

PRESIDENT'S MESSAGE

Throughout the world, child and adolescent mental health professionals are at the forefront of dealing with the major problems confronting the most vulnerable, young members of their society. Child psychiatrists, psychologists, social workers, and mental health nurses in the developed, economically advanced nations are dealing with children whose lives are burdened by multigenerational poverty and the associated features of poor housing, ill health, inadequate education, and hopelessness. In developing nations, mental health professionals are concerned about providing the preconditions for health development for all children, often in the face of impossible limitations or resources and personnel. In too many nations, professionals are trying to deal with the impact of trauma—war, hopelessness, migration, the breakup and forced separation of families, urban trauma, the witnessing and experiencing of atrocities and physical horror.

The rates and severity of mental disorders among children and adolescents appear to be increasing; many problems are appearing at earlier ages, such as involvement in violent crime, and the leading causes of death among adolescents are related to maladaptive behavior (suicide, accidents, drugs, homicide). For many of these difficulties, mental health professionals can offer public health interventions, family and individual guidance, and various types of treatment.

Yet, almost paradoxically, while children and youth are universally acknowledged as a nation's greatest resource, the services delivered to help prevent and ameliorate their problems are being curtailed in many nations. Almost throughout the world, including nations with the most advanced mental health systems, there are threats to preserving mental health services and severe cutbacks are becoming the norm. In the name of economic necessity, health reform,

EDITORS' COMMENTS

We are very pleased with the premier issue of the Newsletter and have received many comments around the world about it as an important vehicle for communicating. "The World Is Shrinking!" Communication of events is rapid, accessible, and informative. We hope our Newsletter offers its readers significant insights that are helpful to understanding children's development and psychosocial needs.

In this issue, we have expanded our goals of reporting about children and adolescents by including statements from youth who describe other perceptions and concerns representing circumstances that many of us may not have directly observed. Throughout the world, children, adolescents, and their families experience the traumatic impact of natural disasters, ravages of war, and the disruptions of individuals' vengeful activities. We present reports about Bosnia, experiences of street children in South America, earthquake victims in Japan, retention camps in Cuba, and political stress among Israeli and Palestinian children.

Enriching activities among youth are prevalent. The Special Olympics events have recently concluded in New Haven, Connecticut, U.S.A. International reports point out the attributes, endurance, motivation, and skill of athletes who suffer disabling cognitive and physical problems but who persist in developing their interests and succeed in competitive participation.

We are pleased with the contributions to the Newsletter by our members. We commend our leadership, under the direction of our President, Dr. Donald Cohen, for advancing collegial collaboration. Numerous international conferences are planned. These will offer personal exchange of ideas and strengthen our efforts to educate professionals who work with children, adolescents and their families. An important foundation of our efforts is the dissemination of research findings. Scientific publication is essential. We began to highlight a

THE AACAP WEBSITE: ITS SIGNIFICANCE TO INTERNATIONAL CHILD AND ADOLESCENT PSYCHIATRY

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Children and adolescents throughout the world are suffering from various psychiatric disorders. Some are caused by disasters, such as war, deprivation and loss, others are the manifestation of psychosocial stressors, medical illnesses or "biological" imbalances. For these children and adolescents, often there is little help or hope. Given our current limitations, both in the number of professionals trained and the accessibility of new findings, the chance of care is minimal and what care there is, is often not state of the art.

As we move into the twenty-first century, technological advances have had a significant impact on our work, redefining the limits of what we can achieve. Information technologies, in particular, are eliminating physical boundaries, allowing communication and teaching to occur across the world as easily as across the street. The Internet, a network of millions of computers that allows instantaneous transmissions between over one hundred countries, represents one such technology. The Internet allows many types of communication via different protocols. The most popular of these is the World Wide Web (WWW). The WWW is the fastest growing area of the Internet and has recently attracted the attention of commercial groups, government agencies, and the general public. Thousand of organizations have now established "Web sites" for providing information.

President's Message (from page 1)

and reorganizing systems of care, administrators and bureaucrats are making vital decisions about the numbers and training of professionals and the range and nature of services that will be available to children and adolescents. Thus, while developing nations are just beginning to organize the infra-structure for children's mental health, developed nations are engaging in radical restructuring and often times thoughtless "experimentation."

Times of rapid change also offer new opportunities for development. Child mental health professionals need to be able to freely assert their knowledge, along with other advocates, about the basic needs of children (for continuity of loving attention within their families; from healthy, safe homes; for education and recreation to facilitate their development; for security in their neighborhoods). They also must be the voice, sometimes the solo voice, for early intervention and high quality treatment when children and adolescents develop mental, behavioral, emotional and developmental difficulties.

Today, we are in the odd situation of knowing a great deal more about developmental psychopathology and therapies and, at the same time, having to make a more pitched argument for preserving training, treatment and research programs of proven value.

For more than five decades, the International Association of Child and Adolescent Psychiatry and Allied Professions has been at the forefront of advocacy, education, planning, and communication concerning the mental health of children and adolescents. As the international umbrella organization of national societies dedicated to child psychiatry, clinical child psychology, social work, and associated fields, IACAPAP has always been willing to tackle the emergent issues confronting children, families and the professions that serve them.

At this moment, a critical issue concerns mental health systems. We need to address the critics, the health reform bureaucrats and medical entrepreneurs with knowledge and conviction about what children need, about treatment, efficacy, and about the various ways in which services can be delivered and by whom. Fortunately, child mental health professionals now have available a broad range of evaluation and

treatment modalities—including public health interventions, early intervention, individual and family psychosocial therapies, cognitive and behavioral approaches, pharmacotherapies, special education, inpatient, outpatient and in-home care, and so on. There are many barriers to financing and delivering a spectrum of care in communities. We must use our clinical knowledge to test alternative approaches that are financially viable, and we will need all our persuasive abilities to encourage policy makers to provide the funding to implement these systems in communities.

During the next years, IACAPAP will work in the area of mental health systems for children in many ways: through regional meetings, presentations at international Congresses, publications, and consultation to governments and organizations. As a non-governmental organization (NGO) within the United Nations, IACAPAP will continue to play a role in bringing mental health issues to the attention of nations and international organizations. The 1998 IACAPAP Congress in Stockholm will serve to focus international attention on new approaches to understanding trauma and the role of mental health professionals in helping children and families recover.

For IACAPAP to achieve its long-standing commitments to children, adolescents and professionals who serve them, the member nations need to work together and share knowledge, perspectives, and resources. I hope that there will be increased exchanges among young clinicians and researchers, in whose hands the future of our fields depends, and ongoing partnerships among societies and universities to collaborate in research, training, and dissemination of knowledge. The new regional organizations in Latin America and Asia – which join the European Society of Child and Adolescent Psychiatry– will play critical roles in supporting the development of child mental health professionals and programs. IACAPAP is dedicated to helping facilitate the exchange of knowledge and expertise among professionals and societies. We hope to soon be able to use the modern electronic communication super-highway to speed up communication, including the dissemination of this Newsletter.

I would like to extend, again, my own hope that all members will feel free to communicate with any of the Executive

Committee and me personally about their suggestions and thoughts. To help with this, I am providing my own e-mail address at the end of this statement. I would like to end by my expression of gratitude to all of those in our fields who are making such valuable contributions to children and their families and to the professions to which we belong, and to my colleagues in IACAPAP.

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Editors' Comments (from page 1)

series of articles from Journal editors regarding publication of research papers throughout the world. We also point out how technological advances involving electrical transmission of information enables rapid and international presentation of information. Our Newsletter soon will be accessible on the Worldwide Web, described in an article in this issue. We are fortunate to have the collaboration with the American Academy of Child and Adolescent Psychiatry to assist in these efforts to establish distribution of our Newsletter via the Worldwide Web.

Yes, The World Is Shrinking! We hope our efforts to inform our members receive your support and active participation. We welcome articles and announcements concerning work with youth and their families and their environments along with letters to Editors, comments, critics, new ideas.

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WHAT IS THE WWW?

The WWW allows users access to documents containing both text and graphics. These documents are organized through "hypertext links." Particular words and pictures in a given document will be highlighted. This "hypertext" is linked to other documents that provide relevant information to the highlighted word. Someone browsing through the document with their computer clicks on the hypertext with a mouse and receives this associated information, wherever it is located. As these associated documents can have links to other documents, and so on, these documents are built into a world-spanning "Web" of information. As an example, the first Web page of the Belgium Federal Government has a graphic based on their flag, followed by the letters "N," "F," "D," and "E." Clicking on one of these letters will take you to a summary page in either Nedelands, Français, Deutsch, or English. The summary page in turn has links to information about the monarchy, the prime minister, or government publications. These links are in their respective languages.

THE AACAP WEBSITE

<http://www.psych.med.umich.edu/web/aacap/>

The American Academy of Child and Adolescent Psychiatry established a Website in October, 1994 with the support of the University of Michigan Division of Child and Adolescent Psychiatry, Department of Psychiatry. The AACAP Website provides information about the AACAP organization, including meeting announcements and most importantly, the AACAP's award winning pamphlet series, "Facts for Families." The series provides information on topics ranging from Child Abuse to Panic Disorder in Children and Adolescents. The entire list contains fifty one topics listed in Table 1. These documents have been very popular. The number of documents requested from the AACAP Website has increased by 40–60% each month since it began from 2,000 files in December, 1994 to 30,000 files in May, 1995. The most popular file requested was Child Sexual Abuse, followed by Child Abuse—The Hidden Bruises, Children and Divorce, Teen Suicide, and

Children Who Can't Pay Attention. The computer that serves these documents to the Internet keeps track of all information access, allowing us to measure what resources are used and tailor new information appropriately.

The sources of these requests come from all over the world, including over 46 countries. Of the 20,644 identifiable file requests from May, 1995, the majority (16,468) were from the United States. This was followed by Canada (2294), then Australia (657), the United Kingdom (411), and Sweden (176). There is a clear bias towards English speaking countries. Table 2 contains the complete list of countries which have accessed the AACAP Website.

THE FUTURE OF THE AACAP WEBSITE

The success of the AACAP Website has resulted in the project receiving support in that it has been awarded a grant by the AACAP. The goals of the grant are:

- To further develop the content of the Website with potential areas of development to include violence and disasters;

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Children and Divorce	Children and Grief	Children Who Can't Pay Attention
The Depressed Child	The Autistic Child	Child Sexual Abuse
Children Who Won't Go to School	Children and Family Moves	Children Who Steal
Teen Suicide	Children of Alcoholics	The Adopted Child
Children and TV Violence	Making Day Care a Good Experience	Bedwetting
Learning Disabilities	Mental Retardation	Psychiatric Medication for Children's Abuse Treatment
The Child With a Long-Term Illness	Know Your Health	Know When to Seek Help for Your Child
Normality	Insurance Benefits	Stepfamily Problems
Know Where to Seek Help for Your Child	Children's Major Psychiatric Disorders	Children and AIDS
Responding to Child Sexual Abuse	11 Questions to Ask Before Psychiatric Hospital Treatment of Children and Adolescents	Conduct Disorders
When Children Have Children	Tic Disorders	Helping Children After a Disaster
Children's Sleep Problems	Manic-Depressive Illness in Teens	Children of Parents with Mental Illness
Children and Firearms	Making Decisions About Substance Abuse Treatment	The Continuum of Care
The Influence of Music and Rock Videos	Children and Lying	Lead Exposure
Discipline	The Anxious Child	Problems with Soiling and Bowel Control
Home Alone Children	Panic Disorder in Children and Adolescents	Questions to Ask About Psychiatric Medications for Children and Adolescents
Schizophrenia in Children	Teens: Alcohol and Other Drugs	
Teenagers with Eating Disorders		
Child Abuse—The Hidden Bruises		

Table 1.

