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#### President's Message

Since my election at the 14th International Congress of IACAPAP in Stockholm in August 1999, I have had an extremely busy time full of activities on behalf of IACAPAP and ESCAP. The main activities covered the following topics:

Establishing stronger ties between national societies and IACAPAP and ESCAP

The impact and activities of a scientific and professional society is very much dependent on the activities of the members. Insofar, it is very important to use scientific and professional meetings in order to establish stronger ties between national member societies and IACAPAP. I have used widely such activities in order to pursue this goal, especially in my role as President of ESCAP and now IACAPAP.

In this function, I was in Modena, Italy at a very impressive meeting entitled "The rights of children—the duties of adults," organized by the vice-president of our organization, Prof. Ernesto Caffo, October 8-9, 1998. This meeting was attended by more than 1,000 persons coming from all over Italy. I had the opportunity to talk in the opening session on "New perspectives of research in child and adolescent psychiatry" and to inform child

psychiatrists and colleagues from allied professions about IACAPAP and ESCAP. Plans for future joint activities were made in Italy.

This meeting was followed by a second one in Brussels (December 2, 1998) devoted to the topic "Listening to children—new strategies for the prevention of child abuse in Europe," also organized by Ernesto Caffo. Our vice-president Herman van Engeland and myself gave talks also centered around the importance of research for child mental health.

Together with Herman van Engeland and our counselor Martin Schmidt and adjunct secretary Andreas Wamke, I attended the German Research Meeting on "Biological Child and Adolescent Psychiatry" (December 3–5, 1998) which was an excellent forum to spread information about the goals and activities of IACAPAP.

A research meeting organized by Prof. John Tsiantis (vice-president of ESCAP) in Athens/Greece (November 20–21, 1999) reassembled approximately 35, researchers all interested in the field of "Evaluation of psychotherapy in children and adolescents." Several members of the ESCAP board and IACAPAP counselor Prof. Phillippe Jeammet and myself joined this meeting which was extremely interesting from the research point of view, but also under the perspective of cooperation between colleagues from different countries from Europe and the United States. The Athens conference on therapy evaluation will have an impact on future work in the field of evaluation and the results will be published in a supplement to the journal *European Child and Adolescent Psychiatry* (ECAP).

From December 8-10, 1998, I visited Helsinki/Finland where I gave the Niilo-Hallman lecture on "The course of anorexia nervosa with onset in childhood and adolescence" which was sponsored in honour of Niilo Hallman, a famous pediatric researcher from Finland who initiated the Finnish Foundation for Pediatric Research. During this visit, I had plenty of opportunities to discuss with our Finnish colleagues the future development of child and adolescent psychiatry in Scandinavia and all over the world.

Trip to Israel (February 18-25, 1999)

The major event, however, was a trip to Israel. The main aim of this visit was to prepare the Jerusalem 2000 congress on "The Promised Childhood" to be held from October 29–November 3, 2000. Our past president, Donald Cohen, and myself came from Frankfurt to Tel Aviv after having spent a good time together in Marburg where I live. During his visit in Marburg, Donald gave an excellent lecture on "Recent advances in research and clinical practice of Tourette's syndrome" and discussed with us clinical cases and research projects. Ernesto Caffo came late in the evening from Italy to Tel Aviv, and Donald and myself met our Israelian colleagues in Jerusalem on Friday evening (February 18) at Jocelyn Hattab's home who is one of the editors of this newsletter.

The colleagues in Israel had prepared an extremely interesting and also very dense program which included visits to several clinical centers in Jerusalem and Tel Aviv as well as visits to Gaza and a mental health center in Ramallah in the West Bank. We also used the time to visit our first honorary president, Prof. Gerald Caplan, whom we found in good health, full of plans and active as ever. Our hosts Jocelyn Hattab, Sam Tyano and Alan Apter did everything to make our trip comfortable and pleasant in spite of intensive work and only very short sleep.

As far as mental health services are concerned, there are remarkable differences in the countries. Very advanced and well-equipped clinical services in Jerusalem and Tel Aviv contrast with also very active, but poorly equipped services in Gaza and the West Bank. Our talks with colleagues from Israel and from the Palestinian territories were fruitful and stimulating. We are very hopeful to have Israeli and Palestinian colleagues at the Jerusalem 2000 congress, thus demonstrating that professional work for the

improvement of mental health of children has no boundaries and can hopefully overcome differences in political and social fields. Our discussions with Dr. Cairo Arafat in the Palestinian territory of Ramallah who informed us about the "National Plan of Action for Palestinian Children" and our visit to the Gaza community mental health program chaired by Dr. Abdel Aziz Thabet were extremely impressive. We found very engaged colleagues who work hard and effectively, but under poor circumstances. Dr. Thabet, for instance, is the only qualified child and adolescent psychiatrist in Gaza community, covering more than one million of people. At the time being, there is no Palestinian association for child and adolescent psychiatry, and we tried to stimulate our Palestinian colleagues to establish a Palestinian Society for Child and Adolescent Psychiatry which could then become a member of IACAPAP.

We were also deeply impressed by our visit to the Psago Child and Family Developmental Center in a new settlement outside Jerusalem and just one kilometer away from the Palestinian territory Ramallah where we met with the staff and participated in a brief conference. Equally impressive was our visit to Hadassah University Hospital where we had the opportunity to see the Mother and Child Mental Care Center of child psychiatry headed by Dr. Esti Galili. An outstanding experience was our visit to the Ben Shemen boarding school for new immigrants. Our host Dr. Ron Levy and his colleagues gave us an outline of the history of this famous boarding school, described the curriculum and the everyday life at this place. We had ample opportunity to talk with children and adolescents in Ben Shemen who demonstrated their activities, producing a newspaper, caring for animals in a zoo, gardening, performing theatre etc. It was most impressive to see how these young boys and girls took over a high responsibility for a larger group of younger children or children and adolescents of equal age which is an excellent preparation for the future tasks as adults.

Another visit took us to the Geha Hospital in Tel Aviv where our hosts were Profs. Sam Tyano and Alan Apter and the Schneider Children's Hospital including a department of child mental health headed by Dr. Aliza Blum. At the Geha Hospital we had also a meeting with the organizing and scientific committee of the Jerusalem 2000 conference where we exchanged our views and made plans for the program which will cover all major issues in the field of child mental health with a special focus on cultural aspects and the perspective of children's rights at the threshold to the next millennium. I am convinced that the three local organizers of the congress—Sam Tyano as the chairman of the organizing committee, Alan Apter as the chairman of the scientific committee and Jocelyn Hattab as the coordinator—have already done a marvelous work and will do everything in order to bring the congress to the utmost success.

Our visit ended with a symposium on childhood schizophrenia and pervasive developmental disorders on Wednesday, February 24, organized by the Israeli Society for Child and Adolescent Psychiatry in Tel Aviv. Donald Cohen gave a talk about "Developmental Neuro-psychiatry Illnesses of Childhood" and I myself talked on "Schizophrenia in Childhood and Adolescence." The meeting was attended by approximately 150 colleagues and gave the opportunity not only for scientific discussions, but also for social communication with many colleagues and friends. One of the most impressive experiences was the case conference at the end of this meeting where we discussed the cases of two monozygote 19 year-old male twins suffering from schizophrenia and the case of a 17 year old catatonic boy who was mute, refused eating and was extremely difficult to treat.

As far as the Jerusalem 2000 congress is concerned, the following lines shall be pursued:

The three sponsoring organizations (IACAPAP, ISAP and WAIMH) shall contribute their

specific aspects to the congress and will be informed about all major activities.

The plenary sessions shall be devoted to more general themes that are important for the welfare and mental health of children all over the world.

But there will also be symposia and workshops that are concentrated on the classical major topics of child and adolescent psychiatry.

Legal aspects as the rights of children and families will have a special place at the conference, and there will be the Declaration of Jerusalem which will lay a strong emphasis on children's rights. The Jerusalem Declaration committee is chaired by Prof. Nathaniel Laor (Tel Aviv).

Our national and international associations in the field of child mental health are invited to participate in the Jerusalem 2000 Congress.

In conclusion, we can say that our visit to Jerusalem was not only extremely interesting and stimulating, but also a great impetus for our future work and rewarding in every aspect. Our deepest thanks go to our hosts Jocelyn Hattab, Sam Tyano, Alan Apter and their families as well as to all their colleagues and friends.

Appointment of two female members from the allied professions to the Executive Committee of IACAPAP:

The IACAPAP bureau (secretary general Ian Goodyer; treasurer Myron Belfer and myself), together with our past president Donald Cohen discussed this issue intensively. There were six applications, and I am sure that the two colleagues who will be appointed will enrich the activity of our association in every respect. Our secretary general, Ian Goodyer, will inform the members of the Executive Committee very soon about the decision of the bureau and will explain in detail the process that led to this decision.

Future activities

11th International ESCAP Congress, September 15–19, 1999, in Hamburg, Germany  
All national societies of child and adolescent psychiatry and allied professions are kindly invited to attend the above congress. IACAPAP will use this congress for a meeting of the Executive Board which will take place on Wednesday, September 15, 1999 in the morning. On Tuesday, September 14, 1999, in the evening, the members of the Executive Committee will have the opportunity to meet the delegates from ESCAP and representatives of the German Society for Child and Adolescent Psychiatry and Psychotherapy. The ESCAP congress will give a good opportunity to continue and consolidate the relationships between IACAPAP and ESCAP and the national societies of child and adolescent psychiatry in Europe. It is my wish and intention to establish a research and training center for child and adolescent psychiatrists in Europe by joint efforts of IACAPAP and ESCAP, Donald Cohen, Ernesto Caffo and myself have discussed this issue frequently and we are optimistic that such a center can be realized in the near future.

Second Congress of the Asian Society for Child and Adolescent Psychiatry (ASCAPAP)

This congress was held in Seoul, Korea on May 6–7, 1999. The Asian society is a very important partner of IACAPAP, and our vice-president Kosuke Yamazaki (Japan) as well as our adjunct secretaries Michael Hong (Korea) and Barry Nurcombe (Australia) are prominent members of this society. I attended this congress not only for lecture purposes, but also to negotiate with the ASCAPAP Board about their meeting so far planned in 2002 as we will have our next regular IACAPAP congress in the same year in New Delhi. I hope that we will come to a good solution which is convenient for both societies.

15th International IACAPAP Congress, New Delhi, October 29–November 2, 2002

The last IACAPAP bulletin contained an attractive description of this congress. We have never been in India with a congress so far, and the 2002 Congress in this part of the

world will be exciting and stimulating in every respect. Our host, the Indian Association for Child and Adolescent Mental Health, and IACAPAP will undertake every effort in order to make this congress an exceptional experience. Immediately after the Hamburg ESCAP meeting, I will concentrate my IACAPAP activities on this meeting, together with our board member Savita Malhotra and her colleagues and including some advisors from the IACAPAP board.

#### 16th IACAPAP Congress in 2006

There is an application of a group of Canadian colleagues to organize the 16th IACAPAP congress in Montreal. I have been approached several times by our Canadian colleagues who invited us to a site visit. Due to other commitments, this site visit has to be postponed to spring 2000. This will be early enough to decide about the 2006 congress. At the moment, there is no other formal application for this congress. But I was approached by several colleagues who had strong arguments for South America.

#### Monograph series

Jerry Young, Pierre Ferrari and other colleagues are now working very hard on the edition of the two forthcoming monographs on "Children and War" and "Autism." The latter is a result of the last Venice meeting in 1998. The monograph that came out at the Stockholm IACAPAP conference, entitled "Designing mental health services and systems for children and adolescents: A shrewd investment" was very well received and has raised great interest. I am optimistic that the two forthcoming issues will be equally successful.

#### IACAPAP Bulletin

The last issue (No. IX, December 1998) was excellent. The review of the Stockholm conference and the richness of the other information have made the Bulletin really an international forum for information exchange and discussions among child mental health workers all over the world. Our Bulletin editors Cynthia Pfeffer and Jocelyn Hattab deserve our deepest appreciation and thanks for their engaged work.

Let me combine my gratefulness and thanks to all who gave me their help and advice for my start in my new office with the hope for further support, cooperation and friendship in the future.

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#### Editors' Comments

It has been approximately a year since the wonderfully successful 14th International Congress of IACAPAP in Stockholm, Sweden. Memories still are fresh about the magnificent ambiance and tasks and plans to be implemented in our international collaborations. Our new executive committee has been extremely active in the past year as noted in our President's Message. Read it carefully because a number of significant themes are presented that are to be followed in the next few years—collaboration,

education, research to better inform about children and adolescents.

In this issue we highlight advocacy for children, adolescents and their families by offering examples of advocacy programs. Advocacy programs, groups, and services are among our best collaborators in providing improved services for mentally ill children and their families. The American Psychiatric Association's Committee on the Chronically Ill Child has developed a listing of advocacy programs in the United States to enable professionals to access this information readily and to educate families about additional resources that may offer support for treatment and education about specific psychiatric disorders. In the lead article of this issue of the Bulletin, we highlight two programs that may serve as models of approaches for advocacy. Certainly, there are numerous other programs and we welcome hearing about them and receiving brief summaries of such programs which we can highlight in the Bulletin.

