

A

December 14, 1976

Mrs. Katherine C. Aisen
Tennessee School for the Blind
115 Stewarts Ferry Pike
Donelson, Tenn. 37214

Dear Mrs. Aisen:

I am enclosing a copy of our reprint,
"Gross Motor Development in (Infants Blind from Birth"
which you requested.

A new book entitled, INSIGHTS FROM THE BLIND:
COMPARATIVE STUDIES OF BLIND AND SIGHTED INFANTS is
being published by Basic Books and is due to be
released in February, 1977.

Thank you for writing to me.

Sincerely,

Selma Fraiberg
Professor of Child Psychoanalysis
Director, Child Development Project

SF/amw



RECEIVED NOV 24 1976



ACCREDITED

MEMBER

TENNESSEE SCHOOL FOR THE BLIND

115 STEWARTS FERRY PIKE DONELSON, TENNESSEE 37214

PHONE (615) 741-4431



ACCREDITED

MEMBER

November 17, 1976

Dr. Selma Fraiberg
Professor of Child Psycho-analysis
Director of the Child Development Project
University of Michigan
Ann Arbor, Michigan

Dear Dr. Fraiberg:

When I was an intern at the Michigan School for the Blind in the early '70s, I vaguely recall that you were doing some research on locomotor patterns of the blind and visually impaired child. Are my recollections correct? If so, I am interested in the results which you were able to draw together. Which of your publications address that concern?

Also, have you come across (or developed) any audio-visual materials that are truly significant and useful in a parent education program regarding the development of the visually impaired child?

I will appreciate your help. Thank you.

Sincerely,

Katherine C. Aisen

Mrs. Katherine C. Aisen, M.A.

Preschool counselor of the visually impaired and/or multiply handicapped

*Send from Austin paper
this has new book coming out*

10/19/76

A Partial Bibliography of
the Writings of E. James Anthony

"The State of the Art and Science in Child Psychiatry." Archives General Psychiatry 29(3) (1973): 299-305

"Emergence of Child Psychiatry as an Academic Discipline." Child Psychiatry & Human Development 1(1) (1970): 4-15

"Primary Prevention with School Children." In Progress in Community Mental Health:II, edited by H.H. Barten & L. Bellak, New York: Grune and Stratton, 1972

"Neurosis in Children." In The Child: his Psychological & Cultural Development:II, The Major Disorders and Their Treatment, edited by A.M. Freedman & H.I. Kaplan New York: Atheneum, 1972

"A Clinical Evaluation of Children with Psychotic Parents." American Journal of Psychiatry 126(2) (1969): 177-184

With Koupernik, Cyrelle, The Child in his Family. New York: Wiley, 1973

These writings are available from the library:

Explorations in Child Psychiatry, edited by E. James Anthony. New York: Plenum Press, 1975

"An experimental Approach to the Psychopathology of Childhood: Encopresis." In Childhood Psychopathology, edited by S. Harrison and J. McDermott. New York: International Universities Press, 1972

"A Study of Screen Sensations." The Psychoanalytic Study of the Child 16 (1961)

Zerox copy of these articles available at front desk:

"Two Contrasting Types of Adolescent Depression & Their Treatment." Journal of American Psychoanalytic Association 18(4) (1970): 841-859

"Folie à Deux: A Developmental Failure in the Process of Separation-Individuation." In Separation-Individuation: Essays in Honor of Margaret S. Mahler, edited by J.B. McDevitt and C.F. Settlage. New York: International Universities Press, 1971

"The Reactions of Parents to the Oedipal Child." In Parenthood: Its Psychology and Psychopathology, edited by E. James Anthony and Therese Benedek, pp. 275-288

"Murderous Obsessions In Mothers Toward their Children." In Parenthood: Its Psychology and Psychopathy, edited by E. James Anthony and Therese Benedek, pp.479-498. Little, Brown and Company, 1970

"A Working Model for Family Studies." In The Child in His Family: The Impact of Disease and Death, edited by E. James Anthony and Cyrille Koupernik, pp. 3-19. New York: John Wiley & Sons, 1973

RECEIVED OCT 06 1976

Gay R. Admire
103 East Second
Georgetown, Texas
78626

October 2, 1976

Dear Dr. Fraiberg,

I am presently taking a course on infant development as preparation for a masters degree in nursing. I have been reading some of the research you have done with blind infants and have found this area of research very interesting. Have you done any additional research that is not as yet published. If so, I would be most interested in reading it. I will possibly be writing a paper on this subject, so any information will be most helpful.

Thank you.

Yours,

Gay R. Admire, R.N.

*you - list of publications
+ new book -*

S.

sent

17A"
RECEIVED
SEP 24 1976
September 24, 1976

Dr. Eugene Abravanel
The George Washington University
Dept. of Psychology
Washington, D.C. 20052

Dear Doctor Abravanel:

I have forwarded the two reprints you requested and to answer your questions concerning sounds and movement, I would direct you to my forthcoming book which is now in press entitled, Insights From the Blind: Comparative Studies of Blind and Sighted Infants, BEING published by Basic Books. It is due to be released late this year or early 1977.

Sincerely,

Selma Fraiberg
Professor of Child Psychoanalysis
Director, Child Development Project

SF/amw



THE
GEORGE
WASHINGTON
UNIVERSITY

Washington, D.C. 20052 / Department of Psychology / (202) 676-6320

Rec'd
9/9/76.

September 2, 1976

Dr. Selma Fraiburg
Child Development Project
201 E. Catherine St.
Ann Arbor, Mich. 48108

Dear Dr. Fraiburg:

Reading your extensive studies on development during infancy in the blind led me to think that you might have some formal or informal information on a question that has interested me. I have been conducting research on the early phase of imitation during infancy in sighted babies. A report of some of this research will appear in the December issue of Child Development. I have wondered about imitation in blind infants. Do you know anything about the course that it takes, whether it be the reproduction of sounds (which should be more intact), or the reproduction of movements (which should be more impaired)? I would be grateful for any information that you might have on this topic.

Might I also request reprints of your following papers:

- ✓
_____, The development of human attachments in infants blind from birth.
Merrill-Palmer Quarterly, 1975, 21, No. 4.
- ✓
_____, The role of sound in the search behavior of blind infants.
Psychoanalytic Study of the Child. 1966, 21

Best wishes,

E. Abravanel
Eugene Abravanel, Ph.D.

EA;tp

Sent
9/20/76.

