

The Signal



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The Emotional Life of the Toddler

by Alicia F. Lieberman, Ph.D.

There is a widespread belief that it is in the very essence of toddlers to be stubborn, defiant and negativistic. In some ways, this is a useful belief. When an exhausted mother emerges from a seemingly endless battle with her two-year-old, she may find herself worrying that she's raising an irredeemable tyrant who will go through life antagonizing friend and foe alike. At those times, we get some comfort from blaming the child's age rather than the child's nature. We know that age changes, but we are not so sure that character does.

This popular perception about the inherent negativism of toddlers is not only unfair but also largely inaccurate. In spite of tantrums and recurrent confrontations, toddlers can be quite accommodating creatures, particularly when we understand *their* point of view. There is no such thing as the "terrible twos" or, at least, the twos will not seem quite so terrible if we take into account that toddlers are coping for the first time with a lifelong existential dilemma: having to negotiate a balance between relying on others and doing their own thing.

In this sense, toddlerhood is an early laboratory for the challenges and dilemmas of adult life. Perhaps more dramatically than any other age except for adolescence, this period brings us face to face with two powerful yet mutually exclusive impulses: the longing to feel safe in the protective sphere of intimate relationships, and the exhilarating thrust of carefree, unrestricted, uninhibited exploration, which allows us to soar free without having to check back with those we leave behind.

For the toddler, the new capacity to walk alone brings about a revolution in her self concept. She no longer needs to rely on others for transportation; she can now decide on her own when and where to go. Never mind that her legs cannot always keep up with her mind, and that she may fall down many times on her way to the goal. The main point is that she is now capable of trying it by herself. "Me do it" is the motto and rallying cry of the toddler years.



While the mother's arms may suddenly seem too restrictive, paradoxically it is her presence -- both physical and emotional -- that frees the child to move away from her and learn about the world. Those of you familiar with attachment theory will recognize here the concept of "secure base behavior", a term coined by Mary Ainsworth to describe

the toddler's use of the mother or preferred caregiver as a haven of safety from which he sets forth to explore and to which he can trustingly return for rest and reassurance before moving off yet again.

The toddler's secure base behavior indicates that even such a young child is capable of monitoring the environment for clues to risk versus safety. Coming closer, staying near and seeking physical contact are *attachment behaviors* which indicate that the child is afraid of external events such as an unfamiliar place or person or an unusual noise, or that the child is internally stressed, for example feeling tired or lonely or simply in need of companionship. These experiences of external fright or internal need encourage the child to move

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closer to the parent in order to feel comforted and secure. On the other hand, moving away, running around or climbing up are *exploratory behaviors* which indicate that the child is feeling safe and motivated to seek novelty rather than protection. When we observe normal toddlers, looking at this pattern of moving towards the parent or away from the parent is an eloquent nonverbal indicator of whether the child is needing reassurance or feeling confident and secure.

The pattern of secure base behavior becomes distorted when the child is not doing well emotionally. These distortions are manifested in three major ways. In one pattern, which I call *recklessness*, the toddler takes off from the mother and does not come back to her. Reckless toddlers dart off into one dangerous situation after another, often with the result that they get hurt again and again. In this pattern of behavior, the toddler exaggerates exploration at the expense of attachment.

In the second pattern of distorted secure based behavior, which I call *inhibition*, the opposite imbalance occurs: the toddler emphasizes attachment at the expense of exploration. These children seem to worry about leaving the parent's side and are familiar with the place and the people around them. They are overly seriously and vigilant, as if the world were a dangerous place and they could never know what to expect.

The third pattern, called *role reversal*, is one in which the mother and the child trade places: it is the child who takes responsibility for his own protection and worries about the mother's well-being. These children are precociously competent in taking care of themselves.

I want to stress that these three patterns are exaggerations of normal ways of responding. Temperamentally active toddlers often dart off unexpectedly without necessarily being reckless; temperamentally shy toddlers are slow to warm up in unfamiliar situations without being

inhibited; and socially attuned children can be precocious in taking care of themselves and others without taking over the parents' role. The patterns that I described are worrisome when they are not just temperamental variations but become relentless, rigid, and affect major aspects of the child's development.

When this happens, the toddler is overwhelmed by anxiety and cannot find a comfortable balance between attachment and exploration, the two central motives of this age.

Locomotion represents not only a physical achievement but also a psychological milestone. It brings about a new sense of personal will because the child can now take independent action to get what he wants. I remember a little girl who chanted "I wantit, I needit" whenever she was seized by the intense desire to have something. She was not being manipulative. Her wanting had such visceral force that she experienced it as a need. This makes complete sense from the perspective of a toddler.

Young children feel first and foremost through their bodies. Erik Erikson vividly described what he called "the rages of teething, the tantrums of muscular and anal impotence, the failures of falling" that are part of the day-to-day experiences of the toddler. It is only natural that the urges of *wanting* should also be experienced as a body need.

But parents have their own wants, needs and plans about how to live their lives, and what they do is not always in line with what their child wants them to do. This is a ripe area of disagreement between parents and child. To compound matters, toddlers and grown-ups do not perceive the world in the same way. The thinking of toddlers is what Piaget described as egocentric: they interpret an event in terms of how it affects them. As a result, they reach their own idiosyncratic conclusions about the relation between cause and effect, they have their own ideas about the magnitude and limitations of their own and their

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parents' power, and they develop unique theories about what is real and what is pretend, what is safe and what is scary, what is alive and what is inanimate.

Sometime ago I overheard a little girl who, watching a lion roar in the zoo, announced: "He is roaring because he wants to eat me for breakfast." She could not imagine that the lion had his own private reasons to roar. In her mind, such an impressive display had to involve her in some way. This kind of magical thinking makes it hard for us eminently rational adults to understand how children perceive the world and to empathize with toddlers' seemingly irrational fears. It stretches a grown-up's imagination to believe that a child is really afraid of being carried away by the rushing water of the toilet, or that she worries that the moon will fall down and land on her head. Conversely, toddlers can cheerfully rush into dangerous situations and protest bitterly when the parent runs interference. Why can't they, after all, cross the street on their own, or ride a horse, or tend that wonderful, shining fire? Don't adults do it all the time? Getting to see the world from each other's point of view, or at least learning to live with each other's perspective, can be a long and trying but also very exciting process for toddlers and their parents.

These discrepancies in perceiving their world are not the only obstacle to interpersonal harmony in the family. Toddlers desire with admirable passion, but they cannot have everything at once. A child cannot be close to mommy while running free. She cannot simultaneously play at grandma's house but also go out with mom and dad for the evening. She cannot be on the swing and go down the slide at the same time. But she wants to, because everything is so full of wonder and possibility.

Some of the emotional turmoil in the second year revolves around this difficult task of learning to choose. Choosing means having something,

but also giving something up. This is not how the toddler would design the world, and she responds to this lousy state of affairs with characteristic bluntness: she refuses to accept it and learns to say "no". This "no" is more than anything a heroic rebellion against the prosaic constraints of ordinary reality. Toddlers have not yet resigned themselves to the limitations of everyday life. Remembering this can help us feel some admiration and even give us a little emotional relief when we are the parents, teachers or therapists of an adamantly defiant two-year-old.