Important features of many advocacy groups are that they are composed of families with specific mental disorders and in this way may offer unique and specialized perspectives about the features of the specific disorder. We publish an example of a statement written by an adult with Asperger's Syndrome, and who works closely with the Swedish National Autism

Association, suggesting important issues not addressed in the IACAPAP Declaration on Autism. Such insights may be lost without the focused attention devoted to hearing directly from individuals with psychiatric disorders.

Another important issue often unique about advocacy programs is that they can confront the political process and assist in the development of innovative services and improved understanding of people with specific psychiatric disorders. Advocacy groups often raise money to further the development of needed research and other clinical services as well as direct education to reduce stigma of psychiatric disease and to reduce barriers for accessing treatment.

Unfortunately, these advocacy associations are sometimes in conflict with professionals of mental health because some advocacy groups may have their own strict views of childhood disorders. We have to overcome these conflicts because we serve the same cause, although in different ways.

We suggest that colleagues initiate such organizations among parents of their patients. Parents are outstanding collaborators in treating children and adolescents. The terrible era of condemning parents for their children's mental disorders is passe, it's over! Arguments against parents have been destructive for them, for their children, and for child and adolescent psychiatry.

As mental health professionals for children, adolescents and their families, we know about the destructive effects of abuse, neglect, bullying, and non-respect of children's rights. Unfortunately, the same children whose rights are violated are the more likely to develop mental and developmental disorders, because of neglect, under-nutrition, battering, promiscuity, teenage pregnancy, drug abused parents, and more. Associations for children's rights, ombudsmen, hotlines, etc. play a crucial role in preventing child and adolescent suffering and the increase of psychopathology.

Although most countries signed the U.N. Declaration of Children's Rights, the situation is far from acceptable. So much is to be done by the joint efforts of advocates for children and professionals and by professionals in mental health, education, welfare, police etc. Some of these issues are emphasized in the articles about the Albert Schweitzer Institute for the Humanities and about the work of the International Center for Psychosocial Trauma in educating teachers to be therapists for war traumatized children.

This post IACAPAP Congress period has stimulated our interest in presenting the thoughts of individuals who professionally work with children and of students who may

someday specialize in professional careers related to serving children and adolescents. These perspectives are essential in advocating for children and adolescents and highlight important and often under-recognized and under-served issues. We hope they stimulate additional discussion and improve the planning of services for children and adolescents.

The widening scope of knowledge about brain development has opened new vistas for research and intervention and stimulated a focus on development. Illustrated in this issue are concepts about neuroscience that are applicable to children and adolescents.

Our planned collaborative Congresses: ESCAP, Jerusalem 2000, and the 15th IACAPAP Congress in India are important for education, collaboration, advocacy, and research about children and adolescents.

We appreciate hearing about newsworthy issues! Send such articles to us.

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Children's Advocacy: Important Networks Promoting Child Mental Health - Telefono Azzurro

The first national telephone line in Italy for the prevention of child abuse and the protection of juveniles was launched in Italy on 8th June 1987 by Ernesto Caffo, Professor of Child Neuropsychiatry at the University of Modena.

This telephone line, named Linea Istituzionale, was mainly used by adults reporting children's problems.

The year 1990 saw the launch of the first free national telephone helpline for children up to the age of 14. On 26th November 1994, this helpline adopted the easily-remembered number 1-96-96. The Linea Istituzionale for adults (051 481048) is still operative. Both lines are open 24 hours a day, 365 days a year.

The telephone operators who respond to the calls are psychologists and educators who have received extensive practical training on how to listen and offer counselling services.

Depending on the type of call, the operator will generally follow two main courses of action. First of all, s/he will offer psychological advice and support. Secondly, when necessary, the operator will pass the case on to local health and social services. The first step allows the operator to begin a process of interaction which engenders a sense of security in the child who can be sure of being totally listened to.

The operator then seeks to analyse the problem, identify the risks, appraise the

environment in which the child lives, and assess what chances, if any, the child has of improving the situation through his or her own action.

At this stage of the delicate task, the operator must be capable not only of identifying severe cases of abuse, but of mitigating the sense of emptiness and loneliness of a child who is forced to live in a household or environment that cannot or will not offer adequate security and communication.

If the child's account indicates that a very grave situation exists, the operator will then move to the second stage and request outside help.

When these sort of serious cases arise, the operator immediately reports the problem to the nearest local social services centre. The operator will contact the services directly and pass on whatever useful information s/he has to hand. This is then followed up by continuous contact with the centre.

So the moment of referral marks the starting point of the collaboration between the Telefono Azzurro operator and the social services.

The decision to involve the authorities is taken during the telephone conversation where there is clearly an emergency situation. This usually means that the child is in jeopardy. In other non-emergency cases, the operator tries to involve the child in the decision-making. The child then feels he or she has an active part to play in effecting changes to his or her environment.

#### Data Collection

In 11 years of intensive work, Telefono Azzurro has responded to more than two million telephone calls from children and adults. Nearly 30,000 of these calls were identified as pertaining to serious problem cases.

Between 1990 and 1996 the free helpline dealt with nearly 11,000 serious cases. Since the launch of the new easily memorized number in November 1994, the total of attempted calls has increased significantly: rising from around 4,000 per day in 1995 to around 8,000 per day in 1996. The roughly 2,000 completed calls handled by Telefono Azzurro each day consisted of, on average, 20 short counselling calls and four serious problem calls. Of these four, an average of one per day required reference to outside health services, social services, the police, courts or schools.

In 1997, the helpline received an average of 11,000 attempted calls per day and increased its average number of effective responses to 2,500 per day. The daily average of short-counselling calls was 25 while an average of five calls per day can be classified as referring to serious problems (the total of such calls in 1997 was 1,652). On average, two calls per day led to the forwarding of a request to the police to intervene.

Since 1987, the Linea Istituzionale (051 481048) has received in excess of 290,000 calls of which more than 19,000 referred to highly problematic cases. In 1997 alone, the number of such serious cases was 1,099, an average of three per day. The police were asked to intervene on average 2-3 times per day.

The collation of these figures not only helps Telefono Azzurro to monitor its response rates but to present a more accurate picture of the situation of children in Italy.

#### Childhood Culture

Having begun life as a telephone line dedicated to listening to children's problems, Telefono Azzurro has quickly expanded its activities and developed a series of child-centered projects. In particular, it has developed a task force of professional people from different backgrounds who work together for the welfare of children. There is a legal department specialising in children and family issues which deals with criminal and civil law. This department provides valuable back-up to the operators. It also gathers and examines legislative texts on children's rights and handles related themes. Its issues critical analyses and reports that allow Telefono Azzurro to interact with the appropriate

governing bodies to improve and modify legislation.

Another source of support for the operators comes from the Telefono Azzurro research centre which was established to gather and analyse the information and data inherent in the calls received. The data is used for national research into the level of child abuse and the extent of distress among minors.

The relationship between children and the media is particularly important for Telefono Azzurro, especially as modern technology poses new risks for children. The educational department of Telefono Azzurro therefore keeps watching on the various media and seeks to raise the awareness of adults and encourage them to exercise responsibility in the use of the media. Telefono Azzurro co-operates with the Italian National Association of Journalists with which it has drawn up agreement known as the "Treviso Charter." This sets out a series of rules and a code of conduct that the press must observe to respect the privacy and anonymity of children.

All of these services were originally introduced to guarantee a high quality of response on the telephone, but in time they have become projects in their own right. Telefono Azzurro has thus grown into a more complete organisation offering a full range of services for children in need.

#### Scientific Research

Engagement with the world of childhood must necessarily be scientifically based. The phases of infant development and the needs of the children require serious and complete study.

The study of the environment in which children live also entails an analysis of family situations, of the social factors that are changing the structure of the family, and the new risks that society presents to the child.

Telefono Azzurro has always defended the importance of such an inclusive approach to research and analysis, and has thus built up a series of contacts with the world of Italian and international science. It maintains close contact with the world of psychiatry and psychology and seeks to work constructively with all those whose life or professions bring them into contact with infants.

#### Information and Awareness Campaigns

Modern society must learn to understand the world of infancy and make room for the needs of children. Our cities are too often planned and built according to an adult standard, and this is gradually alienating the younger generation.

Over the last 11 years, Telefono Azzurro has made itself a mouthpiece for children's needs by means of awareness campaigns which, in addition to highlighting the fundraising needs of the organisation, also try to get adults to stop and think about problems which, if ignored, risk becoming irreversible.

In recent years, the awareness campaign has focused on the changes being wrought to society and family life. One of the functions of Telefono Azzurro as an organisation is to assist in the re-establishment of composure and balance at the core of the nuclear family, for it is here that child finds happiness and comfort.

#### The Commitment of the Volunteers

It is meaningless to talk of Telefono Azzurro without reference to the exertions of its volunteers. It is their work that forms the backbone of the organisation. They are its strength and their conviction and passion enable Telefono Azzurro to go on surviving.

Without the voluntary help of hundreds of young and not so young people who raise funds and organise publicity initiatives, it would not be possible to carry out all the projects that help children travel the difficult road to growth and maturity.

The volunteers are organised into local committees around the country. These committees carry out a whole series of valuable and useful functions, such as:

- Enhancing the level of public awareness of children's rights.
- Fundraising for the telephone helpline and keeping the number (1-96-96) in the national consciousness.
- Keeping up contacts and working with local institutions (public services, local authorities, schools).
  - Organising local social events (meetings, lectures, parties etc).
  - Taking direct action on behalf of children through specific projects. There are two projects already under way in various parts of Italy, involving trained volunteers.
    - One to One: a grown-up by your side. This project provides help to children in need. A voluntary worker offers help to an individual child in difficulty. The one-to-one relationship gives the child an additional source of trust and support and provides a new relationship. The project takes place through schools and has been organised in association with educational establishments.
    - Children in prison: Telefono Azzurro volunteers go into prisons, and, with the full collaboration of the prison authorities, try to improve the conditions for infants (aged 0-3 years) who have to live in prison with their mothers.

The information campaign remains at the centre of Telefono Azzurro's activities. It is through the propagation of the principles and the work of the organisation that children can be made aware of their rights and their minor but important duties. In this manner they can help adults to create a world that is better suited to children's needs.

Telefono Azzurro has begun a project of spreading awareness of the United Nations Convention on Children's Rights throughout schools by distributing a simplified text of the Convention (drafted in 1989 and ratified by Italy in 1989) and by showing videotapes. Children are directly involved in this project and encouraged to talk about the text of the Convention and say what rights they consider the most important.

Telefono Azzurro volunteers are present in the school through the so called "TA Clubs." These are junior branches of Telefono Azzurro, and their purpose is to help children become aware of their rights and directly involve them in programmes.

#### Projects Beyond National Borders

From the outset, Telefono Azzurro has invested a lot of effort and resources in international activities and relations.

As a member of the International Forum for Child Welfare (IFCW: formerly chaired by Professor Caffo), Telefono Azzurro continues to develop and strengthen its collaboration with foreign childcare associations. These international relationships enable Telefono Azzurro to make a contribution to a world-wide movement to engender greater awareness of and respect for the rights of children.

The legislative and political lobbying of Telefono Azzurro in Italy draws on the experiences of its associate child care organisations abroad. Indeed, in the recent past a large number of projects backed by Telefono Azzurro and implemented in Italy are the direct result of meetings and seminars with foreign associates.

Scientific research into childhood issues has received a considerable boost from the relationships cultivated by Telefono Azzurro with US academic institutes. In 1994, Telefono Azzurro organised the first "International Meeting on Listening to Children" in the USA. The conference brought together representatives from the major child help lines from all over the world. Such meetings give participants the opportunity to think about childhood problems from a general and broad perspective that transcends cultural boundaries.

To ensure that further meetings of this sort might take place, Telefono Azzurro created the "Children First Foundation: based in New York. The Foundation aims to stimulate international contacts, carry out research and provide a point of reference for

professionals working in the area of child care.

Drawing on US experience, Telefono Azzurro is currently setting up a new scheme in Italy called "Progetto Emergenza" (Project Emergency) which provides for co-operation between the police, social workers, first aid medical staff and experts from Telefono Azzurro. The project will borrow from the experiences of the Child Study Centre of Yale University which works in association with the Police Department of New Haven. The goal is to set up and train a team composed of specialists in child mental health and police officers. The team will be called to intervene in situations where minors are caught up in acts of violence, whether as victims or witnesses.

Telefono Azzurro has decided to set up a similar project in Italy which will be adapted to suit the different national circumstances. The project will involve the co-operation of the Ministry of Internal Affairs, local prefects, the juvenile division of police departments and the police themselves.

Growth in Europe

As founder-member of the European Forum for Child Welfare, a regional branch of the International Forum for Child Welfare, has always believed in the possibility to create a more "child friendly" European Union in which young people may feel safe and be treated as first class citizens.

The interest recently shown by European institutions in childhood problems offers a great opportunity, and this is why Telefono Azzurro, after 11 years from its birthday, has decided to open an office in Brussels, right at the heart of European decision-making.

Thanks to this office, officially opened on October 1st, 1997, new challenges are opened: Telefono Azzurro will contribute to initiatives in the field of child welfare promoted by the European Commission, the Council of Europe and other bodies. At the same time Telefono Azzurro will be channelling information from Brussels to the relevant institutions in Italy.