Argentina	Greece	Peru
Australia	Hong Kong	Poland
Austria	Iceland	Portugal
Belgium	Indonesia	Russian Federation
Bermuda	Ireland	Singapore
Canada	Israel	South Africa
Chile	Italy	Spain
Colombia	Jamaica	Sweden
Costa Rica	Japan	Switzerland
Croatia (Hrvatska)	Korea (South)	Thailand
Czech Republic	Kuwait	Turkey
Denmark	Malaysia	United Kingdom
Estonia	Mexico	United States
Finland	Netherlands	Uruguay
France	New Zealand (Aotearoa)	
Germany	Norway	

Table 2.

The Web (from page 3)

- To translate the Facts for Families into Spanish, French and possibly Japanese;
- To develop designated areas that are public as well as for members only, requiring passwords for entrance; and,
- To facilitate the develop Internet connectivity for the AACAP Washington Office.

ACCESSING THE WEB

For those interested in seeing World Wide Web pages, two things are required: a computer with Internet connectivity and Web browsing software. Although any computer can be connected to the Internet, accomplishing this task can be complex and is the topic of several books. Examples include The Internet Companion: A Beginner's Guide to Global Networking, Second Edition by Tracy Laquey (Addison-Wesley, 1994) and The Internet Starter Kit for the Macintosh by Adam Engst. (Hayden, 1994). We recommend obtaining such a resource for those who want to make connections. Such books cover all necessary steps in detail.

Complete knowledge of the process cannot achieve a connection, however, without the help an "Internet Provider." This is a company that provides a physical connection

to the Internet. Internet books often provide some means for finding such a provider, although most are focused at providers in the United States. Be certain any book you purchase will connect you to an Internet Provider in your area.

Web software (or a "browser") can often be obtained from your Internet Provider and is simple to use. Some packages are free and supplied with different Internet books.

A BEACON OF HOPE

The AACAP Website has the potential to become a beacon of hope for children and adolescents with psychiatric disorders worldwide. Given its universal accessibility and potential for immediate distribution of information concerning advances in child and adolescent psychiatry, it will facilitate the distribution of state-of-the-art information about their difficulties. Hopefully, it will lead the way in the development of other sites in many other countries. These sites may not only serve the same purpose, but lead to a greater appreciation of the ways in which children and adolescents are both similar and different worldwide and as a consequence have the impact of leading to a universal appreciation of all children's vulnerabilities, needs and potential.

REFLECTIONS ABOUT CHILD AND ADOLESCENT PSYCHIATRY AND PROJECT VIDA IN BRAZIL

Salvador Celia, M.D.

Child Psychiatry in Brazil as far as I know started in Sao Paulo with Dr. Stanislaw Krynski, and it was linked with Pediatrics. Step by step, in other cities like Rio de Janeiro, Porto Alegre, Delo Horizonte, groups were formed. At the end of a decade the ABENEPI (Associaçãõ Brasileira de Neurologia e Psiquiatria Infantil) was created, and this association formed by medical doctors and allied professions. Also in 1968 in Guarujá, Sao Paulo, the First Brazilian Meeting was organized which will hold the XIII National meeting in October 1995 in Brasilia.

We have approximately 300 child and adolescent psychiatrists in our country and still we are working to recognize our speciality in the Federal Council of Medicine. Training occurs in just a few places (Belo Horizonte, Sao Paulo, Porto Alegre, Rio de Janeiro), but efforts occur to get more places and better qualified training. Influences from England, France, United States, have been very important for our field and it is very important to have interchange with colleagues from Uruguay, Argentina, and other countries.

Last April in Curitiba during our Latin America Meeting, we created our Latin America Federation of Child and Adolescent Psychiatry; Dr. Prego Silva, one of the precursors in Latin America of our speciality is our President. Colleagues like Leo Kanner, T. Berry Brazelton, Bertrand Cramer, Gerald Young, Helmuth Remschmidt, Phillipe Mazet, Phillipe Jeamet, Collete Chiland, Reimer Jensen, Joy Osofsky, Robert Emde, Justin Anthony and the Members of the American Academy of Child and Adolescent Psychiatry, and many others have visited our country to lecture. In 1988, we organized an important meeting in Canela, Rio Grande do Sul, when IACAPAP and WAIMH joined for the first time. In May 1997 with the integration of ISAP, a new meeting (Symposium) will be held in the City of Canela (Rio Grande do Sul).

We in Brazil are working in many fields of child psychiatry. In the last few years, great enthusiasm has succeeded with the Family Therapy Study Groups and Infant Study Groups.

Our connections with IACAPAP began with Dr. Krynski, when he was one of the Vice Presidents, followed by myself, since 1982 in the roles of Assistant Secretary, Vice President (twice) and now as a Counselor. The interchange and interaction with these International Associations, especially IACAPAP, has been very important for enhancing the quality in our field.

My professional activities have been influenced by many international experiences. After my graduation in General Psychiatry in 1968, at Federal University of Rio Grande do Sul, I went to UCLA in the Neuropsychiatric Institute working with Henry Work, James Simmons, Edward Ritvo, Edward Ornitz, and others, during 1969. After returning to Porto Alegre, I worked with Nilo Fichtner and Luiz Carols Osorio in the Institute Leo Kanner that was created in 1965 and dedicated to attend children and adolescents in residential and institutions in Latin America. Now, I am the Director of the Institute, and we are dedicated to helping infants and parents and to giving courses dedicated to professionals of mental health fields. We have a special interest in the training of pediatricians and we work together with the assistance of Dr. Bertrand Cramner from Geneve and Dr. Donald Cohen from Yale, our President of IACAPAP, on interesting interchanges that engage more than 80 pediatricians.

In addition to this work, since 1980 I have been working in Public Health, mostly in the area of prevention. In 1988, I was invited by the Governor of the State of Rio Grande do Sul, Pedro Simon, to coordinate a Special Social Program, that we named PROJETO VIDA (Project Life), a humanistic project.

We are a country of contrasts; really we can say that we have two countries. The first, in which, unfortunately, only 5% of the population lives, is wealthy and enjoys all resources of a First World Country. It may be compared with Belgium in its quality of life. The second, with 95% of the population, sadly, may be compared with India. The latter, Brazil, is the country of the malnourished (31% of children have malnutrition of 32 million people), or abandoned schooling (60% leave elementary school), children

from age 10 to 13 live in the worst possible health conditions and earn little (over 2 million people). Girl prostitutes (numbering at least 500,000), street children (seven million), raped women and disrespected senior citizens all live in this deplorable Brazil.

As we can see, Brazil has achieved a fantastic "social apartheid" by means of level of income, level of schooling, employment and social level. Brazil has become the ninth world power, but with a very low quality of life. All this forms what we call "social violence," and is our preoccupation in organizing our Project. The idea was to organize "Reference Humanistic Centers" dedicated to attending the populations described above.

For me, the idea of Man is a biopsychosocial environmental and political being, and a broad anthropological and humanistic concept. The vision of the human being lies in what we have decided to call citizenship, "the state of being a person." This idea brought to us the necessity to integrate areas like Education, Health, Science and Technology, Culture, Sports, Leisure, Human Rights, trying to get the best attention for the population that needs this support.

The name "Vida," life, was chosen precisely to highlight projects, energies, and positive talents of each of us and our communities, which are today under great stress owing to the great number of projects related to violence and death. The idea was to increase the capacity "of resilience," and we started with the preoccupation with the women, the pregnant, the babies, trying to improve bondings and "Ego Resilience" as Dr. Albert Solnit referred, that will be of great importance for the future of each person.

Four thousand persons have been inscribed in the first "Vida Humanistic Center" that is open daily, from 8:30 am to 10 pm, covering 60 activities, for all ages. Besides this, in the villages, around the center, inside slum areas, three programs attend to malnourished children and families. One of the secrets of the good results of this program was the participation of the community organizations (60 entities, including residents associations, mother clubs, service clubs, unions, etc.) to speak, discuss and help organize, and co-manage the activities of the Center.

Coping with stress, believing in the potentials of human beings, offering physical space, emotional opportunities to strengthen resilience, being together, working like a spider web, famous for its characteristics of resistance and flexibility by favoring bonding in a family or a community, we sought to build an

emotional web, a network of solidarity, which lends support, which contains and shelters, and, therefore offers opportunities for the "I" of each person to emerge, increasing his/her self-esteem and quality of life.

In the next few months, a second Center will be inaugurated in a City very near to Porto Alegre, Canoas, with the same objectives. This project was suggested by the Government of the State of Rio Grande do Sul, the Secretary of Trabalho, Cidadania e Assistencia Social, managed by the Fundacao Gaucha do Trabalho e Acao Social.

THE WORLD ASSOCIATION FOR INFANT MENTAL HEALTH: CURRENT DEVELOPMENTS AND FUTURE DIRECTIONS

Joy D. Osofsky, Ph.D.
President

In 1992, the World Association for Infant Mental Health was created from a merger between the World Association of Infant Psychiatry and Allied Disciplines and the International Association for Infant Mental Health. The World Association for Infant Mental Health (WAIMH) is an interdisciplinary and international organization that facilitates world-wide cooperation among individuals concerned with promoting optimal development of infants. WAIMH promotes education, research, and the development of scientifically based programs of care, intervention, and prevention of mental impairment in infancy. All people interested in infants, young children and their families are welcome to join. In addition to individual members of WAIMH, we also have WAIMH Affiliate groups internationally which promote the particular goals of infant mental health specific to their region of the world.

WAIMH holds a World Congress every four years and regional meetings in various parts of the world between the World Congresses. Regional meetings vary from large scientific programs to smaller workshops on a specific topic. In the past year, regional meetings have been held in the following cities: Riga, Latvia; San Francisco, California; Sydney, Australia, and Tokyo, Japan. For many years, initiated by Serge Lebovici, WAIMH has had an ongoing relationship with IACAPAP evidenced most directly by planning joint regional meetings and symposia at each other's meetings. This relationship has been a productive one for both organizations since they share interests in common in addition to their individual missions and goals.

In order to elaborate on some of the activities and objectives of WAIMH, I will describe briefly two of the recent regional meetings. The 1994 meeting in Riga was organized by Dr. Kaspar Tuters, a Toronto psychiatrist who was born and spent his early years in Riga until his family was forced to leave. Since Latvia became independent, Dr. Tuters has made many visits to share his expertise and attempt to help his people. He decided that a WAIMH Regional meeting would provide the opportunity to bring together for sharing and education not only people from the former Soviet Union, but also others from the surrounding countries to build relationships and opportunities for networking. The overall theme of the meeting was "Adaptive Changes to Infant and Child Care in a Rapidly Changing Social-Political-Economic System." The content focused on psychosocial development of the infant and child, direct clinical work with infants, children, and their parents, and theoretical and practical applications to institutional work with infants and children. Much information was shared about local programs and perspectives including the mental health facilities, ambulatory and orphanage settings for infants and young children. The meeting was very successful with WAIMH members becoming quickly aware that in addition to having much to give, we have much to learn by listening and trying to gain an understanding of families and children in different parts of the world.

The other regional meeting held in 1994 was a workshop which took place before the IACAPAP meeting in San Francisco where clinical approaches and case material were

presented and discussed. Two papers served to begin the workshop. Dr. Stephen Seligman of the Infant-Parent Program in San Francisco presented approaches to infant-parent psychotherapy in various situations. I gave the second presentation that discussed post traumatic stress disorder in very young children, presenting case material from two-year-old twins who had witnessed the shooting death of their mother and were in treatment with one of our child psychiatry fellows. The presentations were discussed by WAIMH members from North and South America and Europe. The participants then broke into smaller groups which dealt with pertinent topics, including: infant depression, diagnosis and assessment in infancy; attachment disorders in infancy, assessment of early initiative and willfulness from birth to one year, transference and countertransference in infant-parent intervention, and the IFEEL picture technique (a way of evaluating parents' perceptions of infant emotions). By holding regional meetings in conjunction with other larger international meetings, we find that we have the opportunity to meet new people with interest in infant mental health and expand our network of communication as well as our own perspectives.

