the best advice to be given by a psychiatrist to his/her client as a professional sensitive to developmental issues. This brings up another important point: status of psychiatrists in general, especially child psychiatrists which is basically different from developed countries. They do not practice medicine in a restricted sense; their main task is to challenge the pathogenic attitudes towards mental health and psychiatric disorders. If patients could get past this rigid wall, we could function as what we are: physicians specialized in mental disorders!

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#### School Mental Health Program in Alexandria

Amira Seif El Din, M.D.

Alexandria is situated on the northern coast of Egypt. The governorate of Alexandria covers 2557 km<sup>2</sup> and around four million inhabitants are living in the six main zones. The population is predominantly urban and school children between the ages of six and 18 years constitute 40% of the total population. There are 867 schools in Alexandria (covering all three levels of education: primary, preparatory and secondary) supported by services from 470 school health physicians, 705 health visitors, and more than 2532 school social workers. More than one sector is involved in mental health services in schools; teachers and school social workers belong to the Ministry of Education, while school health physicians and health visitors work with the Ministry of Health. The integration between the different sectors was not well established.

The early appraisals of the personnel dealing with children showed that teachers felt they had little understanding about mental health, and the skills of management with problematic children were limited. The mental health services in school were indeed poor with a demanding curricula and a short academic year, teachers had little time to deal fully with children suffering from psychological problems. The school social workers reported that they had little time for direct interacting and work with children. Much of their time was directed to clerical duties and record keeping. The school health physicians had very poor knowledge and no skills as regarded child mental health.

By 1985, more research concerning school children showed that prevalence of school depression was 10%, anxiety among final year of secondary school was 17%, and the number of smokers and drug dependency among them is in proportional increase. All these data were an alarm showing the seriousness of the problem and that there is a defect in the way teachers and parents are dealing with their children; using odd uneducational ways to rear them as verbal or physical abuse in addition to the superstitious way to treat some psychological problems.

By the end of summer 1987, a mental health team from personnel working in the Ministry of Education, Health, and Faculty of Medicine (Community Medicine department) with WHO support started to develop and work on a voluntary basis to fulfill the following objectives:

1. Training of all personnel dealing with children in school; including physicians, health visitors and school social workers.
2. Orientation for school children on the proper way to deal with their peers and school staff, with great emphasis on respect and sympathy for any person having physical or mental disabilities.
3. Get benefit from this child to convey the proper mental health approach to his family and profit from the support of local mass media (TV and radio).

By the end of 1988 the first child mental health training was established for all personnel dealing with children through a one week training (basic training) for school physicians, health visitors, teachers and school social workers, each separately. One year later, we realize that pediatricians and child, maternal health physicians have to be involved in this training to give better mental health services for early age groups.

All the trainees had to grasp the following knowledge and some skills by the end of the basic training course:

1. To do proper communication

for the child and his family and to have information about psychological social development.

2. To be oriented about the common emotional, behavioral and cognitive problems.

3. To train them on some skills for managing the common child mental health problems faced in the community.

In 1991, there was a meeting with a sample of school health physicians one year after receiving the basic training. There was a drop in their knowledge where the mean percentage of correct answers was 52.88%, a drop of 10% from the previous test.

This raised a big question. How to maintain and improve the knowledge and skills of the trainees to give better services in schools? The answer was to start advanced training in child mental health to fulfill the following aims:

To develop qualified personnel acting as a filter in the different zones in Alexandria where they can do early screening and detection for needy children; manage the detected cases through guidance and counseling to their parents and teachers; give health education sessions in schools if the prevalence of any problems started to be raised; and give knowledge and skills to the team working with him (health visitors and social workers).

This advanced training began in 1991 where 28 school health physicians who received the basic mental health training and showed great interest to work in this field were chosen to be the first group. They received seven weeks' training with an interval of two to three months to give the trainees a better chance to return to their schools and begin to apply what they learned during the different weeks.

The training course covered the following child mental health problems: Child psychiatric examination techniques of effective communication and basics of guidance and counseling with great emphasis on the importance of teamwork; epilepsy; emotional problems among children; behavioral problems; school backwardness generally with special focus on mental retardation; smoking and drug dependency; psychosis and developmental disorder.