When the adult goes along with

the child's wishes, harmony prevails at least for the moment and the toddler learns that he is capable of having the desired effect on the world.



He learns that he is competent and effective in getting his needs met. On the other hand, when the toddler does not have the last word and his will is thwarted by the higher powers, he learns a far less palatable but equally valuable lesson: namely, that frustration, disappointment and failure are integral parts of life and that one can survive them and eventually even find pleasure in something else.

Until the toddler learns to cope more maturely with not getting what he wants, he may have little choice other than a temper tantrum in response to frustration. What else could he do? His language skills are not developed enough to argue his case persuasively. His access to the family resources is minimal, so that he cannot impose his will by threatening to withhold the parents' allowance or taking the car keys away. Dignified emotional withdrawal requires much too much self-control for such a passionate creature. The temper tantrum --

throwing oneself on the floor with a mixture of heart rendering crying and angry screaming -- is a wonderfully eloquent if seldom appreciated expression of the child's inner experience. It represents the child's inner collapse as well as his proud protest at finding out that his will does not reign supreme.

Just as locomotion allows the child to roam over the physical landscape, the need to choose and the experience of frustration enable him to explore the emotional landscape of feelings. In those conditions, the child discovers the ecstatic pleasure of having as well as the despair of deprivation. Saying "no" and being told "no" allow the toddler to find out that he is not a clone of the parents but has an autonomous will, that disagreements with loved ones are inevitable, and that negative feelings can be experienced and overcome.

That is why temper tantrums are so important for healthy development. Tantrums take a child to the very bottom of his being, helping him to learn that anger and despair are part of the human experience and need not lead to lasting collapse. When the adults manage to remain emotionally available even while firm in their position, they also teach the child that he will not be abandoned during difficult moments, that momentary rage will not result in lasting alienation, and that there is calm after the storm.

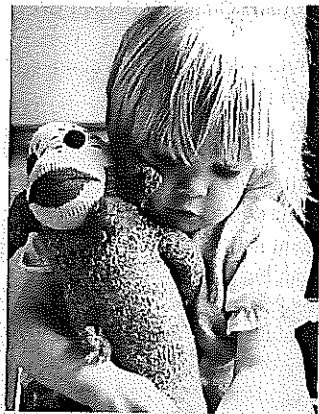
This experience of a well-managed tantrum is the emotional equivalent of secure base behavior. Just as the secure, freely *moving* toddler explores his surroundings but ultimately returns to the mother as a safe harbor, the secure, freely *feeling* toddler explores a range of feelings, including anger, defiance, and despair. In this sense, the body-based, behavioral back-and-forth of secure base behavior is progressively internalized in the form of a psychological secure base. The toddler gradually learns to carry the loving image of the parents within himself.

This process of internalization is a key development of the toddler years, and it culminates eventually in the formation of a reliable sense of right and wrong, of empathy for others, and of identification with the social and moral values of the child's culture. But the process of internalization is long and arduous; and the toddler needs his parents to be reliably available and to give implicit permission to rebel against them and test the limits at least every once in a while. How much, of course, depends on the personalities and value systems of each individual family, not some testing of the limits is essential for the child in order to begin acquiring both a sense of communal belonging and a sense of personal autonomy.

Given this dual task of learning to belong and learning to individuate, it is no accident that the two major anxieties of the toddler years consist of separation anxiety and the fear of disapproval. Separation anxiety involves the fear of losing the parent. Fear of disapproval involves the fear of losing the parent's love. I will describe briefly each of these kinds of anxieties, which often overlap.

Separation anxiety is relatively concrete: it involves the child's fear that being physically away from the beloved parent means that the parent will never come back and will be lost for good. The toddler's rudimentary understanding of time plays an important role in this fear: for the young child, time is experienced subjectively, and sadness or longing can seem to last forever even if by the clock the parent has only been gone for an hour. Many cultures have evolved wonderful early games to teach young children that parents come back after an absence: peek-a-boo for the pre-mobile child, hide-and-seek and chasing and retrieval games for older children who can walk, run and hide on their own. These games are an example of the wonderful power of play to help master early anxieties.

Fear of disapproval is less concrete and as a result there are no simple games (at least that I know of) to help the child cope with it. It comes a little later in the toddler's development, at around 24 months, and it is a consequence of two major cognitive acquisitions: the child's ability to appreciate adult standards (for example, clean and dirty, neat and messy, good and bad), and the toddler's emerging ability to imagine and fantasize. Fear of disapproval is a direct result of the toddler's normal



wish to please the parent and to live up to social standards. In other words, fear of disapproval is the flip side of the toddler's wish to please. Taken together, the child's wish to please and the fear of disapproval are our most powerful allies in the process of socializing a child. For the sake of our approval, toddlers will do the unthinkable: allow themselves to be toilet trained, refrain from biting their baby brother, share toys with a peer. This wish to please and to belong is the earliest substrate in the formation of a moral conscience and a sense of social responsibility.

Toddlers have a wonderful tool in the task of growing up: they can play. Play has many uses. It allows children to experiment with reality by setting up miniature situations that can be changed at will to reflect the child's beliefs about how the world works. Through play, the child can also express his wishes about how the world *should* work and how reality

should be. The toddler's imagination allows her to create play situations where she can live in fantasy what is not possible in reality. In the process, the child can gradually come to grips with her disappointment that things are not the way she wishes them to be. Last but not least, play allows the child to master his fears and anxiety by giving him imaginary control over his life. The child who plays at being Superman or who tells his monsters to go back into their cage is telling us that he needs to feel big and strong to counterbalance the inevitable stresses of being small and vulnerable. The child who scolds the doll for being "bad" is telling us she needs to be in charge for a while to make up for the stresses of being on the receiving side.

How do we know whether a toddler is growing well or not? Toddlers who are growing well seek approval but are not obsessed with it. They can tolerate reasonable amounts of frustration, and they can go back and forth flexibly between asserting their will and complying with the will of others. The healthy child also feels comfortable with a full range of emotions. A three year old boy I know was asked by his solicitous mother if he was happy. After thinking for a minute, he answered: "I am happy and sad and angry and bitey and clingy." He refused to be seduced into acknowledging only his happy side.

This child was able to experience and acknowledge what many adults fear to admit even to themselves: that a human being is neither all good nor all bad, totally happy or absolutely unhappy, only loving or always at war with others, but capable of all these states of mind. Much of the challenge of raising a toddler stems from the fact that this stage is such a mirror of the struggles that adults must constantly wage inside themselves.

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by Miguel Hoffman, M.D.

How much space shall we allot in WAIMH to social issues? Are we mainly researchers, health care providers, educators or a mix? Shall we take a stance regarding certain ethical issues, let's say the use of human embryos for research purposes. What are the boundaries of "science" regarding social, cultural, community, ethical issues?