Donna,
return to me.
Ashley

Borland-Coogan Associates, Inc.
137 North Twenty-First Street
Philadelphia, Pa. 19103
(215) 561-4580

June 11, 1976

File "A"

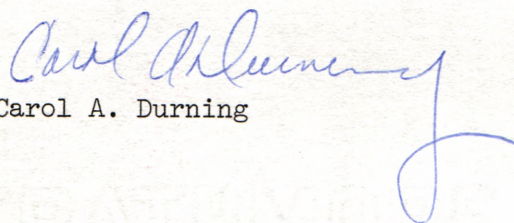
Rec'd
6/14/76

Prof. Selma Fraiberg
201 E. Catherine Street
Ann Arbor, Michigan 48104

Dear Prof. Fraiberg:

Our editor, Joe Coogan, thought you might like a few copies of our
June issue, 1976, of Mind and Medicine in which we refer to your report
published in the Summer, 1975, issue of the Journal of Child Psychiatry.

Yours sincerely,


Carol A. Durning

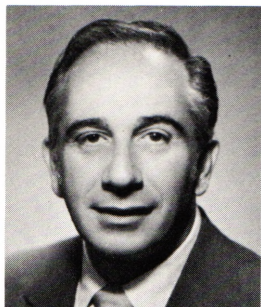
Encs.

P.S. We were happy to hear that you were pleased with our condensation as
published in our other publication, Today in Psychiatry.

ABBOTT LABORATORIES' MIND AND MEDICINE

Child abuse: detection, treatment

An interview with Henry P. Coppolillo, M.D.



Dr. Coppolillo is Professor of Psychiatry and Pediatrics, Director of the Child Psychiatry Division, and Chairman of the Child Abuse Committee at Vanderbilt University Hospital, Nashville, Tennessee.

Q. Do you think a physician practicing in a middle-class or affluent community might tend to be less alert to child abuse than one practicing in a poor community?

A. Yes, he's much more likely to accept the parents' explanation that the injury was an accident. Unfortunately, one of the myths about child abuse is that it only occurs in lower class families. Another is that the parents have a low I.Q. The fact is, the problem cuts across all strata of society and is very widespread. The American Humane Association estimates that some 300,000 children a year are victims of parental abuse or outright neglect.

Q. Obviously, there are cases where the injuries are so horrendous that the physician can't help thinking the parents are responsible. But would you say that, in general, the family physician's greatest contribution in dealing with the problem is to be able to detect when an injury is the result of abuse?

A. He can make so many contributions that it may not be fair or accurate to say which is the greatest. But obviously you can't do anything about the problem if you don't notice it. A surgeon on our committee, Jim O'Neill, did a study showing that abuse frequently begins with minor injuries and then progresses to massive ones. So, a superficial injury shouldn't deter you from considering the possibility of abuse. You might save the child's life. But superficial injuries are often the hardest to pinpoint.

Continued on page 2

Vol. 3, No. 6, June, 1976

CLINICAL BRIEFS

Can acupuncture relieve chronic pain?

While the last word in the acupuncture controversy is still in the offing, research, experiment and debate continue. One of the latest studies, coming from a group of anesthesiologists at the University of Florida College of Medicine and a Veterans Administration facility in Gainesville, is reported in JAMA for June 16, 1975. During four days, 979 acupuncture treatments were given to 261 patients with chronic pain that had proved resistant to all other treatment. A "substantial" number (54 patients) reported a 75 to 100 percent reduction of pain. A month later, 18

Continued on page 6

Ghosts in the nursery: a possible cause of child abuse?

Many people who abuse their children were abused when they were children. They repeat their parents' neurotic behavior. Yet not all who suffered physical abuse in childhood visit the same punishment upon their offspring. Why? What makes them act differently from others with an almost identically traumatic childhood?

Selma Fraiberg, Professor of Psychoanalysis in the Department of Psychiatry, University of Michigan, thinks she may have another important clue to this puzzle. In the *Journal of Child Psychiatry*, Summer, 1975, she and two associates—Edna Adelson and Vivian Shapiro—report on a therapeutic program for child abusers.

"Is morbidity in the parental history the prime determinant?" Mrs. Fraiberg asks, and answers her own question: "This strikes us as too simple. There must be other factors in the

Continued on page 6

Q. What are some other contributions the family physician can make?

A. If he knows the family and is aware of some of the characteristics of high-risk parents, he might be able to prevent the problem. Or if it does occur, he can play an extremely important role in treatment.

Q. What are some characteristics to be on the lookout for?

A. Well, these parents frequently were abused children themselves. They're also relatively isolated people, don't have good ties in the neighborhood or with each other; their relationship is so distant and strained that they can't give each other emotional support. You also often find that they're highly perfectionistic people who live by rigid codes—"I put him on the stove so he would learn not to wet his pants." Then there's something more subtle you can find if you look for it. The abusing parent is unable to appreciate the immaturity of the child. I've heard mothers say, "She would wait until I had my good clothes on and then vomit on me," ascribing intentionality to a three-month-old child. Then, too, you should be alert to potential problems in teen-aged unmarried mothers and in tense, uncommunicative parents who have congenitally abnormal children. They're also high-risk.

Q. But there are people with these same characteristics who don't abuse their children. How do you account for that?

A. The cases we've seen here have led us to hypothesize that child abuse occurs as a kind of "depletion syndrome." Administering to a child's needs takes a tremendous outpouring of energy that has to be replenished. We've identified at least three sources of replenishment for the normal mother. One, as T. Benedek pointed out, she unconsciously relives the gratification she received when *she* was being mothered. Two, the husband becomes very maternal to her during the later stages of her pregnancy and the early stages of infancy. Three, she's replenished by what's jokingly called the Jewish Mother syndrome but is really the human mother syndrome; she feels uplifted as the baby thrives. We've found that all *three* elements are missing in abusive mothers. A woman who received poor mothering herself, for instance, may be "remade" if she marries someone supportive and "maternal."

Q. What about the abusive father?

A. Actually we see more mothers, but that may be an artifact due to our sampling and referral sources. From our experience with fathers and from what we hear from other centers, the same psychodynamics apply. Fathers undergo a great deal of stress during the pregnancy and infancy and they, too, need replenishing.

Q. How would you go about finding out if parents are telling the truth when they say their child was injured accidentally?

A. I want to preface my answer with a statistic physicians should be aware of. It's estimated that about 15 percent of all injured children *under five* who're brought to a physician's attention are victims of parental abuse or neglect. That's a staggering percentage—and so you should be particularly on the alert with that age group. After five they're more active and more likely to *get* into accidents. But regardless of age, you should try to reconcile the injury with the parents' explanation. For instance, if the parents tell you the child caught the side of his cheek as he fell against a coffee table, look to see if the injury's the kind that could be made by a pointed object sliding across the skin, or the kind that

could only be made by a direct blow. Or, though the parents say the child fell on his arm, you might find a twisting fracture.

Q. What do you do then?

A. I would take care of the child first and then discuss it with the parents. I would say something like, "Look, this isn't quite right, I'm not comfortable with it. I have the feeling something's on your mind. Tell me more about the child. What kind of child is he? Tell me about your relationship with her. Have things been pretty rough?" In other words, use open-ended questions that will encourage them to talk about their feelings, what's going on. But certainly don't be accusatory. That's not your job; your job is to gather facts. And by all means, before you even talk to the parents, get your own head straight. You mustn't go into this abhorring or hating them. You have to look on them as the unfortunate and distressed people they are. As *patients*.