The main objectives of the training course aimed at the following skills and knowledge. To: understand the community attitudes toward problems; identify the normal development of children; differentiate between normal and abnormal psychosocial deviation among school age children; identify elements of communication, use effective communication techniques; identify symptoms and signs of different discussed mental health problems; train the trainees on child psychiatric interview and examination; detect early deviation through screening for school children; discuss the lines of management for the different problems; learn the principles and technique of counseling and guidance; develop the skills of teamwork with the health visitors and school staff. The tools used during the different advanced training courses were: lectures, discussion, small group activities, real cases, role play which was very effective to fix the knowledge and improve the practice of the trainees and even was used to evaluate every trainee at the end of the training course.

At the end of the seven weeks, the number of trainees who fulfilled the requirement was 23 physicians. They were located in different centers working as a school mental health physician to provide service to the surrounding schools. Every school's physician already trained (received advance school mental health training) was allocated to provide service to a number of schools covering three to five thousand students.

The role of school mental health physician in his center has two aspects:

A preventive aspect involves: Screening for emotional and behavioral problems at the start of the academic year as part of the school health appraisal activities; orientation of the school staff about the different mental health problems; train the school staff on screening and early detection of needy children; health education for school personnel if a specific problem begins to be more common in some schools (stealing, nocturnal enuresis, aggression); conducting regular visits to high schools to give a talk about psycho-sexual

development during adolescence or about drug abuse. Usually during these visits a religious person, a psychologist and a social worker accompany the physician.

A curative aspect involves: psychological assessment of the child; giving specific guidance and counseling to the child and his family according to the presented problem; prescribe a limited number of drugs; follow-up of the cases if the social worker is unable to handle the condition; establish a systematic referral system between the schools and child psychiatric clinic.

The National Insurance, early in 1993, started to cover the schools in Alexandria, and some of the trained school health physicians left the school health system where the number of school health physicians dropped to 13 but still the school mental health centers were functioning. In 1993, the second advanced training course was conducted for 32 pediatricians who are working with Maternal and Child Health Centers (MCH) and pediatric hospitals. In 1994 the third advanced training course was conducted for 31 physicians; 21 are working in school health and ten in MCH. By the end of 1995, we had 28 centers for guidance and counseling in school health in Alexandria governorate and two neighboring governorates. In addition, there are 11 centers in the MCH and centers in two pediatric hospitals. Since 1994, all who received the advanced training are attending on a regular basis a monthly journal club where the agenda is planned in advance and all are participants in the different presentations. In addition, it is a good opportunity to discuss the problems raised in the different centers.

#### Impact of the training courses on the psychiatric services in Alexandria

The child psychiatric clinic and school mental health centers are following the same system of diagnosis and recording. School mental health centers started to be a filter for most of school mental health problems where behavioral problems, in particular nocturnal enuresis, started to be managed. In addition, drug dependency began to be detected and hysteria is encountered more than in the main child psychiatric clinic in Alexandria. The referral system between the different centers and the main psychiatric clinic became well established.

In school health appraisal, a standardized Arabic translation for some psychological tests are used to screen mental health problems among school children in the first year of preparatory and secondary schools, screening for anxiety and depression. Large numbers of school social workers began to cooperate with school mental health physicians to early detect and refer needy children to the school mental health physicians. The Ministry of Education in Alexandria started to show great interest in mental health and distributed on a regular basis instruction to promote school mental health. For example: methods of better communication, instruction for dealing with stealing and lying problems, instruction for using methods other than beating for discipline. Two marathons among school children were developed where different slogans were raised, such as "mental health is a tool to promote physical health," "healthy mind in a healthy body," etc. Basic training in child mental health is conducted on a regular basis for the final student year at the Faculty of Nursing. Development of several theses for Master and Doctoral degrees studying the child mental health problems (about 12 theses) in addition to the publication of several articles describing the child mental health program and its evaluation. To fulfill the second objective of the training program, the child mental health team conducted visits to students in the high

schools to discuss their problems and help to find proper solutions; if possible in addition to some information about psychosocial development which is an important area of their concern.

A manual for child mental health for para-medical personnel in collaboration with WHO was prepared in Arabic for all the countries in the region. Early in 1996 Egypt joined the IACAPAP by the initiation of Alexandria Child Mental Health Team. A non-governmental organization was established, "Child Mental Health Prevention Association" in 1995 to help spread the concept of child mental health to all people working in this field in addition to resources to help the poor school children. The first Egyptian Child Mental Health Academic Seminar was conducted for five days; October 29–November 2, 1996.

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### Child and Adolescent Psychiatry in Russia

Paul A. Andrulonis, M.D.