Telefono Azzurro is engaged in a series of projects cofinanced by the European Union that enable it to pass on the fruits of its own experience and learn from others. The major project, Dafne, is aimed at establishing a network of European child helplines and is being conducted in association with those of France and Greece. The network may then be used as a means to greater cooperation and will provide an opportunity for the unified management of data.

On behalf of the European Commission, Telefono Azzurro is also conducting a feasibility study into the establishment of an ombudsman for children. Working in association with the Uppsala municipality in Sweden, Telefono Azzurro is exploring the possibilities inherent in the creation of this new institutional figure whose task would be to co-ordinate child care and protection policies. Represent and promote children's rights and act as a mouthpiece for children within the broader socio-political context.

Besides these enterprises, Telefono Azzurro is working on a new project to facilitate the international exchanges of operators in order to deepen the mutual comprehension of techniques. This aim will be reached, also, through the creation of an international library which will gather, in Italian and English language, the outfit of laws, conventions, studies and datas concerning children condition in Europe.

Finally, Telefono Azzurro is developing a new strategy of co-operation with east European countries as part of the Phare and Tacis initiatives. The condition of children in some of these countries is particularly bad, and their rights are still far from being properly recognised. This is a new venture for Telefono Azzurro which is nonetheless confident of its ability to offer a valid contribution towards the development of new and effective means of protecting children.

. . . And This Is Only The Beginning

Eleven years is time enough to allow us to make a tally of our achievements and form a good idea of what has been done to date. It is also long enough for the public to have formed an opinion of Telefono Azzurro. The unexpected success of the 1996 fundraising campaign which allowed Telefono Azzurro to continue to survive was perhaps the most significant message that the public could send.

The figures for telephone responses show that Telefono Azzurro provides a vital point of contact. The number of calls received, especially on the free0phone 1-96-96 number, points to the existence of an alarming level of distress among children. But the high number of calls also reinforces our determination to continue to act as an important force for the prevention of and struggle against the abuse of children.

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IACAPAP Presidential Lecture: Donald J. Cohen, M.D.

Desmond Kaplan, M.D.

Professor Donald J. Cohen, outgoing President of IACAPAP and Director of the Child Study Center at Yale University, gave his outgoing presidential lecture entitled, "The Self Under Siege: The Biopsychology of Tourette's Syndrome and the Integration of the Mind." For many in the audience, this was yet another opportunity to experience the brilliance, dynamism and warmth of the outgoing President in a wonderfully cogent lecture, rich in content and vision. The choice of Tourette's Syndrome (TS) for the Presidential Address was highly appropriate as the Child Study Center has led the field in the treatment and study of this disorder for almost two decades. Furthermore, Tourette's Syndrome provides an excellent model for the "integration" of the human mind.

Firstly, Professor Cohen acknowledged the contributions of a multidisciplinary group with whom he has worked over the past two decades including Professors James Leckman, Fred Volkmar, David Pauls, George Anderson, Robert King, Bradley Peterson, Jerry Young, and Mark Riddle. The clinical will need a new way of thinking about children and their families, said Professor Cohen, that will integrate psychodynamics and biology to move beyond mind and body. Today, we have an outline of a new clinical epistemology to guide child and adolescent psychiatry into the next century.

Professor Cohen then went on to describe the tic disorders. Tics illuminate the boundaries between voluntary and involuntary, conscious and unconscious, and meaningful and meaningless in mental disorders. As with the work of Gilles de la Tourette, said Professor Cohen, Sigmund Freud's work had launched a new field and a continuing line of investigation of the inner world. Throughout this century, these two traditions—the neurological tradition of Tourette and the psychological one of Freud—had occasionally come into contact. Yet they were mainly divergent and had been hard to integrate. Tourette's Syndrome hovers between the two domains of study. It is sometimes located more in the territory of the brain and sometimes more in the mind. Today, said Professor Cohen, we are able to envision a new integration in the traditions of clinical psychoanalysis and neuroscience, two traditions that provide a complementary perspective on the origins and maintenance of an integrated sense of self.

Continuing, he alluded to the general issues in developmental psychoanalysis (as conceived by Anna Freud), that are raised in trying to understand the relations between inherited vulnerability, the effect of vulnerability on the brain, behavioral development and temperament, and the emergence of symptoms. In clinical work, it was now possible to trace the developmental burdens shaping the child's emerging sense of self, effecting the

coherence of his or her inner experience.

Clinicians and researchers now recognize that TS is a familial and genetic disorder, close to the early models of Sigmund and Anna Freud. As the genes and gene products are clarified, research and care will enter a new phase. We will begin to understand the interactions between genetic endowment and psychosocial context in the emergence of specific symptoms and severity. Elucidation of the genetics of TS will allow for effective preventative and early intervention treatments, as well as therapy of children who are vulnerable or are beginning to experience tic syndromes.

The findings at the Child Study Center at Yale, said Professor Cohen, suggest that the symptoms and course of TS are related to abnormalities in the cortico-striatal-thalamic-cortico pathways (CSTC). These pathways integrate the cortical, frontal regions of the brain with deeper brain structures that subservise emotion, movement and sensory systems. Dysfunctions in these integrative pathways may be related not only to genetic risk factors, but also the interactions between constitution and environment. Early recurrent experiences that might impact on CSTC pathways include the manner in which arousal is modulated by parents, the continuity of caregiving, and the impact of sudden losses and other traumas. Models such as these, which bridge the effects of early experience and biological factors, are beginning to approach the level of complexity that is of interest to child psychoanalysis. They are also amenable to empirical examination.

Professor Cohen then very movingly shepherded us into the fiercely difficult inner world of Abe (a patient of his for the past 18 years) who suffers from Tourette's Syndrome. Most touching was Abe's response after listening to his own case report: both verbal, describing the two tormented clashing bulls in his head, and physical, lifting a fatherly Professor Cohen into the air. In adulthood, said Professor Cohen, many children make a very good adaptation, regardless of the severity of their childhood problems. A motto for clinical care should be to treat the child and not the tics. Very good therapeutic results have been seen with a spectrum of interventions including education of the family, support and guidance, school interventions, individual psychotherapy, cognitive behavioral therapy and the judicious use of medication. All too often development is derailed because of the pursuit of "cure." For example, there were children who received poorly monitored polypharmacy, confusing their bodily state and impairing their sense of autonomy.

Tics, obsessions, and compulsions are breakdowns in the normal organization of experience and behavior, he said. The child experiences and emits disjointed, meaningless fragments of behavior and tries to make sense of an alien experiential world. His self is under siege from inner forces. The therapeutic process for children with these breakdowns is aimed at reconstituting meaningfulness and coherence. Specific therapeutic interventions should occur in the clinical context of the relationship, with fully shared concern and knowledge. Taken together, available interventions are effective for the majority of individuals.

In the past, clinicians as well as philosophers have thought about human development from two perspectives—biology and psychology, and have sometimes felt that these were two separate maps: one for the development of the mind and the other for the development of the brain. Today, he said, we know that clinical care and research can lead to a new epistemology that does not split the mind and the brain, but which remains committed to understanding the child as a whole developing person.

Finally, Professor Cohen thanked IACAPAP's international community of child mental health clinicians and researchers who have worked to create bridges across nations and disciplines. At this moment, he said, we can feel a sense of hope, anticipating that in the next epoch, new methods, new understanding, and new approaches to the delivery of

care, will help treat children with the most severe disorders.

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## A Student's Perspective: Accounting for Culture within the Therapeutic Relationships

Jane Jung

Cornell University, Ithaca, New York

The unique opportunity to work on an adolescent inpatient unit at the New York Hospital in Westchester, NY brought the issue of culture and cross-cultural differences within the therapeutic relationship into the forefront for me. Many of the patients on this unit were from a different cultural background than my own, with a large percentage of the population being African American. Thus, the question that was raised in my mind when interacting with these adolescents was whether or not I, as an Asian American research volunteer, could relate with these ethnically and, more specifically, culturally different youths.

Culture plays an enormous role in shaping the identity we perceive ourselves to have. We identify ourselves with a particular ethnic or social culture because it defines who we are in terms of our actions, attitudes, and particular beliefs. Simultaneously, our culture elicits certain behaviors in accordance with acceptable social norms. Cultures can either unite groups of people or it can separate them, for methods of verbal and nonverbal communication are dictated by cultural. Additionally, cultural biases serve as colored filters in interpreting specific social situations. All in all, culture is a social structure that weaves itself into our individual identities. Therefore, it is necessary to recognize and understand another's cultural identity in order to understand the individual as a whole. The purpose of this article is to address this issue within the confines of a therapeutic relationship. How does one relate to a child/adolescent of a different cultural background? Can such barriers be overcome for the purpose of helping a child or adolescent that is from a different cultural background from oneself?

Experience has taught me that this feat is possible. Understanding a person of a different social or cultural background first requires one to recognize that important differences exist between you and that person (Sue, 1981). One must consciously be aware of the differences in values and opinions that he/she may have in respect to the patient and then make active efforts to understand the source of such cultural differences. Often times we do not take the time to address such differences and automatically assume that our trained abilities to empathize and reflect will adequately bridge the wide gap of cross-cultural differences and misunderstandings. By not specifically addressing such issues, we assume we can completely understand those that are different from us. Instead, we need to recognize that people of various cultures react and relate to their family, peers, and other members of the community in a unique and different manner. What we identify as abnormal or strange in one culture could be identified as normal or even acceptable behavior in another. This, it is imperative that those in the helping community view a person's actions and specific behaviors in reference to their specific cultural background.

Secondly, we must recognize and understand that cultural factors permeate every aspect of our lives. Our avenues of sending and receiving verbal and nonverbal communication are influenced by culture, making the ability to recognize cultural cues by the helper essential (Sue, 1981). Additionally, our thoughts and our actions are mainly guided by norms created by our culture, and yet the need to understand different cultures

is a low priority for many. It is on this note that I emphasize the need for those in the helping profession to become aware of the cultural and social differences that lie between themselves and their patients.

My own experiences have taught me that I need to set aside my own cultural biases in order to effectively help others of a different cultural and social background. Relating to young African American girls on the adolescent unit required an open mind and a teachable heart. Cultural differences in these girls' interactions with their family and peers significantly affected my view of them. For instance, I observed a young African American girl being silent toward her grandmother during an arranged family meeting. While most viewed her silence as oppositional, I viewed it as an internal struggle between wanting to express her angry feelings toward her grandmother and wanting to respect her. In order to see the nature of this situation, however, I had to understand specific aspects of this culture. A definitive element of power and authority toward older maternal figures exists within the African American culture. Older maternal figures of the household are relegated much power and respect by other members of the family. Thus, it is not unusual for a young girl of this culture to feel fear and helplessness when in contention with an older figure of her family. Silence might have been her way of dealing with this internal conflict, and yet without looking at the cultural dimensions of the African American family someone from a different cultural background would not have picked up on this. Hence, the issue of culture is highly pertinent when relating to those of a different background from oneself.

The therapeutic process is effective when positive change is enacted within the individual. However, I believe this change cannot be made with an insightful and understanding therapist. Many people today do not have the luxury of being counseled by someone of the same ethnic or cultural background. How then can we ensure these patients are given the best form of care available to them? There are many barriers that close off an effective relationship between the therapist and the patient. Cross-cultural differences as well as different life experiences are among the most prominent of these potential obstacles. Issues such as these, then, must be addressed and dealt with in an effective and intelligent manner within the realms of education and training of professional helpers. Students venturing into these professions should be made aware of such obstacles and given plenty of opportunities to study, explore, and negotiate various methods of relating to others of a different cultural background. Taught within a specific curriculum, this education will better equip students to maneuver and guide future helping relationships within a culturally diverse nation. It is with this insight that I address our need to recognize culture and its differences between people in playing a significant role in our ability to understand one another. In bringing this issue to light, I hope to help foster an effective therapeutic relationship between the culturally different therapist and patient.

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Invitation to the 11th International Congress of ESCAP - 15-19 September 1999,  
Hamburg, Germany

Dear Colleagues,

It is a great pleasure for me to invite you to the 11th International Congress of the European Society for Child and Adolescent Psychiatry (ESCAP) to be held from

September 15-19, in Hamburg, Germany.

The main theme of the congress is "New Challenges–New Solutions," particularly considering the remarkable changes in nearly all fields of life and all over the world.

The Congress is organized in collaboration with the Section of Child and Adolescent Psychiatry of the Union of European Medical Specialists (UEMS) and with the Deutsche Gesellschaft für Kinder- und Jugendpsychiatrie- und psychotherapie (DGKJPP).

The European Society for Child and Adolescent Psychiatry (ESCAP) is the European organization of national societies committed to child and adolescent psychiatry and psychotherapy. Founded in 1954 in Switzerland, ESCAP has been the leading scientific and professional organization of child and adolescent psychiatrists in Europe for many years and pursues the following aims:

- to foster the European tradition of child psychiatry,
- to facilitate and extend the bonds between physicians practising child psychiatry in European countries,
- to spread the results of research and experience in this branch of medicine by publishing reports and organizing scientific conferences and meetings, and
- to collaborate with international organizations with the same or related aims.

I trust that these aims will be pursued at the international meeting in Hamburg, which will cover the whole range of new developments in the field of child, adolescent, and family mental health.

