



WAIMH NEWS

Vol. 1, No.1, March 1993



Standing: Miguel Hoffman, Charles Zeanah, Kathryn Barnard, Justin Call, Robert Emde, Sonya Bemporad, Hiram Fitzgerald, David Lonie
Second row standing: Keigo Okonogi, Jo Sawyer, Graziella Fava, Peter de Chateau, Yvon Gauthier
Seated: Eleanor Galenson, Serge Lebovici, Joy Osofsky, Michel Soule

WELCOME TO WAIMH'S WORLD

Welcome to the first edition of the WAIMH Newsletter! Under the capable and dynamic editorship of Charley Zeanah, the WAIMH Newsletter will bring you regular features, clinical case studies, letters to the Editor, news and views about infant mental health, worldwide training and educational opportunities, and the latest happenings among WAIMH's worldwide Affiliate Associations. We want this to be your newsletter. Please help! First, we need a name. So, participate in the NAME THE NEWSLETTER CONTEST! Rules: Deadline for receipt of suggested names: SEPTEMBER 1, 1993. The winner will receive a free subscription for the 1994 *Infant Mental Health Journal*. Send your nominations to the WAIMH Executive Office, 2 Paolucci Building, Michigan State University, East Lansing, MI USA 48824-1110. Second, we need articles. Use your newsletter to communicate with other infant mental health specialists around the world. Ever want to be a reporter? This is your opportunity to report on scientific, clinical, and outreach

issues related to infant mental health. Send your contributions to the editor. So, in the meantime, sit back, relax, and enjoy reading our first edition!

Hiram E. Fitzgerald, Executive Director

Contents

Postpartum Depression and Infant Mental Health	2
With Evelyn & Dave	7
Message from the President	9
From the Executive Office	11
To the Editor	12
Announcements	13
Upcoming Activities	14
News & Views from around the World	15

POSTPARTUM DEPRESSION AND INFANT MENTAL HEALTH

Charles H. Zeanah, M.D.
Division of Infant, Child & Adolescent Psychiatry
Louisiana State University School of Medicine
New Orleans, LA, U.S.A

Postpartum psychiatric disorders are currently receiving increased attention from a number of different vantage points. There is renewed interest in these disorders as their prevalence has been documented by epidemiological research. There are also major research efforts underway to describe the association between maternal depression and adverse infant outcomes. This has led to an interest in testing various models of intervention to treat depression in mothers and to prevent adverse outcomes in their infants. This paper reviews briefly the literature on postpartum psychiatric disorders and the effects of postpartum depression on infant development, and it concludes with implications for infant mental health clinicians.

Postpartum Psychiatric Disorders

In recent years, a tri-partite classification of postpartum psychiatric disorders has emerged (Hopkins, Marcus & Campbell, 1984; O'Hara & Zekoski, 1988). Perhaps best conceptualized as a spectrum, the classifications include **postpartum blues**, **postpartum depression**, and **postpartum psychosis**.

Transient symptoms of dysphoric mood, crying spells, mood lability, anxiety, insomnia, and/or irritability are most likely related to **postpartum blues**. With an onset of 1 day to 6 weeks after birth, this disorder is identified by the mild quality of the symptoms and their brief duration, from a few days to no more than 2 weeks. Affecting as many as 50-75% of women, the usual symptom peak is at day 5 postpartum, which coincides with maximal diuresis and weight loss. Although no hormonal correlates have been identified, the disorder is equally prevalent in vastly different cultures around the world, which suggests biological etiology. Interestingly, several studies which have serially examined mood suggest that the first 2 to 3 days after delivery are associated with a positive surge in mood. This means that most women with uncomplicated deliveries will be discharged from the hospital at a time when their moods are most positive. Treatment of postpartum blues is rarely indicated because of the self-limited nature of the symptoms. The disorder is important for our purposes because it may initially appear similar to a more serious depression,

Editorial Staff

Editor: Charles H. Zeanah

Editorial Assistant: Dee Bonvillian

Production Editor: Melanie Smith

Editorial Board:

Susan Berger
Salvador Celia
Peter de Chateau
Mauricio Cortina
Graziella Fava-Vizziello
Emily Fenichel
Elizabeth Fivaz-Depeursinge
Peter Fonagy
Cynthia Garcia-Coll
Bernard Golse
Antoine Guedeney
David Lonie
Tuula Tamminen
Michael Trout
Elizabeth Tuters
Hisako Watanabe

Feature Columnist: Stephen Bennett

President's Corner: Joy D. Osofsky

From the Executive Office: Hiram E. Fitzgerald

The WAIMH Newsletter is a quarterly publication of the World Association for Infant Mental Health. Address correspondence to Charles H. Zeanah, M.D., Division of Infant, Child, & Adolescent Psychiatry, Louisiana State University School of Medicine, New Orleans, LA 70112-2822. All opinions expressed in the WAIMH Newsletter are those of the authors, not necessarily those of WAIMH. Permission to reprint material from the WAIMH Newsletter is granted, provided appropriate citation of source is noted. Suggested form is: WAIMH Newsletter, 1993, Vol. 1, No.1, WAIMH.

particularly if feelings of self-reproach and failure about mothering are prominent.