The Albert Schweitzer Institute for the Humanities, based in Wallingford, Connecticut, and the Soros Foundation sponsored a program on "Controversial Issues in Child Psychiatry," from June 23– June 27, 1996 in Nizhny Novgorod, Russia. Faculty members were Drs. Joel Bregman and myself, child and adolescent psychiatrists from Connecticut Children's Medical Center, The Institute of Living, and the University of Connecticut School of Medicine, together with Dr. John Gerdtz, an Educational and Behavioral Consultant from the Spectrum Center at Berkeley. Each faculty member presented several lectures, conducted workshops, met with child and adolescent Russian psychiatrists as well as psychologists and social workers, and visited clinical centers involved with the psychiatric care of children and adolescents. Dr. Andrulonis focused on the concept of Attention Deficit Hyperactivity Disorder and also Pediatric Psychopharmacology, while Drs. Bregman and Gerdtz presented on the diagnosis and treatment of Autism, Asperger's Syndrome, and Mental Retardation including behavioral and educational interventions.

This visit was unique because Nizhny Novgorod had been a city closed both to the Western world and to Russia itself for decades. The city was the site of industry for war machinery including submarines which resulted in the highest level of Russian security. Although the city has been open in recent years, it remains a poor, industrialized urban setting in marked contrast to St. Petersburg and Moscow. Surrounding the city are small farms which primarily grow potatoes. The main employer currently is a huge automobile manufacturer. The people remain poor yet hardworking with a spirit of hope and enthusiasm with the then anticipated Russian election leading to the further development of democracy.

There are major public health problems in Nizhny Novgorod and other urban centers in Russia. The rivers are high polluted. Water from taps cannot be consumed and sanitation facilities are lacking. Nutrition is another major concern because of the lack of most vegetables, fruits, and grains. The diet is primarily based on dairy products, meat, and potatoes. The average life expectancy for men in that area is approximately 50 years of age. The majority of Russian youth smoke regularly and alcohol consumption is high. There is little screening or education about HIV. People live in flats within the city or very small

homes in the country. The standard of living is low for physicians as well as teachers, who are over 95 percent female, since their salaries have to be complemented by their husbands for a modest style of living. All children receive education through the public school system from grade school through the university, including medical school, which follows approximately two years of college education. Medicine is not a prestigious, frequently sought after career in Russia, but the physicians were enthusiastic, devoted and extremely eager to learn about medicine in the United States.

Russian child and adolescent psychiatrists brought up major concerns regarding the lack of mental health services for children and the growing problems of adolescent depression, pregnancy, high school dropout rates, and drug and alcohol abuse. Learning disabilities and attention deficit hyperactivity disorder were appreciated but intervention through special education, behavior modification, parent training, or medications was minimal. Child and adolescent psychiatrists did try to set up intervention programs through the public school system as consultants but working with teachers and parents was most difficult. These psychiatrists, psychologists, and social workers had a good understanding of the diagnostic process using the International Classification of Diseases and DSM from the United States. They utilized traditional behavior modification, individual play therapy, relationship-type therapy, and when possible some family therapy, although as in this country, getting fathers involved remained a special challenge. Psychodynamic principles including theories of individuation and separation were appreciated and applied. Psychiatrists, however, acted primarily as a consultant and diagnostician to help set up the treatment plan, not unlike in the United States.

In this Russian city, mental illness is considered best treated through a holistic approach. During our visits to various facilities, we met and observed children receiving massage, warm baths or whirlpool therapy, acupuncture, various herbs for specific mental difficulties such as anxiety, exercise or physical therapy, and a sleep therapy clinic, where children would come in during the day for a quiet period of rest. These holistic interventions were not done by child and adolescent psychiatrists but by other physicians in pediatrics. Diagnostic tests did include mental status examination, psychological testing, laboratory studies, electroencephalograms, and very limited brain scanning. Psychiatrists were the experts in psychotropic medications, which are available in a limited fashion. Serotonin Re-Uptake Inhibitors such as fluoxetine are scarce and too expensive for the majority of patients. Amitriptyline is the most common tricyclic antidepressant used for depression. Carbamazepine, valproic acid, and lithium carbonate are used for bi-polar illness. Thioridazine, chlorpromazine and haloperidol are the primary antipsychotics. Pheno-barbital and phenytoin are also used for behavioral problems. Stimulant medications were not available in this city.

Mental health professionals in Nizhny Novgorod, working with emotionally disturbed children, were uniformly caring, warm, enthusiastic, and highly receptive to our ideas. Major work needs to be done in clarifying diagnostic categories and more importantly, implementing specific treatment interventions based on diagnosis. The holistic approach tended to clump children with various mental health problems into general treatment programs. We hope to follow-up with continued involvement with these professionals in the future. Another very worthwhile endeavor would be for child and adolescent psychiatrists from Russia to visit centers in the United States in order to learn our diagnostic and subsequent treatment methods

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## Collaboration With A Chinese Psychologist in China

Paul Kay, M.D.

