International Association for Child and Adolescent Psychiatry and Allied Professions
IACAPAP
Association Internationale de Psychiatrie de l'Enfant et de l'Adolescent et des Professions Associées
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International Congresses of Child Psychiatry
Congres Internationaux de Psychiatrie de l'Enfant

I. 1937 Paris
Georges Heuyer, President

II. 1948 London
J. R. Rees, President
(Foundation of the International Association/ Fondation de L'Association Internationale)

III. 1954 Toronto
F. H. Allen, President
Emotional Problems of Early Childhood

IV. 1958 Lisbon
Victor Fontes, President

V. 1962 Scheveningen
Arn Van Krevelen, President
Prevention of Mental Disorders in Children

VI. 1966 Edinburgh
John Bowlby, President
Adolescence

VII. 1970 Jerusalem
Serge Lebovici, President
The Child and His Family

VIII. 1974 Philadelphia
E. James Anthony, President
Children at Risk

IX. 1978 Melbourne
Albert J. Solnit, President

X. 1982 Dublin
Lionel Hersov, President
Children in Turmoil—Tomorrow's Parents

XI. 1986 Paris
Colette Chiland, President
New Approaches to Infant, Child, Adolescent and Family Mental Health

XII. 1990 Kyoto
Reimer Jensen, President
Child Rearing, Education and Psychopathology

XIII. 1994 San Francisco
Donald J. Cohen, President
Violence and the Vulnerable Child

XIV. 1998 Stockholm
Donald J. Cohen, President
Trauma and Recovery: Care of Children by 21st Century Clinicians

XV. 2000 Jerusalem

XVI. 2002 New Delhi

Editors' Comments

The IACAPAP first congress took place in Paris in 1937. It marked the consecration of Child Psychiatry as an independent medical profession. In fact, in very few countries is Child Psychiatry established as a specialty by itself with its own residency program, examinations and practice. In many countries, it is an optional sub-specialty of general psychiatry. In all other countries, it does not even exist as such; general psychiatrists or even general practitioners simply devote themselves to child mental health. Many countries over the world have no Mental Health Services for Children and Adolescents whatsoever. Even in developed countries, Child Psychiatry departments strive to survive and when budgets have to be cut, child psychiatry is often the first to be diminished. In many countries, it is generally the good will of others who determine if there will be child psychiatry in a medical center or even in a town or region. However, in post-communism Eastern Europe, our colleagues are pioneers of new Mental Health services for Children. This Newsletter gives them an opportunity to discuss their achievements and problems.

Amazing findings in neurosciences led to new understanding and explanations of mental functions. So amazing that some of our colleagues in various countries proposed to merge child psychiatry into neurology and in doing so deny its very existence. Child psychiatrists have to learn from neurologists no less than neurologists have to learn from child psychiatrists. We begin a series on psychiatric treatment with an article focused on psychopharmacology in children and adolescents. It emphasizes the importance of professionals to have specific expertise in medication treatment of children and adolescents and the need for specific research in psychopharmacology with children.

Our profession is still far to be recognized and acknowledged by all. This Newsletter, as speaker of IACAPAP, is the defender of our profession and serves its ➤2

President's Message

A fifteen year old, brilliant boy kills himself with a shotgun after a minor disappointment in school. A sixteen year old boy kills a neighbor with a shotgun after an argument about a girl. A nineteen year old dies from a drug overdose. Three teenagers die when their car hits a tree. A seventeen year old girl starves herself until she is cachectic, another girl becomes massively obese. A group of school children are murdered when a teenage terrorist explodes a bomb.

Child and adolescent mental health workers throughout the world are dealing with deadly illnesses: with children and adolescents affected by and infected with HIV, or already suffering from AIDS; with children whose bodies are mutilated as they step on landmines or are caught in crossfire; with children living on the street exposed to every type of predator, including commercial sex.

As child psychiatrists, psychologists, social workers and other mental health workers, we are deeply concerned about the causes and the course of situations that lead children to physical and emotional destruction. These include the full range of causal factors—social, cultural, familial, constitutional, and intra-psychic. These factors are balanced differently in different situations. Too often, we recognize the limitations of knowledge (what triggers the final, fateful decision when a youngster kills himself?) or of our power (what can one do to reduce the trauma of millions of children exposed to war, refugee camps, urban violence?) There are no diseases of childhood more serious than autism, the self-injurious behavior of individuals with retardation, the frozen states of children with obsessive compulsive disorder, and other problems that face us daily in inpatient and outpatient work.

While we are painfully aware of limitations in knowledge and services, we can take some comfort in the achievements within our fields. Advances in the neurosciences and behavioral sciences are providing increasingly refined theories of

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developmental psychopathology to guide clinical research and treatment. The detection and elucidation of genes that are expressed in the brain, the ability to study brain activity through functional neuroimaging, and remarkable advances in basic science of brain development and function provide new concepts for understanding the most serious disorders. Concurrently, more effective pharmacological and behavioral treatments offer hope for children who are seriously dysfunctional. Young professionals are interested in empirically derived knowledge. They wish to know what works and on what basis we make claims about etiology and effectiveness. Government and insurance companies, for different reasons, are also asking us to justify our assertions and our treatments. At times, these requests or demands are intrusive and not helpful: they aim to discredit rather than enhance the services and availability of care. But such external questioning can also be a healthy stimulus to honesty, clarity, and the pursuit of new knowledge.

To translate basic research into clinical interventions will require the concerted efforts of clinical researchers. There are far too few such individuals who have the skills, motivation and resources to utilize new methods and theories and focus these on childhood disorders.

Also, new knowledge is of little use unless the results can be delivered to children and families in the form of effective treatments. Almost everywhere, there are children in need who cannot receive the benefits of available treatment because of finances and other barriers. It will be just as hard to create and sustain new systems of health delivery as to develop the new knowledge that will improve the quality of care.

Child mental health workers care for seriously disturbed children and the most vulnerable children, from infancy through adulthood. The challenges are enormous: to improve knowledge, enhance professional skills, and deliver care. We need to bring this message to the attention of government, foundations, non-governmental organizations, universities and medical schools, and others who shape social policy and allocate resources. The future of any nation is a function of the health of its youngest citizens and most vulnerable children and families. As resources are being cut back for child mental health, there must be international advocacy and education to assure that the seriousness of the difficulties we deal with and their importance to national security are clear to those in power.

For more than 60 years, IACAPAP has served as the voice of children at risk for and suffering from psychiatric, behavioral and emotional disorders, and for the professionals and organizations that care about them. New nations are joining in the work of IACAPAP, and there is a broad, international consensus about the needs for clinical services, research, and training. There are broadly shared values in our fields that cut across all ideological and political lines that may separate nations historically or at present. Through our regional and international Congresses, Monographs, Newsletter, consultation, teaching, correspondence and personal contacts, IACAPAP serves as an important link among professionals and nations, a beacon of hope about the possibility of discussion, sharing and collaboration during difficult times. ■

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professionals. Is it necessary to claim again and again that children are human beings? They have their specific needs and problems and as such, merit skilled and highly trained professionals to take care of them and prevent suffering. This Newsletter presents important insights from youth in the United States, Japan, and Hungary. Their comments illustrate the profound questions that preoccupy youth. As a result, they emphasize that professionals who are concerned with the growth and development of children and adolescents strongly advocate to defend the rights of children and emphasize the need for excellent services, research and training for them. Child psychiatry has a role of integrating and facilitating cooperation between all other professions involved with the development and well-being of children. Child Psychiatrists and other Child Mental Health professionals, as well as everyone concerned with children over the world, are invited to use this Newsletter to present their ideas and propose programs of collaboration between professionals and among countries. ■

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Child and Adolescent Psychiatry in Hungary

By Agnes Vetró, M.D., Ph.D.

Demographic and health service figures of Hungary

Hungary is located in Middle Europe in a region of 100,000 km^2 The number of inhabitants is 10,354,000, with a sex ratio of 52% females and 48% males. Some 70% of its inhabitants live in towns, two million in the capital, Budapest, and 30% in villages.

Medical service of the population is provided by 37,000 physicians; 1,000 of them are specialized neurologists. For inpatient health care 102,097 hospital beds are at disposal. Patients with mental problems are attended by institutes with 17,225 patient beds and 132 outpatient mental care ambulances.

Twenty-one percent of the population is younger than 14 years, and a slight excess of boys is characteristic. Their health care is attended by 2,704 infant- and child specialists. Approximately 9,014 patient beds have been provided for child patients, and a well functioning paediatric network with preventive concept has been established, independently from family health service. Presently, in the frame of new health care reform, merging of this network into family health care, and reducing the number of patient beds are in process, due to the decrease of child population.

Brief historical background of Hungarian child and adolescent psychiatry

Child and Adolescent Psychiatry (hereinafter CAP) started to develop in the borderline of pedagogy, adult psychiatry and paediatrics. It still bears the marks of this origin. The first pioneer of the field was Pal Ranschburgh (1870–1945) at the Institute for Handicapped Children. His disciple, Endre Schnell, established the first Institute for Paediatric Mental Care in 1935, the prototype of institutes for child and adolescent psychiatry. In Hungary Blanka Lorand established the first child psychiatry unit at the Institute of Psychiatry and Neurology in 1950. In 1960 Professor Miklos Vargha became the Head of the child ward at the Department of Neurology of the Medical University of Szeged. It is still the only child psychiatry ward at the Hungarian medical universities. Child psychiatry became an official subspecialisation in 1961.

