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President's Column

In the Northern hemisphere we are now in summer, looking forward to June, July and August with great expectations. Most hopefully the winter season in the Southern hemisphere will not be too hard.

IACAPAP activities go on. The Executive Committee will meet in August at the European Society of Child and Adolescent Psychiatry (ESCAP) meeting in Budapest, Hungary. The preparations for the Beijing Congress in 2010 are at full speed. The next IACAPAP study group will take place in Abuja, Nigeria as an extension of the World Psychiatric Association (WPA) meeting in Abuja in late October 2009, also highlighted in the article in page 17 of this issue of the Bulletin. Olayinka Omigbodun and Brian Robertson are doing a great job inviting participants from the previous African study group to join again, together with a new contingent from the French-speaking countries in Africa.

In order to facilitate and improve the quality of the activities of IACAPAP around the world, especially between IACAPAP congresses, a network of child and adolescent psychiatrists —“IACAPAP ambassadors”— has been set up. The idea behind the network is to have a group of IACAPAP ambassadors who follow the situation of our discipline in their own countries and the surrounding regions and make suggestions and proposals on important tasks for IACAPAP to consider and implement. Such initiatives could include developing further international links, creating closer relationships with regional organizations such as ESCAP, EMACAPAP, ASCAPAP, FLAPPIA and AACAP, for example to jointly support initiatives on important questions related to clinical activities and research in child and adolescent mental health, as IACAPAP has already done with declarations and statements.

Dr Gordon Harper from Harvard (Boston, USA) has accepted to be the chairperson for the group and the following persons have accepted to be IACAPAP ambassadors: Abdulbaghi Ahmad from Kurdistan (University of Dohuk) and Sweden (Uppsala University), Nese Erol from Turkey, Daniel Fung from Singapore, Hongyun Gao from Shanghai (China), Olayinka Omigbodun from Nigeria, Dainius Puras from Lithuania, Brian Robertson from South Africa, Olga Rusakovskaya from Russia and Linyan Su from Changsha (China). Hopefully we will soon have persons from Central and South America and Australia joining the group.

All the best

Per-Anders Rydelius MD, PhD

President



**Contributions are sought for the next issue of the Bulletin.
Please contact the editor (jmrey@bigpond.net.au) with your ideas.**



IACAPAP 19TH WORLD CONGRESS 2010 JUNE 3-6, BEIJING, CHINA <http://iacapap2010.org/en/index.asp>

TOWARDS
BEIJING
2010

THREE YALE
DISPATCHES
FROM CHINA

A YALE CHILD STUDY CENTER VISIT TO CHINA

Andrés Martin, MD, MPH
andres.martin@yale.edu

There are longstanding ties between the Yale Child Study Center and China. Two concrete signposts of this relationship include Donald Cohen's foreword to the first Chinese textbook of child psychiatry (edited by Tao Kuo-Tai, Nanjing, 1999), and the simultaneous publication in 2001 of the original and a Chinese translation of *The Yale Child Study Center Guide to Understanding Your Child* (Mayes and Cohen, Little Brown and Company). In this tradition, it was a special privilege for a small contingent of the Center to visit China in March of 2009, and to be hosted once again by Professor Yi Zheng, MD of Anding University in Beijing. It was the same Professor Zheng who had translated the Center Guide, and who in the intervening decade had had the opportunity to spend a sabbatical year in New Haven.

The occasion for the March visit had been threefold: the annual meeting of the Chinese Society of Child and Adolescent Psychiatry, held in the southernmost city of Sanya, on the tropical island of Hainan; a visit to the spectacular and brand new Children's Hospital of Fudan University, in Shanghai; and a scouting and organizing visit to Beijing, the host city for the 19th World Congress of the International Association of Child and Adolescent Psychiatry and Allied Professions (IACAPAP), to be held June 3-6, 2010.

The Center's ambassadors included Yale medical student Ying Wang, MD '09, child and adolescent psychiatry fellow Edwin Williamson, MD, and Andrés Martin, MD, MPH. The three visitors, covering the educational spectrum, and—in descending order— that of fluency in Chinese, came together in Sanya, where they had the opportunity to meet most of the estimated 200 child and adolescent psychiatrists practicing in China (and about a dozen of the estimated 100 in Taiwan). Ms. Wang, who has written about the developmental impact of China's single child policy, whose MD thesis is about late-life depression in



Everything for Our Children

A visit to the Children's Hospital of Fudan University, standing along the words of former Chinese President Jiang Zemin. From right to left are Edwin Williamson, MD, Andrés Martin, MD, MPH, Yonghao Gui, MD (Vice President of Fudan University, former Director of the Children's Hospital, and Editor-in-Chief of the *Chinese Journal of Evidence-Based Pediatrics*), Hongyun Gao, MD, PhD (Director of Psychological Medicine for the Children's Hospital), and Chong-fan Zhang, Managing Editor of CJEBP.



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“According to Dr. Zheng, there are roughly 20,000 adult psychiatrists in China and about 200 child psychiatrists”

China, and who will likely play a pivotal role in the translation and cultural exchange of the Beijing 2010 Congress, then went off to the city of Changsha, in Hunan province, to spend a month in Xiangya Medical School as part of the well established Yale-China medical exchange program.

Drs. Martin and Williamson travelled on to Shanghai, where they were hosted by child psychiatrist Hongyun Gao, MD, PhD of Fudan University's brand new, 900+ bed capacity Children's Hospital. Among other stops, they got to visit the hospital's wards, the largest neonatal intensive care unit in the world (with over 100 cribs), and to see the seamless collaboration between traditionally Western and Chinese Medicine approaches (including thriving acupuncture and Chinese massage clinics). In addition, they were hosted by Professor Yonghao Gui, MD, Editor-in-Chief of the *Chinese Journal of Evidence-Based Pediatrics* (www.cjebp.net) to an exchange of ideas about ways to enhance the three-year-old and first-of-its-kind publication. Now under consideration as a possible outcome of that visit is an extended visit by members of the journal's team to the Washington, DC-based Editorial Office of the *Journal of the American Academy of Child and Adolescent Psychiatry* (www.jaacap.com), for which Dr. Martin

has served as Editor-in-Chief since 2008.

Dr. Williamson went on to visit a psychiatric hospital in the far-north city of Harbin, where he had spent time during college, and where he had originally started to sharpen his very solid command of Chinese. But before doing so, Drs. Martin and Williamson got to see the city of Beijing –ranging from its still palpable Olympic splendor, through its child psychiatric facilities, services and many challenges, to the preparations for the 2010 Congress.

Our former Directors, the late Al Solnit and Donald Cohen, had each served terms as President of IACAPAP. It is fitting that new generations of Yale Child Study Center faculty and trainees are now a part of the same organization. Al and Donald had helped nurture and develop. It is particularly gratifying that in keeping with earlier experiences in Berlin (2004), Melbourne (2006) and Istanbul (2008), the Beijing Congress is geared toward having a thriving Donald J. Cohen Mentorship Program through which to support the travel and participation of young scholars hailing from around the world. In sum, we remain as committed and enthusiastic as ever to the longstanding ties between the Yale Child Study Center and China, and hope to see many of you in Beijing next June.

TRAINING WITH WIDE LATITUDE

FROM THE TROPICAL BEACH TO THE ICE CITY OF CHINA

Edwin Williamson, MD

edwin.willaimson@yale.edu

The opportunity was alluring: a month during my first year of fellowship to go wherever I wanted, to explore whatever aspect of child psychiatry my heart desired. So I chose China, filled with history, but also changing rapidly with each time I visit. I went to see the face of child psychiatry in China: who is involved, what are they working on and where are they doing their work? I was excited to see clinical work in the hospitals and outpatient settings of Beijing, to meet child psychiatrists from all over China during their annual meeting and to eat a lot of good food.

This was my fourth visit to China. I first arrived in Beijing in August of 1992 for a month-long trip with my brother. Blown away by sights such as the Great Wall, the Terra Cotta Soldiers of Xian and the ancient Pagodas of Dali, I committed myself to studying Chinese language and history in college and returning to explore further. In 1992, Beijing was packed with bicycles, had few cars and skyscrapers were virtually nonexistent. Because electricity was relatively expensive and in short supply, cold beers were hard to find during the hot and dusty Beijing summer.

In 1994, I returned for a cold six months in the “Ice City” of Harbin to immerse myself in the Chinese language. There I found a city emerging from the cold war, fairly poor and based on large-scale manufacturing. With few foreigners, it was a great place to study Chinese, but though cold “Ha Pi” beers were abundant, there were no international stores, no fast food chains, few foreigners, and only one disco.

My most recent visit to China was in 2003. I returned for a medical school elective in Traditional Chinese Medicine and found a Beijing that was on the rise, both literally and figuratively. Cranes dotted the horizon building new structures all over the city, and China's place as a central player in the world economy was rising as well. Economic and political liberalization were in place, and everything looked different. No longer was there only one choice of bicycle, sneaker, or news source. The citizens of China were beginning to have a lot of choices.

This visit brought me back to Beijing, seventeen years after my first visit and a world apart from the China where I lived in 1994. Beijing is now packed with cars, discotheques and skyscrapers. International companies and brands are visible everywhere, from clothing to cars, to *Carrefours*, the French supermarket chain. The new architectural wonders of the CCTV building, the “Bird Cage” stadium and “Water Cube” from the Olympics, the new Capitol Museum, National Grand Theater and the new Terminal 3 at the airport, all proclaim Beijing to be a truly modern city, even while the city is centered on the centuries-old Imperial

Palace of the Forbidden City.