Hamburg is a wonderful place providing not only excellent facilities for our meeting, but also a rich historical background and a manifold cultural and social life. Please join us in Hamburg!

Prof. Helmut Remschmidt, MD, PhD  
President of ESCAP

For further information, please contact:  
E.S.C.A.P.  
11th International Congress  
Fax: ++49/40/3569-2269

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### Jerusalem 2000 - An Extraordinary Congress

In just 18 months on October 26, 2000, the Jerusalem 2000 Congress will begin.

You will receive a detailed second announcement in the next months. However, we would like to sensitize your interest for this outstanding professional, social, cultural and mystic event. We work to provide you with a special, unforgettable experience.

Symposia will elaborate on what has been done for children over the last decades and what we foresee has to be done on law and legislation, schooling, welfare services, psychology and development, psychoanalysis, international adoption, minor migration, psychopharmacology, nosography, epidemiology, communication, brain imaging, service delivery, road accidents, religion, TV programs, and more.

This congress is a joint congress of IACAPAP, WAIMH and ISAP. It will be sponsored by the First Ladies Club; among them, Ms. Hilary Clinton, Ms. Blair, Ms. Chirac, headed by Reuma Weizman, wife of the President of the State of Israel. KENES, Congress organizers, work intensively on a wonderful social, tourist, and entertainment program. It will be an extraordinary congress.

Save the dates and prepare your presentation for one of the many symposia, workshops

and poster sessions.

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## New Techniques in Neuroscience

Paul Lombroso, M.D.

Child Study Center, Yale University School of Medicine

New techniques in the field of neuroscience are now being applied to the study of how the human brain develops under normal or abnormal circumstances. These are exciting developments that will have a tremendous impact on our understanding of childhood psychiatric disorders, and how we care for these children. As child psychiatrists, it is important to appreciate some of the recent advances in these areas. I have chosen to discuss how neuroimaging techniques are allowing researchers to get a much more refined definition of how the brain works, and how recent advances in genetics permit us to understand the underlying molecular basis of many neuropsychiatric disorders. The practice of child and adolescent psychiatry and allied professions will certainly be shaped by this new knowledge, and it will become increasingly important for us to link new findings from laboratory research and the consulting room.

A key controversy in child psychiatry over the past fifty years has been the dispute over whether nature or nurture are more important for determining child development. Few topics have aroused more passion or displayed such swings of the pendulum as the debate over genetic and environmental influences on how the brain develops. Which one reigns supreme in its contribution to the normal or abnormal growth of our children?

The history of research on autism is an excellent area to get a feel for the intensity of this debate. The core symptoms of this disorder were first described by Leo Kanner in 1943. He speculated that the core symptoms of autistic children had a biological basis. Perhaps the inability to develop social attachments was an innate neurological feature.

However, he also commented on the parents of autistic children, who occasionally displayed peculiar personality traits. Unfortunately, it was his commentary on the parents of autistic children that led others to theorize that inadequate parenting could cause autism. Thus began an era in which "refrigerator mothers" were held responsible for inducing autistic behaviors in their offspring. During the 1970s and 1980s however, the pendulum slowly swung back as genetic studies suggested that other factors contributed to the etiology of autism.

Today, the question is no longer whether nature or nurture is more important in the expression of childhood neuropsychiatric disorders. Both are viewed as critically important. It is clear that some genetic mutations are so disruptive that regardless of environment the brain is destined to develop abnormally. More typically, however, it is the interplay between these two factors that determines whether a child will develop normally or abnormally. Similarly, there are times when the extent of environmental deprivation is so extreme that neurological impairments emerge despite the adequacy of the underlying genetic plan. For the typical family and typical child, it is the interplay between these two factors that shapes the development of the CNS and the unfolding of cognitive and social skills over the first few decades of life.

Some of the strongest arguments for the contribution of both genetic and environmental factors to neurological development come from twin studies. Monozygotic twins have much higher concordance rates when compared to dizygotic twins for many physical traits, cognitive skills, and the development of psychiatric disorders. However, it is rare for the concordance rate among monozygotic twins to exceed 50% suggesting that

environmental factors are also etiologically important.

One type of neurological disorder which both environmental and genetic factors clearly contribute is autoimmune disorders that affect the CNS. Recently, there have been several reports suggesting that some cases of Tourette syndrome and obsessive compulsive disorder are autoimmune disorders that result from prior exposure and immune responses to streptococci infection. Although these individuals produce antibodies against streptococci in a normal fashion, the antibodies also cross-react with proteins in the CNS in addition to the streptococci specific molecules. As a consequence of this cross-reactivity with self antigens, the CNS is compromised and neurological symptoms emerge. This mechanism for causing autoimmune related diseases has more generally been referred to as the molecular mimicry hypothesis. It has been speculated that repeated infections in vulnerable individuals can exacerbate clinical symptoms, and this is one explanation for why symptoms in these disorders often wax and wane. However, the evidence for this hypothesis has not been generated yet in the laboratory, and we must await these results before subscribing to this particular theory.

The neuroscientist and the clinician share a fascination with how to link the inner world of the child with emerging knowledge on how the brain develops its capacity for thought, feelings, and expression. Over the past two decades, our basic understanding of the biological and environmental factors that influence brain development has grown dramatically. The clinician no longer has to choose between nature and nurture, but can appreciate their interaction in the understanding of normal or abnormal development. In this new age, basic neuroscience techniques have begun to reveal the continuous interplay between the child's unfolding genetic program and the complexities of experience and activity-mediated changes in the cells of the brain.

High resolution neuroimaging techniques such as functional magnetic resonance imaging (fMRI) show us the changes in neuronal activity within brain nuclei, the concentrations of different neurotransmitters and other neuromodulators while an individual is speaking, listening or learning new tasks. We have reached a new level of understanding of how complex brain functions are localized in normal individuals, and individuals who have different disorders. These techniques are being applied to children with disorders such as Tourette syndrome or dyslexia, and the results are helping investigators determine what neural networks may be involved.

One area of active research relates to the development of higher cognitive skills. In an effort to better understand normal cognitive development, researchers often study abnormal development. For example, to better understand the development of language, investigators have turned to individuals with normal hearing as well as individuals who are born deaf. What leads to certain parts of the brain being dedicated to certain cognitive skills? In deaf individuals, what happens to brain regions that are normally dedicated to auditory processing? Does it simply disappear, never having developed properly, or do they get taken over and dedicated to other sensory modalities?

Functional MRIs have allowed this question to be addressed. This neuroimaging technique allows researchers to measure the amount of activity that occurs in different regions of the brain. If a certain brain region is metabolically active while a subject performs a particular cognitive or motor activity, it is presumed that the brain area is critical for that task. The experiments must be carefully designed to assure that one is actually measuring what it is you want to measure and not an associated feature.

When normal individuals are asked to listen to spoken language, areas that light up intensely are Heschl's gyrus and the associated Broca's and Wernicke's areas. These regions either within or close to the temporal lobes has been known for many years to be involved in the processing of language. Therefore, it was of interest to know what

happens to this area if you are born deaf. Research in the laboratory of Helen Neville has looked at this question. It turns out that there is an increase in visually evoked responses in these regions. By studying how these changes come about in infancy, it has been determined that young infants normally show visually evoked responses over large areas of the cortex, and these become restricted to classical visual areas during the first 2-3 years of life. This does not occur in children born deaf. There is no significant decrease in Heschl's volume, rather, the region is rededicated to processing visual information.

If deafness occurs after this plastic period, however, deaf individuals do not show visually evoked activity in auditory areas. This underscores an important maxim developmental neuroscience which states that there are critical periods during which neuronal growth and synaptic connections normally form and become stabilized. At the extreme of this idea is that abnormal sensory inputs during infancy can substantially alter the types of connections that are established.

Neurobiologists have long been interested in determining how this occurs. The early development of the brain involves the following important steps. Neurons are born early during gestation and soon differentiate into their final cellular type. They then begin to migrate to their final brain destinations, and grow axons roughly to the appropriate targets. These events occur during gestation and are mostly complete by birth. They rely primarily on intrinsic factors within the CNS and are largely independent of environmental events. This is not to say that environmental factors such as drugs, alcohol, and viral illnesses cannot disrupt normal brain development. They can if they occur during critical periods of neurogenesis and migration while the fetus is growing.

After birth, the next phase of neurological development begins. This consists of the laying down of proper synaptic connections between interacting neurons. Environmental factors become critically important during this stage of brain maturation. In humans and other mammals, following birth there is a dramatic increase in the number of synapses. The specificity of neuronal connections is then refined during early postnatal life. Experimental data have shown conclusively that neuronal activity is critical for refining and stabilizing correct synaptic connections. Thus, once the initial circuitry of the CNS is guided by intrinsic factors into roughly correct patterns, sensory inputs drive patterns of neural activity that further specify connections between neurons.

A very important series of experiments were conducted in the nineteen sixties and seventies by the Torsten Wiesel and David Hubel, for which they received the Nobel Prize in 1981. The most important result of their work was that early visual experiences are critical factors for the eventual organization of the adult visual cortex. The primary visual cortex receives input from the two eyes via a relay in the thalamic visual area. Like all cortex, the primary visual cortex is a layered structure, with visual input forming synapses on neurons in layer 4. Initially, synaptic input into the visual cortex is homogeneous. As visual input occurs, there is a clear separation of input from the right and left eyes into alternative bands that Hubel and Wiesel called ocular dominance columns.

The early work on the visual cortex demonstrated that the normal segregation of inputs that is present later in adult brains requires visual input, and that this activity must occur during a particular window of time. If the animal grows with input from only one eye, then the neurons in layer 4 respond only to that eye and not at all to the other. As a result, very little territory will be dedicated to the unused eye.

Another critical result of this work was to demonstrate that this ability to reorganize the pattern of inputs is limited over time. Restricting vision to only one eye in adult animals has little effect on the organization of inputs to the primary visual cortex. Moreover, a return to normal, binocular visual experience in the adult cannot repair the abnormal

organization of inputs to visual cortex resulting from early visual deprivation. The period of time during which the normal establishment of ocular dominance columns may be disrupted is called the "critical period."

Deficits in our ability to see occur if we do not experience normal vision during these early months and years of our lives. A dramatic example of this is seen in infants who are born with congenital cataracts. These children do not have normal visual inputs through the affected eye. If the cataract is not removed early but is allowed to remain in place for several years before it is removed, the child will never be able to see through that eye, a condition referred to as amblyopia. This is obviously in contrast to what happens in adult life. The adult who develops a cataract late in life slowly loses sight through that eye. However, once it is removed normal vision returns.

The visual cortex has been the most extensively studied area of the cerebral cortex. It is reasonable to ask whether other regions of the brain develop in similar ways, and require neural activity to develop normally. We discussed earlier how in brains of deaf children regions that normally belong to the auditory system now respond to visual inputs. A second example comes from children who are bilingual from an early age.

The acquisition of language during the first several years of life underscores how important early activity is to the organization of the brain. Functional MRIs have been used to determine the spatial relationship of language centers in individuals who have learned their own language as well as a second language. If a child learns a second language early in life, both the native and second language are represented in the same cortical region. In contrast, when a second language is acquired as an adult, a new language center is established in the cortex that is clearly separated from the native language center. Although these findings do not yet explain why young children are able to learn a new language more easily than older individuals, it does support the findings that early experiences affect the way the brain develops.

The work from a number of laboratories have provided compelling evidence that certain growth factors may play an important role in much of the activity-dependent growth and development of neuronal structure. These small signaling molecules have long been known to play critical roles in their ability to promote neuronal survival, and for their ability to guide axonal growth. More recent investigations have demonstrated that the same growth factors are able to regulate the extent of dendritic growth, and whether particular neurons will be pruned away. Much of the strengthening of neuronal contacts appears to be mediated by growth factors. This is an area that is only now being explored, and is one mechanism by which an environmental factor (visual input for example) will influence the pattern of cortical growth, presumably leading to strengthening certain cognitive skills.

It appears then that if you do not reinforce certain synaptic connections early in development, they are unlikely to develop later in life. Although much of this work has been performed in the visual and somatosensory areas of the cortex, it is reasonable to assume that similar patterns are established in other brain regions.

What happens if you stimulate synaptic growth early during development by exposing the child to novel or different experiences? Does exposing our children to 'enriched' experiences early in life lead to smarter adults?

Researchers in Fred Gage's laboratory have begun to answer these questions. What is the extent of neuroanatomical plasticity that occurs in the brains of mice reared in an enriched environment? Mice have been raised in special cages that contain a number of additional items, such as wheels, toys, and tunnels. There is little doubt that this type of enrichment is very different from their normal environment in the wild. However, it is a considerable improvement over the starkness of the control cages.

The brains of the animals raised in the “enriched environment” were compared to the brains of litter mates raised in the control conditions. A number of significant morphological changes in brain growth were found in the hippocampi of mice raised in the enriched environments. These included an increase not only in the number of neurons present, but also in the overall volume of the hippocampus. The experimental animals were also found to have improved ability to learn new tasks. Similar experiments have shown an increase in the extent of dendritic arborization and the number of supporting glial cells in enriched environment can have a substantial effect on how the hippocampus develops and wires itself during critical periods of maturation.