Place of CAP in Hungarian health service

In Hungary, several institutions are involved in paediatric mental health service. On the one hand, it is advantageous because the multidisciplinary approach of the problem is warranted; on the other hand, overlapping and/or shortcomings appear in certain fields.

The Ministry of Welfare—that is heading the structural reform of health service—is financing in- and outpatient psychiatry, with the contribution of Health Insurance. The reform is counselled by a Board of Specialists. A common Board of Specialists was functioning for child and adolescent psychiatry, child neurology and child surgery between 1989–1995. In May of 1995, however, it was changed and child psychiatry was integrated into the Boards of Specialists of Paediatrics and Psychiatry. To avoid a split in the field, the two Boards appointed one of its members to act as Vice-Board for child psychiatry and decisions made on important issues are submitted by the two Boards to the Ministry of Welfare. Similar is the splitting between in and outpatient services. A part of hospital wards and outpatient services are independent, while other parts are integrated into paediatrics or adult psychiatry service. Thereby, they have no uniform organizational and functional order.

Medical universities have a unique situation. Regarding patient care activities, they belong to the Ministry of Welfare. Their training activities are supervised by the Ministry of Culture and Education. CAP is also included in this dichotomy.

Mental health service of children is admistered by Boards testing learning capabilities and by child guidance clinics in every county of Hungary. Family counselling center have also been established. Professionally they are supervised by the Ministry of Culture and Education and financed by the local Councils.

Morbidity figures of CAP

If we compare the results of Hungarian epidemiological studies with those of foreign countries, we find that psychiatric morbidity is similarly rather high (depending on age and settlement structure, it is 15-30%). This means that 300–750,000 individuals are in need of psychiatric aid, amongst the approximately three million child and adolescent population. Only a small part, that is, only 11 thousand are registered by the CAP network, and this includes neurological cases.

Objective conditions of CAP

Outpatient Service

Network of child and adolescent psychiatry service

Outpatient CAP service is provided by child and adolescent psychiatry clinics. In all the 19 counties there is but one. In Budapest there are seven clinics where approximately 40 child psychiatrists work. Equipment and staff of these institutions are greatly different. There are clinics where only one psychiatrist works. Other clinics have a multidisciplinary team wherein patients are treated by paediatricians, family physicians, pedagogues, and parents.

Child guidance clinics

These outpatients services are generally headed either by a pedagogue or a psychologist. In order to provide proper psychiatric diagnoses and get acceptance of their therapeutic activities, they employ a child psychiatrist. Children with disturbance in learning are generally assigned by their school. They are in close contact with boards for testing learning capabilities, that might direct the children to special schools, or classes.

Family counselling network

In every county one or more family counselling clinics are operated by the social department of the local council. The institute is headed either by a psychologist or by a social worker. Their major role is to provide social defense, but occasionally they act as child psychiatrists.

Inpatient Care

In Hungary, nine inpatient wards have been established, since the opening of the first one, 45 years ago. Part of them are independent, while the rest are run within the profile of paediatric or adult psychiatric wards. Two of them have been closed due to the lack of proper staff, and one is threatened by scheduled close of the mother Institute – Paediatric Hospital of Buda (Budapest). Currently there are altogether 204 CAP patient beds in Hungary representing approximately 0.2 CAP beds for 10,000 inhabitants, which is rather few, if we consider that the number of psychiatric beds is ten, and that of paediatric beds is nine per 10,000 inhabitants. Further closing of wards integrated into paediatrics is foreseeable in the frame of the new reforms.

Rehabilitation

Background of rehabilitation in child and adolescent psychiatry is provided mostly by training institutions in extern or intern form. Two types of special schools are ➤

known, depending on the intellectual capacity of the children, for debils and imbeciles. Special kindergartens and school groups have been established lately for patients with pervasive developmental disorder (mostly autistic patients). Fate of hyperkinetic children and those suffering in conduct disorder have not been solved. Similarly unsolved is the situation of school children with anxiety symptoms or depression.

Children incapable for training live in nursing homes. These homes are integrated into paediatric health service, and organic concern is characteristic instead of intention for habilitation or rehabilitation.

Staff background of CAP

CAP in the curricula of medical universities

Since in Hungary there is no independent department for child psychiatry on the medical universities, the field is hindered in getting into the curriculum of medical students. Albert Szent-Gyorgyi Medical University of Szeged is the only institution having child and Adolescent Psychiatry Department integrated organizationally into the Department of Paediatrics. The Ward elaborated a training system for medical- and postgraduate students in collaboration with the child and Adolescent Psychiatry Departments of University of Wurzburg (Germany) and of the University of Glasgow (U.K.). It has not been accredited either at university or at national level. Both in Szeged and Budapest students may study as an elective subject, but at the other universities even this option is not available.

Specialization in CAP, training

There are more than 120 physicians specialized in CAP, but only approximately 50–60 work in CAP service. The others are either retired, or work as paediatricians or in adult psychiatry.

Since the field is not represented at Departmental level at any of the Universities, its prestige is rather poor. Few are the candidates for specialization. Because in Hungary it is a subspecialisation, the training starts with specialization in paediatrics or in general psychiatry. Part of the specialized physicians go back to their basic fields of higher prestige.

Specialization is supervised by the National Board of Specialization that is in charge for exams. To sit for the exam, a one and a half year long practice is necessary at a child and adolescent psychiatry ward, depending on the basic specialization, one half year in paediatrics or general psychiatry, respectively, and one half year in CAP ambulances. As a place of practice, any of the seven inpatient wards is accepted, or psychiatry services where a physician specialized in CAP works. Exam consists of a one-week practical (patient examination, diagnosis), and verbal exam.

Annually one or two training courses are held for preparation of candidates for specialization and for training. There are places where discussions on journals of the special field and supervision of case analyses are held with regional character. Child psychiatry working groups of HIETE (Budapest), SOTE(Budapest) and SZOTE (Szeged) have decisive role in these discussions.

Training in psychotherapy (three-years long) has been conducted separately of psychiatry training for five years in Hungary. Every candidate to be specialized in CAP has to take part in a one year long basic theoretical training course.

Activities of Scientific Societies

The Scientific Society of CAP was established in 1990, combining child sections of four Societies (Child Psychiatry Section of Paediatric Society, Child Neurology and Psychiatry Section of Society of Neurologists, and Child Section of Society of Neurosurgery). The CAP Society has been admitted to MOTESZ (Hungarian Society of Physicians) under the name of Hungarian Society for Child Psychiatry–Neurology and Neurosurgery. The Society works in two sections (Section of Child and Adolescent Psychiatry, and Section of Child Neurology and Neurosurgery) separated professionally and financially. Common scientific sessions are held each year in different towns, which was visited by the Steering Committee of IACAPAP in 1991. Our members deliver scientific lectures also in the meetings of Hungarian Psychiatric Society and Hungarian Paediatric Society.

There are rather few Departments where regular scientific word is performed in CAP. Three Ph.D. degrees have been obtained in CAP, all three at Albert Szent-Gyorgyi Medical University.

Our Plans and Objectives

Integration of in- and outpatient network of CAP would be the most important task. To render CAP wards independent, which are now integrated into paediatrics or psychiatry, because they are most endangered by the new health service reform, due to the poor patient bed utilization rate of the former ones. Outpatient network is in a similar situation. Activities of CAP (prevention and rehabilitation) clinics belonging to basic health service are financed by local Councils, while activities of outpatient ward belonging to hospitals as special clinics are budgeted by Social Insurance. Their preventive and rehabilitation function are not supported. ■

Soros Foundation Conference

by Owen Lewis, M.D.

On November 27 to December 1, 1995, the Soros Foundation sponsored a training seminar in Child Abuse and Child Mental Health in Budapest, Hungary. The conference was attended by interdisciplinary groups from each of sixteen eastern and central European countries. The meeting was organized and directed by Drs. Pamela Sicher and Owen Lewis of New York, both child psychiatrists. This initiative of the Soros Foundation was undertaken by Elizabeth Laurent, Director of eastern European Medical Programs.

The countries represented included Albania, Belarus, Bulgaria, Croatia, Czech, Estonia, Hungary, Latvia, Lithuania, Macedonia, Moldova, Poland, Slovakia, Slovenia, and the Ukraine. In each country the Soros Open Society Foundation chose the delegates. In most instances, the teams were comprised of child psychiatrists, psychologists, pediatricians, social workers, teachers, and in some instances, lawyers as well, most of whom were working together in their countries.

Other faculty included several members of Dr. Sicher's clinic, the Connecticut Center for Children and Families, psychologists Dr. Tricia Thomas, Randall Thomas, Allison Bell, and child psychiatrist John Ewing. In addition to Dr. Lewis from Columbia-Presbyterian Medical Center were child psychiatrist Dr. Arthur Green and pediatrician Nicholas Cunningham. Other faculty included former Family Court judge Mara Thorpe and the Italian child psychiatrist Mauro Marriotti, representing Telefono Azzuro.

Topics included the identification and etiology of abuse syndromes and the treatment of abused children and their families. There were special workshops for the pediatricians and lawyers, as well as workshops for the mental health professionals. ➤

There were also presentations and workshops on the topic of developing public awareness of the problem of abuse.

While different countries had had different levels of experience in dealing with problems of child abuse, there was a widespread mandate that these problems needed to be dealt with more comprehensively. The delegates were universal in their desire for more training in this area.

The faculty is currently preparing a report for the Soros Foundation on their findings of the conditions that exist in each country. It is anticipated that the faculty will have an ongoing educational role in these countries and will serve as advisors to Soros for program development. ■

Humanism, Trauma & The Adolescent

(Abstract of the Presidential Address, Fourth International Congress of the International Society for Adolescent Psychiatry, July 5-8, 1995, Athens, Greece.)

by Michael Kalogerakis, M.D.

