

IACAPAP BULLETIN

International Association for Child and Adolescent
Psychiatry and Allied Professions



5.

Association Internationale de Psychiatrie de
l'Enfant et de l'Adolescent et des Professions Associées

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PRESIDENT'S MESSAGE

The ethical delivery of mental health services—including prevention, early intervention, and acute and longer-term therapies—must be guided by scientific knowledge. We need to know what is useful, for which children and families, and when. Mental health professionals have an enormous range of potential social, familial, and individual interventions. Even within a particular modality, such as individual therapy, there are tremendous variations. How can a clinician choose, and what should guide public policy in determining what treatment should be offered and by whom? Today, this question is often asked in terms of economics: how should the scarce funds be allocated to serve the largest number of children in greatest need and most likely to benefit.

Of course, for many children living in adversity—children in persistent poverty, surrounded by communal discord, growing up in refugee camps, being raised by abusive parents or in foster care—there are clearer answers. For these children, mental health professionals serve a critical policy and advocacy role in helping assure health care, nutrition, schooling, economic and physical security, and family support. Yet, designing the systems to provide these services is not at all straightforward. Careful assessment of different approaches is critical to assuring that well intentioned interventions meet the target.

There are even more uncharted domains in relation to the serious developmental, behavioral and emotional disorders that define the narrower field of child psychiatry and psychology, such as autism, affective disorders, and learning disabilities. Child mental health professionals directly provide essential clinical care for these children and their families.

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EDITORS' COMMENTS

This issue marks another milestone for the International Association of Child and Adolescent Psychiatry and Allied Professions. This issue is the first to be called the IACAPAP Bulletin. The name was changed from Newsletter to Bulletin to connote a more extensive, scholarly publication. We write articles that present divergent topics and depth of coverage. Most importantly, this issue joins the previous editions of the Newsletter to promote international communication among child and adolescent psychiatrists and those professionals from allied professions. In this regard, this issue presents an array of important issues that are pertinent to the current major changes in healthcare internationally.

The keynote article of this issue highlights the IACAPAP Work Group Conference in Venice on the topic of "Trauma and Recovery: Mental Health Systems for Children and Adolescents." A review of this conference presented in this issue describes a consensus that the healthcare changes promoted by economic reforms has had significant impact on service delivery for children, the need to reshape child psychiatry training programs, and the varied ways these issues are conceptualized and implemented. A major outcome of this conference was the Venice Declaration which is published in this issue. An additional statement that provides more details is available by writing to Dr. Donald Cohen, President of IACAPAP.

IACAPAP work groups occur regularly between the main IACAPAP International Congress Meetings. Their purpose is to define thematic issues of international significance and to plan for their presentation at the International Congress held every four years. Our next Congress will be in Stockholm in 1998

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IACAPAP VENICE WORKING GROUP

APRIL 1996: DEVELOPING A DECLARATION FOR UNIVERSAL GUIDELINES FOR MENTAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS

Gil Zalsman, M.D. and
Michael Kaplan, M.D.

Introduction

In an ancient monastery on a tranquil island in Venice, an international assembly of child and adolescent mental health experts met for three days this past April to develop a consensus for designing mental health services for children and adolescents. Over 50 representatives from 24 different countries gathered for this unique task which was titled, "A Shrewd Investment: Guidelines for Designing Mental Health Services Delivery Systems for Children and Adolescents." The interdisciplinary group consisted of a broad spectrum of mental health professionals as well as economists and public policy experts. The idea for this special IACAPAP meeting arose from discussions between Donald Cohen, IACAPAP President, and Ernesto Caffo at the last congress in San Francisco, who felt that IACAPAP was ideally suited to address this issue on an international level. Venice provided an environment conducive to hard work, productive debate, and cross-cultural dialogue. The meeting was a collaboration between IACAPAP and Il Telefono Azzurro, a groundbreaking project founded by Dr. Caffo to help children at risk in Italy.

The meeting was divided into two components. First, IACAPAP representatives from different countries presented their systems of mental health services for

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IACAPAP

Association Internationale de Psychiatrie de
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Declaration of Venice: Principles for Organizing Mental Health Systems for Children and Adolescents — 1996

The International Association of Child and Adolescent Psychiatry and Allied Professions (IACAPAP) is the international organization of national societies committed to child and adolescent psychiatry, psychology and allied professions. For more than 60 years, IACAPAP has been an international advocate for children and families. A major goal of IACAPAP is to facilitate the provision of preventive and treatment services and to enhance the work of mental health professionals.

Mental health systems within nations and regions have over-arching goals:

- ◆ to support families, teachers, social agencies, criminal justice systems, pediatricians, maternal and infant health services, and others in the community in the vital social task of raising children who function optimally;
- ◆ to provide access to services and programs, as soon as they are needed, for children who are first exhibiting signs of disorders and troubles;
- ◆ to deliver services that are as effective and safe as possible to all children—regardless of their abilities to pay, race, ethnicity, legal status, nationality or other personal characteristics—in order to reduce suffering, limit disability, and help promote the individual's fullest possible participation within the community.

To meet these goals, the mental health systems of nations and regions should include:

- ◆ a cadre of well trained, committed professionals;
- ◆ a range of settings for prevention, evaluation and treatment that are acceptable and used by families and that are non-stigmatizing;
- ◆ access to services for all families and children in need;
- ◆ suitable methods for financing;
- ◆ quality assurance and monitoring;
- ◆ evaluation and research; and
- ◆ ethical oversight, advocacy, and protection of the rights of children, including the implementation of the United Nations Convention on the rights of children.

IACAPAP asserts the importance to nations and individuals of well organized, high quality, ethically delivered, accessible, mental health services for children, adolescents and their families. To assure the creation and maintenance of optimal mental health systems, government, private organizations, professionals, families and advocates need to work together with shared commitment and values.

14TH IACAPAP CONGRESS



Trauma and Recovery— Care of Children by 21st Century Clinicians

Stockholm, Sweden
August 2–6, 1998

Welcome! It is a great pleasure for us to invite you to the 14th International Congress of the International Association for Child and Adolescent Psychiatry and Allied Professions — Psychology, Social Work, Paediatrics, Public Health, Nursing, Education, Social Sciences and other relevant professions. The Congress will take place in Stockholm, Sweden, August 2–6, 1998, and we will do our very best to arrange a scientific programme of high class. Stockholm 1998 will celebrate the “cultural capital of Europe.” We also hope that the time schedule will allow you to enjoy our beautiful city which we are all very proud of. In Sweden, we emphasize the importance of giving all our inhabitants the possibility to live and work in environments as clean as possible. You will find beaches surrounded by clean water at only a stone's throw from downtown Stockholm. The theme, “Trauma and Recovery—Care of Children by 21st Century Clinicians,” is a great challenge for all of us mental health professionals.

Per-Anders Rydelius — Kari Schleimer

Programme Arrangements

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But we are thus most acutely aware of the tremendous need for new knowledge about etiology, prevention, and cure.

The field of developmental psychopathology conceptualizes the disorders of childhood from the perspective of normal development, just as physiology provides a framework for internal medicine. The developmental framework emphasizes the complex interactions between constitutional factors, experience, risk and protective factors within the family and community, over the course of a lifetime and from one generation to the next. With the help of newer methodologies, we can trace these complex interactions, including both biological (molecular biology, neuro-imaging, neurochemistry) and psychological factors (family studies, behavioral observations, study of the child's inner experience as revealed in talk, play, and interaction). Hopefully, clinical researchers will soon be able to trace the pathway from genetic vulnerability to changes in brain structure and function and the emergence and natural history of disturbances in the context of particularly stressful life experiences. Using this knowledge, clinicians will then be able to write a multi-leveled biography of individuals and groups of children—a nuanced narrative of an illness and of the child and family's adaptation. Such a narrative must respect biological influences, internal psychological functioning, and the surprises and uncertainties of life.

As clinicians and advocates, the goal is to be able to base our care on an increasingly firm foundation of knowledge about development and its disorders. Today, much clinical intervention is pragmatic. In the future, developmental psychopathology should help provide a rationale for specific treatments.

As the international organization concerned with children and adolescents with psychiatric disorders, and with the professions that serve them, IACAPAP is committed to facilitating research and sharing knowledge among nations and professions. IACAPAP is a forum for bringing together the varied traditions of research and treatment from across the world and from different disciplines.

IACAPAP convened an important working group in Venice, Italy, during the Spring of 1996. Leaders in child psychiatry, psychology, social work, and social policy from many nations gathered for a week of discussion and debate. The working group produced the Venice Declaration on mental health systems as well as a backup report concerning the scope of mental disorders, a theoretical perspective, and a framework for intervention. The Venice working group highlighted a broad consensus, across nations, disciplines, and traditions; it also revealed difference in resources, clinical approaches, and theory. The agreements are reassuring. The areas of differing emphasis point to areas for future, fruitful investigation.

The disorders that we treat—suicide, psychosis, depression, violence—are among the leading causes of death and serious morbidity in childhood and adolescence. Indeed, emotional, behavioral and developmental disorders are probably the most frequent, persistent sources of impairment in childhood and adolescence. Mental health professionals have an ethical imperative to share information and search for increasingly effective prevention and therapy. I believe that our research and evaluations can be as robust and compelling as those in other branches of medicine.

Today, throughout the world, governments are questioning the current systems of care. Bureaucrats and politicians are devising new health care systems. Managers demand cost effectiveness. Sometimes, the new criteria of accountability and proven efficacy are used as weapons against mental health systems and providers and reflect the old stigmatization of mental illness and disdain for mental health clinicians. Systems of "managed care" may become methods for reducing costs at the expense of patients and professionals and for the financial benefit of managers and corporations.

To be powerful advocates for our patients and for wise treatment systems, we will need to be as armed as possible with authentic knowledge, as well as with political and administrative skill. We firmly believe that it is shrewd for a nation to invest in children and in their

mental health. We need research to support these passionate beliefs.

The 14th International IACAPAP Congress in Stockholm, Sweden, in August, 1998, will provide a wonderful opportunity for colleagues from throughout the world to take stock of clinical knowledge and to chart future directions for mental health systems and professions. As we plan for Stockholm and afterwards, we will need to work together to assure that governments and administrators understand the vital connection between research and clinical care, and between mental health services and the future of nations. I hope that you will feel free to write to any members of the IACAPAP Executive Committee about your thoughts and suggestions. ■

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Call For...

Items for future Bulletins

Please forward any items for inclusion in future newsletters to:

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with a theme focusing on Reforms in Mental Health Delivery Systems.

This Bulletin marks the expansion of the activities of IACAPAP and its liaison with national societies regarding the mental health of children. As noted in this issue, several new organizations have formed and are developing agendas for training child and adolescent psychiatrists and for approaches to benefit children's and adolescent's mental health development. Dr. Kari Schleimer presents the dilemmas of defining the identity of child and adolescent psychiatrists, especially as new treatments are available and the mental health delivery system has changed. She and Dr. Per-Anders Rydelius are the program chairpersons for the next IACAPAP Congress in Stockholm, Sweden. Plan to attend this very exciting Congress entitled, "Trauma and Recovery—Care of Children by 21st Century Clinicians."

We present in this issue two important articles about psychiatric treatment of children and adolescents to illustrate the complexities of the psychiatric care of youth and to point out areas in need of additional research. To achieve this aim, we offer a paper from Dr. Jack McDermott, editor of the Journal of the American Academy of Child and Adolescent Psychiatry who presents material to inform our international members of issues to consider in planning, implementing, and reporting about new research.

It must be emphasized that IACAPAP has a long history, and our last issue illustrated this by including the logos of many of our past international congresses. In this issue, Dr. Henry Work, who celebrated his 80 plus birthday this year, offers personal reminiscences about IACAPAP. In contrast, we continue to publish articles from children and adolescents in our youth's perspectives format. Perhaps some of these youth will be future members of IACAPAP!

Finally, we are very grateful for the donations in support of the publication of our Bulletin. These are acknowledged cumulatively to emphasize the significance of these contributions. In addition, we hope to receive other donations and ask

our member organizations to develop methods to obtain financial contributions to the Bulletin. We also wish to continue to receive from member associations information about future meetings, articles of interest to child and adolescent psychiatrists and allied professionals, and new features as our members may wish.

We wish everyone a very
Happy New Year!

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Venice Working Group
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children and adolescents. The second component consisted of presentations of compelling and current issues that are essential ingredients in designing guidelines, such as economics, ethics, outcome research, training, epidemiology, and quality assurance.

Overview

Dr. Cohen set the framework for the three-day meeting by posing the following question: Do we have a theory of systems that can be linked with our theory of developmental psychopathology? He emphasized the gap in knowledge and scientific sophistication between our understanding of the biological brain and the child's environment. The advances in the last 40 years have brought about great understanding and techniques to measure the brain, genetics, and neurobiological substrates in a wide variety of disorders. We know that history, culture, family, and society all influence a child's development, but our ability to measure these factors remains poor. Now that the tensions between psychoanalytic, psychosocial,

and biological factions have been reduced, we can bring the strengths of each discipline to develop testable theories of system delivery. Services for children must be grounded in context and continuity. The child's context includes family, community, and schools, and continuity refers to consistency and integration of care. Further, another guiding principle in developing services is to have them adapt to the child rather than making the child "fit" the service. In order to be successful, we need to translate scientific advances into services, evaluate our treatments, and train the next generation of clinicians. Our goal is to allow theories to shape services, which will provide data to re-evaluate our theories.

