IACAPAP Bulletin - April 1998

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UEMS/CAPP-SECTION

The East European Committee in Sweden
Kari Schleimer, M.D., Ph.D.

XXII International Congress of Pediatrics
Amsterdam, August 9-14, 1998
First International Congress on Pediatric Nursing

President's Message

The standard psychiatric nosological Systems

ICD 10 and DSM IV describe dozens of different childhood psychiatric disorders. Some of these are close to the normal fears, behavioral difficulties, and symptoms of childhood, others are among the most catastrophic pediatric illnesses. The most serious conditions afflict from 58% of all schoolage children; all together, 15-20% of all children have some type of diagnosable mental, behavioral or developmental disorder. These are enormous numbers, and they are highest among the children and families who have the fewest resources and suffer the greatest economic, social and political adversity. Children whose lives are burdened from before birth by the correlates of poverty poor housing, nutrition, medical care, and education, often compounded by drugs, alcohol, and family dysfunction have the highest rates of psychiatric and developmental problems. Also, there are multiple millions of children in the world who are deprived of their basic rights. These children are targeted during warfare, become unaccompanied children, are separated from parents, and experience one or another type of exploitation (child labor, sexual exploitation, forced conscription into militias). Among these children are those who live on the street or are abused and neglected by family and society. In discussing the advances and benefits of rigorous scientific research for our understanding of specific disorders, we must always place this type of concern in the context that we know a great deal about the needs of children and families who require our advocacy today. IACAPAP has always been a major, international, multi-disciplinary voice for children and families and those who serve them professionally. Over the decades, IACAPAP also has been committed to the idea that such concern is compatible with the advancement of the scientific basis of child and adolescent psychiatry.

Current theories of pathogenesis emphasize the close relations between genetic/constitutional contributions and environmental experiences in the emergence of persistent, serious psychiatric disorders. Increasingly refined, scientific methodologies are adding new substance to this mantra.

For the children living in greatest risk, the source of their distress and dysfunction is often quite apparent in their prolonged and acute traumas. Yet, even in these terrible situations, there is value in trying to understand the range of outcomes. For example, recent studies on the impact of the trauma of war have underlined the role of parental anxiety and coping and other factors, in relation to a particular child's outcome. As the neurobiological and psychological consequences of stress are better understood, we will be better able to understand how the brain codes such traumas and their enduring impact. Such research may open new approaches to acute care and treatment.

Today, a great deal of scientific interest is focused on the role of genetic factors in brain formation and function. Almost weekly, molecular biologists are discovering new ways that genes shape the normal central nervous system. Also, specific genes are being localized and cloned for medical conditions. Molecular biological research is also providing a new scientific framework for child and adolescent psychiatry. Throughout the world, collaborative research groups are searching for and clarifying the role of genetic factors in neurological and developmental conditions. Recently, genes have been implicated in childhood language disorders and suggestions have emerged about genetic factors in autism. International collaborative projects are bringing together clinicians and researchers to study the genetics of autism, tic syndromes, obsessive compulsive disorder, depression, and other developmental, psychiatric conditions. As genes are discovered, it will become possible to define the ways in which these biological factors affect maturation and function, and also to move towards early diagnosis, prevention, and rational therapies.

Findings in the field of genetics also help to clarify the roles of the environment, including the transmission of risk, vulnerabilities, and protective factors within families and communities. As our field progresses, we will hopefully be able to call upon increasingly broad, rigorous, developmental theories in which the multiple factors that affect development can be accounted for and assessed. Good theories are based on all types of data, from the laboratory and clinic; they reveal what phenomena need further study, and they are open to change with new observations. International collaboration can help provide perspective and balance.

Since the first scientific reports on autism by Professor Leo Kanner fifty years ago, children with autistic disorders have been recognized throughout the world. They have been cared for and studied by child and adolescent psychiatrists, psychologists, social workers, psychoanalysts, pediatricians and other professionals. To a remarkable degree, the children who have been reported in the world literature over these decades have resembled those first described by Dr. Kanner. The stability of the phenotype across time and place is itself a surprise, and a credit to Kanner’s clinical brilliance.

In addition to its importance as the most severe child psychiatric disorder, autism has served as the major testing ground for each new theory and concept about social, emotional, behavioral and developmental deviations. In some ways, it has sometimes led to controversy and barriers to full discussion.

During the last several years, a new epoch has started in the field of autism. For the first time, clinicians and investigators everywhere are able to use the same diagnostic criteria, embodied in DSM IV and ICD 10, and to engage in descriptive discussion that captures, with a high degree of reliability, the clinical characteristics of autistic and related disorders. The broad sharing of knowledge among parents and parent organizations helped by the availability of electronic mail has also increased the consensus among families and clinicians. Clinical work has been helped by studies on early diagnosis and intervention as well as new, useful medications for specific areas of disability. And scientific understanding has been enriched by research on social development, cognition and communication, structural and functional neuroimaging, and genetic and family studies. Further research will, no doubt, dramatically change the current nosology and the diagnostic boundaries between autism and other pervasive developmental disorders. We can look forward to deeper understanding of the pathways leading from biological vulnerability, to brain function and disturbances in maturation, to the range of clinical expressions over the course of

development. Hopefully, this will bring new and more effective treatments that will fundamentally change the usually quite unfortunate outcome, especially for those children with the most severe intellectual and communicative disabilities.

In nations throughout the world, child psychiatrists and other mental health professionals have been leaders in the study and treatment of children and adolescents with autism. They have brought their own theoretical perspectives and national traditions in education, treatment, and research, as well as international influences, into this work. As noted by Dr. Lebovici in the 1970 inaugural volume of the IACAPAP yearbook, The Child in His Family, IACAPAP has an important role in facilitating communication across nations, languages and disciplines. The new edition of the Handbook of Autism and Pervasive Develop-mental Disorders, edited by Fred Volkmar and myself, exemplifies this goal. A large section on international perspectives, written by leading scholars, many of whom have been involved actively with IACAPAP, describes the history and status of research and treatment in more than twenty nations.

In March 1998, IACAPAP is convening an international meeting on autism, to be held in Venice, Italy, under the chairmanship of Drs. Fred Volkmar (USA) and Helmut Remschmidt (Germany). The meeting is co-sponsored by IACAPAP, Telefon Azzuro (the model program of education and advocacy in Italy), and the European Society of Child and Adolescent Psychiatry (ESCAP). Clinicians and researchers from throughout the world will discuss the current state of research and treatment and the most critical areas of future research. Their discussions will become the basis for a Declaration, to be presented to a large national meeting in Italy and at the Stockholm Congress, as well as a Monograph in the IACAPAP Series. Hopefully, the meeting will also encourage further work on the non-autistic pervasive developmental disorders, such as multiplex developmental disorder, and future international collaborations on treatment, neurobiology, epidemiology, outcome, and other domains.

When IACAPAP's roots were planted six decades ago, the field of child and adolescent psychiatry was small. Most nations had no specific training programs or specialists in our field. There was a narrow range of theories on development and pathogenesis; little was known about brain maturation; and treatment modalities were limited and often unproven.

There is still an enormous, unmet need for child psychiatrists, psychologists, social workers, nurses, and special educators in many nations. Yet, the situation is vastly different in relation to knowledge and to the status of child and adolescent psychiatry. Today, there is rapid communication among parents, clinicians and researchers throughout the world, and the fields of developmental psychopathology and neuroscience are advancing more rapidly than we can metabolize their findings. This knowledge will benefit our patients, if it is used wisely and made available broadly. The 14th International Congress of IACAPAP in Stockholm, Sweden, in August, 1998, will provide the fields of child and adolescent psychiatry and allied professions an opportunity to review the developments within our field and to look towards future needs and opportunities.

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Editor's Comments

We wish you a very Happy New Year that brings peace to all and progress to furthering the welfare of children in all countries. This year marks the event of the XIV International Congress of IACAPAP to be held in Stockholm, Sweden from August 26, 1998. The excellent program is being planned by Per-Anders Rydelius, M.D., Ph.D. and Kari Schleimer, M.D., Ph.D. and is entitled, Trauma and Recovery Care of Children. We strongly suggest that you attend and submit proposals to present your clinical, research, and administrative programs. We hope during this drastically changing climate relevant to the health care of children and adolescents and their families that innovative ideas will emerge to guide us as we approach the turn of the century and the advent of a new millennium. The Web Site address is: http://www.stocon.se/IACAPAP

This issue presents a brief review of some of the special events planned.

Notably, we have published a column of the logos, dates and sites of previous IACAPAP International Congresses which highlights the rich legacy of collaboration, knowledge sharing, and interactions among professionals from diverse mental health disciplines who participate in IACAPAP activities. We have received numerous inquiries about how to join IACAPAP. Although there are no individual memberships, clinicians can actively participate by developing programs or enrolling in committees linked with each country's psychiatric, psychological, or other mental health national organizations. Such organizations can become members of IACAPAP. We welcome and need your active participation and interest. Plan to attend the International Congress in Stockholm this year and enhance your bonds with IACAPAP members in other countries.

This issue is devoted to becoming the voice of the people. We have invited students at various levels of training to share their experiences, impressions and insights on issues often not explicitly considered, such as a child providing perspectives on family life and students discussing issues important for children's survival and identity. Experiences and unique opportunities to participate in new training settings are highlighted. It is our hope that these articles will stimulate others to interact on an international level, to seek new ways of acquiring knowledge, and to enrich one's own environment of delivering psychiatric and health care to children and adolescents.

We want to applaud the leadership of our President, Donald Cohen, M.D., whose creative, energetic endeavors have enriched opportunities of others, stimulated vigorous collaborations among professionals world-wide and strengthened the International Association of Child and Adolescent Psychiatry and Allied Professions.

We are looking for logos from past Congresses. Please send clear black and white copies to the Editor(s).

Finally, since the publication of our last IACAPAP Bulletin, we have been able to include it on the Yale Child Study Center Homepage. The last issue and all subsequent issues can be reviewed on the Internet by accessing: http://info.med.yale.edu/chldstdy/sites.htm

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14th International IACAPAP Congress

P-A Rydelius and Kari Schleimer

Dear Colleagues:
It is a great pleasure to invite you to the 14th International Congress of the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP) which will be held August 26 in Stockholm. The congress will address the full range of contemporary research and clinical issues related to the mental health of children and adolescents under a broad organizing theme of Trauma and Recovery Care of Children. The congress organizers view trauma in its broadest sense, including biological, medical, social and emotional aspects, ranging from the prenatal period to the adolescent transition into adulthood.

Four central themes have been selected:

Brain and Mind developmental perspectives (developmental biology of the brain and its implications for emotional health)

Family, School, Social network and Support in life of children (the role of family, school and other social networks, and social support in the emotional life of children)

The child in his social context (i.e., being raised within developing countries or metropolitan areas, during [civil war and other] wars or exposure to large scale and individual natural or man-made catastrophes)

Intervention Caring for Children (effective interventions for caring for children and adolescents including the emotional aspects of acute and chronic physical illness).

Every day will open with a IACAPAP lecture from a distinguished international expert on one of these four main themes, followed by invited main sessions that will provide an update on knowledge and opinions within our disciplines. The afternoon will be devoted to symposia, workshops and submitted papers and posters that will address the full range of contemporary research and clinical issues related to the epidemiology, etiology, prevention, care and treatment of mental and emotional disorders and deficiencies of children, adolescents and their families.

The International Association for Child and Adolescent Psychiatry and Allied Professions was formed to promote the study, treatment, care and prevention of mental and emotional disorders and deficiencies of children, adolescents and their families through collaboration in research and sharing of clinical knowledge among child psychiatry, psychiatry and the allied professions of psychology, social work, pediatrics, public health, nursing, education, social sciences and other relevant professions. This will guarantee that the congress will be of broad interest to a wide range of professionals.

We hope that you will plan to join us in Stockholm and invite you to submit an abstract of your work for presentation at the Congress.

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Pre- and Post-Congress Study Visits

August 2, 12:00 noon - 3:00 p.m. and

August 7, 10:00 a.m. - 12:00 noon

Study visits will be arranged both on Sunday, August 2nd and Friday, August 7th. At the study visits you will meet out- and in-patient services for child and adolescent psychiatry, in a spectrum ranging from child guidance clinics, consultation and liaison work to day care, 24-hour-units and treatment homes. You will have opportunities to discuss treatment, care and training from different views. Psychodynamic approaches, family treatment, pharmacological aspects, training programs, social support are included as well as the long-time care of pervasive developmental disorders, psychoses, conduct disorders, and alcohol and drug abuse.