If, for example, we take, Sameroff's (1992) statement "... (to consider) the study of behavior in context is the most important development in the last 25 years of development research" (cited in Zeanah, 1993), shouldn't we think that context includes social and community issues? Or else, where is the line to be drawn regarding context? Garcia-Coll & Meyer (1993) pointed out that cultures have gross variations in their valuation of individuality; "individual, whereas other cultures emphasize the collectively, often to the point of dissolution of any notion of individuality" (p.58). How much research is directed toward these goals? How much of the research that is being done gets down to the clinicians in the form of concrete guidelines? A good example of an Association that hands down guidelines drawn from research is the American Psychological Association with their different task forces, for example, the one for Services to Ethnic Minority Populations.

Such are but a few of the many questions we may pose regarding the relationship of our work and social and community issues. Are we forced to solve them individually, each for itself? Are we supposed to pay attention to them as a group with special interests and training and therefore perhaps with certain responsibilities vis a vis our communities?

*Arthur Miller, cited by Emde

THE FISH IS IN THE WATER



AND THE WATER IS IN THE FISH*

Quite often we hear that these are problems for the individual or small groups of related professionals. Scientific Societies are and should stay "neutral" beyond scientific endeavors. On what definition of science is such a statement based? What science is supposed to stay uncontaminated with value-loaded problems? Is the object of our science something that might be isolated from the context? Is it valid to speak of a "specific" context, parents and family, and consider that what is beyond that line wouldn't be part of the context of the scientific object?

So called "neutrality" is already an ideological statement, one in which a value is put above others -- not to take sides, not to appear as "ideologically" or politically involved. Therefore, it is taking sides, and it is value-laden.

That there is a divorce between science as academic endeavor and clinical practice seems to be evident from different publications. For example, a recent editorial of the *American Journal of Orthopsychiatry* refers to this in very harsh terms: "Indeed, the focus on research has in some ways become a substitute for action as more and more services are neglected or destroyed" (Shore, 1993, p.4).

Some reaction to this state of affairs seems to be at the roots of new regulations regarding funding of

research. This is the target of recent editorials in the *Society for Research in Child Development Newsletter*, pointing out that the development of collaboration between academic researchers and community service providers is becoming a requirement of the funding sources. In the fall issue, Mordock (1993) elaborates on this: "Academics wedded to one approach to problem solving will need to consider

other alternatives to work well with community agencies" (p.1). The trouble in bringing together both parts is identified in the following way: "Perhaps the largest obstacle to university-community agency collaboration is that the agency has a program of service it would like evaluated, but the academicians in nearby universities are invested in areas of human development unrelated to the agency's needs" (p.12). And this would be a tremendous divorce, that needs at least to be kept in mind, discussed, researched, if not solved.

We find a strong commitment to overcome this divorce between science and application, academy or community services, in Robert Emde's presidential address to the Society for Research in Child Development. "Although some child development research can pursue 'knowledge for its own sake,' (quotes in the original) ultimately I believe that a democratic society will expect that a goal for research knowledge, basic and applied, is that it be made use of in a variety of settings" (p.733). How much the academicians can stay away from application is narrowing more and more, following these different statements and facts. There is less and less space for isolated, "protected", community-detached working. Another question would be if these are problems to be solved by the individual alone or by the professional associations. For us in

WAIMH for example, according to our by-laws, the field is: "... from conception through three years of age..." (p.1 of WAIMH by-laws). Therefore, what guidelines might we provide to our associates regarding the use of human embryos for research purposes? The advisory panel of NIH is providing some guidelines. How long might it take until we take a stance? Or is not this an issue for us as a professional group? I think it is. I accept we might not have a stance right now, but that we should search for one, for example through a task force. Who volunteers? We are risking to face serious questioning from donors or future donors. Are we prepared to face the press on these issues? Would it be easy to send them away by telling that we are not supposed to produce some thoughts regarding these issues?

Hereby, I suggest to open the debate through this column of "Social and Community Issues" which is a

courageous endeavor of our *The Signal*. Let us see what we think about science, scientific work, and its relation to social issues. How do we define these entities? What do we want to attempt in order to answer some of these questions? What do we expect our Association to be. Let us volunteer for task force work for some of the issues we -- consensually -- value the most.

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Editor's note: Dr. Hoffman serves as the Treasurer and an Executive Board member of WAIMH. He is a psychoanalyst who practices in Buenos Aires, Argentina. The Editor welcomes submissions devoted to social and community issues and is willing to devote space regularly to these topics.

Historical Stories of Infant Care in Finland

by Tuula Tamminen, M.D.



he way in which pregnant and breast-feeding mothers as well as their newborn infants have been taken care of in the course of time is often an almost invisible but nonetheless an extremely important part of life and history in every country. The intention of this article is to give you four brief glimpses of how this history looks in Finland. The article offers short stories about four mothers and four little baby girls born in different centuries in my country. The information here has been gathered from a variety of sources: from professional midwife and child care histories, from medical and cultural history books, from folklorists and folksongs, from literature and the history of literature and finally from population statistics

which go all the way back to 1740 when the first systematic and detailed records of births and deaths were compiled in Finland.

The first baby girl whom I am going to describe was born some time between the 13th and 14th century: we do not know very much about her or her mother. The only sources available on their lives are our oldest folksongs and ancient Finnish poems from the Viking Age. In one exceptionally beautiful poem full of joy and sorrow, the eldest daughter of a family sings to a young bride, telling about the directions for women and about the family roles which will help her get along and survive in the groom's tribe. In these days there were only very few people living in the south, and southwestern coasts of Finland who earned their living mainly by

hunting, fishing and burn-beating land. So the young mother had to work very hard throughout her pregnancy, since her husband was away for most of the time while she carried all responsibility for her husband's family. When it was time for her baby to be born, she would ask someone to get the old family and village wives, the so-called "saunagrannies" to help her. She herself went to heat up the sauna. She was very pleased to have a sauna in the first place so that she didn't have to give birth in the sheepfold, the second warmest place in ancient Finnish villages. During delivery, she kept thinking of her own mother as her sister had advised her to. She kept thinking of her sister's song also when she breast-fed and took care of her first daughter and later on of all her

children. In her sister's song, between the long list of her many, almost endless duties, there were also short verses which advised her to caress her infant as often as she could and not to forget to talk to her baby.

The second baby girl I'm going to describe was born in 1550.



At this time Finland had around one quarter of a million inhabitants and was ruled by a Swedish King. Agriculture was the main source of livelihood. The mother was a young girl who was giving birth to her first child. When it was time for her to give birth, she sent for the wise-wife of the village to take care of the delivery. She also asked some of her friends and neighbors, all women, to come along. According to an old custom, all preparations were carried out as secretly as possible to avoid bad spirits. When the mother in her birth pangs left for sauna, she grasped some dirty clothes with her -- she thought that they would get dirty anyway! Unfortunately, this delivery was very difficult and even after trying everything the wise-wife knew, the baby would not come out. The wise-wife performed all the magic she remembered and asked all the women present in the sauna to untie all ribbons and bands and braids they had--but nothing helped. The wise-wife knew that the husband was a fairly calm man and she sent for him. The mother was hanging from her husband's neck but still the baby did not come out. Finally, the wise-wife could do nothing but ask the Magic Man to come and help the younger mother. Most of the women left the scene, since the Magic Man had a very bad reputation. When he came, the mother died, but a strong and healthy girl was born. The wise-wife wrapped the baby quickly in her father's unwashed shirt to make sure that the father would not abandon the little girl. And luckily, the father's unmarried aunt took care of the baby. For the first couple of weeks, the baby was fed by a wet nurse, and after that

she was fed with the help of a reindeer horn. Although infant mortality particularly among babies who did not get breastmilk was very high indeed, this girl survived. Today we know that the old tradition with which the Lapps dehydrated their reindeer horns made them contain bactericidal stuff; it was this that helped this baby survive and grow.