Designing Mental Health Systems in Different Nations

Representatives from different countries presented briefly their systems of care. Diversities and similarities emerged from these presentations and promoted discussion that demonstrated the pressing need for guidelines. What drew the participants together, despite the differences in culture, language, and history, was the similar challenges each nation faced in caring for children and adolescents. These included dwindling resources, governmental pressures, and increasing social needs.

USA: Peter Jensen, M.D. addressed the changing role for the child and adolescent psychiatrist in developing systems of care. What is the appropriate role? Dr. Jensen described the child and adolescent psychiatrist as an expert in the relationship between brain and behavior in a developmental context. The child and adolescent psychiatrist should be part of a multidisciplinary team (but not necessarily the leader) and should coordinate between the educational, social service, juvenile justice, and health care systems. The US has between six and seven thousand child and adolescent psychiatrists.

Poland: Jacek Bomba, M.D., Ph.D. reported on the role of child and adolescent psychiatrists in his country, emphasizing the work in the juvenile justice system. Recent changes include a decrease in inpatient beds and an increase in the number of day patients and outpatient

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clinics in underserved regions. A new idea is to increase flexibility of staff such that they can move more easily from one place to another although this has been difficult to achieve.

Brazil: Salvador Celia, M.D. outlined the difficulties children face in his country. Brazil has the 10th largest Gross National Product but on measures of quality of life, they rank 70th. The total population is 145 million with 50 million individuals under 20 years of age. Only 400 child and adolescent psychiatrists are available to meet the mental health needs of this population. Child and adolescent psychiatrists are not recognized as an independent profession and the majority work in private clinics. Basic issues of development such as feeding and nutrition are the primary concerns of pediatricians, who also serve as the mental health agents in Brazil.

Romania: Tiberiu Mircea, M.D. described the division of mental health services into two components: governmental and non-governmental. The governmental services take responsibility for newborns, abandoned and homeless children as well as assistance for children with special needs. Non-governmental services are supported by private donations and joint ventures with Germany, France, Sweden, Austria and the United States. These international collaborations provide a large number of child services.

U.K.: Ian Goodyer, M.D. noted that the system of care has not changed significantly since the 1950s. The welfare state provides universal coverage and access. The private sector has remained stable at approximately 2%. The United Kingdom has a population of 58 million with 358 child and adolescent psychiatrists. The number of child psychiatrists is held constant by legislated personnel figures that maintain one child and adolescent psychiatrist for every 100,000 children. The system is organized through a series of block grants given to regional health authorities who are the "purchasers" of health care which are then provided by local authority trusts.

India: Savita Malhotra, M.D., Ph.D. began her presentation with population

demographics. In a country of over 900 million, children under the age of 14 comprise 40 percent, or 350 million total. There are less than 4,000 general psychiatrists, 120 child guidance centers, most of which are located in metropolitan centers, whereas 80 percent of the population is rural. Dr. Malhotra placed primary importance on the cultural perspective in case identification, evaluation, treatment, and outcome measurement. Indians typically accept a wider range of pathological behavior. A successful mental health service system for children, she argued, would be integrated into a model of general health.

Scandinavia: Helga Hannesdottir, M.D. reported on the similarities between the Scandinavian countries in the problems they share such as single parent families, and an increase in social problems, multiple languages, and high rates of suicide. As in the U.K., the government provides free treatment. Most of the services are offered in outpatient settings. Despite availability of care and prevalence of disorders, service utilization is low. Services and care for mothers and young children are excellent with a low infant mortality rate and good, affordable preschool programs. A stable population in Scandinavia provides an excellent opportunity for epidemiological studies.

Studies of Treatment Outcome

1. Leonard Saxe, Ph.D. of Brandeis University, spoke on challenges in evaluating systems of care and effectiveness vs efficacy of treatment. His talk was divided into evaluation and prevention. Reviewing a 20 million dollar demonstration project that allowed communities to develop systems of care for children with chronic mental illnesses and to encourage inter-agency collaborations, he made three conclusions. First, agencies that historically have been categorical can become flexible and learn to collaborate and adapt to provide services. Second, no two communities organize systems of care in the same manner. And finally, services that are child- and family-centered rather than bureaucratically driven are more likely to provide more favorable outcomes. A key component of successful programs was the inclusion of respite care for parents in the service model. He commented on the

inefficiencies of the U.S. system and cited the changing boundaries, the new roles for parents and professionals and the change from categorical to integrated service systems.

Communities can also be called upon in the prevention of mental health problems in children and adolescents. Dr. Saxe provided the example of "Fighting Back" for the prevention of substance abuse in the U.S. which targets these children who have not experimented with drugs and the importance of giving alternative lifestyle choices to teenagers.

2. Mario Bertolini, M.D. of the Università degli Studi di Milano, addressed treatment outcomes of psychoanalytical psychotherapy. Politicians, he explained, are interested in economic outcomes and data, rather than subjective ratings from patients and physicians. In a longitudinal study of psychoanalytic psychotherapy, involving 60 patients over seven years, they measured relapses, hospitalizations, and cost. No patient in this study required hospitalization, the duration of therapy was 3.5 years and the cost of treatment for each subject was equivalent to 13 inpatient hospital days.

3. Philip Leaf, Ph.D. from Johns Hopkins University, drew upon epidemiological research methods to look at service system outcomes. He emphasized the need for a population perspective. Unlike research in adults, where days lost from the job is a standard economic measure, the cost to society is more difficult to measure in children. Given that early prevention leads to a decreased dropout rate, he suggested that an important measure of outcome in children and adolescents is school attendance. He reported that children who stay in the school system longer have less drug and alcohol use, less morbidity, and more work productivity. Dr. Leaf is leading a major epidemiological study of children's mental health needs and systems of care in the United States (UNOCAP) that involves 10,000 subjects ages 4-17 from 400 counties in the U.S.

4. Ronald Feldman, Ph.D., Dean of the Columbia University School of Social Work, addressed the research priorities for the improvement of mental health ser-

vices for children and adolescents. The intervention and research efforts of the mental health professions can benefit from fruitful interchanges concerning the merits and liabilities of their respective theoretical frameworks, service delivery systems, and research paradigms and priorities. Toward this end, four key priorities were discussed regarding contemporary social work research about mental health services for children and adolescents. These pertain, respectively, to research concerning risk status, the measurement of children's behavior, treatment contexts, and follow-up intervention systems.

Preventive Interventions: Research and Practice

1. David Schaffer, M.D., Professor of Clinical Psychiatry and Pediatrics at Columbia University, made two important points in his talk on the scope and prevalence of psychiatric disorders of childhood and adolescence. Drawing upon the long history of epidemiology in child and adolescent psychiatry, he concluded that the most important concept in detecting prevalence is the level of severity or impairment rather than the number of symptoms. In addition, he underlined the value of using a mixed approach in epidemiological research, such as using self-reports and follow-up calls and interviews to determine prevalence of disease.

2. Gabriel Levi, Professor of Child Neuropsychiatry at the Università di Roma, described a recent study he completed examining rates of comorbidity in children and adolescents in a public mental health system. They detected high rates of comorbidity (40% had > three problems and 70% had > two problems). He encouraged the audience to think about comorbidity in a developmental model. The difficulty in measuring psychopathology in Italy is the general movement from seeing mostly handicapped children in child psychiatry clinics. A lively discussion followed this presentation. Dr. Cohen asked Dr. Levi when did we know that a child had a disorder ("when is a case a case?"). Dr. Levi responded that time provides the answer. At

that point, Dr. Hattab raised important ethical issues, such as the risk to the child of labeling and remaining in treatment for many years. He also suggested that when "you study the child, you change the child" and he also questioned what is normality and how do we define the range of pathology. Dr. Levi agreed that we need to improve our ability to make precise diagnoses. Dr. Pfeffer, who moderated this discussion, reminded the group to use a multiaxial perspective when considering a diagnosis.

3. Peter Jensen, M.D., Chief, Child and Adolescent Disorders Research Branch, National Institute of Mental Health, also focused on a research strategy for preventive intervention. His talk provided an overview of the advantages and disadvantages of epidemiological research in prevention. The key element in designing intervention strategies, he noted, is a developmental perspective, based on the spheres of influence in a child's life. These "spheres of influence" include the child's biology, dyadic relationships, family context, neighborhood, culture, society, etc. Knowledge of when disorders occur will guide treatment approaches. A final point was made after discussing multisystemic therapy with juvenile offenders that using social workers who are available to families, involving parents in the model, and being "practical" were predictive factors for positive outcome.

Models of Preventive Intervention

Two different models of community intervention were presented. The first was a discussion of mental health teams in day care centers (Miguel Cherro-Aguerre, M.D.) in Uruguay. This innovative program integrated training of psychiatrists into service delivery and consultation. The second model was prevention in schools (Ian Goodyer, M.D.). Dr. Goodyer discussed the concepts of prevention and detection. Both models focused on maintaining the educator in the role of decision-maker. In the discussion, Dr. Cohen commented on the importance of boundaries and the need to guard against the impulse to change schools into mental health clinics. Child and adolescent psychiatrists need to learn how educators work before they can implement preventive strategies.

Economic Issues

1. Mario Zanetti, Professor, Università di Bologna, an economist, initiated several presentations on the relationship of economics, market forces, and mental health service systems for children. In his talk, he addressed the problems in ensuring equal distribution of health care resources and the tension between private and public systems. He stated that a contradiction exists between quality and equity and that to cut costs may reduce quality. He suggested a few ways to maintain quality in an era of diminishing resources: reduction of waste; increase efficiency; allow mechanisms for competition; and create flexibility in personnel planning. In the discussion period, Dr. Tyano commented that these ideas are difficult to implement with chronic patients and he questioned the incentives to make clinicians more efficient. Dr. Zanetti replied that health cannot be an "open market" because health can always be better; it is not a discreet unit.

2. Donald Light, Ph.D., provided an active agenda for child and adolescent psychiatrists who seek creative solutions in a hostile economic environment. After outlining the uniqueness of health care as an economic market (e.g., no clear products, inherent inefficiencies, information asymmetry, "the seller is the buyer's advisor"), he advised that mental health systems for children and adolescents derive a needs-based purchasing plan for calculating budgets. He also stated that the work of child and adolescent psychiatrists leads to cost savings outside of the health care budget such as in the juvenile justice system, the schools and public welfare. These political-economic considerations can be helpful in determining budgets for mental health.

2. Kari Schleimer, M.D., Ph.D., from the University of Lunds, described recent changes in the mental health system in Sweden which included decreased social subsidies, decreased number of inpatient beds, and shorter periods of residential and outpatient care. Authorities have implemented quality assurance for the first time.

3. Helmut Remschmidt, M.D., Ph.D., of Phillips University, presented the German perspective on mental health allocation of

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in other European nations, government-funded health care provides universal coverage for a population of 80 million. Germany has 24 academic departments of child and adolescent psychiatry, over 800 child guidance centers. In the last 20 years, the major change has been in the manpower laws which provide for service providers based on intensity of care needed rather than on strict population figures. All regions work with a fixed budget.

4. Sam Tyano, M.D., Director of Geha Psychiatric Hospital, discussed the Israeli experience of privatization. In 1995, the system of health care delivery changed to a private system of four major HMOs. Mental health will be covered in 1998. Prior to 1995, children could be admitted without demonstrating a need for admission to a third party reviewer and length of stay was not carefully monitored. He listed five major changes in the mental health system which included: integrated mental health into general health; converting state hospitals; relocating the focus to the community; subjecting mental health centers to market forces; and strengthening of planning and oversight.

5. Agnes Vetro, M.J.D., Ph.D., from the Albert Szent-Gyorgyi Medical University, documented the changes in mental health care in the context of rapid political change. New financial markets have been created since the fall of communism which are more responsive to free markets. The economic situation threatens the existence of child guidance clinics. The total number of inpatient child and adolescent beds has remained stable from 1945.

The Developmental Perspective

1. Linda Mayes, M.D., from the Yale University Child Study Center, highlighted several guiding principles for the treatment of very young children, which included: "early is better"; more intensive interventions are more effective in restoring development on track; providing structure and consistency; and to facilitate language development. Multiple

models of treatment exist but there is very little empirical evidence that they provide effective treatment. Poorly standardized diagnostic nosology, lack of informed instruments to assess deviations, lack of systems research and little epidemiological research combine to prevent efforts to plan sound services and evaluation. Principles in the treatment of very young children, such as individual flexibility, treating the child in their context and increasing integration among different interventions are identical to those with older children and adolescents.

2. Robert King, M.D., from the Yale University Child Study Center, discussed the impact on mental health services for adolescents. Several key principles emerged. First, interventions must be targeted at those at risk for disorder; second, adolescents need to be taught specific skills and finally, the developmental issues that characterize adolescence (the search for identity, ideology and the changing relationship to adults) should be incorporated into service systems. Colleagues from Eastern Europe commented in the discussion period on the reaction and response of adolescents to the rapid political, social and economic changes in their countries. Many countries do not have a tradition of adolescent psychiatrists to help manage the increase in social withdrawal, suicide and homicide rates, and increase in radical groups.