In the Stockholm area, child and adolescent psychiatric service to the population is divided into separate in- and out-patient organizations. For in-patient care there are two fully equipped hospital clinics organized in a Northern and a Southern Sector. Parts of the Northern Sector, the University Clinic of the Karolinska Institutet, will in March 1998 be integrated into a new children's hospital, The Astrid Lindgren's Children's Hospital. The outpatient organization covers the whole geographic area and consists of about 40 local Child Guidance Clinics, different units for infant psychiatry, etc. The Maria Clinic is a special clinic for alcohol and drug abuse in childhood and adolescence.

The pre-congress study visits on Sunday cover the hospital units. They will start and end at the main entrance of the congress venue (StockholmsMŠssan, Alvsjo). Transportation is by buses.

At the post-congress study visits on Friday, the Child Guidance Organization will be your host. You are given opportunities to visit a local child guidance clinic, a specialized clinic for treatment of sexually abused children and adolescents, a refugee center, a team of consultant psychologists working at maternal and infant health centers, or a mother baby daycare unit. It is also possible to visit the training institute or the administrative center. Information on transport facilities is given at registration.

Registrations for the study visits are to be made on the enclosed registration form. Please note that the different departments only allow a limited number of visitors. Registrations will be treated on a first come, first served basis. Price: SEK 50.

Please mark on the registration form which of the following visits you wish to participate in order of preference (1, 2, etc.). You are welcome to both pre- and post-congress study visits.

Sunday, August 2

Hospital and Treatment Homes

Child psychiatric consultation and liaison work; Treatment of psychotic adolescents; Units for young children; Family care units; Astrid Lindgren's Children's Hospital; Drugs and alcohol among children and youth; Probationary homes.

Friday, August 7

Child Guidance Organization

Child guidance/outpatient treatment; Treatment for sexual abuse; Refugee center; Maternal and infant health care center; Mother baby daycare unit; Training Institute; Administrative Center.

Stockholm Beauty on Water

Stockholm, the capital of Sweden, is gracefully set on fourteen separate islands, each with a distinct character and charm of its own. To the east lies the Baltic, and clear brackish water

runs throughout the city and downtown areas. To the west lies Lake MŠlaren with its pleasant, sunny beaches.

The first traces of human settlement in the area surrounding the city are very old. The location of Gamla Stan, the Old Town, at the outlet of Lake MŠlaren reflects 13th century military strategy. Gamla Stan was officially founded at this time by Birger Jarl, regent of Sweden. Storkyrkan, the cathedral built in Birger's time, and the early 18th century Royal Palace are located within walking distance of each other in this, the oldest part of the city. Antique shops, fashion and handicraft boutiques, candy stores and art galleries line the narrow winding cobblestone walkways and lanes. The modern city with its big department stores are only a five-minute walk away, and the quay facing the Royal Palace, where quaint white steamboats depart for tours of one of the loveliest archipelagos on earth, is just as close. There may not be time enough to visit all the islands in this yachtsmen's paradise, but one isolated, rocky islet or quiet, picturesque bay can sooth the mind and refresh the body.

About the 14th International Congress of IACAPAP in Stockholm, August 1998

Kari Schleimer, M.D., Ph.D.

Arrangements Programme Local Organizing Committee

The main theme of the congress is Trauma and Recovery Care of Children by 21st Century Clinicians. We are close to the next century and it is important to summarize for our younger colleagues in mental health care what we have learned in this century to help them go on, give them directives in their work into the next century. This congress is aiming at recovery after trauma, including all measures that can be taken to achieve this for the benefit of children worldwide.

The local organizing committee has been constituted with respect to gathering all different vocational groups who are working with children and their families, representing child and adolescent psychiatry, child psychology and social work, pediatrics, general psychiatry, care-taking and nursing and special education.

The structure of the four main congress days is that each day has its central theme and will start with a IACAPAP lecture, referring to this central theme, for all delegates in the main hall. The invited lecturer for each day is a well known researcher and expert.

1st day: Brain and mind development perspectives. Invited speaker: Torsten Wiesel, M.D., F.R.S., president of the Rockefeller University in New York, USA. He is a neurobiologist whose pioneering studies have significantly shaped understanding of brain structure, function and development. He received the 1981 Nobel Prize in Medicine together with Dr. David H. Hubel and Dr. Roger Sperry.

2nd day: Family, school, social network and support in life of children. Invited speaker: Urie Bronfenbrenner, Ph.D., professor emeritus of Human Development and Family Studies and of Psychology at Cornell University, New York, USA. His famous theory on the ecology of human development provides a basis for understanding child development from social and cultural perspectives.

3rd day: The child in its social context. Invited speaker: James Garbarino, Ph.D., professor of Human Development & Family Studies, and Director of Family Life Development Centre at Cornell University, New York, USA. He has studied child abuse and is an advisor and scientific expert in criminal and civil cases involving issues of violence and children.

4th day: Intervention Caring for Children. Invited speaker: Sir Michael Rutter, M.D., F.R.S., Honorary Director of MRC Child Psychiatry Unit, London, Great Britain, and Professor of Child Psychiatry. His famous research activities include resilience in relation to stress, developmental links between childhood and adult life, schools as social institutions, reading difficulties, psychiatric genetics, neuropsychiatry, infantile autism and psychiatric epidemiology.

However, one and the same day will not deal with only the central theme of the day but also include appropriate sessions, lectures, and papers from the other central themes to make a suitable mix and keep up the interest for every day during the whole congress. After the main and central IACAPAP lecture, there will be four other main symposia in the morning. After lunch there will be several concurrent symposia, workshops, roundtable discussions and free presentations. Many well known international researchers have accepted to participate in the program that covers a wide range of child and adolescent psychiatry and psychology under the main theme, Trauma and Recovery.

Besides IACAPAP lectures, the tradition of an international IACAPAP congress is also to present lectures in the names of two well known former, active members of our association.

The invited Caplan Lecturer is Professor Michele Maury, M.D., professor of Child and Adolescent Psychiatry at Centre Hospitalier Universitaire Montpellier, France. She has great clinical and research experience about infants at risk, premature neonates, infants with diseases, eating disorders, sleeping disorders, etc., and their families. Her team has developed different intervention programs together with the medical and surgical pediatric wards.

The invited Bowlby Lecturer is Professor David Magnusson, Ph.D., Professor Emeritus of Psychology at Stockholm University, Sweden. He has developed basic models for individual behavior, models for and empirical analyses of perceived situations and a holistic-interactionistic perspective on individual development. His IDA project is said to be the single most important longitudinal study of this century.

The evening programs will start with a Get-Together party on Sunday at the congress hall, open to all delegates with accompanying persons. On Monday evening a reception with a buffet dinner will be hosted by the City of Stockholm and the Stockholm County Council at the Stockholm City Hall. On Tuesday, the Warship Vasa may be visited. On Wednesday, we want to have a proper Congress Dinner with good food, music and dance Ñ in the traditional Swedish way. The last evening, after the final ceremony at the congress, will be open without any prepared program.

Congress delegates will have the opportunity to take part in study visits at hospitals and treatment homes on Sunday before the opening ceremony or in the Child Guidance

Organization on Friday, the day after the congress. A pre-congress tour to Helsinki in Finland will be arranged July 31 - August 2, and post-congress tours to Lapland or the

islands of Gotland & Bornholm are also available. They all must be booked by advance registration. Also, social programs for participants and accompanying persons will be arranged in Stockholm, like a City tour, Drottningholm Palace (home of the royal family), Art tour and Old Town walk.

So, all together, we would like to present to you a full program both for the mind and for the heart in a town that is called The Venice of the North, or Beauty on Water Stockholm that in August shows its best side with a nice and warm (not hot) temperature, a long light day where, however, the evenings could be chilly.

Welcome to the 14th International Congress of IACAPAP in Stockholm, Sweden!

On behalf of the Local Organizing Committee,

Kari Schleimer, M.D., Ph.D.
Arrangements Chairperson
Vice President of IACAPAP

Stockholm Cultural Capital of Europe 1998

The European Union had many reasons to select Stockholm as Cultural Capital of Europe for 1998!

Stockholm boasts more than 100 theatres, music halls and operas, including Europe's only theatre still using original sets and props from the 18th Century, the Drottningholm Theatre, which was designated by the UNESCO as a World Cultural Heritage. The 91 museums in Stockholm include the startling Vasa Museum housing the world's best preserved 17th century warship. Nearby is Skansen, the world's oldest and biggest open-air museum. A reminder of Sweden's glorious past is the newly-built Gold Room, 23 feet beneath the Museum of National Antiquities. The oldest district of Stockholm, Gamla Stan, is a living museum, with cobbled lanes and dim alleys. Here you find the Parliament, the Stockholm Cathedral and the Royal Palace. Add to this 70 cinemas, cultural boat excursions, festivals and events year round in a city surrounded by clean waters and an archipelago of 24,000 islands.

Welcome to Stockholm Beauty on Water!

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Student's Perspective: Minority Students in the United States

Editor's Comment: Students from diverse cultural backgrounds have special needs in securing their education. This article describes relevant issues.

Sylvia Gonzalez, New York University Neural Science, 1998

The United States consists of a variety of people from all over the world. We are considered to be a melting pot of sorts. There are some areas that are very homogenous and those that are so heterogenous that no one group can be found to predominate. Even though the populations is so varied, there are some groups that are considered to be minorities. The predominate minority groups in American society are the Hispanics, African Americans, and Pacific Islanders. There are other groups that can fit into the category of minorities, but these are the groups that I've most commonly encountered. These groups are classified as minority because they are of lower status in terms of education and wealth in the American society. There are a few exceptions, but that's just it, they are few.

The group with whom I will be placing my emphasis is the Hispanic population. My discussion will primarily be based on personal experiences and other real life situations. As stated, Hispanics are considered to be a minority group because they are perceived as inept in the area of education and deficient in terms of monetary value. The history of the United States is full of stories of racism which has had a profound effect on the development and growth of various ethnic groups. The Hispanic population has been affected in various ways. We have suffered in the classroom and the workplace for many years, but things are beginning to change. There are more and more Hispanic people achieving great feats and becoming successful businesspeople, doctors, lawyers, etc. My emphasis is to attempt to explain how to succeed. What are the risks that we as minorities face in today's society, and how can we overcome them?

There can be no mistake that there is a stigma attached to the title, Minority. Most people will not admit it, but nobody likes to be associated with a person who is though of as stupid or poor. When a child is placed in an environment where this attitude is apparent, it can have deleterious effects upon his development. If a child is told that he cannot succeed in school, the chances of his success are slim. How then does a child succeed? This is a very difficult question to answer because there are so many factors that come into play which vary from person to person.

The obvious answer is to say that the child's family needs to encourage him to strive for the top. They need to emphasize that the fact that he is a minority doesn't mean his is any less able to succeed. Constant reinforcement of this nature has proven to be helpful. What does one do, however, when the family is the producer of negative reinforcements and/or they provide a negative atmosphere for the child in that they believe or fall into the stereotype of the poor Hispanic family? In this instance, there needs to be either an external support service for the child, or one has to hope that the child is strong-willed and realizes his situation and that he looks for a way to overcome these obstacles. In other words, the child must be self-motivated toward success.

External reinforcements are not always available in the Hispanic community. This is due mainly to the family situation. For the most part, Hispanic communities are relatively poor, and there are conflicts among the groups of varying Hispanic heritage. Also, there is a problem in the placement of priorities for this group. Instead of focusing on academic success or success in the workplace, they strive to be the best on the street. This fuels society's perception that Hispanics can't make it in the classroom (mainly because they don't try). There needs to be a universal movement stressing the importance of education.

It is in these cases that support services are so important. Children are at risk to succumb to the way of the street if they don't have some type of reinforcement or push toward the

opposite. To prevent the eventual downfall of the child, there must be a system where children are told at an early age that they can succeed and push toward success. One important movement would be to find a way to de-glorify the way of the streets. In the early to mid-1900s, people survived via the way of the streets in New York. I have heard countless stories of the hardship of growing up in the thirties, forties and fifties, and stories about claiming one's territory. It is one thing when these stories are told as just stories, but when glorified to the younger generation, some tend to think that this is the way to live. With a change in times comes a change in behavior, which some people have yet to realize. This is why it is important to make the distinction between the past and the present, and to stress the way of success in today's society, via academic means.

