



Editors' Comments: This President's Message describes IACAPAP activities of 2000. It is published here to stimulate ideas about our work. Please send your ideas to our President.

President's Message 2001

As this is the first President's Message in 2001, let me look back to the past year 2000, and let me look ahead to what is planned for the future.

Our *Bulletin* of June 2000 had the headline, "See you in Jerusalem." As you all know, this was not possible due to serious political circumstances which cannot be influenced by clinicians and researchers and which have had a tragic impact on children and their families.

The postponement of the planned Congress in Jerusalem, which finally took place in Tel Aviv (April 29–May 3, 2001) and was entitled "The Promised Childhood," was definitely the most unpleasant and sad event for IACAPAP as an international society, for the local organizing committee, the international advisory board and for the large group of colleagues who were enthusiastically looking forward to that special Congress in the year 2000. Due to the political circumstances, the three international organizations (IACAPAP, ISAP and WAIMH) felt that they could not recommend their members to go to Israel at the time when the Congress was scheduled. Therefore the Tel Aviv Congress was carried out as an Israeli meeting with some international attendance, but no longer as a joint effort of the three international organizations.

In spite of the sad background of all our discussions concerning that Congress, the cooperation among the three scientific organizations was an extraordinarily important experience for all participants, because it showed great consent in all important issues and was characterized by mutual understanding, collegiality and friendship.

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President's Message 2002

Dear colleagues,

With this report, I would like to inform you about the major activities and events after our last Executive Committee meeting in New York on June 16–17, 2002.

As all of you have received the minutes of this meeting from our Secretary-General, I will not refer to this meeting in this report. However, I want to mention that the most serious decision in my term as president of IACAPAP was taken in New York, namely to cancel the New Delhi Congress as a IACAPAP event. Meanwhile that Congress took place and I heard that it was quite successful. I am very glad about this.

For the excellent organization and also the financial support of the New York meeting, I would like to thank our Treasurer, Myron, very cordially. Our stay at the Harvard Club in New York was excellent.

Let me now mention some further events and activities:

1. Memorial events for Donald Cohen on Tuesday and Wednesday, June 18–19, 2002

On the one hand, these events were very sad and reminded all participants in many and very sympathetic ways of Donald and his remarkable activities all over the world; on the other hand, it was comforting to see the impact he had on many fields of child and adolescent mental health and which is a powerful source of further activities in many countries all over the world.

On Wednesday, June 19, we had a meeting with colleagues from the Yale Child Study Center and members of the EC in order to discuss further IACAPAP activities in connection with the Yale Child Study Center. Several proposals were made, and we will discuss some of them during our next EC meeting.

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Editors' Comments

We have many expectations for future activities of IACAPAP and they rest on the recent international historic events and our intense efforts to provide for the welfare of children worldwide. Certainly we are looking forward to our long expected next International Congress. It will be held in Berlin in 2004. We have been greatly frustrated, disappointed but with a greater sense of resolve that it is mandatory that we meet soon and benefit from the varied experiences of our International Congresses.

IACAPAP has not had an International Congress since the meeting in Stockholm, Sweden in 1998. Unfortunately, IACAPAP was directly affected by the events of numerous terrorist threats and attacks. Our two planned Congresses, in Jerusalem in 2000 and in New Delhi in October 2002 had to be cancelled, both because security situations. The opening of the Jerusalem Congress was scheduled one month after the beginning of the actual "intifada," the uprising of the Palestinians against the population of Israel. Three months before the New Delhi Congress's opening, the executive committee of IACAPAP decided to cancel this meeting due to warnings from the United States and European governments not to travel to India and Pakistan. These countries were experiencing threats of war. Certainly, most of us have been concerned about how and when we can convene a meeting within a peaceful atmosphere. We are eager to meet colleagues, share ideas, collaborate, and develop new activities that serve humanity, especially the rights and development of children.

We were part of the IACAPAP Executive Committee's discussions and decisions. It was a painful process of weighing the pros and cons of IACAPAP sponsoring the New Delhi Congress. It was decided that serious obstacles prevented IACAPAP moving forward to sponsor this Congress.

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All the other events during the year 2000 were promising, pleasant and future-oriented. Let me mention only a few:

a) The international meeting on "Genetics of Autism" which was held from March 16–19, 2000, in Modena in Bologna and about which we gave a report in our last *Bulletin*, was followed by a very constructive meeting of the Planning Group on October 24, 2000, organized and coordinated by Fred Volkmar. The major aim of the "Genetics of Autism" Planning Group which was formed after the Modena meeting is to coordinate genetic research in autism between the different groups working in this field all over the world.

From Fred Volkmar's summary of the meeting, the following information might be interesting for a larger readership. Research has demonstrated that autism is highly heritable, probably greater than 90%. Based on current models, it is most likely that autism is oligogenic and heterogeneous; the result of numerous interacting genes, each possibly having only moderate effects. Thus far, several independent groups have completed genome screens, based on data collected from multiplex families (mostly affected sib pairs). The findings from these studies, as presented in Modena in March 2000, point to a number of promising regions of interest on several chromosomes. It is, however, clear that further progress in identifying genes that contribute to this severe developmental disorder will be advanced and accelerated if such genetic studies could be completed with significantly larger data sets. Based on this information and insights, the Planning Group proposed the following strategies:

- The first step should be to explore the feasibility of forming a collaboration among all scientists who can contribute to advancing research into the genetics of autism by combining their data and pursuing a focused set of investigations in this area.
- To pursue this general goal, the group agreed on several basic working principles: first, the whole initiative will be an

international collaboration of equals, regardless of each individual scientific contribution. Second, IACAPAP will play the role of a facilitator for this cooperation. Third, the scope of the initial research project will be designed carefully to maintain a balance between what will clearly move the science of autism genetics forward, with what can feasibly be accomplished under current constraints.

- For the initial investigations, all groups who are currently involved in linkage studies with multiplex families of probands with autism will be invited to participate. Target region will be selected (most likely on chromosome 7 plus a few additional regions) for fine mapping.

The second meeting of the international Autism Genetics Planning Group took place on October 24, 2000, at the Markle Foundation in New York in connection with the meeting of the American Academy of Child and Adolescent Psychiatry. The meeting was chaired by Fred Volkmar from whose report the following information is drawn:

The primary aims of this meeting were to explore the feasibility of forming a collaboration among all scientists who can contribute to advancing research into the genetics of autism by combining their data and pursuing a focused set of investigations in this area. The discussions focused extensively on how the collaboration could be formed. There was an agreement on several basic principles: First, the international collaboration is looked upon as a collaboration of equals, regardless of the individual scientific contribution. Second, IACAPAP will play the role of a facilitator for this collaboration. Third, the scope of the initial research project will be designed carefully to maintain a balance between what will clearly move the science of autism genetics forward with what can feasibly be accomplished under current constraints.

The group decided that the most feasible approach to take would be to develop an initial study that is based on existing data sets from all

contributors. Target regions will be selected (most likely on chromosome 7 plus a few additional regions) for fine-mapping. It is expected that several different approaches to data analysis will be undertaken. When the analyses are complete, all data will be returned to the contributing sites, and will not be available for general distribution.

Future perspectives: It is expected that the international cooperation can successfully be improved and new proposals will emerge and be pursued within the rubric of this international collaboration with IACAPAP playing a key facilitating role.

b) A combined meeting of the presidents and two vice-presidents of IACAPAP and ESCAP took place on October 16 and 17, 2000, in Paris. The participants were Philippe Jeammet (president ESCAP), Helmut Remschmidt (president IACAPAP, past-president ESCAP), Ernesto Caffo (vice-president IACAPAP and ESCAP), and Herman van Engeland (vice-president IACAPAP).

Among others, three important issues were discussed in this meeting:

- The plan to establish an international research and study center in Treviso (Italy), sponsored by IACAPAP, ESCAP and the Foundation for Research and Education Concerning Children and Adolescents (Telefono Azzurro, Italy), chaired by Ernesto Caffo and Donald Cohen.
 - Planning the 2nd European Research Seminar for Child and Adolescent Psychiatry in Treviso which will take place in the first week of September 2001
 - Planning the 12th International ESCAP Congress in Paris in September 2003. Within this forthcoming European Congress, the close relationship between ESCAP and IACAPAP will be continued.
- c) An extremely important and promising perspective for IACAPAP is the secondment of our Treasurer, Myron Belfer, to the headquarters of WHO in Geneva since April 2000. This is the first time that international child and adolescent psychiatry and IACAPAP is represented by a highly competent and experienced colleague within WHO.

During his stay in Geneva up to now, Myron has developed important initiatives for international child and adolescent psychiatry. Through his initiative, the following activities have started:

- The acknowledgement of IACAPAP as a WHO NGO agency
- The integration of child mental health issues into the international programs of WHO
- The integration of progressive activities for psychiatrically disturbed and mentally handicapped children within the activities around the World Health Day (April 7, 2001) (cf. the internet homepage: www.who.int/world-health-day)
- The incorporation of WHO as a co-sponsor of the 15th IACAPAP Congress in New Delhi in 2002.

Altogether, Myron's presence and activities in Geneva are a great chance for child and adolescent psychiatry and IACAPAP as its international organization to raise attention for the needs of psychiatrically disturbed and mentally handicapped children and their families all over the world.

- d) Three members of the IACAPAP bureau (President, Treasurer and Secretary-General) met on October 30–31, 2000, in Marburg, Germany. Unfortunately, our past-president Donald Cohen could not participate, but we were able to coordinate our views in a telephone conference at the end of the meeting.

During the Marburg meeting, both the Secretary-General and the Treasurer gave lectures for the medical students. Ian Goodyer talked about "Depression in childhood and adolescence" and Myron Belfer gave a talk on "International child mental health issues." Both lectures raised tremendous interest for research and international development in the field of child and adolescent mental health.

The major issues of the conference were the postponed Jerusalem Congress and the question if it would still be possible to hold this Congress at all, the planning of international activities for child and adolescent mental health and the planning of the study group visit to India (January 27–February 8, 2001). Unfortunately, due to financial

restrictions of both IACAPAP and our hosts in India, only a few members of the IACAPAP Executive Committee were able to participate in this study group. This was a pity, but could not be avoided. The study group consisted of Helmut Remschmidt (President), Per-Anders Rydelius (Vice-President), Michael Hong (Adjunct Secretary), Savita and Anil Malhotra and Paramala Santosh, a colleague from India who is now working at the Institute of Psychiatry in London.

The major aim of the study group was to raise attention for the 15th International IACAPAP Congress in New Delhi (October 29–November 2, 2002) and to prepare the Congress together with Savita Malhotra and the organizing committee in India (see special report on the Study Group visit to India in this issue).

- e) Another important activity of the members of the Executive Committee and the bureau in the past year was to represent IACAPAP worldwide at scientific and professional meetings. This is an important task to make IACAPAP visible as the international umbrella organization for child mental health workers all over the world. Only a few meetings can be mentioned here:

- The meeting of the American Academy for Child and Adolescent Psychiatry in New York (October 23–28, 2000)
- The Second European meeting on Individual Psychotherapy in Oslo, Norway (participants: Helmut Remschmidt, Herman van Engeland, and Andreas Warnke)
- The meeting of the Swiss Society for Child and Adolescent Psychiatry in Lausanne (April 6–9, 2000) (Helmut Remschmidt)
- The meeting of the Italian Society for Child and Adolescent Psychiatry in Rimini (September 20–23, 2000) (Myron Belfer and Ian Goodyer).

- f) Future Congresses:
For the 16th IACAPAP Congress in 2006, there were applications from the Canadian Academy of Child and Adolescent Psychiatry as well as from Australia. Recently, just before the holiday season, another application reached me from Beijing, China.

As you know and as we reported already, there was a site visit of members of the Executive Committee in Montreal, Canada (Ian Goodyer, Per-Anders Rydelius, and John Sikorski). The impression they got was excellent, and the bureau made the preliminary decision for Montreal which was communicated to the members of the Executive Committee already last year.

As far as the Congress in 2010 is concerned, we have still the Austr application and, in case the Chinese colleagues will extend their application to 2010, also the Chinese one.

- g) The Second European Research Seminar in Child and Adolescent Psychiatry will take place from September 3–8, 2001, in Campo-sampiero, Italy. The research seminar is an activity of the International Research and Study Center in Treviso, but will this time be held near Padua. It is a joint activity of ESCAP, IACAPAP and the Foundation CINI (Foundation Child). The themes of the seminar will be: Developmental psychopathology and treatment evaluation. We expect between 25 and 30 participants from many European countries. As far as the structure of the seminar is concerned, there will be lectures in the morning, followed by intensive discussions, and in the afternoon, group discussions of research projects of the participants. This structure has proved to be very successful during the first Research Seminar in Heidelberg, Germany in 1999. We are grateful to our colleague, Ernesto Caffo, and the Foundation CINI who will cover the expenses for the participants' stay in Italy whereas the travel expenses have to be carried by the participants themselves.

- h) IACAPAP homepage (www.iacapap.org). As already in our last *Bulletin*, I would like to draw your attention to our IACAPAP homepage. The text of this *Bulletin* (Nr. XII) will also be available on the homepage (as well as the last editions back to Sept 1997). I would also like to encourage all IACAPAP members to send suggestions and ideas for the home page to my email (remschm@med.uni-marburg.de).

At the end of this report, I would like to thank the members of the Executive Committee for their continuous help and support. I will be happy to receive all kinds of suggestions that might be

helpful to improve our work. I am especially grateful to the members of the bureau with whom I am in continuous contact for their advice, support and friendship.

Finally, my warmest thanks go to the editors of our *Bulletin*, Cynthia Pfeffer and Yosse Hattab, for their tremendous work and through that for their highly esteemed contribution to the successful work of IACAPAP.

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I propose that we can organize this meeting in connection with the next ESCAP Congress (September 28–October 1, 2003, in Paris). Please assign these dates accordingly in your diaries.

2. Personal matters

In the week after the New York and New Haven meetings, I had to undergo surgery and stayed in hospital from June 27–July 5. This was nothing serious, but nevertheless unpleasant and time-consuming. Many of you sent their best wishes via email or called me. I would like to thank you very much and am very grateful for your kind thoughts.

3. 18th World Congress of Psychotherapy in Trondheim/Norway

During this Congress, I represented IACAPAP and gave one of the two introductory talks in the Opening Session, entitled "How can child psychotherapy practice be informed by research findings: Lessons learned from experiences in Marburg." The Congress was very interesting and stimulating, and I used the opportunity to contact the current and new president of the International Federation for Psychotherapy, Prof. Schnyder from Zurich, Switzerland, in order to coordinate their Congress activities with IACAPAP. This organization will participate in the next IACAPAP Congress in Berlin in 2004. Together

with Norwegian colleagues, we also organized a symposium on psychotherapeutic interventions in conduct disorders which I had the opportunity to chair. In this symposium, our Vice-President, Herman van Engeland, gave an excellent talk about their intervention studies in that field.

4. Third European Research Seminar in Camposampiero, Italy from September 30–October 4, 2002

This seminar was sponsored by ESCAP, IACAPAP and the Foundation Child, chaired by Ernesto Caffo. It was devoted to the topic "Study design and assessment" and was attended by 31 young child and adolescent psychiatrists from 16 European countries. The structure provides talks of very well-known experts in the morning, followed by a discussion and then after lunch, the participants split up in three or four small groups to discuss research plans they are asked to bring. The seminar was again very successful and the speakers came from Europe and the US.

On Wednesday, October 2, Ernesto had organized an extraordinary meeting in the Venice town hall and we heard two really remarkable lectures on "Children and War" given by our IACAPAP EC members Amira Seif El-Din (Alexandria) and Yosse Hattab (Jerusalem). This meeting was well attended and provoked an interesting discussion which should be continued. All participants of the research seminar attended this meeting, but it was also open to the public, and many important persons from Venice took part, especially those who are involved in any kind of work with children and adolescents. I had the honor to chair this session. It was an excellent idea of Ernesto to invite Amira and Yosse who not only gave these talks in Venice, but also participated in the whole research seminar. Yosse wrote a report about this meeting which will appear in the next issue of our *Bulletin*.

The program for the seminar was structured by Richard Harrington (Manchester), and Ernesto had excellently organized and also financially supported the meeting.

5. Meeting of the ESCAP board in Venice, October 5–6, 2002

As several current or past members of the ESCAP board are also members of the IACAPAP EC, I will also mention this meeting that took place in the

monastery of San Giorgio Maggiore in Venice. The IACAPAP EC members who participated were Herman van Engeland, Ernesto Caffo, Yosse Hattab as a guest, and myself.

The main topic of that meeting was the forthcoming ESCAP Congress to be held in Paris from September 28–October 1, 2003. We discussed details of the program and joint activities of ESCAP and IACAPAP. As in the last ESCAP Congress in Hamburg in 1999, we are again planning a meeting of the IACAPAP EC in Paris and (hopefully) also a meeting of the presidents of international societies for child and adolescent psychiatry all over the world. I will inform you about details as soon as we are through with the planning process.

6. 16th World Congress of IACAPAP in Berlin, August 22–26, 2004

As you know, after the decision to cancel the New Delhi Congress as a IACAPAP activity, the bureau (Ian Goodyer, Myron Belfer and myself) had immediately contacted the Canadian colleagues to learn if they would be able to pre-draw the Congress in Montreal that was originally planned for 2006 to 2004. Unfortunately, this was not possible, and so the bureau decided to have the next Congress in 2004 in Berlin as it is really impossible for an international organization to have a blank of eight years between regular Congresses. On behalf of the bureau, I asked all of you by email, phone or fax if you agree to this proposal and had the consent of everybody. I would like to thank you very much for your very prompt reactions which enabled the bureau to make a final decision for Berlin.

After that, the bureau met in Berlin on September 12 for an all-day meeting and negotiated with two Congress organizing companies, which had already been contacted before and which had sent a preliminary budget to the bureau members. During the meeting, we inspected several Congress facilities and discussed in detail all important aspects of such an international meeting. On the basis of this information and the preliminary budget, it was decided to place the order to organize this Congress with us with CPO Hanser. Our discussions of the Congress theme resulted in the following:

**“Facilitating Pathways:
Care, Treatment and Prevention in
Child and Adolescent Mental Health”**

This theme will enable us to have an up-to-date review on all kinds of treatment, intervention and prevention from the leading experts all over the world in Berlin. As usual, the Congress will, of course, also cover all other important fields of child and adolescent mental health. The bureau would be glad to receive suggestions from the EC members. We are eager to include new ideas to make the meeting successful in every respect. I would also like to ask you for proposals for the Berlin IACAPAP Declaration. Our former IACAPAP Declarations have found great interest, and we should continue this tradition also in memory of our wonderful friend, former president and past-president Donald Cohen who inaugurated this tradition.

Immediately after the meeting of the bureau and the Congress company CPO Hanser, we produced very quickly the first announcement in order to distribute it at the 49th Annual Meeting of the American Academy for Child and Adolescent Psychiatry. Regardless of the short time, we were successful and all the participants of the MCAP meeting in San Francisco found this first flyer in their Congress bags.

I had been invited to give the Closing Plenary Lecture at that meeting, and I started my talk with an invitation to the 16th IACAPAP World Congress in Berlin.

The decision to call the Berlin Congress the 16th IACAPAP Congress (and not the 15th) pays attention to Savita's wish to take down in the IACAPAP annals that the 15th Congress could not be held under the aegis of IACAPAP due to external reasons. The bureau decided to meet this wish as an acknowledgement of the remarkable activities and efforts of Savita and her Indian colleagues and also of several members of the IACAPAP EC in preparation of the New Delhi Congress. This is the reason why the Berlin Congress is counted as the 16th Congress of IACAPAP.

As usual, the IACAPAP EC will serve as the International Advisory Board to this Congress. The Local Organizing Committee will be formed by the board of the German Society for Child and Adolescent Psychiatry. This organization will be the host of our

Congress and will support the meeting in every respect.

A couple of first announcements will be sent to all of you and I would kindly ask you to distribute them to your colleagues and to the organizations and members of allied professions in your region. You may order further material from CPO Hanser (email: berlin@cpohanser.de).

The bureau will inform you about the further steps in relation with the Congress, and I would like to ask all of you for your help and support.

7. 49th Annual Meeting of the American Academy for Child and Adolescent Psychiatry, October 23–26, 2002, in San Francisco

Together with Myron Belfer, Peter Jensen, Barry Nurcombe, and John Sikorski, we represented IACAPAP at this meeting. I felt very honored to be invited to give the Closing Plenary Lecture on “Treatment evaluation in child and adolescent psychiatry.” The talk was very well received and provoked an interesting discussion. I was appointed Honorary Member of AACAP and the current president gave me a plaque in appreciation of the cooperation and friendship between AACAP and IACAPAP. We will continue this fruitful cooperation not only by exchanging our views and information, but also by carrying out joint activities.

Another important event was that our Treasurer, Myron Belfer, was appointed co-chairman of the International Relations Committee of AACAP. The other senior chairperson is our Honorary President, James Anthony. This committee is important as a link to IACAPAP and for the coordination of our international work.

We had a very interesting meeting of this committee which I had the opportunity to join and discussed several topics of joint interest for IACAPAP and AACAP, such as international research meetings, regional meetings, training seminars, facilitation of research projects in different parts of the world, continuous exchange of information, fellowship programs, etc. The meeting was attended by many international delegates, inter alia from Egypt, Mexico, China, the US, Canada, New Zealand, and Germany.

8. Forthcoming events

Let me now draw your attention to some important forthcoming events:

IACAPAP Research Seminar. February 21–27, 2003. in Sharm-El-Sheikh, Egypt:

This seminar will be a joint venture of IACAPAP, EMACAPAP and the Foundation Child, chaired by Ernesto Caffo. The theme of the seminar will be: “How to implement research into everyday clinical practice.” Amira has taken the responsibility to invite colleagues from the Eastern Mediterranean area. We are planning to structure the seminar in the same way as the European Research Seminars. As I mentioned earlier in this report, Amira participated in the Third European Research Seminar this year and gave an excellent talk about children and war.

IACAPAP meeting on trauma in Venice. March 19–23, 2003:

This meeting was conceptualized in continuation of the former Venice meetings and is a joint effort of IACAPAP and the Foundation Child, represented by Ernesto Caffo. We have formed a program committee consisting of Ian Goodyer, Nathaniel Laor, Barry Nurcombe, and Ernesto Caffo. The meeting will take place in the Foundation GINI on the island of San Giorgio Maggiore in Venice, just in front of St Marcus Place. Those of you who participated in the former Venice meetings will know the place and I am sure will have fond memories of this location. It would be nice to combine this meeting with a meeting of the IAGAPAP EC. We are trying very hard to find a solution for a financial support.

Joint meeting of the German, Austrian and Swiss Societies for Child and Adolescent Psychiatry in Vienna. April 2–5, 2003;

This is the first joint meeting of the three German-speaking child and adolescent psychiatric associations. The meeting will be a wonderful platform to strengthen the ties of IACAPAP to these associations and also to propagate the 2004 IACAPAP meeting in Berlin. At this Congress, there will also be a meeting of the editors of the European Journal of Child and Adolescent Psychiatry (ECAP) and several other European child psychiatric committees.

Meeting of the ESCAP board in Paris. April 3–4, 2003:

This will be the last board meeting in preparation of the ESCAP Congress in Paris to be held from September 28–October 1, 2003. Suggestions for the program and other activities are very welcome.

6th International Conference of ISAP in Rome. June 26–29, 2003:

Traditionally, IACAPAP has had strong ties to ISAP and all our members are asked to attend their next meeting in Rome.

International conference on psychotherapy and psychopharmacology in Amsterdam. October 31– November 2, 2003:

This meeting will also be very interesting for child and adolescent psychiatrists because the combination of psychotherapy and psychopharmacological treatment is very successful in many disorders. Co-organizer of this conference is our EC member Sam Tyano.