The assault on our senses from the world's media is unrelenting: 93,000 children separated from their parents in Rwanda; one and a half million children HIV positive; divorce rates double in two decades; more and more countries besieged by adolescent drug abuse; untold numbers of adolescent girls raped, maimed or killed in Bosnia; and, in the U.S., black teenage males three times more likely to be killed by guns than to die of natural causes.

Thus, even as we may have finally reduced the chances that our youth will die in senseless wars, we continue to find new ways to cut their lives short of destroy their hopes for a healthy, productive life. The result is a population of young people imbued with fear and cynicism, bitterness and hatred, their personalities warped by trauma that precludes any optimism about what life has to offer.

Arguably, the number one challenge of the 21st century for all nations is to produce healthy children, in nurturing families, in communities supportive and protective of their members. Once essential nutritional needs are met, the most basic need is for security—political, economic, physical and emotional, all interdependent. The achievement of such security does not so much require new knowledge as it does the effective implementation of established principles by those in power. Foremost among these are the child's parents or other caretakers; then, educators, political leaders, health and social agencies, and others.

In an ideal world, the desired security would be recognized as a basic human right to be guaranteed to all. The United Nations convention on the Rights of the Child has sought to establish this as a universal principle. Realistically, a given community's limited resources and population size may deny these rights to many. At the same time, the achievement of adequate levels of political, physical and emotional security essential for a healthy society need not await the attainment of comparable levels of economic security. Political, physical and emotional security can and must be pursued by all nations by putting into practice the democratic principles of fairness and justice for all, equal and adequate protection, compassionate concern for all citizens, promotion of a healthy environment and health among individuals, and education and support of families and children.

As mental health professionals, we see the results of the systemic failures that accompany destructive policies, poor planning and ill-conceived practices on the part of governments. Terrorism, oppression, discrimination and racism cause enormous harm to large segments of the population. Their effects inevitably trickling down to individual children, destroying any hope of normal personality development. Cognitive, social and emotional functioning is impaired. At the adolescent stage of development, delinquency, drug abuse, academic failure and out-of-wedlock pregnancy are prime examples of psychosocial dysfunction whose roots can be traced largely to governmental and societal failure.

How can the challenge of the next century be met? What are the responsibilities of governments to their citizens, especially those too young to vote? The ancient tradition of humanism is worthy of reexamination in this context, for it is consistent with fundamental principles of mental health.

Humanism is best defined as a genuine concern for the welfare of others and, in particular, an abiding respect for the individual. Individual psychology is in large measure a humanism of the psyche which finds its greatest expression in child rearing. The failure of societies to tend to their citizens has its parallel in the failure of families to tend to their members. Breakdowns in the execution of the responsibility to children may occur at both the societal-governmental and the family levels, with corresponding damage to those requiring care. Clearly, children, who cannot survive without adequate nurturance and care, are the most vulnerable and pay the greatest price when caretaking fails.

Though in a democratic society the citizenry is presumably in a position to pressure its leaders to be responsive to their needs, at the family level such options are more restricted and quite different. Families are well-insulated from the scrutiny of others and children can neither replace deficient parents nor leave them. Since they cannot function as their own advocates, the intervention of a third force is needed when parents, for whatever reason, are neglecting their responsibility or abusing their power. That force is, of course, the state.

Here the humanistic society differs from all others: it sets the tone for a caring approach to the individual, defines unambiguously the responsibilities of the family, and takes necessary protective action in behalf of children when caretakers prove incapable of providing acceptable standards of care.

Mental health professionals have no more expertise than any other concerned citizens on how governments ought to conduct themselves to promote the general welfare. On the other hand, our training and experience qualify us uniquely to identify the developmental and mental health needs of children and adolescents, to describe how these needs might best be met, to recognize those situations in which this is not occurring satisfactorily, to recommend, and, in part, supply remedies, and to advise other systems involved, directly or indirectly, in the care of families. These systems include education, social welfare, and governments, among others.

For the mental health professional, humanism is an expression at the group or societal level of what at the individual psychological level we consider emotional maturity or health. The emotionally mature individual enjoys satisfying personal relationships, among other reasons, because of having progressed beyond infantile narcissism. The humanistic society takes care of its members, believing that to be essential to a functional society.

The breakdown of such concern leads to a pathological condition, in the individual as well as society, characterized by a maladaptive value system and a hostile rather than nurturing basis for human relations. Intrafamilial deprivation and rejection both reflect what exists in the larger society and further interpersonal hostility, as, for example, in scapegoating, ➤

with resultant ethnic, racial and religious hate. This hatred is then easily transmitted from one generation to the next.

Strikingly, some individuals seem to escape this fate and it is a matter for further study to identify the factors that make this possible. What we know is that cognitively they seem able to cling to more rational thought and emotionally they are essentially devoid of hate. But how does this occur?

Where I have had the opportunity to examine these questions directly, notably in inner-city youths growing up in a violent substructure, I have been impressed that the critical difference lay in the presence of a significant family member who offered an alternative to the group prejudices and behavior. Most often this is an unusually rational parent or other caretaker, one who seem quite free of hostile feelings of any kind. It is the availability of alternative models that appears to be the important point. A child with only one model to relate to is virtually doomed to accept that model and its view of the universe, whatever its objective merits. The child who is fortunate to be exposed to more than one model must choose from among them. This stimulated the cognitive processes and the reasoning mechanism. Comparisons are made, pluses and minuses considered, and a selection follows. The child has reached a decision and, in the process, discovered the usefulness of the rational method of problem-solving, gained a sense of competence and strengthened his or her sense of confidence in relying on independent thinking.

Such patterns are established early, the precursors being laid down in infancy as independent action (and ultimately thinking) is either encouraged, discouraged or blocked. Warmly supportive caregivers encourage exploratory behaviors, uninvolved ones fail to provide needed stimulation, restrictive or punitive ones stir anxiety and wariness about the new and untried.

In a hostile society, there are abusers and victims. Some studies have shown that adolescents are more frequently the victims of abuse than either younger children or adults. Why is this so? Some adolescents are more vulnerable than their peers, biologically or because of earlier life experience. An assertive adolescent boy may be too challenging to an easily humiliated adult male; early abandonment by a father may leave a girl in her teens very needy for male attention. Adolescents may seem fairer game than younger children to a predatory adult or may simply be more appealing to a would-be seducer.

It is barely a decade and a half that serious studies of the effects of severe external trauma on the developing child began. We are still learning about the short-term effects of natural disasters, living in a culture of violence, war, starvation, political oppression, and the like. We have scarcely begun to document the long-term effects (for example, on adolescents of early childhood trauma) and to examine the factors that make a difference in how great an impact will be had in the life of the individual.

We have learned much about the impact of some traumatic events on the life of the child and later adult. We know that the violent adolescent was frequently the victim (or observer) of violence in earlier years; that the promiscuous adolescent or sexual abuser was sexually abused as a child; that children of divorce remain profoundly angry well into their adult years; that the heavy abuse of drugs or alcohol during the adolescent years has devastating effect on subsequent vocational and social adjustment; and that adolescent delinquency is virtually omnipresent in the histories of adult criminals.

We still need to determine the kinds of interventions and the best points in the developmental cycle to apply them in order to prevent severe damage to the personality. The tragedy of traumatized children becoming traumatizing parents cries out for a solution.

As mental health professionals, we must educate the public to the dangers of intergenerational transmission and offer realistic alternatives to the predictable outcome. We know far better than most how difficult it is to reverse or eliminate powerful pathological forces once they have become entrenched, therefore the importance of prevention. As individual clinicians operating in the inner sanctums of our offices, we are powerless to affect the overall course of society in matters of mental health. On the other hand, working collectively through our professional organizations and armed with the relevant and potent experience that our art and science have provided, we can be a powerful voice for change. ■

Review of the ISAP Conference in Athens, July 1995

by Joseph D. Noshpitz, M.D.

The recent conference of the ISAP which convened in Athens July 5–8, 1995 caught something of both the strengths and the stresses in the creative work of international child and adolescent psychiatrists. One of the great achievements of the field is mirrored in the fact that the developmental model was accepted and well represented throughout. Thus, speaking for the WAIMH, Professor Serge Lebovici of France conducted a seminar on the relationships of infantile precursors to adolescent maladjustments. In one way or another, all of the participants noted the role of the developmental precursors and the nature of the advancing adolescent processes as basic to their studies.

On the other hand, the nature of development itself became a site for some measure of difference. Many colleagues worked out of a psychoanalytic framework and conducted their investigations by means of interviewing techniques and the use of dynamic formulations. Other colleagues tended to build on a biopsychosocial approach, and to integrate such concepts as genetics, temperament, risk and resilience, and brain physiology into their formulations.

Another broad range of issues arose in connection with the nature of trauma as such. The conference presented a wide spectrum of sources of trauma as well as a variegated set of images to depict its effects. Several of the morning plenary speakers, in particular, Professors van der Kolk, Garbarino and Pynoos of the U.S., depicted the convergence of psychosocial and biological vectors on the developmental process, the psychological profile of post-traumatic reactions, and the role of the underlying biological matrix on the emergence of these disorders. The psychodynamic version of both etiology and phenomenology was depicted by Professors Jeammet of France and Ladame of Switzerland, and the sociocultural dimension by Professors Anastosopoulos and Abtzoglou of Greece. Dr. Tolani Asuni of Nigeria reminded the conference that not all culture was Western culture.