The review has focused mainly on environmental factors. We are now beginning to appreciate the importance of genetic factors in neurological development. Recent work in several developmental disorders has led to the isolation of the genes that are thought to cause these disorders. One example of this is fragile X syndrome which is the most common form of inherited mental retardation. The gene that causes this disorder was recently isolated, and studies are now underway in several laboratories to determine the function of the protein that it encodes. Other examples of developmental disorders that have a known genetic cause include Prader-Willi syndrome, Angelman syndrome, and several forms of lissencephaly. A number of laboratories have reported that they are close to isolating genes that contribute to autism, Tourette syndrome, and some forms of dyslexia.

We are entering a new age in child psychiatry in which it is becoming important to become familiar with recent developments in neuroscience, especially if one is interested in understanding the etiology of various childhood neuropsychiatric disorders. Many of us were not interested in neuroimaging techniques, in molecular biology, or in neural networks when we began our life long interest in children and their psychiatric difficulties. It is becoming clear, however, we will need to pay attention to these studies that are going to clarify the intricacies of both normal and abnormal development during the first years of life.

Portions of this article were adapted from a series of columns on development and neuroscience that has appeared in the Journal of the American Academy of Child and Adolescent Psychiatry.

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## Nurse's Role in Hospital Care for Suicidal Teenagers with Traumas

Marie-Joseph Ruard  
Stockholm

Before touching more specifically upon the nurse's role in the care provided to suicidal teenagers who have undergone a trauma, allow me to introduce to you the crisis unit where we receive these young people. The crisis unit for teenagers and young adults in Geneva is a hospital unit with 8 beds, in individual rooms, located in an apartment in the centre of town, not far from the general hospital and from the emergency service with which we cooperate. The therapeutical staff is multidisciplinary and specialised (psychiatry nurses, a psychologist, psychiatrists, a social worker, an art-therapist). This unit opened in November 1996. It is the result of a project conceived in the “Hopitaux Universitaires Genevois”, by a team led by Pr Ladame, with the help of the private fund Children Action.

This hospital unit is completed by a phone line where we can assist professionals

confronted to suicides in their work. We also provide as well emergency consultations for individuals (family, close relations, patient him or herself. . .), doctors or social workers.

The crisis unit for teenagers, receives young people from 16 to 22 years old who have tried to commit suicide or who have suicidal ideas. The admission is made on a voluntary basis after an assessment interview with the teenager. For these young persons in crisis, the unit represents a space of treatment and psychic elaboration which, after four weeks at most, results in out-patient care.

In 1997, the average period of stay was 18 days. The ambulatory psychotherapeutic follow up, organised from our unit, represents the best guarantee against very frequent recurrences in that category of the population. This crisis work is based, among other things, on daily psycho-dynamical interviews with doctors and nurses. It is maybe worthwhile to specify that the functioning as well as the results of this unit are assessed by the "Institut Universitaire de Medecine Sociale et Preventive" in Lausanne. After the first assessment, a year after the opening, one could already confirm what the staff have noticed in its practical work: the high frequency of traumas in the life of these youngsters. Although the number of teenagers who fitted exactly in the research protocol was small, this first report stated that 58% had been victims of physical violence and 48% of physical interference including 29% who had undergone rape and 15% who were victims of incest.

Thus stood the question, for us nurses of the specifics of our role in dealing with such patients. We came to the conclusion that the major feature of our role is the ability to ensure a relational continuity with the teenagers throughout their stay at the unit. This relational continuity, in space and time, is supposed to help the patient to develop a feeling of secureness with the others, thanks to a structuring environment which in turn can lead to the possibility for the him or her to feel more secure inside, and help the emergence of thoughts and affects linked to the trauma.

This relational continuity will enable the revelation of the trauma. This revelation is always difficult, for the teenager has to free him or herself from a secret which has been weighing for a long time on his or her actions, thoughts, affects and relations to the others. The teenager chooses then the person he or she will speak to (often a nurse) as well as the timing, the setting (formal or non formal), and talks about what he or she had to go through. The patient has to feel immediately believed and recognised in this part of the secret. When the chosen interlocutor is a nurse, he or she then becomes a facilitator of the speech, like an ambassador to the psychiatrist and sometimes to the family. If the young person decides to speak about it with people around him or her, it can be done in a collective framework, which is thought over with the social worker in charge of relations with the family. The nurse has then to decide what type of attitude, what type of listening, what type of support to be adopted when faced with such a revelation.

Two extremes are to be avoided. Adopt a much too passive attitude which can lead to a bigger lack of confidence vis vis the adult and could even be perceived as a sort of complicity. React, on the other hand, in a very emotional and hyperactive way, with the risk of identifying him or herself with the traumatised teenager, thus reinforcing the effects of the trauma. We feel that the nurse must find the right place between these two opposite poles.

This profoundly empathic attitude is aimed at allowing a multidirectional development: It is supposed to help the patient identify the confusion of thoughts, the confusion of contradictory emotions (shame, guilt, anger, violence, fear, but also desires and impulses linked to adolescence which can be a source of ambivalence and guilt). This attitude has to allow the young person to begin a reconciliation with his or her body which at that time is perceived as something bad. We have to pay a great deal of attention to the various

expressions of the body (headaches, stomachaches, agitation, eating disorders). These symptoms, which the nurse is directly in contact with, can be a way of initiating the relationship with the staff, a way of attracting their attention, of expressing suffering and a linking it with the trauma.

We also have the feeling that the major role of the nurse, thanks to the numerous talks and the relationship woven with the patient in complement to the doctor, is to allow the person to become the actor of his or her own history, and not only the object of someone else's listening. The nurse has to avoid the story being used as a seduction tool. By choosing a regulation mode not too "free" and not too restricted, the professional can help the teenager to develop an emotional meaning to its story telling. We should never allow ourselves to be put in a "voyeur" position by the adolescent. We have now to turn to the role of the nurse in the group. When several youngsters who have undergone a trauma find themselves in our unit, the staff has to make sure to maintain group dynamics and a therapeutical framework. Although the group can help the young person to reduce his or her feelings of solitude and uniqueness, the nurse has to see to it that the group of patients does not form itself around an identity of "traumatised persons" where the aggressor and sex are satanised. Permanent interactions between patients and nurses, daily groups organised by nurses where attendance is mandatory enable such progress. We finally have the feeling that the key word of our role as nurses with these young persons is a type of help that allows the expression of the trauma and of the intra-psychic conflicts which result from it, and not the expulsion of these conflicts.

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#### A Student's Perspective: A View of Bulgaria

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Bulgaria is a formerly communist country on the Black Sea whose language and people are mostly Slavic. Its population is about 8.5 million. Historically, Bulgaria enjoyed a close relationship with the Soviet Union and experienced none of the severe disruptions that other Soviet allies such as Romania, Yugoslavia or Albania did. As a result perhaps, it became well-integrated in the Soviet economic empire and accepted the position of supplier of various foodstuffs, enjoying the growth of the industries producing them (Gianaris 1982). This subservient position allowed Bulgaria to enjoy an uninterrupted progress in its prosperity through the 1980's, when a series of economic setbacks in the Soviet Union jeopardized the Bulgarians' status.

The result was a relative (to its Eastern European neighbors Albania and Romania) wealth that is evident in the infrastructure of the country, including hospitals. At the same time, the government, whether by design or accident, concentrated its health expenditures in urban areas and so a disparity exists between the health of the urban and that of the rural population (Minev et al. 1990). Rural inhabitants, for example, suffer from increased mortality from cerebrovascular disease (Mitseva 1993). But they enjoy lower rates of the tumors associated with urbanization, such as those of the colon. Geographic breakdowns of tumor incidence, in fact show marked decreases in rural areas, especially those populated by Moslems, who consume the most traditional diet and no pork (Valerianova et al. 1996).

Bulgaria is now at a crossroads in health care. The fall of Communism has both created an economic stress on the population that has implications for its health, and opened the

country to new ideas from the West about medicine's organization and delivery.

The challenge to Bulgarians is to provide health care in spite of its diminishing financial resources, to a population that is dying at relatively high rates from chronic conditions. Middle-aged men seem disproportionately affected (Watson 1995).

Bulgaria, furthermore, is in a "third category" of nation. In this conception, the first type is the country that has high birth rates and high mortality, chiefly from acute diseases. The second type is firmly post-"demographic transition," with low birth rates and low mortality, mainly from chronic disease. And the third type is the country that like Bulgaria has low birth rates but higher mortality from chronic diseases than the advanced nations demonstrate.

The gap in life expectancy has in fact widened between Bulgaria and the nations of Western Europe (World Health Organization, 1994). Worse, the stress and dislocations of the transition to capitalism and democracy have created other pitfalls for Bulgaria's centrally planned health system. These include a dramatic rise in smoking in some cohorts that will increase lung neoplasms in the future (Kubik et al 1995). Capitalism and the decline of authoritarian control has also led to an expansion of the black market of health care that has outstripped the government's attempt to regulate it.

The Bulgarian response to these challenges has been to adopt what they perceive as the lessons of the triumph of capitalism over communism. They have initiated critical self-examinations, decentralization of their top-heavy, centrally planned health delivery, reorganizations of primary health care and an attempt to expand the role of the "gate keeper" in primary health care. Those at the highest levels of health care administration have even stated the nation's goal to be the adoption of a system of national health insurance, through there is no means to fund such a system (Vassilev, 1992).

Though Bulgarians have declared their intention to change, their health system is still controlled from the top. Most legal health care is funded by the central government and the moneys are distributed to local health departments by municipalities. Most doctors are salaried and except for illegal demands for extra money ("gratitude money"), there is little fee-for-service compensation in Bulgaria.

Health spending is similar to other developed European nations in the proportion spent on out-patient care vs. in-patient care, the fraction of health care dollars spent on pharmaceuticals, the number of physicians, and the number of inpatient beds. Interestingly, this last is also true for psychiatric beds. Bulgaria has kept a stable number of psychiatric beds for at least twenty-five years. Western European nations such as France and Britain, for example, have only recently reduced their psychiatric beds to the Bulgarians' level.

The largest change that has occurred in this centrally planned system has been the division of health administration amongst "district centers," which will supposedly improve the control of local health care delivery. Policy discussion focuses on the distribution of power and on organization, since most of the population has no money to pay for their health care should the system abruptly become privatized. Because of the nation's poverty, the population is "locked in" to the system of central planning, unless the society were willing to accept a sudden and gross unequal distribution of health care according to economic status. Bulgarians have also considered the British system, in which contracts are awarded to hospital "trusts" to care for a certain number of people, what Americans call "capitation" (Kitov, 1996). This would seem to require a means of guaranteeing a standard of care by juridical or other means, the organization for which does not exist at present. Even now, with health care supposedly funded entirely by the government, medicine in even the most elite health centers is a bit of the Wild West, with physicians' blackmailing patients for money once the patients are under their control.

This reality means that the country can neither resort to the efficiency and incentives that a fee-for-service or other medical system might provide, nor enjoy its health benefits. Also, some authors have suggested that Bulgaria's problems are in part psycho-social, related to years of political and economic frustration (Watson, 1995). Bulgaria's suicide rate, which is comparable to the rest of Europe, does not suggest such frustration. But if Bulgaria's difficulties do have a psycho-social origin, the country's health status may be resistant to meaningful change.

To give some perspective to the problem of Bulgaria's health system, it must be viewed in the context of the world's stated goals in health care. In 1981, a target of a sixty-year life expectancy was adopted by the World Health Organization. The target for infant mortality was less than 50 deaths per 1000 live births. The global range of infant mortality is between 7 and 112 deaths per 1000 live births.

By comparison, the range in Europe is between 5 and 34 deaths per 1000 live births. Bulgaria's total infant mortality is 15.9 per 1000 live births. The worst infant mortality in Europe is that of Albania (33.8). So in terms of infant mortality, Bulgaria is somewhere in the middle of Europe.

Bulgaria actually compares favorably to other formerly communist countries with similar incomes per capita. One might for example, measure a country's success in providing health care using both a country's per capita gross national product and its infant mortality rate. The ideal nation would have few resources (low GNP) but would have no infant mortality because its health system were so efficient. By this measure, Bulgaria falls behind Poland (\$4500 per person-year and 14.4 infant deaths per thousand live births) but ahead of both Albania and Romania. And in absolute terms, Romania and Albania are both much worse off than Bulgaria: Romania has an infant mortality of 23 and Albania, 34.

However, as discussed above, the increase in the gap in health parameters between East and West, as well as the stagnation in average life expectancy, is not explained by the condition of infants, but by the declining health of middle-aged men.

Literature on Eastern European decline, Bulgaria included, has been linked temporally to the collapse of communism. But health trends have been inexorable and long-term. For instance, the diet of Bulgarians has evolved for decades to be what it is today. While the relationship between gross statistics that show increasing consumption of fats (and animal fats in particular), to increased mortality, is unclear, it is obviously an unfavorable trend (Epstein 1989).

If we were to identify all the reasons that Bulgaria is one of the "third type" of nation described earlier, there is also no guarantee that it will conform to the patterns of risk factors we have found in the West. Vitlianova et al have recently found, for instance, that education was an unfavorable correlate for heart attacks in Bulgaria, while the opposite has been found to be true in the most developed nations (1996).