Often themes of our World Congresses and Regional Meetings are general. However, for the first time, at our Sixth World Congress to be held in Tampere, Finland, July 25-28, 1996, the theme will be quite specific—"Early Intervention and Infant Research: Evaluating Outcomes." This theme is consistent with WAIMH's commitment to early preventive intervention, and emphasizes a topic of increasing importance for clinicians and researchers world-wide. The different subthemes of the Congress include: theories of intervention, intervention in different cultures, techniques of intervention, difficult-to-reach population, evaluation and follow-up of interventions, and teaching about interventions. Holding the Congress in Finland provides an important opportunity to reach out to colleagues from Eastern Europe including countries in the former Soviet Union. IACAPAP is presenting an invited symposium as part of our meeting which is being organized by Dr. Salvador Celia of Brazil. For more information, contact either Tuula Tamminen, Medical School, University of Tampere, P.O. Box 607, FIN-33101, Tampere, Finland; fax 358 31 247 43 75 or me (address provided at end of article).

Research and clinical directions continue to evolve and change in the field of infant mental health. Major areas that have emerged in the past few years include: 1) Concern with nosology and diagnosis in infancy and early childhood; 2) Efforts to gain more understanding of the intersubjective world of shared affective and cognitive meaning between infant and caregiver; 3) Interest in intergenerational issues and risk, including continuities and discontinuities and attachment relationships; 4) Concern with the development of effective preventive intervention strategies, especially for infants at high psychosocial risk. In the future, we undoubtedly will see further developments in these areas as well as the evolution of new concerns as our world changes and people become more cognizant of the need for early preventive interventions. WAIMH sponsors two publications to share work in this area—our Journal, the Infant Mental Health Journal and our Newsletter, The Signal. For more information about WAIMH or the Infant Mental Health Journal, contact me at the Department of Psychiatry, Louisiana State University Medical Center, 1542 Tulane Avenue, New Orleans, Louisiana 70112, USA, Tel (504) 568-3997, Fax (504) 568-6246, e-mail JDOPS@UNO.EDU.

Call For... Items for future Newsletters

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COMMENTS FROM CHILDREN WHO EXPERIENCE EXCESSIVE STRESS

Editors' Note: Child and adolescent psychiatrists often do not have direct communication or observation of children and adolescents who endure episodes of political violence. Two youths briefly review their impressions of peace and its sequelae in Israeli and Arab communities as well as other stressful aspects of their lives.

A PALESTINIAN YOUTH'S COMMENTS

Mosua is a 10 year old child living in a family unit consisting of a 46-year-old father, who has been unemployed for the last three years and a mother who is 28 years old, three brothers and one sister. He is the oldest in the family and is in the fourth class. On asking him about his opinion about the peace? He said: Peace is good thing in which no more soldiers are in streets and there are no more shootings. We can go outside our home at night without any fears. The presence of the Palestinian soldiers in the street gave us more security in our life. The streets started to be cleaner than before. There are many new constructions in the area. The education is better and there is no more need to leave the classes for demonstrations.

The only thing bad is the closure of the borders because my father cannot work and our economic status is very bad. We cannot get enough money from father like before when he was at work. He said that the last accidents of bombing is not good because it makes things worse and the border is closed and no more money is coming to us in the Gaza strip. He said the peace will be good if the borders between Egypt, Jordan, Israel, and Gaza opened and the people can move freely from one place to another place. He said that he is optimistic about the peace and it will work.

When approaching this subject, one must understand that Israeli youth do not differ from most world-wide youth in many of the sources of pressure that we are exposed to. Being normal teenagers, we are subject to pressure coming from school, beloved but nagging parents, temptations of drugs and alcohol, the opposite sex, being "one of the gang" and any other pressure sources that any youth is exposed to.

But besides the pressure causing factors listed above, Israeli youth, from the Jewish sector, at least, are exposed to a unique array of situations and constant events, which beyond a doubt cause pressure.

The army, for example. In a few months my friends and myself will be joining what is probably one of the main sources of pressure throughout Israeli youth, since besides the ultra-Orthodox, everyone joins the army, regardless of where they live or their political opinions.

Even before actually recruiting, there is a great amount of pressure on the average 18 year old, coming from family, friends and society as what it would be best for him or her to do in the army, at times each of the factors, pushing in different directions, sometimes ignoring what the recruitee wants.

Going into the army is also stepping into a new, frightening world with a totally different set of rules and behavior, with no one to help you adapt but yourself; almost a new beginning of life. But what probably is the most frightening aspect of the army is death itself. It is clear to my friends and myself that during our military service, one of us may die. And it could even be me. Jokes are told in an attempt to relieve the pressure, but the awareness of the possibility remains.

Another central course of pressure, though not belonging only to youth, is the Arab terror rampaging through the country. Young and invincible that we are, we are as prone to terror attacks as anyone else in the country. I knew three people roughly my age who were killed by Arab terrorists. One of the victims lived just a few block away from my home.

For Israeli youth living in the so called "territories," the situation is even worse. Travelling by car to and from their homes exposes passengers to stone throwing and at times gunshots. There is also a feeling of instability among Judea and Samarian residents as to their future. Will they be evacuated? Will a Palestinian state arise in the area they see as home? When will there be, at long last, peace?

The last question obviously concerns youth throughout the country. Everyone wants peace, there is no doubt about that, but probable even the biggest peace-process supporting youth is bothered by questions like what if it doesn't work, what if the whole process explodes in our face, and what if terrible mistakes are being made, that the next generation of decision makers, my generation, today's youth, are going to have a deal with and try to correct?

The last source of pressure I want to mention is religion, which troubles not only religious youth.

Being at the age of creating self-identity, religion is one of the more discussed and thought of aspects of independent life (mainly among religious youth). Religious youth, who all their lives have been told how to behave, what to think and what to believe suddenly have wonderful freedom of choice and opinion, and can think and decide for themselves. The same is true for non-religious youth, yet the impact is not the same, usually since religious youth are more exposed to non-religious lifestyles and thought than the other way around.

To conclude, Israeli youth are probably more pressure-prone than most youth throughout the world, yet do a good job dealing with the pressure by discussing the issues among friends, speaking with parents, teachers and whoever will listen, and, of course, writing letters to psychiatric journals.

A VISIT TO REFUGEE DETENTION CAMPS IN GUANTANAMO, CUBA

Gordon Harper, MD

BACKGROUND

On 29 and 30 October 94 I accompanied a group from the Schell Center for International Human Rights at the Yale Law School to the refugee camps maintained for Haitians at the United States Naval Base at Guantanamo, Cuba. The group was led by Ron Slye, an attorney who is the Associate Director of the Schell Center and also included Neils Frenzen, another attorney with many years of experience with Haitian refugees; Jean Ford, MD, a Haitian-American who is a pulmonologist at Columbia University; and Ron Aubourg, a Haitian-American interpreter from New York. Stuart Deutsch, an attorney from the US Department of Justice, accompanied the group. The purpose of the visit was to assess conditions at the camp. (Also on the base is a camp where Cubans are detained; we did not visit that camp, which had been the focus of litigation in Federal Court in Miami in the days just preceding our visit.)

The people in the camps fled Haiti by boat, were picked up at sea by the US Coast Guard (or Navy) and brought to Guantanamo instead of being taken to the United States. The policy that brings them to

Guantanamo, rather than the States, their intended destination, arose in the 1980's when the Reagan administration, for the first time in US history, responded to Haitian immigrants reaching US shores without documents by holding them, in some cases for years, in detention centers. The continuing struggle in the courts, with the Reagan, then the Bush, now the Clinton administration contending that such refugees had no legal standing in the US, led in recent years to the use of the Guantanamo base, which the US argues is not on US territory, but only leased from Cuba, to detain refugees without giving them US legal protection.

At the height of the refugee crisis in Summer '94, 15,000 people from Haiti (and another 32,000 from Cuba, each group responding to different crises in their respective countries) were detained in hastily-constructed camps in Guantanamo. After the US military intervention in Haiti and the return of President Aristide, approximately 9000 Haitians have voluntarily repatriated. Another 1000, trained for the new Haitian police force, are awaiting repatriation. Besides those 1000 prospective policemen, approximately 5000 Haitians, unwilling to return to Haiti, are in the camps. They were the object of our visit.

Guantanamo Bay extends several miles inland, past the boundaries of the Military Reservation leased to the US, into Cuban territory. Watchtowers on the surrounding hills mark the frontier with Cuba, said to be heavily mined and patrolled by both sides. The Reservation occupies some land on the western side of the Bay, where the airfield is, then a mile-wide stretch of water crossed by a small ferry, and a larger piece of land on the eastern side, where the base is, normally home to 2500 sailors and 5000 dependents. Since the refugee camps were expanded, the 5000 dependents have been returned to the States, and an additional 8000 personnel concerned with the refugees have arrived. The latter, referred to as the Joint Task Force, live in buildings formerly used for dependents, in schools, and in other buildings, recruited for the purpose, and in two aging ocean liners, one Greek, one Ukrainian, tied up in the harbor. Most of the refugee camps, consisting of army tents pitched on tarmac, staked with reinforcing rods driven into the tarmac, are built on an old airfield in front of the base headquarters. Others are located over a hill to the east; one was even pitched on the base golf course.

On the tarmac are four camps for Haitians, others for Cubans, and some empty

camps where Cubans, recently relocated to Panama, were detained. Around each camp is a "boundary" of coiled barbed wire. In places, the barbed wire is covered by camouflage-cloth spread out on top of the coils, which makes them a bit more visible—say, to children playing nearby but no less likely to scratch. A doctor going on duty in the camp hospital told us they see two to three children a night with injuries from the barbed wire. Watchtowers stand near the entrance of the camps. All around the camps are the facilities of the base—all the buildings normally servicing a community of 7500 people—including churches, schools, even a few restaurants, including McDonald's. Nearby are a beach and beautiful waters for boating. But these resources are available to those in the camps only on special pass: visiting other camps "accompanied, and with permission," going to the beach "once in a while, for a baptism." Not just a refugee camp, in short, but a detention camp.

The camps provide no frills. The tents are pitched side by side in rows with paths in between. In each tent sleep 15 to 20 people, on army cots. The cots are the only furniture. Hanging partitions provide the only privacy for couples. Food is centrally prepared and distributed at mess lines. Rows of porta-toilets at the edge of the camps serve sanitary purposes. Other tents served for group shower. Water is available at spigots at the edge of the camps. "Schools" consist of tents like the others, empty the Sunday we saw them, bare of chairs, tables, books, boards. The camp for unaccompanied minors had a splendid banyan tree, under which a religious meeting was taking place. There was nothing else that could be called a meeting place. In space between rows of tents boys and young men played soccer on the tarmac.

There were some differences among the camps. Near the entrance to the camp for unaccompanied minors stood a smaller barbed-wire enclosure, maybe eight by twelve feet, its only furnishing a plain bench, which served as a "time-out" room for children who fought or otherwise broke the rules. The camp was padlocked (double-padlocked, at that) and had riot helmets and shields lying on the ground, ready for use when needed.

The physical evidence at the police-training camp corresponded to a striking psychological difference there. The men (we were told there were women in training, too, but we didn't see them) were angry and showed it, clustering around, trying to talk several at a time, protesting the delay in getting them back to Haiti, to serve their coun-

try. The animus and activity of this group only made more striking the predominant mood elsewhere, a mood of subdued despondency, little initiative in speaking. Nowhere else was it necessary to ask people to take turns speaking. Elsewhere, people were slow to speak and spoke with little elaboration. Even when stories were told, with horrific details, there was little affective response either on the part of the speaker or on that of listeners. The overall impression was of a traumatized population, still in a state of shock and emotional numbing.

