The Signal

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Psychiatric Interventions in Crisis Situations:
Working in the Former Yugoslavia

by Marie Rose Moro

For a long time now I have been working with children and their families living in precarious and sometimes tragic situations. Some of the situations are linked to natural disasters, famines, etc., but more often than not, they are the results of war and situations linked to the whims of politics and power.

Médecins Sans Frontières (Doctors without borders) is a French humanitarian medical organization that has provided emergency medical aid for more than twenty years throughout the world.

A first Médecins Sans Frontières (MSF) mission with mental health professionals took place in Armenia. It set up a treatment center for children and adolescents having suffered from the earthquake of 1988. A second mission took place in Romania with the children in orphanages. The third was with the Bosnian and Croatian refugees and their families in France, then in Croatia. An exploratory mission was carried out in Mozambique during the war that has lasted for many long years. The mission aimed to analyze arrangements likely to optimize mother-child relationships in such circumstances (famine, war, and displacements). A new mission has been undertaken in Palestine for children and adolescents. In varying degrees, these missions bring together psychiatrists, psychologists, educators, nurses, and other professionals.

The work, however, is very different from one continent to another, and from one country to another. Present interventions such as those being carried out in the former Yugoslavia are special for the fact that they are happening in Europe, which makes them radically different from previous interventions in, for example, Africa. Because of the geographical and cultural proximity, it might be thought that European techniques could be transposed in their entirety, but what we are about to see is that the context must be taken into consideration and understood in its totality. Moreover, these interventions are representative of those now faced by humanitarian organizations. Previously, it was thought that providing

food, treating epidemics, and performing surgical operations were enough. We now know that there are also psychological emergencies and mental suffering that, if left untreated, can become irreversible. This is especially true for babies and young children. Yet, this working together of specialists in food and medical emergencies and those in mental health is not so clear-

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cut. There is need for reciprocal adaptation. Non-psychiatric physicians sometimes have a hard time understanding the rationale of mental work. "Shrinks" of every stripe often lack pragmatism and sometimes take their theoretical quarrels into the field with them! We all know this! So there is a need for an apprenticeship, and of reciprocal adaptation on all sides.

Working in Europe means that in countries where we work, there are already trained health professionals. And whatever the quality of their training, we have to work with these professionals and not instead of them. In fact, it must be said that even in countries without trained professionals, there are always people who fulfill a medical role for their people (however they may be called: healers, matrons, etc.), and they must not be shunned. But do we know how to deal with them? This is one of the major problems in this job. This is what makes me think that these field teams must open up to other professionals: ethnopsychiatrists, for example, anthropologists, mother-infant specialists, and/or sociologists. We then run up against the problem of decentration and a multiplicity of professions. A doctor's expertise alone isn't enough any more than a psychoanalysts', a psychiatrists,' or an anthropologist's is. In short, it's a good lesson in modesty!

There's another snag too: time. Every field worker has at one time or another seen professionals from Paris or New York or elsewhere arrive in the field bearing "gifts," usually a good work more than truly effective help. They've come to tell the locals or the expatriate professionals who have been living and working with the locals in precarious situations for long months how the job should be done. They look, criticize, film, make judgments out of context, then go away again, leaving behind the daily pain, the necessary adjustments due to material difficulties and human limits. They also sometimes leave behind the fear of bombing, of deprivation. On the other hand, field personnel sometimes think it enough to be on hand to be effective! Arriving at a proper balance is required, a subtle alchemy between rigor and humanity that has to be renewed ceaselessly. Now let us turn to the former Yugoslavia as we bear these principles in mind.

Work in the Former Yugoslavia

I'd like to stress a few points that seem to me to be especially new and tragic in this situation. For this, I will depend essentially on work by A. Le Brun (1993) and V. Nahoum-Grappe (1993). The conflict is causing an addition and a multiplication of potential trauma.

1) First of all, in A. Le Brun's terms (1993) the extreme misfortune of the Croatian, then Bosnian people, victims of the implementation by the Serbs of the first racial State in Europe since the Third Reich. Faced with this disaster, our inability to understand and to act. Psychiatric interventions are also bogged down by this lack of understanding.

2) Another disastrous novelty: the concentration-camp life is no longer restricted to Tito's gulag, Naked Island, but has been extended to a large part of the civilian population. "Everyone becomes a displaced person and equally susceptible to being deported, tortured, or executed" (Le Brun, ibid, pg.17). Trauma is, so to speak, no longer limited to very localized situations. Real or potential, they now concern a large part of the civilian population. We are smack-dab in the middle of a concentration-camp experience. We were slow in recognizing "the overflow of the concentration-camp world into civilian society, the very movement itself of totalitarianism which consists in changing whole populations into criminals who have not committed a crime" (ibid, pg.19). It is an H. Arent's expression.

3) I would stress the fact that with this war people wanted to see, at least

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in the beginning, a simple little identity crisis." That is, having been, freed at last from the Tito yoke, cultural identities clashed. Present-day political, historical, even anthropological studies have shown that it is much more like a "totalitarian crisis" that depends on pseudo-populist theories nourished by theorists (note the place of certain psychiatrists of the former Yugoslavia in building these ideological mountains). Any reading that would reduce this to a simple inter-ethnic conflict is clearly insufficient (Nahoum-Grappe, 1993).

In France

At the end of October, 1992, in the framework of the international humanitarian action implemented by the United Nations High Commissioner for Refugees, the French government decided to receive three hundred Bosnian civilians, former detainees in the Serb detention camps of Bosnia-Herzegovina, and their families.

A team from Médecins San Frontières carried out a medical-psychological assessment mission with these refugees. Their report revealed a whole gamut of transgressions committed against the civilian population that come under the legal heading of crimes against humanity. With a great deal of uniformity, all the accounts trace an unrelenting fury to destroy and to torture, whether it be by the concentration-camp rationale within the bounds of the detention camps or by the terror fomented by armed bands within towns and villages transformed into prisons. Given the seriousness of the exactions, MSF decided to make public a first report on the "Process of Ethnic Cleansing in the Kozarac Region" (December 7th, 1992). The aims of the action were to favor an appropriate treatment and to facilitate the restoration of a mental, anthropological, social and legal space for a population particularly tried by the length, multiplicity, and intensity of the trauma they had experienced.