The afternoon panels were equally various. One panel was devoted to the preconditions of trauma; specifically, Professor Halfon of Switzerland and his colleagues spoke for the role of everyday➤

"hassles" in the developing mental unfolding of pre-adolescents; and drew a portrait of the impact of traumatic events on cognitive competence and academic achievement in adolescence proper. Professor Teicher of the U.S. led a presentation and discussion on the state of the brain and neurotransmission in the response to trauma. On the other extreme, Professor Tyano of Israel and his co-workers as well as other clusters of scholars (Dr. Issroff of Israel, Dr. Andreou and a group from Cyprus, Dr. Stuveland with a UNICEF panel from Former Yugoslavia, Dr. Nancy Dubrow who had worked in Angola, etc.) told of the impact of war on youth and the havoc it wrought on the unfolding of vulnerable adolescent processes. The most extreme conditions, however, were depicted by Dr. Max Sugar's panel on Genocide and by the colleagues in Athens working at the Center for the Study of the Effects of Torture. These offered a grim portrayal of the corrosive and all too ubiquitous forces which continue to deform and distort healthy adolescent growth.

Between these extremes, numerous varieties of disturbance came under review: The German contingent led by Professor Schmidt and representing IACAPAP, described the role of trauma in eating disorders; a mixed Scandinavian, Israeli and American group led by Dr. Lange of Norway told of the impact of unaccompanied migration on the adjustment of teenagers. Dr. Aliza Blum of Israel headed a panel which conducted an exploration of the effects of chronic and psychosomatic illness on the adolescent process. In a similar spirit, Dr. Potamianou of Greece led a panel of her countrymen who discussed somatic difficulties and deinstinctualization. Parallel with these exegeses, a different group chaired by Dr. Silber of the U.S. worked on the meaning of AIDS to the involved youth.

But trauma affects not only internalizers but externalizers as well. An in-depth exploration of the role of trauma in creating a matrix in which delinquency could flourish was led by Dr. Adrian Copeland, and, in contrast to this outer directed aggression, Dr. Alan Apter of Israel and Dr. Ottino and his colleagues of Switzerland studied suicide in adolescence and young adulthood. Dr. Michael Stone of New York conducted one panel on the effects of sexual trauma, and Dr. Georges Papanicolaou of Paris and Athens conducted another. In addition, the themes of loss and separation were explored in depth in Professor Jose Cordeiro's group, while the actual profile of post-traumatic stress disorder was spelled out in a separate session headed by Dr. Max Sugar.

Other aspects of trauma were explored by Drs.Herve Benhamou of France and Shozo Aoki of Japan who presented a panel on trauma, hysteria, and somatization, and by Dr. Michael Stone of the U.S. whose group studied the all-too-common phenomenon of cumulative trauma.

Moving now to the more specifically psychoanalytic approaches, the primary themes to be explored were the distinction between real trauma and fantasied trauma, a problem addressed by Freud and one that bedevils the courtrooms of the world as accusations of sexual abuse are hurled by one generation at another. One French group led by Alain Braconnier and Philippe Jeammet conducted a seminar on that topic; in addition, however, these issues were addressed and developed in considerable detail by two Italian panels, led respectively, by Professor Arnoldo Novelletto on inner trauma and outer trauma, and by Professor Enrico de Vito on memory of trauma.

In a supportive counterpoint to these approaches, Dr. M. Teicher of the U.S. focused his panel on the biological aspects of trauma in adolescence.

Taken all in all, these presentations were concerned in large measure with demonstrating the etiologic role of traumatic events in shaping and forming adolescent adjustment and maladjustment. In the nature of things, many therapeutic matters were touched on as well. A good deal of the energy of the conference was, however, devoted to varieties of therapeutic intervention as such. Professor Kono of Japan led a panel which reviewed some techniques that are derivative of Japanese traditions; these speakers reported as well something of the inevitable blending of Japanese with western approaches. Dr. Kunianao Minakawa, also of Japan, led another panel devoted largely to aspects of treatment. In an interesting series of contrasting studies about Uruguayan adolescents, Dr. Fernandez and her group gave their emphasis to the therapeutic approaches and outcomes with a variety of disorders as viewed from a Latin perspective.

In terms of more specific therapeutic modalities, John Dintenfass of the U.S. conducted a group session on group therapy; Dimitris Kyriazis of Greece offered studies in family therapy, and Francois Ladame and M. Perret-Catipovic of Switzerland led a panel on psychoanalytic psychodrama with traumatized adolescents. A particularly imaginative presentation was created and arranged for by Dr. Shelley Doctors of the U.S., who offered video presentations and discussions of psychotherapeutic process as contributed by a French therapist and an American therapist, each working in their own country and their own language. The audience was thus given a chance to consider and compare the styles and details of clinical address in two different cultures.

A series of Greek language panels emphasized the community and public health aspects of trauma as it impinged on the Greek adolescent. In addition, the Greek hosts threaded the meeting through with a series of fascinating lectures on topics such as Adolescence in Classical Greece, in Byzantine Greece, and in Modern Greece, along with a rich array of musical presentations offering a wide spectrum of national creative forms of expression.

Finally, one of the most significant aspects of all such meetings in that they offer to all who come, an opportunity to meet old friends, make new friends, and, under optimum circumstances, forgive old enemies. The presentations opened windows in the mind of those who listened, and thrust new points of view on even the reluctant and committed. It is this mutual fructification by cognitive challenge and by affective enrichment that makes the experience of such a conference the rewarding and enlivening experience that it is. ■

International Conference on Youth Suicide

by Alan Apter, M.D.

"Understanding youth suicide: a meeting of different perspective" was the title of an international meeting held under the auspices of the Israel Society for Child and Adolescent Psychiatry and the Center for Continuing Education in Health Sciences, University of Pittsburgh. The meeting was held in Tel Aviv during August 1995, and was jointly chaired by David Brent, M.D., of the Western Psychiatric Institute in Pittsburgh, and Alan Apter, M.D., from Sackler School of Medicine, Tel Aviv. The scientific committee was chaired by Israel Orbach, Ph.D., Bar–Ilan University, Israel.**The epidemiologic perspective** was reviewed by David Brent, Columbia University; Rene Dikstra, University of Leiden, Holland; and Keith Hawton,➤

Oxford University, U.K. These presentations discussed the very large increase in rates of completed suicide in young males, especially in the 15–24 year old age range. The explanations for this phenomenon have included increased rates of unemployment, greater availability of dangerous means for suicide such as hand guns, AIDS and HIV infection, and the breakdown of parental relationships. These possibilities do not fully explain the gender differences which may be related to changes in gender roles in modern western society or alternatively to the male predominance in alcohol/substance abuse seen in suicide victims. The relation between alcohol and substance abuse and teen suicide may not apply in all countries since in Israel, this association was not found and in Germany, suicide rates have remained low despite rising substance abuse. In addition, it was pointed out that the incidence of suicide is excessively low before puberty but increases steadily throughout the adolescent years until reaching a peak in the early 20s and that more than half of teen suicides occur after the age of 17. There are also important differences in the suicide rates of different ethnic groups that seem to be unrelated to socio-economic factors but rather reflect subtle cultural barriers that are poorly understood. Controlled studies in the United States indicate that over 90% of teen suicides suffered from a diagnosable psychiatric condition in the period before their death, usually with an onset of several years prior to the suicide. In New York, mood disorders, conduct disorder and substance abuse (often in combination) are the most common psychiatric disorders found to be associated with teen suicide. Other risk factors that were discussed included exposure to suicide, family history of suicidal behavior, exposure to family violence, abuse and stressful life events.

The epidemiology of attempted suicide in adolescence is less well understood since this behavior is heavily underreported. There does, however, seem to be marked increases in the incidence of this phenomenon which more often seems to affect females.

Longitudinal follow-up studies of children and adolescents who attempted suicide were presented by Cynthia Pfeffer of Cornell University, New York and Alan Apter. Dr. Pfeffer discussed the results of her follow-up of suicidal prepubertal children and the risk factors which predict recidivism. The effects of treatment on the reduction of subsequent suicidal behavior was also discussed. Dr. Apter followed teenage suicide attempters through their compulsory military service and found that girls have a surprisingly good prognosis while male suicide attempters do poorly under the stress of army life.

The biological perspective included presentations from John Mann (Columbia University, New York) and Herman van Praag (University of Limberg, Holland). Both speakers emphasized the role of dysregulation of serotonin metabolism in suicidal behavior. Dr. Mann described his studies on post mortem brains which appear to localize this abnormality to the prefrontal cortex, while Dr. van Praag discussed his notion of a special sub form of depression characterized by pathology of serotonin 1A receptors. These patients are highly vulnerable to life events which leads to a dysregulation of anxiety and aggression causing depression and suicide. Galila Agam (Ben Gurion University of the Negev) discussed the role oninositol monophosphatase in post mortem brain of suicide victims, and Alan Apter reported finding an inverse correlation between cholesterol levels and seriousness of suicidal behavior in adolescents.

The psychosocial perspective was represented by Ronald Maris (University of South Carolina, U.S.A.). He discussed the notion of a "suicidal career" and the idea that suicide is a "protest against life." He pointed out that aloneness and isolation are powerful factors in the etiology of suicide and that suicides suffer from intolerable psychic pain (what Schneidman has termed "psycheache"). Suicide may also have a "Darwinian" function in that suicide victims may indeed by "unfit for life."