An illustrative example. A woman, Marie-Violette Cherissal, spoke of how she left Haiti. She was a nurse working two jobs. A member of the Fraph organization (terrorists thugs who supported the Cedras government) came to her house and forced her to come to his house to give an injection of medicine to his mistress. Cherissal protested that she was a professional, that she gave medicine only on a physician's order. Where was the order? She was told, at gunpoint, there was none and there would be none, but she still had to do as ordered. She gave the injection of antibiotics. A day later, she heard that the woman, despite the injection, had died of sepsis following an abortion. The nurse went into hiding, just before the Fraph member and his people ransacked her house. Everyone agreed, had they found the nurse, they would have killed her. After hiding for some days, the nurse was able to flee the country.

Two dozen people heard her tell this story, with no visible reaction. When asked about their reaction, a spokesman responded, it was not necessary to ask. Such an event was familiar and all to characteristic of life in Haiti.

This woman, like all the people to whom we spoke, said she would not return to Haiti, that she would sooner die in the camp, that those who perpetrated such atrocities were still at large and a threat.

Others told of leaving because of despair and because they felt that they had no future. Two boys, 13 and 17 had been orphaned, their mother murdered in political violence, their father dead from natural causes. They had lived with neighbors, attending school, but left at the end of the school year when they were informed they would have to pay money to take their final exams. The younger boy, Alex Anatal, was apathetic and fatalistic: I don't know what will happen; we are living on the mercy of God. But he was clear he had no interest in returning to Haiti, where he feels he has no family left.

In this camp, there were said to be 261 unaccompanied minors and 63 unrelated adults, recruited from elsewhere in the camps to serve as camp parents (*garden de la maison*). We had the impression from some of the military that these adults were selected to be foster parents, with an expectation of continuing responsibility, but those in the camp had no such feeling. One camp parent, Wilfred Exais, was responsible for 17 children.

Another couple illustrated the pervasive despair evident in the camp. I found them when looking for a young couple with a baby. The three-month-old girl, their first child, had been born in their first week in the camp, after they fled treats of murder in Haiti with their baby close to delivery. After a few days at sea, they were picked up and brought to the camp. The baby was healthy and had been seen once, but only once, with no follow-up, at the hospital. The father spoke of how difficult it was to care for his family, with no work for him to do, and difficulty in getting food for his wife, if she was lying down with the baby, and not showing up in line herself. I asked whether I could take their picture and the mother assented, and busied herself with dressing the baby and changing her own shirt. I took the picture and thanked them. I thought we had had a pleasant conversation. But when the picture was developed I was surprised by the looks on their faces. They looked stunned, apathetic, and defeated. In just a few hours in the camp, I had habituated, no longer noticing the looks around me. Only the photograph registered how burned-out and exhausted this young couple looked.

The effects of fear were also evident in parents' attitudes to their children's activities. All deplored the lack of positive activity for the children and, despite a complication mentioned below, most wanted their children to attend school for the few hours each day it was offered. Several knew that some out-of-camp activities were offered, with adults taking responsibilities for groups of children, but they spoke of fear about letting children far from sight—I feel better if they are right here where I can see them.

Services in the camps have been organized by the military, who provide shelter, food, and medical care, and by non-governmental organizations. World Relief provides social services. The UN High Commissioner for refugees observes and counsels candidates for repatriation. Various religious organizations provide pastoral services. The International Organization for Migrants provides interpreting and screening. Several comments about these.

First, the military has seen its first role to be providing shelter and security. They are only now considering how to plan for what may well be a permanent settlement.

Second, relationships between the military and those advocating for the Haitians have been marked by dissatisfaction and confrontation. For example, the Haitians and their advocates report seeing the Cubans getting preferential treatment, which they see as the result of American racism.

Third, planning for an appropriate range of education, vocational, and social services has to contend with the tension between the wish to provide adequate services for those in need right now and the reluctance of many to "make it too good" in the camps, in effect, making an arrangement of abusive human rights appear to be satisfactory because it is humanely run.

Fourth, fear of political retribution runs through all parts of the Haitian refugee experience. For example, the International Organization for Migrants, contracted by the US government to provide services, is seen as politically close to the Cedras regime, having employed the same Haitians in immigration screening centers in Port-au-Prince and in Guantanamo, and not to be trusted.

Fifth, school services. As mentioned above, empty tents were pointed out as the "school." Even when classes were being taught, we were told, most children had to look in from outside the tent, for lack of space. And we were told that students are demoralized, as they feel discriminated against as Cubans get a better chance at going to the US.

Finally, the medical services. The military is proud of the logistics and professionalism that have allowed it to provide a standard of medical care at Guantanamo certainly better than at refugee camps elsewhere in the world (for example, they have deployed an air-transportable 50-bed hospital), and often better than the refugees knew in Haiti. For example, Major Pearson, in charge of the hospital, boasted that he has six dentists, four times the usual ratio at such a hospital, and that they average 2.5 extractions per patient. Infectious disease has also been taken seriously. We saw isolation areas for patients infectious with tuberculosis, and another area for patients no longer infectious with tuberculosis, and another where patients no longer infectious but completing a course of treatment live with their families apart from other refugees. The military are concerned that such patients get adequate treatment in a controlled setting lest they interrupt treatment and develop resistant strains. We were told of

daily sick calls at each camp, with referral to the camp hospital as needed.

Despite this effort, we consistently heard people speak of inadequate or, from their point of view, dangerous care. Health education and liaison with patients and their families remain a major challenge. We also saw evidence of untreated acute illness. When I asked whether there were any unmet medical problems, a 13-year-old boy, Maxis Georges, came out of the crowd, with a thumb healing from a periungual or subungual abscess that he said he had drained himself, with a pin, after a visit to the camp hospital, he said, resulted in no treatment.

The most dramatic story we heard from a patient came from a woman in her 20's, Mme. Thermidor, whom we met where she sat, looking disconsolate, outside the camp hospital. Her story was difficult to elicit, with shame, fear and despair interfering, but we eventually learned that she had become pregnant as a result of a rape at the camp. She reported the rape, but the military investigators accepted the perpetrator's assertion that he and the woman were a common-law couple. The assailant remained in the camp and was said at least once to have appeared in the night at the woman's bedside. The woman was in the hospital, according to some, for unexplained hyperemesis gravidarum, possible self-induced. Others said this was the only place where she could feel safe. She wanted an abortion, but was told the military would not provide one. She appeared to us clinically depressed and was reported to have had a serious suicidal ideation. Medical evacuation to the US would appear to be indicated, and promptly.

This case reflects the background burden of traumatic stress carried by the Haitian refugees, which makes them particularly vulnerable to further trauma or victimization in the camps. And the detention experience, in itself, consists of another trauma for people who, with great valor, risked their lives to escape a situation traumatic for all but individually traumatic in a thousand different ways, only to find after days at sea, that a detention camp was to be their reward. Regarding their status as trauma survivors, it is worth noting both that the military health services are not providing significant trauma counseling and that they probably could not, since they are experienced as re-traumatizers as well as protectors.

OBSERVATIONS FLYING OUT

The US military are proud that they are providing "safe haven," a task they did not

choose but are performing, as military carry out orders, in an efficient and responsible way. The feeling arose that the US military is providing a model, showing others “how it can be done.”

The prospect the Guantanamo might provide such a model becomes profoundly unsettling when one considers the “new migration.” Along many fronts and for many reasons, people are increasingly moving not from third-world desperation toward third-world destitution, as in Cambodia, Afghanistan or Rwanda, but from desperation and disadvantage toward opportunity along the margins of the economically developed countries—a movement that is unexpectedly challenging the humanitarian and humanistic traditions of industrialized societies.

Against this prospect, child advocates, clinicians and non-clinicians, must speak up for the needs that are not met by tents, cots, and air-transportable hospitals. The 261 unaccompanied minors, for example, present a true child welfare emergency, growing up in camps without families. Careful, case-by-case review of these children is immediately indicated, with consideration given in advance by Haitian and US authorities to criteria for making these children available for foster care or adoption. These children present a strong case for the US to waive immigration requirements and to enlist private US agencies (like Haitian Women for Haitian Refugees) to find foster or adoptive homes in the US.

Next, the concept of permanent detention camps needs to be considered from the point of view of human rights and human developmental needs. Is the US government willing to impose on several thousand young people, unconvicted of any crime, a life of growing up without community, without access to decent education and without prospects for employment? To have families, under US government care, raising babies where parents have no future to believe in, no future with which to transmit hope to their children? No help, community or professional, in recovering from the effects of psychological trauma? To ignore the lessons of the Palestinian camps, whose temporary status gradually turned into permanent, and the interests of states overrode the interests of generations of children, with consequences of bitterness and alienation still bearing fruit today?

While the Guantanamo camps continue to operate, while no opening to the US appears and while no evidence from Haiti overrides the at-present intractable dread of returning felt by these refugees, an argument can be made that the provision of human services and the facilitation of community

development should be assigned to non-military private agencies. There is room for much creativity here; it is obvious from those NGOs already in Guantanamo that there is abundant goodwill as well as skills available. Such planning must balance the tension between “gilding the cage” and dismantling it, a tension acknowledged by General Ayres, the commander of the Joint Task Force, in quoting a refugee, “You can paint a cage gold, but it is still a cage.”

Before long, I fear, there will be many Guantanos.

A Visit To Bosnia

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Zenica is not a name that appears frequently in the news. It does not have the glamour of Sarajevo, and it is not a site of frequent conflict like Bihac. It is little different than many other similar size towns in the former Yugoslavia—the only reason it has special significance for me is that I recently returned from this former steel town in central Bosnia. I spent several months in Zenica working for an international humanitarian aid organization, the International Rescue Committee (IRC), working with other international organizations and local organizations in trying to develop mental health and psychosocial programs for civilians in Zenica and the central Bosnia region.

As a child psychiatrist, I was not quite sure what I was getting myself into when I seized the opportunity to spend the better part of 1994 working in the former Yugoslavia. I had the same knowledge of the problems in the Balkans as would anyone who reads the papers. Many medical professionals I talked with asked what I thought I would be able to accomplish over there—a belief I frequently encountered was expressed quite well by a former medical school classmate. “I can understand what a surgeon or an emergency room doc would do in a war zone—but what are you going to do, psychotherapy between the shelling?”

Zenica is a “steel town” similar to towns near my native Pittsburgh, a town in which the local steel company, RMK, once employed 80% of the 150,000 inhabitants. It lies in a river valley 40 miles NW of

Sarajevo. Like most towns in Bosnia, prior to the war the population was well represented by Muslims, Serbs, and Croats. Zenica is not one of the larger towns in Muslim controlled central Bosnia. The original population has dwindled to less than 90,000, but over 50,000 refugees from central and northern Bosnia have sought refuge in the relative safety of Zenica over the course of the war. Many have fled from small villages that underwent ethnic cleansing by the Serbs, and have witnessed or been victimized by the atrocities.

Confronted with these numbers and the overwhelming need they represented, my first task was identifying projects that were both feasible and useful. Going from group to group during my first days learning about existing programs, I learned that everyone had a different view of “pressing needs” to be addressed “right away.” Representing an international organization, I was viewed as being all powerful (or at least all-wealthy), and soon found I had more worthy “proposed projects” than I would ever be able to be involved with. Depending heavily upon my assistant/translator, we worked long hours trying to decide which projects and materials would be sustainable or useful after my departure.

There were many people suffering from untreated major psychiatric disorders, but there were a far greater number who needed “psychosocial help” even if they did not have any defined disorder. The combination of exposure to trauma and violence, the destruction of communities and families, the loss of structure of society, the loss of jobs and freedom to travel, the constant threat of harm—all of these had taken their toll on both the refugees and the Zenica population. The children, as in many other conflicts, had suffered greatly by the chaos around them.

There were few local mental health professionals remaining to care for the local population, without even considering the needs of the displaced population. There were a handful of psychiatrists doing the best they could for a hospital full of psychotic patients. Medications were always in short supply, and often unattainable. A small cadre of psychologists were doing their best to take care of everyone else outside the hospital—patients with depression, PTSD, anxiety disorders, as well as the great majority who were affected by the war but did not have a “diagnosis.”