Conference of Autism Europe in Lisbon. November 14–16, 2003:

This meeting, too, is of great importance and will be attended by many internationally well-known researchers in the field of autism and pervasive developmental disorders. I am also closely related to that organization and gave the introductory talk at their joint meeting with the Italian Autism Society in Rome on May 22–23, 2002.

I hope that this information will give you a survey of the activities of our bureau and other members of our association. I feel bound to thank my co-members in the bureau, Myron and Ian, for their excellent, prompt and thoughtful co-operation and friendship and all EC members for continuous help and support.

With kind regards,

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It was very regrettable that we were not able to visit our colleagues in India and to learn from them and share international ideas. We tried our best to surmount the obstacles that precluded an IACAPAP Congress in New Delhi.

Those who have ever organized a congress or conference know the huge amount of work, planning, meetings, money, time involved and invested in such a process! And they can evaluate the painful frustration of the cancellation. IACAPAP Bureau and members want to express their deep consideration and gratefulness to Professor Sam Tyano from Israel and Professor Savita Malhotra from India, who were the presidents of these cancelled Congresses.

Our world is still an arena of too many armed conflicts. It is quite difficult to plan six years in advance for an International Congress and be sure that the Congress site will be free of terror, threat of infectious epidemics, war and other dangers for participants.

IACAPAP cannot endorse a Congress were its members are not secure. But IACAPAP has the duty and will to support children and adolescents not only in well developed and secure countries but mainly where they are the more disadvantaged, the more endangered, the more in need of our help.

Regardless of our decision, IACAPAP has a strong focus on having a very active part to support colleagues who work in stressful circumstances. Without them, our hope to improve the lives and emotional and physical welfare of children cannot occur.

The committed spirit of IACAPAP is to bring assistance to the professionals of child mental health who struggle against harsh conditions to preserve mental health of their young citizens. International meetings are important for many aspects and respects but local meetings in troubled areas are not less important. We salute the program organizing committees in Israel and India who continued efforts of putting forth a successful congress at a more local level. We want to invite those who participated in these two congresses to submit abstracts and summaries of their ideas and presentations to the *Bulletin* so that all in IACAPAP may learn and respond. Furthermore, when medical

needs are not met, children's psychological development suffers. In our current troubled and threatening times, new approaches are necessary to lend support and aide to children, especially those in severely stressful circumstances. We may learn for some other approaches, such as those who organize for physicians to go to troubled areas to provide expertise in creating programs and provide medical and psychological aide. Perhaps, rather than cancel our Congresses, we may substitute direct efforts of care, concern, education, and scientific inquiry. We need new models of functioning as a large international organization which overcomes the frustrations of not personally meeting but innovates activity at the local levels with international support and presence. What we can consider is our challenge to the readership of our IACAPAP *Bulletin*.

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In Homage to Donald Cohen

by Sylvie Tordjnan

(In Press and will appear in the December issue of "Psychiatrie de l'enfant")

Donald Cohen passed away last September, a few days after his 61st birthday. I had called his secretary in the United States because, a week before, I had sent two e-mails and did not yet have a reply. This was very unusual because Donald replied, generally, the same day to all of his e-mails, which

gives an idea of his availability, his organizational capacities and his reliability.

Donald was sick for several months, but he was a fighter and it was difficult to think that one day he would no longer be here. We had even set up a meeting at Yale for October 2001.

In June 2001 he had sent a letter to members of the Child Study Center and Yale University as well as his collaborators. This letter was entitled Child Study Center Transition (he was the director since 1983). He announced in this letter the need to name a new director of the Child Study Center:

"My hope is that a new Director will be named by 2002 or sooner. The decision to begin this transition at this time is based on both good, developmental thinking as well as on my personal situation... I will feel more comfortable, personally, in knowing that I have actively planned for this transition and share in the process of assuring the Center's long-term stability." The letter finishes: "Indeed, even though this has been a traumatic year for my family and me, I am filled with gratitude. I feel that I have been given more than my due – a life full of blessings of family, friendship, work, achievement, and recognition. During these difficult months, Phyllis and I have been deeply grateful for the loving support from everyone in the Center and from throughout the world; this type of true caring means a huge amount at such times."

It is difficult to resume, in a few lines, who Donald Cohen was and what he brought us. Donald Cohen was a brilliant man who was exceptional on a professional level but was also a humanist who believed and situated himself with regard to spiritual values.

To retrace his career in a few lines, he began his medical studies at Yale University in 1962, then specialized in adult psychiatry and in child psychiatry at Harvard University. Upon his return to the Child Study Center in 1972, he completed psychoanalytic training at the Western New England Institute, became a Professor of psychiatry, Pediatrics and Psychology in 1979 at Yale, and was finally named fourth Director of the Yale Child Study Center in 1983, after Arnold Gessell (Director: 1911–1948), Milton Senn (Director: 1948–1966) and Albert J. Solnit (Director: 1966–1983). Here again, I would like to cite a passage from the letter that Donald sent in June 2001:

"In 1983, my selection as the fourth director of the Child Study Center was more than an academic turning point – it was an act of grace. For me, it actualized a childhood fantasy to be a teacher among teachers, a leader of an Academy devoted to advancing knowledge. Being Director of the Child Study Center, Chairman of the Department of Child Psychiatry in this school and university, and Chief of Child Psychiatry in Yale–New Haven Hospital has provided a unique vantage point on New Haven and our academic fields – an opportunity to learn, to grow and to share."

We cannot speak about Donald Cohen without saying a few words about the Child Study Center. The Child Study Center is a care-giving, research and teaching center, created in 1911, with the goal at the national and international level to study "children's development and the application of this knowledge to promoting the welfare of all children and families." However, the Child Study Center is also a hundred clinicians and researchers who share a team spirit. Donald Cohen wrote:

"For many of these individuals, including myself, a career in the Child Study Center has been at the core of life itself. Our work here is much more than work – for many of us it represents the highest expression of our personal, intellectual and, indeed, our ethical beliefs. The Child Study Center has shaped hundreds of individuals – one hears from students and fellows over and over, and throughout the world, about what they received here and took with them forever. In turn, the Center has been shaped by the contribution of hundreds of faculty, staff, and trainees."

I think that Donald distinguished himself by his creativity and his enormous capacity for work that is illustrated in the development of various innovative projects, both in the research and clinical sectors. Indeed, aside from his personal work with an impressive list of publications (over 300 research articles in the best international reviews), he was able to promote, in the Child Study Center, diverse research projects by knowing how to delegate responsibilities. We can mention some of the varied topics developed at the Child Study Center: Research Methods in Child Psychiatry, autistic problems and research on autism, Asperger's and Fragile X Syndromes, Tourette's Syndrome, psychoanalytic research, biological, psychopharmacological, neurochemical and genetic research.

All of these research projects were coordinated by Donald who organized the meetings and was a dynamic role model. An idea that was important for him was that research was an integrated part of clinical work with patients. Donald was at the origin of the creation at the Child Study Center of clinical departments that specialized in certain problems (such as autism, Tourette's syndrome, depression) that articulate diagnostic and therapeutic programs with training and research.

Also in the research sector, he developed a wide network of international collaborations (France, Netherlands, Italy, Israel, Brazil, Germany, United Kingdom, Japan, China, Korea, Turkey, Russia, Egypt and several Latin American nations) which attests to Donald Cohen's capacity to create and maintain links with others.

In clinical work, he developed a mental health service in the Child Study Center that worked closely with schools and included psychologists, social workers and child psychiatrists who saw children referred by the schools or went to the school to follow-up on these children. Donald was equally involved in programs to help children exposed to violence, including the use of firearms. This program led to the creation of a department that worked with the police who came to the Child Study Center during several months to receive training about children's development, their needs, and how to best respond to children in situations in which they are victims or witnesses of violence. The Child Study Center organized an emergency team, specially trained in issues concerning violence, which replied to police calls 24 hours a day, every day, and could see immediately a child in need. This child would then be addressed to the Child Study Center to conduct a regular follow-up psychological exam and therapy.

On a more personal note, I would like to pay homage to Donald Cohen, to thank him sincerely for warmly welcoming me during a year and a half at the Child Study Center and for his attention for me. He had a gift for organizing dinners for which about twenty collaborators and friends were invited to share ideas and jokes. He was especially attentive to team spirit, which was seen in the interest and attention that he devoted to the softball team of the Child Study Center, of which I was a member. The team's name was "The Dreamers."

I continued to better know Donald after my return to France, to discover his wonderful capacity to create an international network of collaboration and to personally follow the work. He was always ready with enthusiasm to undertake new projects and to work with others. I thank him for facilitating my collaborations at Yale, concerning autism with George Anderson and Sara Sparrow, coordinator of the psychology department at the Child Study Center, but also my collaborations in Italy with Roberto Canitano concerning self-aggressive behaviors and at the NIMH with Kenneth Towbin about Multiple Complex Developmental Disorder (MCDD). Donald sought to compare MCDD to "Psychotic Disharmony," a disorder recognized in France, and he put several international teams in contact to assure continued reflection on this and related issues.

Together, we developed the Yale-Paris scales of self- and other-directed aggressive behavior, quantitative and qualitative evaluations of these behaviors but also measures of observer reactions. He helped us also to develop with Genevieve Haag the final version of a grid to note the evolutionary stages of infantile autism.

Donald Cohen is no longer with us but those of us who knew him appreciated him and will share his heritage. To honor his memory is to be worthy of the confidence that he had in his collaborators and to continue the projects that are underway. The best way to pay homage is to continue to teach and to work in the way that Donald would have wished.

To finish this letter in homage to Donald Cohen, I would have liked to tell him: The guests that you invited to your table are still there. There is an empty chair and I cannot mention it without feeling still today a great loss. Your absence is painful, I miss you, we miss you. But be assured, we have not left the table and we will not leave it.

Comments on Prof. Donald Cohen's Sterling Lecture "Life Is With People"

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From birth to death, man is in search of human relations. It is even his main

occupation and duty, says Donald Cohen. Human history, ontogenetic as well as phylogenetic, is that of human relations and their vicissitudes. Donald Cohen reveals for us his personal history as an illustration of his claim: "Life is with people," meaning that life is not in the ivory towers of universities, or in monasteries or in retreats in the desert, nor in the seclusion of the yeshiva. Life is where people live together, close to each other in respect and empathy as in the Yale Child Study Center. Professor Cohen chose to study social life through medicine, pediatrics and child psychiatry where real life occurs and not through philosophy, although he was tempted, nor through experimental psychology "with pigeons in Skinner's laboratory." Living life as it emerges at birth, and when death concludes it, close to the dying person as a caring physician, and influencing lives at the most crucial period of infancy and childhood at the crossroad of the essence of human beings as a child psychiatrist.

Life is with people means that, through human relations, people feel alive and make others feel alive and develop. Through his personal biography, doubts and thoughts, Donald Cohen scans several theories of human relations and development:

Working in Skinner's laboratory stressed the importance of education in forming a child's mental apparatus. It was thought that a values-based education is the only condition for mental well-being. Donald Cohen is dedicated to education. Together with Jim Comer and other colleagues at the Child Study Center, he emphasized the crucial role of educators for child personality formation and well-being, bridging inequalities between communities and giving all children the same level of education, mainly by supporting and directly helping teachers and school systems as a whole.

Quoting Descartes, Wittgenstein, and Milton Senn as "a devoted interactionist," Donald Cohen considers the social theory of mental health. In a well-organized society, based on values of respect, equality, welfare, etc., the members will develop and live as healthy people. That was the claim of communism and also of the kibbutz movement. In his microcosm called the Child Study Centre, and in all societies Donald is part of, his family, friends, professional associations etc., he establishes social relations based on

respect and equality, without judging them.

It may be argued that if education and social structures cannot solve all problems, children and adults have to be psychoanalyzed as soon as possible in order to be mentally healthy. Donald Cohen is a practicing psychoanalyst and psychotherapist. I assume he believes in the effectiveness of these procedures. However he is fairly critical of their theoretical and practical limits. By quoting his two psychoanalysts, he pays his tribute to his own training and their influence on him, and also to the extent that they helped him understand and cope with difficult situations, as in Boston's Children's Hospital working with children with intractable eczema and their parents.

In many other lectures, Professor Cohen has stressed the importance Freud gave to biological factors in normal and abnormal development. Only an accomplished psychoanalyst, with extensive knowledge in all aspects of psychodynamic theory, and deeply involved in the international psychoanalytic establishment, and simultaneously, a geneticist, biologist, biochemist, and neuroscientist could elaborate an integrative model of mental development functions and disorders into a developmental approach.

The genius of our genes enables us to modify our environment and make it viable and even pleasurable. Improved environment, better hygiene for pregnant mothers, better schools, leisure activity programs, pleasant factories, all will enhance and protect. This influence from genes to environment is an ongoing durable process and results are measurable in a reasonable time and can be modified adequately. The other way is much more tricky! Environment seems to influence the genome much more slowly, and men will be adapted to the actual environment in one million years from now! It is not surprising that the more common diagnosis given to children as well as adults is adjustment or personality disorder. However genes can be expressed only in an adequate environment. Professor Cohen develops this interactive and integrative genes/environment activity through his extensive work on these three topics: identifying the gene, in his research on Tourette's syndrome, describing the gene expression, in the biochemistry of autism, and by mapping risk and protective factors in human development.

Professor Cohen invests so much in autism because it is a paradigmatic disorder that confronts us with the brain/mind problem. That can be another and no less important justification to deepen research using autism not only as a paradigm of neuropsychiatric disorders but of brain/mind disorders par excellence.

This integration is more than a scientific and medical approach; it is philosophical. Early in his career, Professor Cohen "learned that once split, the domains of internal and external can only with difficulty, and perhaps not even then, be re-integrated; rather, the challenge, it seemed to me, is to avoid the original epistemological sin of dividing body and soul." "Splitting is the source of much philosophical mischief.' The question remains the same: is the brain the place where all these functions are elaborated and emerge, or is it simply the vehicle for them.

Considering all psychic functions as concrete products of the brain, raises the important ethical implication of new understanding of brain/mind functioning: the question of man's responsibility.

What kind of ethics is that? Both Plato and the Babylonian Rabbi, Reish Iakish, said that no one behaves badly; that is, against social values, knowingly. If behavior considered bad is an expression of genetically determined biochemistry, more or less counterbalanced by education and social events, what kind of responsibility can we place on perpetrators? Is it ethical to consider our patients responsible, is it ethical to consider them irresponsible? Society has to act as if delinquents are responsible in order to protect itself and discourage those who are potential criminals. But is there a criminal potential that can be prevented by the punishment of others? Those who behave according to social values are no more responsible for that behavior than delinquents. They were born with a well developed ethical-brain, supported by good environment and education.

Every human behavior, thought, fantasy and creative work can be evaluated according to the two systems: good/bad and sane/insane. Judges have to relate to their suspects as if there are no developmental and organic determinants in criminal behavior, while psychiatrists have to treat their patients without judging them (and _____ is the arena where the two meet, with no few misunderstandings!).

For Professor Cohen, the far-reaching developments in brain research and understanding of human behavior and mental functioning aim to resolve this philosophical dichotomy. He quotes Descartes, who said that the ability of a finite concrete being such as man to think about infinity, God, is the proof of God. We cannot imagine infinity and the more surrealistic and even unrealistic art works are always, in some way, linked with reality by having transformed it, although you can always find the realistic origin of the work. Even God could not be but represented. So why not accept a closed brain system with no dichotomy? Brain influences environment and vice-versa. In such a system there is no moral responsibility beyond "brain" in its larger sense, as causation.

This lecture raises the problem of social and moral dimensions in disorders. The first hug, smile and mirroring a newborn receives is encoded in his brain as a satisfying experience, creating a neuronal circuit linking words and attitudes to pleasure and a desire for replication. Every effort is made to experience these feelings again and again. During his development the child memorizes words and attitudes that induce these satisfactory feelings. The first of this long chain is the first hug we experienced, what the autistic baby cannot apparently experience and therefore does not seek.

Throughout your outstanding career you received a lot of "hugs," the latest being the Sterling professorship. You are right to feel proud, you deserve it, and much more. I, we, look forward to new research and more extensive findings from the desk of Professor Donald Cohen. We need your profound views on human life and development, and your humanity.

Serge Lebovici

June 10, 1915 – August 12, 2000

Serge Lebovici, Honorary President of our International Association of Children and Adolescent Psychiatry and of Associated Professions (IACAPAP) is no longer with us. He passed away softly after having struggled from a disease from which he suffered much and which prevented him from realizing all he still wished to do. He asked that the poem of Baudelaire, "Sois sage, o ma douleur!" be read. Our pain will not

be "sage" – docile. But his death means that never again will he be present and that we will have to do without his contributions to our debates. Nonetheless, he remains alive within us.

Pediatrician, he became a child and adolescent psychiatrist as well as for adults. He gave up a career in the *Hospital of Paris* in order to become a full time psychoanalyst. He established in France a school for children psychoanalysis, and invented, together with Evelyne Kestember and Rene Diatkine, a type of psychoanalytic psychodrama, which has no equivalent anywhere in the world. He had a decisive influence immediately after the Second World War and this until today.

His career has been retraced everywhere and his important achievements have been recounted. I will therefore only do this quickly in order to dedicate myself to representing him as a living picture: 40 years of cooperation and friendship have allowed me to know his inner self. I mentioned "his achievements." This does not only mean his publications. He was, as Daniel Widlocher mentioned at his funeral, a pragmatic – in the best sense of the word. He created numerous institutions, amongst which the well known Centre Alfred-Binet; he organized scientific reunions and congresses, and established new journals (*La Psychiatrie de L'enfant*, *Devenir*). He directed collections of works (*Le Fil Rouge*, section children and adolescent; the Monographies of children and adolescent psychiatry) and papers (*Traite de psychiatrie de l'enfant et de l'adolescent*, with Rene Diatkine and Michel Soule; *Psychopathologie du bebe*, with Francoise Weil-Halpern) and wrote numerous books. He created lately, together with Bernard Golse, an original collection, *A l'aube de la vie*, accompanied by video clips and an interactive CD-ROM as well as a printed volume. This means that he knew how to stimulate the interest and the collaboration of colleagues. He possessed an astonishing renewal ability. When he received the title of professor at the University of Paris-Nord, in 1978, he renewed his field of studies and dedicated himself to infant psychiatry. He loved "passing along," especially to young people.

To use an expression of our Canadian friends, he had a large "rayonnement" in and out of France. This is why the IACAPAP chose him to be their president (1966–1970) and he

also presided at the Congress de Jerusalem in 1970. He became honorary president of the IACAPAP in 1990. He also was the president of the International Psychoanalytical Association (IPA) and was still their honorary vice president. He also presided at the International Society for Adolescent Psychiatry (ISAP) and the World Association of Infant Mental Health (WAIMH) and became honorary president of both those associations.

He was able to become president of international associations because he spoke English. It is interesting to hear under which condition he learned English: he only had learned German in school; when a war prisoner in Germany, he learned, with the help of the *Assimil* method, a few pages every day. This was his way to defy his jailers and continue working.

He did not consider his position of president as being merely honorary. It meant for him a task to accomplish. He was able to do so at the same time as his "ordinary" work, because, not only did he possess an exceptional ability to work (none of us could equal his work stamina; he would get up at first light to read all the new publications) but also because work was his "religion." Following the footsteps of his father, Solo (but Solo would get up at two in the morning, Serge only at four!), he felt that he was born to work – this was a vital need for him. He was always highly grateful to his wife, Ruth, because she would let him work.

The portrait of Serge Lebovici would not be complete without mentioning that he was always available to others and always extended his helping hand. This man, who was working so hard, was prepared to hear and assist those who needed him: he would open his little notebook and write in their request and the help was given. This hard worker was not a robot – he was a warm human being.

Lucky those who had him as a teacher! Lucky those international associations which honored him as president: he really honored them.

Serge Lebovici (French)

10 juin 1915 – 12 août 2000

Serge Lebovici, président d'honneur de notre Association internationale de psychiatrie de l'enfant et de l'adolescent

et des professions associées (IACAPAP), vient de nous quitter, d'une mort douce, après une maladie qui le faisait beaucoup souffrir en entravant sa capacité de réaliser tout ce qu'il avait encore envie de réaliser. Il a demandé que soit lu à ses obsèques le poème de Baudelaire « Sois sage, ô ma douleur! » Notre douleur saura être sage. Mais sa mort signifie que jamais plus, *never more*, il ne sera là et nous devons nous passer de tout ce qu'il apportait à nos débats, même s'il reste vivant en nous.

Pédiatre, il est devenu psychiatre d'enfants et d'adolescents, mais aussi d'adultes. Il renonça à une carrière dans les Hôpitaux de Paris pour devenir pleinement psychanalyste. Il créa en France toute une école de psychanalyse de l'enfant, et inventa, avec Évelyne Kestemberg et René Diatkine, une forme de psychodrame psychanalytique, qui n'a pas son équivalent ailleurs dans le monde. Il eut une influence décisive au lendemain de la deuxième guerre mondiale et jusqu'à ce jour.

Partout sera retracée sa carrière et seront énumérées ses œuvres importantes. Je ne le ferai donc que rapidement ici pour me consacrer à donner de lui une image vivante: 40 ans de travail partagé et d'amitié m'ont permis de le connaître dans son for intérieur. J'ai dit « ses œuvres », il ne s'agit pas seulement de livres. Il était, comme l'a dit Daniel Widlöcher à ses obsèques, « un pragmatique » dans le meilleur sens du terme. Il a créé de nombreuses institutions dont le Centre Alfred-Binet bien connu; organisé des réunions scientifiques et des congrès, fondé des périodiques (*La psychiatrie de l'enfant, Devenir*), dirigé des collections d'ouvrages (*Le Fil rouge*, section enfant et adolescent; les Monographies de psychiatrie de l'enfant et de l'adolescent) et des traités (*Traité de psychiatrie de l'enfant et de l'adolescent* avec René Diatkine et Michel Soulé; *Psychopathologie du bébé*, avec Françoise Weil-Halpern), écrit de nombreux livres. Il a dernièrement créé, avec Bernard Golse, une collection originale *À l'aube de la vie*, associant des documents vidéo, un CD-ROM interactif, un volume imprimé. C'est dire qu'il savait susciter l'intérêt et la collaboration des collègues. Il avait une capacité de renouvellement étonnante. Quand il fut nommé Professeur à l'Université de Paris-Nord, en 1978, il renouvela le champ de ses études en se consacrant à la psychiatrie du nourrisson. Il aimait « transmettre », tout particulièrement aux jeunes.

Pour reprendre une expression utilisée par nos amis canadiens, il avait un grand « rayonnement » en France et hors de France. C'est pourquoi il a été choisi par la IACAPAP pour être son président (1966-1970) et il présida en 1970 le Congrès de Jérusalem; il est devenu président d'honneur de la IACAPAP en 1990. Il a aussi été président de l'*International Psychoanalytical Association* (IPA) et en était encore vice-président d'honneur. Il a également présidé l'*International Society for Adolescent Psychiatry* (ISAP) et la *World Association of Infant Mental Health* (WAIMH). et est devenu président d'honneur de ces deux associations.

S'il a pu devenir président d'associations internationales. c'est qu'il parlait anglais. Il est intéressant de dire dans quelles conditions il a appris l'anglais; au lycée il n'avait étudié que l'allemand; prisonnier de guerre en Allemagne, il apprenait chaque jour quelques pages de la célèbre méthode Assimil. c'était sa manière de défier ses geôliers et de continuer à travailler.

