



Synapse



THE WEST HUDSON PSYCHIATRIC SOCIETY NEWSLETTER

Published Quarterly

Spring 2005 EDITION

Robert N. Sobel, M.D., Editor & Syed Abdullah, M.D., Co-Editor

"Happiness: Lesson From a New Science"

I heard something quite interesting on the radio the other day. I had just come out of a psychiatry staff meeting at my hospital. As usual, we were discussing threatened cutbacks, insurance rejections, dismantling of area outpatient programs, and absence of any place to refer desperately ill patients, issues all too familiar to the readers of this essay. In my car on the way to my office, I absentmindedly turned on the radio to hear an interview on a talk show. An author was saying "I tell all the young idealists I meet to go into psychiatry instead of international aid agencies or the like." He was Richard Layard, professor emeritus at the London School of Economics, internationally renowned expert on the impact of unemployment and inequality, and former advisor to both British and European Union governments.

Dr. Layard was discussing his recently published book, "Happiness: Lesson From a New Science" (Penguin Press, 2005), in which he presents a radical thesis. Economists and all those who depend on their methodology, like government officials, bankers, businessmen, have got it all wrong. The blind pursuit of economic growth for its own sake, as exemplified by GNP and a host of other statistical measures, does not at all correlate with growth of human happiness. He presents compelling data in his book showing this "decoupling" of economic growth and happiness in all societies studied. He also argues well that happiness can be measured every bit as accurately, at least across a population, as any other product or activity, and increasing the general level of

happiness should be first priority of civilized societies.

The book is written in clear, often humorous prose, unusual for an academic economist, and is rich with important ideas. I would like to present some random quotes that illustrate one of his central points:

"A final key element of (happiness) is health...mental disturbance causes much the greatest dissatisfaction with overall health...(depression) explains more of the variation in happiness than income does, even after we allow for the interrelation between poverty and depression. So mental illness is probably the largest single cause of misery in Western societies. According to the World Health Organization, mental illness or addiction causes nearly half of all the disability that people are experiencing...

For patients who become depressed, either drugs or weekly therapy lift about 60% of sufferers out of their depression...The cost of these treatments is not large relative to the huge improvement in well being. Yet the majority of people who are mentally ill get no treatment...

That is not the way to treat a major human problem. We spend too little on mental illness, compared to with other diseases. If we take the entire toll of disease, which includes both disability and premature death, mental illness accounts for a quarter of the total. Yet in the United States only 7% of health expenditures are targeted at mental illness, and in Britain only 13%. The share of public research expenditures is even less, at 5%.

Our priorities need a radical change. It is a scandal how little we spend on mental illness compared with, say poverty. In the fight against misery, psychiatry

is in the front line. Along the barricades of the twenty-first century, it is a key place where idealists should rally...Psychiatry should be a top branch of medicine, not one of the least prestigious."

What a splendid notion! I hope this important book finds a wide audience and sparks a broad reassessment of personal and national priorities. I'm not optimistic, however. Too many vested interests are hard at work maintaining the status quo. Nonetheless, I don't think I've ever come across anything so affirming of our work from someone outside our profession, and from a respected expert to boot. So, comrades, off to the barricades to fight our good fight! ▲



Andrew Hornstein, M.D.
President

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The Rights of Parents vs. Non-Parents

We frequently come upon situations in which a child is “temporarily” given to grandparents, other relatives or friends for safe-keeping while a parent is undergoing an extremely stressful situation, medical or psychiatric problems or other disruptions to their lives. In nearly all of these cases, of course, when the parent regains their “footing,” recovering from the crisis or stressful situation, their child is returned to them. In addition, in nearly all-

of these situations, courts are never involved in these movements of the child.

But, occasionally, in these situations when the parent turns to the “temporary caregiver,” that caregiver is resistant to returning the child, especially if the caregiver is a family member who may have had some conflict with the parent or who believes that the parent is not yet a suitable parenting figure. Then, the parent must resort to the court to demand that their child be returned. This may then open up allegations by the ‘temporary custodian’ relating to the ‘child’s needs’ and that the child’s best interests would be better served by remaining with that temporary caregiver.