Since June 1996, I have been corresponding with a school psychologist, Professor Liu Ping, in Beijing, China. I met him during a trip to that country last May as part of a group of psychoanalysts from our country and abroad (The Citizen Ambassador Program, formerly the "People to People" program which began in Eisenhower's administration). We visited medical schools, hospitals and universities. We met and exchanged views and experiences with psychiatrists, psychologists and other mental health professionals.

At Beijing Normal University, Professor Ping spoke eloquently about learning problems in children. I spoke to him at dinner that night about keeping in touch with each other when I got home. He seemed eager to do so. We have been doing that through letters and phone calls since last summer. A small group of Fellows and faculty members in the Child Psychiatry Division of The North Shore University Hospital (Manhasset, New York) have joined me in this correspondence. (I call it the American-Chinese-Bridge for starters.) We have been meeting approximately every six weeks either at my home or that of Dr. Fornari, the Director of the Child Psychiatry Division. (Sandy Kaplan, M.D., is the chairperson.)

We have been exchanging views and information with Professor Ping about various aspects of our work and experiences. He has been sending us vignettes of the children he treats for learning (and related) problems and asks for our reactions to them. He also raises various questions about, and makes comments on, social and cultural aspects of his work. We have been responding to his vignettes and questions. He then responds (more or less) to our response.

Dr. Fornari and I hope that the way in which he and I deal with the cultural differences, which exist between us and Professor Ping, may help the Fellows to deal more effectively with the cultural differences which they encounter in their daily work with minority group patients. They may, also, we hope, learn something from our diagnostic and (analytically-toned) psychotherapeutic discussions of the clinical data made available by Professor Ping and ourselves.

Professor Ping is one of the very few school psychologists in China. He has written papers on children's learning problems which he has presented at meetings in other countries. He has, on his own initiative, also been promoting the use of psychological assistance for children with learning and related problems through the print and other media. Psychotherapy, even in its simplest forms, has yet to be accepted by the Chinese public, especially when it involves children, due to cultural and other influences. He has been reading Freud and other psychoanalysts on his own for some years! Freud and psychoanalysis are not exactly popular in China. A few of the younger people in the field of mental health, however, have been fascinated by Freud and psychoanalysis in general and reading the pertinent literature.

I have been sending Professor Ping books, journals, papers and audio tapes which I hope he can use. His education and training, by our standards, seems to be meager. He is essentially self-taught. I regard him as a pioneer. I admire him.

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## Irish Families Under Stress

Michael Fitzgerald, M.D.

There is a myth that children and parents in Ireland live in a harmonious rural society. While Ireland might have experienced a "cultural lag" in the past, there is no evidence for this now.

I will briefly describe studies of 6,000 children and parents conducted in Ireland over the past 20 years. Studies of children in preschool in Dublin found rates of 17% with behavior problems. Of those children with behavior problems, 50% of their mothers showed evidence of depression. While no association was found between mothers antenatal depression and behavior problems of children, at four years, there was a clear link between the mother being depressed when the child was four years old and the child having behavior problems. Children who showed behavior problems experienced low levels of warmth, acceptance and affection from their parents in their home and lived in poor physical environments.

The largest study was of 2,029 ten year olds, of whom 16% showed evidence of behavior problems. The second state of this study, looking at formal child and adult psychiatric illness, found significant associations for both child and parental psychiatric illness between mothers' dissatisfaction with housing; mothers' dissatisfaction with her role as a homemaker; mothers' dissatisfaction with family income; mothers' dissatisfaction with social contacts and leisure activities as well as marital disharmony. It emerged that 18% of the mothers could not confide in their partners and 22% had nobody in the world to confide in. It appeared that it was those families who were socially isolated who were most at risk of adult and child psychiatric problems. In a study of lone parents and their children, it emerged that those parents who lived in the home of maternal grandparents showed lower psychological symptoms in both children and parents while those who live alone in apartments showed high levels.

A ten year followup of delinquent boys found that 20% had substance use problems and a recidivist rate of 92%. A study of children referred to routine child psychiatric outpatient treatment found that 50% had speech and language problems. A study of psychological stress in female adolescents using the Child Behavior Checklist found that 15% showed evidence of psychological stress. A later study found an exactly equivalent number of male and female adolescents at age 14 showing psychological problems. In latency age years, boys far exceeded females in showing psychological problems.