Il n'a pas considéré ses fonctions de président comme purement honorifiques. c' était pour lui une tâche à accomplir. Il a pu le faire. en même temps que son travail « ordinaire », parce que non seulement il avait une capacité exceptionnelle de travail (aucun d'entre nous ne pouvait égaler sa puissance de travail, il se levait avant le petit matin pour lire tout ce qui paraissait), mais parce qu'il avait « la religion du travail ». Suivant les traces de son père Solo (mais Solo se levait à 2 heures du matin et Serge à 4 heures seulement !), il se sentait né pour travailler, c'était une exigence vitale. Et il a toujours eu une grande reconnaissance à l'égard de sa femme Ruth parce qu'elle le laissait travailler.

Le portrait de Serge Lebovici ne serait pas complet si l'on n'évoquait pas sa disponibilité à l'égard d'autrui et sa serviabilité. Cet homme qui travaillait tant était prêt à écouter ceux qui avaient besoin de lui et à leur rendre service: il ouvrait son petit carnet, inscrivait la demande et le service était rendu. Ce travailleur acharné n'était pas un robot, mais un homme chaleureux.

Heureux qui a pu avoir un tel maître! Heureuses les associations internationales qui l'ont honoré du titre de président d'honneur: il leur a vraiment fait honneur.

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Al Solnit

Professor Al Solnit has gone suddenly. He has disappeared without warning. He is not going to participate in any of our next activities. He is not going to give us any advice on a difficult issue. He is not going to supervise any of our clinical works or articles. He is not going to represent us in any forum dealing with Israeli Child and Adolescent Psychiatry. He is not going to give us any more any supervision on a difficult clinical case or a difficult forensic issue.

He did a lot. Many friends, colleagues and fellows will describe during the next years, the amplitude of his work. And, you need this amount of time. I would like to emphasize just on one aspect of his work, on one aspect which represents at the same time, his emotional and intellectual investment during so many years, on his personal involvement and participation in our academic work in Child Psychiatry in Israel.

He started in 1971 when he served on the American Professional Advisory Committee of the Jerusalem Mental Health Center. At that time we were very few in Israel to practice Child Psychiatry, and he was one of the mentors to guide us, how to create a professional body and a training program. In 1973 he spent a sabbatical as Visiting Professor of Psychiatry & Human Development at the University of the Negev in Beer-Sheva. He considered, it was his role to live in the south of the country, where he was the only Child Psychiatrist at that time, in order to attract young fellows to go and train there. After one year of hard clinical work, he presented a large document to the Medical Scientific Council, recommending the establishment of a new specialty in Israel, namely, Child and Adolescent Psychiatry. His request was rejected, asking for the creation of a training program and a University course. Al was not discouraged. As usually, he gathered five members of our local committee and gave us the task, accompanying us, of course, as usual. He became a member of the Israel Psychoanalytic Society in 1977 and continued his membership throughout his life. He was a member of the Medical Advisory Board of the Hadassah Medical Organization starting in 1981, and had been nominated the same year as Chairman of the Sigmund Freud

Cathedra at the Hebrew University in Jerusalem.

Al was very alert about the events in Israel, and always ready to come when invited to lecture, to consult or to supervise. He was a real Zionist.

I met him last time, when we had dinner at the same table on the memorial day for Donald Cohen, in New Heaven. I was trying to recall with him the meetings we had in Israel, and the large impact it had on our future development. I was talking about his activity, and he was directing the conversation towards Donald's achievements. The death of Donald affected him very much. He was Donald's mentor, they planned together how to bring to us the best support we could have. They both did a lot for Child Psychiatry in the world and specifically in Israel.

Al and Donald did it, because they thought children deserve it. Al always saw himself as a children's defender. Defending children's rights on the social and forensic ground.

We will always remember Al Solnit as one of the pioneers of Israeli Child & Adolescent Psychiatry, being for us a mentor and an identifying figure. Identified by his wisdom, his clinical sense, his attentiveness and friendship.

We will miss you, Al.

Al Solnit

by John E. Schowalter, M.D.

*Albert J. Solnit Professor
Yale University Child Study Center*

Al Solnit's tragic death as a car crash passenger on June 21, 2002 was a terrible and untimely loss. Just two nights earlier, Al, a group of IACAPAP leaders from the U.S. and abroad who were in New Haven, CT for Donald Cohen's memorial, and a few others heatedly debated some IACAPAP issues. At the time, a number of participants mentioned that Al's comments were the most cogent and wise. To be more cogent at age 82 than leaders decades younger is so rare that few, if any of us, will have such an experience.

His childhood seems unremarkable. His father moved to Los Angeles after having felt the sting of anti-semitism in the Midwest. The family was close. Al did well academically, but also admitted to at times playing pranks at home and school. He grew up happy and with the

belief that he could contribute something to the world. He decided on medicine and obtained his bachelor degree, a master's degree in anatomy, and his medical degree from The University of California in Berkeley and San Francisco. Al decided on pediatrics and after his residency, he was drafted into the army to be a flight surgeon from 1945 to 1947. He was struck during these years by how much debility was caused children by their psychopathology.

When discharged from the army, he came to New Haven for a psychiatry residency, followed by being the first child psychiatry resident at Yale. Upon graduation, he joined the Yale School of Medicine faculty at the Yale Child Study Center. He was impressed by the writings of Anna Freud and completed both adult and child analytic training at the New York Psychoanalytic Institute. In less than a decade following this training, he was appointed a training and supervising analyst at both the Western New England Institute for Psychoanalysis and the New York Psychoanalytic Institute. Al had a thirst for knowledge, all knowledge. This shows clearly in his wish to understand problems from their basics. Anatomy, child development, psychiatry, and psychoanalysis all focused on our physical and mental roots. He believed if you knew and attacked problems earlier, rather than later, the patient can be better helped. He believed the same was also true for developing health systems, and this later fueled his passion for IACAPAP.

Al's first international interest was Anna Freud. He visited her in London, and, along with Sterling Professor of Law Joseph Goldstein, persuaded Miss Freud to visit Yale regularly. In 1973-74, he was the World Health Organization Visiting Professor to the developing medical school at Ben-Gurion University of the Negev in Israel. From 1974 to 1976, he was President of IACAPAP (and Honorary President from 1990 until his death). Al was the Sigmund Freud Visiting Professor at University College London (1983-84) and at Hebrew University in Jerusalem (1985-87). He served both as a Trustee of the London Anna Freud Centre, and was Secretary of The Anna Freud Foundation at the time of his death. While Director of the Yale Child Study Center (1966-1983) and thereafter, he fostered closer contacts between the Center's faculty and international colleagues.

Al Solnit was a giant. He was a member of the Institute of Medicine of the National Academy of Science, and President of the American Academy of Child Psychiatry, The American Psychoanalytic Association, and The Association for Child Psychoanalysis. He was on multiple editorial boards, including Managing Editor of The Psychoanalytic Study of the Child since 1971.

Al's accomplishments in so many areas of medicine, his passion to teach and learn from everyone he met, and his compassion for all children, truly make his untimely death a loss to the whole world.

Al Solnit in Israel

by Dolores Gee

Al was Visiting Professor of Psychiatry & Human Development at the University of the Negev in Beer-Sheva 1973-1974. He served as Sigmund Freud Professor in the Dept. of Psychology at Hebrew University's Mount Scopus campus in Jerusalem from 1985-1987. He served on the American Professional Advisory Committee of the Jerusalem Mental Health Center starting in 1971 and was on the Professional Advisory Committee of the Research Center for Human Sciences at Hebrew University in 1976. He became a member of the Israel Psychoanalytic Society in 1977 and continued his membership throughout his life. He was a member of the Medical Advisory Board of the Hadassah Medical Organization starting in 1981. On the most current level of Dr. Solnit's ongoing efforts on behalf of Israel in general and his longtime Israeli friends and colleagues in particular, one of the last articles he authored will be appearing soon in the Israel Journal of Psychiatry, of which David Greenberg MD, is the Editor.

Remembrances of Albert J. Solnit

by Barbara F. Nordhaus
Yale Child Study Center

Al Solnit's custody work at the Child Study Center spanned three decades during which he conducted and supervised clinical custody assessments, as well as taught and published on the subject. Throughout this time, I worked closely with him in conducting custody

evaluations and in teaching a weekly seminar. My remembrance is offered from that perspective.

At Al's funeral, his sister, June Solnit Sale, asked rhetorically whether we knew that as a boy Al had done his homework sprawled on the floor listening to his favorite radio program, "The Shadow." ("The Shadow" was a popular program, whose opening lines are famous: "Who knows what evil lurks in the hearts of men? The Shadow knows.") While, alas, we can no longer ask Al directly about the role this early learning modality played in his future intellectual life, we can speculate that several features of Al's later clinical and teaching style may have been linked to the earlier listening experience.

First, he listened for a living and was a focused listener at all times. He preferred listening, interacting, and discussing to lecturing, and was often frustrated reading his own text. "Let's wing it", he would say – meaning he sought to combine spontaneity with design so that he could deftly weave the strands of his broad and deep knowledge. His design depended on what he assessed about his listeners' interests and capacities. He had no use for mass production, dogma, or bureaucracy and always kept the individual foremost in mind. Al's interest in listening to individual stories led him to choose clinical over laboratory medicine. "The study of lives over time has fascinated all who are attracted to the complexities and subtleties of the human condition," he wrote. (Solnit AJ, 2000) In response to a patient's thanking him for help, he in turn thanked the patient for helping him learn. Through psychoanalysis and as a psychoanalyst, he not only listened to the other person but to himself.

A second possible influence of "The Shadow" may be seen in his appreciation of mystery – both in the books he read and in his approach to life and work. He recognized that much was unknown and perhaps unknowable. He taught that the clinical custody evaluation gave us only a snapshot view, leaving much unknown. He emphasized our need for awareness of the limits to what we can know or learn clinically. He never confused speculation with fact. His scientific, pediatric, psychiatric, and psychoanalytic training and his clinical experience with both adults and children allowed him to embrace more fundamental mysteries such as the mystery of nature/nurture and of

mind/body. He was content to investigate but did not seek to solve these grand mysteries. "And we need to keep in mind that the nature and nurture thing is never solved. It's only refined and elaborated." (Raymond L W, ed. 1997) Based, perhaps, on the radio days of his youth, he often sought to create suspense when he taught.

Third, Al had an appreciation for drama, and the ability to pretend and to play. He enjoyed the drama of what he called "creative tension" in intellectual exchange. He "always [did] more than one thing at a time." (Raymond L W, ed. 1997) As he explained it, "I was known to be restless as a child, and to some extent I still am. It's one of those traits that you have to learn to harness." (Raymond L W, ed. 1997) In analytic supervision and in his analytic thinking, he often invoked the concept of the patient's dramatization of conflict. This could result in a dynamic formulation which allowed the supervisee to feel the force of the patient's conflicts as well as to see the psychic *dramatis personae* on an imagined stage.

The interdisciplinary custody and placement work that Al collaborated on with Joseph Goldstein, Anna Freud, and Sonja Goldstein afforded Al the opportunity to examine the subjects which most occupied him professionally. "... I view myself as having been most deeply interested in the application of psychoanalytic theory to the experience of being a child and being a parent, in a wide variety of settings – education, family, law. . . ." (Raymond LW, ed. 1997) The Best Interests of the Child (Goldstein et al. 1996) and its forerunners (see references) satisfied his lifelong interest in children and their families and expressed his desire to help and to advocate on behalf of children. It would be a mistake to think that he "specialized" in custody work – or in anything else for that matter. He thought of himself as a generalist with special interests in many areas, as can be seen by a glance at his writings.

The ideas of the "best interests" books are now widely known. The books propose minimal state intervention in families and protection of the child's need for a continuous relationship with a long-term or permanent caretaker who wants the child. The authors noted, "Continuity is a fundamental characteristic, a common denominator, of healthy growth and

development.” (Goldstein et al., 1996) The books were intended to offer guidelines and principles to courts and lawyers, mental health professionals, and others working with children and parents involved in divorce conflicts over custody and visitation or foster care/adoption placement dilemmas. Al taught trainees that the ideas in the books could be stated in a simple and jargon-free way, as summarized in the introduction to the paperback edition of The Best Interests of the Child:

1. The interests of a child are to be considered separate and apart from the interests of her family as a unit only if and when the family fails to provide nurture, protection, and affectionate guidance according to clearly articulated minimum societal standards. Until then, the state must leave parents to minister to the child’s needs as they see fit, given their own cultural, historical, and family preferences.
2. Once the family ceases to function adequately for a child – if the child is abused or abandoned or when separating parents cannot agree on custody – the state should intervene.
3. Once the state intervenes it must put the child’s interests first, over and above that of even the most “deserving” of adults. Placement of a child must never be used to compensate an adult who has suffered misfortune or injury or injustice at the hands of another adult or the state; otherwise respect for the blood tie can only too easily be turned against the child’s interests.
4. Decisions about care and placement must be made in accordance with the child’s sense of time. Children cannot wait beyond their developmental tolerances – which gradually increase as the child gets older – without their well-being and future development being placed at risk.
5. By the time there has been a need for the state to intervene, there is no ideal solution for the child, only one that is at best the least harmful – the Least Detrimental Alternative. In some instances this arrangement may necessitate leaving (or reuniting) the child with admittedly less than ideal parents because the alternative is intolerable delay or a placement that is no better and may even turn out to be worse.
6. Having intervened, it is the obligation of the state to provide for

the child, with all deliberate speed, a safe and secure place in a family in which she feels wanted and which holds the promise of providing her with continuity of affectionate care and safety. The placement should be unconditional. No further intervention by the state is justified unless the family (be it the family from which the child was removed or a new family) fails to meet society’s minimum standards of child care. (Goldstein et al., 1996).

The guidelines were intended both for use in decision-making and also to serve as a framework for clinicians. Courts and child welfare systems request “parent-child evaluations” to help translate the indeterminate “best interests” standard into concrete custody and placement recommendations for individual children. Such clinical evaluations were overseen by Al at the Child Study Center for more than 30 years. They were based on child development knowledge and direct observation of children both individually and together with their caretakers. In support of families, Al and his co-authors wrote, “We draw upon a body of generally applicable knowledge about child development which recognizes that the law must be respectful of what families of different social and economic classes, of different religions and races, of different colors and cultures, and of different lifestyles, believe to be best for their children.” (Goldstein et al., 1996)

Al was deeply concerned about issues of child neglect and abuse and associated conditions of poverty. He was interested in making recommendations to state systems that would protect children as much as possible from the harm caused by uncertainty in their placements. He sought recommendations for the child which would promote the child’s best chance for developmental progress and would support the child’s potential for recovery and adaptation. He believed that the best of what was available to the child could be advocated by taking into account the child’s developmental tolerances and capacities.

Sound placement recommendations could mitigate against harm caused by the child’s exposure to “traumatic, deprivational [sic], disruptive, disorganizing, and pathogenic social environments as well as neurotic compromise states” (Solnit AJ, 2000) Al was passionate about custody

work because it was an effective means of child advocacy.

When teaching the scientific art of conducting custody evaluations, Al emphasized the importance of focusing on the immediate situation, rather than looking into the distant future, which defies prediction. (see Nordhaus B, Solnit, AJ, 2000) He encouraged trainees to find their own way, believing that “When there’s too much teaching, there’s not enough learning.” (Frumkes LB, 1995) Informally, Al admonished trainees:

1. to have a soft heart and a hard head;
2. to put themselves in the skin of the child, as Anna Freud had taught. He signaled to trainees the difficulty involved in tolerating feelings of helplessness in children who were the subjects of custody and placement disputes;
3. to guard against therapeutic zeal and rescue fantasies which cause harm by making promises to the child that cannot be kept; and
4. to be aware of the Humpty Dumpty phenomenon in families shattered by separation whether through divorce or foster care placement. (All the King’s horses and all the King’s men couldn’t put Humpty together again). The painful reality that broken families cannot be put back together again underlies the least detrimental alternative standard, which requires that the custody evaluator recommend known available options rather than more ideal but no longer available solutions.

Al traveled widely and learned first hand in the field. In recent years, several international custody issues came to our attention. Of the Elian Gonzalez case, we observed, “inviting a six year old to make decisions about where and with whom he shall live is asking the child to go beyond his cognitive, social, and emotional capacities and abandons him to responsibilities he is not capable of taking on.” We concluded, “Where should Elian live? He should live with his father. For the child, his parent is his country.”

The 1999–2000 international case, *Blondin v. Dubois*, involved an issue of child abduction. Under the Hague Convention, child abduction requires the “prompt return” of the child to the country from which the child was wrongfully removed except under certain circumstances. The case was referred to us for psychological

evaluation under one of the four exceptions: "if there is grave risk that his or her return would expose the child to physical or psychological harm or otherwise place the child in an intolerable situation." (Hague Convention, Article 13-b) Al's contribution in this case was to illustrate to the Court that, regardless of our view of the mother's actions in abducting the children and in forging documents to enable her to emigrate with her children, the children should not be returned to their abusive father because return would cause retraumatization. This clinical opinion exemplified Al's skill at staying focused on the children's needs and interests even in the face of powerful distracting adult interests, including violations of civil and criminal law by the mother who abducted the children.

Al's concern for children and families of all cultures continued throughout his life. Al was an optimist and a "glass half-full" person. As an advocate for children, he wrote that "Best interests and least detrimental alternatives should guide us in doing our best to find truth without doing harm and to accept the limitations of what is truth and how we are able to approximate it." (Solnit AJ, 1994) Someone Al helped remarked after his death, "It is a loss to personkind." Although our loss is indeed great, Al has left us with many sustaining memories and a lifetime supply of food for thought.

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The Promised Childhood Congress

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The promise, an inevitable act of parenthood and care, was at the center of the Congress that took place in Tel Aviv between April 30th and May 3rd. The Congress was organized by the Israeli Association of Child and Adolescent Psychiatry and the Israel Psychological Association. Every day of the Congress had offered several parallel sessions on different aspects of child and adolescent mental health. Indeed, the list of all addressed topics is well beyond the scope of this short report.

The sunny beach stood in sharp contrast to the grim events that took place in the Middle East region during that time. But political strife did not break the promise of a scientific interdisciplinary Congress, devoted solely to the study of mental health among children and adolescents.

Interdisciplinary view was the heart of the matter at Peter Fonagy's (UK) opening plenary session "The Gene-Environment Interaction." Following a comprehensive review of biological as well as environmental data, Fonagy has offered the listeners the promise of integration of several research and clinical disciplines.

This promise was soon to be realized: during the next four days, child and adolescent psychopathology was addressed from both research and purely clinical perspectives. Epidemiological, phenomenological, genetic, cognitive, psychodynamic and developmental domains were reviewed. Moreover, most speakers have referred to those different perspectives as complementary rather

than contradictory. For example, several speakers have addressed the epidemiology of adolescent suicide, a major social and mental health problem during the first day of the Congress. Dr. Brent (USA) had presented data supporting gender differences in this age group and refereed to cognitive-behavioral therapy techniques of suicide. Zalsman (Israel) presented haplotype relative risk (HRR) studies of suicidal adolescents. Others speakers provided data regarding outcome studies of psychotherapy in suicide.

Childhood onset psychosis, another severe psychopathological condition, was also discussed during the first sessions of the Congress. Dr. Biederman (USA) presented an open prospective study of Olanzapine monotherapy in the treatment of juvenile mania. Other speakers have presented the outlines of two important longitudinal studies. The Jerusalem infant development study was presented by Aurbach (Israel) and the Israeli high-risk study by Dr. Kugelmass (Israel).

Dr. Laor (Israel) opened the second day of the Congress with a plenary lecture on the Tel Aviv-Istanbul disaster intervention program. Following the 1999 earthquake in Turkey, a group of clinicians from the Tel Aviv Mental Health Center had established a child mental health intervention program in one of the affected villages. Dr. Laor first presented a theoretical model of large-scale community intervention and research program in children at risk for development of post-traumatic disorder.

The neuroscience of substance use, a frequent disorder during adolescence, was presented in the session organized by Dr. Elan (USA). Dr. Gardner (USA) reviewed reward and craving circuits in the brain in relation to hypothesis-based medication development for the treatment of addiction. Dr. Aharon (USA) reviewed fMRI studies of human reward systems. Dr. Elan concluded by reviewing cutting edge developments in the psychopharmacology of addiction. The treatment of substance abuse was also addressed in a separate workshop, organized by Dr. Kaminer (USA). This workshop focused on cognitive-behavioral coping skills therapy of adolescent substance use.

Three sessions have addressed the study and treatment of attention deficit hyperactivity disorder (ADHD). The first session, organized by Dr. Biederman (USA) looked at ADHD throughout the life cycle, including the

characteristics of the disorder in the preschool years, patterns of symptom decline and comorbidity with juvenile mania. Rhode (Brazil) reviewed the epidemiology of the disorder in Brazilian adolescents. The second session, organized by Barr (Canada) addressed the molecular genetics of ADHD. The session presented recent studies regarding the association of ADHD with several genes, including DRD4, 4 HTTLPR and DAT-1. The third session was organized by Rhode and focused on neuropsychological and clinical aspects of the disorder. Schachar (Canada) presented neurocognitive data that supports subtyping ADHD using cognitive measures. Biederman presented the topic of temperamental risk factors for psychopathology in general and ADHD in particular.

In addition, the second day of the Congress also offered sessions on varying topics such as Lacan and psychoanalysis in the 21st century, the treatment of the religious ultra-orthodox population, and public services in child and adolescent psychiatry. The Israel Association of Psychologists also sponsored a special session on psychology in community settings for young children and their families. The phenomenology and subtyping of OCD was the subject of yet another session. Zohar (Israel) presented data from the Jerusalem family study. Combining molecular genetics and classificatory issues, Presburger (Israel) described a subtype of OCD associated with the velo-cardio-facial syndrome (VCFS).

The third and last day of the Congress saw sessions on the subjects of eating disorders, youth migration, family therapy, and psychopharmacology of childhood affective and anxiety disorders. During that day, two sessions addressed the growing field of infant psychopathology. These sessions presented data regarding assessment of infant psychopathology and feeding problems of infancy.

Dr. Tyano (Israel) has taken it upon himself to summarize the Congress in his closing lecture: "The promised childhood: what have we promised". Before the lecture, a short videotaped speech by Dr. Cohen (USA) was presented. Dr. Cohen, who was unable to attend the Congress, had addressed the importance of pursuing the study of the many aspects of development in children and adolescents. In his lecture Dr. Tyano has discussed the multiple meanings of making and fulfilling a

promise: a god to his people, a parent to his son, a teacher to her students. For the many clinicians, mental health professionals and researchers who have attended the Congress, the lecture offered the opportunity to ponder, if only for a brief moment, of what was presented, experienced and learned during the Congress.

Editors' Comments: IACAPAP has experienced world turmoil but it focuses on the various needs of children. This is a fine example of our need to persist.

The Promised, Promised Childhood Jerusalem 2000 Congress

So, we did it!

One month before "the events" in the Middle East, our Congress was practically ready. Almost one thousand participants from abroad were already registered. The program was closed with four plenary lectures, four key lectures, 12 to 15 symposia per day, many workshops, video, poster, meet the authors, around a theme sessions. A rich palette of social events, and many other surprises and new features since the badges, to the bags, to performances by youths... We are more worried by our and our neighbours' situation than frustrated by the cancellation of our Congress. Everyone who once worked for a Congress can understand our thoughts and feel our resentments.

However, we decided after many discussions and hesitations, to have this Congress, even without the umbrella of our international organizations, and we understand absolutely their decision. At the last moment plenary sessions speakers cancelled their coming, and we understand their decision.

Even though, as you can learn from the reports about the quality of this congress. We were particularly impressed and moved by the coming of 300 colleagues from all over the world who participated actively and enjoy with 500 Israelis to be in Tel Aviv.

We hope first of all and above all for peace and well-being for our children in our region and in all the world. We work for this. When these days arrive, we will celebrate peace and friendship between our people by an extraordinary international congress in Jerusalem joining all people of the region.

Inch Allah! Be ezrat Hashem! With God's help.

The Promised Childhood – Opening Ceremony

by Professor Sam Tyano, M.D.