Q. What do you do if they admit injuring the child?

A. In most states it's mandatory to report child abuse even if you only *suspect* it. The physician should certainly be aware of what his state law is. And, even if it isn't mandatory, I would still report any suspicious case. It doesn't mean you're a "policeman." The agencies that handle these cases are there to investigate the problem and to *help* the parents and child, and you're helping them do it. In the mid-60's there was a strong movement to take these children away from their parents, ignoring the fact that the children often have very profound ties to them. That movement has been reversed. So, it's not as though you're necessarily separating families.

Q. Still, isn't it often emotionally difficult for the physician to report the parents, particularly if he knows them and has always looked on them as "normal"? And particularly if they haven't admitted abuse and he only suspects it?

A. It can be extremely difficult. But his position must be, "Look, John and Mary, I have known you for a long time and you know that my interest is in your welfare and the child's. I have no choice in this matter but to ask for an investigation. I know you have the potential for being excellent parents, but there apparently are some situations in which you have problems. I will be available to give you all the help I can." The physician must also bear in mind that most of these parents are horror stricken at what they've done and *want* help, even though they might act at first as if they resent it.

Q. What would you say to a doctor who might hesitate reporting his suspicions because he's afraid it might take too much of his time in court?

A. Most courts don't take huge amounts of a doctor's time in these cases. That's another myth. Their own people do most of the work in gathering evidence. But even if you do have to spend days in court, not to report child abuse is so unethical in my mind that it's tantamount to not reporting a case of typhus. Now, a doctor might also be afraid that he'll be sued by the parents if they're cleared. Here again, most states protect you from such suits.

Q. Are both parents usually abusive? If not, wouldn't the innocent one generally report the other to protect the child?

A. Usually one parent's the abuser. But because of the couple's isolated relationship and a capacity to deny, the parent who isn't abusive usually participates in a kind of conspiracy of silence.

Q. Assuming the child's old enough, wouldn't he tell the physician the truth about what happened?

A. Very rarely. For one thing, as I mentioned, the child remains attached to the parents despite his anger, his hurt. He's afraid they'll be taken away. For another, it's in the psychology of children that, more often than not, when they're abused they think they deserve it. And that makes it even more tragic.

Q. How can a doctor help a youngster tell about it?

A. One approach is to displace the situation from the child. For example, say to him, "I know a boy who was very close to his parents and was afraid to tell people that, without realizing it, his parents were doing things to hurt him. But when he was able to talk about it he found that he helped them and himself." Or if the doctor is a patient and skillful person he can often get a tremendous amount of information by asking the child to draw pictures or make up stories in response to such questions as "What are the different ways things can happen to kids?"

Q. What if the child has a minor bruise or two and the parents give a very frank and reasonable explanation of why they hit him? Would you report that? In other words, when would you consider it abuse?

A. I would certainly ask a lot of questions, and it would depend on a lot of things. If the child was very young—say, under three—my immediate reaction would be to report it. But a lot depends on why they did it and if it was part of their behavior pattern. If I didn't think it was anything I needed to report, I would make a note to check for bruises the next time I saw the child. Now, if I didn't think it was abuse but I still thought they might be high-risk parents, I would discuss it with them. I would say something like, "Do you sometimes think you're at your wits end with the child?" They might come right out and tell you they're afraid they're going to hurt the child. At this time you have to decide whether to refer or handle it yourself. But sometimes that's taken out of your hands—they don't want to go to anyone else. I would see them and the child once a week to enable them to air their feelings. In fact, just seeing you can have a great restraining influence on the parents. Gradually I would try to get them more involved in the community, out of their isolation, perhaps join one of the Parents Anonymous groups that are forming throughout the country.

Q. You spoke of telling the parents you wanted to help them even though you were going to have to report the incident. How can the doctor help after that? Doesn't the state pretty much take over?

A. Most child protective agencies, most juvenile courts, *want* the physician to remain involved, especially if he knows the family well. A great deal depends on the community resources and the case itself. He might be the primary therapist. Or he can play just as important a role by working hand in hand with a psychiatrist, psychologist, social worker, the school.

Q. In counseling the couple, is it usually better to see them separately or together?

A. Here, there's no substitute for clinical judgment. You might find that the parents are able to talk freer when they're alone. Then you might want to see them together.

Q. How can the family doctor help the child?

A. The abused child usually has pretty deep-seated emotional problems and needs specialized help. But the doctor should stay involved, should try to reinforce whatever other help the child is getting. I would like to add, though, that there are some family

practitioners who are so gifted with children that they intuitively do things it takes some of us years of training to learn. So, if the doctor knows his talents and limitations, he can be of great help to the child in exploring his fears in relating to adults, in making him more communicative, more optimistic.

Q. How can he handle the child's feeling that he deserved the abuse?

A. Again, tough to do. But if you work at it gently you can usually get to the source of the guilt. For instance, the child might say he played with matches two years ago and so is a bad boy, and that's why his father knocked him down the other day. You



might say, "That happened a long time ago. I think your father did this because he's troubled himself." You might even be able to tell him there are ways of helping his father. For example, "You're acting as though your father is always mean and angry. I bet if you go up to your dad and show you want to be with him it will help him."

Q. The trend, you said earlier, is to keep the abused child with his parents. Is that working out well?

A. Dr. C. Henry Kempe, who originated the term the "battered child," has shown that 80 percent of these children can be kept at home and can enjoy the positive part of their relationship with the parents if you can supply the parents with "protection" against themselves. That is, giving therapy or providing them with what he calls "surrogate grandmothers," carefully picked, retired people who can go into a home and serve as an example of a loving person. Our abuse committee has used surrogate grandmothers quite successfully.

Q. Who's in the committee and what does it do?

A. In addition to myself, it's made up of a pediatric surgeon, neurosurgeon, child orthoped, radiologist, pediatrician, a hospital administrator and social worker. We're involved in research
Continued on page 6

Consultant on call



Our consultant this month is Louis P. Bozzetti, M.D. Dr. Bozzetti is Associate Professor of Psychiatry, and head of the Community Psychiatry Program, University of California, San Diego School of Medicine.

DRUG ABUSE EMERGENCY

Dear Sir:

Recently, a 19-year-old male came into the emergency room appearing acutely psychotic. He was accompanied by a friend who reported that the patient had been using heroin for some time. Approximately two hours before, he had allegedly "main-lined" some heroin, after which he did not feel the usual "rush," but rather began to become paranoid and then irrational.

This patient had been using heroin for the past year-and-a-half, and most recently had been injecting himself two or three times a day. His pupils were dilated, his reflexes were hyperactive, and he was very anxious—almost in a state of panic. Also, his skin was dry, and he complained of dry mouth.