There were two main components of the work. First, psychological support for the victims: this meant lending support to the refugees as they came to grips with the problems of terror, mourning, exile, and guilt for having survived. Technically, the basis of this support work consisted of establishing links between the mental past and present, a link that may be blocked by the experience of traumatic violence. This meant enabling them to build an account and encouraging existing resources within their traditions and their history.

Second, it meant gathering their eyewitness accounts: in accordance with its humanitarian principles MSF undertook to gather information so as to determine the exact nature of the exactions committed in Bosnia-Herzegovina from March, 1992 to the present. Beyond its legal dimension, the interest in gathering eyewitness accounts is that it helps in the therapy by re-instigating the work of linkage and by articulating experience, thus creating links between individual and collective experience.

Setting up a Treatment Center in Croatia (Karlovac)

Nearly 270,000 Bosnian Muslims have been taken in by Croatia to date. Some have settled into refugee camps, but the majority have been housed in private homes out of solidarity.

The creation of a psychology-treatment center was undertaken after several assessment missions had been to Croatia. In early June, a three-member team (a doctor, a psychologist, and a legal expert) undertook to establish a medical-psychological treatment unit in the Karlovac camp where 400 former detainees and their families (1,600 persons in all) have settled. The Karlovac refugee camp (KTC UNHCR transit camp) is 50 kilometers south of Zagreb and 1 kilometer from the front lines. It is the preferred arrival place of detainees released from Serb detention camps under the ægis of the ICRC (International Committee of the Red Cross). The refugees have been waiting for transfer abroad for periods varying from three to ten months.

The medical-psychological treatment unit is made up of two locally recruited teams (a medical examination and a psychological examination), and an MSF advisory team. The medical examination is intended to provide initial treatment, follow-up of chronic diseases, and management of the pharmacy.

The main work lines in the psychological examination are the same as with refugees in other countries except for certain specifics:

1. Work on infant suffering when the mother is so absorbed by absences and mourning that she is unavailable for her infant. The work aims at rebuilding the mother-infant bond that has often become inharmonious.
2. Work of personal rebuilding for adults within groups (rebuilding self-esteem damaged by the degrading conditions of refugee, torture, rape, etc.).
3. Work with adolescents with a view to providing solutions to the lack of parental and group boundaries and supervision.
4. Work with school age children's groups to enable the children to elaborate on the trauma experienced.
5. Work with elderly persons with the intention of restoring them to their positions as witnesses to the past, as purveyors of meaning regarding the present situation.
6. Support work with local teams so that the suffering they are faced with does not impede their chances of helping.

The reference model for working sessions is that of short-term therapy with care only exceptionally exceeding three months. An assessment of this mission's results is now being carried out.

Conclusions

These psychiatric interventions in the framework of a humanitarian

organization derive from an absolute ethical and human necessity. This necessity depends on eyewitness accounts and the fact of being involved in inhuman situations whatever their origins. Yet, these psychiatric interventions run up against epistemological and technical difficulties: a multi-dimensional approach has to be taught; complementarily and decentration have to be sought, and modesty accepted. They run up against boundaries, i.e., the migration of professionals and their techniques. This does not mean a simple transfer of technology, but a mutual building of systems that have to be adapted to each situation. These technical systems must respect men and women, contexts, situations, and cultures.

Psychological care in these circumstances is a matter of vital necessity. It should be associated with new technical reflection and research in many interrelated fields.

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Infant Mental Health Discourse: Toward a Semiotic Perspective?

by Martin St-André, CM, MD, FRCP(C)

This short essay was stimulated by three questions. 1) a wish to comment on the selection of "The Signal" as the name for the WAIMH newsletter, in the context of the variety, complementary, and sometimes competitiveness of discourses in the field of infant mental health, 2) the question by Stern (1993) in his article on children's narratives as to whether a "narrative perspective ... is a new way of looking at things that is sufficiently general that it embraces aspects of cognitive, social, affective, etc, psychology, such that much of our understanding must be recast in this light?", and 3) a personal attempt to resolve a "confusion of tongues" that became clear in the course of my infant psychiatry training across different theoretical and cultural settings.

What these questions have in common might not be immediately obvious. One way that they are related is by being part of a search for a discourse that can progressively accommodate a variety of theoretical perspectives. The enrichment and expansion of discourse in the field of infant mental health is itself embedded in the post-modern struggle to make sense of an extraordinary variety of perspectives, in part related to the explosion of communications (Lyotard, 1984). With the theoretical cross-fertilization and the cultural expansion of the infant mental health movement, it seems legitimate to reflect at times on the nature of our theoretical discourse and to try to emphasize commonalities in the various theoretical threads that constitute this discourse.

In a way, I think that the name that was chosen for this newsletter and the attending thoughtful editorial comments about this choice are reflective of an attempt to provide a medium and a container to the diversity in our field. In addition to referring to communicative processes within our discipline, the name of our newsletter is also quite representative of our intense curiosity to understand and categorize the variety of signs that are continuously exchanged between an infant and her environment.

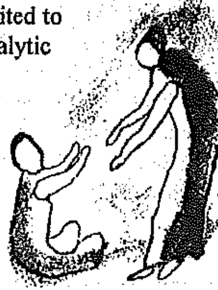
The signs that we are studying come in a wide variety of categories, and include signals, that are more directly associated with biologically determined exchanges such as cries and gazes (Werner & Kaplan, 1984; Leach, 1976), and linguistic signs that are more relationally defined. To mention that babies are immersed in a world of signs from birth maybe comes as a truism, but helps to emphasize commonalities across various areas of infant studies in spite of significant differences in methods (for example empirical/ observational or hermeneutic/ intersubjective). This view is congruent with a semiotic approach that tends primarily to emphasize a "point of view" rather

than "a method" (Deely, 1990). In fact, the expanding interest in our field to various semiotic systems (linguistic, biological, behavioral, systemic) is very consistent with the relatively recent legitimization of direct infant observation by people coming from the psychoanalytic tradition, and conversely, the relatively recent interest in the empirical study of discourse among people with a more developmental and empirical background.

One reason why the study of narrative systems is akin to other semiotic systems can be traced to the origins of semiotics, at the turn of the century, on both sides of the Atlantic. Both the linguist Ferdinand de Saussure and the philosopher Charles Sanders Pierce established the basis for a science of signs (Culler, 1986; Hoopes, 1991). More particularly, the work of de Saussure was seminal in demonstrating the structural organization of language, and the indissociability of content and form. The emphasis on contextualizing linguistic signs within a structure largely independent of its own history had wide-ranging implications to study of other human domains (de Saussure, 1966). This insight into the rules governing systems of signs was applied enthusiastically in the creation of the structuralist movement, and involved a variety of disciplines including developmental psychology and psychoanalysis (Piaget, 1968; Hawkes, 1977).