Dear friends and colleagues, thank you for coming, thank you for having come from so many countries, after the International Societies withdrew their sponsorship from our meeting, because of a sense of responsibility towards their members. Thank you for coming individually.

The Promised Childhood was the theme we have proposed to this Congress, after the notion of "The Promised Land." We didn't realize at that time how close and how far were the two topics. The same distance between the Promised Land, "Land of Milk and Honey" "land of..." and of the actual events in the Middle East as between the programmed

Congress and the actual one, is what is the most important issue which is what we have hoped and promised to our Children and what we can offer them today.

It is usual in opening ceremonies to describe and paint reality so nicely and with a lot of humour and gratitude. What happened to us for the last few months displaced us back to the course of history of the Jewish people. We were discussing already the common program, presentations and chairmanship with our Palestinian colleagues from Gaza, Ramallah and Beith Lehem. It was a promised program. It was a promised friendship. All of them withdrew, some of them in good terms, still remaining friends, some of them by identifying very strongly with the conflict. Instead of discussing treatment issues and psychopathology of Learning Disabilities, we find ourselves dealing again with Post Traumatic Stress disorders.

What should we transmit to our children? What should we tell them? Is it what we hope or is it what we experience? We shouldn't lie but we shouldn't discourage, either. So we split. We create terms, we separate between the sky and the earth, between reality and fantasy – between the ego and the ideal ego – between childhood naiveté and adulthood experience. Or, we shouldn't split at all. We should keep both realities as a unit which according to the Chaos theory, can very well live together. The transgenerational transmission of our people has taught us that it works together. The fact is that although

we were spread all over the world for 2000 years, we are still here in the promised land. Not as we expected to be, but existing and independent. Which maybe, means that we have to stick to the essential of the message we transmit even if some of the details will not be fulfilled. Children must receive continuously the message of Hope and values. Hope is one of the basic issues we must transmit. Unfortunately, in most of the countries today, children are educated on the history of hate and disagreements. Such an education can lead only to aggression and destruction. The Promised Childhood will have to discuss and redefine the right message we want to transmit. Not only the rights and duties of children, but also the optimum environmental conditions they deserve for normal development. Normal I mean in a sense of values and love of creativity and interpersonal relationships. Normal means as close as we can to what we would expect ourselves or the mirroring others to be.

I hope we will have the opportunity to take time during the next few days to discuss in each one of our sessions the implication of our scientific work to those issues I have mentioned. It was very important for us to open today this Congress of Promised Childhood on this Promised land and on behalf of the Organizing, the Scientific and the Coordination Committees, we appreciate very much your presence here today and for the next few days. You understand better why for so many years, our National hymn *Hatikvah*, Hope, was and will remain the most symbolic root of our existence.

The Sharm El-Sheik Meeting and the Declaration of EMACAPAP, the East Mediterranean Association for Child and Adolescent Psychiatry and Allied Disciplines A Historical Landmark

by Per-Anders Rydelius

On 8–11 February 2000, a most stimulating and thrilling meeting of extraordinary importance took place in Sharm El-Sheik, Egypt.

In this conference, child and adolescent psychiatrists and members from the allied disciplines were brought together, coming from the following

countries: Morocco, Tunisia, Egypt, Sudan, Lebanon, Palestine, Israel, Jordan, Kuwait, Oman, the Emirates, Iran, Iraq, Saudi Arabia, Yemen, Belgium, Germany, the Netherlands, Sweden and the USA. The three main languages spoken were Arabic, English and French. The cultural and religious blend was obvious when participants from both different nations and Muslims, Jews and Christians met for rich intellectual and scientific discussions.

Professor Ahmed Okasha from Cairo, Egypt, was the President of the Conference. As the meeting was chaired by the President-elect of WPA and the President of the coming WPA World Congress in Egypt, the importance of the conference became even more stressed.

Professor Amira Seif El-Din from Alexandria, Egypt, had worked hard to prepare for the meeting together with the IACAPAP bureau, the past President Donald Cohen from the Child Study Center at Yale University in the U.S. and Dr. Ernesto Caffo from Il Telefono Azzuro (the Children's Help Line in Italy). Ms. Valeria Vitali from Il Telefono Azzuro was responsible for all the practical arrangements.

Prior to the Sharm El-Sheik conference, Amira Seif El-Din organized a study group in Alexandria. Together with members from IACAPAP and its bureau, the local group of child and adolescent psychiatrists and allied professionals from Alexandria met to discuss clinical methods and current opinions in the treatment of mentally ill children and adolescents. The meeting was extremely productive and it inspired the participants to arrange future study groups, which would cover different aspects of assessing and treating mentally ill children. The next study group will be on learning disorders and will take place in Alexandria in November 2000.

Sharm El-Sheik is a real pearl. The beauty of the Red Sea, the surround mountains and the desert, embraced the multi-cultural group of scientists, enriching the intellectual discussions. The presentations and the discussions covered cutting edge issues in child and adolescent psychiatry.

However, the importance of the meeting was more than the scientific program itself. A historical landmark occurred with the regional child and adolescent psychiatrists founding EMACAPAP during the course of the meeting. Dr. Ahmed Shawky El

Akabaoui from Cairo, was elected the first president of the new regional association, and Dr. Amira Seif El-Din from Alexandria was elected Secretary General. This historical landmark will provide the children of that region with better opportunities for mental health services in the future.

The IACAPAP owe Professor Amira Seif El-Din, her staff in Alexandria, and also her husband, Mr. Nabil Abd El Rahman, much gratitude and deep appreciation for their initiative and help in organizing such a successful meeting.

The Structure of the East Mediterranean Association for Child and Adolescent Psychiatry and Allied Disciplines – EMACAPAP

The Bureau of EMACAPAP consists of the President, Secretary-General, Treasurer, Past President. The Board consists of an individual from each nation in the region. The Executive Committee consists of the Bureau and the Board. Up to five members of the Board can be designated as Vice President.

The President is responsible for proposing a list of three individuals of special distinction to serve as the Nominating Committee. The Nominating Committee must be affirmed by a majority of the Executive Committee.

The Nominating Committee is responsible for proposing individuals for each position on the Bureau and Board, based on criteria established by EMACAPAP. Any Full, Affiliate or Personal Member can propose any number of individuals for consideration by the Nominating Committee.

Officers will serve for three year terms; an officer can be re-elected to the same position for a second three-year term. An individual who has served one or more terms in one office may then be elected to a term to another office. The individual who has served one term in this second office can be renewed at this level for a second term. (For example, an individual can serve one or two terms as Vice President and then serve one or two terms as President). After completion of such a cycle of four periods of three years, an individual cannot be elected to a position for a period of three years.

An individual of special merit can be named as Honorary President for a term

of ten years, by a majority vote of the Executive Committee. This can be renewed without limit.

Using established criteria, the Bureau can appoint an International Advisory Committee and chairperson, to be affirmed by the full Executive Committee. The International Committee will consist of distinguished individuals from throughout the world and will serve for three year terms that can be renewed by the Bureau and affirmed by the Executive Committee.

Using established criteria, the Bureau can appoint a Regional Advisory Committee and chairperson, to be affirmed by the full Executive Committee. The Regional Committee will consist of distinguished individuals from the Eastern Mediterranean region and will serve for three year terms that can be renewed by the Bureau and Executive Committee.

Meetings and Publications: The Bureau and full Executive Committee will communicate and meet on a regular basis. They will convene meetings, working groups, and congresses, as indicated and desirable. EMACAPAP can publish newsletters, bulletins, journals and other types of documentation, and collaborate with others involved in such publication.

Revisions of Bylaw: These bylaws were accepted by the Founding Members of the EMACAPAP on Wednesday, February 9, 2000, at the Founding Meeting in Sharm El Sheikh, Egypt. At that meeting, the Founding Members signed the Declaration creating EMACAPAP and affirmed these Bylaws. These bylaws can be revised by a two-thirds vote of the Executive Committee.

The Promised Childhood Congress

Declaration Jerusalem 2000

The conference endorses the principles of the U.N. Convention of Children's Rights 1989.

The conference recognizes children's rights as inherent and inalienable, reflective of children being full members of the human community.

Rights should be accorded to all children equally, taking into consideration their evolving capacity.

Educating children to exercise their rights is the heart of the process. Participation from an early age, according to their evolving capacity, will

prepare children to participate responsibly in the democratic process.

Children's rights should not conflict with the norms pertaining to families. This requires a change in our perception of the status of children and parents within both the family and the community.

In order for parents to realize their duties and rights to raise their children in the spirit of the Convention, State support is needed in the form of resource allocation and legislation.

States have the duty and the responsibility to create optimal conditions for the development of both children's capacity to exercise their rights and parents' ability to fulfill their duties.

We believe that as nations invest more in education, integrating all agencies that deal with children, while enlisting the most advanced professional knowledge, they will decrease the need to develop programs to correct damage and abuse. Children's rights will then be widely recognized because realized throughout childhood. Children will develop into responsible adults with an inherent sense of human rights.

Declaration of Modena: Genetics of Autism

French Perspectives

The International Association of Child and Adolescent Psychiatry and Allied Professions (IACAPAP) convened an international working group on the Genetics of Autism in Modena, Italy, on March 16–18, 2000. The Working Group reviewed the current state of knowledge concerning the contributions of genetic factors to the pathogenesis of autism and discussed future directions and implications of research. Based on these discussions, important conclusions already can be reached.

IACAPAP is the international organization of national societies of child and adolescent mental health founded more than sixty years ago to promote child mental health through improving the delivery of services, promotion of research, and the education and facilitation of the professions involved in these fields. As a non-governmental organization (NGO) in the framework of the United Nations, IACAPAP includes more than 65 nations as members. A major goal of IACAPAP is advancing knowledge concerning developmental psychopathology and the implications of

research for clinical understanding, services, and treatment of individual children. To these ends, IACAPAP convened an international Working Group in Venice, Italy, in 1998, to review the major areas of advancement and future prospects for research on the field of autism. This Working Group led to a IACAPAP Declaration on Autism and Developmental Disorders. As a continuation of this process, IACAPAP convened a Working Group in Modena, Italy, in March, 2000, to review the field of genetics of autism and bring together leaders in the field to discuss avenues for facilitating future progress.

Child and adolescent psychiatrists first recognized autism almost sixty years ago. Since then, individuals with autism have been diagnosed throughout the world, in every ethnic and social group. Clinicians and researchers have learned an enormous amount about the social, cognitive and language problems in autism, the natural history, and the range of outcomes. Autism is the most severe form of early onset, developmental disorder. Individuals with autism suffer from severe disturbances in the formation and maintenance of social relations, in language and communication, and in flexible functioning and adaptation. Many individuals with autism are intellectually disabled. Individuals with the most extreme forms of autism may be mute, socially detached, burdened with stereotypic behaviors, profoundly intellectually disabled and in need of fulltime supervision. Those with milder forms may have serious problems in the areas of mutual social relations, communication, and flexibility, but they have intellectual abilities within the normal range and are able to function in the mainstream of society.

For several decades, autism has attracted major commitments from clinical services and research programs because of its early onset, major impairments of functioning, burdens on individuals and their families, remarkable symptomatology that affects core areas of development, and life-long nature. Also, the scientific and policy advances that relate to autism have influenced the understanding and care of individuals with other severe psychiatric and developmental disorders. Thus, future advances in research on autism, including the genetics of this disorder, are likely to have important benefits for the broader field of research in developmental psychopathology.

Research and clinical experience concerning autism have supported the concept of autism as a developmental disorder that reflects disturbances in underlying neurobiological development and functioning. Many lines of evidence – including research findings on brain function, the presence of autistic syndromes among individuals with known genetic disorders, and the impact of profound environmental factors — support the view that autism reflects the final outcome of a range of biological and environmental processes that impact early brain maturation. Among the factors that have been associated with autism, it now appears that abnormalities in genetic endowment play the central role. This viewpoint of autism as a developmental disability is influencing social and governmental policies about the need for comprehensive programs of education, clinical care and associated services.

We are now in a new era of research on autism. Using standard diagnostic concepts (including the definitions within the international classification schemes: International Classification of Disorders, ICD 10th edition, and the Diagnostic and Statistical Manual, DSM IV) and diagnostic methods, researchers and clinicians throughout the world can communicate clearly and collaborate scientifically. Advanced scientific methods and concepts are being focused on individuals with autism, including developmental and language research methods, neuroimaging, neurochemistry, cognitive and behavioral sciences and a range of genetic methodologies.

Recent studies on autism have used many of the contemporary approaches to genetic research on complex human conditions. These approaches include studies of populations, families, twins, and individuals with specific genetic and behavioral findings. In the future, it will be important to maintain a broad range of research methodologies and to allow investigators to pursue findings with different methodologies. Research findings on the genetics of autism have led to the recognition that inborn, genetic factors play the prominent role in the cause of the disorder. Careful investigations of identical (monozygotic) and fraternal (dizygotic) twins and of families with more than one affected individual have revealed that genetic factors appear to play a central role for the majority of cases. Mathematical models suggest that a number of genes are probably involved

in the transmission of this vulnerability, but the precise number is not known nor have specific genes yet been discovered. Sophisticated genetic studies from different research groups and consortia have highlighted several areas of the human genome that are highly promising for containing genes associated with autism.

There are indications that the full clinical expression of the disorder reflects complex interactions between the genetic vulnerability and other biological and environmental factors. These factors that make a child vulnerable are not yet known. Genetic research also has supported the earlier clinical concept of a “developmental or autistic spectrum”; that there is a broad range of expression of the underlying biological diathesis or vulnerability. In some individuals, the full-blown autistic syndrome appears; in other relatives, including some parents and siblings of individuals with autism, aspects of the disorder become manifest. Individuals with difficulties on this autistic spectrum suffer from problems in forming and maintaining social relationships. They may be awkward in their social communication and may have problems in the expression and understanding of emotions. Some individuals also may have circumscribed areas of unusual interest or ability. It is not known what leads to the full syndrome of autism or to the milder variants of the “extended” or “broader” phenotype of the autistic disorder.

The Working Group recognizes that research on the genetic factors involved with autism will require many years of sustained, multidisciplinary and multi-site research. This research requires the collaboration of experts in various disciplines, including basic developmental biological and behavioral scientists and clinical researchers. There are essential reasons for the formation and support of international research consortia that can share methods, pool data for analyses, follow-up important findings, and disseminate authenticated knowledge without excessive delay. At present, most research on the genetics of autism has concentrated on populations in the United States and Europe. It is important that future research consortia include research groups and clinical populations throughout the world. Also, there must be a spirit of collaboration between parents and individuals with autism and those who are trusted with research and treatment. Today, professionals and families are joining together

to promote research and improve services, and parents are recognized as their child’s most effective and essential advocates.

When genes for autism are discovered, there will be a long process to define the pathways between genetic factors and full clinical expression and the development of individuals. This process will require the collaboration among many different types of investigators and clinicians. The new field of genetics of autism raises both new hopes and new concerns. The discovery of genetic factors will eventually, hopefully lead to new approaches to diagnosis and intervention, and perhaps even prevention and cure. At the same time, genetic issues raise a range of ethical and policy issues.

While it is still early and no genes are yet known, it is important for researchers, clinicians, families and others concerned about issues in social policy and ethics to begin the process of discussion and clarification of the issues raised by new understanding of genetics in autism. The Working Group affirms recent policy statements by heads of government and others that the fundamental knowledge about the human genome - just as other phenomena of nature - belongs to society as a whole. Thus, genes should not be controlled by patents. At the same time, there should be various ways of promoting and utilizing the new knowledge to benefit individuals and mankind. In addition, it is important for everyone engaged in research to disseminate accurate and current information to both the scientific and lay media in a timely fashion.

It is important to note that the discovery of genetic factors will lead to new issues for parents and families, including concerns about transmission and counseling in relation to recurrence. These clinical and policy issues will require close collaboration among families, their advocates, clinicians and other specialists in the various medical, policy, and ethical fields. In this context, those concerned about autism can learn from experience with other developmental and medical conditions in which genetic factors play a major role.

In considering the future prospects for research on the genetics of autism, the Working Group affirms the importance of open exchange of knowledge among different researchers. The advancement of knowledge about

autism will require sustained engagement by many different research groups and the capacity for sharing information and comparing findings. This is particularly relevant in relation to studies that require large numbers of families and individuals for their timely and successful completion. Also, families who volunteer to participate in research and who provide information and biological specimens have a right to expect that investigators will facilitate the most rapid possible advancement of knowledge.

There are important policy and ethical issues in relation to the importance of sharing knowledge about autism and similar disorders while promoting as rapid an advancement of knowledge as possible. In affirming the importance of such collaboration, the Working Group is aware of the need to preserve the freedom of individual scientists and groups to pursue areas of scientific priority and the legitimate concerns about protecting intellectual/scientific priority. The scientific community must continue to develop framework that will allow for the balancing among different needs for assuring optimal collaboration and optimal individuality in the pursuit and reporting of research findings. In this context, the Working Group encourages researchers and consortia working on the genetics of autism to establish continuing channels for discussion and joining together for pursuit of promising findings.

The rigorous application of developmental behavioral and neuroscience to the study of autism has led to increased understanding of the clinical disorder and of individuals who suffer from it. In the future, the field of human genetics offers great promise for unraveling the underlying, biological vulnerabilities – explaining the basis of individual differences in severity and course – clarifying the complex interactions between constitutional and environmental influences – and providing new approaches to prevention, early intervention and treatment. International collaboration among research programs and consortia throughout the world is essential to fully exploiting the potentials for genetic and other types of research. The new science of human genetics offers great hope for individuals with autism and their families, as well as applications in relation to other major neuropsychiatric and developmental disorders. At the same time, the nature and implications

of genetic research raises important administrative, social policy and ethical concerns that require thoughtful, sensitive and continuing discussion among families, basic and applied researchers, clinicians, government, the faith community, and others concerned about children and adolescents and the promotion of human welfare. The knowledge gained in relation to autism will have important influences on the understanding and care of children and adolescents with other serious neuropsychiatric and developmental disorders.

Declaration of Sharm El Sheikh on the Eastern Mediterranean Association of Child and Adolescent Psychiatry and Allied Professions

The promotion of mental health, development, and welfare of children and adolescents, and the support of their families in pursuit of these goals, are central values of societies and nations in the Eastern Mediterranean region and throughout the world. For children and adolescents to reach their optimal level of functioning, the basic preconditions for their development need to be satisfied. These include preconditions that facilitate development and prevent dysfunction - including stability and continuity in their care by primary caregivers; facilitation of their emotional, intellectual, social and physical development at home, in school, and in the community; opportunities for education and participation in society, security and protection from danger – and preconditions that reduce the likelihood of illness and handicap and reduce disability – including the availability of preventive health care and the treatment for illnesses and disorders that may emerge.

While all nations and societies endorse these general principles, many millions of children throughout the world are today at high risk because these preconditions are not being met. Today, millions of children are vulnerable because of psychosocial adversity, trauma, lack of access to basic health, educational, and other services, and limitations of opportunity for full participation in society. In addition, up to 8 to 10% of all children and adolescents suffer from serious emotional, behavioral, and developmen-

tal disorders that impair their functioning and cause personal and family distress.

The Eastern Mediterranean region includes nations with long and deep traditions of concern for children and families. At the same time, there are millions of children and families in need of preventive health and mental health services and treatment programs for the amelioration of psychiatric, developmental and emotional problems. The needs of children and families are not being adequately met because of limitations of financial and other resources that limit the availability of systems of prevention and care and of professionals of all types.

To promote the optimal development of children and adolescents in the region, we propose the creation of an Eastern Mediterranean Association of Child and Adolescent Psychiatry and Allied Professions (EMACAPAP) with the goal of improving prevention and treatment and facilitating the education and functioning of child mental health professionals in the region. We recommend that EMACAPAP engage in the assessment of national and regional needs for preventive and treatment programs and the design of model systems and programs for prevention and care. We encourage EMACAPAP to promote the goals of prevention, early intervention, and high-quality treatment and care for children and adolescents with sensitive concern for the cultural and other traditions of the region. Working in collaboration with national and international organizations, EMACAPAP should serve as a regional voice for children and adolescents and help shape national policies that are committed to meeting the developmental needs of children and families. EMACAPAP especially should aim at helping to promote the treatment and education for all children with special psychiatric and other health needs. To achieve these goals, we encourage EMACAPAP to support the ongoing academic programs of training for mental health professionals (child and adolescent psychiatry, and other mental health professionals, including psychology, social work, education, nursing, general psychiatry and pediatrics) and to encourage the creation of new programs of high quality training.

In serving the children of the Eastern Mediterranean region, EMACAPAP can join with the International Association for Child and Adolescent Psychiatry and

Allied Professions (IACAPAP) and the Asian, European, and Latin American regional associations on behalf of children and their families throughout the world.

Report on the Visit of the IACAPAP Study Group to India

January 27 – February 7, 2001

Michael Hong, Savita Malhotra, Anil Malhotra, Helmut Remschmidt, Per-Anders Rydelius, Parmala Santosh

Participants:

Helmut Remschmidt (President), Savita Malhotra (Assistant Secretary-General), Michael Hong (Adjunct Secretary), Per-Anders Rydelius (Vice-President) and Parmala Santosh (Clinical Lecturer in Child and Adolescent Psychiatry, Institute of Psychiatry, London), Anil Malhotra (representative of the Local Organizing Committee).

Study Group Visits

The group met on Sunday, January 28, at the Ashok Hotel in New Delhi, where the 15th IACAPAP Congress will take place.

The program for the visit was a very dense one, starting in Delhi, and followed by visits to Bangalore, Lucknow and Chandigarh. The organization for the study group visit (by Savita Malhotra and her husband, Anil Malhotra) was excellent, and everything was carried out according to plan. Paramala Santosh's participation (originally from India and now working in London) was extremely helpful, not only because of his command of Hindi and other Indian languages, but also with regard to all properties of Indian culture and everyday life.

The activities of the Study Group were concentrated on the one hand on the participation in scientific symposia, held at all four places, which were extraordinarily well-attended, and on the other hand on raising attention for the forthcoming 15th IACAPAP Congress and the preparation of this event.

In addition, the Study Group had the opportunity to learn about the situation of children and adolescents in India, the most important neuropsychiatric and psychiatric disorders, the special needs of services and care, the situation of child psychiatry and the necessity to

promote its development and many other aspects that are relevant for children and their families in India and the Asian world.

1. Delhi (January 29, 2001)

The Study Group participated and contributed to a one-day symposium on "Contemporary Global Perspectives on Child and Adolescent Aggression" which was held at the NIMHANS center in New Delhi. The keynote address was given by Prof. J. S. Neki, one of the pioneers of Indian psychiatry. The members of the Study Group participated in three panels on "Family and school variables associated with problematic aggression," "Understanding current media images and trends on aggressive behavior," and "Management of aggressive behavior in children and adolescents."

In addition, they gave talks relevant to the main theme of the symposium.

The symposium was organized by Dr. Nagpal (Delhi) who is also the initiator of the "School-Based Pilot Project on Holistic Health" in Delhi, a project carried out in different schools with the aim of assessing aggressive behavior in children and developing appropriate interventions.

After the talks, there was a lively discussion, not only on the issue of aggression, but on many other topics of child and adolescent mental health in India.

Tuesday, January 30, was an entire day of traveling: The group went from Delhi to Bangalore (1777 km).

2. Bangalore (January 30/31, 2001)

The group visited the National Institute for Mental Health and Neuroscience (NIMHANS) where also the symposium took place.

NIMHANS is an impressive institution, where nearly all relevant disciplines in neuroscience are present at one place. The Study Group had the opportunity to get an overview about the work and the cooperation within the NIMHANS and was able to talk with all important colleagues in the field of child and adolescent mental health. We met first the director of NIMHANS, Dr. Gourie-Devi, who informed us about several severe neuropsychiatric disorders in India that cannot be seen to that extent in the Western world, such as: different kinds of epilepsy, brain damage, subacute sclerosing panencephalitis (SSPE), neurocysticercosis, and Japanese encephalitis. She was very

supportive for the Congress and assured us of the substantial support by NIMHANS.