Postpartum depression includes most of the depressive symptoms of postpartum blues in more severe and prolonged form, in addition to extreme fatigue, anorexia and weight loss, insomnia, guilt, and feelings of helplessness and hopelessness. In my own experience, an almost pathognomonic symptom of postpartum depression is a feeling of being trapped and a powerful urge to flee. Depending on the strictness of the criteria used to make the diagnosis, the prevalence of postpartum depression ranges from 10-20%, making it the most common postpartum disorder requiring treatment. The range of symptom onset is from a few weeks to several months after delivery, although 2/3 of cases present within the first 2 to 3 weeks after delivery. In a large community sample of women diagnosed with postpartum depression 2 months after the birth of their first child, nearly 25% were still depressed 4 months later (Campbell, Cohn, Flanagan, Popper & Meyers, 1992).

Much rarer are **postpartum psychoses**, which occur at a rate of 1-3/1000 births, and which are associated with more serious complications, including suicide and infanticide. The clinical picture of postpartum psychoses can be schizophrenic, bipolar, or psychotic depression, but the most common type is called atypical. This presentation is characterized by the rapid onset of confusions, disorientation, hallucinations (especially visual) and illusions, intrusive psychotic thoughts, and later frank delusions. They present generally from about 3 days to 1 month postpartum, and their course is quite variable. These disorders almost always require emergency psychiatric hospitalization. Because of a recurrence rate of 25-50%, counseling about subsequent pregnancies is always indicated. Women who are at the highest risk for postpartum psychosis are those with a previous history of postpartum psychosis and those with bipolar affective disorders. Women with either of these risk factors should receive close psychiatric monitoring during pregnancy.

Some reports of anxiety disorders presenting for the first time in the postpartum have appeared, but they have not been sufficiently studied to indicate the magnitude of this problem. Given the high comorbidity of affective disorders and anxiety disorders in general, it would not be surprising to learn that this is a clinically significant problem.

Evaluating Research on Postpartum Depression

There are a number of controversies and methodological issues for clinicians to be familiar with in evaluating research on postpartum depression. Several will be mentioned briefly, including diagnostic

criteria, uniqueness, and etiology.

Developmental researchers have explored the effects of postpartum depression on infant offspring. When evaluating this research, it is important to determine how the investigators have assessed postpartum depression. Much of the early literature on infants of "depressed" mothers measured depression with the Beck Depression Inventory (BDI) or the Center for Epidemiological Scale for Depression (CES-D). These instruments measure depressed mood, but they do not diagnose depression. Regardless of the cut-off used, there are always problems with sensitivity and specificity when using self-report measures. This is more than a semantic difference since depressed mood in pregnancy predicts depressed mood in the postpartum, but clinical depression in pregnancy does not predict postpartum clinical depression (O'Hara & Zekoski, 1988). Further, Field and her colleagues (Field, Morrow, Heady, Foster, Adelstein & Goldstein, 1991) highlighted the defensive distortion possible with self-report measures when they found that mothers diagnosed with depression who scored zero on the BDI had more problematic interactions with their infants than did women who were diagnosed with depression and who had mean BDI scores of 20! Clearly, both depressed mood and clinical depression may have effects on infant development, but it is important for investigators and for clinicians interpreting their work to make clear distinctions about what is being investigated. A second issue for consideration is the controversy about whether or not there is anything unique about postpartum depression, or whether it is merely an affective disorder that presents initially in the postpartum period. Obviously, this controversy has implications for symptomatology, prognosis, and treatment. Although noted since antiquity, postpartum depression has not typically been considered a distinctive clinical disorder. In part because of this belief, research on postpartum depression was limited until the past decade. There have been no specific criteria for these disorders in the systems of psychiatric nosology, meaning that for many years there has been little research on these disorders.

O'Hara and his colleagues (O'Hara, Zekoski, Philipps & Wright, 1990) provided some evidence that postpartum depression is not distinctive. They compared depressed mood and clinical depression in women who were pregnant and postpartum to women who were demographically similar but not pregnant. They found that no difference in prevalence of major depression in the two groups, although severity of depressive symptoms and number of women meeting criteria for postpartum blues were greater in the childbearing group. Although the numbers were small, the childbearing subjects who were diagnosed as depressed reported higher levels of depressed mood than

did the depressed nonchildbearing subjects. Finding that the postpartum period was not a time of increased risk for depression led these investigators to conclude that childbirth is a non-specific stressor for depression rather than that there is anything unique about clinical depression that presents at this time. Future research should more carefully address the nature of the symptomatology itself in postpartum and non-postpartum depression.