A semiotic perspective in which categories of signs are reconstructed as part of underlying structures tends to emphasize theoretical parallels in the various domains of infant studies. In other words, if we share a belief in the reconstruction of structures through the study of various groups of signs, it becomes clear that people studying different systems of signs (and eventually using different methods of observation) can share a transdisciplinary quest to study the continuity of structures across domains, across time, and across generations. For example, the notion of structure is implied if not directly stated in various theoretical constructs: attachment as an organizational construct (Sroufe & Waters, 1977), various empirical classifications of adult relatedness (Main & Goldwyn, 1993; Fishler, Sperling, & Carr, 1990), various psychoanalytic attempts at classifying personality organization (Kernberg, 1970, Bergeret, 1985) or at studying the process of symbolization (Ogden, 1985; Green, 1975).

The study of signs across different domains of experience necessitates different methods. For example, the intersubjective appraisal of human motives is increasingly legitimized to examine motivational units in discourse (Bruner, 1990). The increasing recognition of "narrative truth" (Spence, 1982), far from being limited to psychoanalytic theory, shares with



other disciplines a movement away from historicity (Lévi-Strauss, 1966) to emphasize coherence within a system. A serious epistemological difficulty inherent to a hermeneutic method is that an intersubjective relativism can ultimately negate truth beyond language (Sarup, 1993; Messer, Sass, & Woolfolk, 1988). It is reassuring in our field to be reminded that the ultimate justification of our endeavor is to have an impact on infants and their families, and that the phenomenology of various clinical events in infants and their families provides us with a yardstick with which to compare and validate our observations and our constructions. In that sense, narrative approaches that emphasize inter-rater reliability are promising in bridging a gap in our understanding of how subjective events translate into actions across domains, across time, and across generations.

The quest for a transdisciplinary perspective in infant mental health that tries to go beyond the boundaries of our theoretical dialects and modes of enquiry seems well on its way. A narrative perspective, far from being new, is but one part of a discourse reconstructing the organization, transformation and action of different categories of signs exchanged between infants and their environment. This quest privileges heuristics and, at its worst, it might be too general to have any technical applications. At its best, however, it exerts on our discourse an "unbearable lightness" (Kundera, 1984), and it prevents a risk of fragmentation under the weight of seemingly irreconcilable perspectives (Gergen, 1991). Reflecting on our own discourse might be a possible antidote to the compartmentalization of discourse in infant mental health brought both by the variety of conceptual domains in infant studies, and by the transdisciplinary splits that often occur more out of political reasons than out of scientific reasons.

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TALES FROM TRAINING

by Beth Finley, M.D

My initial contact with this case was through the supervisor of my program infant behavior clinic, who said to me; "Beth, how would you like the hardest case in the world?" This, of course, piqued my interest.

I have been working with this family for over two years. The case involves a 22 year old African American mother, Aleisha, and her now 4 year old son, Antoine, the original identified boyfriend for the last year and a half, and Novella, Phillip and Aleisha's 4 month old daughter. All three children have different fathers, but Antoine and Elizabeth have no contact with their biological fathers and call Phillip, "Dad." They currently live in the project of a small city adjacent to a medium sized city in New England. They have been living there one year.

Prior to that, and when I first met Aleisha, she and her two older children had been living on the third floor of a three family house. Aleisha's maternal grandmother lived on the first floor and her aunt and her large family lived on the second floor. This house was located in the medium sized city in an area considered "inner city." They moved after Phillip had been living with them several months.

Aleisha had been well known to a network of clinicians working with adolescent pregnancy, and their psychosocial involvement and support, through the obstetrics, psychiatry and pediatrics departments, since the time of her first pregnancy at age 16. She had had numerous contacts with various clinicians and attempts at engaging her in some type of treatment around parenting and infant/parent work. It seemed, however, that the

Aleisha and Antoine's involvement in a study that my supervisor had been doing involving inner city mothers. Aleisha volunteered for the study prenatally. The study involved several prenatal contacts as well as laboratory and home visits with videotaping. The study participation lasted through the child's second birthday. Several factors led to the referral. During study contacts, a persistent conflicted discomfort in the relationship between mother and child was noted, and described as having a teasing/taunting quality. It was clear that there was a serious, persistent struggle between mother and son.

Throughout the study, Aleisha's self-reports of distress were extremely high, with scores on the Beck Depression Inventory Scores frequently in the severely depressed range. The researchers called Aleisha's attention to a number of their observations about her difficulties with Antoine during a wrap-up session at the end of the study, and they recommended treatment. Aleisha agreed with their observations, admitting to persistent discomfort regarding her relationship with Antoine, and she agreed to treatment. The researchers told her that they would arrange to have someone meet with her at her home to talk about her concerns.

My supervisor and I discussed the case -- specifically, what reasonable goals and approaches might be. Given the significant history of difficulty maintaining treatment conduct, the basic establishment and maintenance of a therapeutic relationship was defined as the initial goal.

My initial session with Aleisha was one that I still remember well. I had arranged it with Aleisha by contacting her on her maternal grandmother's phone, as she had none. I located the house, which was only about 2 minutes from the hospital where I was based at the time. I securely locked my car and headed up the front steps. I pushed wide the partially open front door and advanced into the darkened entry way which housed an overflowing garbage can. I carefully climbed the two darkened flights of stairs, ever ready to flee from running rodents I anticipated seeing at any moment (there were none). As I ascended, I was greeted by the light of a window on the third floor landing. I found the handleless door and knocked. I heard a muffled, "Come!" from inside. I pushed the door open. I entered a dark apartment. A few paces took me into the living room where two women sat on either end of the battered couch. I asked "Aleisha?" and she looked up and said, "Yeah."

Aleisha sat slumped at one end of the couch wearing dark clothes. I could barely discern her features in the darkness but for the light of the large television across the room blaring a rap video. I introduced myself and extended my hand which she took limply. She motioned for me to sit in a deep, overstuffed chair to the side of the couch. She never introduced her companion, who never spoke. Between the two women on the couch was a soundly sleeping boy who appeared to be about two years old, and I assumed that this must be Antoine.