When I arrived in Beijing I was a bit worried about getting by on my rusty Chinese, but I was hosted by the wonderfully generous Dr. Yi Zheng of the Anding Psychiatric Hospital. While I did not understand every word during rounds or during lectures, Dr. Zheng and the rest of the staff were quick to help me out. They patiently taught me the words for schizophrenia, Tourette's, autism and depression.

Anding Hospital is a 600 bed psychiatric referral hospital with a 20 bed child psychiatry unit, as well as outpatient clinics. Dr. Zheng gave me a tour of his busy outpatient clinic and the child psychiatry inpatient ward. My first impression of the clinic was of similarities to the outpatient clinics of our Yale Child Study Center: a busy waiting room, examination full of doctors and medical students, and a hurried pace to see as many children as possible in an afternoon. Medication checks filled the scheduled appointments, which may have been the greatest difference compared to my clinic, where I split my time between medication management and individual psychotherapy. In a country of 1.4 billion people and 200 child psychiatrists, one can imagine that each child psychiatrist has to carefully consider how to dole out their time: how can they help the most children in the least amount of time. Almost every child psychiatrist I met was splitting their time between busy clinical work, research, and teaching the next group of medical students and trainees.

The inpatient department was not so dissimilar to ours, either: children ranging from six years to sixteen, some local and some brought from far away, for a similar grouping of illness: early onset of psychosis, behavior problems related to Tourette's, affective disorders and behavior problems, in that order. The difference was in the proportions. Because An Ding Hospital is a referral hospital, they had more of the rare early onset schizophrenia cases than we see. Compared to our hospital, which is in the middle of a poor urban neighborhood, they had two other differences that were probably related: fewer violent patients and more girls than boys. This may be because China is less violent than the US, that Beijing is less violent than New Haven, or that violence in children is seen less as a mental illness and more of a problem of conduct to be corrected at reform schools.

China has many fewer child psychiatrists than in the US, so it was not surprising to find that many mental health issues addressed by psychiatrists in the US are not under the psychiatric tent in China. Specific illnesses like learning disorders, disruptive behavior, high functioning autism, and issues related to family relationships are not usually seen in a psychiatric setting in China according to our hosts. On a more macroscopic level, psychotherapy is also less a part of the Psychiatric services in China, both in training and in practice.

Another interesting difference in China was the ratio of adult psychiatrists to child psychiatrists. According to Dr. Zheng, there are roughly 20,000 adult psychiatrists in China and about 200 child psychiatrists, for a ratio of roughly 100 adult psychiatrists for every child psychiatrist. In America there is a ratio of 10 to 1. The interest in child psychiatry appears to be growing, both in the lay press and in medical circles, in part due to the widespread reporting of the trauma of the Sichuan earthquake, which left many with emotional troubles. Child psychiatry has a hard time recruiting trainees in China, as it does in other countries. Psychiatry is not as prestigious as many fields, and to specialize in children takes extra time and is only available in six cities: Beijing, Shanghai, Nanjing, Chengdu, Changsha and Guangzhou.

In Beijing I met my professor, Dr. Andres Martin, and a medical student from Yale, Ying Wang, who grew up in China until the age of 11. From Beijing we headed to the tropical Island of Hainan, "The Chinese Hawaii", where we attended the annual meeting of Chinese child psychiatrists. This meeting was especially exciting because the Chinese psychiatrists were joined by their Taiwanese counterparts, sending a strong message that the care and advocacy for children can cross fragile diplomatic boundaries. Dr. John Sikorsky, of University of California, San Francisco was there, and his excitement for bridging cultures and borders was infectious.

From Hainan we went to Shanghai and visited the most impressive campus of the Children's Hospital of Fudan University. A brand new campus, there were buildings for inpatient and outpatient medicine, research and teaching. We met with Dr. Hongyun Gao, the head of child psychiatry there, and she showed us the outpatient clinics where she



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*Beijing 2010 Hospitality
Mastermind: Shuaxing Zhang hosts
Edwin Williamson in Beijing.*



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and her trainees see patients. Set in a children's hospital, the clinics reflect a consultation-liaison bent: they see many children with chronic illness and also somatoform illnesses, a particular interest of Dr. Gao's.

In Shanghai we were also able to meet with the editorial staff of a relatively new journal: The Chinese Journal of Evidence Based Pediatrics. China does not yet have a journal specific to child psychiatry, so Pediatrics journals are very important in the dissemination of child psychiatry literature. The editors enjoyed their time with Dr. Martin, spending time going over the inner workings of their journal. As editor-in-chief of the Journal of the American Academy of Child and Adolescent Psychiatry, he helped them think about their editing process and how they can improve their journal. They have already had Autism as a featured topic for one issue and were very open to the inclusion of child psychiatry issues in their journal.

For my last stop in China I returned to the "Ice City" of Harbin, and even though it was the end of March, the city lived up to its name. Cold and blustery, the Songhua River that runs alongside the town was still frozen solid from bank to bank, and there was snow and ice everywhere. Harbin is a big city and the provincial capital, but I did not know what to expect in terms of psychiatric services. What I found was quite impressive: a large, clean, new and well cared for adult psychiatric hospital. They had open (voluntary) wards for patients mostly with mood disorders, and locked wards primarily for psychotic patients. Unlike at Anding Hospital where patients wore hospital issued pajamas, the patients all wore their own clothes and it had a friendly, casual air about the grounds. On one floor I found the customary "Department for Integration of Chinese and Western Medicine" which I had seen at Anding Hospital and Fudan University Children's Hospital. The outpatient clinic was also new and busy, an impressive sight. The one thing that was missing was a division of child psychiatry, which reinforced the lack of resources for children outside of the five or six biggest cities in China.

In Harbin I found the signs of China's change over the last fifteen years. There was a Zara, the hip Spanish clothing store, several branches of McDonald's, and fancy hotels by the river. But the advances in China are not just evident in more foreign choices. The new, well appointed Psychiatric hospital, though lacking inpatient services for children, shows how many more resources are available for the mentally ill throughout China.

When I got on the plane for the long ride back, snacking on my remaining *jinju* (kumquats) and *longyan* (a petite cousin of the lychee from southern China), I was already thinking about how I am going to stay connected to China. On a personal level, I hope to continue the relationships I started in China: both with the high level doctors like Dr. Zheng, and the younger child psychiatrists I got to spend time with like Dr. He Fan, in Beijing. On an institutional level, the future is bright as well: hopefully the staff of the CJEBP (*Chinese Journal for Evidence Based Pediatrics*) will visit the offices of JAACAP to continue the collaboration they began with Dr. Martin in Shanghai.

Finally, this visit got me incredibly excited for my first IACAPAP conference, Beijing 2010. Traveling with Dr.s Martin and Sikorsky and meeting with the Chinese child psychiatrists who invited us into their clinics and hospitals (and out for many great meals), showed me why IACAPAP is both so exciting and so needed. The lessons learned go both ways. I know the editorial staff in Shanghai seemed grateful to have Dr. Martin visit their journal, but I took a lot out of my visit, too. So many of the things we do are just "because that is how we do them." Since I have been back I have been thinking about all of the questions that arose during my trip: who do we treat, and why? We have more resources than the child psychiatrists in China, are we using them wisely? How does our culture affect our diagnosis and treatment of children with mental illness? I hope to incorporate these ideas into my practice and work on the some of the answers to these questions. Most of all, I am looking forward to heading back to Beijing for IACAPAP 2010, seeing the friends I made, and eating a ton of *Beijing jiaozi*.

RETURNING

BOUND BY TRADITION

Ying Wang

yingwang_1@yahoo.com

I left China at the age of eleven, when I was malleable enough to learn and become American, but also firmly set in certain Chinese ways. Of course, the quiet soul-search, the quest to reconcile my sometimes conflicting national identities and cultural tendencies is a never-ending process. Now, as I am about to end my 5-year journey as a Yale medical student and transition into my next role, that of a psychiatry intern at Harvard, I return to my native country again.

This time I come to China mainly for business. The first exciting part of my journey consisted of attending a child psychiatry conference in Sanya, a meeting that attracted most of the country's 200 child psychiatrists. I was there as a student participant under the tutelage of Dr. Andrés Martin. In addition to learning about recent development in child psychiatry and speaking with child psychiatrists from all over China, Taiwan, and other countries, I also attempted my hand at live translation of Dr. Martin's presentations. Despite feelings of inadequacy, I took on this challenge enthusiastically and was proud that my bi-cultural upbringing was finally put to some good use. I also was incredibly inspired by the energy in the conference room. The audience ranged widely in age. From budding young physicians (as well as some medical students) to those in their 70s, everyone was hungry for new information. Perhaps most telling was the number of attendees who persistently raised their hands for an opportunity to ask questions

at the end, defying the Western notion that Chinese scholars are passive learners too timid to have their voices heard.

The second arm of my trip consisted of a 4 week rotation at the Xiangya Medical School, one of the top medical schools in China. And one with a fascinating history: the institution was founded in 1914 by the Yale-China Association (known at the time as Yale-in-China). Over the past 90 years, Yale-China has remained extensively involved in Xiangya, with numerous ongoing collaborations and scholarly exchanges in different health disciplines. The exchange program of which I was a part was sponsored by the Yale International Medical Education Program. In fact, this marked the first medical student exchange initiative between the two schools.