Eastern European countries are distinguished from their Western neighbors because the average life-span of their people has been stagnating and their standardized mortality rate increasing., particularly middleaged males, since the sixties (Feachem 1994). The greatest component of this increase in Bulgaria is in death from cerebrovascular disease, but Bulgaria's rates of cerebrovascular disease have been high compared to other European nations for at least several decades.

Bulgaria's health situation is distinct from other Eastern European countries as well. Its stroke rates are noticeably higher, and its pattern of risk factors is unique. Bulgarian consumption of cigarettes is lower than many other nations in this regions, though some authors have pointed to an unfavorable distribution of smoking, with smokers disproportionately filling the younger cohorts (Kubik et al. 1995). Alcohol and total fat

consumption are also unremarkable in Bulgaria, while these are elevated in many other Eastern European countries.

Bulgaria, therefore, is distinct from other Eastern European nations, as well as third-world nations (who have high mortality from acute disease) and the highly developed nations (who have lower mortality from both acute and chronic processes).

Bulgaria is in the midst of a crisis of indecision in health care. It now has the freedom to choose whatever health system it desires, not only the centralized one ideologically acceptable to the Communist Party. But it has to come to grips with new problems in the health system like corruption, rising numbers of accidental injuries, and social dislocation. It also has to face what seems to be an older problem, a structurally high mortality from chronic disease. In that we may identify special risk factors that will inform our own society of future or present risks, we will benefit from an elucidation of Bulgaria's special situation.

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More About the 14th IACAPAP Congress: Identifying Mental Health Needs of the Child in Developing Countries.

Desmond Kaplan, MbchB  
and  
Amira Seif El-Din, M.D.

A session entitled "Identifying the Mental Health Needs of Developing Countries" was held on the Monday afternoon of the conference August 3rd. Chairing the meeting were Professor Amira Seif El-Din of the faculty of medicine at Alexandria University and

President of the Mental Health Association of Egypt, and Professor Myron L. Belfer a member of the Executive Committee of IACAPAP the Department of Psychiatry and Professor of Psychiatry at Harvard Medical School. The audience comprised approximately 30 senior mental health professionals from Middle Eastern countries, the United States (a number of whom had recently been hosted by their Egyptian colleagues in Alexandria), and at least one senior Child Psychiatrist from India who very eloquently reported on the Indian experience in developing mental health programs for children. Although the hall was not full, the presentations and discussion seemed charged with a sense of challenge and mission: a genuine attempt to meet the mental health needs of the region's children.

The first speaker was Professor Ahmed Monit from Egypt who is the WHO Regional Mental Health Advisor based in Egypt. He spoke with a wisdom reflective of his obvious extensive Middle Eastern experience and his advisory position necessitating a global perspective. The Middle East, said Professor Monit, stretches from Morocco to Pakistan with a population of 440,000,000. He stressed the changing family structure in the Middle East with rapid and unplanned urbanisation, the breakdown of the extended family, with for example, mothers being forced to work. He noted an average age in the Middle East of 19.8 perpetuated by a lack of population control. Wars creating refugees and the Middle Eastern conflict had obviously greatly impacted on the lives of children in the region. So too had poverty particularly of refugee children.

Next Professor Monit turned to educational systems in the Middle East. Broadly speaking educational programs could be viewed along a continuum. Very poor economies such as those of Sudan and Somalia have very low school enrolment, while wealthier countries such as Iran and Jordan have satisfactory enrolment. Unfortunately however throughout much of the Middle East on reaching secondary schools enrollment dropped precipitously. As regards females enrollment is often considerably lower resulting in widespread female illiteracy which correlates inversely with the health of children. Since 1978 the WHO has been developing National Mental Programs focusing specifically on primary prevention and mental health in the school. Health care systems need to be complex and knowledge based addressing available human resources and facilities, there is a need for a definition of levels of authority, with a need for the delegation of responsibility and strategic planning. Other features of developing countries are a lack of human resources, and standardised and predictable referral systems. Facilities are very crowded, time per patient is highly limited and there is a dearth of secretarial, medical records and staff support. There is also an inability to properly use mental health classifications and no time for continuing medical education. Professor Monit then highlighted the difficulties created by cultural differences in the Middle East with differing perceptions of health and disease, sanity and insanity, methods of treatment and cure. Cultural attitudes needed to be changed.

Finally Professor Monit cautioned against undue pessimism. A recent literature search for example had located over 2000 articles related to child mental health in the Middle East, although most of these articles were written by non-physicians in local languages. The seeds of a Middle Eastern health movement exist and Professor Monit called for its creation. Professionals had to learn from the West, but build on the realities of the region, taking what is relevant to create what is necessary for the Middle East. It would not be wise nor affordable to primarily develop highly specialised services. For example it had been found that the most accurate observers of early signs of difficulties in children were teachers and mothers who had to be trained to elicit early signs of mental illness. Other important goals are the need to focus on selected child psychiatric problems, child psychiatric training which needs to be integrated into paediatric residency programmes

and the need to establish stratified facilities, targeting for example family, school and nursing staff.

The next speaker was Dr. Ahmed El Ansari of the Bahrain Ministry of Health and at present the country's sole child psychiatrist. He informed us that Bahrain comprises 33 islands in the Persian Gulf situation close to Saudi Arabia. It has a population of half a million and after Gaza is the most densely populated country in the Middle East. 48% of the population are unskilled foreigners. The island has a well developed free health system with 22 primary health care facilities. Bahrain has an infant mortality rate 15/1000 with a life expectancy of 72 for women and 68 for men. Dr. El Ansari then proceeded to show slides of what could be described by any standards as a state-of-the-art child psychiatry facilities. There was a child abuse clinic, links with departments of paediatrics, and regular school visits. Schools however were not interested in the detection of mental health and there were attempts to change this. The WHO had sponsored programmes focusing on caregivers and specifically the mother-child relationship. Dr. El Ansari believes that Bahrain's priority should not be the training of more child psychiatrists, rather the introduction of other disciplines such as a speech therapist.

The third speaker at the session was Dr. Thabat Aziz, Project Manager of the Gaza Mental Health Programme, who was asked to provide a brief overview of mental health services for children in Gaza. The first psychiatric hospital was established in 1979 the Gaza Community Health Program was established. Dr. Aziz is at present the only child psychiatrist in Gaza. His focus is on schools, primary mental health, and training of allied professionals. Much of his time is taken up as a supervisor and co-therapist. An epidemiological study which he has undertaken is in press to be published in the Journal of Child and Adolescent Psychology and Psychiatry.

From the chair Professor Amira Seif El-Din provided a brief overview of mental health in Egypt. Egypt has a population of 60 million with children and adolescents comprising 40%. There are a million working children under the age of 12, and children comprise 7% of the work force. Although Egypt has a surfeit of physicians there is no formal degree in Child and Adolescent psychiatry which requiring training abroad for child psychiatrists. Professor Seif El-Din believes that Bahrain's state-of-the-art facilities are unique and not an appropriate model for much of the less affluent Middle East. The other chair of the session, Professor Belfer, also referring to Bahrain, cautioned however against diluting quality training of professionals.

From the floor Dr. Desmond Kaplan, from Israel, and at present in the Division of Child Psychiatry at Johns Hopkins in the USA, stated that Israel too is a member of the Middle Eastern community, and had both a responsibility, and possible skills to contribute, to the mental health of children in the region. Following this Professor Malhotra Savita, a professor at the Postgraduate Institution of Medical Education and Research at Chandigarh in India, and a member of the IACAPAP Executive committee pointed out that "western solutions" to the needs of developing countries had to be adapted. Child psychiatry should not necessarily be seen as a sub-specialty but should be an integral part of preventative psychiatry. It needed to be taught to paediatric, and adult psychiatric residents with child psychiatry a part of a mental health life span perspective. Dr. Abdel-Baky from Egypt stressed the multidisciplinary-team approach (which often ran counter to the physician's hierarchical model), and the need for stratified services. Dr. Cohen, who had visited Alexandria, stated that Child Development and Psychopathology should be the focus in all countries as they were transcultural. The last speaker from the floor was Dr. Cohen who suggested modelling mental health systems on successful programs in countries such as Bahrain and Israel.

Professor Monit concluded with proposals he intends making to the WHO, a focus on

Child Development, an integration of mental health services, the need for different mental health disciplines and a division and stratification of services to make efficient use of human resources and facilities. Thus ended an inspiring session. It left one with a feeling that at least some of the enormous mental health needs of the regions children and adolescents would be tackled by a talented, dedicated and highly committed core of professionals.

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## Teenage Pregnancy: An Unheard Cry

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This summer I was blessed with the opportunity to be able to work on an inpatient unit in a psychiatric hospital. During this experience, I encountered a number of female adolescents who were involved in sexual activity that could and has led to pregnancy. These adolescents sparked an interest in me. Was this a coincidence that these adolescents are or were sexually active and risked becoming pregnant related with the fact that they have been in the hospital? Was this a copying mechanism for their problems? These are the salient questions that aroused me to further inquire about teenage pregnancy among young black females.

Why are the numbers for teenage pregnancy among young black women so alarming? These numbers can be verified along a spectrum for black teenagers that are from different backgrounds and communities. Yet and still teenage pregnancy is a common ground for many. For example, a fifteen-year old, black female institutionalized with a history of an abortion. Another black, sixteen-year old female inpatient engaged in sexual activity, with the hopes that she was pregnant. A young woman was thrown out of her house after her mother discovered that she was pregnant. Everyday, thousands of teenage black females engage in sexual activity and experience the risk of becoming pregnant. What are the contributing factors for this behavior? Low self-esteem, impulsivity, and ignorance may be some of the reasons.

Where are the parents, you ask? Some of the parents may be unavailable, lost to drugs, the justice system, health, or one of many misfortunes. On the otherhand, there are "good parents" who provide adequately for their children, both emotionally and financially, that have children who rebel for various reasons.

Many of these adolescents are trying to fill a void that exists between the parent and child. They bring an innocent life into this world with the hopes of molding this child into someone that fills this void. In discourse with a patient concerning her impeccable need for a baby, she voiced that she would not treat her baby in the same manner that her mother treated her. Her mother was emotionally nonsupportive throughout her life and has caused her to feel resentment and emptiness. As a result, she felt that a baby would satisfy her insatiable needs. Ultimately, this cycle will continue and not end if she gives birth to a baby. She will not be able to provide adequately for her child in the same manner that her mother was unable to provide for her. These adolescents lack the knowledge and the capability to provide for the emotional, financial, and physical needs of the children that they wish to bring into this world. They are not well educated about all of the external necessities that a child needs to survive, as a result, they choose to alleviate their pain with the birth of innocence and dependability; a baby. Therefore, disregarding the reality of it all. With the birth of a child, they see a rebirth of their lives.

They are enriched with optimism for the future.

The lack of education facilitates the growth of teenage pregnancy rates. Without the knowledge of the repercussions that having a baby can cause, the teenagers are forced to think with their emotions instead of their minds. They are unaware of the true financial and emotional setbacks that a child can manifest. As a result, their decision making is geared toward their immediate needs and does not acknowledge the future consequences that may arise. I believe that some of the misconceptions that many teenagers have can be ameliorated with strong educational programs that focus on the responsibilities of parenthood.

The low self-esteem that these adolescents experience caused the impulsive action of engaging in sexual activity. When I asked a patient why she chose to have sex, she said that she thought was in love, and beyond that, she really did not know why. Sex serves as a comfort zone for these teenagers. It gives them a false sense of security and empowerment. Sex is viewed as an opportunity for immediate gratification of their desire for unconditional love.

On July 1, 1998, The New York Times published an article that discussed the issue of unwed pregnancy. The article was titled, "Birth Rate Falls To 40-Year Low Among Unwed Black Women." "Today's report showed that the out-of-wedlock birth rate has been dropping for all age groups of black women. Demographers and Health officials said that some of the possible reasons—an increase in contraceptive use, sex education and efforts by some community groups to encourage abstinence—should allow the trend to continue." This article highlights the importance of intervening factors such as abortion, that assist the awareness and prevention of pregnancy. However, while the overall numbers of unwed pregnancy decreased, my experience has made evident that this problem is real and still taking its course.

If we close our eyes to the problem of teenage pregnancy, we tend to believe that it no longer exists. We sometimes sit back and accept things for what they are. As a result, no one wants to take responsibility. Many fault the teenagers and prefer to cast blame unto them. However, there are other intervening factors that contribute to this misfortune such as unfit parents and environmental stimuli. Educating the parents about issues that are salient to their adolescents can eliminate these problems. Through this knowledge they can learn how to prepare and prevent their children from being involved in unsafe sex and most of all how they can be there for their children in their time of need. This tutelage will also allow the parents to see the importance of a positive environment to an adolescent, and will hopefully inspire the parents to provide an enriched environment for their children. Ultimately, we must work together to bring about active change within our communities and listen to the unheard cries of our youth.