"Bad trip"?

Because he did not have pin-point pupils, we quickly suspected that his last self-injection did not contain an opiate. Our working diagnosis was a "bad trip" from the inadvertent use of lysergic acid (LSD). In order to alleviate the acute psychotic-like symptoms, he was given 50 mgs. of chlorpromazine intramuscularly. Shortly afterward, he unexpectedly went into shock.

Heroic measures were needed to sustain his cardiovascular system. He did stabilize and recover. But this horrendous experience is one I shall never forget, and I would appreciate your commenting on the nature of the syndrome and how one might avert a near catastrophe.

R.D., Glendale, California

Dr. Bozzetti replies:

First of all, let me state that what you have described is not a rare occurrence. Fortunately, this patient survived. Others have not been as fortunate.

The emergency room physician was indeed correct in determining that this patient's symptoms were not caused by heroin. The dilated pupils, hyperactive reflexes, anxiety and psychosis together lead one to suspect he had taken an hallucinogen.

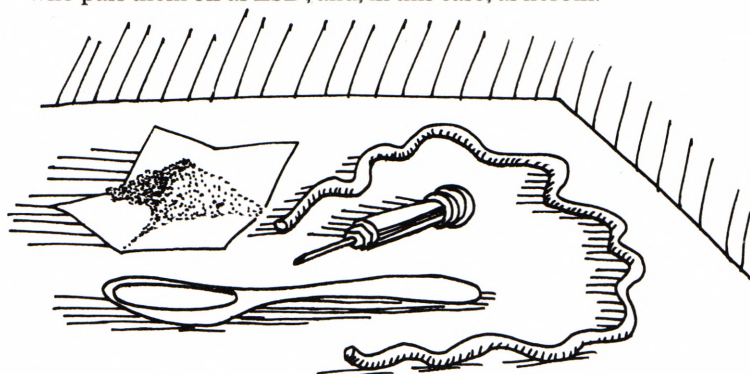
There are four classes of hallucinogens:

- the *cannabinoids*—examples, cannabis and THC (tetrahydrocannabinol).
- datura-belladonna alkaloids*—examples, atropine and scopolamine.
- indole tryptophane derivatives*—examples, LSD (lysergic acid) and psilocybin.

- phenethylamines*—examples, mescaline (peyote cactus) and nutmeg (mace).

Fillers

High doses of all these substances are known to cause hallucinations. The *datura-belladonna* alkaloids are also anticholinergic drugs. These substances are important to keep in mind because they are sometimes used as fillers by street drug dealers who pass them off as LSD, and, in this case, as heroin.



The toxic state produced by an overdose of an anticholinergic drug such as atropine sulfate (a belladonna alkaloid) is almost indistinguishable from that produced by LSD. But two symptoms should alert one to the possibility of an anticholinergic drug overdose—dry mouth and decreased sweating.

Dangerous synergism

In the patient you described, the acute medical emergency occurred when a phenothiazine was administered. Chlorpromazine has received widespread notice as a cure for "bad trips" from LSD. But phenothiazines are synergistic with anticholinergic substances and, by severely depressing the cardiovascular system, can cause shock and death.

Whenever a "bad trip" (that is, a toxic reaction to a hallucinogen) is suspected, it is best to temporize. After a careful history and physical examination reveal no acute medical emergency, one might simply have the patient sit in the waiting room with a friend and relax. Additionally, one might "talk the person down." These individuals frequently respond very well to verbal reassurances.

For your patient, the treatment of choice would be to administer 1 mg. of physostigmine intramuscularly. The dose could be repeated in an hour. If excessive sweating, nausea or vomiting occur, it should be reduced.

This treatment, of course, is designed to alleviate the acute symptoms only. One must not lose sight of the fact that this patient needs more than emergency room intervention. His psychological problems must also be dealt with. Why, for example, does he engage in such self-destructive behavior?

Treatment centers

At this point, the primary care physician may wish to refer the patient to a narcotic abuse treatment center. It is important that the patient be given explicit information about the center, and that the emergency room staff helps get him there as soon as possible. This can be done by having a member of the staff call the center, giving the name and phone number of the person being referred. We have also found it helpful to provide, if feasible, transportation to the center.

These centers have well established programs which not only offer detoxification (withdrawal management), but also provide a holistic approach to the treatment of the complex human problems confronting these people. Without effective intervention in these areas, all other treatment will be to no avail. ■

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A close-up photograph of a woman's face, showing her eyes and forehead. She has dark hair with bangs.

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CHILD ABUSE *Continued from page 3*

and education and serve as advisors to physicians when they have questions about whether a case is abuse and what they should do about it. I can't stress enough how difficult it can be for a doctor to report a case without someone backing him up. So I would suggest very strongly that any hospital that doesn't have a child abuse committee should start one. Or, if the physician doesn't have such a group he can turn to, he should develop contacts with a psychiatric center and feel free to call for advice.

Q. When should the family physician refer a case to a psychiatrist?

A. When he feels uncomfortable with the problem, when it's over his head, when he can't rid himself of the stereotypes about it. Also, the *way* he refers is extremely important. He should say something to the patient like, "There are times in every human being's life when the stress of living is so great that we need a hand. There are specialists in dealing with emotional problems and I would like you to see one." That can evoke quite a different response than, "You ought to see a psychiatrist." Some people feel so ashamed about going to a psychiatrist that it takes us weeks or months to overcome that feeling. But some doctors prepare them so beautifully that much of our work is already done by the time they come to us.

Q. Child abuse has so many aspects to it—legal, social, medical, psychiatric—how can a doctor learn more about it?

A. He should start off by reading two books, both by Dr. Kempe and Dr. Ray E. Helfer: *The Battered Child*, and *Helping the Battered Child and His Family*. Once he's read them he'll probably know more about child abuse than 95 percent of the population. But just being *intellectually* aware of the problem, of its many facets, isn't enough. You have to *really* know it's possible that the well-dressed, intelligent man or woman sitting across from your desk might have hurled this child across the room. And you have to be truly alert to every tip—many come from teachers and school nurses. It can be so tempting to dismiss a call from a teacher as "alarmist," especially if it runs counter to everything you know about the family. You have to be willing to check it out or help by referring them to agencies that deal with problem families. Moreover, it's important to impart your knowledge to others—perhaps work within your medical society to start educational programs for doctors, school nurses, teachers, and so on. It's a huge problem that no single profession can solve. But I don't see any way it *can* be solved if the medical profession doesn't lead the way. ■

GHOSTS *Continued from page 1*

psychological experience of that past which determine the repetition in the present."