In order to understand the circumstances of the ultimate court battle, one must recognize certain aspects of law with regard to parenting. Generally, the rights of a parent to establish a home and bring up children is a fundamental right, beyond the reach of any court, and no court can, for any but the gravest reasons, transfer a child from his natural parent to any other person. In essence, biological parents have a right to the care and custody of their child outweighing the rights of all others, unless the parent has abandoned their child or is proven unfit to assume the duties and privileges of parenthood.

In the same way, the child has a right to be reared by its parent unless there are exceptions created by “extraordinary circumstances.” The courts have always adhered to a generally accepted view that a child’s best interest is to be raised by its parent unless the parent is disqualified by gross misconduct. Between parents and non-parents, courts cannot supplant parents except for grievous cause or necessity.

In case law, courts have defined limited situations in which they would be warranted to inquire whether the best interests of a child dictate displac-

ing the parents custody to that of a nonparent. These would include permanent surrender of the child, abandonment, persistent neglect, unfitness of the parent, unfortunate or involuntary extended disruption of custody or similar extraordinary circumstances. Other than the above, courts cannot displace a child to a non-parent simply because it believes that the non-parent would “do a better job in raising the child.” Without “extraordinary circumstances,” custody must remain with a natural parent.

Even when extraordinary circumstances are found, as in the above, the court must first inquire into the best interest of the child before making a custody determination in which the child’s custody is placed with a non-parent. As a matter of fact, even when deficiencies exist in a parent, these deficiencies certainly could be overcome and do not necessarily constitute extraordinary circumstances, especially if they do not lead to a complete abdication of, or inability to assume parental responsibilities.

As a matter of fact, even in situations where a parent executes a custody agreement giving custody to another individual for the child, if the parent continues to maintain contact with the child, when that parent believes that he or she is ready to have the child returned, except for extraordinary other circumstances, the likelihood is great that the child will be returned, unless it is established that there is such gross misconduct or other behavior evincing an utter indifference and irresponsibility necessary to



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SYNAPSE designed by Lydia Dmitrieff

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Inside APAPAC - How Your Contributions Are Spent

As APAPAC continues to grow and enjoys more and more success, I wanted to take this opportunity to reach out to our supporters and those of you who have not yet supported the PAC to explain the PAC Board's decision-making process. The PAC Board considers many factors when deciding which candidates receive APAPAC contributions and the PAC Board makes every effort to prioritize our PAC activity to assist candidates who clearly champion APA's priority legislative agenda. Approximately 75% of APAPAC-supported candidates have co-sponsored APA priority issues, including, of course, issues such as enacting non-discriminatory coverage of treatment of mental illness in general health insurance and in Medicare, research funding, and medical records privacy. The PAC Board also believes that it is crucially important for APA to stand with our physician colleagues and the rest of medicine on major issues that affect all physicians. These include issues of concern to APA members as physicians, such as the Medicare physician payment update and medical liability reform. If one factors in these issues, the remaining 25% of APAPAC-supported candidates are supportive. This bears repeating: when assessing candidate patronage (through co-sponsorship or voting records) of APA-priority legislation and/or APA-supported physician priorities, all PAC-endorsed candidates have supported APA in at least one, and often multiple, areas.

Of course we hope that the full range of APA's specific priority issues is supported by every Member of Congress and candidate for elective office to whom we give, but this cannot always be the case. PAC contributions also give the APA an excellent opportunity to reach out to and educate individuals who have supported APA on general health

issues such as the Medicare payment update, but who have not previously supported other APA priority issues such as cosponsoring legislation to require non-discriminatory coverage of treatment of mental illness. This educational function can yield tangible results. For example, APAPAC activity allowed our Medical Director to be the sole featured speaker at a breakfast of fiscally conservative (mostly Southern) Democrats who have rarely backed the APA's legislative priorities because of perceived conflicts with their strong pro-business views. As a direct result of this activity, we picked up new cosponsors for the "parity" bill and for our bill to end Medicare's 50 percent coinsurance for outpatient mental health services. If we had based our decision to host the breakfast strictly on prior cosponsorship of APA priority legislation, this would never have happened.