Xiangya Medical School has three affiliated teaching hospitals. My site was at the Second Xiangya Hospital, where the psychiatry unit is located. One of the oldest and better known psychiatric institutions in China, this unit boasts of active research initiatives as well as of a number of outstanding professors. In fact, one of my more

memorable experiences during this rotation was an afternoon spent at the clinic with Dr. Yang De Sen, affectionately known as Grandpa Yang by his students and patients, and one of the most influential and beloved octogenarians at Xiangya, who is also credited by many as an early pioneer responsible for introducing the very discipline of psychiatry to China.

One month of rotation went by faster than I had imagined. During my time at Xiangya, in addition to attending morning rounds on various inpatient wards, observing afternoon clinics, as well as giving and attending various presentations, I also developed a daily ritual of strolling through the campus of an elementary school just a few blocks down the road. Seeing throngs of uniformed Chinese children stirred in me a feeling of bittersweet nostalgia. It seemed not that long ago when I was one of them. Now as I journey into the next phase of my life and contemplate a career in child psychiatry with an interest in Chinese children, I ponder whether there is an element of self-discovery in that path as well. But time does not allow much contemplation. My graduation thesis is waiting to be bound.

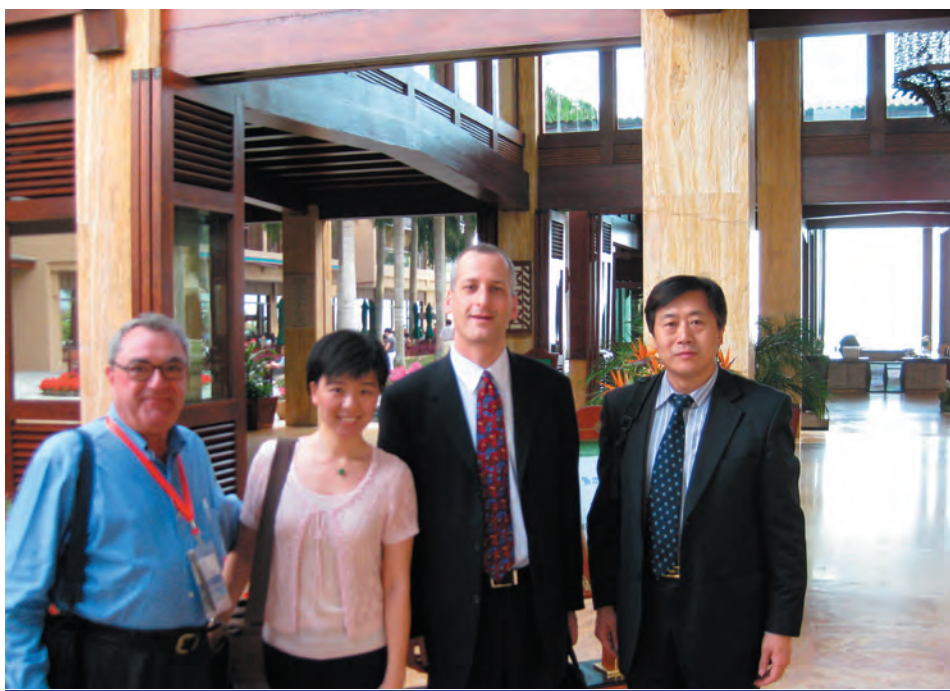


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THREE YALE DISPATCHES FROM CHINA

*In Sanya, IACAPAP old friends,
and new*

John Sikorski, MD, Ying Wang,
Andrés Martin, MD, MPH, and Yi
Zheng, MD



19th World Congress of the International Association for Child and Adolescent Psychiatry and Allied Professions

Beijing, China June 3-6, 2010

Key Dates

• **Deadline for Submission of Abstracts**
November 30, 2009

• **Notification of Accepted Abstract**
January 15, 2010

• **Deadline for Early Registration**
March 1, 2010

• **Dates**
June 3-6, 2010

• **Venue**
Beijing, China

• **Conference Language**
English

CHILD AND ADOLESCENT PSYCHIATRY IN FRANCE



Colette Chiland

Professor Emeritus, Université Paris Descartes; Psychiatrist, Centre Alfred Binet, Association pour la Santé Mentale du 13^e arrondissement de Paris; Psychoanalyst, Paris Psychoanalytical Society; Honorary President of IACAPAP

“Psychoanalysis has had an enormous influence on the development of child psychiatry in France, influence which has not declined as much as in other countries”

INTRODUCTION

Colette Chiland

Joseph Rey, Editor of the Bulletin, invited us to write a few brief articles describing the present French child and adolescent psychiatry. This is a sample of our work. These articles may prepare the readers of the Bulletin attending the 20th IACAPAP World Congress in Paris in 2012 for dialogue with French colleagues and visits to services. The theme of the Congress is «Brain, Mind and Development», a topic at the heart of our concerns.

From the ‘wild child of Aveyron’ to psychoanalysis: a brief historical outline

As in other countries of the Western World, child and adolescent psychiatry was born in France out of interest for “savage children”, and deaf, blind or mentally retarded children in the 18th and 19th centuries.

The story of Victor, a child found in a forest at Aveyron in France, is famous [1]. Jean Itard, an otorhinolaryngologist, who was working at the Institute for the Young Deaf in Paris, tried very hard to educate him, but did not succeed in bringing him to “normality”, “civilization”, or to a full development of intelligence and language. The question concerning those “savage children” is whether they were abandoned because they were “retarded” or whether they became “abnormal” because of the lack of a human environment and appropriate care. After their discovery, these children—who had been raised by or among wild beasts—did not become like the marvelous Mowgli in Kipling’s *Jungle Book*; they did not acquire language and some never learned to stand up and walk as bipeds. There are critical periods for development and learning.

The French contribution to the pedagogy of sensory impairment has been important as exemplified by:

— Hearing impairment: l’Abbé de l’Épée founded the Institute for the Young Deaf, which still exists. He improved “dactylogy”, the use of fingers and hands to communicate (invented in Spain by Pedro Pons de Leon and his disciple Juan Pablo Bonet in the 16th century)

— Visual impairment: in 1784, Valentin Haüy founded an institution for the young blind which still exists in Paris. Louis Braille, who had become accidentally blind in childhood, developed around 1825 the alphabet named after him

— Mental retardation: Édouard Séguin, who had been trained by Itard, educated the deaf and dumb and developed a method for treating “idiocy” (1846).² He subsequently moved to the United States and became a physician. Désiré Magloire Bourneville, a neurologist, set up a ward for intellectually delayed children in Bicêtre at the end of the 19th century and contributed to the creation of special classes for these children in elementary schools. Alfred Binet and Théodore Simon developed in 1905 the first “metric scale of intelligence” to screen for mental retardation in elementary schools.

At the end of 19th century, the first books dedicated to child psychiatry were published. For example, Paul Moreau—from Tours—authored *On Madness Among Children* (Paris, J-B Baillière et fils, 1888). But the focus was only on discovering in children early forms of the mental disorders already known in adults, not to study the psychopathology specific to each age.

In the 20th century, there has been a growing interest in juvenile delinquents. In 1914, Georges Heuyer wrote a medical thesis, *Abnormal Children and Juvenile Delinquents: The Need for a Psychiatric Examination of School Pupils*. He organized the First World Congress of Child Psychiatry in Paris in 1937, and was the first to be offered a chair in child psychiatry in France, after World War II. He was not a psychoanalyst but welcomed psychoanalysts in his ward, Serge Lebovici among them. Lebovici later played a great role in the development of child and adolescent psychiatry nationally and internationally. He was President and later Honorary President of IACAPAP, as well as President of WAIHM and ISAPP.

Psychoanalysis has had an enormous influence on the development of child psychiatry in France, influence which has not declined as much as in other countries and as in adult psychiatry where the use of psychotropic drugs underscores the biological model. Of course, as elsewhere in the world, other trends have developed in France but the influence of psychoanalysis is still present and emphasizes:

- The personal history of the child
- His or her relationships with the family
- The importance of early interactions
- The meaning of symptoms
- The concern of combining quantitative and qualitative studies.

The therapeutic approaches used are multiple: psychopharmacological, cognitive-behavioral, systemic, psychodynamic, individual and group, ambulatory and residential. Allied professionals have an important function in therapeutic teams: social workers (almost always female), psychologists, speech-therapists (both often female), “psychomotricians” (a French specialty—professionals who work on motility, but are not physical therapists, who have a psychotherapeutic role, but are

not psychotherapists) and nurses (in residential care), among others.

The organization of care in France

In France we are able to see patients in intensive long-term treatment without being subject to the restrictions that insurance companies impose in our colleagues in the United States and elsewhere. Our social security system, founded by Charles de Gaulle in 1945, and our organization in catchment-areas that took place in 1960 allow this. The idea was to divide the country into geographical areas, the professionals in each area providing the whole range of psychiatric care to their local population (200 000 inhabitants for child and adolescent psychiatry).

The Alfred-Binet Center, where I have worked since 1961, was chosen to be a pilot for this model under the leadership of Serge Lebovici and René Diatkine. The main characteristic of the Alfred Binet Center was to consider all child and adolescent psychopathology in the context of psychoanalytical theory. This does not mean that psychoanalysis is prescribed for every patient. A whole range of individual and group treatments are available *totally free of charge*. Speech-therapy, for

example, has played an important role for speech disorders, "graphotherapy" for writing disorders. Psychoanalytic treatments usually consist of one or two sessions a week, exceptionally more—different from the preference of our American colleagues for 4 or 5 sessions a week (how do they find patients at that frequency?). We also have the option of working with the parents in various ways.

Psychoanalytic psychodrama³ is a form of treatment specific to the French: a team of psychotherapists receives a child or an adolescent (or an adult, in the case of adults); the young patient proposes a theme to be acted by him or her and the therapists; the director of the psychodrama intervenes to suggest modifications in the playing and interprets what happens. This is a useful treatment for difficult patients who do not verbalize easily.