The Venice Declaration

The meeting led to the review of a draft proposal of guidelines for the organization of mental health service systems for children. The background sections outlined the fundamental principles of any mental health system which include: ecologically sensitive planning; developmental suitability; a spectrum of care; accessibility; consent; effectiveness; competence of professionals who deliver care; diversity of settings of mental health care delivery; parity of financing with other medical disorders; maintenance of high ethical standards, with an emphasis on confidentiality; and an integrated evaluation component. Members of the group were encouraged to have the document translated and circulated within their countries. ■

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*We are please to highlight
recent contributions for
educational support for
publication of the Bulletin
in 1997.*

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Director Emeritus
The Grove School
Madison, Connecticut

PSYCHOANALYTICAL APPROACH TO CHILD MENTAL HEALTH

Colette Chiland

In France and in the countries influenced by French psychiatry, the psychoanalytical approach is the most common. Our colleagues from other countries, which are under the influence of American psychiatry, have the greatest difficulties to understand what we are doing and believe that to be a psychoanalytically oriented psychiatrist is to use psychoanalysis as the only therapeutic tool.

For a French child psychiatrist, the psychoanalytical approach is not limited to having been analyzed, to episodic indications of a psychoanalytic treatment and possibly to do oneself some psychoanalytic treatments from time to time. It is to think the whole of psychopathology in another way. Of course, we know that a child has a body, that his/her psychobiological equipment plays a role as well as occurring diseases. But we think of the child's development as a continuous interaction between body and environment, and fantasy interactions between parents' psyche and child's psyche play a role besides behavioral interactions.

Some viewpoints common to American psychiatrists are foreign to the most of us. For an example; the diagnosis of Attention Deficit Disorder has neither the same meaning nor the same significance as in the States or in Canada.

Usually we prescribe less drugs, and we give an important place to therapeutic consultations. We try to understand the story of the child and parents, their way of functioning, and their relationship. Child and family are seen at variable intervals according to the situation. Only a limited number of children are taken into psychoanalytic therapy. If analysis is considered as a five sessions a week treatment, we never do it. We do three times a week treatment at most, often less. The difference between analysis and psychotherapy concerns the nature of the ongoing process and not the number of sessions.

In child psychiatry, we do team work. A team is composed of one or sev-

eral psychiatrists, a social worker, psychologists, a graphotherapist, that is a wide therapeutic range: writing reeducation, relaxation, speech therapy, pedagogical help, psychoanalytic psychodrama, psychoanalytic psychotherapy, work with parents.

When working in a catchment area system, we try to have a relationship with the community, child welfare, daycare centers, schools, juvenile court, so that prevention could go along with therapy. ■

PSYCHOPHARMACOLOGY IN CHILDREN: INTERETHNIC CONSIDERATIONS

Michael J. Napolliello, M.D.

At the time I was invited to write this article, it would have been tempting to beg off by stating the obvious, that is, there is virtually nothing known about interethnic psychopharmacology in children as established by systematic studies. The reality, however, is that physicians are treating significant numbers of children with psychotropic agents and these children, like their parents, represent diverse ethnic groups. It behooves us, therefore, to examine what we know about adult interethnic differences in psychopharmacology and about adult-child differences in pharmacology, and bring this information to bear on this virtually uncharted area of clinical medicine.

Adults: Interethnic Psychopharmacology

For several decades, a few interethnic tidbits had been known from a number of studies, such as the reduced mydriatic reaction to drugs like epinephrine, atropine, and cocaine, observed in Blacks and Asians, vis à vis Caucasians. Only in the past two to three decades, however, has a more intense effort begun to emerge on a worldwide basis with drugs commonly used in the clinic. Research groups such as Lin et al, at Harbor-UCLA Medical Center, and their counterparts in Japan, China, Europe and elsewhere in

the U.S., are providing the foundation of a data base on this important clinical issue. The aggregate picture to date supported by these data will be briefly summarized.

Antidepressants. Afro-Americans seem to achieve higher plasma concentrations of tricyclic antidepressants such as amitriptyline and nortriptyline, in comparison to Caucasian-Americans, even when dosed on a mg/kg basis. Whether this is clinically significant is a matter of debate. Some clinicians have observed that Afro-Americans get a slightly more rapid and robust response to these medications than their Caucasian counterparts. As for the newer selective serotonin uptake inhibitor (SSRI) antidepressants, there is little information. Few studies of any antidepressants have been done with Hispanic Americans. There is a suggestion that this group experiences efficacy and toxicity with tricyclics at lower doses than do non-Hispanic Caucasians, but definitive studies are lacking. Asian-Caucasian differences have been studied somewhat more extensively with mixed results. Where differences exist, they generally point in the direction of higher and/or earlier peak plasma concentrations, greater AUCs, and lower doses required by Asians to achieve minimal therapeutic concentrations. Nevertheless, there is no established cluster of pharmacokinetic/pharmacodynamic differences between these two groups to provide a take-home message for the clinician. Here again, little or nothing is known about SSRIs.

Benzodiazepine anxiolytics. Asian-Americans appear to metabolize these drugs more slowly than Caucasian-Americans, and show slower clearance rates, higher C_{max} and AUC, and a longer half-life of elimination. The picture is less clear for Afro-Americans, though they appear to be more sensitive to the benzodiazepine adinazolam, based on pharmacokinetic and pharmacodynamic differences. There is no useful information on Hispanics.

Lithium. Therapeutic dose and plasma concentrations seem to be lower in Asians versus Caucasians based on several studies, but additional studies of more rigorous design are needed. Studies of Afro-Americans and Afro-Caribbeans

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suggest a lower dose requirement for these groups versus Caucasians but this data base is even less extensive. Blacks show higher RBC-plasma ratios, suggesting less efficient lithium-sodium countertransport activity in the cell membrane, but the clinical significance is not totally clear.

Antipsychotics. Several studies suggest a higher frequency of extrapyramidal side effects in Asians compared to Caucasians and Afro-Americans. Chinese have shown plasma concentrations about 40–50% higher than those of Caucasians, Blacks and Hispanics on comparable doses. One study showed greater prolactin elevation with haloperidol in Asians versus Caucasians after controlling for body surface, suggesting a pharmacodynamic difference at CNS receptors. No consistent profile has emerged for Blacks or Hispanics versus non-Hispanic Caucasians.

Pharmacokinetics in Children. A few fundamental biologic differences between children and adults impact on how drugs are handled in the body. Neonates are not included in this discussion. First of all, the ratio of hepatic mass to total body mass is higher in the child. This allows for faster metabolism on a mg/kg basis, which is relevant to virtually all psychotropic drugs except lithium, which is not metabolized. Children also tend to have higher volume of distribution (V_D) values than adults. Both these differences account for the need for higher doses on a mg/kg basis in children than adults to achieve the same plasma levels and pharmacologic effect. Little or no differences exist in other kinetic parameters such as absorption, protein binding, glomerular filtration and tubular secretion, all of which reach adult levels within the first year of life. It is important to note that variability among individual children in key pharmacokinetic measures is considerable, as tends to be the case with adults.

In addition to pharmacokinetic differences, children have a number of pharmacodynamic quirks, positive and negative. Children with enuresis, for example, have a more precise dose-

response correlation with tricyclic antidepressants than do adults with Major Depressive Disorder. On the toxicity side, the propensity to neuroleptic-induced dystonia in children and adolescents is well known. More unique is the discoloration of enamel and bone seen with tetracyclines. The effects of corticosteroids on growth and barbiturates on learning are other examples.

Drug response in children is by no means static. Theophylline clearance is considerably higher in children aged one to nine years than in children under one year. Lorazepam used pre-endoscopically shows greater anxiolytic efficacy and less undesirable sedation in children over 11 years than in younger children. It is difficult to generalize from these examples since some of this variance may be molecule-related and not just age-related.

Drugs in Children: Interethnic Studies. As mentioned earlier, data are scant in this area. My own literature search found only Black versus Caucasian comparisons. A study in South African children with seizure disorders found no racial differences on pharmacokinetic measures, but noted that the female patients had significantly lower carbamazepine clearance than their male counterparts, consistent with findings from other studies in children. A second study in South African children with asthma found no racial differences in theophylline pharmacokinetics, but reported faster clearance in the male and the younger subgroups. In contrast, a U.S. study in infants and children reported a 34% higher theophylline clearance for the Black versus Caucasian group, the latter predominantly of Latin ancestry.

A more fundamental finding was reported in a U.S. study which showed a higher frequency of poor metabolizers of debrisoquin in white (7.7%) versus Black (1.9%) children, which was statistically significant ($p=.029$). Debrisoquin is a drug which is used as a pharmacogenetic probe. It is metabolized in the liver by debrisoquin hydroxylase, a cytochrome P450 enzyme which has been dubbed 2D6. The 2D6 enzyme, together with other cytochromes, is responsible for the metabolism of a wide variety of commonly prescribed drugs such as tricyclic antidepressants, non-tricyclic antidepress

sants (fluoxetine, sertraline, paroxetine, nefazodone), phenothiazines, haloperidol, risperidone, carbamazepine, codeine, dextromethorphan, some antiarrhythmics and beta blockers. The finding of a higher percentage of poor 2D6 metabolizers among White children is consistent with findings from adult studies where Whites have a higher frequency of poor metabolizers overall than Blacks.

This brief summary of interethnic differences was by no means exhaustive. It focused on a few key parameters such as clinical effect, dose, plasma concentration, AUC, clearance and elimination half-life. It did not address ethnic differences in drug conjugation, protein binding, body fat ratio and diet. Outside the narrow confines of pharmacologic studies many other ethnic issues such as attitudes toward medication/healthcare, expression of symptomatology, family response to psychopathology as well as the treating physician's own attitude/behavior toward ethnic minorities can contribute to ethnic variance.

Given the absence of a meaningful data base in interethnic psychopharmacology in children, what should be the take-home message from this brief overview? First, there are interethnic differences among adults which, although muddy in spots, are real. Second, although children are not adults pharmacokinetically, they are not exempt from biologic interethnic differences, though the nature and direction of these differences are not necessarily the same as in adults. Therefore, downward extrapolation from adult data may not be accurate. Finally, when the clinician encounters in the child greater toxicity than expected at a particular dose level, efficacy at doses considered subtherapeutic, or any other unexpected response to a drug at a given dose, the possibility of ethnic factors should be kept in mind and treatment adjusted accordingly. ■

C_{max} – Maximum concentration of drug in blood or plasma.

AUC (Area Under the Curve) – Total area under the curve that describes the concentration of drug in the systemic circulation as a function of time (from zero to infinity).

V_D (Volume of Distribution) – A measure that relates the amount of drug in the body to the concentration of drug in the blood or plasma.

PSYCHOTHERAPY RESEARCH FOR CHILDREN AND ADOLESCENTS: UBI SUMUS?

Euthymia D. Hibbs, Ph.D.

What is happening in psychosocial treatment research with children and adolescents? And, what do we need to consider in future research so that the treatments we offer to children are empirically tested and efficacious? In this article, we will present a short review of the historic developments of psychosocial treatments for child and adolescent disorders; describe some of the programs funded by the National Institute of Mental Health (NIMH), and examine some of the future needs for research.

In the 1950s and 60s, the therapeutic modes used for the treatment of children and adolescents were mostly psychoanalytically oriented, focusing on the alleviation of internal conflicts and neuroses. In addition, there was very little research done with children. In the last two decades, however, we have witnessed the emergence of innovative therapeutic techniques and methodological developments, such as behavior therapy (BT), cognitive behavior therapy (CBT), interpersonal therapy (IPT), and others. The treatment aims became more specific and operationalizable focusing on eliminating certain symptom(s), modifying specific behavior(s), and altering maladaptive functioning. Although in many instances these therapies are "hand-me-downs" from successful adult treatments, the methodologies have been adapted to meet the developmental needs of children. Some of the methodological adaptations entailed involving parents in the treatment, training parents to understand and manage their child's illness, consulting with teachers, and/or involving classroom peers as mediators of the child's treatments.

During the same period, we also witnessed the refinement of assessment instruments and outcome measures which facilitated the examination of therapy outcomes across multiple areas of functioning and from multiple perspec-

tives. The development of treatment manuals aided in the scientific examination of therapy outcomes.

It is to be noted that treatments for young people was one of the priority research areas mandated by the *National Plan for Research on Child and Adolescent Disorders*. The Plan charged the scientific community to develop a coherent National strategy in defining, assessing, diagnosing, and treating young children's mental disorders. Five years later, the Institute of Medicine (IOM) "Report Card" on the National Plan indicated that psychosocial treatment research showed greater growth in comparison to other areas, although the overall funding rate had not increased as much as outlined in The National Plan. For the fiscal year 1995, 16% of the active NIMH grants investigating childhood disorders are treatment grants.