There have been movements toward strengthening children in the classroom. One approach has been the institution of special programs that target the special talents of children. The area of greatest concentration tends to be in the sciences, where children who exhibit extraordinary skills are singled out and given special opportunities to succeed. They might be placed into a research atmosphere or a school that specializes in the sciences. This is just one example, but other opportunities exist such as in the arts and sports. There is one problem, however. These programs target older children, children in high school and sometimes junior high school. What do we do with the younger children?

I believe that if there were special programs instituted at an earlier age, there would be more children exhibiting extraordinary skills and there would be more children succeeding overall. When I speak of special programs, I don't necessarily mean that we should be teaching eight-year-old children trigonometry, but that they need proper attention and a push toward doing well in school and life in general.

The other factor mentioned that aids in some person's eventual success was self-motivation. This is not something that can be readily controlled in society. However, I would say that this has probably been the biggest factor to account for minority success. Most of the stories that I have heard deal with a person's self motivation, and the role of external support systems in secondary.

I touched on the idea that many Hispanic communities are relatively poor and the people tend to live via the way of the streets. This encompasses drinking, drug usage, gang involvement, and other forms of deviant behavior. When a young child grows up in this type of environment, the likelihood of him falling into the same routine is rather profound. However, there are those children who are disgusted by this behavior and try to do better for themselves. This has been the case for an individual I know who grew up around an alcoholic father; an abusive alcoholic who was never there for the family. My friend spoke of having to sleep at a relatives house because his father didn't come home, or he came home drunk. Then he would have to take the public bus to school from one of the worst areas of the Bronx. My friend didn't like what drinking did to his father. He lacked a role model and family stability wasn't present. He made a vow to never enter that stage of life by abstaining from alcohol consumption. Although he lacked a male role model while growing up, he serves as a role model for his little brother. He has also struggled to make a better life for himself by going to college, something which people in his neighborhood shy away from because of the financial strain and because of the corruption found on every corner. This young man is doing so well for himself that he is almost guaranteed a spot in a medical school when he applies, after taking part in a research program that is offered to minority

students. This is just one example of how self-motivation and determination can lead to success.

There are other stories about success in the Hispanic community that I can talk about which incorporate the ideas of both external and internal influences, such as my own. My life hasn't been as hard as the young man mentioned earlier, mainly because I grew up in a very different environment. I was born in New York City, but my parents refused to raise their children there, so we moved to a suburb. Therefore, I never encountered the threats of street life such as gangs or drugs. However, my struggle was different. My parents are from the Caribbean and were brought up differently than people in the US. When it came to school, I was usually on my own. My mother couldn't help me with things like American history or advanced mathematics because she never had them in her schooling. Therefore, I had to do everything for myself, and I always strove to be the best. This became more prevalent as I entered high school because then I noticed the division found between the Caucasian and minority students. I as the only minority student in my school who attained Honors status throughout my education. In sociology classes, minorities were discussed in a rather derogatory manner, so I felt an added need to succeed and to prove that minorities were better than they were given credit for. In college I continued to strive to be my best, and I took advantage of the programs offered to students of color. I used these programs to strengthen my skills and to ensure that I would be prepared for my future endeavors in medicine. Although I wasn't faced with blatant racism or the harsh realities of the street, I was still centrally motivated to succeed, and I took advantage of the programs and other external reinforcements offered to aid in my rise to succeed. If these programs were not available, there is no telling if I would be as successful at this stage in my life.

I have given two brief examples of how success can be attained for members of the Hispanic community. It is important to note that not only did we go out on our own to make the best of ourselves, but we also had a lot of support from our families and from our peers once we entered college. Support networks are very important in every walk of life, and it is especially important for minorities. If one has the ability to place himself in a supportive environment, then he should definitely make a move to be a part of that environment. However, society as a whole must become more nurturing and supportive of the development of its youth. Most importantly, however, the Hispanic community must set its differences aside and come together as one for the benefit of its youth and society as a whole. In essence, the overall idea is that the only way to attain true personal success is to take advantage of the opportunities offered and to keep a positive attitude throughout the process. Finally, in order for society to attain true success, emphasis must be placed on the importance of education and ensuring that all children have the support andopportunities necessary to achieve this end.

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Coping and Personal Development: A Young Musician's Experience

Carolyn Kiel, Senior Undergraduate Vassar College, Poughkeepsie, NY

Adolescence and young adulthood involve transitions from familiar surroundings to new environment and circumstances. Although these changes are opportunities for personal growth, they can be stressful as well. People handle stressful events and problems such as these by using coping strategies (Folkman, Lazarus, Gruen & DeLongis, 1986). The success of any coping strategy depends upon the circumstances under which it is used (Wood, Saltzberg, Neale, Stone & Rachmiel, 1990) and panic (Vitaliano, Katon, Russo, Maiuro, Anderson & Jones, 1987), suggesting that mental illness and ineffective coping methods can go hand in hand. Conversely, successful coping strategies often allow people to solve problems and maintain their mental health. Problem-focused coping, which involves doing something to make the stressful event manageable, can be very useful. Distress (Wood et al, 1990) and panic disorder (Vitaliano et al, 1987) are negatively related to problem-focused coping, and problem-solving deficits in families are indicators of substance abuse in adolescent family members (Hops, Tildesley, Lichtenstein, Ary & Sherman, 1990). Therefore, the ability to change one's problems for the better may have an important function in healthy development and mental well-being.

These principles are illustrated in my own experience as an alto saxophone player, when I was able to use problem-focused coping to aid an important transition in my musical development. People often think of saxophone players are jazz musicians who can create original, spontaneous melodies from chords written on music. This kind of playing, called improvisation or improv, has helped make the saxophone such a well-known and appreciated instrument. Until recently, however, I did not identify with the image of the improvising sax player. Although I had learned to play many styles of music, both as a band

member and as a solo performer, I had resisted learning how to improvise. For eleven years, I had been accustomed to playing melodies that were written on the sheet music in front of me, and I believed that improvising was as frightening as walking on a tightrope without a safety net. As a result, I avoided this type of playing; I felt that it was too intimidating to create solos from empty measures of music and unfamiliar chords.

When I came to college and became the lead sax player in the Vassar Jazz Ensemble, however, I could no longer avoid improvisation. The lead alto sax part featured many improvisational solos that I was supposed to play. At first I refused to improvise, saying merely that ÒI don't do that. After much encouragement, I would read through the improv portion of my music and play notes that I recognized in the chords written on the music. Unfortunately, I didn't have much success with this; I would lose my place almost immediately and end up playing any notes that came to my mind. I had always wanted my playing to sound its best, but without any background in improvisation, I was fumbling terribly and embarrassingly through large sections of the music.

In order to play something that didn't sound dreadful during improv sections of the music, my sax teacher helped me write melody lines that I could play during the improv parts. I still couldn't improvise, but I learned how to write melodies from chords. After playing the same written melodies over and over again, I became tired of them. I wanted my playing to sound more spontaneous and interesting, and I was finally willing to learn how to improvise in order to achieve that goal.

I had to acquire some basic skills: studying the structures of different chords and learning which notes sounded good with them. I had to get used to the fact that the notes that sound good change as the chords in the music change. As a result, I had to think ahead constantly and recognize chord structures immediately. I realized that I must be aware of which notes the chords have in common. Additionally, I learned new scales to use when improvising. Finally, I bought play-along CDs to practice improvising with a pre-recorded band. The combination of music theory, practice, and musical listening skills helped me to tie notes together into coherent melody lines.

As I began to improvise successfully during rehearsal, I began to gain more confidence in my newfound ability. I no longer dread being asked to improvise; in fact, I have played improv solos in many jazz ensemble performances. I still have a long way to go before I master this style of playing, but after so many years of resistance, I am still amazed that I am improvising.

My experience with improvisation also had an effect that I did not anticipate: I have been able to use my new ability to create music from chords when I arrange songs for the acappela group in which I sing. Happily, I've found that improvisation and arranging provide their own rewards because when I feel I have done well, I am proud of the music I have created.

Although I still have a lot to learn about improvisation, I believe that I have reached a new level in my saxophone playing and general musicianship. I feel much more integrated as a saxophonist because I can now identify my sax playing with the saxophone's popular image as an improvisational jazz instrument. I have a new image of myself as an improvisational player and musical arranger as well. These are skills that I never imagined I would acquire.

I was able to cope with the problem of improvisation successfully by focusing on what I needed to do in order to master it. As a result, something that I once dreaded has become integrated into my personal identity. Successful coping strategies such as problem-focused coping allow young adults to manage stress, preserve their mental health, and take full advantage of opportunities for personal growth.

References

Folkman, S., Lazarus, R.S., Gruen, R.J., and DeLongis, A. (1986). Appraisal, coping, health status, and psychological symptoms. Journal of Personality and Social Psychology, 50, 571-579.

Hops, H., Tildesley, E., Lichtenstein, E., Ary, D. and Sherman, L. (1990). Parent-adolescent problem-solving interactions and drug abuse. American Journal of Drug and Alcohol Abuse, 16, 239-258.

Vitaliano, P.P., Katon, W., Russo, J., Maiuro, R., Anderson, K and Jones, M. (1987). Coping as an index of illness behavior in panic disorder. Journal of Nervous and Mental Disease, 175, 78-84.

Wood, J.V., Saltzberg, J.A., Neale, J.M., Stone, A.A., and Rachmiel, T.B. (1990). Self-focused attention, coping responses, and distressed mood in everyday life. Journal of Personality and Social Psychology, 58, 1027-1036.

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A Child's Perspective

Written by Dianne, age 11 years, who lives on the East Coast of Australia, near Cape Byron. She's in her last year of primary school and lives with her mother.

I am a very lucky Australian because I've got a caring and loving mother, I live in a great house near the beach, I have really good friends and a fab place to live. I'm healthy and liked at school.

My school is a very small, happy school where you get to have lots of opportunities to go on excursions. It is a very caring school and the teachers are really nice to everyone.

There are many good things about living in Australia. There is lots of coast which means swimming, snorkeling, diving, fishing and walking the dog on the beach. There are no wars here. It's a free country. There is great bush to go camping in, and we have a great Aboriginal history.

But not all Australian children are as lucky as me. Here are some ideas about how to make Australia a better place.

Everyone should get a good education, poor or not. Otherwise when you try to get a job, you won't know how to do a lot of things because you never got told your times tables or how to write or to spell. There are hardly any jobs where you don't need to write or read or count.

I think black or not black, everyone should be counted as equal, like being treated the same, being able to vote, and getting a fair go at everything. Children should feel safe; no child should feel that they're not loved or cared for or that their parents are cold and don't pay enough attention to them. Every child should be loved.

No one should have to live out on the street, cold and hungry. We should at least have a special home where homeless people can go to sleep and eat, all day every day, with no cruel treatment. Some homeless people may use other people to let their anger out on and that is no good. If they had some place to go maybe they would feel a bit more secure.

These are some of the good and bad things that happen in Australia. I wouldn't want to move from Australia, not even for a million dollars.

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Current Issues in Australia and New Zealand

Victor Storm, M.D.

Australia and New Zealand are countries, like elsewhere in the world, undergoing enormous socio-economic change. New Zealand has seen major upheavals in social and political organizations in the past decade. While the pace of change has been somewhat slower in Australia, the impact on the social fabric has been significant. The recent election of a conservative government, after 13 years of socio-democratic administration has hastened some changes. There have been profound changes to the health, welfare and education systems in both countries and major challenges to the basic assumption in social organization.

In Australia some of this disquiet has been expressed in the form of a political phenomenon known as Pauline Hanson. She has spoken out on many issues with a demagogic and isolationist view of Australia. Her comments have disturbed the vast majority of the citizenry, who have, in general, a much more enlightened view of their country and its place in the region.

However, there remains significant difficulties for the indigenous people who have suffered due to the policies of both colonial and subsequent Federal and State Government. This is focused on two central issues, the question of land rights and the recognition of the impact on the removal of children, the stolen generation. The resolution of these two matters will underpin much of whether there is a true reconciliation between the indigenous peoples and other settlers.

In New Zealand, the Maori have moved further forward to address issues that have adversely influenced them since the advent of European settlement. The issue of last rights

has been upheld in a number of areas which have addressed this matter, and the way of such resolution may provide some object lessons globally.