Although I have used the past tense sometimes, our therapeutic options have not changed; we are still working in that way but we are going through worldwide economic difficulties and the quality of care is endangered both in France as elsewhere.

At the time Serge Lebovici left the Alfred Binet Center for Bobigny and the University of Paris-Nord

in 1978, he developed an interest in infants. An association had been created in the United States for infant psychiatry (WAIPAD), which held its second congress in Cascais (Portugal). French professionals who attended this congress returned enthused, joining those already working with babies—like Michel Soulé and Léon Kreisler—and those who were discovering this new field. The association changed its name into World Association for Infant Mental Health (WAIMH) and has a very active French-speaking branch.

Whatever the specific field in which we work, the importance of the early interactions is momentous. Perinatal psychiatry is a place for both therapy and prevention. It deals not only with the observation of behavioral interactions, but with an attention to interactions in fantasy. What parents feel has an impact on babies. But it is the baby who constructs his/her answer to the parents. There is no linear causality from parents to children; everything goes through the psychological apparatus of the child. If there were in the past psychoanalysts who put on parents' shoulders the burden of guilt, the emphasis today is on what we can do to help children and their parents.

The articles in the rest of this section illustrate our work. These texts may prepare readers of the Bulletin who plan to attend the 20th IACAPAP World Congress in Paris in 2012 for their discussions with French colleagues and for visits to professional sites. The theme of the Congress is "Brain, Mind and Development", a topic at the heart of our concerns.

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20th World Congress IACAPAP
July 21-25, 2012 Paris-France

20^{ème} Congrès Mondial IACAPAP
21-25 juillet 2012 Paris-France

Brain, Mind and Development
Cerveau, Psyché et Développement

Informations:
iacapap2012@orange.fr



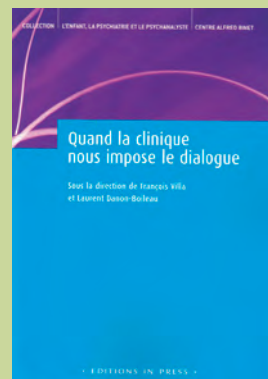
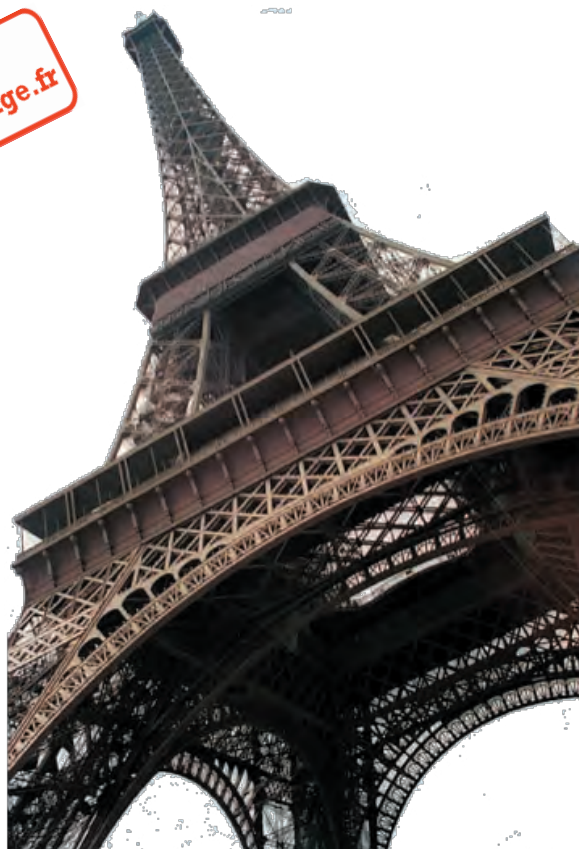
IACAPAP

International Association for
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Société Française de Psychiatrie
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Disciplines Associées



WHY SHOULD CHILD PSYCHIATRISTS BE INTERESTED IN RARE DISEASES?

Olivier Bonnot, Raffaella Lucanto, David Cohen

Rare diseases have a prevalence of nearly 2% in the general population (source www.orphanet.org). To be considered rare, an individual disease should have a prevalence of less than 1 in 2,000 people. Of note, most of these diseases affect only a few people, sometimes less than a dozen cases in France. Caring for these patients is a major issue in the public health system. Patients almost always face the so called medical wandering, a term that describes the need for the patient to typically attend various centres and medical professionals as diagnosis and treatment typically require a multidisciplinary approach. Difficulties may increase when psychiatric symptoms, especially behavioural impairment, occur. Thus, medical practitioners who are qualified in their area of expertise may not be familiar with rare disease. Psychiatrists are not comfortable with heavy somatic pathology and paediatric and genetics professionals are equally uncomfortable with psychiatric symptoms. One answer to this health care issue has been provided by the French government with the 2004-2008 Rare Disease Program Certification. More than 250 medical units have been certified in various domains of rare disease, primarily genetic anomalies. Many rare diseases include nervous system tropism, with consequences for neurodevelopment and association with psychiatric symptoms. A majority of rare diseases are associated with mental retardation, which requires specific education and learning programs.

Our topic in this short paper is not the unspecific psychological consequences for patients and their families when a severe disease is diagnosed. Rather, we are interested in instrumental impairments, learning disabilities, behavioural symptoms, and psychiatric diseases indirectly or directly associated with many rare genetic diseases. Three examples below illustrate why psychiatrists should be interested in rare disease.

Tuberous sclerosis

Tuberous sclerosis (TSC) is a heterogeneous genetic disorder with an estimated incidence rate of 1 in 8,000 to 1 in 30,000 births per year. Two genes are involved in approximately 50% of the reported cases: TSC1 (chromosome 9q34) and TSC2 (chromosome 16p13). Beyond the classical somatic symptoms, mental retardation (MR) and seizures are frequent (40% and 60% of the patients, respectively). The severe (as opposed to mild) psychiatric phenotype typically includes severe MR, seizures, language disorders, and Kanner-type autism [1]. Language abilities are impaired in the majority of individuals with TSC, although there is a wide range in the severity of this impairment. The mild phenotype of TSC is typically associated with normal early development, learning disabilities (e.g., dyscalculia), motor coordination impairments, attention deficit, and visual-spatial

deficits [2]. Although attention-deficit hyperactivity disorder (ADHD) is reported in more than 50% of individuals with TSC [3, 4], attentional difficulties are frequently observed in individuals with TSC without a diagnosis of ADHD. However, few reports on neuropsychological profiles and psychiatric symptoms in TSC have been published. Increased knowledge in this field could be useful for patients and caregivers by providing a functional diagnosis. This functional diagnosis would include psychiatric, cognitive, language, logic, psychomotor, and visuo-spatial assessments, which are essential to helping and caring for patients.

Catatonia

Catatonia is a rare and severe psychiatric syndrome. In contrast to their adult counterparts where bipolar disorder is the most common, schizophrenia is the most frequently associated diagnosis in the child and adolescent population [5]. Catatonia is often misdiagnosed when symptoms are not motor, such as echolalia, mutism, refusal to eat, acrocyanosis, verbigeration and social withdrawal [6]. When encountered in a child and adolescent clinic, the syndrome must lead to specific investigations because it can be caused by a physical illness, usually a neurological, infectious, intoxication or genetic condition. Given that there is likely a bias in reporting organic cases, an estimation of the proportion of organic conditions in catatonic youth is 15-20% [5]. The importance for clinical practice resides in the potential availability of an effective treatment for the underlying illness (e.g., plasmatic changes in catatonia associated with lupus erythematosus [7], D-Penicillamine in Wilson disease). The syndrome is rare but severe and can potentially be lethal. The stakes are large not only for reducing psychiatric symptoms but also for changing the course of metabolic or neurological diseases. Apart from a thorough clinical history, systemic and neurologic

examination, there are investigations that may assist clinicians in making a diagnosis. These are summarised in the Figure (next page).

Cerebrotendinous xanthomatosis

Cerebrotendinous Xanthomatosis (CTX) is an autosomal recessive disease of biliary acid synthesis. It is caused by mutations in the gene CYP27A1, localized in the long arm of chromosome 2 and coding for the mitochondrial enzyme sterol 27 hydroxylase. The metabolic block causes a progressive storage of cholesterol that is deposited in many tissues including the brain and tendons [8]. CTX is associated with non-specific psychiatric symptoms and physical signs including tendinous xanthomas, cataract, diarrhea and neurological signs. Acute psychotic episodes have been described but most psychiatric symptoms occur during childhood or adolescence and are non-specific [9, 10]. Given the cumulative effect of cholesterol accumulation, the course of symptoms parallels diagnostic delay. As an example, we describe two siblings with an early



David Cohen

University Hospital Pitie Salpetriere



psychiatric presentation of CTX with ADHD and oppositional defiant disorder (ODD) followed by regression to mild intellectual disability and major behavioral impairments. In both cases, treatment with chenodeoxycholic acid improved externalizing symptoms and led to the partial recovery of cognitive impairments. The reported cases suggest that the presence of gradual cognitive deterioration after normal early development, learning disability, externalizing disorder and diarrhea in children should lead to the investigation of metabolic disorder. Knowledge of specific signs and symptoms of treatable neurometabolic diseases is crucial.