At present, NIMH funds several research programs that have the objective of testing the efficacy of treatments for child and adolescent disorders. Following are NIMH-funded treatment studies of several of the most impairing childhood disorders, the principal investigators, and location.

Anxiety disorders: Philip Kendall, at Temple University, uses CBT for the treatment of children with overanxious, avoidance, and separation anxiety disorders. David Barlow, at Albany SUNY, uses CBT-group for adolescent social phobia. Wendy Silverman, at Florida International University, uses a combination of CBT and BT for childhood anxieties and phobias. John March, at Duke University, examines the effect of a combination of CBT and medication for the treatment of obsessive compulsive disorders. Cynthia Last, at NOVA Southeastern University, examines whether medication enhances/facilitates the effects of behavioral exposure treatment in eliminating anxiety-based school refusal. In addition, Deborah Beidel, at the Medical University of South Carolina, is testing a new comprehensive treatment, called Social Effectiveness Treatment for Children (SET-C) with social phobia.

Affective disorders: Peter Lewinsohn, at the Oregon Research Institute, examines a group-administered treatment for adolescent depression, called "Adolescents

Coping with Depression" course (CWD-A) based on a cognitive model of depression. Laura Mufson, at New York State Psychiatric Institute, investigates the efficacy of Interpersonal Psychotherapy (IPT) with depressed adolescents. Guillermo Bernal, at the University of Puerto Rico, and his colleagues conduct a comparative study using CBT and ITP, adapted for the Hispanic population, for the treatment of depressed adolescents. David Brent, at the University of Pennsylvania, compares three treatments, CBT, Systemic Behavioral Family Therapy (SBFT), and non-directive support therapy (NST), for depressed suicidal adolescents. Kevin Stark, at University of Texas-Austin, is testing a CBT-school based treatment for childhood depression.

Autistic disorder: Laura Schreibman and Robert Koegel, at University of California San Diego and Santa Barbara, respectively, investigate the effectiveness of parent training as an avenue for the treatment of autism. Philip Strain at St. Peter's Child Development Center, uses a combination of interventions for autistic children, comprising parent training and classroom interventions, as well as peer-mediated interventions. Ole Lovaas, at UCLA, conducts a follow-up study with the subjects of his early study who are now 19-29 years of age. He also has a new multisite study replicating his treatment of autism.

Conduct disorders: Sheila Eyberg, at the University of Florida, is evaluating the effectiveness of Parent Child Interaction Therapy (PCIT) for the treatment of three to six year old children with Oppositional Defiant Disorder (ODD). Carolyn Webster Stratton, at the Washington University, has undertaken an interactive intervention program, using videotape vignettes, for the parents of oppositional defiant disordered children ages four to eight. Alan Kazdin, at Yale University, is studying the effect of Problem Solving Skills Training (PSST), and Parent Management Training (PMT) for the treatment of aggressive and antisocial children. He is also working in developing new treatments of the same population. David Kolko, at Pittsburgh University, uses various techniques such as firehouse orientation, training in fire

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safety skills, and psychological intervention for the treatment of childhood firesetting.

Attention Deficit Hyperactivity Disorder (ADHD): Anastopoulos and his colleagues at the University of Massachusetts, use Parent Training (PT), Problem Solving Communication Training (PSCT), and Structural Family Therapy (SFT) for the treatment of children with ADHD. Russell Barkley at the University of Massachusetts has several research programs. One of them uses a combination of behavioral and cognitive techniques to investigate the effects of early intervention for kindergarten-aged children who are aggressive and have ADHD. In another study he examines pharmacotherapy and psychotherapy outcomes in adolescence. The third study examines outcomes when fathers participate in therapy with adolescents. Howard Abikoff, at the Long Island Jewish Medical Center and Lily Hechtman, at McGill University, are conducting a two-site multimodal treatment study, including pharmacotherapy, for ADHD children. Finally, NIMH developed the collaborative "Multimodal Treatment of ADHD" (MTA) study to evaluate various such as interventions behavioral/pharmacological – alone and in combination, family and school interventions, and their long term effectiveness.

The above mentioned studies are examples of the developments in the field. However, there are more psychosocial treatment studies in progress in institutions that are funded by other than NIMH sources. The results of the majority of these studies are encouraging, indicating that psychotherapy helps.

Psychotherapy research is in its "toddlerhood," and more studies are needed to develop the field into adulthood and demonstrate its merit. Following is a sample of the critical needs for future research in testing the efficacy of psychotherapy:

a) Ascertain via follow-up studies if gains noted after eight to 20 psychotherapy sessions, focusing on symptom relief, are maintained or are due to a placebo effect.

b) Consider developmental level and changes in treatment.

c) Develop multi-site studies to test the therapeutic modalities in various settings and with differing populations.

d) Adjust or develop methodologies for family centered treatments.

e) Test outcomes (symptom relief, functionality, school performance, social skills, etc.) of short term versus long term treatments.

f) Compare different therapeutic modalities for the same disorder.

g) Consider comorbidity in treatment.

h) Develop race/culture/ethnic specific treatments or determine through ongoing studies, using diverse populations, that the same treatments may be used for all.

To conclude, psychosocial treatment research for the child and adolescent disorders field is energetic and vibrant at this point. However, the need to produce empirically based findings, concerning the effectiveness of existing of new treatment, has become compelling in the present changing atmosphere of health care and health delivery. Psychotherapy is the preferred treatment by most parents of children with mental disorders, especially when there is little known about pharmacological treatment for children. Therefore, more research is needed in all areas of treatment, which in turn needs to be disseminated to clinical practitioners. ■

A CHILD AND ADOLESCENT MENTAL HEALTH JOINT TRAINING PROGRAM WITH LATVIA

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

Once again, the department of Child and Adolescent Psychiatry at the Malmö University Hospital, University of Lund, Sweden, has started a project together with a counterpart in the eastern part of Europe, this time with the department of Child and Adolescent Psychiatry in Riga, Latvia. We agreed to their request after having fulfilled a two-year training program in Vilnius, Lithuania. Our colleagues in the East European countries, both child psychiatrists and child psychologists and others, ask for contact with western child psychiatry to learn modern angles of approach to CAP to hold against the Russian type of psychiatry they had to learn and work with before.

From Sweden, it is close to the Baltic Republics, so that's why Swedish CAP and also general psychiatry is engaged in all three of them. Dr. Jewgenij Salzman, M.D., former head of the CAP department in Riga, participated in a IACAPAP regional meeting in Budapest in 1992 as the representative from Latvia at that time. He has been the initiator to the contact between our departments, having visited the Malmö department a couple of times. The head of CAP in Latvia today is Dr. Aigars Kisuro, M.D.

We hope this project will last for two years if not longer. It is supported financially by the East European Committee, part of the Swedish National Board of Health and Welfare, with the intention to support first of all the development of psychiatry in these countries (besides the northwestern part of Russia as well), but also other disciplines. They promote study visits to Sweden, help to build up health care units in Latvia and, not least, support training situations, rather seminars and workshops than lectures.

So, during 1996 our intention is to visit the CAP department in Riga four times, each time for two days. A main

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theme is chosen every time, prepared from both sides with short contributions to the theme, case presentations, etc.

So far we have been discussing depressions in children and young people, the impact of violence and trauma on young people, conduct disorders and psychotic disorders (to come). Our intention is not to act like teachers but to visit them as colleagues, eager to discuss with the Latvian side how we assess, diagnose and treat these conditions here and there in order to learn from each other.

A side effect to these visits has been for the Latvians to meet, as this is a rather complicated situation for them under ordinary conditions. There are about 30 child psychiatrists in Latvia for a population of about 2.5 million people, out of them about a half million children up to the age of 14—still more up to the age of 18.

We have been in contact with the CAP department in Riga since 1994. Since then we have had six child psychiatrists for study visits in Malmö, two at a time for one full week, and will receive two clinical child psychologists in the autumn of 1996.

Within this project we also hope to provide technical equipment for teaching and training at the Mental Health Care Center in Riga. Also we have provided this Center and other CAP units in Latvia with modern textbooks in English and the participants in the project with copies of different articles.

Participating from our side is a child and adolescent psychiatrist and a social worker. Hopefully a child psychologist will enter the project as well—at least she will be very active with our guests to come. ■

THE RELATIONSHIP BETWEEN TEENAGER AND PARENTS

Joseph Cohen, Youth Editor

There is a belief that adolescents bitterly rebel, do not communicate, nor wish to communicate with their parents. This is unquestionably false. The supposed rebel lion of all teenagers is in fact a search for independence, a discovery of values, beliefs, and interests. Of course arguments are inevitable if a teenager passionately disagrees with his mentors and parents. But that is not a savage rebellion. It is all a part of the line of communication that is generally a constant in every adolescent's life. It is a misconception that all teenagers do not wish to speak to their parents and that youths hot-headedly rebel against their parents.

Although my parents and I do not see eye to eye, I still talk with them every night. I am still dependent on their advice and opinions. A relatively open parent-teenager relationship is helpful as both parties can express their opinions, desires, and aspirations. Every day, for instance, I speak about my nagging worries before I go to sleep. Invariably, we have a serious discussion about our day, and I tell them what is on my mind and ask for advice.

I think my experience is common. Of course, sometimes the teenager misleads or openly dislikes his or her parents. Sometimes the parent lives vicariously through the child or doesn't care what the child's emotions are. But adolescence is not usually a rebellion. Yes, some people have such a terrible relationship with their parents that it leaves permanent psychological damage. After all, much of America's youth live in poverty or unfortunate situations where the parent-child relationship is terribly stressed. However, this is the exception. Even if teenagers dislike their parents, most juveniles have workable relationship with them. Even in tense relationships, there is constant communication.

In fact, to see if a close parent-teenager relationship was the norm, I decided to do a survey of students at my high school, the Hopkins School in New Haven, Connecticut. As it is a small, co-educational private school, most of the students are in the middle or upper class.

Only a small minority come from poverty-stricken urban districts.

I asked everybody the same question: "Who would you go to first with a serious problem?" I found out that 33 students would go to a parent, 32 would go to a friend, four wouldn't go to anybody, three would go to a sibling, two would go to a priest and pray to God, one would go to a therapist, and one would drink beer.

Out of the 76 students I surveyed, the largest group of people said they would go to their parents first. Out of the 32 who said they would first go to a friend, about half of them said they would go talk to their parents after talking to a friend. Many talk to a friend first and then a parent, as one person said, "to make sure it doesn't offend their parents." The results obviously show that most people in the tenth, eleventh and twelfth grades (the grades I surveyed) respect their parents. One person went as far as to say, "my mother is my best friend." Perhaps more people would have said that they usually first talk to their parents if they were surveyed privately, away from their friends' peer pressure to say something different than they feel.

Of course my data is not representative of their adolescent population in America. However, in my opinion, this survey is evidence that adolescents don't really rebel against their parents. Although there are frequent disagreements between parent and child, it is not a matter of rebellion. It is a matter of teenagers earnestly trying to understand themselves. As John Keats once said, "The imagination of a boy is healthy, and the mature imagination of a man is healthy, but there is a space of life between, in which the soul is in a ferment, the character undecided, the way of life uncertain, the ambition thick-sighted: thence proceeds mawkishness." The mawkishness of adolescence causes teens to turn to the most obvious people in their lives, their parents. Until the adolescent becomes an adult and knows his full values, the parent in his life will still be a dominant figure.

Please write me any comments you have about my articles. If there is anything that you, your colleagues, or your children want to address, we can start the dialogue that is so vital to the dissemination of information for the international community. My e-mail address is JoeCo2@aol.com. ■

A PERSONAL VIEW OF IACAPAP

Henry H. Work, M.D.

Editors' Note: Each of us has valuable perspectives on IACAPAP. We welcome remarks of professionals who have a lifetime perspective of IACAPAP.

The listing, in your summer Newsletter, of the dates and Chairs of the quadrennial meetings, clarifies the period of my relation to the Association. It became a very significant meeting place and very personal in its effect and in my memories.

I learned about the group early in the fifties, probably from Reg. Lourie, and my first attendance was in Toronto. It was a brief encounter, but I was impressed with the members and their dedicated interests. It was unlike the American societies which I was joining at that time as I was shifting from Pediatrics to Child Psychiatry; it therefore served as a useful bridge.

By 1958 when the nascent Division of Child Psychiatry was emerging at UCLA, I took advantage of a stage in construction to visit Europe and the Lisbon meeting was the focus of that trip. The experience was unique, since the structure of the group was different from formats which I knew and the international setting required a new learning.

A paper on the teaching of psychiatry in pediatric settings was accepted, and it appeared that an almost identical paper had been offered by Loretta Bender. We met the night before the program, but, although I proposed a panel model, we both gave our papers and both were, as I recall, well received. However, that mode did lessen the learning experience and reinforced both the need and the difficulty of more interactive programs, even in a multilingual setting. This was to change.

It marked, however, new contacts with individuals doing similar work, especially in Western Europe. Ongoing correspondence with professionals in such teaching positions led to the planning of a sabbatical which began at the seaside in Schevenigen; followed by the establishment of a base in Zurich; and a peripatetic schedule including visits to the greats at both ends of Switzerland (with attendance at the Swiss Psychiatric Assn.); Munich and Vienna; a great pilgrimage down the Rhine from Basel to Homburg

and Marburg and Hamburg; and wonderful teaching experiences in Scandinavia and eventually Holland again and then Paris and London.