The psychoanalytic perspective was reviewed by Robert King of Yale University and Sam Tyano of Tel Aviv. The psychodynamic concepts relevant to adolescent suicide include: the regulation of aggression; the capacity to bear anxiety, depression and other dysphoric affects; vulnerabilities related to adolescent separation and loss, and the role of ambivalent vs protective object relationships. A distinction can be made between dependent and self-critical depressive traits. There was also a discussion of the destructive role of pathological perfectionism. Dr. Tyano introduced "the decision to live" as a "fourth organizer" of human development crucial to adolescent mental health.

The psychological perspective was introduced by Israel Orbach who dealt with the role of body experience in self-destructive behavior and summarized his empirical studies on high thresholds for pain in suicidal adolescents which he related to early negative caretaking experiences resulting in negative attitudes towards the body. Robert Plutchik of Albert Einstein College of Medicine in New York, and Ronald Maris discussed assessment and prediction of suicide. Dr. Plutchik pointed out that over fifty variables have been isolated as predictive of suicide so that models of interrelationships between factors are important rather than the study of any factor in isolation. Such models include his own two-state model of countervailing forces which amplify and attenuate aggressive motivation, and Maris' life span development approach to assessing, predicting, and preventing adolescent suicide. Brian Tanney of the University of Calgary, Canada, made the controversial point that mental disorders are not a necessary cause of adolescent suicide.

The case study (idiographic) perspective was emphasized by Alan Berman, executive director of the American Association of Suicidology where individual case studies are used to reach an understanding of youth at risk to teach critical thinking in developing theory-based treatment protocols.

The meeting ended with a discussion chaired by Dr. Donald Cohen of Yale University and Chairman of IACAPAP who summarized the discussions, making the point that the study of adolescent suicide, while making great progress in many areas, had come to a crossroads where new methodologies such as links to developmental psychopathology were imperative for future research. ■

Trends in Pediatric Psychopharmacology

Current Status

by Benedetto Vitiello, M.D. and Peter S. Jensen, M.D.

With the notable exception of the stimulants which have been extensively studied in children with attention deficit disorder, the rest of pediatric psychopharmacology has lagged behind its adult counterpart. Several obstacles have hampered the study of psychotropic medications in children. Among them, the most notable have been: 1) limited interest of the pharmaceutical industry that has traditionally perceived ➤

the pediatric market to be financially negligible and potentially risky for product liability, 2) resistance of families and community at large to pharmacological experimentation in children, especially when placebo-controlled exposure to drugs is required, 3) and dearth of appropriately trained investigators.

Despite the lack of systematic research of the efficacy and safety of these agents in pediatric ages, psychotropics have been prescribed to children with increased frequency (Vitiello et al. 1994), which as resulted in a significant off-label (i.e., not approved by Food and Drug Administration) use of these drugs. Concerns about this state of affairs have been addressed in a recent conference organized the National Institute on Mental Health and co-sponsored by FDA, which convened representatives of the various parties involved in research in pediatric psychopharmacology (i.e., investigators, pharmaceutical industry, parents, ethicists, NIH, FDA and other government agencies) (Vitiello & Jensen 1995a).

Why research in pediatric psychopharmacology?

The extrapolation of data from animals to humans, in general, and particularly from animals and adults to children is never easy and not always feasible. Children have been known to respond to psychotropic medication in ways which are distinctly different from adults, and consequences for both safety and efficacy (Vitiello & Jensen 1995B). Age related differences in pharmacokinetics and pharmacodynamics have been identified, which can explain some of these differences. Because the neurotransmitter systems undergo developmental changes in pediatric age, exposure to pharmacological agonists and antagonists at this crucial age any result in short- and long-term effects that cannot be studied in adult populations.

Need for Further Research

Safety Studies

Psychopharmacological treatment in children means exposing their brain to agents which interact with neurotransmitter systems that are still undergoing developmental changes. In several animal species, there is evidence that exposure to various neurotransmitter agonists and antagonists can result in permanent up- or down-regulation of receptors which persist into adulthood (Vitiello & Jensen 1995b). Clearly, the extrapolation of safety data from the animal lab to the clinical setting is arduous, but further research should address these concerns. On the one hand, we need to develop valid animal models that can allow to infer safety from animal species to humans. On the other, we may need long-term follow-up of children exposed to these medications. These studies have some precedents in the neurodevelopmental studies of children treated with phenobarbital for recurrent febrile seizures (Farwell et al. 1990), or exposed in utero to phenytoin or carbamazepine (Scolnik et al. 1994). Long-term safety studies of psychotropics are particularly important, because psychotropics are frequently administered for extended periods of time and, in come cases, indefinitely, in contrast to other pharmacological agents, such as antibiotics and analgesics.

Pharmacokinetics and Pharmacodynamics Studies

These include investigation to determine bioavailability and appropriate dose-effects relationship. For many psychotropic drugs prescribed for children, no adequate systematic phase I studies have ever been conducted. Instead, pediatric doses and frequency of administrations are extrapolated by the treating physician from adult data without experimentally endorsed guidelines. Clearly, studies aimed at determining pharmacokinetics and dose-response curves are worth considering for all new drugs currently in development and for which a possible pediatric use is anticipated. In addition, among the drugs already marketed, those for which a significant use in children is documented should be similarly studied.

Efficacy Studies

Evidence for efficacy comes from controlled studies. In children, besides the well documented efficacy of stimulants for attention deficit disorder, there have been relatively few controlled studies of other psychotropic medications. Pharmacological treatments for mood and anxiety disorders, in particular, deserve attention, given their high prevalence in pediatric age. Only one placebo-controlled trial has recently shown the superiority of active medication (i.e., fluoxeinte) over placebo in depressed children and adolescents (Emsile 1995). More systematic research on antidepressants is expected in the next few years. Controlled investigation on selective serotonin reuptake inhibitors (SSRIs), such as paroxetine, are in progress. clinical research on newly developed antidepressants is particularly relevant to child psychiatry because the classic tricyclic drugs may pose unacceptable risks and side effects in this age group, while SSRIs have a better safety profile. Because clinical research of antidepressants has been traditionally plagued by negative results (i.e., active medication not different from placebo effects), multisite trials have increasingly been considered in an effort to obviate recruitment difficulties and allow studies with sufficient statistical power. Among the anxiety disorders, obsessive-compulsive disorder has been the object of controlled studies which have shown the efficacy of clomipramine, but there is need for further investigation using other potential antiobsessive agents and exploring the interaction of drugs with non-pharmacological treatments. Very limited research has been conducted on the pharmacotherapy of other anxiety disorders, such as social phobia and generalized anxiety disorder, which still are quite common in childhood. Another area that has been understudied and still deserves attention is that of psychopharmacology in patients with pervasive developmental disorders or mental retardation. Few investigators have developed the required expertise to conduct research in these populations. While the anecdotal literature on the use of psychotropics in these patients is substantial, only controlled studies will be able to advance this field. It therefore remains a priority to encourage new initiatives in this area.

There is also an increasing awareness of the fact that children with psychiatric disorders often require more than one type of therapeutic approach. Pharmacotherapy is commonly combined with psychosocial interventions in the treatment of conditions such as attention deficit disorder, depression, obsessive-compulsive disorder. It is therefore extremely important the clinical research test experimental hypotheses that include treatment combinations.

Effectiveness Studies

Even in the case of the stimulants (d-amphetamine, methylphenidate, and pemoline), whose efficacy and safety in the treatment of attention deficit hyperactivity disorder (ADHD) have been well documented, many important aspects of the effectiveness of these drugs when they are administered to children for long periods of time remain unknown. In particular, their impact on the natural history and long-term prognosis of patients with ADHD after several years of administration is unclear, ➤

as well the contribution that concomitant psychosocial treatments can make. Clearly, the traditional efficacy studies cover too limited a time span to be able to answer these crucial questions. Short-term studies have almost exclusively focused on the remission of primary symptoms, while not enough attention has been given to broader indices of functioning at home, school, and community, that can be more relevant to long-term prognosis. Typically, efficacy studies have tested the effects of specific treatments which have been administered to the study sample in a rather fixed and standardized manner. Although methodologically justified by the need to control for the study variables as much as possible, this approach does not always reflect the clinical reality, where pharmacotherapy is individualized to the need of each individual patient. Increased attention to these limitations has contributed to the development of clinical algorithms for research purposes (Greenhill et al. 1995), which allow the clinical researcher a certain degree of flexibility, while preserving a systematic and consistent approach to the experimental hypotheses. In this context, a study that tries to address these issues is the NIMH Multimodal Treatment Study of Children with Attention Deficit Hyperactivity Disorder. This study is currently following several cohorts of children randomly assigned to receive medication, psychosocial, combined, or traditional community treatment for more than one year (Richters et al. 1995). Treatment algorithms have been developed as part of the study protocol (Greenhill et al. 1995). In the same vein, effectiveness studies should be considered for other common childhood disorders, in particular affective and anxiety disorders.

Conclusions

Born before adult psychopharmacology with the introduction of amphetamine in the treatment of hyperkinesis in 1938, child psychopharmacology has not kept the pace with the rapid advancements in the adult field and is still in its infancy. However, the increased use of psychotropics in children, the rising concern about off-label use of medications, and an increased awareness that the developing brain responds to pharmacological agents in certain distinctive ways are currently spurring new research initiatives in pediatric psychopharmacology.

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WHO Calls for Investment in Youth

"Investing in youth is investing in the future," declared Dr. Hiroshi Nakajima, WHO Director-General in a message sent to the Youth Health Assembly held in Vancouver, Canada, March 20–25. The Assembly marks a turning point in the efforts to expand interventions for the health of youth worldwide.