Given these limited resources, the best way to proceed appeared to be to work within the local community, using whatever resources or people available, to develop community supports and individuals who

could act as “mental health extenders.” Teachers, parents, community leaders—all could become mental health “extenders,” able to provide basic mental health support to the community at large. Although unable to treat individuals with more severe problems, they could go a long way to meeting the need for “psychosocial help.”

One task was mobilizing and supporting the mental health professionals working with children in Zenica. Providing information from “outside,” a commodity worth its weight in gold, I was able to convince people to attend several “roundtables”—essentially journal clubs/case conferences where people had an opportunity to learn from each other and discuss cases. Although attendance varied week to week, a handful persisted and formed the core of a mental health resource. We then began inviting teachers, local humanitarian aid workers, and others who were working directly with displaced children. Suddenly the weekly meetings took on the role of case consultations, where the handful of mental health professionals supervised non-mental health professionals on “helping people.” Initially these meetings were held in English, but within a month they were being held in Bosnian with just an occasional question being asked of me in English. These meetings have continued to be held after my departure, serving to support the mental health community, and as a conduit for distribution of information and professional literature, two things that are sorely lacking in central Bosnia.

Other projects included developing a mental health component to complement a physical rehabilitation project that IRC had implemented for spinal cord injured war victims; producing, translating, and distributing community psychoeducational material; and supervising local medical students working for an international humanitarian aid organization on a “Child Mental Health” project, a psychosocial program involving frequent visits to over 300 displaced children in the area. Using simple art therapy and group work, these local students demonstrated how very simple interventions could benefit a significant number of children and their families. Much of my work in Bosnia was very different than my work in the States. Confronted with a situation of tremendous need and few supplies or resources, I worked to educate and support motivated individuals in the community, providing knowledge, support and ideas in order that they could reach and help a far greater number of children than I as an individual ever could.

One of the most rewarding activities was conducting “seminars” for school officials, teachers, and parents in frontline areas that had received little in the way of humanitarian aid or mental health support since the beginning of the war. These “seminars” often started by asking the participants general questions—where they work, what children they work with, and what they wanted to discuss. Often it went slowly as they took advantage of their first opportunity to tell an outsider about the problems they face. Occasionally people would have strong negative feelings about Americans, NGOs, mental health—but even then, they were grateful that someone listened to them.

The issues discussed were similar, whether the children were Muslim, Croat, or Serb. One issue that always came up, and always amazed people, is that children from the “other side” were also having problems. Frequent topics included ways to decrease social withdrawal in children who had been traumatized, ways to handle behavioral problems and aggression, what to do about children who had lost one or both parents, how to tell when parents and teachers should “really” be concerned with children who had been traumatized. Frequently the discussion would involve the poor material conditions of the school, and problems arising from the children having too little food, clothes, etc., and the difficulties in integrating mentally retarded children who have been “mainstreamed” because special ed teachers had either fled or been killed, or MR schools had been destroyed.

In conducting the “seminars,” I often started with a very little theory about trauma and stress, and how it affects children—using examples from what I had seen in Bosnia. Most of the discussion was spent trying to give concrete examples around a couple of main ideas. 1) That it does not take an expert to be able to help children—teachers can be helpful in classrooms, parents at home. 2) Families, groups and social supports are particularly important for children. 3) There are ways teachers might safely be able to have the children discuss some of their wartime experiences, giving the children a chance to decrease the anxiety and arousal associated with their experiences. (Safely refers to both children and teachers, as the adult’s feelings could also easily be overwhelming.) 4) Discussing very basic ideas behavioral interventions for children. We also discussed the participants fears and concerns:

- We are not therapists or psychologists – how can we talk to children about these things?

- None of this will work until you give us more food and pay us.
- We have too many children to do all of these extra activities.

By the end of the day, most people were feeling a great deal more comfortable, had developed ideas for helping their children, and were looking forward to trying them out.

Of course, during my time in Bosnia, things did not always go as planned. There were daily difficulties, a handful of scary situations, and more than a few times I questioned what had possessed me to go in the first place. But overall, the memories I carry with me are of the wonderful people I had an opportunity to meet and the honor to work with, and the lessons I learned from participating in a very unique aspect of international child psychiatry.

THE STREET CHILDREN OF BRAZIL

Jacob and Emily Roth

Editors’ Note: Jacob and Emily Roth are fourth year medical students at Yale University who, with the sponsorship of Dr. Donald Cohen of the Yale Child Study Center, spent five months working with Professor Salvador Celia at his “Project Vida” in Porto Alegre, Brazil.

The experience of childhood and adolescence has changed significantly for many in both the developing and industrialized world. In communities throughout the United States, the impact of such factors as poverty, discrimination, violence, substance abuse, and crime on the lives of children has been dramatic and disturbing. Similarly in Brazil, the lives of far too many of the country’s youth have become more desperate and disabled in the last decade. The effects of accelerated urbanization and a history resistant to addressing the social inequities in educational and economic opportunity served to dramatically increase the number of children who receive virtually no education, often fall into drug addiction and prostitution, and are increasingly at risk of violent death. There is a strong legacy of colonial mentality among the dominant economic and political class of Brazil, with varying levels of indifference or contempt of the poor that contributes to inaction on this problem. Interestingly, 80% of all street children are of African descent and two-thirds of the adult

non-white population earns under the monthly minimum wage of \$85. In this context, it is not unexpected that a traditional aloof and corrupt government heavily burdened by foreign debt has done little to invest in the future of these children of poverty and violence.

Professor Salvador Celia has been an inspirational exception to the others empowered, but so reluctant to make substantive change. On a fellowship through Yale Medical School we worked at *Vida: Centro Humanistico*, a community outreach project funded by Professor Celia in Brazil's largest southern city, Porto Alegre. To work with Dr. Celia is to come to know a remarkable leader who bears a unique combination of extraordinary vision and idealism tied with a forceful practical ability to realize what seem impossible goals. In 1989, Dr. Celia enlisted the support of then governor Pedro Simon to donate a 32,000 square meter defunct ceramic factory ironically slated to be developed for a prison. The northern zone of the city surrounding this factory encompasses the extreme poor of Porto Alegre. It is an area of dangerous violence, substance abuse, teenage pregnancy, and more generally, little sense of coherent family or community. These factors in turn contribute to the depressingly large numbers of abandoned and homeless youths seen throughout this region. The Vida Center was created at this site to help address these problems; its philosophy firmly anchored in a comprehensive and integrated approach to intervention.

Indeed, an exceptional variety of programs was developed at Vida, run by a broad range of professionals (with its origination, over 10,000 people applied for 120 jobs as teachers, physicians, psychologists, nurses, lawyers, athletic instructors, and social workers). In the area of education, there are courses for the learning disabled, classes for primary school age through adolescence, continuing education for the elderly, general day care services, and an impressive library. Within the arts there is a theater program and an array of dance classes, as well as courses in painting, sculpture, pottery, and weaving (with regularly scheduled fairs to sell their work). There is a women's support center with lawyers, social workers and psychologists dealing with concerns from the traumatic (physical abuse, alcoholism, and depression) to the practical (coordinating job placement, day care, scheduling groups or classes at Vida). The integration is compelling when you see, for example, a woman suffering from physical abuse gaining not only free legal counsel, but in addition, sup

port from mental health professionals and placement in one of the Center's women's self help groups. Within sports Vida offers basketball, soccer, gymnastics, volleyball, judo, bocci ball, hand ball, and aerobics classes for all levels and ages. There is a clinic area devoted to preventive health and treatment with programs ranging from inoculation, nutrition, general health maintenance, to counseling on breast feeding. There is truly a dizzying array of programs in which people of all generations immerse themselves (a full 20,000 as regular users). When there are theater or dance presentations, thousands come to see their neighbors perform. People repeatedly described to us how the whole tone of their community had changed over these past four years, and you would see such pride and happiness in Vida in their faces.

Although we took part in a range of programs at Vida, our principal work was involved with the street children coming to the Center. Through researching intake forms at Vida and government census statistics, one quickly recognized the vast differences in the lives of these street children as opposed to youths living at home in Porto Alegre. The large majority rarely attended school, over two-thirds sniffed glue ("lolo"), and greater than 50% identified at least one substance-abusing adult in their original household. Indeed, through academic research, comprehensive interviews, and simply working with these children each day their experience of living on the street came into full relief—a history of continually struggling for food and clothing, resorting often to petty thievery to survive, nearly all facing the threat of violence daily, searching for escape through sniffing glue, and the girls often falling into prostitution by their early teens. Sadly, their lives were, in nearly every realm, profoundly dysfunctional and disabled. Once at Vida, though, these seemingly insurmountable hindrances were confronted with not only invaluable essentials of food, clothes, health care, and a safe environment, but further integrating these children and adolescents in the full range of programs from education, counseling, arts, to sports—enabling them to experience community and develop their lives in a broader way than just the skills learned surviving on the street. Working with these children day to day, it became so apparent how profoundly the experience of Vida affected them and how deeply they valued the program. It was perhaps most revealing when a new street child arrived—one saw much dramatic contrast

with him or her compared to a peer who had already been part of Vida for even a few months. Witnessing this was perhaps made even more compelling in light of the overwhelming cynicism present in the U.S. right now with regard to any project that vaguely hinges at socially aggressive intervention. The example of Dr. Celia's Vida shows that these goals of improving the life of the individual and community can still be greatly helped through social programs as long as there is strong and intelligent leadership that engages the support and interest of the community and follows through long after initial development.

What is further striking though, when considering the lives of these street children (or when simply discussing the experience of the poor in Brazil in general), is how so many of the issues resonate strongly with those found among the poor in the U.S.—teenage pregnancy, domestic violence, substance abuse, single parent families, limited education and parenting skills, depressed sense of hope or purpose. Indeed, in both settings, a fundamental dissolution of family and community (all within the context of inadequate education, overwhelming poverty, and economic and social discrimination) too often created a chaotic, traumatic, and entirely non-nurturing environment for the developing child. Their ability to form trusting bonds, sense of identity or community, sense of self-worth or being valued—qualities all so important for healthy development and well being—is severely diminished. In our experience, it seem Vida helps to restore this necessary bond to the community, developing both strong peer and intergenerational relationships and further enabling the ability to trust and respect others. Perhaps most substantively though, Vida offers these children a deeper sense of self-worth and capability with new hope for fulfilling life purpose.

Once again, it is enormously difficult to fully convey the experience of Vida on paper. When one attempts to describe it to others who have not yet visited the Center, it invariably invites a mixture of awe and incredulity. To witness Vida in substance though, transforms this unbelievable seeming vision into a very real and dramatically compelling program that is truly working with impressive effectiveness. Certainly the problems are deep and complex; however, Dr. Celia's Center works remarkably well at addressing an extraordinary array of needs for the poor of Porto Alegre and most fundamentally appears to provide their lives with a greater sense of value and fulfillment.

EARTHQUAKE

KOBE, JAPAN—1995

Kosuke Yamazaki, M.D., Ph.D

January 17, 1995—5:46 a.m. Shortly before dawn on this day, an earthquake of magnitude 7.2 hit the Kinki region, situated just about in the center of the Japanese archipelago. Transportation and communication was severed in an instant, leading to fragmented information, but as time wore on, it became apparent that it was a quake of unprecedented proportions to hit a large urban area. The tragic conditions gradually revealed via television were beyond normal comprehension, akin to the city of Tokyo razed to the ground ensuing the air attacks in World War II. Damage assessed in the following weeks, although yet incomplete, has been reported at 5,494 deaths, 34,626 injured, 159,544 buildings totally or partially destroyed, 531 fires, 103 children losing both parents, and 401 children having lost one parent. A report from the Ministry of Education of February 15 relates 373 deaths among elementary, junior, and high school students, 111 deaths among college students, with 4,483 educational and cultural facilities destroyed. Approximately 40,000 elementary, junior, and high school students (about 8% of all school-age children in Japan) have lost their homes, resulting in 30,323 children being sent to stay with relatives and friends in unaffected areas, although such children are starting to return to their parents starting in March.