Such networking grew naturally out of the regular meetings and, by Edinburgh, we were ready for the English version and the friends there. It began more and more to fit into developments at home and in our own Academy. Although the Scotch/English groups produced an endearing meeting, there was Israel yet to come; fortunately, in time for another sabbatical! It was a meeting that made the meaning of work with children very real but also very responsibly demanding.

My final contact with this group was in Dublin, with a hearty warmth and a most mature program. Indeed, the maturation of the Association has been one of its valued aspects. It was always a more personal group but with an unusual nidus of control over program and membership, unlike many American groups. Yet it demanded participation and gained its academic value therefrom.

For me, the associations and friendships with individuals in similar teaching positions offered opportunities to learn methodology as well as content. Later Russian and Siberian visits were to be influenced by the European models. The contacts with pioneers from Leo Kanner, Bowlby, and Piaget to those peers who have now become both productive and famous, provided an unmatched framework for subsequent teaching and practice.

It was a valuable learning vehicle for an important part of my career path. It never became a haven to which I could "bond." ■

EDITORS' CORRECTION

The Jerusalem 2000 Congress will be held in full collaboration between the International Association of Child and Adolescent Psychiatry and Allied Professions, the International Society for Adolescent Psychiatry and The World Association for Infant Mental Health. This Millennial Congress to be held in Jerusalem, Israel, is intended to mark the beginning of the 21st Century by coordinated efforts by the above three organizations as well as others concerned about children's psychological development and health. ■

IDENTITY OF THE CHILD AND ADOLESCENT PSYCHIATRY SPECIALIST

Kari Schleimer, M.D.

Editor's Note: With vast changes in health care worldwide, the roles of child and adolescent psychiatrists are also different. We present an important article about child and adolescent psychiatrists in Sweden to continue our reviews of perspectives of child and adolescent psychiatry in different countries. This article presents views on professional role identity. We appreciate reader's comments on these issues, especially in specific countries.

Preamble

What I am going to say here has to do with my position as a child and adolescent psychiatrist in Sweden. So, it's a description of the situation there—and I hope I'm not offending anybody who might feel differently. I am one of six directors of studies supervising the postgraduate training programme for residents in CAP, thus being in charge of the southern region of Sweden with responsibility for about 12 residents at different departments and clinics. This group of directors is constantly reviewing and discussing issues of teaching and training, preparing log-book and examination besides inspecting departments and clinics to achieve everyone's understanding for standards and quality assurance for the situation for the trainees, who should get all help according to the Swedish description of aims and objectives for their training programme. The six of us are elected by the Swedish Association for Child and Adolescent Psychiatry. I am one of two Swedish representatives at the UEMS (Union Européenne des Médecins Spécialistes).

At a UEMS meeting in Vienna in autumn 1994, I presented a paper on the Swedish postgraduate training programme in child and adolescent psychiatry (CAP). I mentioned the aims at achievement not only of knowledge and skills but also of attitudes. Obviously this

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factor of "achievement of attitudes" and "identity" of a CAP specialist is not generally included in the description of CAP residence programmes in other European countries.

The Swedish description of aims and objectives for the residence programme in CAP, launched January 1st 1992 and revised 1995, states that concerning attitudes, special demands are made upon the CAP specialist both regarding ability of communication and ethical awareness. The most important single instrument of examination in the psychiatric inquiry is the personal interview. Therefore the resident should develop an ability of positive relationship and communication with both children and adolescents of different ages and with their parents in all situations. The ability of establishing an open and trustful contact with both patients and staff members may to some extent be learned theoretically but will above all have to be achieved through practical training under supervision by an experienced specialist of CAP. When practically assessing children, adolescents and their families, the psychological reactions of the examiner on the patient are of utmost value of information—provided one condition: good self-awareness. To accomplish this, the resident should get deeper knowledge of his own personal psychology from psychotherapy or in any other comparable way with focus on "professional self" and "private self" with emphasis on the former.

Daily collaboration with behavioural scientists such as psychologists, pedagogues and social workers necessitates knowledge and attentiveness for understanding scientific as well as hermeneutic theories.

What then is this hard-to-understand something, making us a good child and adolescent psychiatrist with basic trust and confident identity? What separates us from any very technical, skillful surgeon, clinical pathologist, any other colleague within quite a different medical speciality? This something has to do with respect and patience, emphatic feeling and humility, even fantasy, not to speak of the ability to relate with and retain relationships with children and their parents, an ability to

establish an open and trustful contact that holds even when it's rather windy. We may end up in situations where reliance on us may easily get lost since we have to be the advocate of our patient.

I am prepared to claim the child psychiatrist, besides being skilled, will have to be—or rather should be—a mature, mentally well balanced person with life experience and so much self-confidence and self-knowledge, that he can manage his own life problems without transferring them onto his patient. He should know and be convinced that personal problems cannot be solved by working with patients who ask for help. Fantasy and empathy will support him to treat his patients openly and honestly to establish trust—without handing out his own life situation to confirm his own capability. On the other hand, may he profit from personal life experience—it supports emphatic feeling!

The resident of CAP should have a personal tutor for professional guidance to achieve identity. The tutor, in turn, should have been trained for this function for really knowing what tutoring is about. The resident should meet his tutor on a regular basis once a week. Thus he can be helped to work with main questions of attitudes and identity by recalling situations in daily practice.

Quite often, we, as child psychiatrists, are met with suspicion from colleagues in the somatic field. If this may be due to the unease people generally feel about mentally ill children, or if this may be due to the often muddled, diffuse, unserious image we here and there may present because of our consciousness of secrecy and out of consideration for others involved—I don't know. To my opinion, the main reason for this suspicion can be found in our showing an indistinct, insecure identity out of fear to fail, not daring to act as a psychiatrist, a medical professional, denying our basic knowledge and skills, maybe to please and not to provoke other professionals in the CAP team? This may sound silly—but remember my Swedish background! We have had situations like this, especially in the 70s and 80s, maybe even today! Identity for a child psychiatrist means to have the courage to stand for and take responsibility for this knowledge and skills in the middle of the

team, which not always is an easy thing to do. However, since we all want to assess a child from different viewpoints—the biological, the psychological, and the psychosocial—we as CAP specialists really will be needed in the CAP team. If we do not assume responsibility for our identity as a medical professional, we will have no proper function within the multidisciplinary team in child psychiatry. However, with proper identity, we will be respected and may also work as psychotherapists, most likely with better self-assurance.

The work we carry out with our patients is asked for by their parents, who give us the mandate to do something for their children. Therefore, we will have to help parents as well with leaving aspects of morals causing their children's problems and diverting their feelings of guilt. How then could we do this without a professional identity? With a confident identity, we can help the whole family to proceed in a better way with our understanding and emphatic feeling.

In teamwork, the child psychiatrist, collaborating with psychologists, social workers and other professional groups, will often be the one person to summarize aspects and assessments from different points of view, which implies empathy and understanding also for these other team professionals. The importance of knowing their working methods and respecting their professional identity should not be forgotten.

The identity of the prospective child psychiatry specialist should be developed early in his postgraduate training, before turning to complementary departments for training in general psychiatry, paediatrics and maybe in other fields. He should have at least some germ of identity when temporarily leaving his home institution and be able to stand for child psychiatry values and be respected for this.

Rarely a resident of CAP shows no ability whatsoever to attain the right attitude to and identity in his profession despite efforts of his tutor or supervisor, helping and supporting him. In that case, the resident should be advised to look for some other medical field to work in, where he could find a better identity as a physician. Thus life-long suffering as well for him as well as unpleasantness for his patients maybe can be avoided. ■

INCREASING SCIENTIFIC PUBLICATION AROUND THE WORLD

John F. McDermott, Jr., M.D.

Editor, *Journal of the American Academy of Child & Adolescent Psychiatry*

Editor's Note: This is another article from Journal Editors we hope will highlight the importance of scientific publications and encourage scientific activity internationally.

There is good news and bad news about the international knowledge base in our field. First the good news. Important epidemiologic studies are like blinking lights around the globe. The prevalence and characteristics of conditions such as ADHD are being tracked in Europe and North America. But here's the bad news. There are big holes in that global network. Little or nothing from Africa or Asia, eastern Europe or the former Soviet republics. Thus, while the picture is becoming clear in parts of the world, important pieces describing much of the world's young population are missing. Why such gaps?

For one thing, the world of scientific publishing is uneven. The two major journals that are international in scope are located in the West. Of those, only one, the *Journal of the American Academy of Child and Adolescent Psychiatry*, better known as the Orange Journal, is published monthly. That Journal's job is to describe the moving front of new research in our field to advance theory, research, and clinical practice in child and adolescent psychiatry. It welcomes manuscripts from a variety of viewpoints, not only epidemiological, but genetic, neurobiological, cognitive, behavioral, and psychodynamic. Current major priorities include studies of the diagnostic reliability and validity of DSM-IV, and the efficacy of the psychotherapeutic and psychopharmacologic treatments. And there lies part of the problem—the lack of an integrated global network of diagnostic and treatment studies that can be compared and contrasted.

No question. Scientific journals have changed so much in the past few years that it's harder and harder to get data published in them. Research has moved from a narrative description of clinical experience, "First I saw this or that, then I did this or that," to databased studies. There is a clear trend toward increasingly sophisticated research designs. The reason is obvious. You can draw more solid conclusions from a single controlled clinical trial than you can from any number of case reports. Case reports often mistakenly imply that a cause-and-effect relationship exists between an intervention and an outcome without considering that they may be chance findings. They just don't present a realistic picture of the way things are beyond that single case. In other words, they aren't generalizable because the conditions aren't standardized.

Yet manuscripts submitted from developing countries may be written in the older narrative style that lacks the organization and structure of modern scientific articles. They may not state the question to be tested, or they may report descriptive data without statistical tests of how likely their hypotheses are to be true. Simply using last year's hospital and clinic admission rates to predict patterns in the general population is about as accurate as trying to predict weather around the world from our own weather at home. Journal review of these manuscripts will identify specific limitations in the collection, organization, and presentation of data for the author. They may even help spell out the hidden hypotheses and how to test them. But negative reviews can be more discouraging than encouraging to authors, especially if the technical knowledge that's needed to reverse that trend isn't available at home. So instead of revising or redoing a flawed study, investigators may choose to publish their work in non-peer reviewed local publications to be left unindexed and uncited in the world scientific literature for the international audience to see.

On the other hand, there is a mythology that exaggerates the problem even further. One myth is that publications in the major international scientific journals are all based on an experimental research design. While experimental

design may be a stronger one than others, the ex-post facto or retrospective design, more common in clinical work, is quite respectable. Actually, there are ways to translate everyday clinical experience into research designs. One place to start is the more powerful methods for studying individual cases. For example, the so-called single case design (AB AB) is one in which an intervention is alternately administered and withdrawn over a period of time so the response of the subject can be systematically monitored. It is the state-of-the-art model for case reporting. And it is a readily available research design in the clinic or hospital setting in which psychiatrists do their work. Of course, the truth is that you do need access to state-of-the-art research methodology and data analysis, but there are ways to bridge this gulf. Training is one. Using consultants is another.

So much for the myths. What's the reality? The reality is that we desperately need a worldwide database for the epidemiological and clinical spectrum, so that consider cultural similarities and differences in the prevalence and incidence, prevention and treatment of psychiatric disorder. Furthermore, countries everywhere, industrialized or non-industrialized, have the same concerns about problems among their youth. Problems that reflect psychiatric disorders of hyperactivity and attention, learning disabilities, major depression and suicide, alcohol and drug abuse, physical and sexual abuse. And that presents an even more serious problem than the incomplete global knowledge base I've described. Developing countries cannot begin to address their own needs without systematic data collection. The first step is planning a national program for the prevention and treatment of mental illness to describe the population at large and the disorders found in it. And that first step has yet to be taken in many parts of the world. We hope that young investigators of the future are listening. ■

X CONGRESSO LATINO AMERICANO DE PSIQUIATRIA DA INFANCIA E DA ADOLESCÊNCIA

and the Foundation of the new

Latin-American Federation of Child,
Adolescent, and Family Psychiatry and
Allied Professions

Federacion Latino-Americano de
Psiquitria da Infância, Adolescencia,
Familia, y Profesionales Afines—FLAPIA

J. Gerald Young, M.D.

Editor, IACAPAP Monograph Series

After years of preparatory work, a committee and the Assembly established the Latin-American Federation of Child, Adolescent, and Family Psychiatry and Allied Professions during the X Congresso Latino Americano de Psiquiatria da Infância e da Adolescência in Curitiba, Brazil, April 20–22, 1995.

The Congress was very well attended, with a large audience from Brazil and representatives from most other Latin American countries. The participants were from many clinical professions and the topics of the presentations were varied. The Congress was organized by Dra. Amélia Thereza de Moura Vasconcellos, President, and her Organizing Committee. Their extensive preparations made the Congress very comfortable and well organized, and the scientific sessions were both at a high level and very practical for clinicians attending them. The International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP) was formally represented by J. Gerald Young, M.D., Editor of the IACAPAP Monograph Series, as well as by Salvador Celia, M.D., IACAPAP Counselor from Brazil, and Miguel Cherro-Aguerre, M.D., IACAPAP Assistant Secretary-General from Uruguay.