The third girl I'm going to describe was born in 1840, the seventh child to a peasant's wife. By this time Finland had a population of around one million, and it was an autonomous Grand Duchy under Russian rule. Life was hard, the fields were small and full of stones, the crops often failed because of frost. However, many things were better than earlier. The mother was thinking of this during her seventh delivery. So many things had changed. Her first slightly malformed child had been born in sauna with the help of an old "delivery woman", and now she was lying in a clean bed and a trained midwife, the first official county midwife, was there giving precise orders to everyone. The delivery was quick and easy and after careful cleaning and swaddling, the midwife put the newborn infant to the mother's breast. The midwife visited their home every now and then during the first year of the baby's life and gave good advice about breast-feeding and dressing up the child. However, when the baby was eight months old, she went down with smallpox and after a few weeks she died. The mother was desperate. She buried her little girl with her own hands under a young birch tree as so many other mothers did during those days (one infant out of six died during their first year of life). In her deep grief she sang a beautiful wail that brought some comfort to herself and her husband. And even today, these

songs are still sung by some mothers as lullabies to these babies during the dark winter evenings in Finland.

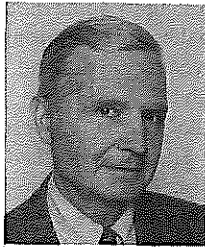
The fourth baby girl I will describe was born just a few years ago, in 1990. She is the first and only child of a well-educated working couple. She was born in a central hospital on a maternity ward with all the modern facilities including a rocking chair for the mother and a resting chair for the accompanying father. Her birth was an unforgettable and profoundly touching moment for her parents, even though the father felt deep inside himself an unspoken loneliness. He was, as a father, doing something that his father and his father's father had never done. And when he was holding his wife in labor, he realized that he was still just an outsider. The mother stayed at home and took care of the child for the whole first year. She breast-fed the baby until she went back to work. The parents felt that they were very lucky when they found an unemployed home helper to take care of the girl. Now this four-year old young

lady is going to start in a day-care center, and she and her mother and her grandmother are all absolutely thrilled. This little girl is looking straight at us now -- with so much confidence in her bright eyes.

This article tells you about the births of four baby girls because, fundamentally, human knowledge bound up with pregnancy and birth, and breast-feeding is carried forward from mother to daughter, from woman to woman. This long and strong mother-daughter chain is something that we should be keenly aware of in our clinical practice and research work today.

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Stephen's Corner

Stephen Bennett

AN AFTERNOON IN BOBIGNY

It is the end of May. My wife and I get off the train from Strasbourg at the Gare de L'Est in Paris and take a cab to the Université-Paris-Nord in Bobigny to visit with Serge Lebovici. The reason I am in Paris is, first of all, to be in Paris, but also later in the week, to attend the meetings of the International Conference on Infant Studies. While here I hope to achieve some sense of how infant psychiatry is approached in France. Dr. Lebovici's agreement to talk to me is an auspicious beginning in that he is one of the pioneers and pillars of infant psychiatry, not just in France but worldwide.

Bobigny, a new, but quickly aging suburb outside of Paris on the way to the Charles de Gaulle Airport, is a sprawl of high rise apartments that are an ugly contrast to the charm and oldness of the low buildings of central Paris. The afternoon is warm and the university campus is filled with young people taking in the sun, a replication of a new college in Middle America.

My visit with Dr. Lebovici quickly becomes more than an interview, also more than I bargained for, turning into a 6 hour immersion into his professional life. Monday is his teaching day and what I experience is a succession of supervisory sessions, classes, and a private consultation. But this description does not catch the intensity of the long hours. All through the shifting and demanding crowd of students from his packed classes and a chorus of assistants, he moves with an invincible serenity, like a politician who has lived his life in public. He tells me that

he is retired -- on a pension as he puts it -- and does this all for fun. One student tells me that he is around all the time. The teaching program in infant studies is one long day a week for a year and is open to professionals from a wide variety of backgrounds, not only psychiatrists and psychologists, but pediatricians and other health practitioners. From what I can see from the classes the majority of participants appear to be young graduate students. The handbook describing the courses is exciting and what is offered is rarely available in any formal way in the United States. Over the year these courses provide a rich view of development and pathology. Perhaps most things sound better in French but one of Dr. Lebovici's courses has great appeal -- "Interactions précoces et psychopathologie du nourrisson." The instructors are major figures in French infant mental health. Diplomas don't mean much to me anymore, but I do covet a Diplôme Universitaire de Psychopathologie du Bébé.

My usual attempt during an interview is to place the subject's interest in infancy studies within the context and flow of his life. I do start this and receive some fascinating pieces of biographical information which I wish to follow up some other time, but this objective is superseded by the onrush and urgency of the enormous present. So, instead of a developmental and longitudinal approach this will be cross-sectional, an intensely varied slice of one afternoon.

Some sense of the student body is obtained from sitting in on several

supervisory sessions. One Roumanian student is planning a paper on the totalitarian personality within a family and considering the impact on children. A young man working as a psychologist in a daycare center is having a hard time with job acceptance in an all female environment. Dr. Lebovici feels that a consultant has to give "care to the daycare agency" and this leads to a discussion of the work on daycare by David and Appell. A young woman from Charles University in Prague who appears to be a teaching assistant, hopes to return there to work with young children.

The first class, which is just down the hall from Dr. Lebovici's office, leaves me with two first impressions. One is simple-minded in that I am struck by his fluent use of videos and that the equipment worked. Most of the hospital presentations I attend something always goes wrong with the video equipment. Dr. Lebovici has expert help in this area and in his teaching he uses videotapes in a virtuoso and easy-going way. The other impression is that students are extraordinarily well behaved. Most audiences I have experienced in the United States vary between apathy and shrill combativeness. Maybe the secret ingredient is that all the students seem in awe of Dr. Lebovici.

The videotape presented to the class focuses on a toddler whose mother is unable to wean him. Fortunately for me, the commentary is in English since it is to be presented at a meeting of the World Association for Infant Mental Health in Riga, Latvia the next week. The little boy with cheerful persistence insists on the mother's breast, and she, appearing distracted and depressed, is unable to resist him. Dr. Lebovici has the advantage of having seen the mother 10 years before when she was an adolescent. Drawings from that time catch imagery of her distress, her charged transference to men, and preoccupation with the breast. The family history gives a sense of intergenerational transmission in that

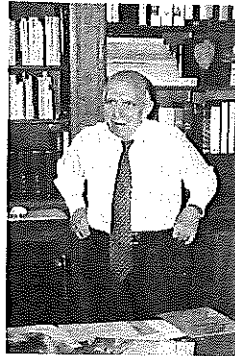
the mother's mother had abandoned her and there appears to be incestuous fantasies about her father. The impact on the mother is that she does not want to let go of her own baby. Also, there has been an avoidance of a sexual relationship with her husband, accomplished by having her son sleep with her.