Aleisha and I have met weekly, initially often in her still darkened apartment with rap video playing. Often times, the children were present and she was able to talk about her frustrations with their constant neediness and her own feelings of neediness and emptiness.

I asked her about her understanding of my being there. She explained that she understood that I was there to talk with her. She immediately began complaining about Antoine awakening her early in the morning and her needing to lock him out of her room. She explained that Antoine was home today from Head Start where he went from 9:00-4:30 daily since the age of 18 months. He was home today because he had had an appointment at the hospital for a speech evaluation because of his "mumbling." The recommendation today was to bring him back in 6 months. Aleisha felt it had been pretty useless. I made a mental note of this first mention by her of her distrust of caregivers but [timidly] I didn't address it at the time.

About 30 minutes into the interview, as my arm lay on the armrest of the chair, I noticed a feeling of movement on my right hand and looked over to see a cockroach. I quickly raised my hand in a sweeping gesture to dislodge him, at the same time suppressing the urge to scream and flee. As I lowered my hand in a movement that I hoped looked like I had been smoothing my hair, it appeared to be unnoticed--all other eyes were glued to the rap video.

Soon, Aleisha woke Antoine by roughly shaking him. She explained to me this was so he would go to bed at a reasonable hour that night. When he sat up, she stuck a cookie in his mouth which he grabbed and removed. She then took a cookie and began eating it herself. She said he liked to watch videos and put the remote control in his hands. Taking his hand, she pushed the buttons while telling him how important it was to know how to change channels.

Antoine was clean, though he had a perpetually runny nose. He sat on the couch for the duration of my visit without any toys or significant activities with which to busy himself. Aleisha got up once to go to the door in response to a knock. When she returned, Antoine had picked up the television control. Aleisha pushed him roughly and said, "Are you mad at me?" He did not respond. She pushed him again, and he responded by hitting back at her. A few minutes later, Antoine was sitting very still and had almost fallen back to sleep. Aleisha hit him lightly, saying, "Wake up!" He hit back at her

several times. She looked over at me and explained that "he's just falling back to sleep." Soon after that I got up to go. When I said good-bye, Antoine spontaneously began to cry.

Aleisha and I have met weekly, initially often in her still darkened apartment with rap video playing. Often times, the children were present and she was able to talk about her frustrations with their constant neediness and her own feelings of neediness and emptiness. At times, family or friends would be there when I got there or they occasionally barged into the house interrupting us. At these times, Aleisha behaved as though powerless to alter this.

As we have continued to meet, I was rapidly integrated into Aleisha's extended family with everyone knowing that I was "Aleisha's doctor" and making social contact with me. Our relationship was established, but was it going anywhere?

A breakthrough occurred, and I gained some insight into Aleisha and our relationship after about 7 months. Aleisha, over several sessions, began mentioning and then became increasingly disturbed about her new social worker through the department that encompassed child protective services. Her social worker, whom she had only met briefly on a few occasions, was talking about removing her two children from her home.

Aleisha had first become involved with the department several years previously around a question of sexual abuse of her daughter by a boyfriend, but nothing had been substantiated. Contact had continued without significant activity. Aleisha did have a parent aid two days a week through child protective services. The suggestion of removal of her children seemed to come out of the blue. Neither Aleisha nor I had any idea what was prompting the suggestion at that particular time.

Aleisha had been initially very hesitant to even involve me with child protective services. Her rationale was that she experienced the department as threatening, antagonistic bureaucracy. She had not found it to be helpful at all. She said that she really trusted me and felt that I was helpful. She was afraid that our relationship might be tainted in some way by an association with child protective services. I think that she was also afraid that I might disappoint her by being "like the others" or by being powerless to help.

Nevertheless, our discussion about her concerns allowed Aleisha to let me get involved. Initially, this meant meeting with Aleisha and her social worker together. I was astonished at how confrontational, abrasive and directive the social worker was with Aleisha. She seemed to me to be quite prejudiced by and focused upon the written department file on Aleisha. Without having spent any time with her and the children and without having attempted to find out what was going on now between Aleisha and the children, the social worker was quite accusatory and was making unfounded assumptions. In the process, she provoked Aleisha into a very angry, withholding and uncooperative stance.

I tried to intervene to interrupt this destructive process, but to little avail. I then wrote a letter about my observations to the social worker, but the precipitous removal process continued. I then wrote a letter to the court, and this led to swift action. The social worker was subsequently removed from the case as a result of the letter. This concrete advocacy was a turning point in my relationship with Aleisha.

Aleisha has become an active advocate for her children's educational and emotional needs. I have been repeatedly surprised and frustrated by the bureaucratic systems that still often label Aleisha as uncooperative, neglectful, or obstructive when I know now that Aleisha merely wants to be involved in the care of and decisions regarding her children.

It has truly been a privilege for me, during my training, to work so closely with a family over such an extended period of time. I have really begun to understand the hopelessness that can be bred from dependency on a system that is loaded with confusing and inefficient bureaucracy. I have learned, much to my frustration, a lot about the prejudices, misconceptions, and apathy prevalent in the myriad of bureaucrats that many individuals who are dependent on the state are forced to depend on. I have also begun to understand the difficulties, misunderstandings, and potentially disastrous results of the indirect and circuitous communications characteristic of these agencies.

I have worked with Aleisha as she has established herself in an intimate relationship with a man. This was not smooth, as initially it was clearly physically abusive. With the help of some periodically intensive couples work, it has developed into a generally supportive partnership.

Aleisha initially had begun talking about her history of significant abuse hesitantly. She gradually has begun talking about the abuse more openly with her family as well. She has begun setting appropriate boundaries and limits around contact with her family.

Knowing Aleisha has taught me to be ever more sensitive to the important and varied meanings of seemingly insignificant actions or comments, especially when individuals are from different cultural and ethnic backgrounds. I have also been allowed to begin to know intimately, in many ways, a life and culture completely different from my own.

In this process, I have become increasingly sensitive to aspects of myself, my upbringing, and my culture that were potential conflicts or stumbling blocks that I needed to

overcome (through recognition and sometimes discussion) in order to be helpful to her.

Aleisha has become an active advocate for her children's educational and emotional needs. I have been repeatedly surprised and frustrated by the bureaucratic systems that still often label Aleisha as uncooperative, neglectful, or obstructive when I know now that Aleisha merely wants to be involved in the care of and decisions regarding her children. Even recently, the misunderstandings have required significant activity on my part to clarify them. This increases my frustration at times with a system that continues to blame the victims unquestioningly.