In this context, in Australia and New Zealand there remains significant difficulties for the general health of indigenous peoples, as has been witnessed in other nations around the world.

Psychiatrists and How They are Trained

There are nearly 2000 psychiatrists in Australia and New Zealand, of whom the vast majority of psychiatrists in Australia and a significant proportion in New Zealand are Fellows of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP). Nearly 250 are members of the Faculty of Child and Adolescent Psychiatry of the College. There are some 20 trainees in both countries. There is also a small number of British and American trained child psychiatrists who are not members of the College. A significant number of those are in New Zealand.

The College coordinates a five year training program in general psychiatry which includes six months in child and adolescent psychiatry before a major examination in the fourth year. In general, specialist training in child and adolescent psychiatry is then undertaken for a further two years. It is possible to undertake some of the two-year program earlier; this includes a series of seminars, lectures and tutorials, with close individual supervision and varied clinical rotations. At the end of this training, trainees receive both the Fellowship of the College and the Certificate of Training in Child and Adolescent Psychiatry.

Another mode of training is available for those who enter from a pediatric background. It is possible for trainees to jointly qualify in Pediatrics and Child Psychiatry in a cojoint program with the College of Pediatrics. This is a seven year program: three years in pediatrics, four years in psychiatry, two years in child and adolescent psychiatry.

Allied Health Disciples and Training

Psychologists generally undertake a four year undergraduate degree and then register as clinical psychologists to undertake either a two year clinical master’s degree or doctoral degree.

Social workers all have a minimal four year undergraduate degree and many proceed to post-graduate master’s qualifications.

Occupational therapists generally have a four year undergraduate qualification.

Mental health nurses now train in a three year undergraduate degree but all staff who work with children have undergone further specialized training.

All professional groups have their own relevant professional bodies.

Psychotherapy and Family Therapy training is available in post graduate format from all disciplines in a variety of settings. More recently the post graduate institute which taught and

trained in these skills have established formal university linkages and relevant post graduate qualifications are graded.

Issues Facing Child and Adolescent Psychiatry

The growth of interest in infant psychiatry has seen a very energetic expansion of this discipline. Multiple meetings, conferences and other gatherings are held on this theme.

Overall recruitment in psychiatry training has reduced somewhat in the last decade although the interest in child psychiatry has not waned in Australia. In New Zealand, there has been a major difficulty in securing funding for training posts in child and adolescent psychiatry.

Future Linkages

The challenges child and adolescent psychiatrists and their allied professional colleagues face revolve around the significant changes to health, education and welfare network. While many changes are needed to the infrastructure, many problems arise when services lose funding and the burden shifts to other parts of the system, which are not adequately resourced to undertake the added load. The lack of a systemic perspective in social policy development highlights many of the difficulties.

The Faculty recently held an offshore meeting in Indonesia with significant participation from our colleagues in Indonesia. It is hoped that the conference will lay the basis for further regional linkage and dialogue. The Faculty has also been involved in teaching and training in Vietnam, with several Vietnamese psychiatrists receiving training in Australia. It is hoped that further linkages will take place with other countries in the region to promote mutual understanding and promote the needs of children, young people and their families.

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Development of Child and Adolescent Mental Health in India: The Last 40 Years

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In India, the earliest document to record child development was Ayurveda. The study of child psychopathology was considered as a downward extrapolation of psychopathology of adults. Thus, the growth of child psychiatry in India has occurred following the growth of adult psychiatric services. Though in the Western world, child mental health services were started about eight decades ago, In India, its origins can be traced back to only about four decades. This is probably because psychiatry was introduced in India by the former colonial powers having a different cultural background and language than that followed by the

Indians. There were no opportunities of mental health care for children, as their development rested with the local socio-cultural milieu. It was only when native psychiatrists emerged and were able to understand the existing conditions as a result of communication with the local population that they began some services for the children.

Existing Training Facilities

Undergraduate Level

At an undergraduate level, students have to undergo a fifteen day clinical term in Psychiatry during which hardly or no emphasis whatsoever is given to child and adolescent psychiatry. Besides, in the final year examinations since there is just one short note on a topic in Psychiatry and at some places since this too is optional, there is practically no awareness about child mental health at an undergraduate level. The training for students is also limited to one or two weeks only in Psychiatry during which they get almost no exposure to child psychiatry cases.

Postgraduate Level

At a postgraduate level, Child Mental Health is included in the training program for students training in the fields of MD Psychiatry or Diploma in Psychological Medicine, MD Pediatrics or Diploma in Child Health, and Preventive and Social Medicine. In Psychiatry there is a lack of skilled training personnel and in the other fields there is no mandatory training as such in child psychiatry, hence even at a postgraduate level, students do not have much experience in identifying and dealing with mental disorders in children and adolescents.

Other

In India, few specialized courses are available in the areas of Child Psychiatry, Child Psychology and Social Work. There are limited facilities for training courses of paramedical personnel and community health workers. There are few training centers for teachers in the area of mental retardation and special learning disorders.

Existing Services for Treatment

There were only about 75 child guidance clinics in 1973 (Marfatia, 1973) which increased only marginally to about 120 child guidance clinics managed by general psychiatrists in 1989. Recently some genetic diagnostic centers, crisis intervention centers, centers for substance abusers and special schools and vocational training centers for mentally disabled children and adolescents have been set up, mainly in the urban areas of our country. These centers are managed by the general psychiatrists, pediatricians, clinical psychologists and psychiatric social workers and nurses. Special schools for the mentally retarded, mentally handicapped and gifted children are being run by special teachers trained or interested in handling these children. A lot of orphanages, correctional institutions and non-government organizations have been set up with the aim of helping such children and adolescents. As per Master in 1992, there is a lack of well qualified, trained staff in our country.

The number of specialized inpatient and outpatient facilities for children are very few and are mostly attached to Psychiatric and Pediatric departments of various medical colleges and other special institutions. These also differ in their structure, functioning, and in the available

therapeutic facilities and are mainly situated in urban areas. There are practically no facilities available in the rural areas. That the services are still inadequate has been reported by workers from Africa (Hazera 1972; Izuora 1970, 1972; Asuni 1970) and Southeast Asia (Ramanujam 1968; Marfatia 1973; Rosheen Master 1988).

Training Facilities and Treatment

Services Required

Basic knowledge of child psychiatry should be incorporated at an undergraduate level, and during internship there should be compulsory exposure to child psychiatry cases.

At least six months training in child psychiatry should be made compulsory for students doing their postgraduate in Psychiatry so as to train them to be able to identify and treat the common mental disorders in children and adolescents. Similarly postgraduate students in the areas of Pediatrics and Preventive and Social Medicine should have mandatory training in Child Psychiatry for at least one month of their total tenure.

Adequate facilities should exist for training of clinical psychologists, social workers, occupational and speech therapists and psychiatric nurses to deal with Child Psychiatry cases.

School teachers and community health workers should be trained for early identification and prevention of psychiatric disorders in children and adolescents.

Many more special schools with trained personnel should be started for exceptional (gifted) children, mentally handicapped

children, and children with specific learning disorders.

Educational programs should be held to increase awareness in parents, teachers, as well as the local population regarding the proper development of children, and prevention, early identification and management of psychiatric disorders affecting children and adolescents.

Child Guidance Centers managed by skilled mental health professionals need to be set up in the urban as well as rural areas.

Research Studies

In India, hardly any studies have been done in the field of child and adolescent psychiatry. The ones that have been done concentrate mainly on the epidemiology and the use of assessment schedules. Very little research has been done in the areas of phenomenology, etiopathogenesis, treatment and adverse effects.

Epidemiology

Epidemiological studies at the community level were initiated about two decades ago. In a multicentric WHO sponsored study of childhood mental disorders in primary health care in four developing countries, Giel et al (1980) reported that 12 - 29% of children attending a

primary health care facility in Columbia, India, Senegal and Sudan had identifiable psychiatric disorders of which 80-90% are consistently missed.

In the urban areas, studies by Sethi et al (1967), Verghese et al (1974) and Lal and Sethi (1977), revealed a prevalence rate of 9.4%, 8.2% and 17.2% respectively, whereas in the rural areas, studies by Sethi et al (1972) and Nandi et al (1975) revealed a prevalence rate of 8.09% and 2.5% respectively. Clinic based studies conducted on individual child psychiatric disorders have shown a wide variation in prevalence of behavior disorders, ranging from 3-36% (36% Bassa, 1962; 13% Chacko, 1964; 3.3% Murthy et al, 1974; 3% Praveen et al, 1988; 4.6% Singh and Gupta, 1970); and neurotic disorders ranging from 3.7%-54% (Chacko, 1964; Manchanda and Manchanda, 1978; Nagaraja, 1966; Praveen et al, 1988; Raju et al, 1969; Sharma et al, 1980). A study conducted on school children by Jiloha and Murthy (1981), reported a prevalence rate of psychiatric disorders in 20.7% children and the common disorders reported were enuresis (8.8%), mental retardation (5.9%), stammering (2.1%) and emotional problems (1.7%). Another study on school children conducted by Deivasigamani (1990) reported the prevalence of psychiatric disorders in 33.7% children, and the common disorders were enuresis (14.3%), conduct disorder (11.1%), mental retardation (2.9%) and hyperkinetic syndrome (1.7%).

The drug abuse surveys in school have identified alcohol and tobacco as the most commonly abused drugs in children (Varma et al, 1979). A recent study on drug abuse by Bansal and Banerjee (1993) in child laborers has revealed a higher prevalence (45%) than in school children, and tobacco smoking was found to be the commonest followed by tobacco chewing, snuffing, cannabis and opium. Studies have also been carried out investigating different variables linked to child abuse. For eg. Gil (197)) investigated social class and family size, Light (1973:556-98) investigated unemployment, and Garbarino (1977:721) investigated social isolation in child abuse.

Assessment Schedules

The main work pertaining to assessment schedules has been done in the field of assessment of intelligence. Only a few assessment schedules have been developed in the area of psychopathology. These are: Mental Health Item Sheet (MHIS, Verghese et al, 1973) for children up to 12 years of age, 16 items Symptom Checklist for Hyperactive Children (Chawla et al, 1981) and Schedule for measuring Temperament in children between 4-14 years of age (Malhotra et al, 1982; 1983a, 1983b, 1983c). Recently new assessment schedules have been developed: Psychiatric Symptom Screening Schedule (PSSS, ICMR, 1987) for children up to 16, Childhood Psycho-pathology Measurement Schedule (Malhotra et al, 1988), and Parental Handling Questionnaire (PHQ, Malhotra, 1990). As regards the mentally retarded children, there is a need to develop an assessment schedule which is not only limited to intellectual functioning, but which may also give an idea of the individual's strength and weakness globally (Nizamie et al, 1989).

Phenomenology

In the last 10 years, various research studies have been carried out studying different variables linked to mentally retarded children. For example, Chaturvedi et al (1984), and Somasundram and Kumar (1984) studied behavioral characteristics; Thuppal and Narayan (1990) studied disabilities associated with mental retardation; Madhavan and Narayan (1992) studied epilepsy and mental retardation; and Tandon et al (1990) studies the

orodental pattern of mentally retarded children. Some research studies have also been conducted in the area of time utilization and perceived burden of a mentally handicapped child (Wig et al, 1985) and multidisciplinary rehabilitation of the mentally retarded (Master, 1984).

The research work on manic depressive psychosis in children and adolescents is negligible. The symptomatology of juvenile manic depressive psychosis is reported to mimic that of adult manic depressive psychosis (Narsimha Rao et al, 1982; Srivastava et al, 1991). Patkar et al (1990) reported cases of prepubertal bipolar disorders with rapid cycles as are found in the adult population.

The phenomenology of schizophrenia was studied by Tandon et al (1991) and the symptomatology of hallucinations was studied by Tandon et al (1985). Some phenomenological studies have also been done on hallucinations in hysterical children and adolescents (Tandon and Sitholey 1987), temperamental characteristics of children with conduct and conversion disorders (Malhotra, 1989), autism in tuberous sclerosis (Khanna and Sood, 1991), specific development disorders in the children attending a child guidance clinic (Malhotra and Chhada, 1987) and somnambulism (Singh et al 1990).