Perhaps because the quake had been generated with the focus directly beneath a large city, the response of clinicians was rapid. The Japanese Society of Child and Adolescent Psychiatry immediately set up a "Special committee for the relief of children struck by the Hanshin earthquake," initiating consultation activities working from the Kobe Child Guidance Centers as the base of operations. Relative organizations started telephone consultations at about the same time, while producing manuals for guidance and treatment. Great differences were not seen among such manuals prepared independently by the various associations and organizations, and were not considered as possible sources of unwarranted confusion.

From about a month post-calamity, consultations regarding children have been on the rise. Various physical symptoms—

insomnia, night terror, severe dependence and wheedling—believed to be cases of mourning reaction and post traumatic stress disorder are being encountered in succession. These cases appear to involve boys more often than girls. Meaningful statistics from the clinical and guidance institutions will probably take some time, and reports are so far limited to restricted survey reports. The result of one such questionnaire survey was compiled on the responses from 112 sixth graders by a newspaper publisher with the cooperation of elementary schools. They report the following responses in answer to the question, "What was the greatest hardship experienced in relation to the earthquake": death of friends—29.3%, death in family—22.6%, being separated from friends—12.2%, lousy meals—6.7%, losing homes to return to—7.3% and having been unable to bathe—6.7%. On the contrary, in response to the question, "What made you most happy following the earthquake": 18.4% responded being reunited with friends at school, 11.0%—safety of family members and themselves, 8.9%—resumption of electricity, gas, and water, 5.3%—eating good food, 4.7%—taking a bath/receiving supplies from all over the country, and 4.2%—kindness of volunteers/finding their homes intact. However partial this survey may be, it is sufficient to portray the significance of friends for children. In conducting this survey, 57% of the children responded that they did not want to answer, indicating refusal to verbalize their quake experience. Additionally, a separate survey conducted by an elementary school six weeks from the earthquake has revealed 36% of the subjects experiencing repeated playbacks of what happened during the quake in their minds, 27% being unable to sleep well, and 23% anxious of ending up alone, indicative of the depth of the scar the experience has left on the children.

On the other hand, the tremendous energy harbored by children has also become apparent. Listening to the groundswell of restoration surging around him, a child having refused school for many years came to the conclusion that he had to make the final decision himself, and decided to take the step of studying abroad in England. Other children were able to restore contact with friends during life in evacuation centers, coming to take concerted action with the others. It is undeniable that the entire ordeal was a most tragic

and unfortunate experience for the children. Nevertheless, we can only pray that they will also come to delineate a valuable aspect to the experience as well, enabling them to grow in many ways.

Going through the mountain of references being sent to us from abroad from immediately after the quake, I was astounded by the detailed survey and assessment being conducted on the calamities which hit San Francisco, Armenia, and other such regions, along with the fact that contingency plans and countermeasures have been constructed reflecting those results. Surveys and research have been attempted following the many natural disasters striking Japan, but perhaps due to cultural differences, cooperation in such surveys and studies have been pitifully poor, characterized primarily by criticism. More importantly, instances of results of such surveys being cycled back to society, and being actually incorporated into constructing countermeasures are just about unheard of. Perhaps it is that the Japanese are simply inept at such systematic efforts. What is called for is not the lavish activities promoted by temporary excitation, almost as a manic defense during disasters, but serious, down-to-earth, long-term interdisciplinary evaluations. Whether we will be capable of conducting down-to-earth supportive operations and interdisciplinary surveys and studies rooted in regional society should prove to be the real test regarding qualification to speak on child mental health in the coming years.

As a final note, I would like to express sincere gratitude for all the concern, encouragement, and invaluable references from the members of IACAPAP.

Street Children of Brazil (from page 12)

Indeed, the children come to Vida labeled "meninos de rua" or "street children," soon display such pride in referring to themselves as "meninos de Vida" or "children of Life."

CHILD AND ADOLESCENT PSYCHIATRY AND PSYCHOTHERAPY IN GERMANY

Helmut Remschmidt, M.D. Ph.D.

1. History of Child and Adolescent Psychiatry in Germany

In Germany, child and adolescent psychiatry was defined as a discipline of its own only since 1968. According to the definition of the German Medical Association, the field of child and adolescent psychiatry is defined in the following way:

“Child and adolescent psychiatry comprises diagnostics, non-operative treatment, prevention and rehabilitation of psychiatric, psychosomatic and neurological disorders and of psychological and social behavior disturbances.”

From a historical point of view, child and adolescent psychiatry has two main roots: adult psychiatry and neurology and pediatrics. But there were also many important influences from the field of psychology, social sciences, sciences of law and from the field of social welfare.

The first German Association for Child Psychiatry was founded in 1940 in Vienna. Its name was at that time “German Association for Child Psychiatry and Remedial Pedagogics.” The further development of this association was handicapped by the war which precluded publication of its journal, the “*Zeitschrift für Kinderforschung*” (Journal of Child Research).

During the Second World War, some psychiatrists and pediatricians were involved in several actions of euthanasia, killing thousands of mentally handicapped children in so-called “Children’s Departments” of psychiatric state hospitals.

In 1948, the association was re-established during a congress of the German Association for Psychiatry and Neurology in Göttingen, and the first child psychiatric meeting took place in Marburg. In 1960, the “German Association for Adolescent Psychiatry” was officially established as a medical discipline. Since then, child and adolescent psychiatry has become a specialty in its own right with close contacts and cooperation with the fields of pediatrics, psychiatry, psychology, education, remedial pedagogics, and jurisprudence.

In 1976, the name of the association was changed to “German Society for Child and Adolescent Psychiatry,” and in 1994 to “German Society for Child and Adolescent Psychiatry and Psychotherapy.” The German society organizes scientific meetings and congresses, is responsible for the training and education of child psychiatrists and has a close cooperation with the “Professional Organization of German Child and Adolescent Psychiatrists” which was founded in 1978 and has taken over the responsibility for all the problems of child psychiatrists in practice.

With respect to the theoretical orientation, four traditions can be distinguished in German child psychiatry:

- The neuropsychiatric tradition,
- the clinical-remedial (educational) tradition,
- the psychodynamic-psychoanalytic tradition, and
- the empirical-epidemiological orientation.

2. Training of Child and Adolescent Psychiatrists

Training of child psychiatrists takes place within 100 institutions, among them 20 university departments. The curriculum of training of child psychiatrists is defined according to the German Medical Association as follows:

Detailed knowledge and experiences concerning diagnosis, the theoretical basis and clinical practice of psychiatric disorders in childhood and adolescence, including neurological examination, differential diagnosis of psychiatric and neurological disturbances, pharmac- and somato-therapy of psychiatric and neurological disorders, methods of psychotherapy, including the indications of psychoanalytically based psychotherapy.

The curriculum itself is subdivided into five fields:

1. Basic knowledge;
2. Knowledge and experiences with respect to symptomatology and etiology of psychiatric disorders in children and adolescents;
3. Knowledge and experience with respect to diagnostics and differential diagnosis;
4. Therapy, prevention and rehabilitation;
5. Child and adolescent legal opinion.

There is a final oral examination at the Board of Physicians in each of the 18 states of the Federal Republic of Germany.

At the moment, the German Society for Child and Adolescent Psychiatry has about 650 members; however, not all of them are child psychiatrists. There is a special category of extraordinary membership for selected non-physicians. There are not enough child psychiatrists to fulfill all necessary tasks. Most of the active child psychiatrists are working in institutions. There are only 140 child psychiatrists working in private practice (spring 1991). The German Society for Child and Adolescent Psychiatry proposes a ratio of one child psychiatrist per 250,000. Thus 250 to 300 more child psychiatrists would be necessary.

3. Children and Adolescents as Psychiatric Patients

In the Federal Republic of Germany, children and adolescents under 18 years comprise about 25% of the general population. According to national and international epidemiological studies, the rate of psychiatrically disturbed children and adolescents can be estimated between 7 and 15%. Studies on the rate of psychiatrically disturbed children and adolescents who are in treatment show that the rate of these patients varies between 1.8 and 3.9%. This means that many children and adolescents with psychiatric disorders, or at least, with symptoms, are still without treatment.

An expert group of child psychiatrists, nominated by the Federal Government, has defined six groups of children who are not sufficiently diagnosed and treated in West Germany:

1. Children and adolescents with antisocial and delinquent behavior;
2. Children with neuropsychiatric disorders (e.g. developmental language disorder, dyslexia) and attention deficit syndromes;
3. Children and adolescents who are drug-dependent or dependent on alcohol;
4. Children and adolescents with suicidal behavior and personality deviations;
5. Children and adolescents with autistic syndromes and pervasive developmental disorders;
6. Battered and sexually abused children and adolescents.

The above mentioned expert group has proposed a plan for the promotion of child and adolescent psychiatry and for meeting the needs of psychiatrically disturbed children and adolescents and their families.

4. Treatment Facilities for Children and Adolescents with Psychiatric Disorders

Currently there are about 100 facilities for the diagnosis and treatment of psychiatrically disturbed children and adolescents.

In principle, there are enough services for inpatient treatment, but their distribution over the country is uneven. Structural changes are necessary. Special deficits exist in the following fields:

- Day treatment: There are only a few facilities, located in large cities.
- Child psychiatrists in private practice: A ratio of 1:250,000 must be required.
- Integration of child psychiatric competence into child guidance clinics: There are about 800 child guidance clinics in the Federal Republic of Germany (80 Mill. inhabitants). Only a small proportion of them have access to child and adolescent psychiatrists. This system has to be developed in the near future.
- Mobile child psychiatric services for rural regions: In the Marburg area, the mobile child psychiatric service has proved to be an excellent instrument for treatment for children with psychiatric disorders and for counseling their families, but had to stop for financial reasons.

5. Prospects for Future Development

The Child Psychiatry Expert Commission has proposed general principles and special measures for the further development of child psychiatry in the Federal Republic of Germany. Among the general principles are: paying more attention to developmental processes, family relationships, and to the situation of nursery schools and schools. At the same time, it seems very important not only to pay attention to risk factors for the development of children, but also to protective factors and prevention. Child psychiatry should be more integrated into the field of medicine, and all services should work close to the living place of the child and his family (community oriented child psychiatry).

Special measures comprise several proposals based on evaluation research in Germany and other countries, concerning the following fields:

1. Adequate distribution of child psychiatric institutions and child psychiatric competence all over the country.

2. Paying more attention to groups of children and adolescents who are neglected or at least insufficiently treated.
3. Facilitation of child psychiatry in general practice.
4. Integration of more child psychiatric competence into child guidance clinics.
5. Facilitation of all outpatient and day patient services, including mobile services for rural regions.
6. Facilitation of early detection and prevention in all fields of child psychiatry. This can be done only in close cooperation with pediatrics, public health and child welfare agencies.
7. Improvement of training in child psychiatry, not only in the medical field, but also for social workers, psychologists, teachers, etc.
8. Improvement of clinical and epidemiological research in the field of child psychiatry.

One of the most important problems to be solved in the near future is the integration for German child and adolescent psychiatry into the European development. On the level of the European Union, there is already a section of child and adolescent psychiatry and psychotherapy, which is now trying to harmonize the curricula for the training of child and adolescent psychiatrists and psychotherapists through the whole European Union. The curriculum proposed is based on a five-year training course including psychotherapy.

As far as the situation in Germany is concerned, the following questions need to be addressed:

- Including measures of quality assurance to all tasks and developments in child and adolescent psychiatry,
- modernization for the facilities and paying more attention to a community-oriented child and adolescent psychiatry and psychotherapy,
- establishing of departments of child and adolescent psychiatry and psychotherapy at all universities.

ACAPAP HONORARY PRESIDENTS

Gerald Caplan, M.D., D.P.M., F.R.C., Psych.

Gerald Caplan was born in 1917 in England, where he studied medicine, psychiatry, child psychiatry, analytic group psychotherapy and psychoanalysis.