My work with this case has certainly contributed to both my personal and professional growth. It has taught me to examine my own and others attitudes, assumptions, and prejudices more closely. It has also helped me appreciate to a greater extent the necessity of accepting people or patients "where they are" rather than focusing on where "we think they should be."

I have also been forced to really ponder the inequities between different classes of individuals. Both Aleisha's mother and grandmother also were dependent upon the state for support. It is really a three generational way of life for her extended family. I have come to better understand the challenges, many of them psychological, of moving out of that system.

Since I was asked to write about this case from the perspective of the impact it had on my training, I have had many mixed feelings. I have also just begun the process of termination, as I will be ending my training this summer, and for personal reasons terminating with patients in April. Aleisha has been very direct about her disappointment and feelings of abandonment regarding our impending termination. She has elaborated on her sadness and the aspects of our relationship that she has found most helpful and will miss the most. I would certainly like to believe that our relationship has had a positive impact on Aleisha and her family. I think mostly it has allowed Aleisha to recognize and acknowledge her own innate worth as a person, as well as her own resilience, strength, and resourcefulness. It has been, for me, truly a vivid illustration of the power of human connectedness.

Editor's Note: Dr. Finley is a resident in child psychiatry at the Brown University School of Medicine in Providence, Rhode Island.

Stephen's Corner

Stephen Bennett

INSCAPES

It is a clear October day, and I walk down upper Fifth Avenue feeling the quick cold slaps of the autumn wind and the warmth of the noon sun. I turn east on 129th Street where the blocks become ragged. A friend of mine once said that in New York if you are at loose ends, wherever you are, then just look up. I do this and see on the brownstone and brick buildings the stone designs on the lintels made stunning by the shifting light. This elegance and artistry pleases me, an aesthetic experience usually missing from my day.

My destination is the Children's Storefront, a private school in Harlem which, indeed, after having started in a storefront, now resides in a solid four story building near Park Avenue. Up here, this avenue holds an elevated railroad track which for a moment in the sun possesses a beauty but without reflection darkens and scars.

The reason for my visit is to talk to its founder and headmaster, Ned O'Gorman. He is also a poet. Up here, poets are recognized. Only two blocks down is Langston Hughes Place. Poets come in many shapes and sizes and this one is a tall and solid man, agile in his movements, who gives out an authority, a longshoreman's toughness. Although you could imagine him declaiming poetry in the Whitehorse Tavern years ago with Dylan Thomas, you wouldn't want to get into a fight with him.

The moment I enter the school a class of ten-year-olds bursts out, and I am caught in a twirl of energy that spins about them, twisting and rising within me, and though there are tears on one face and anger on others, the collective mood, dancing and darting, is wild relief and exuberance from being turned loose. This experience touches me, and a phrase from Gerard Manley Hopkins slams into my head -- "scatter a colossal smile". This line is from "Henry Purcell" and catches the essence, "so arch especial a spirit", of a complex image of man, music, angels and seabirds turning in

the storm. The "thisness" of a thing, its very being, is what Hopkins terms inscape. That Hopkins comes to mind makes sense because that is why I am here. I asked Ned once who were his favorite poets, and he answered Hopkins and Petrarch. I want to have a conversation about Hopkins.

I follow him inside his office and get an immediate feel for his mood. He is doing many things at once, disciplining his terrier, reasoning with a small boy who is in his office for the third time out of the day, and on the phone arranging a dinner party while giving instructions to two receptionists. I see and sense the driven state I had left behind at the hospital 20 minutes before, where anything inside is knocked out of you -- your soul perhaps -- by the shrill imperative of the outside until you finally exalt in this motion. Maybe for Ned there is an autonomous and secret preserve that stays aloof.

My short walk has allowed me to calm down from our child psychiatry clinic's frantic preparation for a visit from the Joint Commission on the Accreditation of Health Organizations. "Continuous Quality Improvement" is an obsessional system run wild. Although getting the charts together is all for the good, what we have spent the morning doing is taking down the children's drawings from the wall, hiding them to put them back again when the JCAHO leaves, because violating their rules is better for us than bleakness.

We sit on the front steps of the building so Ned can escape the mob scene inside. We trade favorite lines from Hopkins. Mine is, "Selfyeast of spirit a dull dough sours." Our attempted escape doesn't work for long because people grab Ned coming in and out. The mood isn't right for poetry, let alone someone so intense as Hopkins. In my own selfish way I have gotten what I came for -- the inscape. I felt it, the connection, the resonance with the children's exuberance.

A good question that probably has come to the mind of anyone reading this is what in the world does all this have to do with infant mental health. Maybe not a lot, but just hold on.

It is now several weeks later, and I am on my way downtown to see my old friend, Beatrice Beebe. I want to discuss her ideas on mother-infant interaction -- specifically, on interpersonal timing and gradients of emotion. We first met at the New York State Psychiatric Institute in the late 1960's when she had been Dan Stern's first graduate student. I had been spending some time with Dan

already, and I think of him now because his ideas touch on what is floating around my head. I feel sheepish about my jumbled thoughts, the daydreamy state of a long subway ride -- the experience with the school children, subjective worlds, inscape, the rhythm of mother and infant play, the neurophysiology of perception and memory. These thoughts seem a little too loose, and Beatrice requires precision. But then the connection comes to me. They are linked by Stern's particular concept of intersubjectivity or amodal transfer. What connects is what he now calls affect shapes, a more general aspect of his vitality affects. The basic currency of exchange is intensity, shape and time which make possible analogies across the senses, allowing acceptance of the claim that my love is like a red red rose and a melody sweetly blown in tune. These are the intrinsic talents behind affect attunement, that ability to pick up something in one sensory channel and play it back in another. The infant gives out rhythmic squeals and the mother matches its timing, intensity and contour with moves of her body.

Over chicken satay in a small Thai restaurant we look out at a busy avenue in Chelsea. The best way to describe Beatrice is to say that she is the personification of vitality affects. Her body and soft grey hair toss with her rapid shifts of expression and her gestures display a richness that seem to require no words. But the words are primary and convey ideas that possess an order and pungency. You feel that you should tape record on the spot everything she says and publish it.