Etiopathogenesis

Thuppal and Narayan (1990) studied etio-pathogenesis in patients of severe mental retardation and found the common etiological factors to be idiopathic, infection to the brain, birth anoxia, and trauma. Malhotra et al (1992) studied life events in children with psychiatric illness and found a positive correlation of live events with various child psychiatric disorders. The study of Chakraborty and Paik (1993) has revealed that interaction of many sociological factors may be related to an increased chance of developing delinquent behavior. It is obvious from the negligible amount of studies done on the subject that extensive research needs to be carried out in the area of etiopathogenesis of psychiatric disorders in children in India.

Pharmacotherapy and Adverse Effects

Various drug trials in children have revealed the efficacy of Hydroxazine (Manchanda et al 1969), Imipramine (Mahendru et al 1970), Phenytoin sodium (De Sousa et al 1989) and Mentat (Shah L. P. et al) in hyperkinesis and behavioral disorders. Narsimha Rao et al (1982) and Khandelwal et al (1984) have revealed the efficacy of Lithium as a therapeutic as well as a prophylactic agent for manic depressive psychosis in children. Singh and Mishra (1993) have stressed the role of Piracetam in dyslexia. Two prominent case reports have been published reporting the adverse effects on children and adolescents. One is related to bilateral frontal lobe CT scan abnormality following ECT in an adolescent (Janat and Banerjee 1992) and the other is related to Lithium neurotoxicity in an adolescent.

Future Trends

Designated centers at a state level to provide training and research facilities for all mental health professionals involved with children and adolescents, i.e., psychiatrists, psychologists, social workers, nurses, teachers, etc.

A need to develop an Apex center for training and research in child psychiatry.

A need to sensitize other professionals like general practitioners, probation officers, police personnel, etc., who are likely to deal with such children and adolescents. Short-term courses conducted on a weekly basis so that it does not impinge on their work schedule would also play a preventive role.

For adolescents in school, a need for school counseling programs which include vocational and career guidance, and at a community level, a need for youth guidance which includes guidance on family problems, sex, drug abuse, etc.

Conclusion

It is obvious that as yet, not much work has been done in the area of child and adolescent mental health, though there is a lot of potential for the future. The Indian Psychiatric Society established a Child Psychiatry section in 1987. On November 22, 1991, a separate association, the Indian Association for Child and Adolescent Mental Health, has been established with the purpose of promoting positive mental health in children and adolescents. It holds biennial conferences and is an affiliate of the Asian and International organizations.

Suggested Reading

Kewalramani, G.S. (Ed). Child Abuse: A sociological study of working and non-working children, 1992. Rawat Publications, New Delhi.

Malavika, Kapur. Developmental child psychopathology. In: J. N. Vyas and Neeraj Ahuja (Ed). Postgraduate Psychiatry 1992. Churchill Livingston Pvt. Ltd., New Delhi.

Marfatia, J. C. (Ed). Psychiatric problems in children. Popular Prakashan 1957.

Savita Malhotra. Child Mental Health in India: Needs and Priorities. In: Malhotra, S., Malhotra, A., and Varma, V.K. (Ed). Child Mental Health in India. Macmillan India Ltd. 1992.

Shekhar Seshadri. An overview of child psychiatric epidemiology in India. In: Malavika Kapur, Sheppard Kellam, Ralph Tarter, Renate Wilson (Ed). Child Mental Health, Proceedings of the Indo-U.S. Symposium. NIMHANS publication no. 32. 1993.

S. K. Tandon. Perspectives of child psychiatry in India. Presented in CME at the 15th annual conference of Indian Psychiatric Society, Central Zone, Jabalpur.

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Training and Working in the U.S.: the experience of a foreign (international) medical graduate

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The early eighties was not a time to easily find post-graduate medical training in psychiatry in the US. Required examinations such as the ECFMG, FLEX and the now defunct VQE, filtered out more than 85% of the applicants. The few survivors had to apply through the computerized (NRMP) National Resident Matching Program, along with the MDs coming out of the US medical schools, for the relatively few funded training positions offered at the time.

I was indeed fortunate (after finishing medical school in Chile) to have been working as a post-doctoral fellow at the Drug Dependence Research Center, Langley Porter Psychiatric Institute (LPPI). This Center, which in fact offered me (through the NRMP) a much desired trainee position. I am certain that the disadvantage of being a foreign doc was outweighed by the good word put in on my behalf by Dr. Reese T. Jones, my boss during that research year. Gina Shiba and Laurel Koepernick also lent me a hand when, a stranger, I first walked into a place where foreigners were not so prevalent.

After a grueling six months in Internal Medicine and Neurology, I began my in-patient psychiatry rotation at San Francisco General Hospital (SFGH). That semester gave me not only exposure to the widest (and wildest) garden variety of psychopathology, but also the chance to build my self-confidence and confirm my love for the field I had chosen as a career.

My Spanish came in handy as many of the patients were Latino (Mexican and Central American). The cross cultural aspects of psychiatry were fascinatingly integrated into the knowledge about severe psycho-pathology, psychopharmacology and community psychiatry. The seventh floor of SFGH was divided into four psychiatric units: the Latino, Asian, African-American, and jail wards. From that clinical experience emerges my deepest appreciation to John T. Hopkin, MD, Chief of Psychiatry at SFGH and Vice-Chairman of the department. He taught me a great deal about psychiatry, San Francisco, the US, life and friendship.

Following these six months, I felt ready and prepared to deal with any kind of psychiatric emergency, anytime, anywhere. Needless to say many of the regular bystanders of a busy San Francisco street would be considered crazy (or at least quite bizarre) by other cities' standards. Just imagine who gets hospitalized against their free will in that city!

The following year, I rotated through three in-patient units, all of them at the LPPL, the Crisis Intervention Unit; small, well structured and run by Renee Binder, with acutely ill patients belonging to a somewhat higher socioeconomic group than the SFGH patients.

The Adolescent Unit, psychoanalytically oriented and run. Medications or biologically inclined formulations were still not well tolerated. It was probably the last enclave of dynamically-based psychiatry at a place that prided itself on major contributions to that field. Not to mention the illustrious presence of Robert Wallerstin, MD, chairman of the department at the time, and with whom I had the privilege of taking a year-long seminar on psychotherapy.

The Neuro-Science Unit, just along the hallway from the adolescent unit, but a thousand miles towards the other end of psychiatry. You could breath DSM-III-only nomenclature, neuroendocrinology, neurochemistry and high profile neuropharmacology there. Not much in terms of intra-psychic structures, personality disorders, dynamic formulations andÉeven less so about psychotherapy.

How is it then that the mind really worked?, the puzzled psychiatrist wondered. Those fascinating, enlightening and schizoid times helped me become aware of my own urgent need for integration of biological, psychological and social factors and interventions in mental health and illness. As I saw some of my fellow residents take an extreme turn towards one or the other side of the prism, I couldn't but wonder if a developmental perspective could further add to my already adopted Meyerian and (Engelian) bio-psycho-social approach.

My rotation through Child and Adolescent Psychiatry just reaffirmed my interest in children and in the development of the mind. The third year of training was both satisfying and also less intense than the previous two. Consultation & Liaison Psychiatry at the University Hospital and Out-patient department were the main course. As a consultant to medical teams in the General Hospital, particularly to Neurology and Neurosurgery, I learned a great deal about psychophysiological, factitious and somatoform disorders. Caring for ambulatory patients allowed me to become more acquainted with a variety of psychotherapeutic approaches. Needless to say, all those patient-care, clinical activities were accompanied by at least twice a week individual supervision of all clinical cases, Clinical Grand Rounds, and a variety of theoretical seminars on psychopharmacology, psychotherapy, psychoanalysis, development and even a once a week process group for all residents in my class.

My training in General Psychiatry had provided me with important tools and resources to begin understanding the mind and treating its disorders. The social and cultural experiences that had arisen from living in San Francisco, California, further opened my own mind.

Subsequently came my sub-specialty training in Child and Adolescent Psychiatry, for which I moved to New Haven, CT. The Yale University Child Study Center offered what, I thought at the time, was the opportunity to attempt to integrate the pieces of knowledge I had acquired. Being a resident again was not that difficult, as there was so much to learn from so many gifted teachers.

However, learning to care for hospitalized, severely disturbed children, was quite a task. Some of them mistook you for a piece of furniture, yet others made you feel like adopting and saving them. Learning to draw the line took both much introspection and good supervision.

Like a child in a candy store, my attention shifted from one subject to the other, not being able to fully concentrate and comprehend (or swallow) any one completely. Autism (PDD)

Clinic, Tourette's Disorder Clinic, Child Development Unit, Programs for the Poor and Disadvantaged, School Intervention Programs, Psychotherapy, Psychoanalytic Thinking, Developmental Psychopharmacology, etc. The two years of training went by very fast. Learning about development, as well as about psychopathology of childhood and therapeutic approaches, from a variety of perspectives, helped in my quest for integrative understanding of the mind.

Formal and informal learning from people like Drs. Donald Cohen, John Schowalter, Albert Solnit, James Leckman, Fred Volkmar, Samuel Ritvo, Robert Evans, Kirsten Dahl, Robert Gossart, Mary Schwab-Stone, Mark Riddle, Nathaniel Laor, Kyle Pruett and many others, including my fellow residents, made of this training an unforgettable experience.

Many questions and uncertainties about the mind, its development and disturbances, remained, of course. However, it seemed as if I had learned to look for the patient, and the person behind it, through the most appropriate face of the prism. Appropriate, given the patient and his or her needs, not the one most palatable or convenient to (me as) the clinician.

Research opportunities, many. I stayed an extra couple of years learning more about research methodology through on-going projects at the Child Study Center. I also worked on a Masters degree on Public Health at the Yale School of Epidemiology for those two years. Clinical work, plenty. I had the chance to be clinical director of an adolescent unit for substance abusers in a private hospital for a year and be clinical director of a psychiatric ward for severely disturbed adolescents in a state hospital the following year. I did some clinical work and supervised mental health professionals (psychologists and social workers) from two Child Guidance (community) Clinics. Also I had the chance to work at the Board of Special Education of a nearby Connecticut city. And had a wonderful time with my wife and two children (now there is a third) in beautiful New England.

I was indeed fortunate to have had the privileged opportunity to train, work and live in the United States for almost ten years.

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An Excellent Professional Experience in England

Dr. Eric Fombonne
Consultant in Child & Adolescent Psychiatry
Reader in Epidemiological Child Psychiatry

Although I was born, bred and trained in Paris, I had already spent several periods of my life away from France, when, four years ago, I decided to move to Great Britain. There are only a few hundred kilometers between Paris and London, but the thirty miles of channel separating France from the UK felt, this time, an abysmal distance.

I landed at the Maudsley Hospital in South London and today, with hindsight, I do not regret my decision at all. The first months of work were, however, rather stressful. The first day I started, for example, I remember sitting five hours in a row in various committees where

issues I barely understood were being discussed. I thought at first that it was due to some form of linguistic failure but at the end of the day, I was quite reassured when, having enquired from the man sitting next to me (a typical Maudsley psychiatrist), my colleague replied that he had not understood either. At that time, major changes were implemented in the National Health Service and discussions revolved around: going to the market, purchasing services, GP Fund Holding Practices, ECR or extra-contractual referrals, value for money, and so on.

These expressions were highly reminiscent to me of the wild entrepreneurial 19th century-style capitalism for which my French experience of the Providence State had not prepared me. Indeed, I observed over these years a progressive pullulation of managers in our hospital halls, a corresponding increase in the cost of the Health Service and an expansion of the waiting lists and patients' waiting times. The distinct lack of coherent centralized planning in introducing these changes in the NHS was unbelievable for me who was used to a Napoleonic approach to decision-making.

I also remember the first conference intake (a five-hour consultation, where I was supposed to run the show in front of an audience of fifteen to twenty colleagues and trainees) which I had to do as one of my duties. Nobody had briefed me beforehand, I didn't know what people were expecting from me, and I had to operate in a foreign language. Fortunately, the Registrars, Senior Registrar, Psychologist and other members of my team were very supportive and helped me to survive these first stressful times. I had to relearn some of my medicine, and I can now (almost) confidently practice medicine in English, convert stones into kilograms, measure head circumference in inches, decode technical abbreviations easily, etc. Over these years, I have fully appreciated the help and kindness of my colleagues, be they consultants, trainees or secretaries. I have been positively welcomed and this quickly helped me to feel that I was fitting in.