He worked in mental hospitals in Birmingham and Swansea, and then at the Tavistock Clinic in London. He worked in Israel during the period 1948–1952, and then joined the staff of Harvard University in Boston, U.S.A., where he worked for 24 years, first at the School of Public Health and then at the Medical School, where he established the Laboratory of Community Psychiatry. In 1977 he returned to Jerusalem to establish a department of child psychiatry in the Hadassa-Hebrew University Hospitals. Since 1985 he has directed the Jerusalem Institute for the Study of Psychological Stress and its Family Center that seeks to prevent psychological disorder in children of disrupted families. Dr. Caplan has pioneered concepts and techniques of preventive psychiatry and community mental health, and has published 21 books and 160 journal articles on these topics. He was appointed Professor of Psychiatry Emeritus at Harvard University in 1978 and Professor of Child Psychiatry Emeritus of the Hebrew University of Jerusalem in 1984. He served as a Secretary General of the International Committee of Child Psychiatry and established the International Association of Child Psychiatry in 1948, and since then has served on its Executive Committee. Dr. Caplan was elected its Honorary President in 1970.

Serge Lebovici, M.D.

Serge Lebovici was born in Paris in 1915. His father was a family doctor and was killed by the Nazis in 1942. After medical training, he became a pediatrician and participated in the "Resistance" against the Nazis. He had a secret wish: to become a psychiatrist and a child psychiatrist after WWII.

Dr. Lebovici was able to become the first assistant of Professor Georges Heuyer at first a "good father" and at the end of his life a real detractor of his efforts. Dr. Lebovici was not appointed his successor, but at the end of his military engagement, had another chance: to meet Sacha Nacht. Thanks to him, Dr. Lebovici accomplished another wish: to be analyzed. He was appointed as an Associate

Member of la ~~Société~~ **Société** ~~Psychanalytique~~ **Psychanalytique** de Paris in 1947. In such a way, his double affiliation to Child Mental Health and Psychoanalysis developed.

With a group of friends, Dr. Lebovici was able to apply his concept of a dynamic public psychiatry in funding the Community Department of Adult and Child Psychiatry in the XIIIe. Arrondissement in Paris. "Le Centre Alfred Binet," the child department, was a real influence in France for many reasons. It was able: 1) to promote a public center for the clinical and therapeutic approach, 2) with a good survey of work, to classify cases, which was very influential for the creation of ICD9 by WHO; 3) to train doctors and psychologists in child and adolescent analysis; 4) to conduct clinical research; 5) to found the first day hospital for psychotic children and later some part-time units; 6) to begin and continue a long-term survey of one sample of the general population of this district of Paris. The "enquête Vulpian" began with 60 children of six years, followed up for more than 20 years.

Dr. Lebovici was appointed in 1978 as a full professor of Child and Adolescent Psychiatry at the University of Paris XIII at the Experimental Medical School Leonard de Vinci. He concentrated his clinical and research work on newborns' and infants' development and psychopathology and interactions, intergenerational transmission, therapeutic consultations, a research network coordinating the programs of 12 research units in France and Switzerland. His latest book is entitled: The Baby, His Mother And The Psychoanalyst. Dr. Lebovici founded Psychiatrie de l'Enfant and more recently, Devenir.

***Albert J. Solnit, M.D., Commissioner
Connecticut Department of Mental Health***

Albert Solnit is Sterling Professor Emeritus (Pediatrics and Psychiatry) and Senior Research Scientist at the Yale University Child Study Center. He is principal editor of The Psychoanalytic Study of the Child, published annually by Yale University Press, and co-author of Beyond the Best Interests of the Child, Before the Best Interests of the Child, and In the Best Interests of the Child. Other recent books Dr. Solnit has co-authored/edited include: The Many Meanings of Play, When Home is No Haven, and Divorce and Your Child. His bibliography includes many other books, chapters, original articles as well as numerous other publications.

Dr. Solnit, honorary president of The International Association of Child and Adolescent Psychiatry and Allied Professions, served as Secretary General of IACAPAP from 1970-74 and also as President of the organization from 1974-78. He has also served as President of the American Psychoanalytic Association, the American Academy of Child and Adolescent Psychiatry, and the Association for Child Psychoanalysis.

Dr. Solnit received The American College of Physicians' William C. Menninger Award for distinguished contributions to the science of mental health in 1979; was awarded the first Irving Philips Award of the American Academy of Child and Adolescent Psychiatry for his work in the fields of child psychiatry and psychoanalysis.

An internationally recognized advocate of children's rights, Dr. Solnit has the distinction of having an endowed chair in his name at the Yale Child Study Center and a nursery school named in his honor at The Anna Freud Center in London. Aside from his governmental and academic pursuits and achievements, Dr. Solnit continues his scientific and psychoanalytic work, studying crises throughout the life cycle, while actively fulfilling his many national and international involvements.

SPECIAL OLYMPICS INTERNATIONAL (SOI)

The SOI is an international organization devoted to improving the lives of individuals with intellectual disabilities (mental retardation). By providing special opportunities for sports and recreation, the SOI also brings the competencies of individuals with mental retardation to public awareness. In this way, for more than 25 years, SOI has been an international pioneer in helping improve the inclusion of people with disabilities into the mainstream of society.

The 1995 Special Olympics International World Games held in New Haven, Connecticut, in July 1995, were the world's largest sporting event of any type during the year. More than 150 nations sent athletes to

the World Games and more than 7,000 athletes with retardation demonstrated remarkable skills in virtually every sporting event, from horseback riding and boating to basketball, track and tennis.

IACAPAP has worked closely with the SOI for the past four years. A special symposium on the Special Olympics was held at the IACAPAP San Francisco Congress in 1994. Donald Cohen, President of IACAPAP, also served as the Chairperson for the SOI International meeting on law and human rights relating to retardation (held at Yale Law School) which issued a special report (available on request to Donald Cohen); a symposium on religion and spirituality; and an international symposium on science, law and social policy relating to intellectual disabilities co-sponsored by the United Nations and held in the international UN headquarters in New York in June, 1995. The Committee also facilitated the first research project to demonstrate that participation in the Special Olympics improved the adaptive behavior of athletes.

Child mental health professionals play a major role in the diagnosis and treatment of children, adolescents and adults with intellectual disabilities and associated handicaps, including behavioral disorders. In our work, we especially emphasize the view of individuals with MR as whole people whose functioning is related to their personalities, motivations, and self-esteem, and not only their IQ level. Our clinical work demonstrates that individuals with disabilities benefit from the full range of human opportunities, including opportunities for being included in their families and communities and sharing in recreation as well as education. By working collaboratively with SOI and other such service and advocacy organizations concerned about promoting the development of individuals with intellectual disabilities, child mental health professionals can help provide new opportunities for people with intellectual disabilities to develop their fullest potentials.

THE JOURNAL OF CHILD PSYCHOLOGY AND PSYCHIATRY AND ALLIED PROFESSIONS

Jim Stevenson

Editors' Note: Exchange of scientific information is of utmost importance in advancing clinical practice of child and adolescent psychiatry and research. The Newsletter endeavors to inform practitioners throughout the world about some of the policies of professional journals that focus on publishing clinical and scientific papers in child and adolescent psychiatry and psychology and allied services. We have asked the editors of several journals to describe the scope of other journals as a means of enhancing international exchange of information.

The Journal of Child Psychology and Psychiatry was founded in 1960 and since that date has become established as the leading international journal publishing in this field. The Journal currently appears in eight issues per year. Since 1990 one of these issues has been devoted to an Annual Research Review comprising commission papers providing an authoritative overview of current research trends. The Journal publishes empirical papers, but in addition provides regular Annotations and occasional Practitioner Reviews. The Annotations are relatively brief summaries of specific issues in child psychology or psychiatry. The Practitioner Reviews are longer commissioned reviews that attempt to integrate research findings with specific aspects of clinical practice. A forum for scientific discussion of articles published in the Journal is provided in the Debate & Argument section of the Journal which appears when required. Authors whose papers are the subject of critical comment are invited to make a rejoinder. Comment and rejoinder are published together. In recent years Editorials have been introduced in each issue with the aim of highlighting for clinicians and practitioners the take-home message of the research papers published. Finally, the Journal publishes reviews of important, recently published books.

The vast majority of submitted papers comprise accounts of empirical research studies. Occasionally theoretical papers are accepted and very occasionally, case studies are accepted. The Journal attempts to be truly

international in the papers it receives from authors. To help achieve this end, the Journal has established a system of corresponding editors who have been selected to be a focal point for authors from outside the UK. These corresponding editors currently consist of Professor David Offord of the Child Epidemiology Unit at McMaster University Medical Centre, Hamilton, Ontario, Canada; Professor Margot Prior, at the Department of Psychology, Royal Children's Hospital, Parkville, Victoria, Australia; Dr. James F. Leckman, Child Study Center, Yale University, USA; Dr. Carol K. Whalen, School of Social Ecology, University of California at Irvine, USA; Professor Joe Sergeant, of the University of Amsterdam, The Netherlands, and Professor Martin Schmidt of the Zentralinstitut für Seelische Gesundheit Kinder- und Jugend-psychiatrischen Klinik, Mannheim, Germany. Authors may submit their papers either to the local corresponding editors or to the editors in the London office. Via either avenue, the papers are sent out for review by at least two independent referees. Authors are entitled to ask for blind refereeing. After the refereeing process has been completed, corresponding editors may recommend the paper for publication but the final decision on acceptance rests with the editors in London.

The Journal actively encourages submissions from authors outside the main academic centers in the UK, Europe, USA and Australia. To this end, authors will be given detailed editorial support and advice on revising manuscripts once the research has been deemed suitable for publication. In 1993 and 1994 papers appeared in the Journal from the following countries:

The readership of the Journal is truly international and the library and individual subscriptions are very widely spread. The material in the Journal is published in English but since 1992 Japanese translations of the abstracts have been made available.

To summarize, the Journal is proud of its international authorship and readership. Although based in the UK and published in English, it has a policy of encouraging submission from non-English speaking authors. Without compromising the scientific quality of papers, the Journal editors maintain a policy of facilitating the publication of authors from the international scientific community. Overall, however, JCPP has in recent years gone from strength to strength and we receive far more submissions than can be published. Our policy therefore is to give preference to papers that make a substantial and original theoretical contribution to the field.

ETHICS OF KNOWLEDGE

Information on IACAPAP Activities

On March 30th, 1995, IACAPAP held a regional meeting headed by President Donald Cohen, at Beit-Gavriel on the shore of Galilee Lake. The topic was: "Do we know what we do and do we do what we know." This meeting gathered psychiatrists, psychoanalysts, psychologists, philosophers, geneticists, clinicians and researchers. Its aim was to discuss several issues concerning our knowledge and practice.

Medical activity in general and psychiatry especially are based on training, experience, intuition, belief and some well-proved data. Facing our patients, we have to give a quick, convincing and assertive answer to their suffering.

We are immersed in a growing flow of information and data which is generally convincing but we have hardly the time to read the titles and new papers that cover our desks. At the same time, we have to continue our clinical activities guided by our training, experience, intuition and the latest information. Do we really know what we do? For example, we give neuroleptics to children without any well-based data about their efficacy.

On the other hand, do we really do what we know? On many occasions, we conduct examinations and treatment under pressure of time or money, or administration or threat of malpractice suits, and do not act in accordance with our knowledge. We act as experts in custody and adoption disputes and make crucial recommendations for children without any well based data about the outcomes of such recommendations. It is sometimes almost impossible to behave according to our academic training and researchers' recommendations. What kind of compromises are we ready to accept without insulting our ethical duties?

Psychoanalysis has a special place in our professions. If well accepted as a theory, it is hardly controversial in its practice. Did it integrate the wonderful findings in biology and genetics related to mental health? Is this not its main challenge today?

Psychoanalytically-oriented psychotherapies are largely used and recommended. Their efficiency is hardly demonstrable for many reasons, mainly because of the "Catch 22" situation of transference and counter-transference as the core and curative factors of this treatment. Is an unprovable science

already a science? How do we conduct research in child and adult psychiatry? What must be ethical recommendations for it? Confidentiality, informed consent of an insane patient, limits of autonomy?