I have not seen her for awhile because she has been holed up writing a book on interpersonal timing which has been a long term project. The interplay between mother and infant is similar in its timing to adult communication, and each partner is exquisitely in tune with the temporal pattern of the other. Striking predictions can be made from the degree of synchrony between the dyad. Another idea of hers is that mothers and infants match the emotional gradient of the other, not just the specific emotion displayed. Basically, the response is not only to the other's comings and goings in a physical sense but to emotional direction. I have seen dozens of times Beatrice's tapes of an infant not letting a looming mother score with direct eye contact, a virtuoso performance of what she calls chase and dodge. But also, mothers and infants track the

other's affectual trajectory, not just the discrete expression, but whether a smile or frown is expanding or closing down.

I think also of how the data was pulled out of the film. I did some frame-by-frame analysis with Beatrice back then, and I remember the feel of it. Before the fancy video equipment came along, where time is manipulated with a flick of a switch, we had to use a film editor and reels where the film was moved back and forth by hand. Truly, those data were handled, grabbed at, in order to catch an event lasting only a fraction of a second.

I try out a little Hopkins on Beatrice, and she responds with enthusiasm, saying that he was a favorite of hers when she was in college. I remember once quoting Hopkins to Dan Stern so as to illustrate a point about perception, and he matched my emotional direction by following me into it and saying that his roommate at Harvard was so captivated by Hopkins that he himself became a convert. I wonder whether for a time I will only speak intensely with Hopkins fans. Such a stance becomes a little snotty and rarified, but any attitude that defends against "Continuous Quality Improvement" can't be all bad.

My talk with Beatrice about the timing of speech and the direction of emotion makes me think of poetry's thousands of years attention to the rules of rhythm. The ancient poets thought that iambic rhythm, an upbeat meter of short to long, was nearer to ordinary speech and so was used for dialogue in dramas. In contrast, trochee "trips from long to short" and comes from the Greek "belonging to the dance." It was used in lyric and dramatic poetry and because of its lightness in comedy, as well.

I think also, on the subway ride back, of the history of the concept of the underpinnings of affective communication, whether it be from direct experience with another person or through music, dance or poetry. Stern's concept of "feeling shapes" has been around a long time under various guises. Sylvan Tompkins felt that the Darwinian emotions had discrete patterns of neural firing based on their density over time -- whether they rose, fell, or remained steady. Stern called them activation contours but made them the basis for vitality affects. The rushes, swoops, tumbles and crashes of emotion were called by the philosopher, Suzanne Langer, "forms of feeling". Schneirla's approach/avoidance belongs here, as well. I heard the latter talk back in the 1960's on the comings and goings of his beloved ants. Beatrice makes special mention of Heinz Werner's concept of "dynamic-vectorial cues".

I find that I have taken on too heavy an intellectual load and need to return to Hopkins. Now back home, I can pull together these ideas, which is hard to do on the run. What is the appeal of Hopkins to me? One answer is that I admire someone who tried to understand the process of perception and internal structure -- something that lots of people have attempted -- but he expressed it in a poetry of eccentric intensity, catching searing images of the outside and inside. And he did "catch" it, a favorite word of his. "I caught this morning morning's minion, kingdom of daylight's dauphin, dapple-dawn-drawn Falcon." A fin-de-siecle poet and Jesuit, he was, like Emily Dickinson, unpublished in his own lifetime. He was obsessed with the essence of things out in the world, his inscape, and its resonance with the observer's inner world, called by him "instress." Such a fascination with the external world was suspect in a religious order. He observed, "What you look at hard seems to look back hard at you." And indeed, he did look hard, spending hours scrutinizing, almost getting inside of flowers, clouds and trees. He felt that, when you became deeply involved with a thing or a person, this object transmitted meaning back. To achieve a conversational intimacy, Hopkins devised a metrical system which he called "sprung rhythm." He felt it was closest to ordinary speech and nursery rhymes.

A preoccupation of mine is how, in the flow of sensory experience, small events can grab hold of you. A current project of some colleagues and mine is to ask mothers to watch their young children play and then to interview them about the subjective experience it evoked. Hopkins provides a way of conceptualizing that serves as an alternative to the usual psychological theorizing about representations. Still, this needs be a private admiration because it would not be welcome in our scientific journals.

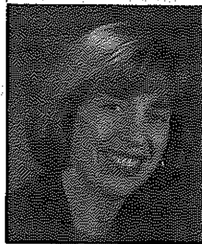
I decide again that I need to talk to another Hopkins' lover. If you live in a hospital world, such conversations are hard to come by. One lead is Ellen Spitz, who has come up to speak to us twice on the impact of the visual images in children's books. Reading to a small child that classic, *Good Night Moon,* conveys to the child, in an intimate imagery, a blend of pictures and words. She is a psychoanalytically trained art and literary critic. She writes wonderfully offbeat articles such as a post-modern approach to the comic strip, *Calvin and Hobbes.* I discovered that she had written on Hopkins' poem, "Thou art indeed just Lord." Over the phone, we trade favorite lines, and then she puts me in touch with Mary Ann Caws, who is a professor of English, French and Comparative Literature at the City University of New York Graduate School, and who has written about Hopkins. Mary Ann describes to me one possible interpretation of contemporary inscape as the interior landscape or architecture of a poem or object perceived--for example, a tree--and instress the energy that resonates from and back to the reader or watcher. This architecture and energy is what you marvel at.. She

was struck by the use by the psychiatrist, Robert J. Lifton, of the phrase "psychic landscape" and felt that this unique intuition of subjective surroundings was really inscape. In her articles on Hopkins, she describes the intensity of his looking, not only his scrupulous attention to detail, but also the passion to the point of open identification with the object of his vision. I have to imagine that Hopkins would have enjoyed frame by frame analysis. Both Ellen and Mary Ann in their affection for Hopkins, transmit their own sense of instress.

I am now back in my hospital world talking to the foster mother of a three- year-old boy with autism who attends our therapeutic nursery. We watch him float about the room for 30 minutes, and then I ask her what leapt out at her. Her answer is immediate. She describes an occurrence of only a few seconds when they kissed, and she felt their eyes meeting for an instant. She felt his love pour out of him into her and hers flow back. While describing this, she cupped her hands and pulled into her body as if holding a palpable substance -- there it was, she saw and felt it -- then letting her own love spill out into her hands, she pushed them forward to place the love back inside him. "How often does this occur?" I ask. "Every 15 minutes or so," she answers. This exchange, seen and sensed only by the two of them, touches and sustains them during their long and difficult days together.