The most notable achievement of the Congress was the foundation of the new Latin-American Federation of Child, Adolescent, and Family Psychiatry and Allied Professions.

The Federation has been the subject of considerable discussion and planning over many years, so it was a significant accomplishment when the Curitiba committee gathered together these different groups of associations and individuals. The Constitution of the new Federation will be the beginning of an organized effort to better know the most imperative problems affecting the child, the adolescent, and their families, enabling Federation members to find and work with the resources necessary for their improvement. There are not associations for child and adolescent psychiatry in every Latin American country, and it is anticipated that the existence of a Federation will facilitate the creation of the new associations needed in these countries.

Many years ago, in 1955, the President of the new Federation, Professor Luis Prego-Silva, coordinated the first "Seminario Latino Americano de Higiene Mental Infantil" as a consultant to the O.M.S. He was concerned about the helpless, neglected Latin American population needing conscientious health care professionals and government administrators. Over the subsequent forty years, Professor Prego-Silva pursued these aims in the face of many challenges, and views the creation of the Federation as the basis for developing practical, effective working plans to help Latin American families.

The meetings of the special Committee responsible for establishing the new Federation were a model of democratic process combined with the firm hand of the President when it was clear that final decisions had to be made or they would have to wait for completion of the process at the next Congress. Dra. Amélia Thereza de Moura Vasconcellos prevailed, with a mix of good humor and determination, and officers of the new Federation were elected. The officers will meet periodically in preparation for the next Congress and to continue the preparation of the Constitution of the new Federation.

A partial list of the members of the Board/Executive Committee of the Latin-American Federation (FLAPIA) who were elected in the Assembly is as follows:

Chairman/President

Prof. Dr. Luis E. Prego-Silva
Montevideo, Uruguay

1st Vice President

Dra. Amélia Thereza de Moura

Vasconcellos

São Paulo, Brazil

2nd Vice President

Dr. Guillermo Carvajal Corzo
Bogotá, Columbia

3rd Vice President

Dr. José A. Arias
Asunción, Paraguay

Secretary-General

Dr. Arturo P. Grau Martinez
Santiago de Chile, Chile

2nd Secretary

Dr. Marcos Gheiler
Lima, Peru

3rd Secretary

Dra. Berta Benitez de Nale
Rosario, Argentina

Treasurer

Dra. Olga Garcia Falceto
Porto Alegre, Brazil

Assistant Treasurer

Dr. Alberto Weigle
Montevideo, Uruguay

Fiscal Counselors/Financial Administrators

Dr. Miguel Cherro Aguerre
Montevideo, Uruguay

Dr. Roberto Fernández Labriola
Bueno Aires, Argentina

Dr. Mauricio Knobel
Campinas, São Paulo, Brazil

Members

Dr. Julio Aray

Caracas, Venezuela

Dra. Georgina Fariñas

Havana, Cuba

Dra. Esperanza Pérez de Plá

Mexico City, Mexico

Professor Prego-Silva is a former Vice President of IACAPAP, and well familiar with international concerns and activities on behalf of children. Many of the members and new officers of the Latin-American Federation are active internationally, and it can be anticipated that a united voice from Latin America will help bring attention to the needs of her children and make others aware of clinical and research advances in these countries.

Latin American countries from Mexico and the Caribbean basin to Argentina and Chile are represented in the Federation. The discussions by the organizing assembly for the new Federation were quite similar in tone to

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those in other regions of the world in recent years. Planning for the Constitution concerning the nature of the committees to be established, the officers, and other matters were managed with relatively little disagreement. However, more difficulties arose when discussing other matters. As encountered in other cross-national organizations, these controversies largely focused on the best methods for representation and voting. Should this be a Federation of individuals, or of countries? If of associations in each country, how should the association(s) representing each country be selected? Is it possible that an organization of associations could inadvertently aid in the persecution of individuals in a country? If there is no association in a country, should individuals be selected to represent the country for a specified period of time? How many associations or individuals should represent each country? How are excluded associations to be dealt with? Should each country have one vote or more than one? Should all countries have the same number of votes, regardless of population size? These open, rich discussions provided a good foundation for the Federation in future years.

Further international congresses are planned in Brazil and Chile in 1997. An International Symposium will be held in Canela, Brazil, in May, 1997. It is being organized by Dr. Salvador Célia of Porto Alegre, Brazil, a former IACAPAP Vice President who is now a IACAPAP Counselor. The International Symposium is co-sponsored as a regional meeting by the International Association for Child and Adolescent Psychiatry and Allied Professions, the World Association for Infant Mental Health, and the International Society for Adolescent Psychiatry. The theme of the International Symposium has not yet been determined.

The XI Congress of Latin-American Child and Adolescent Psychiatry will be held in Santiago, Chile, on September 15, 16, and 17, 1997. It will also be co-sponsored as a regional meeting by IACAPAP, the World Association for Infant Mental Health, and the International Society for Adolescent Psychiatry. Dr. Arturo Grau Martinez of Santiago will be President of the Congress and will chair the Organizing Committee. The theme of the XI Congress will be "The Changing Future." ■

ASIAN SOCIETY FOR CHILD AND ADOLESCENT PSYCHIATRY AND ALLIED PROFESSIONS (ASCAPAP)

Kosuke Yamazaki, M.D., Ph.D.

Amidst the rapid change affecting society, economy, and the political situation in the Asian countries in recent years, the issues relative to child mental health are increasing in gravity, calling for rapid institution of effective countermeasures. However, the only Asian nations listed as Full Members in IACAPAP are Japan, Korea, and India. The others still remain in the realm of Associate Members. Given this situation, the networking of specialists in child and adolescent psychiatry and the allied professions in the Asian region has been a matter of top priority for some time.

In July, 1990, the 12th International Congress of IACAPAP was held for the first time in Asia, at Kyoto International Hall. Refugees, street children, homeless people, drug abuse, child abuse, organ transplants, artificial insemination, women joining the work force, reduction in number of siblings; i.e., not only mental disabilities, but issues of social psychology, politics, and economics as they affect children were widely discussed.

Approximately 1,400 participants from 41 nations gathered together for the meeting at which 624 papers were presented. During the Kyoto International Congress, which ended in great success, requests for the creation of an Asian Association was brought up by many, and we promised to delve into the possibility. The wish was simple—to discuss together the status quo of child mental health, keeping in sight the traditions, cultures, economies, and politics of Asia. Following the Kyoto Congress, we received many letters of thanks from all over the world. But from our colleagues in Asia, many of the letters also voiced strong requests for an Asian Society.

Using the "International Exchange Fund" of the "Japanese Society for Child and Adolescent Psychiatry and Allied Professions," established in commemoration of the success of the Kyoto Congress,

we have been deepening exchange through inviting one to two researchers from Asia each year to our annual local congress. Thus, we have been consulting with Prof. K. E. Michael Hong of Korea, Prof. Chen-chin Hsu of Taiwan, Prof. Tao Kuo-Tai of China, and Prof. Felice Lieh Mak (current President of the World Psychiatric Association) at every opportunity. And in August, 1993, when these personages once again were in Japan for the World Federation of Mental Health (WFMH) meeting held at the Makuhari Messe, our Japanese colleagues involved in setting up the Asian Society met with them again in the company of Dr. Natotaka Shinfuku of the WHO (currently Professor of Kobe University) to map out the finer points. The discussions led to the decision to establish the Asian Society for Child and Adolescent Psychiatry and Allied Professions (ASCAPAP), with the first Congress to be held in Japan. We then actively sought out Prof. Sze Tai Wong of Singapore, who had already initiated activities in the Asian region as the ASEAN Forum, and met with him in July, 1994, for final adjustments on the composition of the organization, and actual dates of the congress.

It was through such processes that we moved to establish an Asian Society for promotion of academic exchange and mutual understanding between the specialists in child and adolescent psychiatry and allied professions in the Asian nations, to evaluate what we can do, and must do, for the future of children in Asia. Given that the region is home to the greatest percentage of children in the world, and that the nations harbor various social, economical, and political issues, it was the wish of researchers residing in this sector to create a forum in which we could come together for open discussion on the various problems we are facing.

Most fortunately, the inaugural congress, held April 18–19, 1996, at the Toranomon Pastrale in Tokyo, was blessed with the attendance of 317 participants from 16 nations including: Australia, Hong Kong, India, Indonesia, Korea, Macao, China, Pakistan, Papua New Guinea, Philippines, Singapore, Solomon Islands, Taiwan, U.S.A., Thailand, and

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Japan. The program was brought to a most successful conclusion with 105 oral presentations, 27 posters, and special lectures by Prof. Donald J. Cohen (President, IACAPAP), Prof. Felice Lieh Mak (President, WPA), Prof. Masahisa Nishizono (Chairman, Organizing Committee), and Ms. Chikako Saito (United Nations High Commissioner for Refugees Branch Office, Japan).

In the General Assembly, the Constitution was ratified, and the Board of Directors elected to office, as follows:

ASCAPAP Executive Committee

President

Masahisa Nishizono, Japan

President Elect

Kang E. Michael Hong, Korea

Secretary General

Kosuke Yamazaki, Japan

Treasurer

Wei-Tsuen Soong, Taiwan

Vice Presidents

Felice Lieh Mak, Hong Kong

Kiyoshi Ogura, Japan

Kuo-Tai Tao, China

Sze Tai Wong, Singapore

Committee Members

Cornelio Banaag, Philippines

Savita Malhotra, India

Yoshibumi Nakane, Japan

Zhang Shi Ji, China

Khalida Tareen, Pakistan

Soemamo Wignyosumarto,

Indonesia

Peter Kim, Korea

Associate Secretaries

Taizo Sato, Japan

Sadaaki Shirataki, Japan

Soo-Churl Cho, Korea

Chiao-Chicy Chen, Taiwan

The Second Congress of the ASCAPAP will be held in Seoul, Korea, in the spring of 1999. We extend our warm invitation to all those interested in ASCAPAP to participate in our Second Congress, which promises to be a most exciting and valuable meeting at the close of this century. And for those of you interested in joining ASCAPAP as a member, please contact the Secretary-General, Kosuke Yamazaki. ■

PREVENTION OF SUICIDE AMONG YOUNG PEOPLE IN THE NORDIC COUNTRIES

Danuta Wasserman, M.D.

The Nordic countries (Finland, Sweden, Norway and Denmark) have approximately 23 million inhabitants, of whom slightly more than three are aged 15–24.

In this age group, some 600 suicides occur annually. Of these juvenile suicides, 475 are boys/young men and 125 are girls/young women. The total represents over one-tenth of all suicides committed each year in the Nordic area.

In addition to the above, there are approximately another 150 cases a year that are classified as “undetermined suicides,” i.e., where it is unclear whether the deaths are accidental or self-inflicted. Age-specific suicide rates are presented in Figures 1–3.

Suicidal acts on the part of children and young people are perceived as more shocking than those involving adults, since in our culture, there is a wish to see children as happy individuals. There appears to be a tendency for people in the young person's proximity not to (wish to) perceive the problem, and thus not to react to his or her actual signals. Opportunities of obtaining professional help in time before a suicidal act are therefore often impeded or missed.

Primary and secondary prevention

In the Nordic countries, efforts to date have mainly concentrated on measures of secondary prevention focused on individuals, i.e., early diagnosis, treatment and rehabilitation of suicidal young people.

In population-oriented programs of primary prevention, i.e., measures initiated before illness is detected, the main emphasis until now has been on prevention of road and other accidents. One example is the extensive campaign in Sweden to advocate free car seats for infants up to the age of one year.

In this perspective, it is hard to understand why society allows so many young people to die from suicide without devoting corresponding resources to an attempt to reduce their number. Preventive measures should be employed

early, and it is important to see health problems in a lifelong perspective.

In the national program for suicide prevention drawn up by three of the four Nordic countries, the problems of youth have been given particular attention.

Norwegian national program for suicide prevention

One reason why the initiative for the program was taken—by Professor Nila Retterstol, who had long been a driving force in international work of suicide prevention—was that suicide among young people in Norway was increasing sharply. Professor Oivind Ekeberg, assisted by a reference group, was the author of the program.

The importance of enhancing school-children's social skills and capacity to solve conflicts and problems in ordinary life situations is stressed in the program. Several measures are proposed, of which the most interesting are theme instruction relating to personality development, communication and life crises, on such topics as bullying, low self-esteem, acceptance/rejection by others and substance abuse. In the Norwegian program, the decision was taken not to treat problems of suicide as a separate theme but, rather, to discuss these problems when they are brought to the fore by schoolchildren themselves. The theoretical model used in devising means of intervention when there is a danger of suicide, and also treatment and care after suicide attempts, is based on the crisis perspective. This model also underlines the importance of cooperation with parents.