We then talked intensively to Dr. Shoba Srinath (head of the Dept. of Child and Adolescent Psychiatry) and Dr. Mohan Isaac (head of the Dept. of Psychiatry) and to Dr. Malavika Kapur (professor of clinical psychology at NIMHANS) who all were extremely interested to participate in the Congress and who will contribute substantially.

The NIMHANS Center as such is a very impressive institution. It developed in 1937 from a mental health hospital, became a training center in 1945, and is now a post-graduate institute for neuroscience. As far as child psychiatry is concerned, a forty-bed inpatient facility in a very nice new building will be opened this summer, and a special three-year course in child and adolescent psychiatry will start at the same time.

The symposium at NIMHANS was devoted to the theme "Parenting and Family Issues" with contributions from Dr. Kapur (NIMHANS) and the members of the Study Group (Michael Hong, Per-Anders Rydelius, Helmut Remschmidt and Paramala Santosh), followed by a lively discussion.

Thursday, February 1, was also an entire day of traveling: The group went from Bangalore to Delhi and from Delhi to Lucknow.

3. Lucknow (February 2-4, 2001)

The members of the Study Group were guests of the Dept. of Psychiatry at King George's Medical College in Lucknow. They participated in the Foundation Day and international Continuing Medical Education (CME) program on child and adolescent disorders and psychopharmacology.

The program started on Friday, February 2, with a formal inauguration function with distinguished guests, among them Prof. N.K.S. Gaur, Minister of Cane Development, Sugar Industry, and Medical Education of the State Uttar Pradesh, and the Vice-Chancellor of Lucknow University, Prof. D.P. Singh. This inauguration function was followed by a symposium on "Child and Adolescent Psychiatric Disorders and Psychopharmacology."

The Foundation Day Oration was given by IACAPAP President Helmut Remschmidt on "Childhood Schizophrenia: History of the concept and recent studies." The CME program included lectures by Savita Malhotra on "Psychiatric assessment of pre-school

children,” Per-Anders Rydelius on “Management of conduct disorders,” Michael Hong on “Rapid social changes, crises of child rearing and implications for psychopathology,” and Parmala Santosh on “Psychopharmacotherapy of autistic spectrum disorders.”

The CME program was continued on Saturday, February 3, by further talks of the Study Group members: “New horizons in pharmacotherapy of childhood psychiatric disorders” (Helmut Remschmidt), “The nature and treatment of comorbidity of ADHD and tic disorders” (Michael Hong), “The pharmacotherapy of ADHD: Protocols and guidelines” (Parmala Santosh) and “Anorexia nervosa: Etiology, treatment and course” (Helmut Remschmidt).

Again, there was an interesting discussion and Prof. Prabhat Sitholey (head of the Dept. of Psychiatry) had prepared a nice brochure, “Foundation Day and International CME on Child and Adolescent Psychiatry” which included summaries and full text of the papers given and a report on the activities of the department.

There was ample opportunity to discuss the 15th IACAPAP Congress with the members of the department, and there will be quite a number of contributions from Lucknow.

During the stay in Lucknow, the members of the Study Group were guests of the State of Uttar Pradesh and stayed at the government guesthouse in Lucknow.

The group left Lucknow on Sunday, February 4, and reached Chandigarh (via Delhi), the last station of the visit, in the evening.

4. Chandigarh (February 5-6, 2001)

The program in Chandigarh where the group was received most cordially by Savita Malhotra at her department started with a visit to the Dept. of Psychiatry (head: Savita Malhotra) where the members of the Study Group had the opportunity to talk with the staff in different parts of the department: inpatient ward (Remschmidt), drug ward (Rydelius), outpatient ward (Hong). We were impressed by the high standard of clinical work and research at the Dept. of Psychiatry in Chandigarh which belongs to the Postgraduate Institute for Medical Education and Research (PGIMER).

After an instructive meeting with the director of PGIMER (Prof. S.K. Sharma), a symposium took place with lectures by members of the Study Group

on the following themes: “Early-onset schizophrenia” (H. Remschmidt), “Children of alcoholic fathers” (P.-A. Rydelius), “Comorbidity of tic disorder and ADHD” (M. Hong), and “Psychopharmacology of ADHD” (P. Santosh).

The session was chaired by em. Prof. N. N. Wig who was the founder of the Dept. of Psychiatry at the PGIMER in Chandigarh.

During a dinner in the evening, the members of the Study Group had the opportunity to talk with several members of the Local Organizing Committee and with Dr. B.N.S. Walia, em. Prof. of Pediatrics at the PGIMER who was very helpful in promoting the forthcoming Congress.

In summary, the Study Group visit was highly successful, perfectly organized by Savita and Anil Malhotra and their colleagues, stimulating in every respect and extremely helpful as a preparatory activity for the forthcoming Congress.

Our most cordial thanks go to Savita and Anil Malhotra and all the other colleagues in India for their warm hospitality and kindness

Compte-Rendu du Congrès de la Société Française de Psychiatrie de l'Enfant et de l'Adolescent (French)

La violence sources et devenir - Nice 18, 19 mai 2001

Jacques Hochmann

Ce thème ne peut laisser personne indifférent et les organisateurs du congrès ont souhaité qu'il soit envisagé à un niveau psychopathologique en dépassant les réponses purement médiatiques ou sécuritaires. On essaiera ici de repérer quelques unes des lignes de force qui ont parcouru les débats.

1. Plusieurs orateurs ont tenté de définir la violence, cette force qui abuse le sujet et qui s'oppose au double travail de subjectivation et d'objectivation (Philippe Gutton). Jean Bergeret a rappelé qu'elle était un instinct naturel de tous les temps et de tous les lieux, une affirmation purement narcissique de soi par rapport au danger que représente le non-soi et B. Gibello l'a décrite en tant que « mode de pensée ».

2. Les participants se sont en même temps interrogés sur l'origine de la violence au sens plus habituel du terme, c'est à dire sur l'origine des conduites violentes qui manifestent la déliaison de cet instinct inné d'avec sa nécessaire contrepartie libidinale. Cette déliaison est peut-être, en partie au moins, déterminée par une vulnérabilité biologique sur laquelle F. Azkénary a proposé quelques hypothèses, très discutées dans l'assistance.

Pierre Ferrari et Martine Myquel, chacun à leur manière, ont retracé les étapes développementales de ce processus de liaison - déliaison dont les racines plongent selon les travaux des équipes de Michel Soulé présentés par Mme Soubieux jusque dans la vie fœtale, dans l'interaction triadique fœtus - placenta - mère.

Deux ordres de facteurs pathogènes ont été relevés:

- Bien sûr, d'abord, les facteurs externes, depuis le déni de l'intersubjectivité dans les interactions précoces que Philippe Mazet a illustré par un film impressionnant montrant la faillite empathique de la mère - environnement, jusqu'aux éléments plus sociétaux sur lesquels chacun à leur manière ont insisté tant Roger Misès que Marie-Luce Gibello ou Catherine Eppelbaum.
- On a beaucoup parlé de la carence de l'autorité dans notre société, d'une société de transparence qui dénie l'espace psychique privé, d'une plus grande tolérance vis-à-vis des comportements agis dans un contexte où les normes sont en discussion. Toutes ces composantes nouvelles du champ social favorisent des expressions comportementales nouvelles dont Philippe Jeammet, en commençant son exposé, rappelait qu'elles sont nombreuses. Mais il disait aussi que l'adolescent pénétré par les autres était aussi un adolescent ouvert qui se laisse intruser voire qui appelle l'intrusion par une conduite de dépendance, un véritable lien addictif à l'objet qu'il reliait à une faillite des auto-érotismes.
- L'importance des facteurs externes (comme ceux subis par ces enfants combattants du

- Guatemala interviewés par Bernard Doray) ne doit pas en effet faire oublier les facteurs internes, la violence désorganisatrice de la pulsion, en particulier au moment de l'irruption pubertaire dont Philippe Gutton a tracé le destin chez Mishima et qui correspond à la fixation perverse sadomasochiste de l'homo-érotisme sur laquelle Jean Bergeret a insisté.
3. Quelle qu'en soit l'origine endogène ou exogène, la violence a des effets dont l'étude a aussi traversé les discussions. Désobjectivation, déssubjectivation sont des mots qui sont souvent revenus, sans qu'on oublie pour autant les effets structurants et reconstructifs de la violence "accoucheuse de l'histoire."
 4. Ces réflexions ont conduit à une clinique différentielle de la violence qui semble déborder les figures nosologiques traditionnelles. On a bien sûr insisté sur les différences entre violence et agressivité ainsi que sur de nouvelles constellations pathologiques comme ces "enfants terribles" dont ont parlé Martine Myquel et Marie-Michèle Bourrat. Philippe Jeammet notait leur besoin d'emprise violente qui efface tout le plaisir de l'échange et qui représente une véritable carence de la pensée en privilégiant l'expression par le corps et ses agis. Face à ces troubles, on a évoqué aussi les troubles de la parentalité qui ne favorisent pas pour l'enfant l'établissement de ce que Ph. Jeammet appelait "une base de repli," un abri pour l'intériorité psychique.
 5. Il est bien de condamner, de se scandaliser, d'accuser l'école, par exemple les conceptions didactiques leurrantes (M. Charlet y) ou encore des émissions de télévision comme Loft-Storry qui actuellement fait fureur en France. Il faut peut-être aller plus loin et préparer l'intégration de la violence qui, pour J. Bergeret, appartient à la prévention primaire. Marie-Luce Gibello rappelait les effets ravageurs du déni de la violence, dont on pourrait rapprocher le déni actuel de la sexualité infantile trop vite dénoncée comme une pratique perverse. Elle montrait le rôle que pourrait, que devrait jouer l'école, en particulier dans les petites classes de l'école élémentaire pour la mise en latence des pulsions.

6. Une fois le mal installé, plusieurs approches thérapeutiques ont été développées. L'utilisation des groupes par Marie-Michèle Bourrat permet de fournir des scénarios figuratifs. G. Schmit a montré l'intérêt de l'approche familiale et Marie Christine Mouren Simeoni a donné de précieuses et prudentes indications sur le maniement des médicaments. Le travail en réseau développé à Nice par Martine Myquel auprès de très jeunes enfants n'infirmes pas, l'intérêt de l'hospitalisation rappelé tant par Marcel Rufo, que par Thierry Rochet ou par Jean-Yves Hayez ainsi que par R. Puyelo. (Mais J. C. Chanseau montrait aussi les risques d'excès dans ce domaine en critiquant la pratique actuelle des ordonnances de placement par le juge des enfants). Si le traitement psychothérapeutique est heureusement aujourd'hui nuancé par une attention et un accompagnement sur le plan cognitif (Martine Myquel) ou éducatif (Jean-Yves Hayez), on voit s'esquisser un débat qui mériterait d'être poursuivi entre ceux qui se faisant plus adolescents que les adolescents vont les rejoindre là où ils sont (ce qui est une manière de caricaturer le point de vue de M. Rufo) et ceux qui souhaitent insister sur la nécessité d'aménager des espaces de réflexion, de retour sur soi, de travail sur ce que M. M. Bourrat appelait l'épaisseur psychique, cette épaisseur psychique que Michèle Cadoret cherchait à rattacher à la culture et au transgénérationnel en envisageant l'adolescent dans sa fonction de "passeur de limites." Il avait été beaucoup question tout au long des débats, de la nécessité d'une autorité, d'un rappel de la loi. "Au nom de la loi je vous arrête" disait à sa petite patiente Marie-Luce Gibello et on pourrait associer sur le coup de sifflet du maître qui lorsque nous étions enfant à l'école arrêtaient nos jeux violents.
7. Ce coup de sifflet manque peut-être dans notre société moderne ou se perd dans le brouhaha. Peut-être faut-il commencer par balayer devant notre porte et reconnaître aussi nos limites: limites de notre pouvoir technique et de notre champ d'intervention, limites de nos connaissances, limites aussi entre le réel et l'imaginaire, le caractère métaphorique de nos modèles

psychopathologiques et la réalité biologique et sociale à laquelle nous sommes confrontés.

Il faut remercier Martine Myquel d'avoir su organiser une rencontre aussi riche.

Child and Adolescent Mental Health in Australia

*Barry Nurcombe
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Introduction

In a land mass about the size of the United States, Australia has a population of 20,000,000. The earliest immigrants were of Anglo-Celt origin; however, after World War II, there was a large influx of people from Northern, Central and Southern Europe, and, more recently, from Asia. Australia has a policy of multiculturalism, although the precise nature of how that should operate is the subject of vigorous political debate. The original inhabitants of Australia may have numbered 300,000 in 1788, but today only about 150,000 identify themselves as full-descent or part Aboriginal.

Australia is a Commonwealth of six states and two territories, governed by a federal system in Canberra and through the capital cities of each state. All Australian citizens are covered for their health care by a National Medical Insurance system, financed by taxation; while about 40% of the population choose to purchase private insurance, as well, primarily for elective surgery and hospitalisation. Although health care is funded by the federal government, it is administered by the state governments.

The Organization of Psychiatry

Psychiatry, like the rest of Medicine, is divided into public and private spheres. The public mental adult system deals predominantly with patients who have severe psychiatric disorder. Deinstitutionalization from mental hospitals is now well advanced, most patients being treated either in general hospital psychiatric units or in regionalized community mental health centres.

Clinical psychology training is less advanced. Although an increasing number of psychologists are going on to obtain doctoral degrees and to function as scientist-practitioners, many enter the

clinical field with no more than baccalaureate training, and acquire their skills on the job. Cognitive behaviour therapy has become so well developed and so dominant scientifically that other forms of therapy have been virtually swamped out. Social workers, however, have embraced family therapy, and many social workers and mental health nurses seek training in group therapy. The role of speech and language pathologists in child mental health has been a subject of some debate.

Research

Despite a relatively small number of researchers, significant contributions have been made, for example:

- The prevention of depressive disorders (Spence, Patton)
- The prevention of anxiety disorders (Barrett)
- The treatment of anxiety disorders (Dadds, King, Tonge)
- The prevention and treatment of disruptive behaviour (Sanders)
- The epidemiology of psychiatric disorder in children and adolescents (Zubrick, Sawyer)
- The treatment of early psychosis (McGorry)
- The treatment of sexual abuse (Nurcombe, King, Tonge)
- Early recognition and treatment of suicidal depression (Martin)
- The psychological concomitants of chronic asthma (Sawyer)
- The treatment of eating disorder (Beaumont, McDermott)
- The cognitive functioning of autistic children (Prior)
- The development of temperament (Prior, Oberklaid)

An increasing number of clinicians are going to doctoral research training.

Innovations

Among the most interesting approaches that have been, or are about to be, introduced are the following:

- The development of “shared-care” networks involving schools, child protection agencies, family practice, and mental health
- Consumer involvement in the design and monitoring of mental health services.
- A national treatment outcome measurement system
- The use of telemedicine to support mental health care in remote rural areas

- The development of a well accepted children’s telephone counselling service (Kids Help Line)

Problems

The following problems are of great concern:

- The high rate of suicide among male youths (which appears to have peaked in 1992/93, possibly as a result of concerted preventative efforts)
- The disastrous condition of many Aboriginal settlements, torn apart by alcoholism, domestic violence, and child abuse
- A lack of understanding of the cultural background and mental health needs of southeast Asian migrants
- The lack of adequate services for adolescents with substance use disorder.
- The meagre “social capital” in country towns which have been affected by radical changes in the rural economy.

Current Trends and Future Perspectives of Child and Adolescent Mental Health in France

I will try to answer to the questions raised by Helmut, but in a different order, to introduce a logic which deals with the situation in France. The order was: research, training, services, handicapped/psychiatrically disturbed, IACAPAP and WHO. I will follow this order: training, services, handicapped/psychiatrically disturbed, research, IACAPAP and WHO.

After a period during which a development of child and adolescent psychiatry has been possible, we have entered a difficult time: not enough psychiatrists, not enough money, inadequate requirements from the administration, unsolved problems for sick and handicapped children grown-up.

First. Training and education: the shortage of child and adolescent psychiatrists has been created by the government and the administration which cut the number of possible residents in psychiatry. Without psychiatrists, child psychiatry will disappear. It is postulated that all could be done by questionnaires and counsellors.

Second. Services. Patients have to wait too long to get an appointment with a psychiatric team. We have not enough places to take the children in treatment. We have not enough institutions to welcome the more severely impaired children. We have developed services for babies and parents, adolescents. We need services for the pre-adolescents. There is a lot of work to be done with schools. Junior high school and violence are main problems.

We need to evaluate our activities, but the administration does not understand that psychiatry is not surgery, obstetrics and so on. Our scope is not limited to a week of treatment.

Up to now, we were lucky enough to choose our way of treating patients, and not to depend on a private system of health insurances. We hope to be able to save our National Insurance.

Third. The lack of resources is especially high when the severely handicapped or disturbed children became adults (eighteen). They cannot stay in the institutions for children and there are not enough institutions for young adults.

Four. Research. We never had the same amount of money as in the US. We are used to making do with little. Many multicentric researches have been done on autism, babies, anorexia nervosa, adolescent suicide, and so on.

Five. IACAPAP and WHO. Among us, Myron is the one who can answer the best, because he has just spent a year in WHO. When I was President of IACAPAP, I tried hard to work with WHO. I met several times with Norman Sartorius, without any results.

A final word. I wish heartily that IACAPAP does not become a place of a unique language and unique thought. Our Association is bilingual by constitution. And there is an originality of the French speaking psychiatry (I do not mean only France) which deserves to be heard. Many of us remain attached to psychopathology and dynamic thinking.

Current Trends and Future Perspectives of International Child and Adolescent Mental Health in India

Savita Malhotra

1 Services:

Specialized services for psychiatric disorders and developmental disabilities

in children are virtually lacking for the vast majority of the population in India. There are very few psychiatrists or psychologists (almost negligible) in the country that also, in the metropolitan cities, practice child psychiatry in any significant manner. Most of these are not specially trained. There is acute need to start organized service in the country. The main difficulties are lack of trained manpower and financial resources.

2. Training and education:

There are no postgraduate training centers in child psychiatry in India. There is urgent need to have trained professionals, some of whom could be trained abroad first and then to take up the leadership in starting training centers in India. We need to develop postgraduate training centers of excellence in India where training and research could be carried out.

3. Research:

Major research needs are:

- a) To develop suitable, cost effective systems of care suitable for India, e.g., integrating child mental health with primary care or general health care.
- b) To develop new methods of treatment that are not dependent on highly trained manpower or a labour intensive approach.
- c) Conduct research into community and family resources in the care of children that are available locally and are effective.
- d) Epidemiological studies.

4. Actions and activities:

- a) Raise the profile of child psychiatry in the country and advocacy.
- b) Increase training component in the curricula for MD in general psychiatry and pediatrics.
- c) Start collaborative major research projects in identified subjects which have mass or community level applications, e.g., disaster management; children living in extremely deprived conditions; nutrition and child mental health, etc.

5. Role of IACAPAP and WHO:

- a) Collaborate with government and non-government institutions for technical and financial support
- b) Develop an International College of Child Psychiatry where professionals from poorer countries can get the benefit of registration and

certification through distant learning, mobile faculty, etc. I think this would be the single most important contribution.

- c) Support the development of academic departments/centers.
- d) Arrange for the training of trainers – the first generation experts in the field.

Current Trends and Future Perspectives of International Child and Adolescent Mental Health

IACAPAP Discussion at Meeting in Dozza, Italy – August 2001

Discussant: Cynthia R. Pfeffer, M.D.

1. In the United States, research has burgeoned despite the greater difficulty in getting grant support. With the development of biological techniques involving genetic assays using microchips and the use of neuroimaging techniques, advances in research design focuses on description of brain functioning and potential etiology of psychiatric illness. Approaches of studying service delivery is another active area of research investigation. These techniques can be applied to research with children. However, a problem is that there is relatively little research funding from hospitals or academic institutions available to clinical investigators. As a result, many child psychiatrists are not involved in research.

2. In the United States, much needs to be accomplished in training child psychiatrists and others about mental health and treatment of children. There is a shortage of child psychiatrists. Little funding is available to support teaching activities of faculty. Many medical students are not attracted to pursuing a career in child and adolescent psychiatry because of worries about financial security.

3. In the United States, service delivery has been impacted by the economics of health care systems. As a result, programs for psychiatric hospitalization, day treatment programs, and other intervention resources have been closed in many cities. Time to see patients has been reduced by the limits of managed care insurance. There is stress on health care providers as they do

their work. Underserved populations have psychiatric needs that require attention. Such populations are suffering from poverty, family losses, illness, drugs abuse, and comorbid psychiatric disorders, such as mood, anxiety and disruptive disorders. Collaboration with other service systems, such as schools, judicial programs, and social welfare agencies are important and need development.

4. -Actions are needed to enhance community awareness about detection and treatment utilization of mental health services. Patient advocacy is needed to ensure that services are received by those in need. Consumer action to remedy the problems of managed care are important. Methods to ensure compliance with health care utilization should involve enhancing feasibility of obtaining care and access to services.

5. -The role of IACAPAP and WHO to improve international child and adolescent mental health is to enhance international collaboration through promotion of education about mental health practices and characteristics of mental illness of children. This should involve seminars consultations within countries. Making available books, journals, and email connections will enhance sharing of new ideas. Making communities aware of characteristics of mental illness and health promoting and prevention methods that include more frequent utilization of mental health services may decrease human suffering from psychiatric disorders.

Current Trends and Future Perspectives of International Child and Adolescent Mental Health: the Uruguayan Situation

Miguel Cherro-Aguerre

1. Research:

Which are the major research trends in child and adolescent mental health in your country resp. your part of the world?

Ours is a country of only 3,500,000 inhabitants; 741,660 are children under 13 (censo de 1996). A clear social phenomenon is happening in our society that is called: infantilization of poverty. Fifteen per cent of our families live below the poverty line, but they have half of the children. Poor families usual-

ly have many children and early in life, opposed to the non-poor families whose trend is to have less children and later.

The so-called non-poor families are also living in a difficult situation. We depend on the economy of our big and powerful neighbors, and their economic and social situation is actually quite bad. So we have a growing economic uncertainty, with nobody feeling sure and optimistic about the future.

Our country, once known as the Switzerland of America, is now in a very bad economic and emotional situation; that supposes a risk situation for the rearing of children.

Our main mental health problems now are:

- depression and suicide
- violence
- adolescent pregnancy
- drug abuse

Our aim today is to foster resilience in our children. We know that all of them will have to face, and actually they are facing, a lot of problems. We need them strong enough to cope with difficulties in a healthy way.

We are planning and working in different levels in order to achieve our goal. "Caring for the one that cares" is one of our slogans. Working with parents and with teachers, giving them the necessary herramientas to bring up and educate our children in a resilient way.

2. Training and education:

Which are the major needs in training and education in the field of child and adolescent mental health in your country, in your part of the world?

In the pre graduate level we need more integration with the other pediatric disciplines. We need to increase their knowledge in psycho-education, and their skills in early detection of risky situations. In the postgraduate level, we are working hard in the field of continuous formation and re-certification.

3. Services:

Which are the major needs with regard to services in the field of child and adolescent mental health in your country, your part of the world?

The whole health system is in a big crisis now in our country. Regarding mental health services, they are still not really available for everybody. Our public services are overcrowded, and they cannot face the real needs. The private services are expensive, and the group of people that can pay for them is

getting smaller. We also would need a stronger sense of multidisciplinary team, with real interdisciplinary and interinstitutional integration and coordination. The coordination between public and private policies in agreement about education and health needs to be worked out.