Editor's Note:

Dr. Stephen Bennett is Chief of Child Psychiatry at Harlem Hospital and Assistant Professor of Clinical Psychiatry at Columbia University. He has been a baby watcher for many years. At present, he straddles the ivory tower concerns of academe and the pressing real world problems of the inner city. His column is a regular feature of this newsletter.



President's Perspective

Joy D. Osofsky

March 1994

As we embark on our second official year for WAIMH, it seems like a good time to "take stock" -- assess our progress as well as consider our vision and needs for the future. We have had much success in moving forward with our mission to reach individuals concerned about the mental health of infants and families in the past year through active participation in regional meetings in developed and developing areas of the world. Our colleagues in Europe, led by the commitment and never-ending drive of Serge Lebovici, have reached out to besieged individuals in war-torn areas in Eastern Europe, Hungary, and Romania. As I reported in my last column, we had a very successful meeting in Punta del Este, Uruguay, jointly sponsored by three international organizations and providing an opportunity for colleagues from Argentina, Brazil, and Uruguay to continue to build links and joint efforts in the area. In the past year, we have had a Regional Meeting in Graz, Austria as well as workshops in Amsterdam, The Netherlands and in New Orleans, Louisiana. In the coming year, Regional Meetings will be held in Tokyo, Japan and in Riga, Latvia. A workshop is planned for San Francisco in July in conjunction with the IACAPAP World Congress to be held there. Thus, we are continuing with our activities and "spreading the word." We are reaching more people and our affiliates are growing.

At the same time, Hi Fitzgerald, our extremely competent and efficient Executive Director, and I continue to be concerned about finances. We are trying to develop new ways to raise the funds that are needed to continue current activities and, hopefully, to expand since we feel that the work that we are doing is important and serves a crucial need in our world to address issues of prevention for infants and their families. In order to be successful, training is needed so that more individuals will become both skilled and comfortable in addressing mental health problems faced by infants and families around the world. If any of our readers can think of additional efforts for outreach that we are not addressing, please contact Hi or me. Or, if you have creative fund-raising ideas, please let us know and we will pursue them. Our newly-formed Finance Committee will be meeting at the end of July, 1994 during the IACAPAP meeting in San Francisco.

In the United States, we are continuing to build relationships with groups that share similar interests. In late February and early March, Charley Zeanah and I co-hosted Fellows Week in New Orleans for the fellows of Zero to Three, National Center for Clinical Infant Programs. This organization focuses in the US on similar issues to those of concern to WAIMH, although with more financial resources through grants and donations, and has been able to support a training program for Fellows for many years as well as other outreach activities. Interestingly, the Fellows came from a variety of backgrounds this year, including child psychiatry, pediatrics, clinical

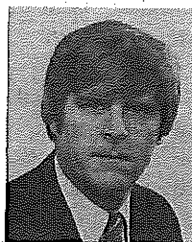
and developmental psychology, nursing, social work, and occupational therapy. They also included two international fellows, one from Turkey and another from Israel.

The Fellows formally presented their ideas for research or intervention projects that were then discussed by the faculty and the other fellows. The projects included well-designed research studies, intervention projects, and more clinically-oriented efforts. Their main training and mentorship takes place at their academic site; however, by being Fellows of Zero to Three, they have had the opportunity to travel to Washington twice a year to meet together and with members of the Zero to Three Board as well as participate in Fellows' Week once a year. Interestingly, Zero to Three is planning to restructure their training efforts including the Fellows Program. We will look forward to seeing the new directions they choose for work in this area.

The model of visiting a site for a period of time for training of various kinds is one that has been mentioned as a possibility for WAIMH, if we are able to find ways to fund such efforts. In contrast with the Zero to Three model, many of us have envisioned such opportunities for individuals from countries where research or specialized clinical training is more difficult to obtain to be able to spend time in another country that offers such training. Although WAIMH has supported a limited amount of consultation to other countries; however, the intensive experience of visiting for an extended period of time could be very beneficial for many of our colleagues. The idea of spending an intensive week in such a setting, we can accomplish both academic objectives and develop good relationships for the long term. International collegial relationships are extremely important to nurture in order to continue our commitments to work together for infant mental health. The training model for Fellows in Zero to Three is one that would be exciting to implement for WAIMH at an international level; it is a goal well worth aspiring to.

One other new development that may be of interest to our members is that we are planning to join with ISAP (International Association for Adolescent Psychiatry) and IACAPAP (International Association for Child and Adolescent Psychiatry and Allied Professions) to advocate for the United Nations Rights of Children. I have been working (with the guidance of our Executive Committee) with the President of ISAP, Michael Kalogerakis, and the President of IACAPAP, Donald Cohen, on this effort and will keep you informed about our progress.

Our plans for 1995 to date include a US Regional Meeting in Dallas, Texas in April, a Regional Meeting in Sydney, Australia, possibly a workshop in London in March, and possibly a workshop in Rome in late June. We will also be doing a site visit in Lahti, Finland planning for our next World Congress in July, 1996. We welcome input from our members in any form -- tel. (504-568-3997), fax (504-568-6246), internet (JDOPS@UNO.EDU), or letter (Department of Psychiatry, LSU Medical Center, 1542 Tulane Ave., New Orleans, LA. 70112).



From the Red Cedar

Hiram E. Fitzgerald
Executive Director

Theory, Myth, and Infant Mental Health : A point of view

Many theories, including some that are favorites among infant mental health specialists lack strong empirical support. In many instances applied programs that are driven by such theories fail because no scientific base is available to structure an evaluation of program effectiveness. On the other hand, many empirical databases have no theoretical foundation, so it is difficult to generate applications beyond the laboratory walls that generated the "facts." Finally, many applied programs have neither solid theoretical structure, nor empirical verification. In each of these instances we are vulnerable to fads and myths (see Clarke & Clarke, 1976). As Robinson noted in the *Chronicles of Higher Education,* myths conceived in the social, behavioral and health sciences threaten our credibility with the scientific community, with policymakers, and with the general public. I will comment briefly on two topics to illustrate this point about fads and myths.