Thus, the PAC Board believes it is important to keep in mind APA's overall legislative advocacy objectives and to bolster the work of the APA's advocacy efforts and to foster good working relationships with all Members of Congress who have a direct impact on our overall legislative priorities, including both "APA-specific" issues and issues of more general concern to psychiatrists as physicians. The PAC Board aims to represent all APA members and strongly believes that to properly and thoroughly advocate for our patients and our profession we need to educate, lobby, and support both candidates for Congress who already support our issues as well as those who do not at this time.

The PAC also contributes to Members of Congress in positions of leadership (Speaker, Majority & Minority Leaders of both houses, Committee Chairs and Ranking Members, etc). The leadership sets the

priorities for House and Senate legislation, thus impacting APA's interests in a myriad of ways. Not supporting leadership would be immediately noticed and would, in our judgment, be politically dubious and would potentially damage the APA's on-going advocacy efforts. Even where we have all been frustrated with the difficulty in getting the Mental Health Equitable Treatment Act through this Congress, our PAC efforts have helped achieve a record, bipartisan level of cosponsors in the House and the Senate. APA support for the "doubling" campaign for research funding was also materially helped by bipartisan support in the House and Senate leadership and general membership. PAC dollars, working in tandem with our hard-working Department of Government Relations lobbying team, also help in ways that are not always visible to the membership by opening communications that are useful in ways beyond straight cosponsorship of APA priority legislation. PAC-supported Members have, for example, written letters to Federal agencies on behalf of APA issues, supported APA nominees for appointments to advisory panels, and quietly helped craft non-legislative solutions to issues that impact our members in many ways.

We attempt to concentrate PAC support to members of the committees and subcommittees in Congress that have jurisdiction over health issues (including but not limited to the: Senate Appropriations Committee {Subcommittee on Labor, Health & Human Services, and Education}, Senate Finance Committee {Subcommittee on Health Care}, Senate Committee on Health, Education, Labor & Pensions {Subcommittee on Substance Abuse & Mental Health Services}, Senate Committee on Veterans' Affairs,

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Donald E. Cameron, M.D.: A Tale of Research and Medical Ethics

Dr. Donald Ewen Cameron was a world renowned psychiatrist having gained his fame from the experimental work he did with mental patients at the Allan Memorial Psychiatric Institute in Montreal, Canada. Born in Scotland in 1901, he immigrated to the United States and worked in Canada for 28 years. He became the head of Allan Memorial since its opening in 1944. To his credit goes the stance to unlock doors through out the hospital. He declared that the mentally ill had to be treated rather than feared. It is to be noted that this "open door" policy was a revolutionary concept in those days. In the 1950s a strange phenomenon occurred during the Korean war. Many American prisoners of war made confessions or signed petitions demanding an end to the American presence in Asia. It was believed by the Intelligence agencies that these prisoners, some 70%

of a total of 7,190, had been brainwashed by their Korean and Chinese captors. A cover organization, Society for the Investigation of Human Ecology (SIHE), was set up by CIA for funding research on brainwashing. Cameron, because of his reputation in the field, was chosen to conduct such a study.

Dr. Cameron was busy for some time in a series of experiments which he labeled "Psychic Driving." This was based on the benign sleep-teaching method developed by Max Sherover who helped his patients overcome nail-biting habits by continuously playing a tape recording to them while they slept. Cameron streamlined this technique drastically to reach deep into the psyche of the individual to erase disturbed memories and implant new learning. He introduced this form of therapy in a paper published in the American Journal of Psychiatry in

January 1956. He explained that psychic driving allowed for "the penetration of defenses, the elicitation of hitherto inaccessible material, and setting up of a dynamic implant" of recurring thought that influenced the patient's behavior. He experimented with a number of variations in the technique on those who were resistant to this approach.