In children attending a child psychiatric outpatients, 20% received a diagnosis of depression. In a normal latency age school, 15% of the children thought life was not worth living most of the time and 15% had thought about killing themselves. There has been a very rapid increase in suicide in young people in Ireland.

A study of child care in Dublin found that fathers undertook 20% while mothers undertook 80%. Another study found that 36% of children attending disadvantaged schools were 18 months behind in their reading.

Irish families live in an age of "calculators" where the "cash nexus" is supreme. Irish society has entered a post Marxist age, a post structural age, a post industrial age, where the self is decentered and the text is deconstructed. The families live in a very similar environment to those in North America with the exception of low rates of homicide and gun-related crime. These data are available in *Irish Families Under Stress*, edited by M. Fitzgerald, Volume I, 1991; Volume II, 1991; Volume III, 1991; Volume IV, 1995; Volume V, 1996, and published by the Eastern Health Board in Dublin.

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#### First Ladies, Women Leaders Pledge Unprecedented Efforts on Mental Health

Inaugural meeting at Pan American Health Organization sets new initiatives  
Washington, 28 September 1996

First Ladies, Ministers of Health, and mental health experts from more than 20 countries of the Americas today made an unprecedented pledge to support efforts to improve the mental health of women and children through programs "directed to foster, protect and restore mental health and well-being."

Convened by the Carter Center and the World Federation for Mental Health, the meeting of International Women Leaders for Mental Health included First Ladies and former First Ladies from Antigua and Barbuda, Belize, Bolivia, Colombia, Costa Rica, Mexico, Panama, Trinidad and Tobago, and the United States of America. First Lady Hillary Rodham Clinton met with the other First Ladies and expressed her support at the meeting, held at the Pan American Health Organization in Washington.

"The Conference is an important first step in raising awareness of the mental health concerns and issues affecting women today," said former First Lady Rosalynn Carter, Chairwoman of the Inter-national Committee of Women Leaders.

Bolivian First Lady Ximena Iturralde de Sánchez de Lozada noted that drugs, alcohol, and family violence are causing serious increases in mental health problems, adding: "Mental health must be identified with quality of life and must be dealt with in the home, at work, in schools and on the street, where people can either lose their mental equilibrium or can learn to preserve it and live in harmony with their social groups and environment."

Both developed and developing countries face an epidemic of psychosocial and psychiatric disorders characterized by increases in schizophrenia, dementia, depression, and alcohol dependence and abuse. "The most visible symptom of all these disorders is violence—homicide, suicide, and domestic violence against women and children. And while many behavior-related problems are treatable, ignorance and inaction exact a widely underestimated social cost," according to a summary of world mental health problems presented at the meeting.

In Latin America and the Caribbean, some 17 million children suffer from psychiatric disorders and need intervention. "This is just the tip of the iceberg," said Dr. George A. O. Alleyne, Director of PAHO. We hope that through meetings such as this we can do more for the invisible majority who remain unaccounted for and untreated."

#### A Joint Statement of International Women Leaders for Mental Health

We, FirstLadies and Wives of Heads of State or their designated personal representatives, have convened at the Inter-national Meeting of Women Leaders for Mental Health to address concerns over mental health in the Western Hemisphere.

We have taken note of the platforms for action contained in the "Declaration of the Rights of Mental Patients" of the United Nations; the report presented to the United Nations by Harvard University entitle, "World Mental Health Report"; the initiative, "Nations for Mental Health" coordinated by the World Health Organi-zation; and the strategic orientations of the Programs on Mental Health and on Women, Health and Development of the Pan American HealthOrganization.

In order to initiate proactive steps toward improving mental health and well-being of the peoples of the Americas, we pledge to:

- Firmly support existing national mental health programs, work to forge a coordinated effort in conjunction with ongoing initiatives being implemented in other social sectors, and promote at least one activity in each of our countries that will help to improve the mental health of citizens.
- Assist in the establishment of international programs directed to foster, protect and restore mental health and well-being.
- Assist nongovernmental organizations and institutions involved in the fostering and development of mental well-being.
- Support ongoing initiatives that raise awareness of mental health issues in our countries and across the Americas, and promote the inclusion of mental health as an item on the agenda at the Seventh Conference of First Ladies and Wives of Heads of State to be held in Panama in 1997.
- Call upon governments that have not yet done so, to ratify the Inter-American Convention for the Prevention, Punish-ment and Eradication of Violence against Women. To signatory countries, request the implementation and enforcement of this Convention.
- Support policies, programs and activities that promote an integrated approach to mental health which incorporates a gender perspective.