Finnish national program for suicide prevention

The requisites of suicide research and the basis of the national program were created as early as the 1970s, thanks to active research cooperation with Professor Norman Farberow from the Suicide Prevention Center in Los Angeles. In 1987, retrospective investigations of all 1,397 suicides which took place in the course of one year were carried out in Finland. The survey was headed by Professor Jouko Lönnqvist, and the findings yielded several doctoral theses and were published in several international

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and national journals. On the basis of this ambitious research program, an action strategy, of which a special section is devoted to young people, has been drawn up.

Action in the Finnish program relating to young people

Recommendations for action are described under specific headings, and in the margin beside each heading are noted the institutions that should primarily become involved, or which are involved, in the work of suicide prevention. There are also a number of action proposals under each heading. Examples of recommended action described under specific headings are as follows:

- The backgrounds of youngsters who have attempted suicide need to be thoroughly investigated and the necessary support and treatment arranged for them.
- Every sign of self-destructive behavior in young people should be taken seriously, and attempts made to reduce the number of contributing factors and to alleviate their effects.
- A youngster's mental ill health needs to be recognized at an early stage and interpreted correctly.
- In cases of family crisis or chronic problems, special support is to be arranged for children and youngsters.
- Children and youngsters need more support in gaining control over their lives, strengthening their self-esteem and coping with their problems.
- Public discussion of military conscription and the civilian service option is needed in relation to their influence in helping young men discipline their lives and improve their ability to cope with stress.
- Basic material security for young families and individuals about to become independent has to be understood as a fundamental factor for preventing serious problems and suicide.
- The integration of young people into working life in appropriate ways needs to be secured through legislation.

The interesting aspect of the program is that all its measures are to be developed locally and regionally but in nationwide cooperation with central public authorities. These central authorities are responsible for defining general objectives, providing inspiration and compiling information compendia and databases.

Senior Inspector Maila Upanne of the National Agency for Welfare and Health has been the secretary of the expert group and now has primary responsibility for the execution of the program. In cooperation with a working group, she is now supporting the local projects and is engaged in evaluation of the effects of suicide-prevention projects.

Swedish national program for suicide prevention

In Sweden, suicide is now the foremost cause of death among boys and young men aged 15–24, having overtaken deaths from road accidents.

The Swedish national program for suicide prevention commenced its work in 1993, when a National Council for Suicide Prevention was formed with the task of creating a Swedish program. The General Directors of the National Board of Health and Welfare and the National Institute of Public Health are the chairmen of the National Council, which includes representatives of the Swedish Church (the Archbishop), the Health Care Board of the Swedish Defense Forces, the National Police Board, the Federation of Country Councils, the Swedish Association of Local Authorities and the Swedish Psychiatric Association. A leading medical journalist is also linked to the group.

At the time of writing, work on the national program is in progress and is expected to be completed in 1995.

The Norwegian and Finnish programs of suicide prevention considerably encouraged the start of work of the Swedish program.

Prevention of suicidal actions among children and young people has been adopted as one of the primary targets of the Swedish program for suicide prevention. This concentrates on the fact that children and young people need to learn to solve conflicts and crises while they grow up, and also to recognize suicidal signals both in themselves and in their

friends. Schools will play an important part in this work.

To implement, encourage and evaluate the national suicide prevention program, the following authorities and institutions will bear general responsibility: the National Board of Health and Welfare, the National Institute of Public Health, and the National Centre for Suicide Research and Prevention at the National Institute for Psychosocial Factors and Health, Karolinska Institute, in Stockholm. The Centre was set up following the Swedish parliament's decision to meet the national need of knowledge development in the field of suicide prevention. This national centre is integrated with the Stockholm County Council's Centre for Suicide Research and Prevention at Karolinska Hospital, which has been operating since 1 January 1993.

The idea is that the program work and all the measures should be developed locally, and that the central authorities' role should be that of providing inspiration and taking the initiative.

The National Centre for Suicide Research and Prevention is responsible for interdisciplinary research and developing suicide prevention methods and evaluating the effects of suicide prevention.

One example of a project relating to young people conducted at the Centre is a pilot project in an upper secondary school in Stockholm to devise a method that can be used for entire school classes by school nurses, psychologists and social workers in order to:

- give the students knowledge of medical and psychosocial problems and of proposals for solution
- provide information on various treatment methods and where specialist help is available
- impart hope that personal problems can be solved
- help young people to help themselves
- boost their sense of fellowship and capacity to support one another
- enhance the social network for students with problems

This project, which is an instance of preventive mental health care, also includes sections on depressions, suicidal crises,

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attitudes towards suicide prevention, identification of suicidal thoughts and suicide attempts, and also instruction on where to turn for help and how to deal with suicidal thoughts.

The educational program includes discussion of the fact that it need not be worrying for a teenager to sometimes ponder about suicide. In youth, in particular, it is natural to think about the meaning of life, and in that context, about death and sometimes suicide. Thoughts of suicide may, however, become persistent and serve as warning signals of a life situation perceived as hopeless, and of severe depression. It is essential to learn to distinguish between serious thoughts of suicide and those thoughts that may be a normal part of the development process. Since young people primarily address their ideas about suicide to their peers, school is an important forum for disseminating knowledge of these issues. School welfare services can perform a vital function by conveying knowledge

and information about suicide, thereby attempting to make it a less taboo topic of discussion, and teaching pupils how to obtain help if they need it.

Preliminary results from the above-mentioned "Preventive Mental Health Care" project show that one can, within the framework of school work, talk to school-children about difficult life issues and crises. Pupils at the above-mentioned upper secondary school showed (1) highly positive attitudes towards the scope for preventing suicide, and (2) increased knowledge of risk situations and risk groups, and also of how to interpret suicidal signals.

This suicide preventive method will be assessed for another few years before a model—which, it is hoped, will be used in more Swedish schools—is presented.

Danish work in suicide prevention

As yet, there is no national program for suicide prevention in Denmark. However, highly intensive suicide research and efforts to prevent suicide are under way at the Unit for Suicide Research in Odense under university lecturer Unni Bille-Brahe. The

Odense unit has an important role for both the current WHO multicentre project and the EU project on parasuicide, in which youth issues are underlined.

The Odense unit is also to host a Nordic symposium that is being held from 25 to 29 April 1995, at Frederik VI's Kro in Odense, concerning prevention of suicidal actions among children and young adults.

Summary

At present, intensive work on programs for suicide prevention is in progress at national level in three of the four Nordic countries (Norway, Finland and Sweden). Youth issues are being given high priority in all three countries. The national suicide prevention programs, combined with the WHO's and UN's commitment to combating suicide globally, make a sound basis for the political and administrative initiatives that are needed. Only these initiatives can make available the requisite resources that will permit success in this important—and hitherto neglected—area. ■

CONGRESSES REPORTS

Editor's Note: You are invited to use this column to report on congresses, symposia, and conferences, either local, regional or international, of relevant interest for Child and Adolescent Mental Health Professionals.

THIRD INTERNATIONAL CONGRESS

"Psychological Effects of Abortion"
Rome, February 8–9, 1996

Jocelyn Y. Hattab, M.D.

Organized by Italian Pro Life Movement in collaboration with The Psychoanalytic Institute for Social Research of Rome and The Obstetrical and Gynecology Institute of the Catholic University of Rome. Attended by some 200 participants, mental health professionals, gynecologists, obstetricians, and priests, this Congress was

unsurprisingly against abortion. Papers presented were of two sorts. Most were clinical reports, psychotherapeutic reports, and theoretical elaborations on the topic. The others were scientific research presentations. Some presented convincing data proving the so-called "Post Abortion Stress Disorder" and others, no less convincing, of the inexistence of this syndrome. Professor Rue, from New Hampshire, reported on research among American and Russian women who overcame induced abortion. The Americans seemed to be more psychologically influenced and suffered more than their Russian mates. Philip Ney, from Vancouver, established a clear relation between abortion and child abuse in the same family. Dr. North, from St. Louis, was the only one who brought, quite courageously, statistics against negative psychological effects—even positive short- and long-term effects of abortion.

We were invited to present clinical and theoretical material on children's psychic reactions to history of abortions in the family. ■

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

Sixth World Congress
Tampere, Finland — July 25–28, 1996

Peter de Chateau, Chair
Antoine Guedeney, Co-Chair

This is the first WAIMH World Congress with a more specific theme: Early Intervention and Infant Research: Evaluating Outcomes. We are happy to have received over 500 submissions, more than any other WAIMH Congress so far. They came from all over the world; many from Northern Europe and from France. We are especially glad for the many joint international contributions coming from all five continents.

In designing the program, we tried to follow the special themes of each day:

- Thursday: Theories of Early Intervention
- Friday: Techniques of Early Intervention in Different Situations
- Saturday: Evaluating and Follow-up of Early Intervention
- Sunday: How to Learn and Teach Early Intervention ■

ESCAP EUROPEAN SOCIETY FOR CHILD AND ADOLESCENT PSYCHIATRY

European Child Psychiatry Research
Invitational Meeting
September 5-7, 1996

This biannual meeting was devoted to the themes, "Therapy Evaluation and Quality Control in Child and Adolescent Psychiatry" and was attended by approximately 40 colleagues from different European countries. The papers, as well as the discussion, covered a wide range of interesting aspects including therapy evaluation in inpatient and outpatient facilities, evaluation of medical treatment, quality management in a child psychiatric hospital, general principles of evaluation of psychotherapeutic methods and methodological problems. At this meeting, the decision was made to establish ESCAP research seminars for young researchers in different European countries over the next years. ■

ESCAP EUROPEAN SOCIETY FOR CHILD AND ADOLESCENT PSYCHIATRY

10th International Congress
Utrecht, Netherlands
September 17-20, 1995

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

The 10th International Congress of ESCAP was chaired by Prof. Herman van Engeland, President of ESCAP.

The congress had a very international character, as about 800 participants from nearly all the European and many extra-European countries, e.g., USA, Canada, Japan, Australia, attended the meeting. This led to an intensive exchange of information— not only on the scientific level, but also with regard to practice problems, the situation of medical service supply in different countries, training problems, and

cooperation with neighbor disciplines. All in all, it was a congress of superlatives with lectures of high quality, seminars, workshops, poster sessions, an outstanding organization without any visible mishaps, a really harmonious atmosphere, and a diversified social program with a lot of occasions for informal talks between colleagues of many countries.

The congress was opened with a short talk by the ESCAP president, Herman van Engeland, who pointed out the European idea and especially the standardization of postgraduate training programs in the growing Europe. The official opening was made by the Minister of Health of the Netherlands, Mrs. E. Borst-Eilers, who is a physician with many years of experience in the management of a large hospital. She stressed the importance of child and adolescent psychiatry for the mental health of children and reported several initiatives of Dutch child and adolescent psychiatrists with regard to mental health of school children and epidemiological studies.

The scientific opening talks were given by H. Remschmidt, Germany, and P. Jeammet, France, and were dedicated to the themes, "New perspectives in child and adolescent psychiatric research," and "Perspectives in developmental psychopathology." The lectures complemented each other very well insofar as the first speaker reviewed empirical research trends and their possible future perspectives, whereas the second one dealt rather with the theoretical basis and patterns of psychopathology.

The first day of the congress was dedicated to a variety of topics, out of which the symposia on autism and related disorders, on the long-term development of children at risk, on self-injurious behavior and on the significance of new imaging techniques for child and adolescent psychiatry shall be mentioned. The day ended with two outstanding plenary lectures on familial transmission of anxiety states (van Ijzendoorn, Netherlands) and on the implication of genetic findings for child and adolescent psychiatry (Sir M. Rutter, England). Whereas van Ijzendoorn pointed out possible interactions between constitutional and environmental factors in the "transmission of anxiety states," Rutter focused on the central issues of

genetic research without mentioning the "disposition-environment dichotomy." According to him, this dichotomy concept is long overcome, because on the one hand, no clear distinction is possible between constitutional and environmental factors, and what is more, there is a complementary effect, and because, on the other hand, constitutional factors might be responsible for the choice of a certain environment.

Extensive poster sessions concluded the first day, offering a lot of opportunities for discussion and exchange of experiences.

The second day of the congress started with some well attended and scientifically excellent lectures about "Longitudinal and follow-up studies," "Gilles de la Tourette's syndrome," "Suicidal behavior," "Borderline disorders," "Autism and affective disorders," and ended with a very distinct and problem-oriented plenary talk of the well-known Dutch psychophysiological M. N. Verbaten on "Psychophysiology in child and adolescent psychiatry."

After the General Assembly of the European Society for Child and Adolescent Psychiatry with the election of a new Executive Board, a historical evening was arranged in Zeist Castle that impressed all participants by the singular atmosphere of the 18th century combined with old and modern music.

The third day of the congress dealt with the following issues: eating disorders, psychopharmacotherapy in child and adolescent psychiatry, the impact of traumatic events, infant psychiatry, behavioral genetics, learning disabilities and developmental psychopathology, and early onset of schizophrenic disorders. During the whole congress, daily poster sessions were scheduled.