By administration of sodium amytal, the so called truth drug, by inducing pro-longed sleep and using LSD and other drugs to induce a state of confusion and disorganization he claimed access to

the deepest level of the patient's psyche. In this state of defenselessness recordings of statements were constantly played to the subject in an effort to re-pattern his thinking. In keeping with the climate of the day, he sometimes referred to his procedure as brainwashing. Academically and professionally these research activities brought many recognitions to Dr. Cameron. At different times, he was the President of the Quebec, Canadian, and American Psychiatric Associations. He was also the co-founder and the first president of the World Psychiatric Association.



There was no let up in his enthusiasm to "de-pattern" his subjects. He remained convinced that "you could regress patients, particularly schizophrenics, back to their infancy." For those who were still resistant to changing he added increasingly frequent courses of ECT at much higher levels than it had ever been applied before. Cameron felt that a more forceful application of ECT was likely to produce more impressive results. Rather than administering a single shock he would shock the patient six times in rapid succession. Some patients received this treatment as many as three times a day for up to thirty days. Some became unable to walk or feed themselves. Many developed incontinence and chronic memory loss. Cameron's high academic standing was such that he had no difficulty in getting his papers peer reviewed and published in prestigious professional journals.

Cameron called his technique "Psychic Driving." In January 1956 he published a paper in the American Journal of Psychiatry under the same title in which he made the following conclusions:

1. Psychic driving is a potent procedure — it invariably produces responses in the patient, and often intense responses.
2. The responses tend



Continued on next page

ultimately to be therapeutic. To account for the effect of psychic driving the following working hypotheses has been set up:

- a. penetration of shielding. - defenses of the individual against the full implications of his verbal communication are circumvented by using air conduction only, rather than the synthesis of air and tissue conduction to deal with which his defenses were organized.
- b. Driving. - constant repetition of the verbal cue locks the patient into continual response in terms of the community of action tendencies of which the cue is part.
- c. Talking and listening. - Working ideas concerning these and their bearing on the penetrating effect of driving have been set forth.
- d. Dynamic Implant. - A given period of psychic driving may continue to produce additional effects after the period of actual driving has been terminated. To account for this, a premise has been advanced that a period of psychic driving may set up

within the individual an area of intensified responsiveness, which calls him back repeatedly into activation of the area concerned.

- 4. Psychic driving lends itself to a great many modifications with respect to its application. These have been listed, and include autopsychic and hetropsychic driving, variations in the mechanical procedure and variations in the preparation of the patient for psychic driving. It is still too early to determine the various particular values of these; the material presented has been derived primarily from short-term autopsychic driving without adjuvants."

If the reader finds it difficult to understand the above statement it will not be his fault. The use of neologisms was a style of Dr. Cameron to describe his use of heroic amounts of ECT, sometimes combined with the administration of LSD and amobarbital sodium given intravenously, to "brain wash" and dis-inhibit the patient and break his defenses. The "driving" in of "healthy thoughts" was

then tried by excessive repetitions of such thoughts during prolonged sleep.

Due to poor showing in the real world of clinical outcomes, the increasing objections of civil rights groups who questioned the lack of informed consent, and above all due to the loss of financial support from SIHE, Cameron's "psychic driving" came to a grinding halt in 1964. In 1966 he left Allan Memorial hospital and died, essentially in disgrace in 1967, of a heart attack. The New YorkTimes obituary headlined: "Led Research in Geriatrics at Hospital in Albany."

One good that came out of Cameron's efforts was the introduction of increasingly stricter controls over researchers who use human subjects. When we hear the complaints, voiced by some researchers, about the "watch dog" committees looking over the shoulders of the well intentioned scientists, we must remember the recent history of abuses in medical research because of the lack of such constraints. ▲

Syed Abdullah, M.D.