4. Actions and activities:

Which actions and activities are necessary in order to improve the situation of mentally handicapped/psychiatrically disturbed children and their families in your country, your part of the world?

We have many people working in a non-coordinated way in the topic. We are organizing a big meeting in October to gather them, and to achieve shared plans and a rational organization based on the real needs and resources. We are actually working in an epidemiological research of both needs and resources.

5. Role of IACAPAP and WHO:

Which role could IACAPAP play in cooperation with WHO in all actions and activities aimed at the improvement of international child and adolescent mental health?

IACAPAP and WHO together can:

- promote research
- promote professional training
- generate cross-cultural coordination and integrations in order to establish policies in huge regions of the world.

Czech Center for Assisting Children and Families

Dear colleagues,

We are so glad that we can write to you about our program.

The civic association STREP (Czech abbreviation for Center for Assisting Children and Families) is a non-governmental, non-profit-making organization whose activities are focused on protection and help for children who are threatened by dysfunction within their own family.

At the beginning, the association operated on a voluntary basis, which had an extremely limiting effect on opportunities for project implementation and the promotion of its ideas in practice.

After gaining its first grants in 1997, it became possible to put the activities of the association on a professional basis.

The main activity was the implementation in practice of the project for the recovery of the damaged family environment and work in improving the project. At this time STREP has five employees, four social workers, one social tutor and 20 volunteers.

Research carried out within the Czech Republic are current experiences based on work with families in risk situations which show that within the field of comprehensive care for those families, there exists a gap in the social services network. According to statistics, approximately 2,000 children per year are placed in institutional care. The most common reasons for their acceptance into institutions are social reasons (28%).

Although the risks and results of mental deprivation are known for children whose healthy development is disturbed as a result of dysfunction within the family of residence in the infant institution in an orphanage, the most wide-spread form of care for endangered and socially orphaned children is thus far institutional care.

Until now, in the Czech Republic there was no integrated program for working with families which neglect the care of their children. Practical experiences conform that solely repressive measures against parents, the guilty parties, are ineffective unless they are part of a complex program of help.

The civic association STREP offers a program which plugs the gap in the social services network. The main ideal of the association is to establish an integrated conception of work with socially threatened families in legislative amendments within the framework of the transformation of the Czech Republic's social policy.

Guidance of families as an alternative to removing children from home

This is an alternative experimental psychosocial program for families with children in difficult life situations. The means by which the program is implemented is the recovery of the damaged family environment. Recovery means work in the natural family environment with the aim of putting an end to the problematic situation and the subsequent renewal of its healthy functions. The aim of cooperation with families, and, last but not least, prevention and solving of CAN syndrome problems. The program is also an alternative for care orders or ordering or cancelling of institutional upbringing for custodial courts, bodies for the

sociolegal protection of children and for other institutions which ensure the protection of the interest of children threatened by care neglect or physical and mental violence.

We have been working on the program on a professional basis since April 1997. In 1998 we worked with:

Areas of help for families:

- Assistance to acquire valid documents.
- Counselling and training of the skills necessary for conflict-free dealing at state offices.
- Counselling and assistance to deal with housing problems.
- The acquisition of skills necessary to run a household.
- Development of social skills and communication within the family.
- Practice in positive communication between parents and between parents and children.
- Sharing out attention between children.
- Care for newborn children (especially for very young mothers).
- Constructive solutions to conflict situations.
- Sociopedagogical guidance of family members.

Working principles:

- we work with families (not instead of them, or for them)
- we strengthen the strong positive aspect of the family
- we lay down realistic and comprehensible goals
- we respect ethnic traditions of clients.

Target group:

The target group is made of families in hazardous life situations with children zero to sixteen years of age and which are motivated to make a positive change. We received recommendations from bodies for the sociolegal protection of children, trustees for the custodial court, infant institutions and orphanages, medical and school facilities, paediatric clinics, police, NGOs, etc.

Our project has three parts:

1) Intervention part

First six weeks from start of cooperation with family. The main aim is identifying important problems and make social plane of solving this. We create social

cooperation with every member of the family.

2) Stabilization part

Six to eighteen months after intervention part. This time is for realization of the social plan. Stabilization of financial and housing situation of family, strengthening relations between parents and children, cooperation with state sociolegal services for children etc.

3) Follow up care part

This part continues one year after the stabilization part is finished. This is the time of independence from the family regarding professional services. But in this time it is possible that the family can have many problems and need the support of social work. In this work we used volunteers which helps to solve problems and to be a friend of parents or children.

Other clinical project:

- Project of direct financial aid to families include financial resources from small-scale are intended for specific purposes and provided to families who, for objective reasons, do not have a right to state social support payments.
- Sociopedagogical strengthening of Romas families – this project was established to support Romas parents; how to understand education and preparing children for school.
- Voluntary program of follow up care – students of helping professions (social work, social tutor, children's nurse) working two hours a week with our client families which finishes intensive intervention cooperation with professional employees of STREP or complement or professional services.

The main idea is from the Convention of Children's Rights which declares the rights of children for living in family with own parents.

Our contributions in a conference could be about: starting point of work, methods of work, principles of our work, present individual projects of STREP, presenting some client cases with video records of working with family.

We have some problem – in the Czech Republic it is very difficult to get a financial grant for active participation in international conferences. But we

think that it is very useful and important to meet with other professionals and we could exchange experiences and knowledge. Please, could you write us if you have some partners from the international foundation which will support the staying of some small organization in this conference.

Statement for Brazil

Salvador Celia

1. Research

Fortunately, in the last few years we are empowering research in our field. I know some research projects about ADD in Porto Alegre and Sao Paulo; Depression and Eating Disorders in Porto Alegre and Sao Paulo; also Adolescent Pregnancy in Porto Alegre, Sao Paulo and Rio de Janeiro. In my case, I'm doing research in Malnutrition and Child Development, Mothers Expression and Infant Development, Mental Health Impact Program for Pediatricians, and the introduction of one scale for early detection of risk of "Mother-Infant's Interaction Observation."

2. Training and Education

We have participated in the training of Mental Health and in the last few years, we dedicated special attention to Medical Students since the first years of Medical Education.

3. Services

We need to open more outpatient facilities, therapeutic schools and add more attention to prevention and psychoprophylactic initiatives.

4. Actions and Activities

We need to inform the community in general and the politicians about the situation of Mental Health in general. We know according to WHO, that 400 (four hundred) million persons in the world are suffering from Mental Disorders, and we know about prevention, that three first years attentions are the basic for the future development. We need to develop more knowledge and practice about "Resilience."

5. Possible role of IACAPAP and WHO

Excellent idea, "working together" IACAPAP and WHO. We can participate "Sharing Initiative" of organizing programs for capacitation of Multidisciplinary Professionals, include-

ing mainly the training of Medical Students.

We need to be more linked to the "WHO Bureaus" of each country or region, and also be more linked with the governments, giving supervision, support, offering our help. Many developing countries have economic problems and the resources are not well applied. We can help a lot, and IACAPAP and WHO can be very beneficial for people of the world.

Statement for Egypt

by *Amira Seif El Din*

1. Research

Major research in Child and Adolescent Psychiatry is limited but there is a great amount of research in different areas of the field.

The major problem we are facing is that there are no resources available to research or a mid line to know the previous or the ongoing research. In addition there is no special journal for child and adolescent psychiatry.

2. Training

Adult psychiatrists are very numerous but there are very few child and adolescent psychiatrists as with regard to the great need of this specialty as the total number of our children is about 40% of the total population.

There is no degree for child and adolescent psychiatry.

There is a great need for training and education in the field of child and adolescent psychiatry for all personnel dealing with children (pediatricians, psychologists, social workers and therapists in addition to the psychiatrists) to develop better services for this large sector of the population.

3. Major Needs

In my country, the development of infrastructure and qualified personnel is needed in the field of child and adolescent psychiatry, such as psychologists, developmental psychologists and therapists that can work as a team to provide the services for the child at home, at school and in the community.

4. Actions and Activities Necessary to Improve the Situation

In our situation in Egypt, I think it is necessary to develop the following

activities in order to improve the child and adolescent psychiatric services

a) Training of the trainers:

Training courses in the field of child and adolescent psychiatry and to have a recognized certificate with the credit hours. In addition, practical training courses in well established centers in child psychiatry can help in developing the trainers who can train other psychiatrists in the field of child and adolescent psychiatry.

b) Conferences and Workshops

This can cover several areas of interest or needs for our psychiatrists and pediatricians to develop better approaches to deal with several faced problems.

c) Development of materials

Development of booklets and books in the native language to help the families and most of the infrastructure personnel to have some material to guide them in the management of several child and adolescent mental health problems.

Statement for Israel

Sam Tyano

1. Research

The main topics in research on children are

- Psychopharmacology of psychotic children
- Psychopharmacology of ADHD
- Epidemiology of early onset Schizophrenia
- Genetics of ADHD
- Genetics of Schizophrenia
- Genetics of Suicidality
- Attachment in Infant Psychiatry
- PTSD in Infants
- Suicide in Adolescents
- Risk and Protective factors of suicidality during Adolescence

2. Needs concerning our Mental Health teams

The main difficulty for us is getting enough supervisors in order to create new community centers. We also need teaching of group therapy for children, and good supervisors in Cognitive Psychotherapy.

3. Psychiatric network

We have developed a large network of services from the primary care to the Psychiatric Hospital, including beds in

every Pediatric Department. We are now developing our Infant Psychiatry network.

4.

In order to improve our setting in Israel, we have to reconsider our institutional network. We have to focus on the creation of therapeutic educational centers having psychiatric support instead of medical Institutes supported by educators.

5. IACAPAP Roles

I think IACAPAP should focus on getting an international informative communication between National Societies. IACAPAP should create educational programs on Child and Adolescent Psychiatry and let the different National Societies profit from these programs.

6. WHO Roles

The WHO should focus on Epidemiology in Child and Adolescent Psychiatry in different countries and facilitate the links between Regional close Scientific Societies. The WHO should elaborate on the diffusion of the Educational material, and its application in the different countries.

Statement for Germany

Helmut Remschmidt

Current trends and future perspectives of international child and adolescent mental health: The situation in Germany

Child and adolescent psychiatry in Germany has made great progress during the last 20 years: For a population of 80 Mill. (among them 21% of children and adolescents below the age of 20), about 860 qualified child and adolescent psychiatrists are available. There are 26 Departments for Child and Adolescent Psychiatry at the 32 Medical Faculties in Germany, and there exist about 100 Departments for Child and Adolescent Psychiatry outside the universities.

1. Research

The major research trends at present are genetics, including molecular genetics, with regard to several disorders (such as dyslexia, eating disorders, schizophrenia, autism, Tourette's syndrome and ADHD), treatment evaluation, research in different fields of experimental psychopathology, and with regard to

several disorders such as conduct disorders, ADHD, schizophrenia and drug dependence. Research projects are mainly funded by the German Research Association (DFG), the ministries for health and research, foundations, and the pharmaceutical industry.

2. Training and education

Training in child and adolescent psychiatry covers a five-year period with at least three years of child and adolescent psychiatry and at least one year in pediatrics or adult psychiatry. Training in psychotherapy is included in the specialists' training program. There is a final examination in every state in Germany at the board of the Medical Association.

3. Services

There are more than 120 Departments for Child and Adolescent Psychiatry, including 26 Departments at the universities. All of these departments have inpatient and outpatient units; some, but not all, have the possibility for day patient treatment.

In addition, there are approximately 350 child and adolescent psychiatrists in private practice. Since psychologists are allowed to have their own private practice since 2000, there is an oversupply in some places with regard to outpatient care.

4. Actions and activities

The following actions and activities are necessary to improve the situation of mentally handicapped (psychiatrically disturbed children and adolescents and their families): A better distribution of services all over the country, special services for children and adolescents with conduct disorders and drug problems, special services for forensic problems, and a better coordination of all types of services in the different regions. There is also a need to train therapists for special interventions in dyslexia and autism.

5. Possible role of IACAPAP and WHO

Both organizations could and should facilitate research and training seminars and inaugurate plans of actions in a world-wide context. Such an initiative could, e.g., cover the following topics: Depression in children and adolescents, prevention of suicide, children of psychiatrically disturbed parents, and a campaign (as already initiated by WPA) against stigmatization of psychiatrically disturbed children and adolescents.

Some Brief Comments from Sweden on Today's Situation

P-A Rydelius and Kari Schleimer

When IACAPAP organized the 14th international congress in Stockholm in 1998, professionals from many different disciplines became aware of the organization. The Bulletins have been of great importance to enhance this awareness. Of most importance is that IACAPAP seems to bring knowledge, new ideas and visions to the local colleagues, giving them "guts" to stand up and fight for improving children's well-being.

Clinical services

From a Parliament decision in 1958, services in Child and Adolescent Psychiatry covering both in- and outpatient departments were successively being built up in all Swedish county councils to support children and adolescents and their families.

In parallel each community also had social programs to provide children with good upbringing conditions and in the public school, there was support to all children through a nurse, a doctor, a psychologist and a social worker. In some of the big cities, school psychiatrists (branch of child and adolescent psychiatry) were employed.

From the 1950's until today, there has been a number of shifts in current opinions on the benefits of social programs in the communities, the need for special psychosocial school teams and how child and adolescent psychiatry should be organized.

From the 1980's there has been a number of reductions of the health-officers in the schools, the social welfare committees have been changing their supporting programs and there has been a true reduction ref to the knowledge on child mental health that existed earlier.

Sweden is a very rich country. It belongs to the top five countries in Europe giving child and adolescent services to the population. Although this is the fact, there has been a number of alarming reports on mental health problems in the child and youth population.

During the year 2001 both the National Association for the County Councils (the county councils are responsible for the health care and services in the country), the National

Board of Health and the Government have been publishing data on the health status and well-being of the young population and the different kinds of services provided all over the country.

On August 23, 2001, a Government report was published. In a survey covering every thousand adults living in Sweden (over 900,000) a sample of their children born 1982–1990 (approx 1400) were interviewed using a method including taped answers through a Walkman earlier used in both the US and GB.

Although the living conditions are very good, (children usually have separate rooms, a TV set of their own and every third has a cellular phone of his/her own), every third child is living among divorced parents. 13% in the age group 16–18 years are drinking alcohol on a regular basis, 18% of them are smoking and every 4th–5th are not having breakfast every day. Every 4th is feeling tensed and nervous, every 10th is worried, feeling in a bad way.

Tables:

There are 62 individual disciplines/specialities in Medicine in Sweden.

Number of members in each sub-association of the Swedish Medical Association <65 years of age.

Rank of the 62 disciplines after size and the proportion of females in each discipline

1.	General practice	5,324	40%
2.	Internal Medicine	2,691	29%
3.	Surgery	1,570	12%
4.	Psychiatry	1,496	48%
5.	Paediatrics	1,217	41%
6.	Obstetrics/gynaecology	1,216	51%
7.	Intensive care/anaesthesiology	1,177	27%
8.	Orthopaedics	992	6%
9.	Radiology	920	25%
10.	Occupational health	687	28%
...			
17.	Child and Adolescent Psychiatry	321	61%
...			

Rank of the 62 disciplines after proportion females/males

1.	Child and Adolescent Psychiatry	61%
2.	Geriatrics	60%
3.	Dermatology/Venerology	59%
4.	Gynaecological oncology	59%
5.	School health	58%

Proportion of Child and Adolescent Psychiatrists in age-group within the speciality and within the sex

Age	Percentage of all	Males	Females
36-45	16% of all	10% within sex; 4% of all	20% within sex; 12% of all
46-55	44% of all	43% within sex; 17% of all	44% within sex; 27% of all
56-65	40% of all	47% within sex; 18% of all	36% within sex; 22% of all

Bioethics in Child Psychiatry

Jocelyn. Y. Hattab, MD

Bioethics acknowledges that human beings, from even before birth until their death, in their biological dimension, are subjects of moral consideration. Both the spiritualistic approach, where mind is the man's *primum movens* and only specificity, and the materialistic approach where man's psychic functions are but brain interactions, defend the basic human right to be respected in his body.

This may seem to be true, but there is nothing that cannot be questioned in human mental functioning, particularly regarding ethical discussions. Thus, all evidence has to be re-questioned and re-analyzed. Ethics is always a dilemma between two values. When this dilemma is resolved and the solution is accepted, in a given society, the solution becomes a law. Behaving according to a law is not considered moral but obedient.

Child Psychiatry has a long tradition of moral concern towards children. Child-care professionals understand the uniqueness of each child, as a person in himself rather than an adult in potential. As such, a child can only be involved in any procedure; clinical, research, social or educational, if the procedure is of direct interest to the child, or it is with his acceptance and if it will not cause him any harm.

Neurology and psychiatry grew hand in hand for many years. Then they separated but never definitively

divorced. Today, it seems that they are ready to live together again. They are both mature enough and self-assertive enough to cope with one another. They are not threatened anymore by the long living brain/mind dichotomy.

Brain research tries to bridge this gap. Its results provide more and more evidence of the complexity of the brain, not only in its motor, sensory and vegetative functions, but also in the cognitive, affective, memory, pulsions and so-called high functions. This knowledge can be interpreted in different ways according to the basic belief of the researcher: either in a materialistic or psychic mode.

This uncertainty on the one hand, and the extraordinary specificity of the brain, the cerebrality (Dagognet) on the other hand, confronts us with a specific ethical duty. Due to the fact that we know so little about brain/mind relations and are unable to totally manipulate the brain and the mind, whether using psychosurgery or psychotherapy, we have to be extremely careful and humble even when coping with the brain and mind. Clear differential diagnoses need to be made between reality and fantasies, between organ-brain and metaphorical-brain.

The ethical dilemma of brain research in child psychiatry can be posed in the following terms:

1. When children suffer from developmental and psychiatric disorders their mental functions are altered and provide a handicap to their full autonomy.
2. There is increasing evidence that these impairments are brain-based, either anatomically or biochemically or in its metabolism etc.
3. Proving these facts will be a tremendous progress in understanding and, more importantly, in treating these suffering children and their families.
4. The only way to improve this knowledge is to conduct research on all children, both normal and sick. As stressed by Donald Cohen, there is a moral obligation to conduct research in child psychiatry in order to adapt treatment to the specific needs and nature of the children, rather than in the undirected, blind manner that is generally done today.
5. This research uses procedures that are intrusive and are the only way to really understand a fact or try a new promising treatment, e.g., x-rays, venipuncture or lumbar puncture, even to normal children for the sake

of correctness of research, in the positive understanding.

6. Ethical duty obliges every scientist to consider children's rights; to be questioned, required informed consent and assent, respected in his/her mind and body, and for families to be consulted, listened to and respected.

This dilemma is generally answered by displacing the question onto the researcher and/or IRBs: "Responsible scientists must themselves balance the research question with an obligation to protect children." Or "the participation of children in research entails consideration of a variety of scientific and ethical principles. These include: the scientific validity of the question, the calculation of costs and benefits to the child and to society; the necessity for the project to be done in children; issues of assent, permission and consent; consideration of the special status of children who are members of special groups (mentally retarded, mentally ill, wards of the court)."

All of us, both clinicians and researchers, have our biases and blind points. Although we may have very good intentions and care greatly for the children, no one is perfect. Human biases such as "human nature from its beginning," competition between research teams, publication, promotion, fear from changing, routine, self-esteem, selfishness, self-assertiveness, self-service, must be considered. As such, individuals alone cannot answer the ethical dilemmas, certainly not the scientist himself (even the more moral scientist), nor the clinician, or the IRB if composed only of scientists and clinicians, particularly if from the same academic institution or hospital.

The answer can be approached by an independent board composed of scientists, clinicians, representatives of families or advocacy groups and lawyers, who have been nominated for this specific research program. This procedure may seem difficult to manage, but ethical requirements are sufficiently important to justify complex procedures. One solution is to have pre-formed committees who are able to meet upon request. Once established, these committees would be able to consider every specific technique or procedure.

Autistic children are the more striking subjects of neurobiological research and are at the same time more problematic from an ethical point of view. We are all eager to understand

what occurs in these children's brains to make them autistic. This knowledge would open up the doors of early development, language, social skills etc. An autistic child is obviously unable to give his/her assent and consent to a research project, and their families are often either overprotective or abandoning. The temptation is strong; does this child really feel pain when punctured? Does he feel manipulated when scanned? The cost/benefit calculation is almost obvious.

More and more voices in America call for unifying Child Psychiatry and Child Neurology. The arguments for it emerge from that which has been said previously, and they are convincing. However we have to weigh the ethical price of this unification, or in other words, the 'neurologication' of psychiatry. Even if there is no longer a place for brain/mind dichotomy, human beings cannot be reduced to a body or an admirable complicated nervous system, even if it is scientifically right. We also have social obligations, our societies have other considerations toward their subjects beyond scientific considerations. As psychiatrists, we are, or need to be more aware of the social dimensions of diseases, development, affective disorders, conduct disorders etc. Biochemical explanations of diseases are important but insufficient in order to solve them and understand their impact upon families and society. Thus, there is a need for 'psychiatrisation' of neurology.

Psychiatrists have long requested a multidisciplinary approach; and joining neurologists will be of great benefit and ethically correct.

In conclusion, Bioethics in Child Psychiatry is psychiatry itself; it is approaching the developing and suffering child and his family as a whole in all their dimensions; neurological, societal, affective and in the dimension called 'mind.' This final dimension, the concept of mind, is the essence of being human. It is ultimately unimportant whether mind is a reality or not, but it is an unavoidable concept, not only to understand human behaviour but also human history, human society, human laws and what is human at all.

Jewish Kabbala divides the creation into the inert, the vegetal, the alive and the speaking. Man was created by God from earth which is altogether inert, vegetal and alive, and he infused in him 'spirit'; that is, his specificity and his

condition to remain a speaking, mindful creation.

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Children in Turmoil during the Greek Civil War 1946-1949: Today's Adults A longitudinal study on children confined with their mothers in prison.

In memory of late Dr Mando Dalianis-Karambatzakis

Per-Anders Rydelius, M.D., Ph.D.

During the Greek civil war, Mando Dalianis-Karambatzakis, a young female Greek doctor was imprisoned together with other Greek women; many of

whom were mothering infants. Small children were allowed to stay with their mothers in prison for some time and were then placed elsewhere. Older children were immediately separated from their mothers going to prison and were sent to children's villages, foster homes or relatives. As adults they could return to their families if still alive.

Dr Dalianis left Greece, stayed for some years in England, finally settling down in Sweden. She became a paediatrician and a child and adolescent psychiatrist as well. When she retired from active work, she traced all the children she had met in prison together with their siblings and other family members to study the long-time effects of their stress early in life. The results were presented in her thesis in 1994. Dr Dalianis died in 1996, but as her study is of interest, a summary is given.

From Dr Dalianis thesis the following is reprinted:

This study investigates short- and long-term developmental effects of repeated exposure to multiple, sequential, massive and extreme war traumatization from infancy and onwards.

Three groups of children (Ia, Ib and II) whose partisan mothers (MI and MII) were imprisoned before, during and after the Greek civil war, were followed up to assess their development and adult adaptation in relation to early maternal separation and war trauma.

Hypotheses

1. The massive sequential psychic traumatic experiences left scars on these children's soma and psyche and have affected their physical, psychological and, especially, emotional development.
2. Children with disturbed emotional development run the risk of developing social adjustment problems during adulthood, especially in their ability to have warm, human relationships (for example marital capacity, parental ability, etc.).
3. Consequently the children's impaired parental functions have affected their children's development. (Data have been collected through a questionnaire. The findings will be presented later.)
 - Prison children (Ia): 119 children were confined with their 106 mothers (MI) in prison (39 in the womb, 80 at the breast when the mothers were arrested).

- Non-prison children (Ib): 40 older siblings of the prison children and II; 44 children of 37 imprisoned mothers (MII).

The children in groups Ib and II were never in prison with their mothers and were under five at the maternal separation. They were included to test the impact of the prison environment.