The French government has certified one center for psychiatric symptoms in rare disease. In all the other centers (250) there are few psychiatrists or psychologists. However, functional diagnoses, in addition to the etiological diagnosis, could be useful for patients. The above examples show (i) the importance of a functional diagnoses in guiding professionals in caring for these patients and planning an integrative treatment; (ii) the need that professionals be aware that psychiatric and cognitive signs are associated with rare diseases (sometimes treatable) and that improvement in psychiatric and cognitive symptoms (often the first symptoms observed) is greater when diagnosed and treated early; and (iii) the importance of knowing about severe forms of psychiatric disease, such as catatonia, that have specific symptomatic treat-

ments (e.g., lorazepam) and a high prevalence of comorbid organic conditions (up to 20%).

For further information: <http://crepsymar.aphp.fr>

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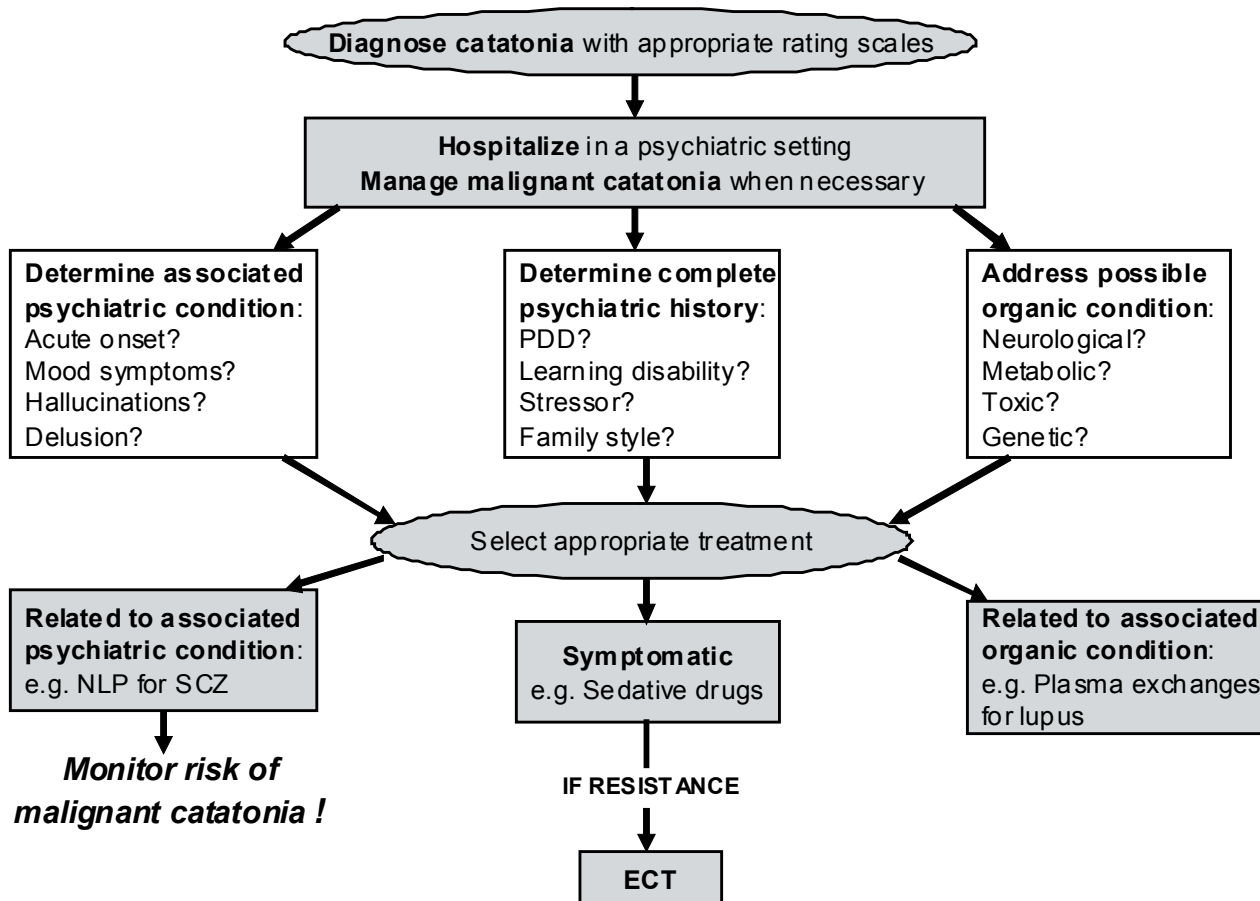
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Olivier Bonnot MD, PhD, Raffaella Lucanto PsyD, David Cohen MD, PhD


Centre for Rare Disease with Psychiatric Symptoms (<http://crepsymar.aphp.fr>); Department for Child and Adolescent Psychiatry, University Hospital Pitie Salpetriere/Assistance Publique-Hôpitaux de Paris; 47 boulevard de l'hôpital, 75013 Paris, France.

E-Mail olivier.bonnot@psl.aphp.fr

Figure. Catatonia in children and adolescents: a multimodal framework for evaluation and treatment



PDD: pervasive developmental disorder; NLP: neuroleptic drug; SCZ: schizophrenia; ECT: electro-convulsive therapy. (from Lahutte et al., 2008)



FAMILY-BABY PSYCHOTHERAPIES IN TRANSCULTURAL SITUATIONS

M R Moro, D Rezzoug, A Harf, O Taïeb, T Baubet

Transcultural psychiatry is a method that devotes equal time to the disorder's cultural dimension and to an analysis of psychological functions. It has existed in France for more than 30 years. It has two methodological reference points, psychoanalysis and psychiatry and anthropology (Devereux, 1972). Transcultural psychiatry requires decentering. It accepts a critical reading of the classification of data, which leads to a revision of nosological classifications.

Basic principles of transcultural psychiatry

The first principle is psychological universality: psychic function is that which defines a human being. It is the same for each one. The second principle refers to another universal human characteristic, that all men and women have a culture, which is perhaps the foundation of their humanity and universality. One of the approaches of transcultural psychiatry is to work on the specific without speculating on the universal—not immediately knowable but too often inferred without passing through the specific. Based on these principles, we use a complementary methodology incorporating anthropology to understand collective representations and psychoanalysis to understand individual meanings.

The technical setting

We work mostly with babies and families. We invite the entire family to the session: mother, father, children, other family members and the team that referred the family to us. They settle into a group formed by the principal therapist and co-therapists of varying nationalities and ethnic groups, speaking a wide range of languages. Sometimes, especially for families from Africa—where a myriad of languages and dialects exist—an outside interpreter may be necessary. Parents are always given the option to speak in their own language.

This multi-professional and polyglot group (including psychiatrists and psychologists) fulfils three functions for the family and child. (1) It is made up of diverse representations of otherness—of women and men, of whites and blacks, of neither white nor black, close relatives, close relatives of relatives and so on to distant relatives. These parcels of otherness embodied by group members and represented in space enable the family to experiment with another form of otherness that is neither monstrous nor threatening or destructive, but on the contrary is an otherness that is representable and creative. (2) The group provides a second function regardless of the planned clinical situation: that of holding. Once the family is sufficiently "held" by the group, it can in turn "hold" the child. The same logical process is recognizable: A is to B what B is to C. With the child acknowledged in his otherness and effectively held, an exchange relationship can then be established. (3) The group provides the materialization of the passage from one universe to the other. This is a very important function for the

child who often identifies with the interpreter and leans on him/her to do this difficult work of linking (outside/inside).

The cultural representations surrounding the baby can be divided into three levels of complexity. First, there are representations concerning the nature of the infant (ontological level): What is a baby? What does he need? What is a mother? What is the father's role/place? Second, there are etiologic theories concerning the nature of the infant's disorder, delayed development, sleeping problems, mother-infant difficulties; such theories may reflect belief systems involving jinx, witchcraft, attack by spirits and so forth. Third, there are cultural representations of care. Depending on the ontological



Marie Rose Moro

and etiological level, parents' expectations do not necessarily correspond to what is proposed: protection, humanization, divination, breast feeding or bottle feeding, massaging or not, going to a healer or a medical doctor.

Furthermore, certain migrations are traumatic and the arrival of an infant forces the parents to face this trauma in order to construct their parental position harmoniously. All post-partum pathologies and the different forms that they can take depending on the cultural origins of the mother prove this: inhibitions are related to witchcraft theories and, on the contrary, excitement is linked to the representation of possession. Finally, the therapist should elaborate his/her position concerning the difference in culture to not apply ethnocentric judgments either on the parents or the child. The elaboration of this cultural counter-transference is indispensable in order to establish an efficient framework to allow parents to talk about their suffering with their own choice of words and images.

In this setup the two worlds that structure the child can be used and bridges between these worlds can be built. The parents' world with its specific cultural representations about the child, its disease, the causes, the way to treat it, and the outside world with its own rationales. The therapeutic process consists in allowing the child to rebuild a filiation

(insertion in the generations) and affiliations (insertion in groups). Affiliation requires a necessary and transitory passage through the parents' cultural representations. Rebuilding a filiation without reference to affiliations is not enough for the children of immigrants. Relying on cultural representation opens the way for conceiving these affiliations in order to help the child build his own road, which for the children of immigrants will be of mixed color.

Here and there, we will praise human complexity, his alterity, and the necessity to take into account this singularity in order to better understand and treat babies and their families whatever their color or culture.