Ghostly possession

While working with patients in the new Infant Mental Health Program, which she heads, Mrs. Fraiberg says they have encountered ghosts in the nursery: ghosts who represent the repetition of the past in the present. "There are ghosts," she says, "in every nursery—the visitors from the unremembered past of the parents, the uninvited guests at the christening." Under favorable circumstances a spontaneous parental love will protect the child, and banish any unfriendly, unbidden spirits—much as evil spirits are defeated in fairy tales. In any

family, says Mrs. Fraiberg, there are those unguarded moments when the ghosts break through, when a parent and child will re-enact a moment or scene from another time. "Such events are unremarkable in the family theatre. But there are those families who become possessed by their ghosts. The intruders from the past take up residence in the nursery, and the new young family replays a tragedy from an older family script."

New hypothesis

Mrs. Fraiberg has developed a hypothesis which she believes is supported by their case studies: "Those who can and do remember the pain and suffering of childhood without repressing it are saved from the blind repetition of the morbid past. Through remembering, they identify with the injured child (their own childhood self); but the parent who does *not* remember is likely to find himself in unconscious alliance with the fearsome figures of the past. In a way which seems beyond his or her control, the parent inflicts that past upon the child."

When the patient remembers and re-experiences childhood suffering, the ghosts are exorcised. ■

ACUPUNCTURE *Continued from page 1*

percent still felt as much as 75 percent relief, and 17 percent as much as 50 percent relief. There were no adverse side effects.

The Florida research, conducted by Dr. Peter Ky Lee, Dr. Thorkild W. Andersen, Dr. Jerome H. Modell and Dr. Segundina A. Saga, aimed not only at determining the ability or inability of acupuncture to decrease pain, but also attempted to find whether the location of the needles would affect the outcome; specifically, whether needles applied at the traditional meridian points, which the Chinese consider "the pathways of body energy," would prove more effective than needles applied at points on the body chosen at random.

All acupuncture treatments were administered by Dr. Lee, formerly the chairman of anesthesiology at the National University of Taiwan medical school. Dr. Lee had studied under a master of acupuncture in Taiwan, in addition to being trained in Western medicine at centers in Denmark, the United States and Canada. Dr. Modell visited acupuncture centers in China in the Spring of 1974.

Wide age range

The age of men and women participating in the experiment ranged from the 30's to the 80's. All had unrelieved pain from a wide variety of ailments including arthritis, headaches, neuralgia, and back problems. All had been referred to the study by their physicians after conventional medical or surgical treatment, or both, had failed. The experiment deliberately excluded those who were able to be helped by more conventional methods of therapy.

On four consecutive days, the participants received acupuncture treatment with a 27-gauge hypodermic needle and electric stimulation. (The authors used the hypodermic needle rather than the acupuncture needle because earlier studies had shown that results of both were equal.) Patients were interviewed immediately after treatment.

The carefully controlled comparison of the placement of needles indicated no difference between the use of traditional acupuncture locations and the sites chosen at random.

Conservative conclusion

In analyzing their results, the authors take a half-empty, half-full approach. "Since pain returned in the majority of patients, it

may be a waste of time to employ a technique that is at best 35 percent effective or, perhaps more critically, 18 percent effective. On the other hand, we might emphasize the fact that these 18 percent found relief in acupuncture after the failure of more conventional Western therapies." They conclude that "acupuncture may have a place as one of many possible treatments for chronic pain resistant to other methods."

"We had to raise the placebo issue," Dr. Modell said in an interview with *Mind and Medicine*. "Acupuncture may produce a placebo effect stronger than that achieved with the customary tablets of sugar or cornstarch. But we did not want to emphasize or de-emphasize the placebo aspect. It may or may not be the reason at work. We don't know yet."

As a result of his first-hand observations of acupuncture centers in China, Dr. Modell feels "it would be necessary to understand the culture and society of China, as well as their health problems and their health delivery system in order to understand the role that acupuncture plays. It may not be so simple to transplant this one aspect of their medical practice and achieve similar results." ■

Finding the "hidden" alcoholic

Although attention on alcoholism is increasing, the practicing physician knows full well that, among his own patients, alcoholics easily escape detection. The alcoholic comes into the doctor's office for attention to various medical ills, but does not volunteer the "real problem," and the doctor doesn't usually think to ask about it. To cope with this situation, to make possible a rapid identification and assessment of the alcoholic, psychologist Wendell M. Swenson, and psychiatrist Robert M. Morse, from the Mayo Clinic in Rochester, Minnesota, have recently developed a brief alcoholic screening test the patient himself can take, and which can be interpreted in a short time. Drs. Swenson and Morse, reporting on their test in the April, 1975 issue of *Mayo Clinic Proceedings*, write that the test could be useful to all doctors in identifying the alcoholic who might otherwise go undetected.

The questionnaire, grounded in a solid knowledge and understanding of the alcoholic's habits and problems, is—on the surface—remarkably simple and to the point. Here are a few of its 34 questions: Have you ever awakened the morning after drinking the night before and found you could not remember a part of the evening? Are you able to stop drinking when you want to? Have you ever lost a friendship because of your drinking? Do you ever drink in the morning? Have you ever had severe shaking, heard voices, or seen things that were not there after heavy drinking? Have you ever been arrested—even for a few hours—because of drunken behavior?

Drs. Swenson and Morse began to explore the possibility of a workable screening test when the Alcoholism Treatment Unit was opened at the Rochester Methodist Hospital in March of 1972. They based their questionnaire on an earlier instrument known as the Michigan Alcoholism Screening Test; but they refined, added to, and otherwise improved upon it. In the early states of refining their test, they gave it routinely to 100 patients (70 men and 30 women) admitted to the alcoholic treatment unit.

Spouse most accurate

The patient's spouse, if available, was asked to fill out the same form, assessing the patient's alcoholism. Once he'd gained

an adequate knowledge of his patient, the counsellor assigned to him (a former alcoholic) also completed the form. The authors report that, of the three, the patient, while frank, assessed his problem at the lowest level, the counsellor at the highest; the spouse's rating tended to fall somewhere in-between. The researchers concluded that the spouse's assessments are usually the most valid and objective.

Because the chief goal was to isolate and identify the alcoholic in a general medical population, the questionnaire was next administered to a control group of 100 patients randomly chosen from general and psychiatric hospital admissions. Within this control group, the questionnaire identified nine patients as "having significant alcoholic problems." Later they found that six of the nine had had significant records of previous alcoholism. The authors believe it's particularly important to detect the "hidden" alcoholic as soon as possible, since there is some evidence that early detection is closely allied to a more positive prognosis.

Surprising frankness

In evaluating their findings, Drs. Swenson and Morse commented on the surprising frankness of the subjects in both groups. All gave them full cooperation and none had any significant concern about invasion of privacy. This frankness (substantiated, the authors found, by other etiological studies), plus the appropriateness and directness of the questions, makes the test an effective screening device. Dr. Swenson sees no contradiction between the patient's undisclosed alcoholism and his frankness. The alcoholic remains "hidden" not so much because he wants to hide but simply because no one had ever asked him the direct question: "Are you an alcoholic?"