Stressing to the class that the focus is on fantasies, Dr. Lebovici demonstrates his interdiction of further breast feeding by helping the mother deny her breast to the child. The little boy accepts the prohibition and turns to play with some toys. Dr. Lebovici asks for my response and my comments are rather concrete. I am impressed by the power of his authority, but wonder whether the compliance would stick unless she is helped to find other developmentally appropriate substitutes for her concern. Dr. Lebovici says he does not agree with me and goes on to describe his response to the maternal fantasies or what he called an enactment or the use of psychodrama. Here I get a little nervous and imagine that Dr. Lebovici will insist that I sign up for his yearlong course so I can get things right.

I had been prepared for his concept of fantasmatic interactions and have a dry intellectual sense of his concept of intergenerational transmission, that is, how what is in the mother's head gets into the baby's through affect exchanges. What I have not been able to do is grasp them in a quick and intuitive way. Certainly, in this instance enough family and fantasy material is available to allow a feel for the mother's subjective world. However, I realize that I have been heavily programmed to look for objective evidence, make a DSM IV diagnosis, and come up with a treatment plan that is based on an objectively verifiable intervention. This is the American way. The French are less plodding. I then think of the first line of Laurence Sterne's *A Sentimental Journey*-- "They order, said I, this matter better in France--". In

the next two sentences the narrator is queried whether he has actually been to France, does he know what he is talking about, and by the 5th sentence he decides immediately to go there, which will give him the right to make grand judgments. I feel that I have made it to the fifth sentence, so with my instant experience I become a critic and commentator.

Next is a private consultation. Lebovici explains that such "therapeutic consultations" are always videotaped and used for educational and research purposes. The subject of our attention now is a 3 year old who



joyfully bounces off the walls, opens every cabinet in the room, and gleefully bangs the baby dolls, never stopping for a moment. The parents appear helpless. One issue is the parent's complex feelings about this boy, who is a product of in vitro fertilization. Another consideration is attention deficit hyperactive disorder. The use of Ritalin comes up and I learn from Lebovici that giving it to children is interdicted in France except for rare situations. His rough estimate is that no more than 50 children at a time are taking it. In our clinic there are at least that many children on it and I would like to feel that we are rather judicious in the use of such medication. Here, I begin to feel concrete, biological, and American again.

It is not until the last class in the early evening that I feel I finally catch onto psychodrama, a therapeutic technique that follows from intuitions

of the fantasmic and imaginary interactions. Dr. Lebovici shows a marvelous tape of a late adolescent girl who is borderline and severely depressed. Although Dr. Lebovici keeps up a running translation for me, I feel that I miss all the subtleties. However, the broad outlines are clear by reading the changing facial expressions of the participants and listening to the affect conveyed by the voices. In the first act, Dr. Lebovici speaks with the young woman and she, with a painful wariness and shyness, tries to engage. The capacity to grab hold of another person is there. In the next scene the mother is introduced. She states her concern with a stridency of language and a jabbing energy of her body. It is painful to watch the young woman shrink away into helplessness. The mother is dismissed, but now the stage is set for a classic theatrical device that drives the dramatic unfolding. This is the intruder from the outside, the charged provocateur of either sex, the seductive hired man or the pretty new maid. In this melodrama the outside agent is Mrs. Lebovici, herself a psychotherapist, who comes in and takes over, acting more powerfully bossy than the mother, yelling at Dr. Lebovici, pushing him around until he finally gets rid of her. In this triumphant Oedipal resolution Dr. Lebovici sits with the young woman who looks at him with security and gratitude. I wanted to applaud at the end of this magnificent theater.

My appreciation of the sheer showmanship brought me back, as if in a time warp, to the 50's when I first considered, then actually trained in psychiatry. At this time psychoanalysis in the United States enjoyed dominance. Not only was it an era of razzle-dazzle performers, but of more importance was the sponsorship of a scrutiny that started with behavior but traveled into subjective experience. But there was a fall from grace so that now, except for the confines of analytic institutes, the inner world

now is rarely brought up. One exception, a submerged Atlantis, is in mother-infant work. In the United States, largely as a result of Selma Fraiberg's work, the world of representations are seen to have power and importance.

I could say -- well, the old master can pull it off because only he has the unique dramatic skills and intuitive conviction. But, much more than that, the old pro knows all the moves and plays backwards and forwards. The anticipation, which allows him to tune in on breast fantasies immediately, comes not just from native gifts but also from long practice. Here, he may say that I am taking away some of his magic -- maybe so -- but from what I can tell from his writings he has examined videotapes over and over with his associates. He believes in recording all his interviews, so unlike many analysts of the past whose insights were based on hermetic musings from their isolated offices, Lebovici flaunts his data. This material has allowed him to organize in his writings all the variations of breast symbolism, then trace the sweep of ideas from Freud to the theories of Klein, then the post-Kleinians and the geography of fantasy to his own fantasmic interactions.

What about the younger, rising stars? I had asked Dr. Lebovici for names and he sent me off to two of them. Both teach at Bobigny and so contribute to the ideas presented to the students.

Dr. Bernard Golse is a man of about 40 with a crisp and emphatic manner. He is chief of child psychiatry at the St. Vincent de Paul Hospital. This is a general hospital that is a 10 minute walk south of the Luxembourg Gardens, a jumble of buildings ranging from the 17th century to temporary, recently erected structures. His department follows three major interests: the development of language and symbolic processes, the study of psychotic processes, and the impact of peri-natal events, especially those that

result from the new reproductive technology. Clearly, Golse and Lebovici are not analysts who are isolated in their offices, but are caught up in the rough and tumble of clinical practice.

Dr. Golse describes psychoanalytic training as primary and occurring before child training. In France, he feels, the psychoanalytic influence overshadows the biological and believes that it is the only point of view that catches the unity of the child. The majority of French psychiatrists view their clinical experience from an analytic perspective, and most pediatricians do so as well. I wonder about this generalization, but still it fits some stereotype of the mystical French mind. In my current experience the major child psychiatry influence in the United States is epidemiology and psychopharmacology. Among American pediatricians, except for Berry Brazelton, the influence of psychoanalysis is zero.

Dr. Golse's fascination with infancy came through his work with psychotic processes and archaic levels of experience, especially autism. His lecture at Bobigny is -- *La genese des representations mentales*. In the United States the analytic approach to autism became out of fashion years ago. Golse's view of autism is that there is a block in first steps of development. In order to understand these mental processes he has what he calls a unit for therapeutic observation, a daycare setting where the staff can study -- as Golse puts it, understand deeply -- and treat 7 or 8 autistic children. French and American differences in approach to autism are caught clearly by Dr. Golse's article and the Yale rejoinder in the April-June 1994 issue of this newsletter. If anything, the surface presentation is a little too polite but you do not have to read very far between the lines to sense the profound differences in mind set.