Will genetics and brain research change drastically our psychological approach to mental disorders, the importance given to environmental factors and also to prevention?

As in such discussions, there is no final answer but the discussion itself fulfill its aim. It was a very fruitful one and we recommend our friends anywhere to try to organize such meetings. This meeting has been recorded and will hopefully be published. As such it will serve friends as a basis for further elaboration of this crucial problem.

ADOLESCENT STRESS IN THE UNITED STATES

Joseph Cohen

The stresses of adolescents are obviously related to the societies in which they are living as well as to the special problems that all adolescents have to deal with. The typical adolescent problems are universal and familiar to grownups from their own development—getting along with parents, being accepted by friends, becoming accustomed to sex, dealing with temptations relating to cigarettes and alcohol. But probably most adults do not realize how much tougher adolescence has become for many young people, including adolescents in my own fortunate situation.

For instance, a survey conducted by me and my schoolmates found that half of the 11th graders at the college preparatory school that I attend reported that they feel stressed all the time. Some of this stress is because of the school's demand for good grades and tough work and the school's emphasis for the student to attend a good college. This is an expectable situation, since Hopkins is a very old school (more than 300 years old, which is old for the U.S.) and for centuries has been a "feeder school" for Yale and other Ivy League colleges. In schools like Hopkins, the amount of work assigned may seem impossible to people from other nations who have heard the stereotype about lax American education.

It is not unusual for student to have five hours of homework a night and in our survey we found that many students sleep only four hours per night. One night I had so much work that I talked to a teacher I respected and went over how much homework I had; we figured out that it was impossible to finish all of my homework in one night. Without sleep, with too much stress, I personally saw that depression eventually works its way into the combination and eventually, for many of my peers, this equation will turn into a heavy weekend of drinking or more frequent drug abuse. The pressures of school become much worse when a student is having troubles at home. Usually people think about adolescents causing troubles for their parents. This is no doubt sometimes the case. But in my experience there are students who suffer because their parents are having troubles in their marriages and in their lives, or are already divorced or depressed. The students I know that are most seriously involved in drugs and alcohol are very stressed because of family situations and worries coming from outside of the school environment.

The experiences of students at Hopkins are consistent with those of other American students in some ways. According to a survey by the Center on Addiction and Substance Abuse at Columbia University, 32% of adolescents (aged 12–17) said that drugs were the greatest stress for people their age. At Hopkins, where most students come from professional and academic families, drugs are talked about and even used during school. In fact, as in most schools in the United States, drugs and alcohol have taken their toll: many people cannot remember that they have an exam the next day because of marijuana, at least a few people that I know have become seriously ill because of alcohol, and some of the students can hardly run one or two miles without feeling exhausted because they have been smoking. It is easy to see how anybody would be very worried when they think of a friend nearly dying because he or she drank too much vodka or beer. The Columbia study found that half of all 10th graders were offered to share or buy drugs. With such an easy way out of the day-to-day stresses that a harried child may receive in the US, drugs seem like a viable solution, even to the most brilliant of adolescents. While Hopkins students have opportunities to become involved with drugs, Hopkins (and I think other similar prep schools) differs from other schools, because

we have a beautiful, safe campus. In the Columbia study, the second biggest worry for American adolescents was crime in school, and Hopkins and similar sheltered schools for affluent young people (and for fortunate students who receive scholarships, who tend to be intellectually promising) have really no crime.

America is a remarkably diverse country, and the contrasts are very sharp when it comes to the lives of adolescents in school. Only a five or ten minute drive from Hopkins there are young people whose stresses are very different from what most adults think about as adolescent worries. In New Haven, a health and behavioral survey is conducted to assess the experiences of school children and adolescents. The most recent survey indicates that close to 50% of students reported that they had seen others victimized by community violence, such as stabbings and muggings. These frequent experiences lead to the fact that only 58% of students feel safe in their school. Inner city adolescents are often deeply upset by their lives at home, in the community and in school. Twenty-eight percent of the surveyed students reported that they were depressed about life in general and 14% of 10th graders were suffering from what appeared to be clinically significant depression. Students in these inner city schools often feel that adults are not aware of their achievements. For example, only 26% of 10th graders in the New Haven health and behavior survey felt that their teachers definitely noticed when they were doing a good job and letting the student know about it. This is especially unfortunate for children from deprived families whose self esteem needs to be boosted by a teacher's support. This self esteem is especially needed, I think, by the 26% of the 10th graders who have used marijuana in the past 30 days.

The things that I have commented on throughout this article are not simply the United State's problem. I have been provided with the results of a survey organized by Professor M. Chierro Aguerre of Uruguay that was undertaken for this Newsletter. The survey was conducted in seven sites in Uruguay by a team of nine clinicians. The students, ages 13–17 years, were asked about their basic needs and concerns. The stresses that adolescents of Uruguay reported are nearly identical to the stresses that I have observed and that have been reported for the United States, including violence, illnesses, alcohol, substance abuse, emotional upsets

(love), academic worries, and personal relations (peers, parents). Professor Aguerro summarized his findings: "Some kinds of answers surprised us, and showed us once again that the concerns and needs of adolescents are not always well known by adults."

It is not enough to simply study the epidemiology of adolescent stress. Society must not just write off the problems of adolescents if we want them to be healthy adults in the future. The adolescent adventures of the past, like a beer in the forest, are now heavy drinking and drugs at home and in public; the roughhousing of young boys is now knifings and shootings.

There are simple, cheap things that can be done. In New Haven, we just had the international games of the Special Olympics, the recreational program for individuals with intellectual disabilities. The experience was remarkable. The Olympians were cheered for their achievements; everyone greeted them and their coaches with friendliness and concern; the athletes were given gifts, health care, entertainment and food. The entire city was changed by the experience—there was less crime and more pride, and everyone felt positively related to the Olympics and to each other. Wouldn't it be possible to offer youths similar opportunities, all year round? There should be ways of offering support to a child before he gets involved in drugs, during, and even after he stops abusing illegal drugs. We could do the same thing if we see that a person starts to look or talk depressed. Teachers and others in a neighborhood should be able to notice when a kid needs a pat on the back or should be noticed for doing something useful.

In the United States, we have a successful program for preschool children, Head Start, but there are neighborhoods without a safe place for adolescents to play basketball or socialize. If there were more youth clubs, adolescents could spend their days playing sports or studying interesting subjects. As members of the programs reach high school, they could be given an opportunity to work or be an intern at any place they find interesting. These are the extraordinarily exceptional programs that will hopefully mitigate the stresses that children would feel—his self confidence would be carried through into their teenage years and beyond. Of course, no simple program will reduce the major stresses of really poor children, of adolescents from dysfunctional families, or of those

with true mental illness, such as depression. When I drive through some really deprived neighborhoods in New York and even in my own small town, I think that life for many adolescents must be really unbearable. The young people in these neighborhoods deserve a lot more than society is offering them. But there are things that can be done for adolescents that would make a real difference. Perhaps what would help the most is allowing adolescents to do things for themselves to increase their self esteem.

Stress in adolescence is a part of growing up and of life. Being overwhelmed by it and in agony are not.

REPORT ON THE UNITED NATIONS YOUTH FORUM PLANNING MEETING

JULY 17-19, 1995

*Joel Klein and Erica Goldman
Yale Child Study Center
Yale University Medical School*

Two years ago, the United Nations convened its first "Youth Forum," a meeting devoted to issues and problems facing young people across the globe. Hundreds of delegates from non-governmental organizations (NGOs) and U.N. agencies devoted to youth attended the meeting, but with poor organization and procedural disagreements, the Forum was not very successful. The U.N. plans to convene a second Forum next summer, and to prepare for it, a smaller planning meeting attended by about fifty youth organization delegates was held in New York last week. Unfortunately, setting a clear agenda and ironing out logistical difficulties kept even this planning meeting from being as productive as it might have been.

The stated purpose of the Youth Forum, according to one U.N. document, is to "discuss the problems of communication between the United Nations system and youth organizations with a view to improving those channels and establishing effective structures of communication and cooperation." While this written objective remains

vague, the idea of increasing international cooperation among youth organizations has considerable merit. For example, youth organizations need access to financial resources for their activities, such as the United Nations Youth Fund (disbursing over \$400,000 over ten years). Coordinating publicity efforts and political pressure would increase the effectiveness of human rights organizations concerned with youth education, employment and health. Student internship and educational opportunities worldwide could benefit from a central bank of openings and positions to which youth could apply. Finally, written exchanges between worldwide professionals and their organizations bring new ideas and new partnerships, a benefit well-understood by IACAPAP.

Given this wealth of possibilities for youth offered by global communication, it was vital for the U.N. meeting to be well-organized and structured to take full advantage of the delegates' experience. However, last week's planning meeting suggested that the U.N. was less than prepared for this need. Too much time was spent explaining the hundreds of pages of background material given to each delegate and deciding who would chair the three-day meeting. The written agenda was not clear as to specific topics for discussion: delegates were asked only to "exchange views on the objectives and work programme of the Youth Forum." And the unwieldiness of having nearly 75 people all struggling to be recognized made communication difficult at best.

Optimally, the Youth Forum would work in smaller groups, each with a specific problem area (such as youth mental health) attuned to the expertise of the delegates, and with parliamentary and procedural questions resolved well in advance. These smaller groups would then report back to a larger group with recommendations or even specific policy suggestions. Unfortunately, the U.N. does not seem intent on such an approach. At the last Youth Forum, most of the time was absorbed by a large disagreement over gender equality among the attending delegates. The Forum's U.N. organizer, Amr Galeb, expressed concern over this distraction from the concerns that face the world's children and adolescents, but seemed hesitant to assert control over the discussion.

In spite of the absence of orderly discussion, the delegates at the planning meeting and at the Youth Forum itself still had the opportunity to form contacts and share their organization's activities with each other.

ANNOUNCEMENTS

42ND ANNUAL MEETING OF THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY

New Orleans Marriott and
The Monteleone
New Orleans, Louisiana

October 17—22, 1995

For more information, contact

AACAP
3615 Wisconsin Avenue, NW
Washington, DC 20016
(202) 966-7300

THIRD BIENNIAL CONFERENCE

INDIAN ASSOCIATION OF
CHILD AND ADOLESCENT
MENTAL HEALTH

"Coping with Stress in a
Changing World"

Hyderabad, India
November 10—12, 1995

For information, contact

The Organizing Secretary
3rd Biennial Conference
4-8-812, Gowliguda,
Hyderabad-500012, India
Phone 501555, 519999
Fax 040-551936

PLAN TO ATTEND

FOURTEENTH INTERNATIONAL CONGRESS OF IACAPAP

August 2—7, 1998

Stockholm International Fairs
and Congress Center
Sweden

For information, contact
Dr. Kari Schleimer
and

Professor Per-Anders Rydelius

NOTE; THERE WERE NO
ADDRESSES OR FAX/TEL
NUMBERS GIVEN.

United Nations ... (from page 19)

Brian Hill, of the Youth for Youth Health Conference in Vancouver, Canada, distributed a magazine detailing his group's writings and other work with teen pregnancy, eating disorders, and infibulation. A gentleman from a Japanese youth job-training and tree-planting program made available his group's fact sheet and bumper stickers. One college student, representing the World Esperanto League, said that his only real purpose in attending was to meet other student organization officers and to get a sense of how their worldwide operations are run. If the planning meeting produced nothing useful for the upcoming Forum, he said, his attendance would have still been worthwhile.

The benefits of increased international cooperation between youth organizations is well understood, but it remains unclear if the U.N. will mobilize its ample resources to effect that cooperation. If well-planned, the Youth Forum could prove quite valuable to worldwide youth organizations. Whether the approaching Forum will be as beset with difficulties as previous meetings will depend on the U.N. organizers' preparation in the coming months.

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