The practice of child psychiatry at the Maudsley Hospital has been a very interesting experience. This hospital is mostly a tertiary referral center and therefore we see, in my team (autism clinic and depression clinic), children and adolescents referred for complex diagnostic and management problems. I have been truly impressed by the high level of competence of my colleagues, and also with the breadth of their interest and range of their skills. The cases are discussed using a variety of approaches which combine genetic, psychological, pharmacological, familial and systemic issues, both in modeling our understanding of each case and in designing ad hoc interventions. My colleagues have open minds and they are willing to consider any hypothesis or theory in so far that it can be properly tested. This emphasis, in clinical practice, on electic and empirical approaches which are nevertheless inspired by sound theories, is really a feature of British child psychiatry which I appreciate most. Coming from a country where a narrow, theoretical model of child psychopathology has been imposed on training and practice and has extinguished intellectual curiosity in one generation, I do appreciate the fresh air from the Maudsley tradition. I have also enjoyed the relationships with patients and their families. I do not find it easy, however, to follow subtle emotional changes which ordinarily accompany interactions with clients; most notably, it seems that non-verbal cues are reduced and emotions are simply less expressed, which deprives me of one of my usual modes of communication (interestingly, I have noted that this was not the case with people of Welsh or Irish origin). On average, but this might reflect a selection bias in the families I have seen, I have found English parents more demanding, requesting more explanations and justifications for the decisions made; in other words, as users of the Health Service, they

often adopt the same consumer stance which is found in other areas of social life. On the other hand, I have often been astonished by the resignation shown by parents facing a lack of educational resources for their children with special needs, or their willingness to put up with the long waiting lists typical of the British NHS currently.

Working with the trainees at the Maudsley is a rewarding experience. The standard of their work is generally very high, and giving lectures and seminars to the trainees is an enjoyable experience. Perhaps this reflects the particular intake of the rotation at the Maudsley Hospital but, compared to my past experience, I found the basic scientific training and minds of the trainees quite high in the UK. Most of them are well aware of research methods and recent research findings, which facilitates case discussions, formal teaching and research activities. However, I found on several occasions that, when the time had come to actually do a piece of research, the practical know-how was somewhat deficient as if the technological skills were not at the same level as the reasoning ones. This difference (almost amounting to a verbal/performance discrepancy!) might reflect a more pervasive weakness of the British educational system.

My appointment at the Institute of Psychiatry (the research institute based on the Maudsley Hospital premises) was an important incentive for my move. Our Academic Department of Child Psychiatry is very strong, although there are relatively few permanent academic staff. Often linked to the MRC Child Psychiatry Unit, our research programs are numerous and being involved in a variety of ongoing studies as I am suited me very well. The Institute of Psychiatry has a huge research output and, as a consequence, it attracts visitors, trainees, and PhD students from all over the world, who all contribute to the lively and exciting atmosphere of the place. Recent appointments of several North American scholars are a good indicator of the research vitality of the Institute of Psychiatry worldwide. Still, I wonder why these excellent minds do not deserve cleaner building and larger office space.

I will always feel, and always be regarded, as an immigrant. Although I am generally happy with my life in the United Kingdom, there are a few points which I could easily give up: the weather, the food, and the strong South London accent of my three sons when they speak English. And there is one London feature which I cherish most: the 15 daily trains which run so quickly from Waterloo Station to Paris.

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Thoughts on the Experience of a Psychiatrist in the USA

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The letter is here on the table. It announced my approaching departure to the USA. I have been granted a French scholarship for a one year research program on childhood autism at the Child Study Center of the University of Yale. The Child Study Center is a child psychiatry center that includes research activities, consulting, psychotherapy, and hospitalization. Only a few months ago, I could not say where Yale was. YALE actually, in New Haven, between

New York and Boston. As a psychiatrist, I had applied for this grant at the end of my internship, not believing I would get it, not thinking about the consequences of my departure. Yes, I dreamed about it, as one dreams a remote dream, a child's dream And the dream came true

As I arrive on campus, I go from one surprise to another. The medical library is open every night until midnight, as are most American libraries (what bliss for someone who

studies mainly in libraries and who had found only one open until midnight in Paris). Students at Yale have free access to Medline as well as a computer room open 24 hours a day. University tennis courts are also free for students. Along with my ID card, I am given a photocopy card with a credit of 1,000 copies. A free shuttle bus is also at the students' disposal. Since a student was murdered one night in New Haven, this bus functions as a taxi from 6:30 pm until 12:30 am. You simply give a phone call, and the shuttle picks you up and drops you wherever you need. It was always a pleasure to ride across New Haven on this bus. There is a great view of the campus with its neo-gothic buildings and the neighboring houses surrounded in summertime by large gardens with sunny lawns.

Yale is a private university which seems to be well funded. Money comes mainly from tuitions as well as donations from alumni. In New Haven, I found out about bookshops, which are both libraries and coffee restaurants where you eat seated in the middle of the bookshelves.

The medical school cafeteria is open (only!) until midnight, and the nearest supermarkets are open seven days a week, 24 hours a day, whereas in Paris, only a few supermarkets are open until 10 p.m. At each checkout desk, an employee bags your groceries. In the US, the client is king! (which is far from the case in France). For example, the American customer, if unhappy with the service or the attitude of a salesperson, does not hesitate to complain to the manager; this practice is very unusual in France. The consumer's word rules. Salespeople know it and act as a result (this mirrors an economy based on a consumer society, but also the precariousness of these salespeople's positions).

New Haven, where the campus stands downtown, starts to get crowded at the end of August with the return of students and newcomers. At the same time, the graduates I knew were leaving to go to work in other cities because they have finished with their studies. That's another thing about the US, this difficulty to keep stable relationships, for people move quite often. The first move takes place when one leaves College to enter University; then, there is the move after University, as one finds a job or a research grant someplace else; and even after that, one moves according to the work opportunities that are offered at the moment Americans move much more easily than Europeans.

As the days go by, I get set (progressively) in New Haven. The Child Study Center is multi-disciplinary and includes clinicians as well as researchers with diverse trainings (psychologists, psychoanalysts, sociologists, biochemists, geneticists). This multi-disciplinary creates a competitive spirit, a dynamic which seems to promote advances in the domain of research and new ideas. One aspect of the American university life that struck me since I arrived is that everything that is apparently well established is called into question. French students have a very respectful attitude toward their teachers and (faith)fully retranscribe the words of their masters. On the contrary, American students do not hesitate

to fire questions at their professors and they do not satisfy themselves with ready-made answers.

America is a young country that gives a chance to the youth and to renewal. The other side of the coin is that it is always necessary to prove oneself, even when one believes she or he has made it; cutthroat competition, the law of the has been prevails. If one is no longer productive or efficient, one is quickly put aside and forgotten I think, therefore, I am can be replaced by ÒI produce, therefore, I am! Given that, a young person in the US has virtually as much chance to succeed as another in research. Restrictions are due more to budget problems. Whereas French research laboratories are free to manage the annual budget they are given by the state, American laboratories survive only according to the grants they are able to obtain. These grants are given based on the quality of the research project, but also on the adequacy of the project with the market's need, as well as the publications' list of the authors of the project which actually amounts to a business card. Thus, Americans cannot allow themselves to take too many risks. They must produce and publish at any price, only to survive (the American production economy exists at all levels!). The first time I entered the office of the biochemist with whom I was going to work thereafter, I was impressed by the number of his publications. For that year only, about thirty articles were pinned on a board in rows: articles in press, published, in revision, in process, and submitted. The American multi-disciplinary and multi-collaboration system allows this type of record! I was also surprised when I arrived at the Child Study Center by the batteries of evaluation scales administered during the first consultations and followups of children. In France, quantitative evaluations are seldom used, for French child psychiatry is still influenced by psychoanalysis. All along my stay in the US, I would be surprised by this need to quantify and to measure which can be found in every domain: in the workplace, streets, buildings, museums, numbers and scores impossible to memorize are fired at you (numbers of employees, of visitors, speed of the elevators), and this seems to reassure Americans. One feels to be living in the kingdom of numbers and that these numbers have a life of their own

To speed up my integration and to get to know people, I began to play in the baseball team of the Child Study Center. You cannot imagine how much it improved relationships. Baseball is a national sport that unleashes passion. What a show! As soon as a point is won, players of the scoring team spend several minutes to give each other five while yelling enthusiastically. Putting aside my difficulties to understand the rules, my active participation in the baseball team helped me a lot to integrate. I was faced with a painful dilemma when the Child Study Center team played against the French Department team; I quickly solved this dilemma, for there was only one Frenchman who played on this team.

To sum up, the most positive aspects of my professional experience in the US, which actually lasted for a year and a half, were the following:

a) The comparison between multi-disciplinary approaches where one can turn to specialists in different domains.

b) The contribution of a rigorous methodology calling for real professionalism.

c) The stimulating effect of a productivity dynamic.

But it seems to me, to be constructive, to engage in a reflection on the limits of these positive aspects;

a) The same productivity dynamic can lead to a need to publish at any price and to avoid risk taking.

b) The teams' hyper-specialization can lead to rifts because of too much technicality, to a decrease in creativity, and finally to an inertia if some of the participants are absent.

c) Quantitative evaluations reassure clinical or research teams by giving them concrete measures which refer to a scientific truth, something statistical, objectifiable. In fact, these quantitative evaluations seem as subjective as the qualitative approaches; the apparent objectivity of numbers often conceals the scorer's subjectivity. A score, in itself, would have a real meaning only if it is discussed by a knowledgeable team, and the evaluation context is taken into account. It remains that these evaluation instruments can represent extremely useful working tools, yet one has to be aware of their limits.

Finally, I gained experience from the positive aspects previously described, and I tried to assimilate them into my professional life. The most difficult thing, after a process of metabolization, wasÐand still is to adapt them to French culture, to our different means and economy, while attempting to keep our specificity.

My stay at Yale's Child Study Center has changed my way of working and thinking. My reflection, which I began to elaborate following this year and a half experience, is far from over. It is continuing at present within the frame of new collaborations with the Child Study Center.

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A Dutch Child Psychiatrist Looking Back on a Two Year Visit to the USA

Ruud B. Minderaa, Child and Adolescent Psychiatrist, Groningen

In the nineties Dutch medical students are used to traveling all over Europe and other parts of the world. About 70% of the medical students from Groningen follow some part of their curriculum in a faculty abroad.

For residents in medical specialization, like internal medicine or pediatrics, the USA is a popular country in which to work for one or two years to expand knowledge and experience in medicine and to enjoy life. Until now, however, this was not common for people specializing in child and adolescent psychiatry.

From 1981 to 1983, I was so fortunate to be able to work in the US at the Yale Child Study Center. As a young child psychiatrist, I had been responsible for the development of an academic outpatient clinic in Rotterdam in the Netherlands. In September 1981, I, with my

wife and (at that time only) child, went to the US to do research; visiting and being a guest of what seemed to me the best place to be, the Yale Child Study Center.

The early eighties was a period of change in child psychiatry; change from thinking in terms of models (psychodynamic, family dimensional, behavioral therapeutic, etc.), as I was educated, to a much more evidence based, research oriented (child) psychiatry, as I was confronted with in the US. The beginning, as I experienced it, of something new. New insights, developing from multidisciplinary research efforts, to what we call now developmental psychopathology.

My first thoughts in the US about my child psychiatric educational development were: I don't know enough about the facts. I have to start studying. So the first period became a phase of learning (child development, brain functioning, psychopharmacology, neurochemistry, working in the neurochemical lab) and a confrontation with new ways of clinical thinking and practice. This all inspired by a large group of talented and experienced clinicians and researchers, in a different culture of customs in collegial interaction.

A process of learning and dealing with such a new atmosphere of clinical and scientific cooperation in a foreign country has its ups and down. In dealing with colleagues in a foreign country, the reactions you learned over so many years and the expectations you take for granted don't prove to be successful in all circumstances.

A new set of ideas and interactional reflexes must be developed. And that is not only in relation to the work but also in relation to all aspects of your daily life.

My wife was ambivalent in leaving Holland, but she became very enthusiastic about our new life. In fact, she was at least as ambivalent about returning to Holland two years later. But inbetween a period of orienting, trying to get used to a new way of life, finding her way with a two-year-old son, and a hardworking husband who had daily contacts with a lot of people, being on her own, trying to make new friends and being able to meet with scientific needs in terms of studying at Yale, had to be passed.