My second visit is with Dr. Martine Lamour, an intensely animated woman with an agile sense of

humor. Her research background consists of an apprenticeship at the NIMH with many of the major child researchers. She and her co-workers -- one of them Dr. Lebovici -- present a poster at the ICIS meeting -- "Triadic Interactions and Father's Representations." Her Bobigny lecture is -- "Les Peres." This study of triadic interactions is new material to me and is also the subject of a symposium the last day of the meeting chaired by Dr. Lebovici entitled -- "Origins of the Mental Representations during the Process from Triadification to Internalization (Triangulation)." At its most basic the experimental situation has much of the possibilities of the Strange Situation, but instead of observing what the young child does with one parent, both parents are introduced. This work gives a sense of the child learning what it means to be in a family. Dr. Fivaz-Depeursinge from Lusanne has been the driving force of most of this research. Her lecture at Bobigny is -- "Processus de Triadification."

My reflections at the end of the ICIS meeting serve as coda to the afternoon in Bobigny. This organization is a spin-off of SRCD and contains the hard-core infant researchers. There are fingers left over when you try to count on your hands the psychoanalysts participating. So why is Lebovici there? It is because this is where he belongs. The triangulation research videos of parents with their young child help him take further his belief that "interactive exchanges have psychic consequences" and the exploration of that subjective experience, "the fantasy of reality," can "become reality by the virtue of reconstruction." I in turn become reconstructed and the fantasmic Bobigny becomes real and part of my memory.

Editor's Note: Dr. Stephen Bennet is Chief of Staff of Child Psychiatry at Harlem Hospital and Assistant Professor of Clinical Psychiatry at Columbia University.



President's Perspective

Joy D. Osofsky

As 1994 comes to a close and WAIMH is moving into a new stage of growth and development, it is time to take stock of where we have come from and where we hope to be going. I have been stimulated to do this "stock-taking" by an e-mail message that I received recently from Rivkat Muhamedrakhimov from St. Petersburg, Russia. We met Rivkat during the Riga Regional Meeting and he visited me and several other WAIMH members later in the summer under the sponsorship of the American Psychological Association. Rivkat and his colleagues are part of a group doing early parent-infant intervention work in St Petersburg and are very enthusiastic and eager to learn and share. What impressed me about his e-mail message was his enthusiastic elaboration about all of the benefits of WAIMH that he appreciated so much after we sponsored him for membership through the Beacon Club. He mentioned how much he enjoyed receiving the quarterly Newsletter, the *Infant Mental Health Journal*, the membership directory, the membership application accompanied by a questionnaire and survey. He had also requested information on how to form an Affiliate Group in St. Petersburg and had now received this material from WAIMH. I must say that hearing from Rivkat with his enthusiasm communicated even through electronic mail made me believe that we are reaching out to others whom we have not reached before and that we are forming

relationships that would be long-standing for WAIMH. It made me want to do more.

Let me review briefly some of the recent past history and share some thoughts of the Executive Committee on what "more" we would like to be able to do. After WAIMH was established in 1992, following the merger of the World Association for Infant Psychiatry and Allied Disciplines and the International Association for Infant Mental Health, it seems to me that we went through some adjustment to our new identity. WAIMH had to define itself more broadly--having now become more than an organization with an international and interdisciplinary mission because of the new structure that now incorporated both established and newly forming local affiliate groups. People who had led each of the organizations previously had to listen carefully to the perspectives of the others and figure out how to integrate similar, though differently defined goals. It feels to me, as we begin another new year, that this integration is now taking place and that our membership is recognizing the important newly defined directions of WAIMH.

Individuals are joining in record numbers; subscriptions to our journal, the *Infant Mental Health Journal* have never been higher; for the first time, we have a formal membership directory; our newsletter is becoming more professional looking and sounding; we even have WAIMH membership cards thanks to the creative initiative of Melanie Smith at the WAIMH central office in East Lansing, Michigan.

There have been many discussions among the WAIMH Executive Committee about how we should define our goals, what should be the predominant directions, and what our organization offers to the membership. At a recent meeting of convenience of a small group of us in Dallas, we discussed different initiatives that WAIMH might take which would be economical, but provide better communication and sharing of useful information with the membership.



WAIMH international exchange in Porto Alegre (Brazil). (R-L) Bertrand Cramer, Joao Gomes Pedro (Portugal), Carmen Nudelmann (Brasil), Salvador Celia (Brasil), Carlos Prego (Uruguay) in Porto Alegre, summer of 1994 during the International Meeting about Pediatrics and Mental Health.

You will be hearing about these initiatives in a more formal way from our Executive Director, Hiram Fitzgerald; however, I will share the general ideas as I think you will be interested and excited by some of the possibilities that are being discussed. I have asked Bob Emde, WAIMH's International Advisor, to Chair an *ad*

hoc committee concerned with international training initiatives. In this capacity, he shared some of his ideas with the group, and we brainstormed about ways that WAIMH can be helpful to people internationally in assembling training curricula, bibliographic references, and video materials. One immediate initiative will be to combine with the ongoing efforts of the Michigan Association for Infant Mental Health in expanding their existing video rental library. As part of this process, we will be developing other ways to centralize and network in this area. Bob has prepared a list of topics that many of us have already presented on in various countries; in addition, we will be soliciting information for additional topics and key references that will then be available centrally and should increase networking possibilities.

In addition to assembling curricular materials, training modules

with references, and video materials, several other ideas were discussed. We are interested in your feedback about what training efforts have worked well in different countries and which efforts have been less effective. A more formal request for feedback will be forthcoming from Hi Fitzgerald's office. We are also very interested in finding ways to generate funds for international fellowships for colleagues and students to visit with colleagues in North America and for people from North America to visit other countries for more extended periods of time. If any members have ideas about how we might find funding for these efforts, we would welcome hearing from you. We are committed to finding the most effective ways to share information about infant mental health worldwide which will require all us working together to accomplish these goals.

I see us moving into a new phase for WAIMH. We are established and growing and now can move forward to

try to accomplish even more of our goals. Study groups have been discussed as an important way for each country to share information and develop ideas. We encourage such efforts and will be pleased through our Newsletter, *The Signal*, to communicate the activities of these groups on a regular basis. If there are additional suggestions that you have for communication through the *Infant Mental Health Journal*, I would welcome your input. We will be publishing more extensive articles on two of our recent regional meetings in an upcoming issue of the Journal. In order for WAIMH to respond to the interests of members from around the world, we need to hear from you about what your needs are and how you feel about the initiatives that we are considering. I look forward to this communication and want to take this opportunity to wish all of you the best for 1995.

A JOB DESCRIPTION: INFANT MENTAL HEALTH THERAPIST

A newspaper in Michigan, USA recently carried the following advertisement for an Infant Mental Health Therapist who would serve at a child guidance clinic. What do you think?

Nature of Work: Senior practitioner with a high level of competency to assess the needs of referred infants and young children. Treatment is provided from a preventative viewpoint and in the form of outreach services, largely within the home to at-risk infants and their families. Coordination and collaboration with other child-care professionals within the community is a major aspect of the work. The clinical capacity to develop a range of required services and the ability to develop community

cooperation so that infants and their families receive comprehensive services is desired.