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MR Moro. PhD, MD, Professor of Child and Adolescent Psychiatry, University Paris Descartes; Head of the Department of Child and Adolescent Psychiatry, Cochin et Avicenne Hospital (Assistance Publique, France); Technical Advisor, Doctors Without Borders (MSF); Editor-in-Chief of the journal *L'autre*. France. www.clinique-transculturelle.org. D Rezzoug MD and T Baubet MD, Child psychiatrists at the department of Child and Adolescent Psychiatry (Bobigny, France); Lecturers at the University Paris 13; Consultants, Doctors Without Borders (MSF). A Harf MD and O Taïeb MD, Child psychiatrists at the department of Child and Adolescent Psychiatry (Bobigny, France), University Paris 13.





MAISONS DES ADO- LESCENTS

Aurélie Harf, Marie Rose
Moro



Aurélie Harf

“Maisons des Adolescents” literally means “Houses for Adolescents.” This is the term used for adolescent-specific clinics. The Maisons des Adolescents were initiated in France in 2004 as a result of two observations. First, the lack of medical facilities and counseling centers specifically designed for adolescents (aged between 12 and 21 years). And second, the absence of services where adolescents, their families and the various professionals caring for adolescents within a given area, could come together and connect. There are now 59 Maisons des Adolescents in France. The government’s goal is to create at least one per district [what does ‘district’ mean – e.g., approximately how many people]. These clinics are meant to give adolescents quick access to any form of multidisciplinary help they may need, be it health, social services, educational or legal aid.

There are various types of Maisons des Adolescents, each has specific circumstances (within a hospital or not, part of a psychiatric department or not, with or without in-patient beds), but all share common goals: to inform, counsel, and support adolescents, their families, and the professionals working with them.

How can an adolescent go to a Maison des Adolescents?

Access to a Maison des Adolescents is free cost, confidential and easy —i.e. without appointment and without prior parental consent. Minors [how young? 12? 13?...] can be seen without their parents during the first few appointments; involving parents can be subsequently negotiated. Reasons for consultation can be physical, psychological, educational, social or legal. Adolescents themselves seldom seek a consultation. Sometimes relatives are the ones who call, but more often it will be a professional in contact with the teenager. Therefore, an essential part of the groundwork is to create a good referral network. Each Maison des Adolescents belongs to a network and is well-grounded in its area, thereby encouraging all types of cooperation and connections between health professionals (institutional or private), the Board of Education, social services, child protection services, local administrations and associations. Any professional working with adolescents within a given area is part of this network whose goal is to increase prevention and avoid interruptions of care. The Maisons des Adolescents participate in raising awareness and in training professionals who work with teenagers. Professionals seeking an opinion on a teenager or who need advice on his referral can also contact the Maison des Adolescents for help.

There are many reasons for consultation: teen-angst, family conflicts, anxiety-depression, language disorders, behavior disorders, self-aggressive acting-outs, suicide attempts, eating disorders, school refusal, school phobia or drop-out, psychological disorders linked to a chronic somatic pathology, addiction (cannabis, alcohol, other drugs), psychotic disorders, ill-treatment, trauma, and neurotic disorders among others.

What can a Maison des Adolescents offer adolescents and their families?

They will first be met by a multidisciplinary team that will welcome them, listen to them, inform them and assess their needs. Subsequently, depending on each particular case, they will be referred either

to an adolescent psychiatrist, a general practitioner, a specialist physician (pediatrician, gynecologist, dietician, endocrinologist), or to a facility offering individual psychoanalytical or cognitive-behavioral therapy, group therapy, occupational therapy, relaxation or speech-therapy. The use of different mediators [?? What does this means?] encourages creativity and the expression of suffering and conflicts. Other forms of help can also be provided, such as social assistance, educational support and legal aid.

Patients and their families can also access transcultural consultations and family therapy. Indeed, informing parents and assisting them is one of the Maisons des Adolescents’s core missions. After the initial assessment stage, parents can be referred to a support group or to another institution for help. The Maisons des Adolescents have strong links with parent-specific institutions.

If hospitalisation is needed, the adolescent can be admitted to the Maison des Adolescents itself if it has in-patient beds (for instance, the Maison des Adolescents at Cochin Hospital in Montparnasse), or to partner hospitals (such as the closest pediatric ward for example). The Maisons des Adolescents are therefore multipurpose institutions where every aspect of care is taken into account, be it physical,

“Access to a ‘Maison des Adolescents’ is free of cost, confidential and easy — i.e. without appointment and without prior parental consent”

psychological, relational, social or educational.

For further information go to:

<http://www.derpap.com/ressources/mda.php>

<http://travail-solidarite.gouv.fr>

Aurélie Harf MD, Department of Child and Adolescent Psychiatry and General Psychiatry, Avicenne Hospital, AP-HP, Paris 13 University, EA 3413, Inserm U669, 125, rue de Stalingrad, 93000 Bobigny, France. aurelie.harf@avc.aphp.fr Marie Rose Moro PhD, MD, Professor of Child and Adolescent Psychiatry, University Paris Descartes; Head of the Department of Child and Adolescent Psychiatry, Cochin et Avicenne Hospital (Assistance Publique, France); Technical Advisor for Doctors Without Borders (MSF), Editor-in-Chief of the journal L’autre. France. www.clinique-transculturelle.org

SPAIN RECOGNISES THE SPECIALTY OF CHILD AND ADOLESCENT PSYCHIATRY

Bernat Soria, the Spanish minister for health at the time, announced on April 6, 2009 that child and adolescent psychiatry (*psiquiatria infanto-juvenil*) was to be formally recognized as a medical specialty.

“This has been a surprise but the happy outcome of more than 30 years of lobbying and advocacy” said Dr Maria Dolores Dominguez Santos, President of the Spanish Association of Child and Adolescent Psychiatry (*Asociación Española de Psiquiatria del Niño y del Adolescente*, AEPNYA) full member of IACAPAP. For many years our Spanish colleagues, supported by IACAPAP, have worked tirelessly to achieve this recognition, necessary to recruit more and better-trained child psychiatrists. It is of note that Spain, a developed country and member of the European Union, has more than 2,600 psychiatrists working in their public health system. The first resident training posts in child and adolescent psychiatry are expected to be available in 2011.

Success was achieved thanks to the alliance between child mental health professional associations—AEPNYA, the Spanish Society of Psychiatry and Psychotherapy of Children and Adolescents (*Sociedad Española de Psiquiatria y Psicoterapia del Niño y del Adolescente*, SEPYPNA, also a full member of IACAPAP) and the child section of the Spanish Association of Neuropsychiatry (*Asociación Española de Neuropsiquiatria*, AEN)—and a consumer group set up for this purpose, the Platform of Families for the Creation of the Specialty of Child and Adolescent Psychiatry (*Plataforma de Familias para la Creación de la Especialidad de Psiquiatria Infantil y Juvenil*). This Platform was umbrella for more than 300 patient groups across the country. This highlights how important coalitions between professional and patient advocacy groups are to influence government and achieve improvements in child mental health—a good model for other countries with similar issues.

“I received the news on the phone directly from the minister. I cried madly and cannot believe it yet” said Lola Palomino, the co-founder of the Platform. “This was a difficult decision, but necessary. It is not a mistake; it will change the course of mental health in Spain” she added.

Dr María Jesús Mardomingo, former president of AEPNYA, had lobbied for this outcome for a long time and was immensely pleased to hear the news: “We finally achieved it!” However, Dr Maria Dolores Dominguez Santos warns that much work remains to be done. In particular, negotiations with the regional governments (*Autonomías*), which have a strong voice in the implementation of these changes, may prove difficult. “We are full of energy and enthusiasm and prepared to do all the work still required.”

Demonstration by Platform supporters in front of the Ministry for Health building in Madrid, April 30, 2008



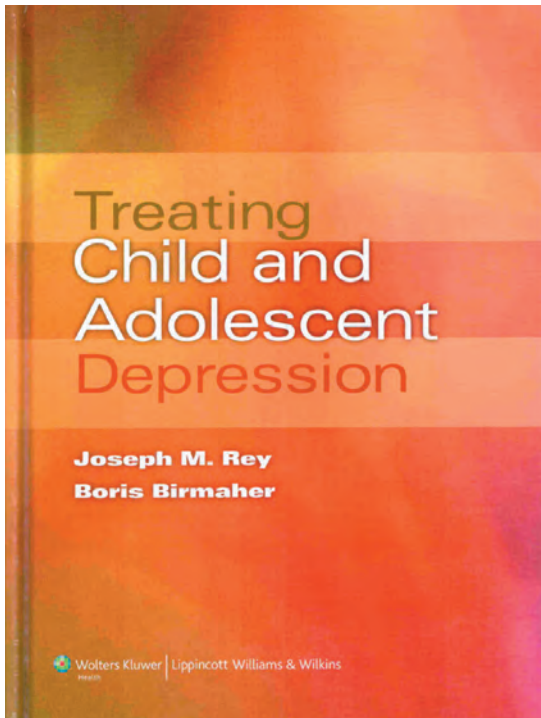
Poster of the Platform seeking support

“We are full of energy and enthusiasm and prepared to do all the work still required”



Dr Maria Dolores Dominguez Santos, President of AEPNYA

A new resource for the treatment of child and adolescent depression



Treating Child and Adolescent Depression. Rey JM, Birmaher B (editors). Philadelphia: Lippincott Williams & Wilkins, 2009, pp. 260. ISBN-13: 978-0-7817-9569-2

A recently published book on the treatment of depression counts among its contributions well-known researchers and clinicians working on this area, such as David Brent, Graham J. Emslie, Judy Garber, Ian M. Goodyer, Stanley Kutcher, and Laura Mufson, to name a few.