Today, almost fifteen years later, I can say that the impact of that experience was and still is enormous. First there was the feeling of being successful, coming back with an enormous amount of data, enough for writing a thesis and a handful of publications. And there was the feeling of having successfully survived such an impactful period, working in such a prestigious institute, living with my wife and son in an exciting country, leaving behind so many dear friends, within as well as outside the academic family. Many dear memories.

I came back with inspirative ideas about new research and especially, new insights and an impetus for original new thinking about clinical aspects of child psychiatry, especially related to topics like pervasive developmental disorders, Tourette's syndrome, ADHD and OCD. I found my colleagues in Holland different from what I remembered. There was, generally spoken, an increased orientation on research, a move in thinking to integrate ideas, e.g., from biological psychiatry into clinical work. This led to a process of absorption of much recent knowledge into the already well organized and relatively well developed systems of child and adolescent psychiatric care for children in the Netherlands. I feel that my visit to the US has contributed much to this successful development of Dutch child psychiatry in the eighties and nineties.

The connections have been kept alive: revisits to Yale and visits from Yale friends to the Netherlands; research exchange and cooperation between the Yale Child Study Center and different academic research groups in the Netherlands were established. I am most aware of the impact of those two years when I look at my position today as professor of child psychiatry and medical director of an academic clinic for child and adolescent psychiatry in Groningen.

At this moment, we have a visitor from the YSC who is discussing his experience with MRI in research with children with young researchers in my department and MRI specialists in our academic hospital. His visit was inspired by a six month's stay of two of our students, a psychology and a medical student, who worked in research at the YCSC.

These students are working as researchers now in my department; one on epidemiological and genetic aspects of autism, the other on PDDNOS and discussing the possibilities in Groningen of MRI with an experienced researcher from Yale. So, the circle is completed.

Looking back, in many aspects of the very fast development and enormous growth of our department in Groningen, I recognize those elements that have their inspiration in that unique experience of those two years in the beginning of the eighties. A core element is the scientific curiosity and open exchange of ideas within an atmosphere of friendship. That's what inspired me in those days. That's what I learned from all the people I worked with then, explicitly and implicitly. And that's what I try to transfer to the young colleagues here now in order to develop a department for general and academic care, teaching and research for the benefit of children and youngsters with psychiatric problems.

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Child Psychiatry in Egypt - Present Status: Needs and Demands

Prof. A. Okasha

Among a population of 60 million, Egyptian under five children constitute 14.8% (9.5 million) and those between five and 16 years old constitute 24.7% (14.5 million) of the total population. So almost 40% of the Egyptian population is under 16 years of age.

The state of education of Egyptian children is a reflection of an underdeveloped country as shown in the rate of enrollment and the miniature public expenditure on education. Approximately 177,740 Egyptian children are place in kindergartens with no information available regarding their share in the total budget; 6,155,100 are enrolled in primary schools with a budget equivalent to 62.5 LE per year per child! and 9,567,967 children are enrolled in secondary school with a budget of 97.4 LE for each per year! Only 3.8% of the total number of children are placed in the nurseries (4,400 nursery in 90/92). Finally it may be noteworthy to mention that the number of working children under 12 years of age is 1,014,300, i.e., Egyptian children constitute 7% of the total labor force in the country (CAPMAS 1992).

Regarding health, the available public health services for children involve urban health centers (n=173), health offices (n=347), mother and child health centers (244), school health

centers (11), school health units (108), and rural primary health care centers (2237), all working within a total health expenditure of 1.9% of the total budget, which is meant to provide health care to 60 million people. The neonatal mortality rate remains at a sobering 29.5/1000 live births; the infant mortality rate at an average of 37.5/1000 live births (37.1/1000 live births for males and 38/1000 live births for females), and an under five mortality rate of 56/1000 live births (54/1000 live births for males and 58/1000 live births for females).

Psychiatric morbidity in childhood

One of the most difficult classifications in psychiatry is childhood psychiatric disorders. Psychiatric diagnosis necessarily involves several different elements. Thus it may be desirable to note the type of mental disorder, whether or not there is mental retardation, and the presence or absence of associated organic brain disease.

Apart from the classical presentations of psychiatric disorders, i.e., similar to their presentation in adults, children tend to demonstrate their anguish differently, and sometimes less directly than adults. The total number of schoolchildren aged between six and 12 years was the subject of an epidemiological study investigating the prevalence of anxiety symptoms in childhood and the underlying psychiatric disorder (Okasha and Sayed, 1994). The prevalence of anxiety disorders was found to be 7.9% while that of hyperkinetic disorder is 2.2%. Nocturnal enuresis was represented in 1.9% of children in Egyptian surveys. Bed-wetting was found to be tolerated in a child up to the age of five - six years. The age at which parents decide to do something about it depends on their tolerance and their degree of sophistication; usually it is between seven and ten years of age. The highest number of stammerers (0.98%) was found in two age groups, six to seven and 11 to 12 years. The apparent rise in the incidence between six and seven years may be due to the prevalence of the onset of stammering before school entry and soon after beginning to mix with schoolmates, while the 11Ð12 peak could be attributed to the onset of puberty. The problems of independence, widening of the horizon of the adolescent, fear of the opposite sex, self-criticism and moral judgment, may be factors in precipitating the onset of stammering.

Behavior disorders in children represented 5% and 8.2% of all cases attending the outpatient psychiatric facilities in Ain Shams University hospitals in 1967 and 1990, respectively (Okasha, et al, 1993). Behavioral and autonomic changes are frequently the clinical presentation of an underlying depression. In a study carried out on 157 children diagnosed with depression, the following were the presenting symptoms: Abdominal pain (71%), nausea (22%), vomiting (24%), headache (39%), inability to fall asleep (61%), anxiety (74%), lack of confidence (61%), excessive clinging to mother (39%), and social withdrawal (68%) (Okasha, 1988). Mental disorders among children can be multiple. A study carried out in a unit for mentally retarded children (Okasha and El Fiky, 1983) showed that children can suffer the full-blown picture of an additional mental disorder on top of their mental retardation, no matter how severe it is. Behavioral problems in childhood are frequently interpreted as misbehavior that can be managed by punishment or reward within the family. Within the overcrowded schools, teachers are less likely to differentiate between children with developmental disorder, with adjustment disorders and mild mental retardation. While a category of those can benefit from psychiatric intervention, all together are discarded as children with scholastic malachievement and may leave school with never having a chance of being identified, diagnosed or receiving the proper management.

Egypt has 500 psychiatrist, including 33 under training. The ration of psychiatrist/ population in Egypt is 1:200,000. The number of child psychiatrists does not exceed 2% of them. Child psychiatry in Egypt and all the Arab World needs reinforcement in human resources, facilities and postgraduate education.

What we need is a public awareness that mental disorder can start in childhood and that its early detection and management can spare the community a high percentage of adulthood disorders. Most parents with emotionally disturbed children prefer to take them to a GP or pediatrician rather than a psychiatric clinic. Pilot studies show that treating childhood mental problems in primary care setting is more effective and regarded more positively by parents. School mental health and assessment and screening of school children by qualified psychologists, social workers and psychiatrists is mandatory if we want to provide our children with the elementary opportunities for healthy development and growth.

References

CAPMAS (1992): Central Agency for Public Mobilization and Statistics. 1992 Statistical yearbook.

Okasha, A. (1988): Clinical Psychiatry. Anglo-Egyptian Bookshop, Cairo.

Okasha, A. and El Fiki, R. (1983): Psychiatric morbidity in a mental retardation unit. Egypt. J. Psychiat., vol. 6, no. 2.

Okasha, A. and Sayed, M. (1994): Prevalence of Anxiety Symptoms in Childhood and the Under- lying Psychiatric Disorder. MD Thesis in Psychiatry, Faculty of Medicine, Ain Shams Un.

Okasha, A., Seif, El Dawla, A, Asaad, T. (1993) Presentation of hysteria is a sample of Egyptian patientsÐan update. Neurology, Psychiatry and Brain Research, 1:155-159.

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The Building Blocks of Childhood, A Spotlight on Foster Care Children

Editors Comment: Service delivery systems for children must expand to children's basic needs as this article about foster care indicates.

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Childhood is a crucial time. It is during this period that children develop their identities, morals and values. The experiences they have during this period influence and define their characters. Foster care is one of those experiences. The foster care system is a division of the Child Welfare Administration of the department of Social Services of the United States of America. It is a national system under which each state in the country can gain custody of a

child, from a number of different ways. A parent or guardian may voluntarily place his or her child in foster care. During a voluntary placement, the parent or guardian temporarily gives up his or her rights to the child. The state then becomes the legal guardian of the child. Children are place in foster care for a variety of reasons. One reason is financial strain; the parent or guardian may no longer be able to afford the child. Other reasons include incarceration, lengthy hospitalizations, drug abuse rehabilitation or inadequate housing. Since it is a voluntary placement, custody may be regained once the necessary condition(s) is met.

An alternative manner of admission into the foster care system is through an involuntary placement which occurs when a child is removed from the parent or guardian because he or she is in imminent danger to life or health. A report is made to the Child Welfare Administration of suspected abuse or neglect. Child protective services investigates the report within 24 hours. If the alleged abuse or neglect is confirmed, the child is immediately removed from the home. An involuntary placement does not require the consent of the parent/guardian. The child may be retrieved once it is proved to the court that the child is no longer in imminent danger to life or health.

Foster care was designed to be a temporary placement for children in the US who cannot live with their parents/guardians. The foster care system is part of the child welfare system and cares for all children, of any race, color, religion or sex. Throughout my college experience, I worked with foster care children as inpatients, outpatients, and day hospital patients as well as community children in Maryland and New York. I believe that there are universal fundamentals or building blocks that children require during childhood.

The primary building block is unconditional love. Children need to know and feel that regardless of their behavior, mistakes or successes, they will be loved by their parents or guardians.

Another building block that can aid the success of a child's future is respect: the expression of esteem, concern, consideration or high regard. Children must learn to consider other people's feelings and opinions, regardless of the situation or circumstance. They usually learn this behavior from their parents or guardians.

Children should also receive mutual respect from parents/guardians. If a child is not treated with respect from his or her parent or guardian, from whom will they learn?

It is also important that parents and guardians develop a bond of security with their children. This will help the child feel safe and protected. Although environmental factors may prevent the child from being shielded from violence or harm, the parent or guardian can offer the child a sense of security. Many children in foster care reside in impoverished and dangerous environments, making it very difficult or impossible for children to feel safe.

While this self-esteem grows, children also learn to develop trust in themselves. Some parents or guardians who place their children temporarily in foster care do so because they cannot trust their abilities to raise their children. For these children, it is important that they trust the decision made to place him in foster care: the child must trust that the parent or guardian will one day retrieve him. In other cases, the child must trust that the adult who removed him from his family did so because it was in his best interests. These are difficult concepts for a child to understand. Werner & Smith (1992) found trust to be a factor that

positively influences the child's resiliency and success. Therefore, a child who cannot trust anyone, including himself, may find it very difficult to succeed in becoming healthier. Parents and guardians must support their children's decisions. This support will demonstrate to the child that they trust their judgment. The child must know that regardless of the nature of the situation, they can confide in their parent or guardian. If not, the child will feel alone and isolated without someone to turn to during times of distress. Vailliant (1993) demonstrated that a child's ability to establish one good, strong relationship with an individual is the single best predictor of his/her success in treatment.

I chose to discuss the characteristics of unconditional love, respect, security and trust because I believe these characteristics are fundamental to the field of child and adolescent psychiatry. The additional stresses that children in foster care have can be minimized if professional who work with them employ these characteristics. These professionals have the opportunity to educate and train biological parents, foster parents, and guardians so their efforts can ease the suffering of foster care children.

All children, particularly foster care children, do not receive the same set of building blocks during childhood. In fact, it seems that less children are receiving these blocks than ever before. Yet, as a student who will begin her career in child psychology during the early years of the 21st century, I recognize that the new millennium may leave more children than ever without those blocks. This reality does not scare me or discourage my efforts. I embrace the challenges that await me and thank those professionals who taught me how to employ these characteristics. I am eager to join their efforts in searching for more opportunities to assist children and families, as they understand the necessity of such building blocks during childhood.