The Youth Health Assembly is convened by the International Association for Adolescent Health and the Society for Adolescent Medicine, and co-sponsored by the World Health Organization and UNICEF. It brings together governments, nongovernmental organizations, professional and scientific associations and young people from many countries, to speak for themselves and forge a better future for all.

"Youth is a time of life when equity between the sexes—a foremost principle of healthy development and good partnerships between people—can be promoted," emphasized Dr. Nakajima. "This Assembly is a fine example of the many kinds of partnerships which need to be forged to promote health for all."

"Young people are, in many ways, our greatest resource," added Dr. Nakajima. "They are at a crossroads in life in which creativity, energy, enthusiasm, and the will to do good must be tapped and developed for the betterment of all people."

Nearly 30% of the world's people, one and a half billion, are between the ages of ten and 24. Of these, more than four out of five live in developing countries, often in conditions of economic deprivation.

"The world is changing in many ways, some of which put the health and development of young people at risk," says Dr. Herbert Friedman, Chief of the WHO Adolescent Health Programme.

Such changes include rapid urbanization, the extension of telecommunications across cultural and geographical boundaries, and the disappearance of the extended family that once predominated and is now giving way to smaller families and the phenomenon of street children, estimated to number about 100 million worldwide.

According to WHO, the social changes taking place are putting young people at risk of a host of reproductive health problems which arise from unprotected sexual relations. These include, too early and unwanted pregnancy and childbirth consequences of induced abortion in hazardous conditions, and sexually transmitted diseases including HIV/AIDS.

Globally, over one-half of all newly acquired HIV infections occur in young people aged 15 to 24, mainly girl adolescents and young women. As more and more women are becoming affected, cases of mother-to-infant transmission are increasing.

Moreover, the use of tobacco, alcohol and other drugs, which most often starts in adolescence, can have both short- and long-term effects harmful to health and life itself. Tobacco use by young people is widespread, and is increasing in developing countries. According to WHO, about one-half of all the adolescents who take up smoking and continue to smoke throughout their lives will be killed by tobacco-related causes in later life. ➤

Results of a qualitative research study carried out by WHO in 1992 among street children in selected developing countries, suggest that between 23% to 43% of street children use drugs other than nicotine. Comparison with peers in their communities shows that street children are more likely to engage in the abuse of psychoactive substances. They are also more vulnerable to the negative health consequences of such substance abuse due to poor living conditions and lack of access to and use of health and other services.

While adolescence is a time of necessary experimentation which inevitably brings with it risks of many kinds, many injuries can be prevented by a safe environment and protective practices by young people themselves. "Violence is also a problem of great concern among young people which would be diminished by a health-promoting and safe environment," underlines Dr. Friedman.

WHO also argues that nutrition and oral hygiene are most important for overall health and development, but are not always given the priority they deserve. Although much progress has been made, communicable diseases have not yet been sufficiently reduced. In fact, tuberculosis and other endemic diseases affect the ability of young people to make their full contribution to their communities and societies.

According to WHO, in order to make youth health interventions more effective, the world community needs to ensure that young people have the opportunity to acquire skills and knowledge to enable them to adopt a healthy behavior and to avoid the health risks they face. A safe and supportive environment should be created at the national, community and family levels. Most important, youth must be given access to information and health services sensitive to their needs. This includes the screening and early identification of developmental disorders; products to prevent pregnancy and sexually transmitted diseases; services to ensure maternal health; prevention and treatment of endemic diseases; and rehabilitation for disabilities due to disease, accidents and substance abuse.■

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IACAPAP AND WHO

by Jocelyn Y. Hattab, M.D.
Coordinator between IACAPAP and WHO

IACAPAP and WHO's Mental Health Division share the same concern for populations and specifically, children who live under adverse conditions. The action of WHO for these populations is well known and appreciated. The action of IACAPAP members has been described in previous issues of this Newsletter. During a private visit in Geneva, I was appointed by our President, Professor Donald Cohen, to meet with Professor Costa E'Siva, Director of Mental Health Division and Doctor John Orley, Senior Medical Officer of this Division. They were both very enthusiastic to establish or re-establish contact with IACAPAP. We discussed many common issues about training of pediatricians in mental health and development, research, ethical issues, programs of intervention for populations in need, and more.

We decided to promote the knowledge and use of ICD 10 through this Newsletter and other media in order to make this International Classification available and used by all mental health professionals over the world. WHO will use its influence on WHO's Child Division to introduce Child Mental Health training as part of the curriculum to pediatricians. We planned a Symposium on this issue for our 2000 Jerusalem IACAPAP International Congress.

WHO and IACAPAP are aware of the tremendous changes in school systems and functions together with the increase of aggression into and around schools. Programs of intervention have been developed in several centers and particularly at Yale Child Study Center together with police departments. This is an important field of collaboration.

IACAPAP members, as mental health professionals, have already been deeply involved in providing support for populations and training for local professionals in their field. WHO will try to organize such missions in needed countries and IACAPAP will hire members interested in these actions and will design programs of intervention in such cases. The financial problem is crucial; neither WHO nor IACAPAP have money for such important actions but they can join to convince sponsors and governments. We look forward to this new and fruitful cooperation. ■

OVERVIEW: XXI INTERNATIONAL CONGRESS OF PEDIATRICS

September 1995, Cairo, Egypt

by Jocelyn Y. Hattab, M.D.

"TOWARD A BETTER CHILDHOOD: NEW FRONTIERS FOR THE COMING CENTURY"

For the first time, IACAPAP was officially represented by its delegate at this important Congress. This fact expresses that both organizations are equally eager to strengthen their ties and collaboration. It is more and more evident for child psychiatrists to know more about pediatrics. Pediatricians have discovered that approximately 50%, at least, of their patients have functional or psychological problems. We share the same concern for children's well-being.

This Congress was attended by 3,000 participants from sixty countries; the large majority from the Third World and developing countries, under the patronage of President Mohamed Hosny Mubarak. It was beautifully hosted and wonderfully organized by the Cairo International Conference Centre.

All major pediatric issues were discussed: intensive care, nephrology, rheumatic diseases, cancer, hematology, HIV, pneumology, antibiotics, vaccinations, etc. Also included were: The girl child and the right to health; violence and injury; safe motherhood; social pediatrics; the Rights of the Child; Child Health Services; Child Psychiatry in Developing Countries. Pediatricians seem to be more and more concerned and aware of social influences on pediatric pathologies. This pathology changes. Infections are progressively eradicated, cancer decreases by 50%, but emotional and psychosocial pathologies are in constant increase. As pointed out by the President of the Executive Committee, Professor Robert Hagerty from Rochester: "Social support is the penicillin of the 21st Century." They acknowledge that family counseling improves the psychic status of children with chronic diseases and helps them cope. Our pediatrician colleagues are now ready to participate in "a comprehensive program for children's health."

Pediatricians and child care professionals in the developing countries are very concerned by the right to health care for every child. In India and Egypt, for instance, couples prefer to give birth to boys rather than to girls. Ultrasound examinations enable them to decide which fetuses will ➤

live and which will not. Girls receive less care than boys. In Egypt, 600,000 girls are missing because they don't receive adequate medical care. In Korea, there are two boys for one girl. This does not speak to equal education and opportunities for girls and boys.

Professor Ahmed Okasha, President of the Egyptian Psychiatric Association taught the audience principles of DSM IV classification and stressed the importance for pediatricians to have basic knowledge in psychiatry. He suggested strongly that pediatricians must train in child psychiatry as child psychiatrist should train in pediatrics. J. Y. Hattab chaired a workshop to emphasize the tremendous importance of collaboration between child psychiatrists and pediatricians in diagnosis, in prevention, in treatment programs, in research. This very enriching experience of participating in a pediatric congress is recommended to all colleagues and as well as to present more papers to these congresses. The same must be done among pediatricians. The Organizing Committee of our next Congress in Stockholm has suggested inviting officials of the World Pediatric Organization. Last, but not least, the receptions were pharaonic. We enjoyed many concerts, folkloric dance representations and abundant buffets. ■

Report on the United Nations Youth Forum Planning Meeting

July 1995

by Joel Klein and Erica Goldman

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

The stated purpose of the Youth Forum, according to one U.N. document, is to "discuss the problems of communication between the United Nations system and youth organizations with a view to improving those channels and establishing effective structures of communication and cooperation." While this written objective remains vague, the idea of increasing international cooperation among youth organizations has considerable merit. For example, youth organizations need access to financial resources for their activities, such as the United Nations Youth Fund (disbursing over $400,000 over ten years). Coordinating publicity efforts and political pressure would increase the effectiveness of human rights organizations concerned with youth education, employment and health. Student internship and educational opportunities worldwide could benefit from a central bank of openings and positions to which youth could apply. Finally, written exchanges between worldwide professionals and their organizations bring new ideas and new partnerships, a benefit well-understood by IACAPAP.

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

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

In spite of the absence of orderly discussion, the delegates at the planning meeting and at the Youth Forum itself still had the opportunity to form contacts and share their organizations' activities with each other. Brian Hill, of the Youth for Youth Health Conference in Vancouver, Canada, distributed a magazine detailing his group's writings and other work with teen pregnancy, eating disorders, and infibulation. A gentleman from a Japanese youth job-training and tree-planting program make available his group's fact sheet and bumper stickers. One college student, representing the World Esperanto League, said that his only real purpose in attending was to meet other student organization officers and get a sense of how their worldwide operation are run. If the planning meeting produces nothing useful for the upcoming Forum, he said, his attendance would have still been worthwhile.