Because immediately after delivery a woman undergoes the most precipitous hormonal changes she has ever experienced, much research has been directed towards discovering biological contributors to postpartum depression. To date, little evidence of estrogen, progesterone or prolactin abnormalities have been identified. It does seem clear that levels of most prominent hormones are not affected, although sensitivity to different levels of hormones may be affected. On the other hand, although results have been somewhat mixed in different studies, there is evidence that more stressful life events in pregnancy and the postpartum are associated with more severely depressed mood and increased likelihood of diagnosis of depression. Marital dissatisfaction and low social support do appear to be risk factors (see O'Hara & Zekoski, 1988, for a review). Ultimately, the etiology of postpartum depression is likely to be multifactorial, and careful assessment by clinicians of vulnerability and contextual factors is indicated.

Postpartum Depression and Infant Development

There are considerable data documenting an association between maternal depression and child adaptation. A review by Beardslee, Bemporad, Keller & Klerman (1983) indicated that as many as 40% of the offspring of parents with affective disorders will receive a psychiatric diagnosis at some time before reaching adulthood. Other evidence suggests that other kinds of maladaptation are also common (Downey & Coyne, 1990; Field, 1992; Gelfand & Teti, 1990; Puckering, 1989; Zuckerman & Beardslee, 1987).

A number of mechanisms have been proposed to account for these findings. First, because of familial aggregation of affective disorders, a direct genetic effect has been considered. This mechanism is more helpful in understanding a propensity for affective disorders in the children of depressed parents than in understanding other forms of maladaptation and disorder, such as attentional deficits and disruptive behavior disorders. Another mechanism proposed is that infants of depressed parents have more difficult temperaments, implicating constitutional differences in central nervous system functioning. Non-specific familial characteristics and stressors related to the postpartum depression may also contribute to infant maladaptation. Finally, at the

experience-near level, problematic interactions between depressed mothers and their infants have been documented by a number of investigators and these have been thought to place children at increased risk for subsequent psychopathology.

In general, depressed mothers' affective ranges are constricted and poorly regulated during both laboratory and naturalistic observations with their infants. Cohn & Tronick (1989) have described four interactive patterns in depressed mothers with their infants. In one pattern, depressed mothers are sad, slow, silent and withdrawn, with few positive affective displays. In a second pattern, they make angry and/or tense facial displays, and they are intrusive and rough during interactions. In a third pattern, mothers are generally positive and engaging, although they look away from their infants more than non-depressed mothers. The fourth pattern is a more heterogeneous mix of the first three. It is not yet clear whether these patterns are stable within mothers, or whether they vary at different times or different developmental periods.

In response to these patterns, infants of depressed mothers demonstrate less positive affect, more fussiness, more withdrawal, less attentiveness and lower activity levels (Weinberg & Tronick, in press). Together, depressed dyads contingently respond to and reinforce one another's negative affects and spend more time in matching negative states (Cohn, Campbell, Matias & Hopkins, 1990; Field, Heady, Goldstein & Guthertz, 1990). Both Field (1992) and Weinberg & Tronick (in press) have described models for understanding how less sensitive and available depressed mothers have infants who are poorly regulated affectively, physiologically and interactively leading to continuing distress for both partners and compromising infant development and adaptation.

Intervention

Treatment for postpartum depression is generally multi-modal, with medication, psychotherapy, and self-help groups frequent major components. What is often missing from treatment, in my experience, is attention to the infant as someone other than one of a number of stressors.

In contrast to the usual fragmentation of services for postpartum disorders, Jennings, Wisner & Conley (1991) recently described a uniquely comprehensive program at the University of Pittsburgh for mothers and young children. Women who are pregnant with psychiatric disorders, women with postpartum psychiatric disorders, and mothers with symptomatic infants all receive comprehensive and integrated services within the same program. This approach inherently recognizes the bi-directional effects of infant-parent relationship disturbances and maternal postpartum

depressions. Its family-focused approach is a model for the field. Investigators are also beginning to consider the effects of treatment of postpartum depression for infants as well as for mothers. Cooper & Murray (1992) recently described an investigation of treatment of postpartum depression and its effect on infant development currently being conducted in Cambridge, U.K. The investigators randomly assigned women diagnosed with major depression at two months postpartum to one of three treatment conditions or to a control condition in which women received routine care without additional contact with the research team. Treatment was eight weeks of in-the-home psychotherapy with the baby present. The three treatment conditions were non-directive counselling in which women were encouraged to express their feelings about current concerns, cognitive-behavioral therapy in which the mother was assisted with management problems with her baby, and psychodynamic therapy in which the attempt was to change the mothers' representations of their infants. Outcome measures assessed the infants in a number of cognitive and socioemotional domains. The questions that they hope to address with this design are whether early, brief treatment can prevent adverse infant outcomes, which treatment is most effective, and whether different domains of infant development are ameliorated by different treatments. This strategy includes a prevention and a treatment design within the same intervention. This and similar research in the future may provide us with answers to a number of pressing questions.