References

Rosenfield, A. A., Pilowsky, D. J., Fine, P., Thorpe, M., Fein, E., Simms, M. D., Halfon, N., Irwin, M., Alfaro, J., Saletsky, R. and Nickman, S. (1997). Foster Care: An Update. Journal of the American Academy of Child and Adolescent Psychiatry, 36(4):448-457.

Vailliant, G. (1993). Wisdom of the Ego. Cambridge, MA: Harvard University Press.

Werner, E. E. & Smith, R. S. (1992) Overcoming the Odds: High Risk Children from Birth to Adulthood. Ithaca, NY: Cornell University Press.

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The International Initiative: Mission Statement and Ethos

The International Initiative is a Foundation, established in 1992 in The Netherlands with the support of the Dutch Ministry of Health, Welfare and Culture and from experience drawn from eighteen other countries.

Mission Statement

The International Initiative recognizes the important role of the family in providing a nurturing environment. It acknowledges the need to protect and to respect the rights and unique identity of each child, young person, parent or other family member as well as of the family unit as a whole.

Its philosophy and practice are based on current research drawn from innovative programs and methods which aim to meet the challenges of a changing society. The International Initiative strives to bring about changes in work with children, youth and families, and to provide policy makers, managers, practitioners, researchers and educators with the stimulation and support necessary to achieve these changes.

Ethos

The ethos of The International Initiative is based on the knowledge that children have a need to live in their families, as long as their safety and basic physical and psychological needs are met.

Professionals should be encouraged to work in partnership with families, helping to strengthen and empower them, avoiding unnecessary placement outside the home. When a placement does occur, however, then all necessary resources should be used to re-integrate the child with its own family. For young people this may include a wider network of contacts, while continuing, if appropriate, to build links with their own family of origin.

The following guiding principles were developed through an analysis of international programs working with children, youths and families. They underpin the ethos of The International Initiative and demonstrate a sound basis for good practice for organizations and individuals.

Guiding Principles

To work with the family in the community and not just with the child.

To allow the child and parents to set the agenda and not the professional, working with them rather than for them.

To work in a positive, productive way, step by step, achieving pragmatic and realistic goals.

To work only with what the family knows or is able to understand at each state.

To build on strengths rather than emphasizing problems, focusing on the possibilities and resources of all persons involved.

To recognize the diversity in families and in all work respect the special cultural, racial, ethnic and religious traditions that make them distinct.

The philosophy underlying these principles should be embodied in policy, management, practice, research and education. They should be applied in relationships between colleagues and other organizations and permeate every level of the work with children,

youth and families. This requires a general shift in perspective throughout the system of care for children, youth and families.

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European Forum for All Psychiatric Trainees (EFPT)

The EFPT is an all European organization whose main object is to secure the organization of persons engaged in the practice of psychiatry as trainees. This group includes all subspecialties of adult and all of child and adolescent psychiatry. The EFPT was founded in 1992 and had its fifth meeting in Athens at the end of March 1997. Along with most (17) EEG-EFTA countries, five East-European countries were present. They expressed their intention and wish to become a full member of our organization.

The main aim of the EFPT is to promote and improve our psychiatric training and to give us a voice in the evolution of European training standards. We are convinced that this is an important way to promote the highest possible standards of treatment and care in psychiatry. We strongly support the work of the different psychiatric Boards within the UEMS (Union Europeenne des Medecins Specialistes). Our viewpoint is that the Charter on hominization of training (UEMS, December 1996) is an excellent basic document and can be seen as minimal ideal requirements.

To have a voice in the discussion on training, the EFPT tries to make statements on the different aspects of psychiatric training. We have constructed statements on:

National trainee organizations

General medicine and neurology in psychiatric training

Training in child psychiatry

Requirements for teachers

Quality of training: supervision and evaluation

Quality assurance in training: independent inspection of training institutions

Logbooks

Experience in research

Exchange of trainees between different countries

Part-time training

We put a strong emphasis on inspection by means of visitation teams. We believe that regular visits by an independent team should be conducted and that a trainee should take part.

The Congress of the EFPT takes place in Belgium from the 24th until the 26th of April 1998, with the first symposium on the 23rd of April. The subject is Training in psychiatry and child and adolescent psychiatry. Lectures will be held by numerous international professionals.

For more information on the EFPT, the statements or its first symposium, please contact

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More information can be found on the Internet:
http://allserv.rug.ac.be/~hhoeben/EFPT.html

EFPT (European Forum for All Psychiatric Trainees) Symposium

Training in Psychiatry and Child and Adolescent Psychiatry
Antwerp (UIA), Belgium, 23 April 1998

Teaching and Supervision

Interactive teaching: using the right side of the brain
Dr. P. Mielants (Antwerp, Belgium)

Expected competence after current psychiatric specialist training experiences of Finnish trainees
Dr. R. Kaltiala-Heino (Tampere, Finland)

Being the patient of a psychiatrist is like flying in a plane with a pilot who learned his job from reading about flying and from having been a passenger
Prof. T. Compernolle (Amsterdam, The Netherlands)

Clinical guidance (supervision) on the call function
Dr. Torben Lindskov (Roskilde, Denmark)

Quality Assessment

Monitoring of psychiatric training in the UK and the Republic of Ireland
Dr. L. Sheldon (London, UK)

The introduction of a logbook in the UK
Dr. L. Cornwall (Newcastle upon Tyne, UK)

How should specialists be trained to be good mentor-supervisors?
Prof. K. Schleimer (Lund, Sweden)

The psychiatric residents in-training exam: an educational tool
Prof. Scully (South Carolina, USA)

Harmonization of Training in Europe

Dr. von Salis, President of the Board of Child and Adolescent Psychiatry
(ZŸrich, Switzerland)

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UEMS/CAPP-SECTION

Kari Schleimer, M.D., Ph.D.

The UEMS (European Union of Medical Specialists) was founded in Brussels in 1958. Its statutory purpose is the harmonization and improvement of the quality of medical specialist practice in the European Union (EU). Education is a key element in this field and the UEMS has been pursuing the formulation of a common policy in the field of training for many years. In 1993 the Charter on Training of Medical Specialists in the European Community (EC) was adopted by the Management Council of the UEMS. This Council consists of the delegates of the national specialist organizations in the European Union. The Charter forms a framework for harmonization of postgraduate specialist training in the EU in each specialty.

Specialist sections, 30 from the beginning, went to work to specify the training needs in their speciality within the framework of the Charter. These specialist sections consist of two delegates of each of the national scientific/professional organizations in the speciality. From Sweden, the delegates are Kari Schleimer and Mats Ageberg. The task was completed in 1995 and the present European Charter on Training gives a complete picture of the consensus on training programs that has been reached within the medical specialist profession in the EU. Together with the Charter on Continuing Medical Education, the two

documents are professional recommendations. Responsible national organizations are strongly recommended to implement these recommendations into their national training programs.

Since 1993, The Swedish Association for Child and Adolescent Psychiatry has participated in the work of the CAPP section (Child and Adolescent Psychiatry/Psychotherapy), founded the very same year. Representatives from CAPP in 16 EU countries as well as from Norway and Switzerland are meeting annually the last was summer 1997 in Lugano. New president for our section is Thomas vonSalis, Switzerland. The Central East European countries may send observers to these meetings and have done so to some degree. The president of the EFPT (European Forum for all Psychiatric Trainees), Dr. Robert Vermeiren, Belgium (a trainee of CAPP!) was also an observer.

Within the section there are six working groups to attend to different matters, among them one pursuing better cooperation with the CEEC (Central East European Countries). Chairperson of this working group is Kari Schleimer. We are planning a conference in spring 1998, maybe in Hungary, to facilitate for representatives from the CEEC to meet and discuss their training programs with representatives from the UEMS/CAPP section in order to improve their programs and make them harmonize better with the Charter on training.

Next meeting of the CAPP section will take place in Brussels in October 1998, when the UEMS will celebrate its 40 years of existence.

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The East European Committee in Sweden

Kari Schleimer, M.D., Ph.D.

The East European Committee started its work in 1992, after the structural changes in Central and Eastern Europe. The initiative was taken by some people in Sweden who wanted to bridge the gap between East and West, especially with countries in the vicinity of Sweden, namely the Baltic States and Poland; later on, St. Petersburg as well. It as a joint venture between the Swedish National Board of Health and Welfare, the Swedish Medical Society, the Swedish Medical Association and the association of trained nurses. The committee was to promote good health in the mentioned five regions and contributions were based on local, single initiatives, spontaneity, idealism and demands on contribution from the Swedish initiator to a certain percentage of the total cost.

Funds came from the Swedish International Development Authority (SIDA) 1992-1996 and thereafter from SIDA-East, which has implied structural changes for the East European Committee into an idealistic association with paying members and an executive board with a managing director, in charge of the committee's secretariat.

Today the Committee is favoring a stronger professional direction towards local joint projects, concentrating on basic, broad (including different vocational staff groups) and prospective projects adjusted to the needs in the counterpart country. Priority is given to prenatal care, child welfare, adult, forensic and child and adolescent psychiatry, physical

handicaps, dental service, infectious diseases (especially tuberculosis, HIV and AIDS) and district health care. The region Bosnia-Hercegovina will be included as will Archangelsk, Murmansk, Kaliningrad. For all these different priorities, there exists groups of experts to prepare applications for projects. In the psychiatric group, there are representatives from adult psychiatry, forensic psychiatry, and child and adolescent psychiatry (KS). Swedish child and adolescent psychiatry has worked together with its counterparts in Estonia, Latvia and Lithuania. So far some contacts have also been taken with St. Petersburg. The Committee has supported 25 child mental health professionals from Estonia, Latvia, Lithuania, Polen and St. Petersburg for participation in the IACAPAP 14th International Congress in Stockholm this August.

The main objectives for the East European Committee are:

To transmit knowledge and influence attitudes through conferences, seminars, workshops, etc. and site visits in order to promote good health and welfare in East European countries, and

to build up model activities and achieve structural changes.

For this purpose, the East European Com-mittee has at its disposal in 1997, around 19 million Swedish crowns, and psychiatry is given priority, now and in the future. Levels of contribution: support to locally based cooperative projects, support to larger strategic and prospective cooperative projects, related to ongoing reform processes in other countries, support to long-term cooperative projects of reforming character which partly may be financed by the European Union.

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XXII International Congress of Pediatrics

Amsterdam, August 9-14, 1998

First International Congress on Pediatric Nursing

Robert A. Holl

Dear Colleagues and Friends,
On behalf of the International Pediatric Association (IPA) and the local organizing committee, I would like to invite you to participate in the 22nd International Congress of Pediatrics which will be held in the RAI International Congress Center in Amsterdam, The Netherlands. At the same time, the First International Congress on Pediatric Nursing will be held.

Pediatric Health Care is a broad specialty with many sub-specialties that are also closely related to general pediatrics. This is one of the reasons why the upcoming ICP is a unique event where all aspects of child care can be seen from different angles. This congress will not only create the possibility to discuss the latest medical-technical developments, but it will

also focus on prevention; especially the immense health care problems in non-industrialized countries and the external influences on a child that can be a threat to its development.

This is the main reason that the congress carries the title, From grass roots to genes. The scientific program with eminent speakers from all over the world will not only give basic information and state-of-the-art lectures, but it will also focus on recent developments and future expectations. Consequently, this congress will be much more than only an occasion to exchange information and to give accredited education. In Amsterdam, decisions are to be made to protect the child against all dangers in this world.

The dialogues between general pediatricians, sub-specialists, heads of pediatric departments in hospitals and representatives of world federations such as UNICEF and WHO, should lead to a combined proposal from all parties involved to develop child health care in all its aspects onto a higher level. It is required that as many pediatricians as possible will be present during the next ICP to take part in this discussion. The world will look upon us with great excitement, waiting eagerly what we as pediatricians will do to achieve this.

Besides the fantastic scientific program, there are, of course, many other reasons that should make you decide to come to The Netherlands in August 1998.

Amsterdam is, by far, one of the most beautiful cities in the world. The Netherlands is a beautiful country to spend a wonderful holiday with your family and enjoy the various tourist attractions for young and old. The social program offers various nice cultural and artistic events and should be one of the reasons for your accompanying persons or your family not to miss one day of this congress.

Please read all information in the 2nd announcement carefully, and I am sure you will agree with me that this world congress of pediatrics is worthwhile visiting. The local organizing committee is looking forward to receiving your registration and abstract forms.

See you soon in Amsterdam!

For more information, contact:

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