The authors feel that the test's being self-administered can save important professional time, yet yield invaluable background information on the patient. Of course, they point out, any patient whose score nearly approaches that of "alcoholism" should be fully examined and evaluated, and, if necessary, be given the required treatment as early as possible. The test is now being effectively used in some segments of the Mayo Clinic among a "mixed" medical population. ■

ABBOTT
LABORATORIES' **MIND
AND MEDICINE**

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Editor Joseph P. Coogan.

All correspondence should be addressed to:

Mind and Medicine
137 North 21st Street
Philadelphia
Pennsylvania 19103.



DESCRIPTION — Chemically, TRANXENE (clorazepate dipotassium) is a benzodiazepine. The empirical formula is $C_{15}H_{11}ClK_2N_2O_4$; the molecular weight is 408.92.

The compound occurs as a fine, light yellow, practically odorless powder. It is insoluble in the common organic solvents, but very soluble in water. Aqueous solutions are unstable, clear, light yellow, and alkaline.

ACTIONS — Pharmacologically, clorazepate dipotassium has the characteristics of the benzodiazepines. It has depressant effects on the central nervous system. The primary metabolite, nordiazepam, quickly appears in the blood stream. The serum half-life is about 2 days. The drug is metabolized in the liver and excreted primarily in the urine. (See ANIMAL AND CLINICAL PHARMACOLOGY section.)

INDICATIONS — TRANXENE is indicated for the symptomatic relief of anxiety associated with anxiety neurosis, in other psychoneuroses in which anxiety symptoms are prominent features, and as an adjunct in disease states in which anxiety is manifested.

CONTRAINDICATIONS — TRANXENE (clorazepate dipotassium) is contraindicated in patients with a known hypersensitivity to the drug, and in those with acute narrow angle glaucoma.

WARNINGS — TRANXENE is not recommended for use in depressive neuroses or in psychotic reactions.

Patients on TRANXENE should be cautioned against engaging in hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles.

Since TRANXENE has a central nervous system depressant effect, patients should be advised against the simultaneous use of other CNS-depressant drugs, and cautioned that the effects of alcohol may be increased.

Because of the lack of sufficient clinical experience, TRANXENE (clorazepate dipotassium) is not recommended for use in patients less than 18 years of age.

Physical and Psychological Dependence: Withdrawal symptoms (similar in character to those noted with barbiturates and alcohol) have occurred following abrupt discontinuance of clorazepate. Symptoms of nervousness, insomnia, irritability, diarrhea, muscle aches and memory impairment have followed abrupt withdrawal after long-term use of high dosage.

Caution should be observed in patients who are considered to have a psychological potential for drug dependence.

Evidence of drug dependence has been observed in dogs and rabbits which was characterized by convulsive seizures when the drug was abruptly withdrawn or the dose was reduced; the syndrome in dogs could be abolished by administration of clorazepate.

Usage in Pregnancy: Reproduction studies have been performed in rats and rabbits and there was no evidence of harm to the animal fetus. The relevance to the human is not known. Since there is no experience in pregnant women who have received this drug, safety in pregnancy has not been established.

It is assumed that TRANXENE (clorazepate dipotassium) or its metabolites are excreted in human milk. Therefore, this drug should not be given to nursing mothers.

PRECAUTIONS — In those patients in which a degree of depression accompanies the anxiety, suicidal tendencies may be present and protective measures may be required. The least amount of drug that is feasible should be available to the patient.

Patients on TRANXENE for prolonged periods should have blood counts and liver function tests periodically. The usual precautions in treating patients with impaired renal or hepatic function should also be observed.

In elderly or debilitated patients, the initial dose should be small, and increments should be made gradually, in accordance with the response of the patient, to preclude ataxia or excessive sedation.

ADVERSE REACTIONS — The side effect most frequently reported was drowsiness. Less commonly reported (in descending order of occurrence) were: dizziness, various gastrointestinal complaints, nervousness, blurred vision, dry mouth, headache, and mental confusion. Other side effects included insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression and slurred speech.

There have been reports of abnormal liver and kidney function tests and of decrease in hematocrit.

Decrease in systolic blood pressure has been observed.

DOSAGE AND ADMINISTRATION — TRANXENE (clorazepate dipotassium) is administered orally. The capsules may be given in divided doses. The usual daily dose is 30 mg. The dose should be adjusted gradually within the range of 15 to 60 mg. daily in accordance with the response of the patient. In elderly or debilitated patients it is advisable to initiate treatment at a daily dose of 7.5 to 15 mg.

TRANXENE capsules may also be administered as a single dose daily at bedtime; the recommended initial dose is 15 mg. After the initial dose, the response of the patient may require adjustment of subsequent dosage. Lower doses may be indicated in the elderly patient. Drowsiness may occur at the initiation of treatment and with dosage increment.

TRANXENE-SD tablets (22.5 mg.) may be administered as a single dose every 24 hours. This tablet is intended as an alternate dosage form for the convenience of patients stabilized on a dose of 7.5 mg. capsules three times a day. TRANXENE-SD tablets should not be used to initiate therapy.

DRUG INTERACTIONS — If TRANXENE (clorazepate dipotassium) is to be combined with other drugs acting on the central nervous system, careful consideration should be given to the pharmacology of the agents to be employed. Animal experience indicates that TRANXENE prolongs the sleeping time after hexobarbital or after ethyl alcohol, increases the inhibitory effects of chlorpromazine, but does not exhibit monoamine oxidase inhibition. Clinical studies have shown increased sedation with concurrent hypnotic medications. The actions of the benzodiazepines may be potentiated by barbiturates, narcotics, phenothiazines, monoamine oxidase inhibitors or other antidepressants.

If TRANXENE (clorazepate dipotassium) is used to treat anxiety associated with somatic disease states, careful attention must be paid to possible drug interaction with concomitant medication.

MANAGEMENT OF OVERDOSAGE — Overdosage is usually manifested by varying degrees of CNS depression ranging from slight sedation to coma. As in the management of overdosage with any drug, it should be borne in mind that multiple agents may have been taken.

There are no specific antidotes for the benzodiazepines. The treatment of overdosage should consist of the general measures employed in the management of overdosage of any CNS depressant. Gastric evacuation either by the induction of emesis, lavage, or both, should be performed immediately. General supportive care, including frequent monitoring of the vital signs and close observation of the patient, is indicated. Hypotension, though rarely reported, may occur with large overdoses. In such cases the use of agents such as Levophed® (levarterenol) or Aramine® (metaraminol) should be considered.

While reports indicate that individuals have survived overdoses of TRANXENE as high as 450-675 mg., these doses are not necessarily an accurate indication of the amount of drug absorbed since the time interval between ingestion and the institution of treatment was not always known. Sedation in varying degrees was the most common physiological manifestation of TRANXENE overdosage. Deep coma when it occurred was usually associated with the ingestion of other drugs in addition to TRANXENE.