All these children were exposed to extreme war traumatization from infancy onwards, continuous repression, individual and social marginalisation, throughout childhood and adolescence. All but five of the prison children and one out of two of the non-prison shared their mother's exposure to persecution, arrest and trial.

While in prison the children's experiences included:

- a strong symbiotic attachment to a depressed, imprisoned mother;
- absence of any father relationship;
- environmental deprivation, segregation, impoverishment, isolation and, for a majority of the children, maternal separation at the age of two-three years;
- upbringing in substitute care of varying material standard and emotional atmosphere;
- little or no subsequent contact with the mother;
- reunion with the mother in pre-early, or late adolescence, or not at all
- Some children were uprooted at least three times after the loss of their mothers.
- Data were already collected in prison 1949-50 when the prison children and all the mothers were in my medical care.

In 1980-86 follow-up data were obtained on the parents, especially the mothers, the children and the latter as adults with families of their own. (Two children could not be traced, three died, 10 emigrated and 10 did not participate.) This was done at the subjects' homes, through taped interviews, free and semi structured. Also using psychiatric examinations, quantitative and qualitative data and public records, the children's personality development has been described and compared. From a methodological point of view, it must be stated that the study was designed as a risk investigation, focusing on traumatization and expecting negative outcomes.

The results indicate that despite the traumatization, a majority of the children have achieved an adequate psychosocial adult adaptation. Most of the grown-up children are parents, and seem to be in good physical and mental health. They appear to be socially well adapted regarding education, profession and marital adjustment. Only one child, with neglected hypothyroidism, is mentally retarded. None are psychotic or criminals.

Twenty families, including 20 vignettes of prison children and 10 non-prison, (3 and 7 from groups Ib and II, respectively) are presented to illustrate their traumatic and protective factors as well as coping strategies as suggested by researchers such as Rutter, Garmezy, Werner, et al.

The cases suggest that resilience was promoted by the child's personality characteristics, environmental factors in the family and networks, and their interaction. A careful statistical analysis was applied, but gave only limited information on possible traumatic and protective factors.

The systematic, positive interventions in the prison environment of the mothers and their children could explain why there were no differences in adult psychosocial adaptation between the prison group and the children who had not been in prison during their childhoods. In this way the study shows that, maybe, it is possible to compensate for the negative prison environment by systematic interventions, based on knowledge of developmental psychology like the studies by Spitz and Bowlby.

Since these efforts were unique for this particular group of children, the results cannot be used to generalize about the effects of early imprisonment when such interventions are lacking.

However, even if the prison experiences of this group of children were ameliorated, the group still experienced massive traumatizations, as did the non-prison group. It still remains to explain why most children fared well as adults despite their severe experiences during most of their childhood and adolescence.

The study should be seen as a pilot longitudinal investigation of effects that war traumas (particularly violations of human rights) and societies in civil strife may have on the psychological adaptation of children. Further research is needed with a more parametric, multi-disciplinary approach. The methods

should be improved, the measurement of traumatization standardized, by mental and health workers with experience in transcultural psychology, psychiatry and sociology, as well as by others. Anthropological approaches, including medical anthropology, could make a valuable contribution in this field.

Generative Tensions Molding Child and Adolescent Psychiatry in the United State of America

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Child and adolescent psychiatrists in the United States have had the advantage of a political and economic stability which allows a rich mixture of influences on its research, training and clinical services enterprises, and the gradual development of sustained productivity. Through many publications, and the words of American colleagues here, these activities are well known to you. My comments will be directed instead toward the generative tensions shaping our field, the activities necessary to carry us past our current obstacles, and how the coordinated activities of the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP) and the World Health Organization (WHO) can provide unique solutions to aid in this process.

The professional approach to the problems of the developing child in the U.S. hinges on a continuing validation or refutation process achieved through research, the gradual application of the findings from research in clinical settings, and eventual inclusion of the best of these results in training. While we think in categories, and conventionally describe clinical, research, or training content in terms of specific categories, such as oppositional-defiant disorder, or psychodynamic training, or managed care clinical services, the evolution of a field can be considered in terms of the tensions existing in the controversial topics of the day, spoken or unspoken. Such tensions mold child and adolescent psychiatry in the U.S. at the current time. Illumination of these tensions can aid in our attempts to improve the lives of the children and families under our care.

Role of IACAPAP and WHO:

- They can help in providing the expert personnel to develop and implement the training.
- They can partially sponsor some of the training activities or conferences.
- They can provide some channels to develop a liaison with other international activities in the field of child and adolescent psychiatry.

Report of the Third Research Seminar in Camposanpiero, Italy

September 29th–October 4th
2002

by Yosse Hattab, M.D.

As a joint initiative of ESCAP, IACAPAP and CHILD FOUNDATION, 32 young child and adolescent psychiatrists from 16 European countries and leaders of Child and Adolescent Psychiatry in Europe and the US met in Camposanpiero, province of Venice, in “La casa de spiritualita.”

The mornings were for plenary lectures, beginning with Paul Lombroso from Yale Child Study Center, on genetics; Janice Naegele from Weisland University on biochemistry of traumatization; Helmut Remschmidt, our IACAPAP President from Marburg University, on classifications; Richard Harrington of Manchester University on pitfalls of statistics; Ernesto Caffo, founder and President of the Child Foundation, on traumatization; Jocelyn Yosse Hattab from Hebrew University on ethics in research; of Oslo University on translation of rating scales; Tuula from Tampere University on Infant Psychiatry; Martine Flamand from Paris University on rating scales.

In the afternoons, there were three working groups, neurobiology, epidemiology and longitudinal research, clinical and services research where the attendees presented their programs and received help and criticism. They all acknowledged the fruitfulness of these discussions for their carriers as central child psychiatrists in their countries and the future of our profession there.

On Wednesday afternoon, we were all invited by the council of the City of Venice to the marvellous City Hall. Professor Amira Seif Al Din from Alexandria University lectured on the suffering of children in war all over the

world and Jocelyn Hattab described the situation of the Israeli children living under terrorism and its consequences. They both agreed and decided to work jointly to protect children from the consequences of this deadly conflict. The next meeting of the Eastern Mediterranean Association for Child and Adolescent Psychiatry in Sharm El Sheik in February will give opportunity to implement this decision. The ambiance was one of intensive work and friendship. We all discovered how our profession is developing in countries like Serbia, Croatia, Armenia, Russia and many others. More developed countries of Europe will continue their support to the others for the best interest of children wherever they live.

It was decided to meet again with the same group in 2005 to evaluate the improvement of the programs presented and also for the sake of our new friendly relations.

We discussed with our President the possibility to enlarge such initiative to other regions of the world; South America, the Far East, the Eastern Mediterranean, where IACAPAP has already set linked Associations.

We are all grateful to President Helmut Remschmidt for the idea of these seminars and for leading them and to Professor Ernesto Caffo, our Vice-President, for organizing and funding them so efficiently and kindly; and to all lecturers and participants.

Postscript: This work began prior to the outbreak of new conflicts in the Mideast and must continue. The promise to convene this group in 2005 is a hopeful necessity.

Resume of the Voices of Participants in “The Promised Childhood”

by Martin Feichtinger

“The Promised Childhood Congress,” originally planned as the 15th World Congress of IACAPAP, has proved to be, in the estimation of both participants and organizers, a resounding success despite the conference’s original format undergoing many changes, including postponement and a switch of venue from Jerusalem last year because of concerns due to the political unrest. Eventually the Israeli Association of Child and Adolescent Psychiatry and the Israel Psychological Association took over the planning and in May, 2001, in

Tel Aviv, more than 160 participants arrived from abroad representing about 40 different nations, together with about 400 from Israel. Although this was far fewer than originally expected, for those who came, enthusiasm and satisfaction were the key words used to describe their experiences.

Participants came literally from the most distant parts of the world, which, from a Middle Eastern point of view, included Australia and New Zealand. Many were highly motivated to travel long journeys and one participant from India had a journey of about 45 hours including almost 40 hours on an uncomfortable train from Assam to New Delhi!

The atmosphere at the Congress was described by participants as friendly and familiar— this was a positive effect quickly achieved by the interaction of the fewer number present, although the decreased number of participants was frequently regretted. Also advantageous was the diversity of professional groups. In addition to psychiatrists, psychologists and pediatricians, there were also social workers, lawyers and health workers representing their subjects from their point of view.

The theme of “The Promised Childhood” played an important role during the conference. Parallels between this title and the subject of “The Promised Land” were frequently drawn, with all the chances and disappointment contained in both concepts. The current political situation and the subsequent change of the form of the Congress gave reason to additional aspects in this comparison. Very touching was the gratitude expressed by the Israeli Organizing Committee for every participant who decided to come from abroad, despite the particular kind of coverage of the current situation in Israel as presented by many of the international media. The greetings of the Opening Event found their climax in the excellent performance of three adolescent musicians, which started with some pieces from the classical repertoire and ended with an instrumental interpretation of the popular Israeli song *Machar* (Tomorrow), a powerful expression of hope in the future which moved many in the auditorium.

Though for many people the present situation in Israel might have been a reason to cancel their participation (especially considering the image as shown in the majority of the media) nevertheless those who came

unanimously expressed that they felt safe. Some hesitated before coming but their concerns about security matters quickly disappeared after arriving in Israel and seeing a country which lives a normal life in most places. Facing reality in Tel Aviv, Jerusalem or the Galilee seemed a long way from the dangers suggested by TV pictures at home. On this basis some were surprised about the advice of some governments against traveling to Israel.

One of the few ways to encounter security awareness was the well-known Israeli phenomenon of attention to ownerless objects. One guest became acquainted with it when she lost her wallet, dropping it on the floor of the conference hall. Coming back after a while, she found it had attracted a number of security officers to the spot (one could see from this that the danger of finally losing possession was quite low...!).

For some participants the conference's location in Israel was an important additional reason to come, either out of their connection by their Jewish origin or, in case of a number of Christian guests, out of their wish to express their love for the land and the people of Israel in such a practical way. Many expressed regret about the cancellation of the Palestinian colleagues, following a statement of the Palestinian Authority which called for the conference to be boycotted.

As a result of the reshaping of the program, the Congress tours to Jerusalem and the Galilee took place at the third day of the conference, not as usual during the pre- or post-Congress period. This was an idea particularly welcomed by many participants. The well-organized tours offered a chance to visit historical and otherwise significant places, such as the Sea of Galilee, Capernaum and Tiberias for one group; the Holocaust memorial of Yad Va'Shem, the Old City of Jerusalem with its four different quarters, the Western Wall and the Church of the Holy Sepulcher for the other. Besides the interest of these places the timing of the tours was seen as advantageous, due to the opportunity to have a free day after the frequently intense presentations during the preceding days.

Very enjoyable was the relaxed atmosphere at the Social Program and the beautiful frame chosen for the different events. The reception and visit in the Tel Aviv Museum was both a social and a cultural highlight, in which

the guests could not only enjoy the delicious banquet in an easy ambience but also marvel at the collection of classical and modern art. The Farewell Dinner was also a delicious highlight, whose location on the beach of Old Jaffa could hardly be surpassed in regard to the beauty of the site.

In summary, "The Promised Childhood" was an excellent Congress in which the organizers overcame successfully the problems of preparation and sometimes even enhanced the quality of the event by the solutions they developed. The Congress took place in beautiful and most interesting surrounding and presented high caliber lecturers who gave presentations on a wide variety of subjects. These and other factors contributed to the great experience of this conference, which will remain a pleasant and professional memory for a long time to all those who participated in it.

Sanctuary: the Donald J. Cohen Auditorium

*Andres Martin, M.D., M.P.H.
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The one I loved has turned into a ghost.
I am the place of its apparitions.

Juan Jose Arreola: Tale of Horror.

Much of what is said here
Must be said twice,
A reminder that no one
Takes an immediate interest in the pain
of others.

Billy Collins: The Blues.

The main conference room of the Neison and Irving Harris Building of the Yale Child Study Center was dedicated as the Donald J. Cohen Auditorium during a two-day celebration this past June. The confluence of three traditional Jewish concepts marked the event for me, and I will use them here in an attempt to convey to others the spirit of both the occasion and the space.

The first such concept, *Tikhun Ha'Olam*, literally means 'to repair the world' and can be taken as one of the main common denominators of Donald's career. Indeed, his far-reaching efforts to improve the lives of children around the world have been recognized, among other ways, through memorials in the previous issue of this *Bulletin*, and with parallel dedications in Chile, Italy, Israel

and Turkey. During the New Haven dedication, however, the concept had an additional and very concrete meaning: the acclaimed artist Mindy Weisel collected some fifty of her abstract works, and under the unsurpassable title of *Tikhun Ha'Olam*, graced the walls of the Center with them. Her gesture was not only spontaneous and generous (proceeds from sales have gone toward the endowment of the Donald J. Cohen Professorship), but a perfect example of the second concept – that of *Chidur Mitzvah*.

Chidur Mitzvah refers to the act of beautifying a religious obligation or good deed (a *mitzvah*) so as to complement it and maximize its potential. Lighting candles on the Sabbath can serve as a classic example: while the required (and sufficient) obligation is to light two tapers at sundown on Friday night, doing so using ornate silver candleholders adds beauty and meaning to the act. Along comparable lines, it would have been sufficient (and some would argue that it was required) to remember Donald through the dedication of the Auditorium. But doing so in a space that has been complemented with pieces that add to its intrinsic architectural beauty – one that Donald was intimately involved in achieving – took the need and the obligation to remember him into a higher spiritual plane.

In addition to a piece from the Weisel exhibit that has remained as a gift from the artist to decorate the entrance to the Auditorium, two objects of supplemental beauty deserve mention. The first is Donald's portrait: a black and white photograph dating from 1997 and showing him as we so vividly remember him today: with a warm smile, and donning the *kippah* he always wore at home, as well as the ever-present necktie – a personal fixture consistently knotted just a tad askew... a gift from his friends at the Western New England Institute for Psychoanalysis where he taught for decades. The plaque under the portrait summarizes Donald's professional life as seven complementary facets: 'physician, humanist, scientist, clinician, psychoanalyst, teacher, mentor.'

By contrast, the wall facing his portrait is anything but black and white: a vibrantly colorful and textured quilt orchestrated by Deirdre Stowe, senior member of the Center's business office. Near the very end of Donald's life, as he lay in the Infirmary of the Yale Health Plan surrounded by his immediate

family, Deirdre went to everyone at the Child Study Center: to the many whose lives he had touched so directly and who felt at a loss not being able to see him or say goodbye directly. In her brief and quiet visits to each one, where there was so little that could be said, she passed around small pieces of golden yellow fabric. Those pieces, on which the extended Child Study Center family wrote final words of appreciation and gratitude, became the recurring theme and bonding element of the quilt. Sewed together into a magnificent coat of many colors, the quilt accompanied and covered Donald during his final days. I read today the words I wrote then, in the half-daze of those painful days – days further compounded by their proximity to 9/11. My words on the quilt, incongruent, disjointed and agrammatical as they were, retain their intended meaning today: *'We will always love you and carry you in and you on.'*

That we carry him *in* is evident to the many fortunate ones among us who came under his direct spell. Evident to the point of being tautological: we can conceive of no possible alternative. But that we carry *on* with his work and legacy may be less obvious, particularly to the many who did not know him and yet regularly apply his teachings during clinical, scientific or policy endeavors: *Midor L'Dor* reads the inscription at the entrance of the Auditorium, *'From Generation to Generation.'*

This third and final Jewish concept, of the transmission of values from one generation to the next, has recently taken a turn of almost unbearable sadness. For Al Solnit, the third director of the Center, whose vision had included the recruitment and grooming of a young Donald into its fold; who had moderated the child psychoanalysis seminar during the first day of the Dedication ceremonies just a few days before; and who remained intensely active to the very end, tragically died in a car accident on June 21st.

As we all did, Donald loved and respected Al. One of the many tokens of that appreciation was the dedication of his classic paper, 'to Dr. Albert J. Solnit... on the occasion of his 70th birthday' (1990). That paper, cited perhaps more than any other during the scientific activities of the Dedication, has a title that is poignantly appropriate today; a title that could be applied to this piece, to this and the last issues of the *Bulletin*, to our very lives during these days of heartbreak: *Enduring Sadness.*

The Donald J. Cohen Auditorium will become the vehicle to transmit the values and teachings of these two stately princes of child psychiatry. It has also become a sanctuary: one better suited as a place to be in their closeness than as a shrine to pay them the deserved homage that would have made them both equally uncomfortable. Our very selves will become that shrine – a place for their welcome apparitions. Our gratitude and love have been compounded and multiplied by the grief of our double loss. We can, and indeed should, take solace in something that applied to them becomes yet another truism: Death ends lives, but not meaningful relationships.

A Child Psychiatrist Goes to Brazil

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In 1982, at a small study group meeting in Oxford, organized by Ronnie MacKeith, the founding editor of *Developmental Medicine and Child Neurology*, I met a Brazilian pediatric orthopedic surgeon and that encounter led to one of the most rewarding experiences of my professional life. The surgeon, Dr. Aloysio Campos da Paz, Jr., presented a paper on poor outcomes of orthopedic surgery for children with cerebral palsy, especially those surgeries which were designed to improve gait. He speculated that the results were poor because the children could not accommodate to the new body image, and he described how he and others working with him had been influenced by Piaget. I was intrigued by this extraordinary juxtaposition of orthopedics and Piaget, and after a dinner conversation and some correspondence, I was invited by Dr. Campos da Paz to visit the hospital which he directed, and to carry out a total program consultation, to evaluate the "institutional psychology" of the hospital and to offer suggestions for improvement. Some months later I was flying down to Rio (yes, thinking of Fred Astaire and Ginger Rogers in one of my favorite childhood movies) on my way to Brasilia, to spend six weeks working, and living, at the SARAH Hospital there.

But first, a few facts about Brazil. It is fifth largest country in the world, with the eighth largest economy. Originally colonized by the Portuguese in the sixteenth century, it is a cultural mix of a number of other ethnic and racial groups, including native Indian, West African Black, Japanese, Italian and German, with a total population of approximately 170 million. Under King Pedro I, Brazil declared its independence from Portugal in 1822, and became a republic in 1889. Fearful of a drift to the left, and unfortunately supported by U.S. policy at the time, a military dictatorship seized power in 1964, and held it for twenty years until democracy returned in the mid-eighties, after a peaceful, non-violent transition. The topography of the country is quite varied, from the beaches in the Northeast, to the Amazon rain forest, to the interior farming plains, to the Tyrolean hill country in the south. Rio de Janeiro is spectacularly beautiful, but with appalling areas of poverty. The high-rise metropolis of Sao Paulo has 12-15 million people, is the commercial center of Brazil, and even makes New York seem small; the Bahian capital of Salvador has music and cuisine which can compare to New Orleans. Brazil has over 120 medical schools, and many of the students undertake post-graduate training the U.K., the European continent or the U.S.

My initial trip to Brazil was spent at the hospital SARAH-Brasilia. This hospital opened in 1980 and was designed by the Brazilian architect, Dr. Lele, a protégé of Oscar Niemeyer, the architect of Brasilia, who also built the United Nations headquarters in New York. Brasilia, a city of striking architectural innovation, was inaugurated as the new capital of Brazil in 1960. SARAH-Brasilia is a model rehabilitation hospital which sits elegantly within the hospital district of the city. The building has wide verandas on each of its six floors, interior gardens, an arts and crafts "Center of Creativity" for children, state of the art surgical suites, a computer-driven gait analysis laboratory, two swimming pools, an audiovisual department with commercial television capability, liberal office and comfortable patient-care space. It offers free services to children, adolescents and adults of all social classes. A wide range of orthopedic, neurologic and neuromuscular pathologies are treated: cerebral palsy, spina bifida, muscular dystrophy, para- and quadraplegias resulting from diving or auto accidents

or gunshot wounds, cerebrovascular accidents producing motor impairments, diabetic neuropathies, etc. SARAH-Brasilia has also become a referral center for children for developmental disabilities, including autism, Rett syndrome, and other behavioral phenotypic syndromes such as Williams, Prader-Willi, Angelman, and Lesch-Nyhan. The hospital staff includes the disciplines of pediatrics, internal medicine, neurology, neurosurgery, orthopedics, psychology, social work, education, physical and occupational therapies, radiology, genetics, and pathology but no child psychiatry. Brazilian child psychiatry remains dominated by private office practice psychoanalysis based on Kleinian theory, and there is simply no tradition of liaison child psychiatry within a general hospital setting.

I first visited SARAH-Brasilia in 1983 and I have returned for follow-up visits once or twice a year for two to three weeks for the past 16 years. During my first visit, I followed the staff through all of their activities, observed, listened, asked questions and then compiled a report of my findings and recommendations. I was assigned a young university student, fluent in English, who served as my translator. (Now my Portuguese, though not stellar, is good enough to understand cases presented to me and to engage in some informal social discourse; for formal lectures, I have a translator, but many of the staff have serviceable English). In my initial visit I was most impressed by the dedication, commitment, hard work, and compassionate humanism of the staff. I vividly recall an outreach home visit that I, together with a psychologist, physical therapist and teacher made to a mother and her blind, retarded, epileptic infant, living in a "favela," or slum, in the outskirts of Brasilia. This depressed mother seemed to be in a hopeless state, and was particularly distressed that she could not stop her baby from crying. I watched as the physical therapist stroked and soothed the baby, then showed the mother how to do it, and then the baby stopped crying, much to the relief of the mother, who felt that, at last, she could do something for her child. The team scheduled further visits to show the mother how to bathe and feed the baby. The approach underlying this "simple" intervention was testimony to the care and concern of SARAH personnel.

Over the years I have been involved in many consultative activities at the

SARAH Hospitals, beginning in Brasilia, and later in other SARAH hospitals which were opened in the cities of Salvador, Sao Luis, and Belo Horizonte. Working with my colleagues at SARAH, we changed hospital policy in 1983 to encourage mothers to stay with their children during hospitalization. A genetics service has been established, using faculty from my medical school as trainers. I have taught a two credit hour course in child psychiatry for pediatricians and allied health personnel as part of their master's degree requirements at the SARAH University. I have trained pediatricians in the use of appropriate psychopharmacologic agents, and psychologists in child psychiatric diagnoses and treatment, so that the combination of these two disciplines can somewhat fulfill the role of a child psychiatrist, still absent in the SARAH network. Protocols have been developed for the preparation of children for anesthesia and surgery. Parent support groups have been established. Multidisciplinary teams make inpatient rounds together with the physicians. Numerous case consultations have been given, emphasizing diagnosis, treatment, family dynamics, resistances, noncompliance issues and intervention priorities. (Via e-mail and fax, case consultation continues when I am not physically present at SARAH.) Seminars and discussions have been held with the oncology service on death and dying. In some instances my contribution is to "validate" what the staff are already doing, and to tell them that we could not do any better in the U.S. The hospital architect and I have met around design questions related to community activities. I have been invited to speak to government ministers about our experience with managed care health delivery. So far the Brazilians have avoided this pitfall, and continue to fund the SARAH programs by government grants from the Ministry of Health, administered by the SARAH Foundation. While I am working in Brazil I don't have to fret about length of stay, and utilization reviews; I can just teach, consult, and have long, after hours dinnertime conversations with good company and friends. More recently I have been helping staff write papers for publication in English language scientific journals, by assisting them with organization and editing. I am pleased that several have recently been published.

When I first went to Brazil, I had little awareness of how much of my life would become enmeshed with my connections south of the border. Beyond being a consultant, I think that a part of my own identity has become that of at least an honorary Brasileiro.

Editors' Comments: Leaving home for adolescents is difficult. This teenager describes how she learned to cope while at boarding school.

A Student's Perspective: An Artist's Journey

by Alexis Greer

As a shy eleventh-grader entering my first year at boarding school, I felt very unsure of myself. For once in my life, I could see no "niche" that I would fit comfortably into. In public school, I had found many people like myself, people who were unable to be categorized; those who would not fit under a label that others made for them.