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

Youthful Impressions

Editors' Comment:
We are pleased to include impressions from youths living in Hungary, Japan and the United States about their perceptions of issues important to their cultural, social experiences and needs.

To be a Child in Hungary

by Andrew Varga

I like to be a child in Hungary because the school is very good and the children in my class are all fine. There is a friend of mine who is called Marci. We often play, talk together or we just do anything. The teachers are correct, but demanding as well. There are also special hobby-classes at school. I take artistic classes my three sculptress will be sent to a competition. The three sculptress are about Hunor Magyar and the magic deer/Hungarian symbols. ➤

Besides I go to row, but in winter time has exercised in the school. I have just got sick after running outside without a pull. Anyway, I prefer rowing on the river to inroom exercises. Twice a week I go to dance-classes, too. I started to like it, but it was hot me who decided. I like bicycling with the neighbours. At the moment I don't play any music instrument but later I would like to play the saxophone, I well enjoy computer plays, but unfortunately we don't hose any machine. So it is like that to be child in Hungary.

Japan: A Youth's Perspective

by Sakura Tajima

One of the most dreadful accident happened in Japan this year was the sarine gas attack on the Tokyo subway system in March. As is it broadly known, Aum Shinricge draws suspicion in launching the toxic gas.

The things done inside the cult are now gradually become known and one of a surprising fact is that the cult had quite many promising young scientists. They are bright enough to succeed in their own ways for sure—the questions is, what was the magic which Aum used to attract these people?

In my thought, I imagine a man like this: He was brought up always beside his mother. The mother has an ambition for her son to be bright and to get into a high-paying enterprise then he will take care of his mother with enough money to have rich life. For the thing to be carried out, her son has to get into high leveled school in order to get into University which gives the maximum profit by the name to be employed by an enterprise which she thinks right.

The mother always takes care of her son and she almost does everything for him except his study. In many ways he is spoiled abut his mother does not say anything as long as he gets good marks in exams.

Fortunately or not he is bright in school study and he succeeds in getting into a future promising university then has a position in a major enterprise. At this time he admits himself highly qualified in his school-college career and has no experience in being collapsed. When he enters the firm people treats him as a freshner.

A freshner usually has a job of small things such as photocopying or walking business in which one has to go many places all around Tokyo in a day to get appointments or contacts, sometimes a freshman is made to go buying a cigarette for his superior. The high-qualified young man could not stand his situation and his job. He thought the job given was not suitable for his qualifications and his does not deserve it. In fact, he could not satisfy his superior with his job done and it was almost every day that he was called down severely. The rage risen inside him was almost burst in one typhoon-night. That night he could not get any contract and he rang the bell in a girl student's room. Probably she was up nothing to do and used him to spend time. He carried on explaining and advertising for a long time. He was confident that the girl would have a contract but never he knew her betrayal, he was unable to restrain his anger.

So hard to work I've done, but one has easy life doing nothing and making a fool at me. Because you are bitch you can live without the misery that I have experienced!! He strangled her and left her room.

The next morning when he read the newspaper he was first upset by the thing he has done but gradually felt as if he was given a social valuation, and he attracted the attention of the people, which he deserves as he survived all the keen competition.

When he was arrested he killed six girls in total, always in a typhoon night. He told the motive to the detective: "The reason why I chose a typhoon day for murder was that I thought I can express my rage against society more precisely in a dreadful weather. I could say, typhoon can produce the rage the best."

This is actually a story from a book. This is of course fiction but I can easily imagine that this kind of man can exist in Japan now. These people would be psychologically normal but are definitely abnormal. The young scientists in Aum can be similar. They can not suit themselves in a system and be lost the way to go. At the certain time if Aum gives them what they want such as aim, confidence, money, a position in a system the young scientists may feel happy in a system of Aum.

One reason of getting into Aum is the loss of aim. There are so many young-age who doesn't have future dream or anything they want to do. The problem is they do not know what they really want or want to do. As mentioned above the mother decides her child's way to do, and most of the time, it is linked to a good university and well-paying enterprise. There are so many children who are not good at school—study or who does not like to obey their mothers. I think they should do something interesting for themselves and choose job suitable for them.

Fortunately I know myself I like studying and I will study only for myself. I have dream of becoming a doctor in future and as I am a medical college student the preparations are steadily processing. Many people in Japan go to university for such reasons; to obtain high qualifications for employment. To have break between the hard study period for entrance exam of university and the hard work after getting into firm merely to have communication with various people or even some people say they have no reason but go to university because their friends go. I don't say the reasons mentioned above are useless but at least I think these are not reasons to decide going to university paying a lot of money, and spending four full years. I think it is wasting. I was surprised that fact that even in medical college there are quite many people who are not keen on being a doctor or studying and do the minimum amount of study to pass the exam. I always wonder how they consider participation in patients life.

People in Japan do not see possibility in their own choice for future and in conclusion they do the same thing each other. People are under suppression of society and parents for many years through the youth and when they become adult some people find their own way but some other people become out of control and I think young scientists in Aum were happy in the cult as they would feel themselves needed and were not abandoned dangerous substances and that is, they are not under suppression to do what they want.

As I have heard that many young Aum people have withdrawn from Aum and the arrested people do not hesitate in answering to the detectives questions, they notice now the madness in what Aum were doing. I fear the society which creates people who look normal but inside there are something terrible wrong but is hidden under the coat of the qualification. There will be some people of this kind who are running a part of government and education system in Japan. So this is why I could not choose who to vote in pre-week election for members of the House of Counselors and put a white paper into an election box on the day.

Cultural Values in Japan and the United States

by Lisa Pfeffer

Myths, legend and story-lines are essential for the understanding of a culture. Each culture adapts its own characteristic myths, ➤

legends and storylines. Through these stories, life gains meaning and reality is comprehended. As cultural creatures, humans tend to follow the derived style of their own culture. By exploring the myths, legends and story-lines in James Oliver Robertson's *American Myth American Reality*, and Ruth Benedict's *The Chrysanthemum and the Sword*, the similarities and differences between Japanese and American tradition, and the reasons behind these similarities and differences in culture are better fathomed.

When traveling to another county, the phrase, "I experienced culture shock" is often used. Miss Mashima vividly reveals the shock she experiences as a Japanese student submerged in American culture:

"My pride in perfect manneredness, a universal characteristic of the Japanese, was bitterly wounded. I was angry at myself for not knowing how to behave properly here and also at the surroundings which seemed to mock at my past training. Except for this vague but deep-rooted feeling of anger there was no emotion left in me." She felt herself "a being fallen from some other world. My Japanese training, requiring every physical movement to be elegant and every word uttered to be according to etiquette, made me extremely sensitive and self-conscious in this environment, where I was completely blind, socially speaking." It was two or three years before she relaxed and began to accept the kindness offered her. American, she decided, lived with what she calls, 'refined familiarity.' But familiarity had been killed in me as sauciness when I was three." (Benedict, 226)

Why did Miss Mishima experience so much anger and frustration upon entering this other culture? The answer to the question may best be answered by examining the effects of Japanese and American myths, legends and storylines on life.

"A myth is a story told or an oft-told story referred to by label or allusion which explains a problem (for example, 'that's his Achilles' heel' or 'it was a Trojan horse'" (Robertson, 6) Myths are the time honored and continuously repeated stories in any culture through which reality comes to be understood. A legend is a moral tale about a historical figure that forms today's reality; the legend of the samurai and George Washington with his cherry tree both demonstrate myths. Finally, a story-line suggests the ideal plotlines of a culture. Through these apparatuses, tradition develops.

The story of George Washington and his cherry tree represents both a myth and a legend. When George Washington was a little boy, he was given a hatchet for his birthday. George Washington could not wait to use his new present and decided to try it on his father's cherry trees. One day, when George Washington's father found one of his cherry trees chopped down, he asked his son if he had cut down the tree.

George said, "I cannot tell a lie, Pa. I cut down your cherry tree with my new hatchet." George's father put out his arms as George ran to hug his father. "My dear boy, thank you for telling me the truth," George's father said.

Clearly, this legend has many variations; yet, it is not the details that make this story an American myth. "It does not matter whether George Washington actually cut down a cherry tree, so long as Americans 'know' that he did—so long as there is in that story a structure of ideals and understanding, a logic which answers important American questions." (Robertson, 11)

These American questions may be understood by thoroughly dissecting this legend. George Washington, the hatchet, the cherry tree, honesty and redemption make this story an American legend (Robertson, 15); the existence of these essential elements delineate the importance of the details. Aspects of American morality and social culture may be understood through the meaning of these essential elements.

George Washington is not merely the first American President. He is an American symbol. A symbol, is a representation that carries emotional freight. The versatility of a symbol is so powerful that the same symbol may represent respect for one individual while it dramatically hurts another person. As an example, at an American University, a student created an uproar as she hung the Confederate Flag from her dorm room window. To this student, the hanging of this flag may have exemplified her pride in her state; conversely, to another student, this same flag may have reminded him of America's wretched slavery years. Many American's have attached emotional significance to America's founding father George Washington. Whether this emotion is positive or negative is no matter. The mere fact that these feelings exist make George Washington a historic symbol.

As a result of George Washington's symbolism, his presence in the story of George Washington and his cherry tree are essential. Washington's act of cutting the cherry tree represent both defiance as well as destruction. What was this act a destruction of? Who was this defiance against? The tale of George Washington may be viewed on either a familial or national level his cutting of the tree was defiance against the ruling power. In either case, this action was directed toward the destruction of authority. It portrays a separation that Americans can relate to almost too well.