The congress ended with two outstanding plenary lectures: Prof. Philip Graham, England, the outgoing Past President of ESCAP, spoke on "Alcohol and the young" and the Past President of ESCAP, Hermann van Engeland (Netherlands) spoke on "Brain and behavior in child psychiatry: 'Where do we go?'" Whereas Philip Graham discussed epidemiological facts and figures of adolescent alcoholism, possible genetic and

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psychosocial causes, factors, and measures of prevention and treatment, Hermann van Engeland, starting from new findings in electrophysiology and neuro-imaging techniques, gave an outline for a possible way for future behavioral research in child and adolescent psychiatry, based on neuroscience. He pointed out that there are, indeed, enormous possibilities for new findings, but was reticent about their implications for therapy, due to the fact that the step from the correlation between brain physiology and behavior patterns to a development of effective therapy methods is naturally a huge one.

Finally, the newly elected President of ESCAP, Prof. Helmut Remschmidt, Germany, thanked Past President Hermann van Engeland and his co-workers for the excellent congress, as well from the scientific point of view as from the organizational aspect, and announced that the 11th European Congress of ESCAP will take place in 1999 in Germany, possibly in Berlin.

During the General Assembly of ESCAP, a new Executive Board was elected, consisting of the following members:

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The new president expressed his thanks to the outgoing president, Prof. van Engeland, for his excellent work during the last four years; to Prof. Philip Graham for the long time he spent working intensively for the European Society, and to the outgoing vice presidents.

He announced that he would try to arrange regional symposia and training courses during the next four years until the 1999 congress in order to promote a further standardization of child and adolescent psychiatry training in Europe and to stimulate research cooperation across countries and linguistic boundaries. ■

COPELFI:

The Fourth Conference of the
French-Israeli Association of Child and
Adolescent Psychiatry
October 1996

Miri Keren, M.D.

"Disorders of Infancy and Their Future" was the title of the two-day meeting held under the auspices of the Israel Society for Child and Adolescent Psychiatry and the French Society for Child and Adolescent Psychiatry, and with the cooperation of the French Ministry of Foreign Affairs.

The conference was attended by multidisciplinary Israeli and French professionals, including a few pediatricians, a fact which reflected one of the messages transmitted by this conference: the increasing awareness of the somatic expression of the infant's psychological distress makes imperative the need to gather the somatic and the psychic teams and have them work together.

The first day of the conference took place in the Kibbutz Shefaim and was opened by Prof. Michel Vincent, French President of COPELFI, and Dr. Jocelyn Y. Hattab, Israeli President of COPELFI. It started with a pantomimic representation entitled, "Wonder of Birth." Dr. Miri Keren, Tel Aviv University, presented the dyadic psychotherapy of a Premature Twin with Failure to Thrive and Depression, using concepts both from American (D. Stern) and French (F. Dolto) approaches. The presentation emphasized the complex interplay of very early biological and psychological risk factors and misunderstood by the medical team, which led to a severe developmental pathology. The case was discussed by Dr. Francoise Jardin, Director of a home-based unit for Mothers and

Infants at the Alfred Binet Centre (France), well aware of the very early origins of the severe psychopathologies. She greatly contributed to the psychodynamic understanding of the case by analyzing both protective and risk factors which were involved in its pathogenesis and in the outcome of the dyadic psychotherapy. The open discussion raised additional interesting topics, such as the impact of a gastrostom on the very young child's body image, and the significance of taking it out. The afternoon was dedicated to workshops, covering topics such as ethnopsychiatry, artificial fertilization, early treatments in infancy and their outcomes, and therapeutic consultations for infants. The common denominator to these workshops was the unique occasion we had to think together, as opposed to passively listening to well prepared notes.

The second conference day, at the Renaissance Hotel in Jerusalem, was opened by Prof. Sam Tyano's commemoration of the late Dr. Didier Weil, one of the founders of COPELFI. Prof. Bernard Glose, of the University of Rene Descartes (Paris) in his lecture entitled, "The Infant Psychiatry in 1996: theoretical and therapeutical aspects," presented his multifactorial and inter-relational model of psychopathology, contributing to the emerging trend in France to find a way of integrating the psychoanalytic thinking with the developmental approach, without derogating any of these. He applied this model to the understanding of any psychopathology in infancy, such as autism, maternal and infantile depressions. Finally he reviewed current prevention and intervention strategies, including some recent data about the impact of early intervention in transmission of attachment patterns. Dr. Neta Gutman-Avner (Ichilov Medical Center, Tel Aviv), Golse's discussant, emphasized the encounter of the intrapsychic with the intersubjectivity, of the inside with the outside world. She illustrated the theoretical concepts of the fantastic parent-infant interaction, based on projection and projective identification, with several short clinical vignettes. Finally, she gave an overview of the clinical work done at the Ichilov Mother-Infant Clinic. The afternoon hours were again for workshops, such as the Hidden

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Children of War, Adoption and Restituted Families, videotapes of therapeutic consultations. The conference ended with a debriefing with the participants and the organizers, regarding suggestions for the next COPELFI meeting. The majority asked for the addition of a third conference day, which would be dedicated to discussion of live clinical cases at some of the main psychiatric institutions in Israel. This spontaneous suggestion, I think, did reflect the uniqueness most of the participants felt in this bi-national meeting between theoretical approaches and clinical experiences in the context of different nationalities and societies.

To conclude: we had an "inter-relational conference" about an essentially inter-relational subdomain of the child psychiatry: infant psychiatry. ■

REPORT FROM A CONFERENCE IN MELBOURNE, AUSTRALIA

November 1996

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

The Second National Conference on Child and Adolescent Mental Health was arranged in Melbourne, Australia, November 20–23, 1996. It was organized by the Coalition of Child and Adolescent Mental Health Professionals in the state of Victoria, formed in 1988. This conference continued the work of the Inaugural National Conference, held the year before in Adelaide. Thus child psychiatrists and their allied professional collaborators have managed once more to gather child and adolescent mental health professionals from all over Australia to engage in mutual efforts to work for Australia's young. There were representatives from all states in Australia, from cities and smaller places as well as from the outback. One person expressed her luck to be able to meet people she until then had only spoken to on the air—the normal way for her of communicating with others!

One evening, an inaugural general meeting was discussing the feasibility to form a national coalition, an Australian association for infant, child, adolescent and family mental health, which, no doubt, will take shape next time in Sydney at the coming third national conference. The question was whether to take in consumers into this association since Australian child psychiatry is working very close to consumer organizations already.

The theme of the conference was "Who counts? Mental Health Outcomes for Australia's Young." The main themes were: assessment and intervention outcomes, promotion of psychological well-being, outreach and consultative work, especially with at-risk or vulnerable groups, equitable access of mental health services and opportunities for legislation to enhance this, evaluation of efficiency, effectiveness and cost-benefit outcomes of services. Dr. Winston Rickards was the chair of the conference organizing committee. His enthusiasm was contagious, which characterized the whole conference. IACAPAP amongst other organizations was sponsoring this event and therefore, Prof. Kosuke Yamazaki, from Japan, Secretary General, and Asst. Prof. Kari Schleimer, from Sweden, Vice President, were invited as keynote speakers. Prof. Yamazaki presented a lecture on "The vulnerable children and adolescents in Asian countries" and Prof. Schleimer spoke of "Mental health services in times of economic restraint: viewpoints from Sweden and Europe." Other main speakers were Prof. William Yule from the U.K., "Epidemiology, experiment and experience: applying child psychology for the benefit of all our children," especially mentioning his engagement in Bosnia, and Prof. Barry Nurcombe, formerly from the U.S. but today from Brisbane, presenting a brilliant lecture on "Quality" within health care, taking the child or adolescent psychiatric inpatient unit as an example.

Besides plenary panels and sessions, there were organized poster sessions and concurrent sessions covering most actual themes. To visitors coming from overseas, the "Forum on aboriginal and Torres Strait Islanders issues" was most interesting and instructive, touching different

aspects of their very special difficulties within a modern society. Another, to me, unusual way of presenting a problem was "Eating disorders—presentation of a hypothetical by a study group," covering different aspects of the problem.

All together, we had three full days filled with interesting presentations on many issues and problems, techniques and service models—where of course, as always, you would have liked to listen to more than you possibly could. Sociably they had arranged a welcome reception combined with a youth art exhibition and a wonderful conference dinner with cheerful and informal speeches of thanks. The organizing and scientific program committees are to be congratulated on a well accomplished and utmost interesting conference, that showed the spirit and good will from all CAMHS professionals, engaged to do their best, even in times of economic restraint. ■

THE CHILDREN'S HOME OF PITTSBURGH

Charting a Course...Infant and
Child Attachment

The Children's Home of Pittsburgh, a licensed adoption agency, sponsored a national conference entitled, "Charting a Course...Infant and Child Attachment," October 13–15, 1996, at Sheraton Station Square in Pittsburgh, PA. Designed for adoption and other social service professionals, parents, and foster parents, this conference offered five keynote sessions and 20 dynamic education workshops. Continuing Education Units (CEUs) and Continuing Medical Education Units (CMEs) were offered.

This conference addressed, for the first time, attachment issues as they relate to the adopted child, the medically high-risk infant, trends in child welfare and the family. Participants learned about current theory, especially as it relates to emotional, social, and biological development; will be able to better identify child-related disorders; learned methods to facilitate attachment in at-risk infants, children and families. Keynote and work-

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shop faculty included: Marlene Goodfriend, M.D., Dana Johnson, M.D., Robert Karen, Ph.D., acclaimed for *Becoming Attached*, Klause Minde, M.D., and Charlie Zeneah, M.D., acclaimed for *When the Bow Breaks*. For additional information about the conference, contact Becky McIntyre at (412) 441-4884. ■

28TH ANNUAL MARGARET S. MAHLER SYMPOSIUM ON CHILD DEVELOPMENT

The Colors of Childhood:
Separation-Individuation Across Cultural,
Racial, and Ethnic Diversity

Saturday, April 26, 1997

Sponsored by Thomas Jefferson University
and the Philadelphia Psychoanalytic
Institute and Society.

Place: Twelve Caesar's — Philadelphia, PA

Speakers:

Daniel Freeman, M.D.
Carlotta Miles, M.D.
Purnima Mehta, M.D.

Discussants:

Calvin Settlege, M.D.
Salman Akhtar, M.D.
Jennifer Bonovitz, Ph.D.

Information and Registration:

Maryann Nevin
1201 Chestnut St., Rm. 1502
Philadelphia, PA 19107
(215) 955-8420

CME, CE and CEU credits.

ESCAP CONGRESS 1999

The next congress of the European Society
for Child and Adolescent Psychiatry will be
held in Hamburg, Germany from Tuesday,
September 14, to Saturday, September 18,
1999. More information will be available in
upcoming Bulletins. ■

BIOGRAPHIES

Editors' Note: We are pleased to print the brief biographies of Drs. Schleimer and Rydelius who are presiding over our next IACAPAP Congress in Stockholm, Sweden.

Kari Schleimer, M.D., Ph.D. was born in Berlin, Germany. German father, Norwegian mother, Austrian husband. Two children born in Sweden. Schooling in Germany, Norway and Sweden. Medical degree at the University of Lund, Sweden. Specialist competence in pediatrics and in child and adolescent psychiatry. Doctorate in child and adolescent psychiatry. Doctorate in child and adolescent psychiatry at the Karolinska Institute, Stockholm.

Present position: Chief and Consultant Child and Adolescent Psychiatrist at the department of CAP, Lund's University, University Hospital MAS, Malmö. Assistant Director. Senior Lecturer for under- and postgraduate training within the medical faculty. Research within the field of eating disorders.

For many years, on the Board of the Swedish Association for Child and Adolescent Psychiatry, eight years as Secretary for Scientific Matters. Secretary General of IACAPAP 1989-1994, then Vice President. One of two representatives from Sweden in the UEMS (Union Européenne des Médecins Spécialistes). Co-author of Swedish textbooks of child and adolescent psychiatry and other medical manuals. ■

Per-Anders Rydelius, M.D., Ph.D., born in Stockholm, Sweden, December 5, 1945. Married 1969 to Eva-Lena. Two children, a girl born 1970 and a boy born 1971. Graduated from the Medical Faculty at Umeå University in 1971. Clinical training in child and adolescent psychiatry at Umeå University and at the Karolinska Institutet and the S:t Görän's Children's Hospital in Stockholm, 1971-1977. Scientific training and Ph.D. at the Karolinska Institutet in 1981. Thesis: "Children of Alcoholic Fathers-Their Social Adjustment and Their Health Status over 20 Years." *Aca Paediatrica Scand*, 1981, Suppl 286. Clinical appointments at S:t Görän's Children's Hospital since 1972. Associate Professor at the Karolinska Institutet in 1982. Professor and Chairman of Child and Adolescent Psychiatry at the Karolinska Institutet and clinical director at the Karolinska Hospital/S:t Görän's Children's Hospital since 1989. Member of the Editorial Board of *Acta Paediatrica* and member of the Advisory Board of *European Child and Adolescent Psychiatry* 1982-1986; President 1986-1990. Secretary of the Planning Group of the Swedish Medical Research Council for Child and Adolescent Psychiatric and Social Pediatric Research since 1983. Program chairman for the 14th IACAPAP Congress, August 2-6, 1998, Stockholm, Sweden. ■



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