During the 1970s Klaus and Kennell (1976) published data suggesting that mothers who had contact with their newborn infants within hours of the infant's birth, formed a unique emotional bond to their infants. As a result of their influence massive changes in perinatal practices took place not only throughout the United Staes but throughout the world. Few of us here today would question the positive benefits that derived directly from this research; mothers were brought into

contact with their babies immediately after the birthing process, fathers made their entry into the delivery room, hospitals constructed birthing rooms so that complete families could be present for the birth, and midwivery rebounded as more and more home births were desired. However, Klaus and Kennell enveloped their research findings in ethological theory, particularly emphasizing the temporal specificity of events during the organization of biobehavioral systems, or in other words, emphasizing a hard-wired version of the critical periods hypothesis (Lorenz, 1943). With a paucity of empirical data, but loads of heavy theory, programs designed to assure bonding spread like wildfire, as did guilt among those parents who did not have the opportunity or did not wish the opportunity to have immediate contact with their newborn infants. Bonding, therefore, provides an example of a theory-driven concept that promised long-term developmental benefits as a function of events that did or did not occur during the first 4 hours after birth (Hildebrandt & Fitzgerald, 1982). Note that enhancement of the joy of giving birth, of having a support person present during birth, or of reducing the sterile and mechanical atmosphere of the hospital delivery room are not at issue here. What is at issue is the theory-driven promise that if these events occur, positive developmental outcome is assured. How many clinical infant mental health specialists spent countless hours working with parents who blamed their interactional difficulties on their failure to bond, or who questioned whether they should proceed with their long-awaited adoption since bonding was no longer a viable option?

In my graduate course on theories of development I spend considerable time trying to impress upon my students the power of theory. Suppose, for example, we were to discover incontrovertible scientific evidence that the essence of humanness was not present in the fetus until the 8th monthof pregnancy. Do you think that the right to life movement would be any less adament in its opposition to first-trimester abortion? I suspect not. Facts accumulate, ideas convert.

The second example of fads and myths occurred to me as I was finalizing a letter to Michael Trout telling him that an article he submitted to the *Infant Mental Health Journal* was accepted for publication (I was editor of the journal at the time). In his article, Michael presented an eloquently reasoned argument to justify recommendations for training of infant mental health specialists that he believed would produce both an increase in the quality of their training and an expansion of training sites. Who among us would argue with such objectives.

And yet, there were two aspects of his argument that troubled me. The first was the belief that parents have known all along that which infancy researchers and clinicians are now discovering. I agree completely that infant mental health specialists must be good listeners, that they have to have a realistic sense of the contextual influences on families from extraordinarily diverse backgrounds, and they must use clinical data presented to them to generate solutions rather than imposing solutions based on the infant mental health specialist's own "ghosts in the nursery" (Fraiberg, Adelson, & Shapiro, 1975). However, I do not believe that parents always know best. If parents have known these things all along, I suspect that we would have no need for mental health specialists. I agree with Jeree Pawl (1984) who observed, "There is no parent, however well functioning and privileged, who would not at some time have his relationship with his child enhanced by some kind of very ordinary but often missing intervention, be such intervention described as concern, interest, information, support, or counselling (p. 264)."

The second point of concern addressed Michael's call for clinical training and, indeed, analysis for all individuals involved with infants. When one considers the literature on the effectiveness of psychotherapeutic treatments, the evidence does not justify a requirement for clinical training or analysis for everyone who works with infants. Interdisciplinary efforts in the field of infancy, it seems to me, will benefit by having individuals who have been trained as competently as possible within their respective fields and who have been given an interdisplinary perspective as part of that training. As a researcher I want to bring the strongest knowledge of research design and methodology possible to an interdisciplinary team, and I want to have an equally competent clinician point out how I will have to modify that design in order to take into account the realities of the clinical population or ecological setting that is being evaluated. To be sure, there are individuals who are competent scientist-practitioners, but there are many others whose expertise is more specialized. I should not have to be a social worker, pediatrician, psychologist, researcher, and clinician in order to work with nurses who want to develop a preventive-intervention program for their NICU unit. I should not have to be a clinician in order to provide research consultation with infant mental health specialists working in a community mental health agency. Well, it is unfair of me to debate Michael in absentia but I hope that our desire to listen to parents will not translate into a myth that "parents know best," or that our enthusiasm for interdisciplinary efforts will not translate into a myth that it is possible to educate massive numbers of rennaissance men and women.

One way to guard against the generation of myth is to strengthen the model used by several individuals

who can be counted among the founders of the infant mental health movement. I have in mind the models used by such individuals as Rene Spitz, Donald Winnicott, Selma Fraiberg, Sally Provence, and Arnold Gesell. Each of these individuals combined theory, research, and practice in their efforts to understand the dynamics of infant development and caregiver-infant relationships. *(I'll continue this essay in future issues of The Signal. I invite commentary and alternate points of view.)*

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Letters & Announcements

To the Editor:

We have the pleasure of informing the members of WAIMH that in 1993, Dr. Bernard Golse has been named Professor of Infant and Adolescent Psychiatry at the René Descartes (Paris V) University. Born in 1950 in Paris, he is married with two children, Véronique and Nicolas.

Intern of the Hospitals of Paris (Hôpitaux de Paris) then head of the Universities' Clinic, he acquired the double specialization of pediatrics and psychiatry, and successively obtained a Doctorate of Medicine, a Doctorate of Science, and a Doctorate of Human Biology (devoted to the study of genetic, enzymatic and endocrinological aspects of the early autistic and psychotic processes).

At the same time as this medical and scientific training, Bernard Golse pursued a psychoanalytic training within the framework of the Psychoanalytic Association of France, and as a psychiatrist and psychoanalyst, he at present, directs the Infant Psychiatric Unit at the Saint Vincent de Paul Hospital within the Cochin - Sainte - Anne Port Royal Hospital University Center.

Very close to Professor Michele Soule and to Professor Serge Lebovici, he has written several articles and works, devoted, in particular, to the early psychic development and to the establishment of the symbolization process.

Dr. Golse was an active member of WAIPAD, and now he is an active member of WAIMH. From 1989 to 1992, he was Editor of the WAIPAD Newsletter. He also made a number of scientific visits to infant mental health professionals in countries like Poland and Czechoslovakia.

We should all congratulate him on his new appointment and wish him success in his new endeavors.

Sincerely,
Serge Lebovici
Past-President, WAIMH

Correction:

In the last issue of *The Signal* the authorship of "Pregnancy Following Perinatal Loss" was erroneously attributed to Joan Alar and Care Thorwick. The names should have read: Joan O'Leary and Carol Thorwick. Our deep apologies to Ms. O'Leary and Ms. Thorwick.

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