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Albert Schweitzer Institute for the Humanities and Child and Adolescent Psychiatry

Children and adolescents throughout the world are suffering from mental illness and psychological trauma as a consequence of poverty, family turmoil, political unrest, war, and a lack of resources. The Albert Schweitzer Institute for the Humanities in the spirit of Albert Schweitzer's philosophy of "REVERENCE FOR LIFE" is supporting projects and seminars to promote the emotional health for children in developing nations. As Rhena Schweitzer Miller states "at the dawn of the new millennium, we are confronted with profound changes. The ethic of Reverence for Life, espoused by my father nearly 80

years ago, still resonates today. The Albert Schweitzer Institute for the Humanities has worked in the spirit of my father for 10 years, disseminating his ideas so they can influence and inspire a new generation.” This spirit was vividly manifested on April 9, 1998 during the 50th anniversary of the Universal Declaration of Human Rights and the presentation of the 1998 Albert Schweitzer Institute’s Presidents Award to Ms. Sonja Licht, President, Fund for an Open Society, Yugoslavia. During this celebration the young people of the open club of Novi Sad, a multi-cultural and multi-ethnic group of refugee and local children from Yugoslavia gave a special dance performance illustrating both the suffering and triumph of that war-torn nation. Such children inspired me with the realization of how important psychological strength is to overcome terrible circumstances through the resiliency of the human spirit.

As nations build democracies and more open societies, the needs of the population will include mental health awareness, treatment of such problems as post-traumatic stress disorder and depression, and projects to prevent mental illness through the development of clinical services, education, humanitarian aide, and outreach. The ASIH has initiated a series of conferences on child and adolescent psychiatry for the mental health care workers in developing nations. Such programs combine educational components with clinical consultation resulting in opportunities for change in mental healthcare delivery systems. The goal is to improve the quality and accessibility of mental healthcare in such countries as Russia, Yugoslavia, Macedonia, Lithuania and Estonia, where the mental health conferences and site visits occurred.

In Nizhny Novgorod, Russia, child psychiatrists, general psychiatrists, pediatricians, psychologists and nurses were most eager to understand both how we diagnose, but even more so, how we treat a wide variety of mental health problems. Mental illness there is treated through a holistic approach using massage, warm baths or whirlpool therapy, acupuncture, sleep therapy, exercise, physical therapy, and herbs for a variety of childhood behavior problems. Pediatricians treated most of the children, while psychiatrists did use some psychotropic medications which were very limited. Some medications were not available such as stimulants for attention deficit disorder or serotonin reuptake inhibitors such as Prozac for depression. Yet we were impressed with the high degree of warm, enthusiastic, dedicated service which the children received. There is a growing concern in Russia about the increase of adolescent depression, unwanted pregnancy, drug and alcohol abuse, and drop out rates in high school. There is really no special education services or parent training available. Most families are poor and not psychologically minded. The Russian physicians were extremely eager to learn about medicine in the United States to enhance their skills.

These doctors work very long hours in spite of having extremely low salaries. Over 90% of them were women. We were impressed by their love of their clinical work and their eager acceptance of us as consultants and teachers. At the present time in Russia, employment is the main concern of the people who live with major public health problems such as a diet with very few vegetables, fruits, or grains, an extremely high rate of smoking and alcohol consumption, and water and air pollution. In spite of these difficulties however, there is a spirit of hope as the concept of democracy continues to develop.

While the conferences in Belgrade, Yugoslavia, centered on autism, again we had the opportunity as in Russia to visit schools and hospitals to meet with staff and interview patients. Here children with neurological difficulties are mixed with children with psychiatric problems in the same hospital wards. Families seeking out-patient or in-patient services come from all over the country and can wait for several days in order to see a psychiatrist or a neurologist. Again in spite of limited medical equipment and

medications, the healthcare workers and teachers were highly committed to the children. They were most eager to receive knowledge through magazines or text books which they could translate since current periodicals were almost non-existent. The tremendous political tension added to the burden of the caretakers as daily demonstrations were occurring in the center of Belgrade. We did gain a much greater appreciation of the human suffering in Yugoslavia including talking with displaced and unwanted refugees who suffer from post-traumatic stress disorder. Unemployment there was almost 60% for adult males which added to the ethnic tensions and the continuing possibility of further war. Such tension was also evident between family members in Belgrade which included Serbian Nationalists and those favoring a new democracy. This atmosphere has a striking impact on family integrity, adolescent identity, and the psychological development of children. We left with a profound respect regarding the resilience and strength of those providing medical care and still developing services for youth despite the political chaos and poverty.

In Macedonia, we were struck again by even more extreme poverty particularly among the Roma or gypsy population living in the inner city slums and often begging in the streets. As in neighboring Yugoslavia, there was the awareness of the religious and ethnic tension illustrated by the mounting problems in the north in Kosovo and to the east in Albania. We again gained an appreciation of the extremely complex history of this part of the world and the ancient heritage including Greece. This was the only country where child and adolescent psychiatry as a specialty does not exist and there are no specific mental health services for children. General psychiatrists and pediatricians serve emotionally disturbed children in pediatric clinics and in adult psychiatric institutions. The latter are immense and adult oriented with little knowledge of specific child psychopathology, no means to do individual work with children, and recognizes the need for specific mental health services designed for children, adolescent, and families and are eager to develop such in partnership with pediatrics.

Our two trips to Lithuania with one including Estonia were the most comfortable not only because of less poverty and political tension but also because of a much greater sophistication in the understanding and treatment of childhood mental illness. Child psychiatrists and neurologists have greater knowledge of diagnostic classifications and treatment interventions that are in harmony with those used in the United States. Child psychiatry in Lithuania is an established discipline with outpatient and inpatient facilities designed specifically for the care of children and adolescents. The atmosphere there is more peaceful with a sense of liberation and hope having been independent from Russia for the past several years. There continues to be a strong sense of family and in Lithuania a continuing Catholic identity as a tradition. Although medications are much more limited than in the United States, many are available and utilized together with more traditional psychotherapy for children and families. Our visits to more rural areas, however, again demonstrated very few resources for mental health requiring most families to come into the major cities. Funding for mental health services, particularly for children is extremely limited and child psychiatrists must become more politically active to demand such. There is a general sense of passivity and acceptance of the inadequate funding for programs by many child and adolescent psychiatrists with the exception of several leaders at the University who are trying to modernize, rehabilitate and expand facilities and services. The Lithuanian child and adolescent psychiatrists and pediatric neurologists, seem uniformly hungry for new knowledge to treat children. Several are working on major research projects in such areas as pervasive developmental disorders and adolescent depression. This latter difficulty together with a high incidence of drug and alcohol abuse by Lithuanian youth and the struggle to form a new identity as a free

nation are some of the factors resulting in Lithuania having the highest suicide rate in Europe. Such is over twice the rate of that in the United States. We are now hoping to conduct a joint research project on this phenomenon in order that the factors contributing to this may be changed and preventive measures instituted.

Our seminars, site visits to various facilities, and interviews of faculty members and patients have made a lasting impact on both visitors and hosts who continue to communicate in an open fashion. We are in contact with various professionals from each of these countries through the exchange of information including educational materials and follow-up consultations regarding children and adolescents seen on our visits. We have certainly gained a much deeper appreciation of how much good can be done for children in these countries through the dedication of the mental health and pediatric caretakers in spite of extremely limited resources and poverty. Through the example of our foreign hosts and professionals, we as physicians from the United States have strengthened our core identity as helpers of the sick and teachers in spite of our world of managed care and business concerns. We now feel more privileged and fortunate than before for our knowledge, training, medical supplies, the respect of society, and our more than adequate salaries. But even more importantly, we are enlightened regarding the privilege of helping fellow physicians and their patients in need. We wish to return and make such experiences of helping a continuing part of our lives and our vocation as physicians. We have regained our appreciation of the importance of the bond between doctor and patient. We have learned that the determination of the human spirit can do good deeds in spite of bad times and bad conditions.

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A Student's Perspective - Alone in a Hearing World: Therapeutic Communication with the Deaf

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The other day, I was fortunate to have the opportunity to sit in on the first meeting between a newly-admitted adolescent psychiatric inpatient and his assigned therapeutic treatment team. While this youth was as individual as any other inpatient in terms of the nature and cause of his psychological troubles, he was particularly singular in one respect: he was profoundly deaf. The members of the treatment team, which included psychiatrists, social workers, and other mental health workers, were not new to this particular type of impairment, yet in order to communicate with this young patient, an American Sign Language (ASL) translator was necessitated. This translator was an employee of the hospital, so one would assume that she was as experienced as anyone else when it came to the intricate signing that must become necessary when attempting to translate the intimate, probing questions that a therapist might ask, not to mention the ambivalent, complex responses from the patient. So it would seem that this contingent of highly skilled professionals would be up to the task of providing this patient with the same level of therapeutic response that they would to anyone else. Unfortunately, it became readily apparent that this was not the case.

The conversation between the patient and the therapists began well enough. Through the translator, the boy was able to enumerate fairly well his troubles at home and the subsequent events that lead up to his hospitalization. What struck me during this interaction, the event that moved me to write, occurred when one of the psychiatrists

offered the youth a simple question, "how do you feel?" Instead of immediately launching into a series of signs as she had done several times previously, a puzzled expression came over the translator's face. "Hmm," she ruminated. "Let me see if I can establish mood." Thereupon, she began to repeat a series of signals to the patient, over and over: happy face, sad face, thumbs up, thumbs down. The gist of the message being sent was clear: choose one.

I found myself shocked. In the course of therapy, a patient is generally presented with a myriad of questions, requests for explanation, clarification, and so forth. Professionals rely on nuance, very intricate and specifically phrased questions. They then sort through the language with which the patient responds, looking for clues, overt or otherwise, as to the root of the patient's emotional disturbances. They use this information to formulate their next question, and on a grander scale, the next step in the patient's therapy. All of this interplay between the therapist and the patient is predicated on the notion that the two have a viable means of communicating. Disheartening though it might seem, it felt to me at the time when I witnessed this episode that the lines of communication had in fact broken down before the therapeutic relationship had even begun to form. It seemed that through the interpreter, even such a general and relied-upon query as "how do you feel" could not be properly asked. What happens when the question asked is more specific, when the therapist asks, "how does it make you feel when your father hits you?" or "how do you feel when your mother says she won't come and visit you in the hospital?" If the best we can do with sign language is offer choices, how can we hope to get at the unique root of each hearing-impaired patient's problems? And what was this particular patient's response to the translator's attempt at "how do you feel?" A puzzled expression crossed his face before he offered just one sign, a rather worthless one from the therapeutic standpoint. The translation: I'm fine.

In order to avoid sensationalizing this issue, I should point out that this patient has improved through therapy and has since been discharged from the hospital's inpatient unit. It is also important to emphasize that the hospital translators do an invaluable job, because without them there would be virtually no way at all to reach many of these patients. Consequently, this circumstance of a deaf psychiatric patient in a world that hears is not a hopeless one. But imagine this same scenario if the therapist was skilled in the art of sign language. Picture a professional helper who can communicate one-on-one with this child who is in so many ways cut off from the world around him. Imagine that there was no "middle-man," so to speak, no risk of a third party putting his or her own distinct spin on the messages being conveyed back and forth between the patient and the therapist. Imagine an individual so skilled in both this unique method of communication as well as the art of clinical psychology. Surely, this individual can be sure that the questions he or she poses to the patient are the ones the therapist intends to ask. When confusion arises, the therapist could modify the question, but remain confident that the question being asked is similar enough to the intended one. And through the experience of melding sign language with the unique language of therapy, this professional could develop a peerless repertoire of signs, a singular way of utilizing the language so as to most reliably elicit the desired responses from the patients. In short, a hearing-impaired and emotionally disturbed individual might receive psychiatric treatment as easily and confidently as anyone else.

To be fair, there are psychologists, psychiatrists, and therapeutic social workers out in the field who can sign. But several individuals familiar with the field of sign language translation have assured me that there are not nearly enough. There is also little extant research that explores the link between hearing impairments and psychopathology. Nevertheless, it would be safe to assume that any individual who has such a pervasive

communications issue would at the very least be at somewhat of an increased risk for psychological problems. As such, they comprise a very salient and unique subset of the disturbed population, one that the majority of professional helpers are not qualified to deal with adequately. So how do we rectify this problem? Perhaps sign language instruction programs should become a strongly encouraged part of clinical psychology degree programs. I am even tempted to suggest that ASL should be a required aspect of Social Worker training. While many psychologists can pick and choose among clients and populations, most social workers must work with clients as they are assigned. These professional helpers, more than any other group, would probably benefit the most from being familiar with at least some basic signs. I believe that if ASL training were to become a common option in various psychology, psychiatry, and social work programs, even if it were just that, an option, it would serve to elevate therapy for the deaf from an obscure specialty to a prominent aspect of clinical practice. If we could proliferate professionals in the psychological community who have mastered both therapeutic techniques and sign language communication as I have envisioned, the possibilities for sound therapeutic practice with the hearing impaired would be truly astounding.

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"Teachers as Therapists": A Program to Help War Traumatized Children Around the Globe

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With the armed conflicts taking place in a number of countries around the world, an alarming number of children and adolescents are being killed, maimed, bereaved and displaced. For example, a few years ago, bloodletting in Rwanda caused the deaths of over 200,000 people the majority of victims were women and children. Similarly, in the bombing of the federal building in Oklahoma City, a large number of the victims were also women and children.

In Bosnia and Herzegovina, of 200,000 people killed during the war, 17,000 were children. Moreover, a significant number of children who survived are suffering from severe psychological trauma produced by the exposure to war atrocities. According to a UNICEF survey, 7% of the children have lost one or both of their parents; 23% have been forced to leave their towns or villages; and 66% have been in a situation in which they thought they would be killed. More than half of the children have been shot at by snipers. As a result, 37% are severely clinically depressed, and a saddening 92% reported feeling so desperate that they often thought of killing themselves.