The book, edited by Joseph Rey from Sydney University (and editor of this Bulletin) and Boris Birmaher from the University of Pittsburgh, seeks to make evidence-based, up-to-date information on the treatment of child and adolescent depression available but also to offer practical advice on the implementation of a wide range of interventions in a variety of clinical situations (e.g., when depression does not respond, when depression is comorbid with other disorders) and when treatment is delivered in particular settings, such as primary care, paediatric medical wards, or cross-culturally.

The focus is on “how to,” in giving as much practical advice as possible on how to deal with common and uncommon clinical circumstances that arise during treatment, such as when patients are noncompliant, become homicidal or suicidal, develop side effects, or when there is family discord. To that end, most chapters include resources for patients, families, and practitioners, as well as information sheets, rating scales, and other potentially useful aids—most in the public domain, thus able to be used, reproduced, or handed out.

The first section of the book (three chapters) describes general aspects of depressive illnesses, aetiology, and assessment. The second section (17 chapters) discusses practical management, covering topics as diverse as treatment resistance; engaging, involving, educating, and supporting patients, families, and schools; how to use a variety of treatments (pharmacologic, interpersonal psychotherapy, family therapy, complimentary and alternative medicine, psychodynamic etc.); preventing and dealing with side effects and with crisis in the course of treatment; and managing depression in primary care settings. The third section (four chapters) deals with the problems of treating paediatric depression in special groups: the chronically ill, the developmentally disabled, those from culturally diverse backgrounds, and international views and practices.

In the words of Gabrielle A. Carlson MD, Professor of Psychiatry and Paediatrics, Stony Brook University School of Medicine: *“It is quite surprising, given the interest in mood disorders in children and adolescents, that there really are no recent volumes on treating depression in young people written for clinicians. Many volumes are available to the lay public. And there are books on childhood depression and on treating adults. This book, however, not only provides a thorough grounding for clinicians of all sorts who treat young people, it does so in a user-friendly way... As it stands, ‘Treating Child and Adolescent Depression’ will remain an extremely important source of information for many years to come.”*



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Martin Beckmann

EVOLVE

A service to help children in care Queensland, Australia

“It is a delight working in a public health system that allows longer term therapy, input and advocacy for these vulnerable children”

When for whatever reason parents can no longer care for their offspring, the state —on behalf of society— may act on their place. However, children ‘in the care of the state’ do not have a reputation for getting the best deal. Regularly children in care receive critical media attention and, in Australia, these child care systems have frequently been in the news. I am a child and adolescent psychiatrist working in Queensland for a service exclusively helping children in the care of the state. I briefly report the history of our service and describe the tragic events that triggered the government’s response. I report also how our service works.

Queensland is the North Easterly Australian State with 4.3 million people, about 20% of population of Australia. Its society is multicultural and multiethnic. 3.3% of the people are of aboriginal descent. About 34% of the people are younger than 25 years. Since 2006, Queensland has a specialist child and adolescent psychiatry-led therapeutic service exclusive for children in the care of the State.

Background

The Queensland government commissioned in 2004 an inquiry into the abuse of children in foster care (1). Incidents reported at the time included abuse by foster carers, ongoing exposure to the perpetrator and harm inflicted to children whilst in care. Individual workers were found responsible but overall systemic faults were also found and required change. The inquiry made 110 recommendations covering child-focussed reforms, foster care reforms, indigenous reforms, legislative enhancements, strengthened partnerships and internal reforms. A progress document in 2006

shows that 89 recommendations have been implemented (2).

Two of the recommendations are in my view the most important for child and adolescent psychiatry. One was the need for a specific therapeutic service for children in care, which was called “Evolve” —the name was decided upon following a survey of clients. The other was for devolution of the department of social services at the time (Department of Families) into a department of child safety (exclusively dealing with child protection concerns) and a department of communities.

The service

An Evolve team typically consists of a child and adolescent psychiatrist, clinical leader of the team, the team leader who has organisational responsibility, allied health clinicians like psychologists, social workers, occupational therapists and nurses, and a “senior indigenous health worker” of aboriginal background. The team is also supported by clerical staff, a professional development coordinator and a service evaluation research coordinator. At an administrative level Evolve has two branches, therapeutic services and behaviour support team. The latter is not led by a child psychiatrist and has a disability focus, i.e., children with low IQ, developmental disorders with severe handicap and autism spectrum disorders.

Evolve is now in its third year. Currently there are seven teams and two more are being set up, so that all of the state is covered by an Evolve service. There are differences between an Evolve service and a standard child and youth mental health service. Evolve focuses on attachment and trauma



The Evolve team at Logan, Queensland, after a training day

work and has special confidentiality guidelines which allow sharing information on a need to know basis.

The role of the child and adolescent psychiatrist includes a case load, as well as clinical and team supervision and working in close liaison with the administrative team leader.

Each child has a "stakeholder group" consisting of all the relevant parties. These can include biological parents, foster parents, teachers, NGOs, sometimes forensic services and youth workers and, if the child is in-out-of-home care, the workers involved in that. A child can therefore have a group of up to 20 stakeholders that need to be involved or receive support in addition to the identified patient.

Referral to Evolve

Referral can only be instigated by the Department of Child Safety (DChS). A child safety officer would firstly discuss a referral with the team leader of DChS. Once this is approved, the case is discussed with a panel consisting of representatives from DChS, Evolve, education, and disability services. Once the case is accepted, involvement would initially be for 18 to 24 months, which can be extended. Clients are reviewed at least every 3-months. Children are rarely referred for assessment only.

Conclusion

Evolve provides a great opportunity for children in the care of the State of Queensland. The fact that the Queensland government funds therapeutic services exclusively for children under its care is encouraging. It is a delight working in a public health system that allows longer term therapy, input and advocacy for these vulnerable children.

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K M Beckmann, Affiliate member with RANZCP, MRCPsych UK, 3. Staatsexamen Munich, Germany. Consultant in Child and Adolescent Psychiatry with Evolve Therapeutic Services Logan, Queensland, Australia

Email: martin_beckmann@health.qld.gov.au



Olayinka Omigbodun

IACAPAP STUDY GROUP ABUJA, NIGERIA 19-21 OCTOBER 2009

The 2nd IACAPAP study group in sub-Saharan Africa will be held in Abuja, Nigeria, October 19-21, 2009 — a very exciting event for both faculty and participants in first IACAPAP study in sub-Saharan Africa (March 17-20, 2007, Nairobi, Kenya) as several of us will be meeting again.

Brian Robertson (South Africa) was the leader of the first study group with Olayinka Omigbodun (Nigeria) as co-leader and Myron Belfer (USA), Alan Flisher (South Africa) and Rachel Kang'ethe (Kenya) as full time faculty. There has been much progress in child and adolescent mental health (CAMH) in Africa since this initial meeting and is anticipated that our coming together again will further strengthen CAMH in Africa. The aim of the Nairobi study group and of the one to be held in Abuja remains the same: 'To promote the development of effective and sustainable child and adolescent mental health care in Africa.' The Nairobi study group primarily aimed at developing leadership skills through sessions on leadership, policy, service development, training, service management and cultural competence. As a result of feedback from participants and discussion among faculty, the Abuja study group will focus on strengthening clinical assessment and problem solving skills and training in a range of therapeutic interventions such as CBT.

Three of the previous faculty, Brian Robertson, Myron Belfer and Olayinka Omigbodun will be leading this group. A full day CBT course will be taught by Cornelius Ani, an African child psychiatrist based in the United Kingdom. We also hope that a child psychiatrist based in Eritrea will facilitate a session on perinatal mental health and child development in primary health care.

IACAPAP STUDY GROUP

Held at Kenya School of Monetary Studies, Nairobi
17th - 20th March, 2007

Seated L - R Dr. Oluwiyemi Ogun (Nigeria), Dr. Birke Abesse (Ethiopia), Dr. Monique Mucheru (Kenya), Dr. Ntone Felicien (Cameroon), Dr. Ruth Kizza (Uganda), Dr. Puleng Mokoena - Molepo (South Africa).

1st Standing L - R Dr. Keith Kirimi (RSA), Dr. Rachel Kang'ethe (Kenya), Dr. Dolores G. Moreno (USA), Prof. Alan Flisher (RSA), Dr. Olayinka Omigbodun (Nigeria), Dr. Tolulope Bella (Nigeria), Dr. Yonas Baheretibeb (Ethiopia).

2nd Standing L - R Prof. Brian Robertson (South Africa), Dr. Patricia Ibeziako (Nigeria), Dr. Okello James (Uganda), Dr. Myron Belfer (USA), Mr. Preston Garrison (USA), Dr. Naoufel Gaddour (Tunisia).

Seven of the participants in the Nairobi study group are able to attend the Abuja study group also, one of them, Naoufel Gaddour (Tunisia), will this time be participating as faculty. Others expected to attend include Monique Mucheru (Kenya), Oluwayemi Ogun (Nigeria), Puleng Mokoena-Molepo (South Africa), James Okello (Uganda), Tolulope Bella (Nigeria) and Keith Kirimi (South Africa). Two others, Birke Anbesse and Yonas Baheretibeb (Ethiopia) are unable to attend because both are undergoing training in child psychiatry outside of their country. There are applicants from several Anglophone and Francophone African countries to fill the additional places. Fortunately we have faculty competent in both English and French language.

Despite logistic difficulties and the high cost of travel in the African continent, we are forging ahead with arrangements and looking forward to another excellent IACAPAP study group. This study group will take place just before the World Psychiatric Association regional conference —also in Abuja (October 22-24, 2009) — and most of the faculty and participants will stay on and attend the conference where the African Association for Child Mental Health (AACAMH) will meet and hold a symposium.