Boarding school, however, brought with it a homogeneous crowd of people. All of the faces in my classes seemed to be white; all the bodies dressed in the same sweaters and jeans. In a school with a dress code but without a uniform, it seemed as though the students had made a uniform for themselves. I had come from a background where it was considered "uncool" to look like everyone else; now I was thrust into the opposite situation. I held onto my own ideals—I did not want to look like these people—but at the same time, I felt completely alienated.

I had not expected conversation with my classmates to be very difficult. I had never had an easy time making friends due to my shyness, but I had never been friendless, either. I tried many times to make small talk with people in my dorm, in my classes, on the quad. I failed miserably. The other students were very judgmental, and I found that among the favorite topics of conversation at my school was putting down one's closest friends behind their backs. My attempts at conversation were snubbed, but I soon found that these were not the sort of people I would have wanted to talk to.

As the year progressed, I began to settle into the academic routine. The classes were much more interesting than those that I had taken in public school, and the smaller class size made it more

difficult to fall asleep instead of concentrating. I threw myself wholeheartedly into my schoolwork as a substitute for any sort of social life. The books weren't much for company, though, and I felt very lonely. My German roommate began to get annoyed at me for crying so much and listening to depressing music.

My one salvation that first semester was my drawing class. I had put it on my schedule simply because I had never gone for a semester without taking some sort of art class, and I did not plan to break that pattern just because I was away from home. Drawing was a class where I was not scorned for being quiet; in fact, silence was a necessity. There was no fear of being called on, or of needing to know the "right answers." We were given assignments, but even those were open-ended; it was nearly impossible to do them the "wrong way." We learned to draw with charcoal, with different kinds of pencils, with pens. We were taught shading techniques.

In drawing class, I shone. I did not have to speak; my drawings spoke for me. Every once in a while, a classmate would saunter my way, look over my shoulder, and gasp. Soon a crowd would develop around me, full of compliments for my latest project.

Our final assignment for the semester was a larger-than-life self-portrait done in charcoals. We were supposed to accomplish this by making grids on photographs that the teacher had taken of each of us, and dividing a very large piece of paper into proportional grids. We then drew what we saw in each grid of our photographs into the corresponding grid on the paper. I spent many hours working on mine, and when it was finally finished, I had reason to be proud. The class's self-portraits were placed on display in the school cafeteria. For weeks, people whom I barely knew were stopping me in the hallways to say, "I saw your self-portrait. It looks exactly like you!" It was a wonderful feeling.

My art was a source of confidence for me, and perhaps the only one that I had at the beginning of my boarding school career. I did well academically, but I did not feel that I was any more intelligent than the other students were. My social life eventually started up a little bit when I met Ebony, a black girl from Michigan with whom I had more in common than anyone else I had encountered at the school. I began to spend time with her and her friends,

most of who were also black. At mealtimes, I would sit at the "black table."

I did not talk much, but they accepted me. They invited me to go places with them, and came to my room to drag me out when I was feeling unhappy. They were always laughing, and their energy was contagious. I loved being with them. I knew that I didn't have much in common with most of them, aside from Ebony; but they were clearly in the minority at a school of white, upper-class students. As a small, somewhat chunky Jewish girl from New York, dressed in baggy clothing instead of the catalog-ordered sweaters and fitted jeans worn by the other white girls, I was obviously an outcast and therefore also part of a minority. They could sympathize, and it seems that they did.

I took a painting class my second semester at boarding school. It was then that I discovered oil paints, which have since become my passion. The only painting that I had done before taking the class was at an arts camp that I had gone to for three summers, and I had always used acrylic paints simply because I knew that oils were more difficult to clean up. In painting class, however, I was suddenly expected to paint with oils.

My first efforts were a little shaky, but I began to experiment with blending techniques and discovered that oil paints were much easier to blend than acrylics. They took longer to dry, so it was much easier to make adjustments on my paintings. After our first two assignments, our teacher let us each decide what we wanted to paint. I was at a loss for ideas, so I went to the teacher for suggestions. She came up with the idea of making a painting of the self-portrait I had made in drawing class the semester before.

I was a bit dissatisfied with this idea at first. I wanted my painting to be something special, not something that I had already done in charcoal. Adding realistic color seemed to me a boring concept.

Then I had a revelation. I could paint myself in reds, oranges and yellows—colors that I thought would display my "inner spark." I chose a dark purple background for contrast. I became immersed in the project, perfecting every little detail. I was not terribly worried about whether or not the painting would be realistic, but I wanted to convey the fire that I held inside, the

part of me that no one at my school had ever seen.

I still have that painting; it hangs in my bedroom, right beside my mirror. I consider it one of my greatest accomplishments, and I probably always will. Perhaps, as the artist, I see things in it that no one else does. In my opinion, that particular painting is not a portrait of me. Rather, it is a representation of a facet of my personality, of a certain rush of emotion. It is a painting of one of the

things I admire most about myself: my passion. For it is that same passion that flows into my artwork, my poetry, my friendships, and even my academic life. It is that ability to throw myself into things that produces dramatic results, and these results become the source of my pride and self-esteem.

Art has always been present in my life. When I was a young girl, I wanted to be a fashion designer. I used to sit in my elementary school classes and draw female figures in elaborate outfits. The teachers never minded, because they knew that I was able to listen while I was drawing; I always got high enough grades to get away with it. Later in life, I gave up fashion design in favor of more intellectual pursuits; but I never gave up my art, even when I made the choice of going far from my parents and the city in which I had spent my entire life.

Art proved to be a valuable tool for me, helping me to adjust to the difficult situation that boarding school presented. As a high school senior, my second year of boarding school was much easier than the first. I made two friends who are very dear to me, and still kept my friendship with Ebony, though I spent less time with her group of friends. And, needless to say, I kept painting.

I am now a sophomore in college, and because of my experiences, I have strong feelings about the value of art in the life of every human being. Even those who don't feel that they are talented in the visual arts can still feel the therapeutic release given by self-expression. Art classes provided an outlet for me when I most needed one. I believe that anyone can benefit from the feelings that this sort of an outlet brings, whether the outlet of choice is painting, drawing, writing, dancing, or any other sort of art form.

Editors' Comments: These issues are particularly relevant for current world events.

Students' Perspectives: Reactions to War

by Lily Benjamin, Erin O'Connell, Ryan Shugarman, Brooke Watanabe, Cornell University, Ithaca, NY, and Ingrid Gonzalez, Barnard College, New York, NY

This article was written while these students were on a summer internship at the Childhood Bereavement Program of Weill Medical College of Cornell University.

Consider the Vojvode family, ethnic Albanians from Kosovo. In April of 1999, NATO planes accidentally destroyed their home. As Mrs. Vojvode stated: "The planes were very low, and I saw them drop a bomb in the street. And then I heard the screaming from my house." Her husband died that day, and their five children were hospitalized for injuries. These children are just some of the many that have lost one or both of their parents during the recent years of chaos in the former Yugoslavia. The atrocities that have been highlighted in the news recently in Yugoslavia and elsewhere should draw our attention to the millions of young children and adolescents who are being affected by the bereavement and traumatic stress induced by war.

Grief reactions involve a complex variety of symptoms, including intrusive yearning, mild depression, and anxiety. In addition, individuals must cope with the changes in life structure that accompany the loss. Complications frequently arise in the grieving process; major depression, generalized anxiety, traumatic grief, and post-traumatic stress disorder are common.

War adds further complications that interfere with proper grief resolution. The loss of family members is often compounded by the destruction of neighborhoods, geographical displacement, chaotic disruptions of daily life, and the loss of a general sense of security. When devoting all of their energy to survival, individuals may not be able to attend to their grief. The horrific and pervasive nature of the loss and the lack of resolution may lead to a greater incidence of psychopathology.

Bereavement in any context is particularly difficult for children and

adolescents. For infants especially, the loss of a primary caregiver can lead to future difficulty in the formation of healthy attachments. Children's grief is typically of a longer duration than adults', since they do not have the cognitive and emotional capacities necessary to understand and integrate the loss into their lives. Preschoolers view death as temporary and reversible; they may expect to be reunited with the deceased person, leading to chronic disappointment and a prolonged grieving process. Because of their lack of ability to deal with painful and intense feelings for extended periods, children express their grief in short, intermittent episodes over a long time span. Furthermore, the anxiety and helplessness that most children experience often complicates their successful acquisition of important psychosocial skills. For adolescents, puberty and the developmental tasks of separation from parents and identity formation both complicate the grieving process, and become more difficult to achieve as a result of bereavement.

In order to properly resolve their grief, children require a stable and secure environment. Beyond their needs for basic sustenance, they require consistent nurturance from an attachment figure. If children lose their primary caregiver, it is essential that someone else fulfill that role. This is no easy task, as close relatives in a time of bereavement are often focused on their own grief reactions, making them emotionally unavailable. This becomes most extreme in cases of war, where survivors are concerned not only with their grief but with the tasks of survival.

Adolescents face somewhat different stresses. They may be forced to grow up too quickly during times of war. They may be taken from their families and thrust into combat, where they have to resolve the crucial issue of defining their identity as they fill the role of the soldier. When they carry out the tasks of battle, their moral beliefs may be called into question. They may witness the brutal deaths of their peers, for a purpose they might not entirely understand. Off the battlefield, adolescents might be called upon to take more adult responsibilities, either because parents have been lost or are unfit to carry out their duties.

In the aftermath of war, the profound grief of bereaved families like the Vojvodes cannot be overlooked. We need to be attentive to the ways in which

traumatic stress complicates the grief resolution process. Clinicians and government administrators should be particularly sensitive to the problems that can arise when grief is not properly dealt with, and should prepare to intervene when necessary. It is not enough to physically rebuild a country; a country needs to be emotionally rebuilt as well.

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A Student's Perspective: Notes from a IACAPAP Fellow

by Peter Leckman

I watch as Palestinian children reenact a funeral. Girls pretend to be lamenting mothers and boys chant slogans of glory as they bury a small doll in a sand box. The walls of their classroom present a drastically different mood, adorned with the bright and sloppily painted smiles of six-year-old artists. These children have never faced a bullet nor thrown a stone, but I fear their hidden injuries will be harder to heal than physical wounds. As I recall their voices and remember my own anxiety, I realize that my intellectual interest in human rights has become profoundly and painfully existential.

It has been 53 years since the signing of the Universal Declaration of Human Rights. The dignity and quality of human life have been proclaimed and paradigm shifts in thinking have begun to refocus disciplines toward their human components. From Amartya Sen's Nobel prize winning economic theories of human development to new international courts of justice that protect the global community, human rights are a prime concern of politicians, academics, and advocates around the

world. Despite this calibration of the world's moral compass to a defined and accepted standard, deviation remains the norm. Regardless of location, nationality or ideology, political, civil, and economic rights are routinely violated. Paper decrees and rhetorical guarantees have yet to embed themselves in the practices of most societies.

One cause of this gap between rhetorical commitment and actual practice, in my opinion, is that rights are often seen as the basis for civilized liberal practices instead of the result of such practices. If the cause and effect of rights are misplaced, one begins to believe that the establishment of rights will guarantee civility. Such a top-down conception of rights, however, ignores the problematic psychology of human morality. Our evolutionary desire is to separate ourselves and protect those within our defined communities. Within community, mutual understanding, respect of differences and empathy for others shields us from the fear and misunderstanding that lead to abuse. In recognition of this fact, a new wave of human rights theory has begun to shift the focus away from idyllic conceptions of universal rights and towards a more practical understanding of a so-called "ethical community." Instead of insisting, from above, that everyone has to maintain certain rights, programs attempt to expand the boundaries of our defined communities to include potential antagonists. In other words, if I can understand and accept the hopes and fears of my competitor, I'm less likely to feel threatened and less likely to try to harm that competitor.

Over the past year and a half, I have watched the hopeful beginnings of an ethical community collapse and seen – on a personal level – why the efforts to create such communities are so difficult and so necessary.

In August 1999, I was given a small grant by IACAPAP to volunteer at the National Plan of Action for Palestinian Children (NPA). Based in Ramallah, this research and advocacy group is technically under the auspices of the Palestinian Authority's Ministry of Planning and International Cooperation, but is independently housed and financed. I began work comparing the financial and rhetorical commitments made to children by the Palestinian Authority, local non-profit organizations and international donors. Our belief was that Palestine's pre-state status and lack of institutional legacy presented a

unique opportunity. If pro-child policies and their costs could be identified, incorporating them into the national budget debate would be relatively easy. Since most Palestinian governmental institutions have only been extant since 1994, there were few historical precedents and structures to combat.

This was a time of hope. Although most Palestinians were still frustrated by their situation – continued occupation, high unemployment, restrictions on movement – their future imagined of statehood and peace seemed an ever-closer reality. Yasser Arafat and Ehud Barak appeared to be discussing the final details of a final agreement and there was an anticipation that things were going to improve. At the NPA, we had begun to strengthen low-level partnerships with Israeli counterparts. Sharia Simsim and Rehov Sumsum, the Arabic and Hebrew versions of Sesame Street, for example, developed a partnership to help build cross-cultural understanding. The planning and organization of the IACAPAP conference, Jerusalem 2000, brought together child mental health workers from both sides, as they struggled to form a truly representative conference.

This collaboration was mirrored throughout the West Bank and Gaza. Of course this was not always without incident and the vast majority – on both sides – remained skeptical and fearful of the other, but movement tilted toward the positive. Workers traveled to Israel, joint security forces patrolled certain areas and cooperation was the norm for many key projects. With every forthright conversation a new brick was laid in the establishment of empathy, understanding and an ethical community. On Thursday, the 28th of September 2000, these beginnings of an ethical community crumbled.

The beginning of the *Intifada* changed everything. On both sides, moods and personalities seemed to change overnight. Pro-peace activists were soon neutral and those neutral were suddenly hostile. In reflection, it is difficult to describe my emotions. At first, there was an excitement, as if anticipating a blizzard or hurricane. But just as with a storm, after the snow turns brown or your home is damaged, you wonder why you were ever excited – and ashamed of your fantasy. After a few days of stunned inaction, our office attempted to get back on track, developing a curriculum for traumatized children and, in effect, developing an ad

hoc therapy for ourselves. The friendships that had been developed during earlier interactions could not survive the polarization. There was no outreach; no communication from either side.

We are forced to sort out what we believe is true through an ever shifting kaleidoscope of news articles, personal opinions and human emotions. Yet it seems that we often seek out information that conforms to our prior conceptions. One tends to dismiss information one disagrees with and focuses on what has already been established as 'true.' From my perspective, it was difficult to discuss the conflict with most Palestinians and Israelis because they both thought I was on the other side. Any news article that went against their opinion was summarily dismissed and rebuffed. And I was certainly guilty of this myself. By only accepting the information that comfortably fits within our own worldview, however, it is much easier to polarize and much harder to understand. This dynamic sounded the death knell to those tentative beginnings of an ethical community. There was no empathy, no mutual understanding of the fear and anger that both sides were experiencing. When one cannot see the self in the other then it is easy to devalue the existence of the other. And then it is far too easy to rationalize and maintain the cycle of atrocities that continue to fuel the *Intifada*.

Despite the perception in the Western media that all Palestinian children are in the streets throwing stones, the vast majority of youth remain inside. What has lingered since my return are the images of these children; the ones who have never faced a bullet or thrown a stone. On the surface it seems nothing has changed. They still smile and run around and make fun of my broken Arabic. But after being with them for some time it is clear how altered their world has become. Pictures are painted in dark hues of purple, red and black. Last month's soccer game was replaced with Arab and Jew' – a game similar to 'Cowboys and Indians' that is basically a reenactment of the anger and suffering witnessed on television. Ironically, nearly every Palestinian child wants to play an Israeli. In their young minds, they pass over the nationalistic rhetoric of television, and attempt to confront their anxieties by pretending to be on the winning team. Even before the *Intifada* began, they watched as the most powerful person in

their world – their fathers – were forced to give deference to young Israeli border guards. The Israeli settlers who border their run-down neighborhoods, often live in the opulence of green grass and real homes. The implied message is that the Israelis are the ideal; they are the ones with opportunity. Palestinian children choose to play the Israeli in this childhood game because then, for at least a few moments, they attain the power and freedom they desire. As these children grow older, resentment deepens and the conflict is passed to yet another generation.

Research has demonstrated that the psychological consequences of war are grave and long lasting. Child and youth exposure to violence, either as victim, witness, or participant, has been linked to a wide range of mental health and behavioral sequelae including depression (Richters and Martinez 1993, Fitzpatrick and Boldizar 1993), anxiety (Singer et al. 1995, Schwab-Stone et al. 1999), low self esteem (Sturkie and Flanzer, 1987), posttraumatic stress (Thabet and Vostanis 2000), low academic achievement (Schwab-Stone et al. 1995), and poor peer relations (Osofsky 1995). Violence can also alter a child's worldview, expectations for the future, and moral development (Garbarino et al., 1991).

Faced with this litany of negative sequelae, the establishment of an ethical community in this oft-violent region is a prodigious task. Borders, both physical and psychological, are insecure and given the current levels of fear and anger, creating cross-national empathy and mutual respect is simply an impossible short-term goal. The challenge – whether short-term or long-term – is to ensure that this does indeed remain a goal. Creating an ethical community is the only palatable solution to the Palestinian/Israeli conflict and it is in the best interest of the children of both sides. If the worth of the other is devalued, if communication remains so sparse that stereotypes and misconceptions strengthen, this goal will indeed disappear.

Child mental health is key to keeping the goal of an ethical community alive. Being exposed to violence as a child increases the likelihood of being exposed to violence later in life.

We must work on both sides of this sad equation: stopping the violence and helping all who are exposed to violence. We must strive to understand the pathways that turn violence exposure to

psychopathology and then work to steer children toward positive, healthy outcomes. We must replace environments of humiliation, fear, anger and aggression with those of security, hope, understanding and love. Perhaps this sounds naively optimistic, but there is simply no other way to provide peace to the next generation of six-year old artists.

Peter Leckman was a IACAPAP fellow in late 1999. He returned from Ramallah in December 2000 and will attend Berkeley Law School in the Fall of 2000.

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Editors' Comments: Terrorism is increasingly felt around the world. The effects of such acts make it necessary to appraise those who are affected and to ensure that they are adequately supported emotionally, financially, and in other necessary ways. Knowledge about those affected is critical in planning relief efforts. These students highlight a method of determining how those affected may be understood.

Developing a Database of Victims Who Died on September 11, 2001

by Karen Wong and Tiffany Turner

This article was written while these college students had a fellowship in the Travelers Summer Research Program at Weill Medical College of Cornell University and participated in the Childhood Bereavement Program at Weill Medical College of Cornell University. Ms Wong is a student at Cornell University and Ms. Turner is a student at Howard University.

This summer, we had the privilege to work with Dr. Cynthia Pfeffer, who is the Director of the Childhood Bereavement Program at Weill Medical College of Cornell University. The major project that we were involved in was the creation of a database that includes information about the individuals who perished on September 11, 2001. Through initial research by individuals involved with the project in the past, it was discovered that there is no public domain where a complete list of victims is listed along with their demographic, family, and death information. Several websites on the internet did attempt to complete this task, but they were incomplete since each one only addressed some of the variables we felt were important characteristics to know about the victims. Some of the variables we were interested in were the victim's age, place of residence, location of death, marital status, spouse's name and age, number of children, and children's names and ages.

The collection of information for the database was an emotional task since it involved reading through the personal profiles and biographies of individuals who are no longer with us. Many stories were poignant in the fact that young

children were left behind without the ability to comprehend why a parent would be taken away from them. We found over 3,000 victims for our database and discovered that of these individuals, they left over 2,900 children behind. In addition, this is probably an underestimate of the number of bereaved children since some victims may not be accounted. We were in shock as we think about how many lives were lost within minutes and the number of bereaved children that resulted from these events.

Another issue that stemmed from the attacks on September 11 was the number of international individuals that also became victim to this tragedy. Not much information was found on these victims, which brought up the question of how their families were being supported. Without information on these families it would be difficult to understand the type of relief they need. Relief can constitute several different things such as financial, emotional or even psychological support. After learning the specific needs of these families, the question still remains, who will provide the support? Should relief be provided by each victim's native country or should the United States be responsible since the attacks did occur on American soil. In any case, the source of relief is irrelevant. What is important is that these families receive the help they need to survive.

What is the purpose of completing the database? First of all, it can help the general public because disaster relief planning can begin for any events that may occur in the future. This includes the immediate creation of relief funds for individuals who are affected in the event of a disaster. In order to deliver the aid in an efficient and effective manner, organizers need to be aware of the population they are serving. For example, the victims of 9/11 were mainly part of the American working class and were major providers for their families. As mentioned before, there were also victims from outside of the United States whose families need to be accounted for as well. In this case, some programs need to be implemented in order to address the financial issues of the families who were affected, regardless of their citizenship. Secondly, a detailed database would also allow contributors to seek out organizations that serve the population they wish to help. Within this resource, aid can be

distributed to those in need in a more expeditious manner.

With the database completed, we can now begin to answer questions that were not answered before. For instance, we discovered that nine children (age 18 and under) died as a result of the attacks. Statistics such as these are important for physicians to be able to conduct detailed research on this issue. This type of information can be used to better understand how a traumatic event of this magnitude can affect a diverse collection of people. Diversity can encompass several things such as social class, cultural background, gender, and family status. As the data is reviewed from now on, we will begin to discover significant trends within the victims – thereby painting a better picture for those who wish to seek additional information about these tragic events.

Adolescent Crime and Child and Adolescent Psychiatry

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1997. The city of Kobe was struck by a serial murder and assault case committed by a third year junior high school boy, known as the "Sakakibara Seito" case. The utterly gruesome murder in Kobe, as yet showing scars from the Hanshin-Awaji earthquake, this time rocked the entire nation. Followed by the series of serious adolescent crime in the subsequent months, the phenomenon, named "17-year-old crimes" has become a serious social issue in Japan.

With each such incident, various commentaries on the genesis of the crimes or the psychological state of the adolescents committing the crimes are published by the press, and diagnoses such as Conduct Disorder, Dissociative Identity Disorder, Borderline Case, and even Asperger syndrome have appeared splashed across the pages. And in association, the fact that child and adolescent psychiatric care is still unrecognized in Japan, and that we are as much as half-a-century behind the Western nations in this regard has been made public knowledge.

Looking at the backdrop to these adolescent crimes which filter through from the press reports, a number of characteristics appear in comparison to the clinical cases.

1. Neither inevitability of the crime nor its context can be inferred from the growth history of the child, the regional setting, or his/her school life.
2. As in the "Sakakibara Seito" case, the abstruse phrasing and totally abrupt, exaggerated and distorted modes of behavior employed by these children point to a certain imbalance. It is as if they are shrouding their lack of experience and immaturity behind the shocking and abstruse language picked up from video games and films.
3. Although their criminal behavior is totally beyond the understanding of adults, it can be said that the actions are only as expected in light of their culture. Children in the same age group refer to the actions as being somewhat "understandable," for which they even harbor a certain sense of longing or esteem.
4. The children appear to harbor constant anxiety (a primordial fear they are not even aware of themselves), making them hypersensitive to the outer world. Although appearing gentle, they suffer imaginary traumas, and harbor an almost delusory consciousness of victimization.

What is the social backdrop giving rise to these problems affecting the adolescent mind? A number of factors are imaginable.

1. Drastic change in social structure and uncertainty.
2. Effects of the unstemmed lessening in the number of children per family.
3. Change in family structure and lowered capacity for moral education in the home.
4. Child-rearing anxieties perceivable through the trend for early education.
5. Effects of the visual culture and abounding vulgar sexual information.
6. Lack of sufficient social support.
7. Dissatisfaction and revolt against adult society.

Impressum

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