ANIMAL AND CLINICAL PHARMACOLOGY — Studies in rats and monkeys have shown a substantial difference between doses producing tranquilizing, sedative and toxic effects. In rats, conditioned avoidance response was inhibited at an oral dose of 10 mg./kg.; sedation was induced at 32 mg./kg.; the LD₅₀ was 1320 mg./kg. In monkeys aggressive behavior was reduced at an oral dose of 0.25 mg./kg.; sedation (ataxia) was induced at 7.5 mg./kg.; the LD₅₀ could not be determined because of the emetic effect of large doses, but the LD₅₀ exceeds 1600 mg./kg.

Twenty-four dogs were given TRANXENE orally in a 22-month toxicity study; doses up to 75 mg./kg. were given. Drug-related changes occurred in the liver; weight was increased and cholestasis with minimal hepatocellular damage was found, but lobular architecture remained well preserved.

Eighteen rhesus monkeys were given oral doses of TRANXENE from 3 to 36 mg./kg. daily for 52 weeks. All treated animals remained similar to control animals. Although total leucocyte count remained within normal limits it tended to fall in the female animals on the highest doses.

Examination of all organs revealed no alterations attributable to TRANXENE. There was no damage to liver function or structure.

Reproduction Studies: Standard studies of fertility, teratology and reproduction were conducted on rats and rabbits. Oral doses in rats up to 150 mg./kg. and in rabbits up to 15 mg./kg. produced no abnormalities in the fetuses and no impairment to fertility and reproductive capacity of adult animals attributable to TRANXENE (clorazepate dipotassium). As expected, the sedative effect of high doses interfered with care of the young by their mothers (see *Usage in Pregnancy*).

Clinical Pharmacology: Studies in healthy men have shown that TRANXENE has depressant effects on the central nervous system. Prolonged administration of single daily doses as high as 120 mg. was without toxic effects. Abrupt cessation of high doses was followed in some patients by nervousness, insomnia, irritability, diarrhea, muscle aches, or memory impairment.

Absorption — Excretion: After oral administration of TRANXENE (clorazepate dipotassium), there is essentially no circulating parent drug. Nordiazepam, its primary metabolite, quickly appears in the blood stream. In 2 volunteers given 15 mg. (50 μ C) of ¹⁴C-TRANXENE, about 80% was recovered in the urine and feces within 10 days. Excretion was primarily in the urine with about 1% excreted per day on day 10.

HOW SUPPLIED — TRANXENE (clorazepate dipotassium) is supplied as capsules in three dosage strengths:

3.75 mg. capsules (gray with white cap) in bottles of 100 (NDC 0074-3417-13) and 500 (NDC 0074-3417-53). Also available in ABBO-PAC® unit dose packages of 100 capsules (NDC 0074-3417-11).

7.5 mg. capsules (gray with maroon cap) in bottles of 100 (NDC 0074-3418-13) and 500 (NDC 0074-3418-53). Also available in ABBO-PAC® unit dose packages of 100 capsules (NDC 0074-3418-11).

15 mg. capsules (all gray) in bottles of 100 (NDC 0074-3419-13) and 500 (NDC 0074-3419-53). Also available in ABBO-PAC® unit dose packages of 100 capsules (NDC 0074-3419-11).

TRANXENE-SD is supplied as 22.5 mg. tablets (tan-colored) in bottles of 100 (NDC 0074-2997-13).

ONCE-A-DAY
Tranxene®
(CLORAZEPATE DIPOTASSIUM)

the Thoughtful Therapy

for Anxiety

A.

April 7, 1976

Mrs. Linda Abbott
Fegan 6, Children's Hospital
300 Longwood Avenue
Boston, Mass. 02115

Dear Mrs. Abbott:

I am enclosing 3 copies of "Ghosts In The Nursery"
for your use.

I am sorry but we cannot provide more reprints
for you. We are limited in our supply. It might
be possible to get some from the publisher if you need
a supply.

Sincerely,

Selma Fraiberg
Professor of Child Psychoanalysis
Director, Child Development Project

SF/amw

sent 3
4/7/76



The Children's Hospital Medical Center

300 Longwood Avenue, Boston, Massachusetts 02115, Telephone: (617) 734-6000

Rec'd
4/1/76.

Send 3

Mrs. Selma Fraiberg
201 E. Catherine St.
Ann Arbor
Michigan 48108

Dear Mrs. Fraiberg:

I have just read your article, "Ghosts in the Nursery" and have found it very useful to my work with parents and children. I would find it helpful if you could send me several reprints of that article which I could share with my colleagues.

Lily
Should we
change or how
should we handle this?

Sincerely,

Linda R. Abbott

(Mrs. Linda Abbott, RN, MS)
Fegan 6
Children's Hospital
300 Longwood Ave.
Boston, Ma.
02115

March 30, 1976

Mr. Austin G. Anderson
Director
The Institute of Continuing Legal Education
Hutchins Hall
University of Michigan
Ann Arbor, Michigan 48109

Dear Mr. Anderson:

Thank you for your very kind invitation to be a part of your program, "Managing the Lawyer's Life" at Shanty Creek.

I am very sorry but I will be out of town at that time and will not be available.

Thank you for inviting me.

Sincerely,

Selma Fraiberg
Professor of Child Psychoanalysis
Director, Child Development Project

SF/amw

THE INSTITUTE OF CONTINUING LEGAL EDUCATION

THE UNIVERSITY OF MICHIGAN LAW SCHOOL

WAYNE STATE UNIVERSITY LAW SCHOOL

STATE BAR OF MICHIGAN

AUSTIN G. ANDERSON, DIRECTOR
HUTCHINS HALL
ANN ARBOR, MICHIGAN 48109

313/764-0533

March 24, 1976

*Rec'd
3/26/76*

Selma H. Fraiberg
Director, Child Development Project
and Professor of Psychiatry
201 East Catherine Street
Ann Arbor, Michigan 48109

Dear Ms. Fraiberg:

I am the Director of the Institute of Continuing Legal Education of the Law School of the University of Michigan here in Ann Arbor. We are presently developing a program entitled "Managing the Lawyer's Life" for attorneys and their spouses. The course will focus on topics related to a professional's life, not including the actual practice of law. A course schedule is included for your information. A similar course was offered last June by the Washington State Bar Association and was extremely well-received.

Dr. Robert Carpenter, who assisted me in planning the program, recommended you as a lecturer on the subject "What Do You Do With Your Teenage Child?" The topic is of great interest to lawyers and their spouses. Your considerable expertise in the area of child development would be a valuable addition to the course.

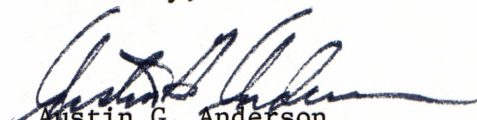
The program will be held June 11-12, 1976, at Shanty Creek, a resort complex located near Traverse City. We will limit enrollment to approximately 100 lawyers and their spouses in order that there might be interaction among the registrants.