With this high prevalence of psychological trauma in the children exposed to war atrocities, there was an urgent need for mental health professionals (MHP) who were proficient in detecting and treating grief and psychosomatic, behavioral and psychiatric conditions that are associated with trauma exposure. However, there were not enough trained mental health professionals in Bosnia and Herzegovina who could handle such a large number of psychological casualties. According to the reports of the Ministry of

Health of Bosnia and Herzegovina, only a handful of MHP remained in the city of Sarajevo to serve the 60,000 children exposed to war trauma. This disproportion between the number of MHP and the children in need of help created the necessity to train “lay therapists.”

Consequently, a University of Missouri (UMC) team of mental health professionals, under the leadership of this author, a child psychiatrist by training, developed a program to train teachers in diagnosing and treating children suffering from post-traumatic stress disorder (PTSD).

The selection of teachers as therapists was based on the observations that teachers in Sarajevo have been recognized as the one who have intuitively and effectively provided psychological help to their students during this war. The research literature has repeatedly advocated the use of teachers as interventionists for the children following trauma. Children trust their teachers, with whom they spend as much time as with their own families. Teachers have extensive experience in relating to children, they have exposure to children in crisis, and they often have intuitive mental health care skills that allow them to acquire mental health education rapidly. Thus, these 5,000 teachers of Sarajevo provide an effective pool of sophisticated workers who can be trained in detecting and treating PTSD and depression in their students.

Since early 1994, this author with other UMC faculty has made 16 trips to date to Bosnia and Herzegovina and has trained 2,000 teachers who are now providing help to approximately 20,000 children. In addition, the UMC team has trained over 200 mental health professionals in Bosnia who provide supervision to teachers.

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Italy, For Example

Editor's Comments

Perspectives on career development, issues of clinical psychiatry, and international collaboration were stimulated by our 14th International IACAPAP Congress as illustrated by the following article.

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When I came back home from the Stockholm IACAPAP Congress in midsummer 1998, I brought with me the impression that international cultural differences may be somewhat less marked than the range of views and practices which can be found within any one country. It had been a warm and intelligent gathering of many interesting and mature people from all continents, who care for the mental health of their countries' children and their families. Although a kaleidoscopic experience, I could not help seeing in other nations the same qualities, in different amounts, of most of the human, technological and market factors which are evident in Italy.

Since Columbus discovered America on behalf of a foreign queen, Italy has been a country of tremendous strengths and appalling weaknesses. In 1978, when I received my medical degree, Italy enforced a much needed Act that outlawed psychiatric asylums—the so called Basaglia Law. A few years earlier, special classes for the handicapped children had been similarly closed down in schools. Inclusion at every level was to be enforced, as opinion leaders were of the view that mental illness was the mere by-product of social inequalities.

In the 20 years that followed, a few competing psychodynamic models became the

established moral code. For example, during my residency in child neuropsychiatry, I was exposed to the teachings of both the London Tavistock Clinic (infant observation) and the Paris Centre Binet (team work). I could not decide which one was better. When I decided to include biostatistics in my curriculum, I was told by my tutors that this was my form of personal defense. In the early 1980's, we were working hard to assess and treat children, updating ourselves on exegetic readings of translated books. Going abroad and reading the English language scientific literature—as I eventually did—was regarded as amateurish.

Back in Italy, after attending the psychiatric epidemiology training program at Columbia University in New York City, and after a short stay at the Institute of Psychiatry in London, I realized, unfortunately, that my odds ratios, reliability coefficients, multiple regressions and life events interview packages were seen only as a hi-tech option to impress the audience. They were not regarded as a tool to improve scientific credibility. Above all, there were very few jobs available in Italy, especially after having been abroad for so long—and particularly the case at a time when the Catholic Church, the communist party and the masons controlled most of the key positions in the field. Psycho-analytical training was required as a pre-condition to being employed in psychiatry. Meanwhile, ten years after the Basaglia Law, many mentally ill patients still lived in disguised asylums, and family associations began complaining of risks at home and the risk of homelessness.

What was to be done? I worked initially for five years in the neurology department of a private research hospital. Meanwhile, I continued to collaborate with my child psychiatric colleagues as an outsider, working on an epidemiological study at a regional level. In 1993, in the wake of the anniversary of Kanner's paper, autism appeared to be a worthwhile topic for research. With rare exceptions, Italian psychiatrists rejected any international approach to classification involving autism. An Italian neurological journal turned down a review of mine because autism was not part of the field; and the Italian Telethon Foundation rejected a grant application because, in spite of the enclosed bibliography, autism appeared to their reviewers to not have a genetic basis. At the same time, a group of parents of autistic children in Milan were lobbying local authorities for some sort of action. The then current diagnostic and treatment attitudes included private psychotherapy and revolving door repeated evaluations. Most adolescents and young adults with autism were labeled oligo-phrenics, fitting neither a psychological nor a neurological diagnosis.

To gain consensus from the family groups, the regional health authorities agreed to implement an observation programme to monitor and record cases of autism, and to put on hold new interventions. Following innumerable difficulties, but thanks to the collaboration of many child psychiatrists and allied professionals, 1000 cases were identified by the beginning of 1998. The lack of psychodynamic 'purity' could now be seen as one of the characteristics to be studied.

While Italian academicians are considering the advantages and drawbacks of splitting child neuropsychiatry into neuro- pediatrics and child psychiatry, more and more mental health workers are integrating the neurosciences in their explanatory models. The Observatory on Autism, which I run for the Region of Lombardy, is endorsed by child mental health workers who are genuinely motivated, but who suffer from a lack of international training and continuing education. Successful initiatives may help to spread renewed interest in the welfare of today's children and tomorrow's society. An example is the Telefono Azzurro—a national non-governmental helpline which is acquiring international momentum thanks to an Italian child psychiatrist, Ernesto Caffo, who is also a vice-president of IACAPAP. Such practical initiatives should teach us the benefits of

organization and motivation compared to simply sharing theoretical concepts and good ideas.

The last two decades have seen pervasive improvement and, at the same time, confusion all over the world. The Italian state has seen more changes in its government than any other country in the European Union. We have the highest ratio of physicians to population, and the lowest birth rate in the world. There are significant differences in the distribution of child (neuro)psychiatry services within the country, not to mention different working models. Due to the demographic trend, psychologists and child psychiatrists compete looking forward to less parochial ways of practicing our profession in a country that no longer deserves the stereotypical image of the “mummy-Dependant.” In addition, pedophilia has recently been unveiled chez-nous; we host a high divorce rate; and more and more children need clinical attention for depression, felonies, and for all the alarming reasons described at the Stockholm Congress. In this context, autism is now being viewed as a somewhat refreshing field of study.

Obviously what is occurring in Italy is far from unique. The point is that on the one hand the mass media make the planet look like a global village, while on the other, the varied needs of the child population of the world require varied professional responses, if of similar scope. That is why IACAPAP offers an opportunity to learn from each other.

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## Child & Adolescent Psychiatry: A Viewpoint for Developing Countries

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Child and adolescent psychiatry, as it is practiced in the US and several other Western European or eastern developed countries, as an independent, highly specialized discipline depending heavily on the highly trained manpower, appears like a distant dream and luxury to countries which, unfortunately, are less developed or are poor. Children and adolescents living in the so called “the first world” and “the third world.” though share their dreams and ambitions, needs and aspirations, but live in total contrast as far as their realities and circumstances of life are concerned. Child (includes infants and adolescents as well) psychiatrists do not endeavor to direct the needs and aspirations, potentials and limitations of children and the best ways to realize those bring it to the attention of the society which in turn is expected to make significant changes in the psychosocial and physical environment of children.

There is now sufficient research evidence that application of the principles and practice of child psychiatry makes a significant positive contribution to the lives of children in terms of reducing morbidity, ameliorating dysfunction and distress, and supporting normal development. The question is how to apply this knowledge and skills to a vast majority of children living in the developing countries such as India. Since there are very few professionals to deal with the situation, the solution would lie in looking for alternatives.

Being an Indian, I would like to speak in reference to India. Evaluation of several health related programmes and policies, that came into operation since India became independent in 1947, indicates that in India, we have recognized the importance of pre, peri, and postnatal as well as infancy periods of life. There are several programmes that target maternal health and nutrition during antenatal period, safe delivery, immunization

in infancy, prevention of communicable diseases in order to reduce perinatal and infant mortality and prevent certain congenital and acquired diseases. The integrated child Development Scheme (ICDS) started in 1975, provides additionally for non-formal education to children 6 years of age and has covered approximately 70% children in the country. These programmes have succeeded in lowering the infant mortality significantly and the gross morbidity rates to some extent.

The period of childhood i.e. 6-12 yrs. and adolescents 12-18 yrs. is relatively neglected in terms of special attention or programmes, as if, all is well and assured for a child who survives the first five years of life. As we know that appropriate and timely intervention can make a difference to the outcome of pregnancy and child birth, in the same manner, an appropriate and timely intervention strategies in childhood will make a difference to the adult outcome.

The child develops in a microcosm of his (gender used generally) gene pool, which is in constant and reciprocal interaction with his macrocosm of the environment including physical as well as psychosocial. The family, the school, other social institutions exercise a significant influence on the process of child development. Child development is to be seen as a continuous process until adulthood and childhood is to be seen as a period of transition and vulnerability. The quality of childhood one has lived will determine the ultimate nature of adulthood that one gets a differentiated into.

If the stage of the best and the maximum productivity is the flashpoint of adulthood, then childhood is a period of preparation and shaping into that stage. In India, child mental health has been paid less attention than it deserves due to several reasons. Apart from the reason that children have no political voice or power; that they are unproductive members of the society; that they are a responsibility of their parents; it is also the lack of knowledge about what mental health intervention can do or achieve that is responsible for neglect or low priority accorded to child psychiatry. Children are neglected for being children today least realising that they are adults of tomorrow. We need to look after children today for shaping a better tomorrow.

Child mental health, in this context, will have to be seen as a discipline, that can influence the mental health states of adults through possibilities of early intervention and prevention of mental disorders continuing into adulthood. Recent research has increasingly shown that childhood psychiatric disorders, developmental disorders continue into adulthood and cause significant morbidity. Adult general psychiatrists do need to know about the continuation of childhood disorders in later adult life and that the roots of many adult psychiatric disorders lie in childhood, our current state of knowledge of biological, social, psychological and environmental factors that influence the psychological development of children, if applied appropriately and adequately in practice, can bring about significant reduction in morbidity. Thus child psychiatry could be considered preventive psychiatry for adults. If we accept the life span approach as the defining dimension, child psychiatry can even be termed alternatively as developmental psychiatry.

Argument for prevention of illnesses in adults could be more effective with politicians and planners than the argument for care of children for their sake. Perhaps in the present era where economic productivity, cost-benefit ratios, are considered more relevant in guiding the allocations of resources, child psychiatry needs to be similarly packaged in alternative terminology for becoming effective in attracting attention and resources. My assertion, therefore, is to highlight those aspect of child psychiatry that deal with prevention of morbidity and promotion of positive growth into adulthood for at least a country like India.

Child psychiatry would be integrated into and form a major proportion of curriculum for MD psychiatry and MD pediatrics. Intervention strategies should involve and look upon

parents as a very important resource and allies in treatments. It is time to shift focus from parents being construed as the cause or contributors of pathology to them being helpful, concerned and committed resource in therapy. This is particularly relevant to Indian culture and tradition where a strong family system still exists and exerts a powerful influence on development of children. Let child psychiatry in countries like India, move out of "specialized clinics" to the home and families where children live.

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Invitation of the 11th International Congress of ESCAP

September 15–19, 1999

Hamburg, Germany

Prof. Helmut Remschmidt, M.D., Ph.D.

President of ESCAP

Dear Colleagues,

It is a great pleasure for me to invite you to the 11th International Congress of the European Society for Child and Adolescent Psychiatry (ESCAP).

The main theme of the congress is "New Challenges – New Solutions," particularly considering the remarkable changes in nearly all fields of life and all over the world.

The Congress is organized in collaboration with the Section of Child and Adolescent Psychiatry of the Union of European Medical Specialists (UEMS) and with the Deutsche Gesellschaft für Kinder- und Jugendpsychiatrie - und psychotherapie (DGKJPP).

ESCAP is the European organization of national societies committed to child and adolescent psychiatry and psychotherapy. Founded in 1964 in Switzerland, ESCAP has

been the leading scientific and professional organization of child and adolescent psychiatrists in Europe for many years and pursues the following aims:

- to foster the European tradition of child psychiatry
- to facilitate and extend the bonds between physicians practicing child psychiatry in European countries
- to spread the results of research and experience in this branch of medicine by publishing reports and organizing scientific conferences and meetings, and
- to collaborate with international organizations with the same or related aims.

I trust that these aims will be pursued at the international meeting in Hamburg, which will cover the whole range of new developments in the field of child, adolescent and family mental health.

Hamburg is a wonderful place providing excellent facilities for our meeting, a rich historical background and a manifold cultural and social life.

Please join us in Hamburg!

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