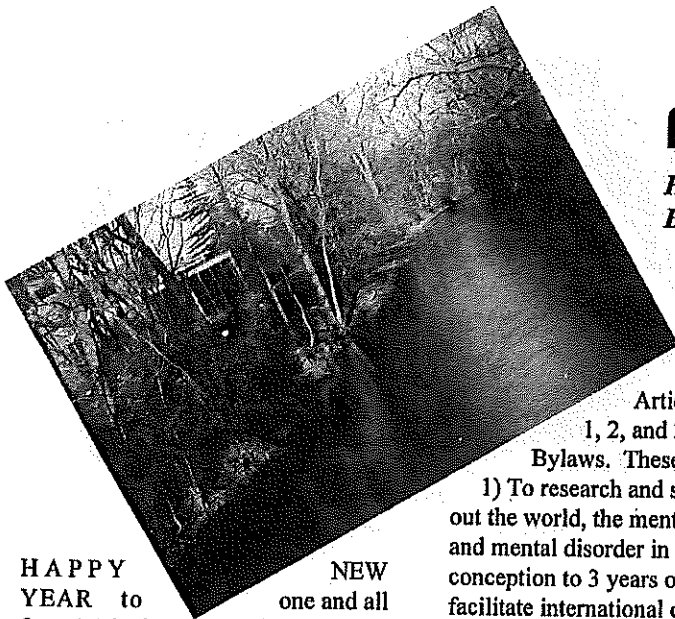
Examples of Responsibilities:

- Conduct client home visits to assess parent-infant interaction and the home environment; obtain individual and family history and family systems information as it pertains to the psychotherapeutic process.
- Undertake assessment of infant status, parent-infant interaction and the home environment using developmental inventories and instruments; apply results to clinical impressions for the purpose of comparison and clarification of problems and strengths.
- Interpret issues regarding infant's growth and development and the parents' psychological growth in the process of providing treatment to infants and families.
- Facilitate positive parent-infant

interaction by providing information regarding child-care methods and demonstrating infant stimulation activities.

- Utilize resources within the community to assist families in providing the best physical and emotional care possible for their infants.
- Cooperate with public health nurses, hospital personnel and other child care providers in developing comprehensive intervention plans for high risk infants and families.
- Serve, when necessary, as expert witness or consultant to protective services and the court on child abuse, neglect and custody issues.
- Provide program and case consultation and training to caregivers working with infants and their parents in various settings.
- Conduct parent-infant group intervention.

(continued page 14)



From the Red Cedar

Hiram E. Fitzgerald
Executive Director

HAPPY YEAR to one and all from Melanie Smith and me! We hope that each of you has a wonderful 1995. Because reports from the central office are offered "From the Red Cedar," we thought that you would enjoy seeing a portion of the Red Cedar River as it flows past the Kellogg Center, where the WAIMH offices are located. We commissioned Melanie's spouse, David Smith, to take pictures of the area around the central office and he did a wonderful job. You will be seeing more of his work in forthcoming issues of *The Signal*.

Over the next several months, President Joy Osofsky, the WAIMH Executive Committee, and other interested individuals, will be working on a document that will result in a generic--though dynamic--definition of infant mental health. Bits and pieces of the definition can be found in anthologies, journal articles, conference presentations and elsewhere. But to date, we do not have a definition that has broad based support. The need for such a definition becomes evident when one tries to raise money for infant mental health programs. What IS infant mental health?, people ask. Perhaps soon we will have a brief written document that will reveal all.

Another aspect of definition is related to the purposes of an organization. WAIMH's Purposes are

described in Article II, Sections 1, 2, and 3 of the Bylaws. These purposes are:

- 1) To research and study throughout the world, the mental development and mental disorder in children from conception to 3 years of age;
- 2) To facilitate international cooperation among individuals concerned with promoting conditions that will bring about the optimal development of infants and infant-caregiver relationships;
- 3) To encourage the realization that infancy is a sensitive period in the psychosocial development of individuals;
- 4) To promote education, research, and study of mental development during infancy on later normal and psychosocial development;
- 5) To promote research and study of the mental health of the parents, families, and other caregivers of infants;
- 6) To promote the development of scientifically based programs of care, intervention, and prevention of mental impairment in infancy;
- 7) To conduct meetings, workshops, symposia, and congresses throughout the world; and
- 8) to publish and disseminate research on infancy through newsletters, books, monographs, studies and other means in any language and to make the foregoing available through electronic media.

How are these objectives linked to WAIMH activities? This is the main topic of my column in this issue of *The Signal*. The following outline of WAIMH's activities flows rather nicely from the purposes described in the by-laws. They are arranged in three categories: Current, In Progress, and In Process. **Current activities** refer to the things that WAIMH currently does. **In Progress** refers to

things that the WAIMH Executive Committee has approved and that are being implemented. **In Process** refers to activities that the Executive Committee is discussing which may or may not become WAIMH activities.

Current Activities:

A. Scientific/Clinical Meetings

- WAIMH World Congress (every 4 years)
- WAIMH Sponsored Regional Conferences (annually)
- WAIMH Sponsored Regional Workshops (annually)

B. Affiliates:

- *Current Affiliates:* Australia, Canada (Ontario, Quebec), France, Greece, Mexico, Scandinavia, United States (Illinois, Delaware Valley, Louisiana, Maine, Michigan, Minnesota, New Jersey, Oklahoma, Texas, Virginia,
- *In progress:* Canada (British Columbia), Wisconsin, California), Japan, Germany, Russia (St. Petersburg), United States (Ohio, Kansas, Wisconsin, California).

C. Publications

- *Infant Mental Health Journal*
- *The Signal*

D. Communications

- The Beacon Club
- Membership Directory
- History of Infancy Committee

E. Study Groups

- European Working Group on Diagnosis and Classification Issues in Infant Mental Health. Dr. Maria Jose Cordeiro, organizer.
- Specificity of Psychoanalytic Work with Parents and Infants. Antoine Guedeny, coordinator.

In Progress:

(Being implemented, watch for news in future issues of *The Signal*)

A. Communications

- LISTSERVE electronic communication through internet.

B. Training & Education Materials

- Video Library: Training and Education (collaborative with MAIMH Affiliate).
- Infancy Curriculum Data Base
- Institution Training Programs in Infant Mental Health Data Base
- Study Groups

C. Policy and Information Dissemination, Sonya Bemporad, Coordinator

D. Definition of Infant Mental Health, Joy D. Osofsky, Coordinator

E. Program Outcome Evaluation Policy

In Process:

(Being discussed by the Executive Committee)