We would be pleased to have you present for as much of the conference as your schedule would permit; however, your formal obligation would not extend beyond your 45-minute lecture and any questions that might ensue. We would be pleased to cover your travel and lodging expenses, and pay you an honorarium of \$100.

I sincerely hope that you will be able to join us, and look forward to your response. I would very much appreciate hearing from you by March 31.

Thank you for your consideration.

Sincerely,


Austin G. Anderson
Director

AGA/ces

MANAGING THE LAWYER'S LIFE

Shanty Creek

June 11-12, 1976

FRIDAY, JUNE 11

9:00 - 11:00 a.m. Some Facts and Fancies About
Your Health Maintenance

When Things Get Tough:
Some New Approaches for
Relaxation

Alcohol: Understanding and
Managing Its Use

11:00 - 12:30 Type A, Behavior, Tension and
Your Heart

12:30 - 2:00 Lunch

2:00 - 3:30 Type A, Behavior, Tension and
Your Heart (continued)

3:30 - 4:30 Unravel as You Travel: Expert
Tips on How to Do It

6:00 Barbeque - Poolside

SATURDAY, JUNE 12

(Morning free for unstructured activities)

11:00 - 1:00 p.m. Financial Planning for Attorneys
and Spouses

1:00 - 2:30 Lunch break and
unstructured activities

2:30 - 3:15 Deciding Together What is
Important in Life

3:15 - 4:00 Personal Interaction

✓ 4:00 - 4:45 What Do You Do with Your
Teenage Child?

THE UNIVERSITY OF MICHIGAN

DEPARTMENT OF PSYCHIATRY

P. Fraiberg
Rec'd
1/9/76.

Fite

MEMO TO: Chiefs of Programs
FROM: W. J. Aparicio WJA.
SUBJECT: Cost of Analysis by Program
DATE: December 23, 1975

The enclosed schedules represent a detailed cost analysis of your program.

A summary sheet with specific backup material is provided. Faculty effort is broken down by FTE's and dollars into Teaching and Patient Care components. Indirect costs, such as heat, light, maintenance, and cleaning are not included in this information.

The chiefs of the two major services will receive in addition to the schedules of cost by program, a complete summary of all costs attached to the Adult and Youth Services, including faculty.

A similar summary analysis was prepared for the programs under the Chairman's office.

I hope this cost data will help the chiefs of programs better understand the resources in their respective areas.

If any additional information is needed in understanding the cost data being distributed, please do not hesitate to call me.

cc: G. Yank
D. Miller, M.D.
R. Benson, M.D.

PSYCHIATRY

COST OF FACULTY by AREA OF ACTIVITY

CHILD DEVELOPMENT PROJECT

1	2	3	4	5	6	7
		PATIENT CARE	TEACHING TEACHING RESEARCH	ADMINIS- TRATION	TOTAL	
1						1
2	FILMIBERG	0.27	0.14	0.20	0.07	2
3		\$11,420	\$5,922	\$8,459	\$2,961	3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
22						22
23						23
24						24
25						25
26						26
27						27
28			FTE	\$		28
29						29
30	P. CARE		0.34	\$14,381		30
31						31
32						32
33	TEACHING		0.34	14,381		33
34						34
35						35
36				\$58,762		36
37						37
38						38
39						39
40						40

THE UNIVERSITY OF MICHIGAN

November 19, 1975

To: Mr. Donald Koos

From: Adele Wilson, Child Development Project

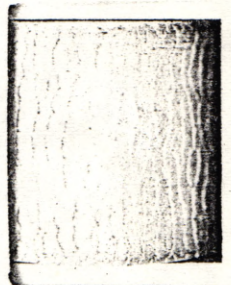
This form (Faculty Effort Analysis) has been completed while Professor Fraiberg is out of town.

I have completed it to the best of my ability but want you to know that it may be somewhat inaccurate.

RECEIVED

NOV 19 1975

D. A. KOOS



DEPARTMENT OF PSYCHIATRY
FACULTY EFFORT ANALYSIS
1975-76

FACULTY MEMBER NAME:

SELMA FRAIBERG

ACADEMIC RANK:

PROFESSOR

APPOINTMENT FRACTION:

0.88 FTE 37.222

PATIENT CARE EFFORT:

Major Service: Provide infant assessment, clinical study
and parent guidance in a home-based program on behalf of
Program: AN INFANT MENTAL HEALTH PROGRAM /children

Chief of Program:

Selma Fraiberg

DISTRIBUTION OF PATIENT CARE EFFORT:

Location: 201 E. Catherine St.
%: 40

1) Inpatient Floor: _____

2) Outpatient Clinic: X

3) Brief Description of Patient Care Involved: Diagnostic, assessment
and treatment in a home-based program.

4) Other: _____

DISTRIBUTION OF TEACHING EFFORT:

%: 20

Bona Fide Medical School Course: _____

1) Supervision:

a) House Officers: Weekly consultation with senior staff on
behalf of patients.

b) Psychology Interns: X

c) Others: Social Work and Pediatric Nursing (post masters)

2) Committee work dealing with teaching: _____

3) Other teaching activity not described above: _____

2 seminars held weekly and bi-weekly. Visiting

lecturer to other University of Michigan departments

and other universities throughout the country.

RECEIVED

NOV 19 1975

D. A. KOOS

RESEARCH (cont.):

%: 30

Specify what type of research are you involved with:

- a) Patient Care: _____
- b) Teaching: _____
- c) Other: _____

ADMINISTRATION:

%: 10

Patient Care Administrative Committee Time: _____

Other: Grant administration

ACCOUNT NO. 208110 ? CHILD DEV PROJECT
208110

CLASSIFICATION
TITLE

BUDGETED
HOURS

BUDGETED
DOLLARS

C-4

F. WILSON

40

9,417

TOTAL

40 hrs

\$9,417

FTE = 1

Finan



Jan. 4th, 1976

Dear Selma, Louise and Lisa,

Chloé says "Thank you
very much for the lovely
pink dress."

We hope you can
visit us soon.

Wishing you a Happy
New Year

Evelyn, Dushil and Chloé

★ Huichol Yarn Painting from Mexico. Design contributed to benefit UNICEF, the United Nations Children's Fund. ★ Dessin en fil de la tribu Huichol (Mexique) offert à l'UNICEF, le Fonds des Nations Unies pour l'enfance. ★ Diseño huichol hilado, México. Contribución al UNICEF, el Fondo de las Naciones Unidas para la Infancia. ★ Витканый рисунок Уичоль (Мексика). Подарок Детскому фонду Организации Объединенных Наций (ЮНИСЕФ). ★ 惠卓尔族（墨西哥）线织图案，赠给联合国儿童基金会。



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