A separation is vastly evident when George Washington destroys his father's prized possession. From the establishment of this country, to the present time, separation has existed in American heritage. This country was established by breaking away from England, its authority. Currently, the breaking away from family is vividly apparent as more and more teens venture far from home to attend college. In addition, American's easiness associated with withdrawal shines as divorces rate continues to rise. Even marriage, an institution that people vow to hold dearly "until death do [them] part" has a premature means of termination and separation. As early as two or three, children experience the breaking-away from parents as they are sent to nursery school, away from their parents. Separation is bred at an early age in America.

Conversely, other cultures hold attachment to authority figures as a necessary tenet for survival; separation from this ideal would serve as a direct insult to tradition. A Japanese student like Miss Mishima may be shocked or even disturbed by the actions of America's great forefather George Washington. America's abandonment of England's King would be the equivalent of separating from the Emperor within the Japanese spectrum. To remove oneself from the highest authority, the Emperor, would be a crime worthy of death in Japan. the Japanese ideas behind respect and loyalty toward authority fall within the realm of hierarchy. The importance of hierarchy makes the move away from authority inconceivable. "Every Japanese learns that habit of hierarchy fist in the bosom of the family and what he learns there he applies in wider fields of economic life and of government." (Benedict, 56) In Japan, the knowledge of taking one's proper place is nearly innate. From one's role in the family, to one's role in the workplace or in society, individuals know "their place." The high ideals of Japanese hierarchy are surely ➤

a result of Japan's own myths, specifically the legend of the Samurai.

Japanese individuals may also be surprised by the American convention of marriage and the ease in which this institution may be terminated. Americans often marry because the are "in love." Yet, many times, this love is not of such great respect and the marriage ends in divorce.

The Japanese set up no ideal, as we do in the United States, which pictures love and marriage as one and the same thing... The Japanese judge differently. In the choice of a spouse the young man should bow to his parent's choice and marry blind. (Benedict, 184-185)

Japanese marriages are often purposeful and are arranged by parents. These purposes may include, repaying a giri[1], or moving up in hierarchical status. Like marriage, divorce is also a decision of parents. "A man of stronger moral character obeys ko[2] and accepts his mother's decision to divorce his wife." (Benedict, 208) In America, a wife often becomes enraged upon learning her husband has been involved with a prostitute. It is likely that under such conditions, she would file for a divorce. On the other hand, a mistress or prostitute is often accepted in Japanese culture and the existence of such a mistress would not lead to separation. "Only the upper class can afford to keep mistresses, but most men have at some time visited geishas or prostitutes." (Benedict, 186) As marriage represents an institution of purpose for the Japanese, it is difficult for these people to conceive the readiness by which Americans separate and thereby end their marriages.

Separation from authority in the story of George Washington and his cherry tree is not the only aspect that may disturb a Japanese individual. By the further exploration of American tradition, the relevance of the hatchet in this myth becomes apparent. The hatchet reflects the American need for materialism. The wilderness was cut down by this tool for the establishment of civilization. Although a civilized society, Japan does not place such great importance on the need for materialism. Benedict describes the Japanese avoidance of materialism in exchange for the supremacy of spirit in war.

"The more shortage of food that is, the more [the Japanese] must raise our physical strength by other means." That is, [the Japanese] must increase our physical strength by expending still more of it The American's view of bodily energy which always reckons how much strength he has to use by whether he had eight or five hours of sleep last night, whether he has eaten his regular meals, whether he has been cold, is here confronted with a calculus that does not rely on story of energy. That would be materialistic. (Benedict, 24-25) This passage explains how, according to the Japanese, the inner being may move an individual through a crisis situation rather than material items.

Finally, the legend of George Washington and his cherry tree presents the American ideals of honesty and redemption. Throughout life, Americans hear the cliché "Honesty is the best policy." In grade school, American students here the story of the boy who cried wolf too many times until nobody believed him when a wolf was actually there. Had this boy not lied, and been honest, he would still have his virtue and been redeemed. Unlike the boy who cried wolf, George Washington is revered because he told the truth; he is still a virtuous man. The Japanese can relate to the importance of virtue in their need to feel shame. When an individual is able to feel shame, he is labeled a virtuous man. "Shame, they say, is the root of virtue. A man who is sensitive to it will carry, out the rules of good behavior. 'A man who knows shame' is sometimes translated 'virtuous man,' sometimes 'man of honor." (Benedict, 224) Although Americans and Japanese may not hold the same characteristic as a representation of true virtue, the cultures are able to understand the significance these differing characteristics.

The story of George Washington is both a legend and myth that has created today's reality. Separation, the need for civilization and the virtue of honesty all demonstrate accepted aspects of American life. By analyzing this myth, in conjunction with the values of Japanese culture it becomes obvious that several aspects may be disturbing, or at the very least different for the Japanese individual.

The Japanese also hold sacred myths and legends which have been a basis for the development of Japanese culture. The legend of the samurai[3] portrays the irreplaceable ideal of hierarchy within Japanese society. With the establishment of the samurai came the foundation of a class system in Japan. This new class system emphasized the importance of social position.

A great gulf separated the samurai from the other three classes: the farmers, the artisans and the merchants. These last three were the "common people." The samurai were not. The swords the samurai wore as their prerogative and sign of caste were not mere decoration. They had the right to use them on the common people...[this] policy was based on strict hierarchical regulations. (Benedict, 64)

To be a samurai was such a great honor that people even tried to buy samurai status. However, even the samurai was lower on the hierarchical scale than his liege lord. "The great traditional giri relationship which most Japanese think of... is that of a retainer to his liege lord and to his comrades at arms." (Benedict, 137) The following Japanese myth reveals the giri that a samurai owes to his lord.

One day, a samurai and his lord were out traveling when they encountered enemies who were searching to capture the lord. In an attempt to disguise the lord from the enemy, the samurai slapped his lord across the face.

"Why would the samurai slap his lord, a man that he reveres?" thought the enemy.

As a result, the enemy believed the samurai's plan and the lord was saved. However, the brave samurai thought it was now his turn to die for slapping his respectable lord.

"You may now kill me," said the samurai. The lord responded, "You may be pardoned."

This legendary story identifies the roots of Japanese giri and hierarchy. Clearly, as the samurai protected the lord, he performed his duty of giri. However, his means of protection disrespected a being higher on the social scale. For this, he expected severe punishment. As a lord, it was his right to make the choice between killing the samurai and allowing him to be pardoned.

Regard for the Emperor also displays the significance of respected for those on a higher social level.

Within the reign of the present Emperor, a man who had inadvertently named his son Hirohito—the given name of the Emperor was never spoken in Japan—killed himself and his child. (Benedict, 151)

Although this murder–suicide may be no surprise in Japan, it would be viewed as an atrocity in the United States. In America, a parent would not be scorned or accused of disrespect for naming their son Bill Clinton. Naming a child after a President may even be considered a compliment in comparison to the malicious press coverage a president receives. To the Japanese, the reference to ➤

President Clinton as "Clinton" in the press is a sign of complete disrespect. However, for Americans, this reference is merely a continuation of the American idea that everyone is equal. Americans have difficulty relating to this extreme level of hierarchy as the essence of America lies in its freedom to equality. To an American this unconditional respect for the lord may be foreign.

America has often been described as the "land of opportunity." It is the country where everyone has the chance to "make it big." Most of all, America is a country for the people thereby representing a democracy.

Alexis de Tocqueville describes how majority power promotes equality in America in his book, Democracy in America.

The majority has absolute power to make the laws and to watch over their execution; and it has equal authority over those who are in power and the community at large, it considers public officers as its passive agents and readily confides to them the task of carrying out its designs. (Tocqueville, Volume 1, 262)

However, in Japan, the legend of the samurai places individuals at different hierarchical levels; the ruler would prevail over the majority.

Not only do myths and legends serve as a basis for understanding the realities of a culture, but storylines aid in deciphering the traditions of a country. In fact, a story with the same beginning often has diverging endings for different cultures. The following story demonstrates typical plot lines of Japanese and American heritage.

A happily married man has just allowed his elderly mother to move into his home with his wife and children. After three weeks of living in her son's home, this mother decides she dislikes in daughter-in-law and asks her son to divorce his wife.

At this point, the story may have two endings. An American son would explain to his mother he is in love and wishes to remain married to his wife. He may even suggest that his mother move to a retirement home, a convention typical of America.

Conversely, in a Japanese story, the wife would be forced to leave and the mother would remain in the home. Within Japanese tradition...it is proverbial that the mother-in-law does not like her daughter-in-law. She finds fault with her, and she may send her away and break up the marriage even when the young husbands is happy with his wife and asks nothing better than to live with her. ...The husband of course is doing ko in submitting to the break-up of his marriage. (Benedict, 120)

Recognizing that there are different ending for this story based on cultural context helps one to better fathom the realities of one's own culture. This recognition forces individuals to question why they behave in such a manner they behave in. Behavior is not merely a natural instinct as one will ultimately realize that the essence of culture behavior lies in the myths, legends and storylines of a society. After analysis of American and Japanese myths thereby gaining a better understanding if the roots and meaning of culture, Miss Mishima's frustration becomes clearer. By study of the foundations of tradition, one may comprehend the motivation behind thoughts and behavior. ■

Notes:

[1] "These debts are regarded as having to be repaid with mathematical equivalence to the favor received and there are time limits." (Benedict, 116)

[2] "...repayment of one's [passive obligation] to parents..." (Benedict, 117)

[3] "In feudal times the warriors, two swordmen. Below them were the common people: farmers, artisans, and merchants." (Benedict, 319)

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