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WHPS Gets APA Grant

This is the letter sent to APA headquarters that brought our district branch a \$5000 grant.

Dear Dr. Scully,

I am writing as President-elect of the West Hudson Psychiatric Society, a district branch of the New York State Psychiatric Association and of the APA. We have been advised that the Board of Trustees has approved \$100,000 for "infrastructure assistance to the DB's" in addition to the \$280,000 allocated for distribution as \$2500 for each DB" (but for NY, CA and MO) and the balance based on voting members. We are seeking a total of \$10,000 in order to continue our activities and to buttress our infrastructure as discussed below.

As you can see from our enclosed balance sheet, our cash has been dwindling and will soon be exhausted. The cause for this includes the following:

We have maintained one of the lowest dues in the country for over 20 years. We have done this to keep our members' total APA dues low and as our contribution to retaining members in the national organization.

Like many district branches and the Assembly, we have debated using pharmaceutical company support for our educational efforts. Recent meetings were paid for out of our own funds.

We are extraordinarily active (see below) for a small district branch, consuming resources in the process.

Our activities include the following:

We operate an effective and cost saving ethics process, avoiding substantial costs to the central office on several occasions.

Our newsletter, Synapse, serves as an effective communication tool with our members, winning an APA newsletter award nearly every year.

We pioneered depression screenings at a shopping mall, one of the most successful depression screenings in the country. We continue this every Mental Illness Awareness Week in our local mall, the second largest in the country. Our success has been published in the press, in professional journals and presented at the APA Annual Meeting.

We began and continue to lead a successful and extremely active Mental Health Coalition of multi-disciplinary providers and consumers. Dr. Lois Kroplick won national public affairs awards for her efforts.

We hold at least two educational meetings a year for all our members and representatives of other local professional associations.

A woman's group meets monthly to discuss topics of interest.

We meet with and represent the interests of organized psychiatry to local state legislators on an ongoing basis.

We operate an informational phone service for prospective patients. This includes publishing and mailing a brochure with "Facts About Psychiatry" and a listing of our members in

private practice. We have responded to 5 calls a week for over 10 years.

We have sent members to Ground Zero, winning awards in the process.

We have maintained all these activities without any staff or office. We have kept our costs low by using our executive council's volunteer time and resources. Our infrastructure is the goodwill and collegial relationships of our members and our leadership, spanning many decades.

2004 Balance Sheet

| | |
|--|------------------|
| Income: | |
| APA, Advertising, Meeting fees | 11,135 |
| Expenses: | 15,866 |
| Hourly Secretary, (a new expense) | 3150 |
| ATT | 331 |
| Verizon | 1374 |
| Printing | 1851 |
| Stamps | 89 |
| Depression Screening | 657 |
| Monthly Luncheon - Exec Council Meetings | 989 |
| Biannual Member Meetings | 6716 |
| Catering, speakers, equipment, etc. | |
| Mental Health Coalition | 300 |
| Advertising | 355 |
| Post Office Box Fee | 44 |
| | - \$4,731 |

This is the first year we have operated at a deficit, for all the reasons cited above. We now require a grant to avoid substantial dues increases and/or a curtailment of our activities. These monies will give us the cushion to maintain all our programs while we plan how to continue our operations without a deficit. We will use this grant to

1. Increase hourly secretarial assistance, taking the burden of these chores off our physician members
2. Improve email and computer programs for efficient communication between executive council members and the membership
3. Maintain our potentially very expensive ethics board
4. Fund our monthly executive council meetings, the cornerstone of our morale and operations

Ours is truly a successful, local, grassroots organization with wide ranging and nationally recognized activities. We hope you can approve a grant of \$10,000 to allow us to continue.