Olayinka Omigbodun

2009 SA ACAPAP
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17th Biennial South African Association for Child & Adolescent Psychiatry & Allied Professions Congress

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FORTHCOMING EVENTS IN ABUJA, NIGERIA, SEPTEMBER 2009

- IACAPAP study group: September 21 to 23
- World Psychiatric Association Regional Meeting: September 24 to 26
- Norman Sartorius's leadership training for young psychiatrists and allied professions: September 27 to 29



Ulf Engqvist holding his thesis, nailed to the bulletin board of the Department of Child and Adolescent Psychiatry of the *Karolinska Institutet*, Sweden

Follow up into adulthood of former child and adolescent psychiatric patients in Sweden

Ulf Engqvist at the *Karolinska Institutet* in Stockholm, Sweden has just defended his thesis, "Suicides, Psychotic Disorders and Criminality among Former Child and Adolescent Psychiatric Patients Followed into Adulthood". In Sweden, the training program for a PhD examination covers four years of full-time work. During this period the student completes PhD courses and conducts a research project. The results are usually published as a summary of four (or sometimes more) individual papers covering the topic of the project. The majority of the papers should have been published in peer-reviewed journals. The results may also be presented as a monograph.

Ulf Engqvist has described the results of his research in the three papers: "Death and suicide among former child and adolescent psychiatric patients." *BMC Psychiatry* 2006, 6:51; "Child and adolescent psychiatric patients and later criminality." *BMC Public Health* 2007, 7:221; and "The occurrence and nature of early signs of schizophrenia and psychotic mood disorders among former child and adolescent psychiatric patients followed into adulthood." *Child Adolescent Psychiatry Mental Health*, 2008, 2:30. A fourth paper, "Young adult and middle-aged psychiatric patients - a comparison of those with and without a history as recipients of child and adolescent psychiatric care," has been submitted for publication.

Three weeks before the dissertation the thesis is made public by nailing it in the Library of the *Karolinska Institutet*. This follows an old tradition going back to the 1400s; the Dean signs the thesis as approved and it is then actually nailed to a stock in the Library. We have a local tradition too; the thesis is also nailed at the notice board at the department, as seen in the picture.

Swedish child and adolescent psychiatry has a very long tradition of using longitudinal prospective approaches as well as cross sectional designs to describe the mental health outcomes for children, former child and adolescent psychiatric patients, and different cohorts of children at risk. We have now prospective studies going from 1928 to 2003; the majority of the studies cover the period from the 1950s to the 1980s. Ulf Engqvist's thesis is one in a group of upcoming studies that will fill the gap from 1980 until today.

Despite great societal changes from the 1920s until now, rather similar results have been found. The "typical" boy coming for child and adolescent psychiatric assessment is a "10-year old with behavioural problems" while the "typical" girl is "14-years old, sad and depressed".

The results of the present study have been compared to the follow up of 2000 child and adolescent psychiatric (CAP) patients from Stockholm outpatient services in the early 1950s. They were followed for 20 years and the results were presented by Ingvar Nylander in *Acta Paediatrica*, Suppl. 276 in 1979. When comparing the two cohorts of CAP patients, the number of individual boys and girls assessed and treated either in CAP or general psychiatry from psychotic disorders —bipolar disorder or schizophrenia— were few, while the main negative outcomes are becoming delinquent or abusing substances in adulthood. It is alarming that the risk for boys of having a criminal record in the present study is twice as high as boys in the 1950s. Even more alarming is that the corresponding risk for girls has increased almost seven fold! "It seems plausible that the changes in the organization of child social welfare work and the school system, the change of treatment strategies in Swedish CAP (when the multimodal way to assess and treat children was abandoned in favour for psychotherapeutic treatment approaches) and the decline of collaboration between CAP, school psychiatry and child social work that took place from 1970 until today, as well the increased consumption of alcohol in the Swedish population from the 1970s has contributed to today's higher criminality risk among CAP-patients."

Of course, a study of this kind has a number of limitations. It is also "tricky" to compare these results with those of studies from outside Sweden or other Nordic countries. One reason is that child and adolescent psychiatry in Sweden was established to promote mental health, this is why it was free of charge until the mid 1990s —when a small "symbolic" fee was introduced. There have been no economic restrictions for CAP professionals in how to assess and treat children, which could be different to other countries. Nevertheless, the results may be of interest for other countries and cultures.

Per-Anders Rydelius

News from Turkey

Professor Nese Erol and colleagues have set up a website for the Turkish Association for Infant Mental Health (WAIMH). The first issue of the Turkish Bulletin of Infant Mental Health is available at that website [www.bebekruhsagligi.org.tr] Below are the front page of the Bulletin and an English version of the last page .

As part of the education program, Professor Nancy Cohen from Canada's Toronto University has been in Istanbul on May 16 and 17 providing training on "Watch, Wait and Wonder: an Infant-Led Approach to Infant-Parent Psychotherapy".



THE TURKISH ASSOCIATION FOR INFANT MENTAL HEALTH



We would like to increase family awareness that **pregnancy** is a critical period that stands to make a great impact on their lives.



We would like to encourage better understanding that **mental health of caregivers'** affects the mental health and developmental well being of infants and young children.



We would like to develop increased awareness that infancy and early childhood should be regarded in the context of the **life cycle**



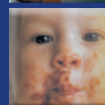
We would like to provide awareness that infancy and early childhood is also an important transitional period **across generations**



We would like to promote the awareness that the first 3 years of life should be considered as a **critical period** relevant to all aspects of development



We would like to promote the understanding that psychological development during infancy and early childhood has an effect on **later normal development** as well as **emergence of psychopathology**.



We would like to establish the principle that "**wait and see**" **policies are not good for promotion of child development**. Instead, behavioral, emotional and developmental problems should be addressed as early as possible.



We would like to be the voice of all infants and toddlers irrespective of their circumstances. We know that we are responsible for supporting their rights, and that we also have the power to protect them.

To Unity and Sensible Hearts...



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- Asociación Argentina de Psiquiatría y Psicología de la Infancia y la Adolescencia (ASAPPIA)
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IACAPAP OFFICERS

www.iacapap.org

President

Per-Anders Rydelius MD, PhD

Professor of Child and Adolescent Psychiatry
Astrid Lindgren Children's Hospital
SE-171 76 Stockholm, Sweden
per-anders.rydelius@ki.se

Secretary General

Luis A. Rohde MD, MSc, DSc

Child and Adolescent Psychiatric Division, Department of Psychiatry, Federal University of Rio Grande do Sul
Rua Ramiro Barcelos 2350
Porto Alegre, RS, Brazil, 95035-003
Lrohde@terra.com.br

Treasurer

John B. Sikorski MD

The Children's Center at Langley Porter Department of Psychiatry
350 Parnassus Ave, Suite 309
San Francisco, CA 94117, USA
john.sikorski@ucsf.edu

Past President

Myron L. Belfer MD, MPA

Professor of Psychiatry
Harvard Medical School
Department of Social Medicine
641 Huntington Ave, 2nd floor
Boston, MA 02115, USA
Myron_Belfer@hms.harvard.edu

Permanent Secretariat and Archivist

Kari Schleimer MD, PhD

Mellanvångsvägen 45
SE-223 55 Lund
kari.schleimer@comhem.se

Honorary Presidents

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Vqanthonya@aacap.org

Colette Chiland MD, PhD

(France)
cchiland@orange.fr

Vice Presidents

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phyllis.cohen@yale.edu

Nese Erol PhD (Turkey)

erol@medicine.ankara.edu.tr

Kang-E Michael Hong MD

(Korea)
kmhong@snu.ac.kr

Barry Nurcombe MD

(Australia)
bnurcombe@uq.edu.au

Amira Seif El Din MD (Egypt)

amira@contact.com.eg

Samuel Tyano MD (Israel)

styano@post.tau.ac.il

Assistant Secretaries-General

Marie Rose Moro MD, PhD

(France)
marie-rose.moro@avc.ap-hop-paris.fr

Sadaaki Shirataki MD, PhD

(Japan)
shiratak@maia.eonet.ne.jp

Robert Vermeiren MD, PhD

(The Netherlands)
robert@vermeiren.name

Adjunct Secretaries

Suzanne Dean PhD (Australia)

suz.dean@bigpond.net.au

John Fayyad MD (Lebanon)

jfayyad@inco.com.lb

Joaquín Fuentes MD (Spain)

fuentes.j@telefonica.net

Andrés Martín MD, MPH

(USA)
andres.martin@yale.edu

Olayinka Omigbodun MD, MPH

(Nigeria)
fouryinkas@yahoo.co.uk

Brian Robertson MD

(South Africa)
brian.r@mweb.co.za

Andreas Warnke MD

(Germany)
warnke@kjp.uni-wuerzburg.de

Yi Zheng MD

(People's Republic of China)
yizheng@ccmu.edu.cn

Counsellors

Helmut Renschmidt MD, PhD

(Germany)
remschm@med.uni-marburg.de

Sir Michael Rutter MD, PhD

(UK)
j.wickham@iop.kcl.ac.uk

Ernesto Caffo MD (Italy)

caffo@unimo.it

Monograph Editors

Elena Garralda MD (UK)

e.garralda@imperial.ac.uk

Jean-Philippe Raynaud MD

(France)
raynaud.jph@chu-toulouse.fr

Communications Committee

Phyllis Cohen EdD (USA)

phyllis.cohen@yale.edu

Andrés Martín MD, MPH

(USA)
andres.martin@yale.edu

Bulletin Editor

Joseph M. Rey MD, PhD

(Australia)
jmrey@bigpond.net.au