- Call upon international organizations responsible for technical and financial support to assist efforts to enhance mental health and well-being in the Western Hemisphere.

Signed at the Headquarters of the Pan American Health Organization in Washington, D.C., on this twenty-eighth day of September, Nineteenhundred and Ninety-six.

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Third Congress of the International Association of Bioethics

San Francisco, 22–24 November 1996

Jocelyn Y. Hattab, M.D.

Concern for and interest in Ethics is not new. All religions and philosophies preached morality and a consideration of one to the other: "Thou shalt love your fellow like yourself." Philosophers emphasized the need for morality as a condition for social relations and organization of the City. One can ask himself, if so, why it took such a long time to found Associations of Ethics and BioEthics.

There are two major answers to this question. The development of Sciences in general and of Biology and Medicine specifically, confront scientists and everyone with ethical dilemmas, if and how these discoveries can be used without any physical or psychological harm to people. As a rule, Science proceeds Ethics. Ethicists try to understand the ethical consequences of scientific findings after they are public domain, in many occasions, after a long series of mistakes or even catastrophes. This is the first reason for establishing an International Association of BioEthics and its Congresses — to be as close as possible to developments in any field relevant to human and societies' well being and prevent misuses and abuses.

The interest for Ethics in the last decades arose from the human catastrophes that we witnessed, mainly the Shoa, but also in Armenia, Rwanda, Biafra, Vietnam, Middle East, and the list is still long. Moral is not yet an Evidence. Behaving ethically is not new; what is new is thinking about it. Ethics has been considered as evident. It is not longer evident. When a value becomes evident, it is not a value any more. Our modern history has questioned many evidences. Is the Declaration of Human Rights still an evidence after the Holocaust? Nationalisms cause destruction and deportation of populations. It is evident that people want to live. It seems today that it is most important for many people to die somewhere than to live anywhere. Well established and rooted systems like communism and socialism have collapsed. It was an evidence that parents love their children and for years, we refused to admit child abuse. That is the second explanation for this renewal of interest for Ethics. Our societies and history have been dangerously and harmfully hurt by their confidence in human basic morality that revealed itself as hypocrisy.

Bioethics acknowledges that human beings, in their biological dimension, are subjects of moral consideration, since their birth—even before—till their death. Both a spiritualistic approach where mind is the man's primum movens and only specificity, and in the materialistic one where the main psychic functions are brain interactions, defend the basic human right to be respected.

Nothing is evident in human mental functioning. Nothing is evident for an ethical discussion. All evidences have to be

re-questioned. Ethics is always a questioning. Ethics is always a dilemma between two values. When a dilemma is resolved, in a given society, the solution becomes a Law. Behaving according to a Law is not being moral but obedient.

This third Congress of the IAB was important for its multinationality, participants from all five continents, multidisciplinary, medical doctors, researchers in all fields of research, lawyers, ecologists, clergy, anthropologists, educators, advocacy groups leaders. All presentations and workshops reflected this mosaic. The message is that BioEthics crosses the frontiers between people, nations, professions. It is the condition for our societies to survive. Solving BioEthics dilemmas is the duty of every human being.

Illustrated are a few examples of the richness of topics dealt with at this meeting. We all agree with the request for informed consent from the patient and/or his parents, before any medical procedure. We do also acknowledge and respect cultural different values. What attitude should be adopted concerning excision of pre-adolescent girls or even circumcision of Jewish and Muslim babies. Those are surgical procedures, not for health purposes at all, harming and destructive, at least the excision. To what extent can we respect cultural practices opposed to the well being of children? The United Nations Declaration of Children's Rights can be the basis for discussion and request from the countries that signed it (120) to follow all its recommendations. Gay and Lesbian perspectives on health care raised the obligation for medical professionals, and specifically surgeons, to treat everyone, even when at reasonable risk of contamination. Managed care, service delivery, equality of opportunities for good care, and welfare policy were addressed, not only as a Sunday sermon, but considering basic social trends and human weaknesses. It seems that only education at schools and training programs on Ethics for all professions, mainly medical, can at least reduce the burden. IBA is in close collaboration with the "Health for All" mission of WHO set forth in its 1978 Declaration of Alam-Ata.