Sincerely,

James W. Flax, MD
President-Elect

Inside APAPAC, cont'd

House Appropriations Committee {Subcommittee on Labor, Health & Human Services, and Education}, House Committee on Education & the Workforce {Subcommittee on Employer-Employee Relations}, House Committee on Energy & Commerce {Subcommittee on Health}, House Committee on Veterans' Affairs {Subcommittee on Health}, House Committee on Ways & Means {Subcommittee on Health}, and the Congressional Mental Health Caucus. It is critically important for House & Senate Leadership and legislators on committees of jurisdiction to receive support from the APAPAC for many of the reasons discussed above, since they are the individuals who have the most control over the issues that affect our patients and our practice.

There has been some concern that APAPAC dollars are too balanced between Republicans and Democrats, given what is perceived to be a stronger base of support for our issues among Democrats. Over the last few years, we have worked very hard to ensure that APAPAC is more balanced than it has been in the past. It is a fact of Washington life that with one party in control of Congress and the White House, it would do us no good to be perceived as a PAC that is dominated by support for the political party out of power, and we can assure you that party leaders keep close track of this. Despite that fact, you should know that of medical association PACs, APA is in fact still - by far - the most "Democrat-oriented" PAC, a source of some clear irritation among the GOP. We believe APAPAC has done a very respectable job of supporting our friends while acknowledging the reality of our current political landscape.

Generally, incumbents enjoy a tremendous advantage in the election process and often times run unopposed

or virtually unopposed (which is reflected in the PAC's list of support). In the case of open-seat races, the PAC Board works with APA members in that district and state as well as the District Branch to ensure we obtain any and all information possible. The PAC Board also looks to support Members of Congress that are considered our allies, those who are both pro-psychiatry, and pro-physician, regardless of their leadership status or committee assignment. In most cases, APA joins with medical specialty and health industry associations in co-hosting events for these individuals, presenting an important unified face to matters we are concerned with as a physician community.

In addition to these factors, the PAC Board considers requests from APAPAC members and those that come directly from District Branches/State Associations. For all potential contributions: the candidate, opponent, district, position in Congress, legislative record (of both candidates and when applicable), and likelihood of victory are all considered.

Rest assured; the PAC Board does not make these decisions lightly. Each contribution is thoroughly evaluated based on a comprehensive candidate

review while keeping the APA's advocacy agenda and strategy as the top priority.

Thanks for the opportunity to provide a general explanation of how these voluntary APA-members' contributions are distributed and how the PAC Board of Directors works to protect and represent the interests of all APA members. If you are not yet a member, please join many of your colleagues by contributing to the PAC online at www.psych.org/members/apapac/index.cfm. For more information, please contact APAPAC Manager Jason Pray at jpray@psych.org or (703) 907-8581. ▲

*John J. Wernert, M.D.
Chair, APAPAC Board of Directors*



Rights of Parents, cont'd.

supplant the biological parent. There are situations in which a parent may leave a child with a grandparent or other caregiver for a period of time, but without evidence that the parent abandoned, surrendered or voluntarily relinquished custody of a child, that child must be returned to the parent.

A frequent argument in the litigation, in these cases, by the temporary custodian, such as a grandmother, is that the child has "psychologically bonded" with that caregiver. While an argument could be raised that the disruption of that psychological bond would result in psychological trauma grave enough to threaten disruption of the child, it is extremely difficult to prove that trauma.

In essence, courts generally have held that the rights of a parent to his or her child and the rights of a child to live with his or her parent, barring the above described 'extraordinary circumstances,' supercede the rights of all non-parents.

Finally, even if the extraordinary circumstances are found, courts must then inquire into the "best interests of the child" before making a custody determination and possibly displacing

a parent.

We have all learned much from the numerous writings and books of Anna Freud and her colleagues regarding the "best interests of the child," but, despite what we as psychiatrists may believe, the courts have a very definite view of the paramount rights of parents

to raise their children.

I am indebted for much of the information in this article to the soon-to-be Family Court Judge Linda Christopher, who has provided me with much of the case law regarding this issue. ▲

Alan J. Tuckman, M.D

Ed Whalen

Susanne Kauderer

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