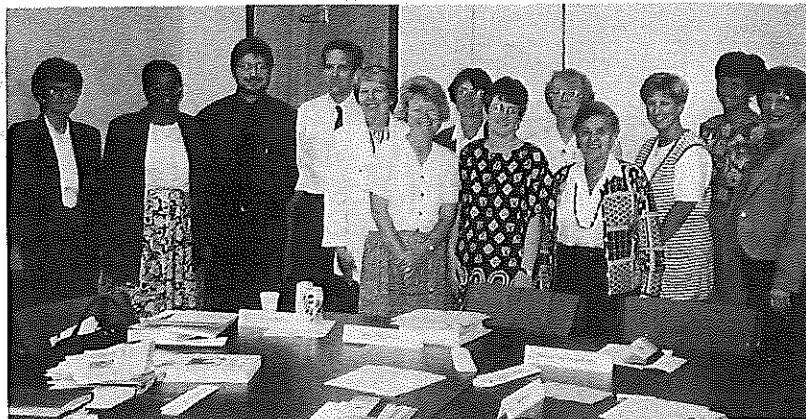
A. Communication

- Bulletin Board Electronic Data Base

B. Education & Training Materials

- Development of Curriculum Guides

I hope that you agree that the number of programmatic activities WAIMH has developed since the merger of WAIPAD and IAIMH is impressive. Indeed, it should be clear that the Executive Committee is making substantial progress toward implementation of all of the purposes described in the WAIMH By-laws. More, of course, can be done. Each member of WAIMH has an opportunity to participate in the process of determining the program activities of the association. Send your ideas to your Regional Vice Presidents, to the Central Office, or to any member of the Executive Committee. You will find all of the relevant names and addresses in the membership directory. Use the post, send FAX, or electronic mail, or simply call the central office on the "old-fashioned"



Infant Mental Health professionals in Ohio taking a break after lengthy discussions with Hi Fitzgerald about affiliate development. Hi is also the photographer!

telephone. All comments, recommendations, proposals, etc. will be brought to the Executive Committee for discussion. Participate in YOUR association!

BEACON CLUB: As of January 5 (when I am writing this report), we have received \$1400 in contributions to the Beacon Club, more than double the amount contributed during all of 1994. This means that 14 colleagues in developing countries will receive free subscriptions to the *Infant Mental Health Journal* and will receive all WAIMH newsletters. We have heard from several of last year's recipients and know that the copies of the *Journal* and newsletter are well worn from colleagues hungry for knowledge about infant mental health. If you want to bring the joy of knowledge to colleagues with limited personal resources, join the Beacon Club today. A \$100 contribution (tax deductible for persons in the United States) provides a year subscription to the *Infant Mental Health Journal*, four issues of *The Signal*, and all correspondence from WAIMH. Contributors can designate who is to receive the membership, or can allow the Beacon Club Committee to select the recipient.

(continued from page 12)

Knowledge, Skills and Abilities Required

- Knowledge of the principles and practices of infant/child development.
- Knowledge of current theories and practices in the field of infant mental health and prevention strategies.
- Knowledge of the psychodynamics of pregnancy and attachment and parent-infant interaction in the building of object relationships.
- Skill in assessment and providing intervention and therapy with individuals, families and groups.
- Ability to work effectively with interdisciplinary staff and persons in other agencies within the community.
- Knowledge of available community resources.

Education and Experience Required

- Master's Degree in Psychology, Social Work or Nursing, with preference given to those who have completed a recognized IMH program.
- At least one year's experience in providing mental health services to children and families, subsequent to obtaining the Bachelor's Degree.
- Experience with family therapy.

(Reprinted from Everyday's Child, Newsletter of the Maine Association for Infant Mental Health, Summer 1994)



News & Views

Upcoming Conferences

April 7-8, 1995 in Arlington, Texas. North American Regional Conference cosponsored by WAIMH and the Texas Association for Infant Mental Health. "Babies Can't Wait: A collaborative approach to planning for infants and toddlers in the legal system". The conference will focus on issues concerning appropriate planning and intervention for infants and toddlers who, because of disruption in their family of origin, are drawn into the legal system and are adversely affected by it. To request registration materials: JCJC Child Abuse Intervention Training Project, 4801 Marine Creek Parkway, Fort Worth, TX 76179, USA. Fax: (817) 232-7707.

April 29-May 2, 1995 in Ann Arbor, Michigan. Annual conference of the Michigan Association for Infant Mental Health. Key speakers are Daniel Stern, Ph.D., and Charles Zeanah, M.D. For information, contact U-M Conferences & Seminars, 541 Thompson St., Rm. 112, Ann Arbor, MI 48109-1360. Tel: (313) 764-5305. Fax: (313) 764-2990.

June 30-July 1995 in Buenos Aires, Argentina. A conference sponsored by the Department of Children and Adolescents of the Psychoanalytical Association of Buenos Aires. "Fantasy, Creativity and Action". Registration cost is \$50. For information contact: Dr. Luis Mario Minuchin, Part. Mansilla 2431 9 "A" (1121) Buenos Aires. Tel/Fax: 54 1 961 4122

Saturday, July 29, 1995 in San Francisco. WAIMH will hold a one day workshop before the International

Psychoanalytic Association meeting. The topic is "Reality and Early Trauma: Developmental Pathways". For information and registration materials contact Dr. Joy Osofsky, Department of Psychiatry, Louisiana State University Medical Center, 1542 Tulane Avenue, New Orleans, LA 70112, USA. Fax: (504) 568-6246.

July 28 and 29, 1995 in Seattle, Washington. A twelve hour seminar conducted by Dr. Daniel Stern and sponsored by the Seattle Institute for Psychoanalysis. "Infant Psychotherapy: An Overview and a Unifying View." Dr. Stern will discuss his research, highlight major issues in psychoanalytic theories of infant development and offer new understanding of therapeutic approaches

effective in preventing the development of psychopathology in children.

For information contact Lola Richards, Executive Secretary, The Seattle Institute for Psychoanalysis, 4020 East Madison St., Suite 230, Seattle, WA 98112. Tel: (206) 328-5315.

Call for Papers

The Administration on Children, Youth and Families, Department of Health and Human Services, in collaboration with Columbia University and the Society for Research in Child Development, announces Head Start's 3rd National Research Conference, "Making a Difference for Children, Families and Communities: Partnerships Among Researchers, Practitioners and Policymakers", to be held June 20-23, 1996 in Washington, D.C. Direct inquiries to: Dr. Faith Lamb Parker, Project Director, Columbia University, School of Public Health, CPFH/MCH, 60 Haven Avenue B3, New York, NY 10032. Tel: (212) 304-5251. Fax: (212) 305-7024.

COMMITMENTS FOR PARENTS

I will always love and respect my child for who he is and not who I want him to be.

I will give my child space--to grow, to dream, to succeed, and even, sometimes, to fail.

I will create a loving home environment and show my child that she is loved, whenever and however I can.

I will, when discipline is necessary, let my child know that I disapprove of what he does, not who he is.

I will set limits for my child and help her find security in the knowledge of what is expected of her.

I will make time for my child and cherish our moments together, realizing how important--and fleeting--they are.

I will not burden my child with emotions and problems he is not equipped to deal with, remembering that I am the parent and he is the child.

I will encourage my child to experience the world and all its possibilities, guiding her in its ways and taking pains to leave her careful, but not fearful.

I will take of myself physically and emotionally so that I can be there for my child when he needs me.

I will try to be the kind of person I want my child to grow up to be--loving, fair-minded, moral, giving and hopeful.

Source unknown. Reprinted from O Baby! A Guide for New Parents, Detroit Free Press, Wednesday, December 15, 1993.



WAIMH 1995 MEMBERSHIP APPLICATION

Date _____ Renewing Membership _____ New Membership _____

Please print or type
NAME _____ DATE _____

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