New techniques, transplants, umbilical cord blood procurement and its banking, brain banks, embryonic cell transplants for Alzheimer and Parkinson patients, raised again the two basic dilemmas of definition of death and use of a human being's disadvantage for the profit of another fellow. We discovered issues we never thought about. This Congress stimulated our curiosity about: "Irresponsible Reproducers: Race, Class and Dominant Hegemony of Poor Women's Reproduction"; "Color and Culture: Long Term Contraception"; "Do Physicians Under-treat Pain?"; "Feminism, Disability and Genetics"; "Choice Between Two Vices: Ethical Dilemmas in China's Population Policy and Population Planning"; "Reframing Conceptions of Social Justice in Clinical Research on Women"; "Transsexualism and Body Transformation"; "Justice in an Unjust World" and much more.

We want to invite you to participate more actively in BioEthics programs in your own universities and hospitals, and to attend the next International Congress in Tokyo in November 1998.

We were invited to participate to the Mental Health and BioEthics Panel. We discussed "Advance Directives in Research on Mental Disorders: A Critique," "Use of Brain Banks for Research." Two hundred seventeen cases of Electroshock Therapy with Children and Adolescents have been published. That means that much more have been practiced. Were

they necessary? Is it ethical to electricize developing brains? The other two papers were: "Why Psychiatric Research Subjects Require Added Protections" and "Ought We to Sentence People to Psychiatric Treatment?" Their mental impairment and lack of adequate protection puts these disabled persons at greater risk of exploitation in experimental research than other vulnerable groups. The mentally ill, let us remember, were among the first "undesirable" victims upon whom the Nazi doctors experimented.

This Congress took place in the wonderful city of San Francisco and was directed, managed and headed by its President, Professor Alexander Morgan Capron. The president is now Professor Daniel Wikler of the University of Wisconsin. Professor Emilio Mordini from Rome, Director of the Mental Health Section at the International Association of BioEthics, founded a section of BioEthics at the World Psychiatric Association that will work hand in hand with Judge Carmi's section of Law and Ethics. We took the responsibility of organizing the Symposium on BioEthics and Mental Health at the next Tokyo IBA Congress and we will open the pages of this BULLETIN for discussion on BioEthics and Child & Adolescent Psychiatry. We look eagerly toward your comments, papers and letters to this BULLETIN.

I would like to conclude this Congress report with its main, official declaration.

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#### Medical Science Under State Control

On 21 November 1946, the twenty-three defendants in the Doctors' Trial were arraigned before the Nuremberg military tribunal. All entered plea of "not guilty," but over the next eight months, sufficient testimony and documentary evidence were introduced to lead to the conviction of fifteen defendants (not all of them physicians) of war crimes and crimes against humanity for having performed unethical medical experiments on concentration camp inmates and prisoners-of-war. In the course of rendering judgment on August 20, 1947, the court articulated the ten principles of permissible medical experimentation that became known as The Nuremberg Code.

The fiftieth anniversary of this historic trial not only provides an opportunity for solemn commemoration of the victims of the Nazi doctors but for careful reexamination of the Code that stands as a memorial to their suffering. It also offers an opportunity to place the judgment at Nuremberg into the context of other experimentation carried out in other countries. What lessons can be learned from comparing the German experiments with what was done in the United States during World War II (but not acknowledged by American experts in Nuremberg) or since then (in the radiation experiments), or with the experiments carried out by the Japanese military in China and Manchuria during the war, for which the Allies never brought them to account? Is research performed under official auspices more likely to raise ethical problems? Beyond human experimentation, what is the legacy of the Nazi regime for bioethics regarding eugenics and euthanasia?

How adequate have the Nuremberg Code and other attempts to state international standards, such as the repeatedly revised Declaration of Helsinki, proven to be in avoiding further instances of unethical experimentation? Was it naive to think that American judges reviewing atrocities of a conquered foe could develop a universal code for medical research,

applicable around the world? Likewise, are organizations of scientists and physicians (such as the World Medical Association or the Council for International Organizations of Medical Sciences) appropriate bodies to formulate generally applicable standards? And what should health practitioners and researchers do when they find that unethical experiments or genetic research have provided results that would be useful in their own current work?

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Project "To Live Together": An Effort at Building Peace Into Minds

Geneva Foundation to Protect Health in War, and Geneva University Multi-Faculty Program for Humanitarian Action (supported by Marcel Mérieux Foundation)  
Annecy, France and Geneva, Switzerland  
January 26—February 2, 1997

This workshop brought together 30 Israeli and Palestinian educators, physicians, psychologists and sociologists, as well as a dozen Swiss researchers. One half of the participants belonged to the academic field (four Palestinian and four Israeli universities), while the other was composed of school teachers, health and social workers, and representatives of governmental or non-governmental organizations.

The objectives of the meeting were defined as follows:

1. Review the relevant regional

experience in the field of education towards tolerance, understanding, coexistence and peace between Palestinians and Israelis.

2. Enhance confidence-building between groups and individuals and encourage their efforts at becoming

partners in collaborative projects.

3. Invite participants to design several action-research projects based on the lessons drawn from the review of the field and the perceived needs for the future.

As an opening to the scientific sessions, Dr. Ephraim Sneh, member of the Knesset and former Minister of Health, and Mr. Jamal Al-Shobaki, member of the Palestinian Legislative Council, discussed the psycho-political perspective of the Israeli-Palestinian conflict.

Over the week-long workshop, all three objectives were largely met. The promotion by some groups of tolerance and reconciliation through educational activities, whether by organizing youth encounters, training of teaching staff, direct teaching of children, coeducation, or transforming school curricula, bears witness to an admirable motivation. It seems, however, that in most of these initiatives, efforts have been mostly focused on adolescents and adults, and much less on children at primary school or kindergarten level and that, in most projects, there was no element of scientific evaluation. Thus, the results of such efforts remain

unknown or uncertain, whether in terms of changes in attitudes and behavior, or in terms of their impact on mental and social health.

In an outstanding spirit of partnership, the outlines of several joint research-action projects were discussed and will be worked out in greater detail to be later formally submitted to the Geneva Foundation and Geneva University. It is hoped that modalities for financial and academic support will be found for the most promising of these projects.

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Child and Adolescent Psychiatry Program in France: A Latin American Point of View

German Casas-Nieto, M.D.

One of the most important goals of the governments and international community in the recent years is the child's health. The Latin Countries have been worried about the statistics of pediatric's morbidity and mortality and work a lot to reduce this reality. Colombia, a Latin American Country located in the north of South America, is an example of how in one country at the same time are very difficult situations for children and a big effort of institutions who work to help.

Colombia is a country of 28 million people, half of them less than 25 years old. That means Colombia is a young nation. The principal cause of death is violent death and almost 50% of these deaths are children and adolescents. (1) In spite of knowledge of political problems and terrorism, there is something that almost nobody knows about the real causes of death in Colombia which has been caused by psychological phenomenons, especially for children and adolescents. For example, a recent study found that 60% of dead people have been drunk before their death and the same study found also that 65% of teenagers called "violent" started to drink since they were 15 years old. (2) In 1993, only in Bogota, the capital, 110 institutions worked for children and adolescents in hard situations. In spite of all that, the problems are not over; they are increasing.(3) How can we stay calm in this kind of situation?

This is the first reason that a Colombian psychiatrist goes out of his country to study the specialization of child and adolescent psychiatry and choose for his goals to learn another language and another culture, and come to France to start the specialization program offered by the Department of Child and Adolescent Psychiatry of Medical School in Paris (Bicetre) whose manager is Professor Pierre Ferrari.

For a psychiatrist with this motivation, this French program has great characteristics: First is access to theoretical understanding of child psychiatry. This is a special place where there is training in the psycho-therapeutic treatment as well as the interdisciplinary work both in terms of prevention and intervention. It also provides a basic training in General Pediatrics in the Paris Medical School of Pediatrics. This program is certainly eclectic. It gives the student an opportunity to choose what he thinks is the most important for his own formation.

This program teaches approaches to biological, neurological and psychodynamic issues. The sociological and anthropological theories are also taught and a consultation– liaison psychiatry has an important place. The hospital practice where I worked in France was in the Interdepartmental Public Hospital. "Fondation Valee" is very important to me. This hospital is an example of how child psychiatry developed in the last century.

The work of the French Team is the big factor of this program: I learned an interesting and new system of classification of Mental Troubles of Children and Adolescents which is to me very useful for my country where we have a lot of problems of classification and diagnosis. The CFTMEA (Classification Francaise des Troubles Mentaux de l'Enfant et l'Adolescent)(4) considers differences in pathologies.

In France there is an important focus on Child and Adolescent Psychiatry for the medical community, pediatrics, medias, and the Government.

To study in Paris is an appointment with history: Here Pinel freed psychiatric patients. Freud was there to discover Hysteria. In Paris, too, Heuyer, Lebovici and Bourneville established for the first time Child Psychiatry. Now it is still here where someone can find a lot to learn.

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Items for future Bulletins

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August 24–28, 1998

The Future of a Disillusion

La Sapiniere (by Montreal) (in French)

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