Postpartum Depression and Infant Mental Health

What are the implications of current research about groups of postpartum depressed mothers and infants for the infant mental health clinician faced with a particular dyad? Several conclusions seem apparent.

- 1) Given the high prevalence of postpartum depressions (and related disorders) and their importance for mothers and infants, the infant mental health clinician is in a uniquely advantageous position to identify and intervene with these problems.
- 2) Infant mental health clinicians should be alert for the possible presence of postpartum disorders in mothers of symptomatic young children, especially mothers with infants in the first few months of life. Worrisome symptoms in the postpartum, in ascending order of concern, are listed in Table 1. If women present initially with symptoms 1-4, they should be carefully and closely monitored. With symptoms 5-7, they should receive immediate treatment. If they present with symptoms 8-12, they should be considered a psychiatric emergency, and hospitalization should be considered.

TABLE 1. CLINICALLY SIGNIFICANT SYMPTOMS IN THE POST PARTUM PERIOD

- 1) Crying spells for more than two weeks
- 2) Persistent loss of appetite
- 3) Ongoing, unexplained exhaustion
- 4) Difficulty concentrating
- 5) New, or considerably intensified, feelings of guilt or worthlessness
- 6) Intense urges to run away
- 7) Aversion to the baby
- 8) Suicidal thoughts or attempts
- 9) Thoughts or images of harming the baby
- 10) Delusions
- 11) Hallucinations
- 12) Disorientation

- 3) Infant mental health clinicians should help make health care providers and other mental health professionals aware of the need for referral of young children of affected women. It is imperative that infants be considered in assessment and treatment of their mothers' postpartum disorders. Infants are clearly involved in their mothers' postpartum depressions, and thinking about them ought to be central among case planning issues.
- 4) Several different interactive patterns in postpartum depression have been identified and suggest that some heterogeneity is typical. Understanding both a dyad's interactive style and the meanings of the baby for the mother are central to appreciating the role(s) of the infant in postpartum disorders.
- 5) Mothers' perceptions of spousal support and of infant difficulty have distinguished depressed from non-depressed women in the postpartum and also predicted who recovers more quickly (Campbell et al., 1992). These findings underscore the importance of a family-based approach.
- 6) Preliminary evidence suggests that effective treatment of postpartum depression is beneficial to infants as well as to mothers. More research is necessary to determine which types of treatment are most effective for which types of mothers and for which domains of infant development.

REFERENCES

- Beardslee, W.R., Bemporad, J., Keller, M.B. & Klerman, G.L. (1983). Children of parents with a major affective disorder: A review. American Journal of Psychiatry, 140, 825-832.
- Brockington (Eds.), Motherhood and mental illness 2: causes and consequences. London: Wright, pp. 17-63.
- Campbell, S.B., Cohn, J.F., Flanagan, C., Popper, S. & Meyers, T. (1992). Course and correlates of postpartum depression during the transition to parenthood. Development & Psychopathology, 4, 29-48.
- Cohn, J.F., Campbell, S.B., Matias, R., & Hopkins, J. (1990). Face-to-face interactions of postpartum depressed and nondepressed mother-infant pairs at 2 months. Developmental Psychology, 26, 15-23.
- Cohn, J.F. & Tronick, E.Z. (1989). Specificity of infants' response to mothers' affective behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 28, 242-248.
- Cooper, P. & Murray, L. (1992). The impact of postnatal depression on infant development: A treatment trial. Plenary address, Fifth World Congress of Infant Psychiatry and Allied Disciplines, Chicago, IL, USA.
- Downey, G. & Coyne, J.C. (1990). Children of depressed parents: An integrative review. Psychological Bulletin, 108, 1-27.
- Field, T.M. (1992). Infants of depressed mothers. Development & Psychopathology, 4, 49-66.
- Field, T.M., Heady, B., Goldstein, S. & Guthertz, M. (1990). Behavior state matching in mother-infant interactions of nondepressed versus depressed mother-infant dyads. Developmental Psychology, 26, 7-14.
- Field, T.M., Morrow, C., Heady, B., Foster, T., Adelstein, D. & Goldstein, S. (1991). Mothers with zero Beck Depression scores act more depressed with their infants. Development & Psychopathology, 3, 253-262.
- Gelfand, D.M. & Teti, D. (1990). Gelfand, D.M. & Teti, D.M. (1990). The effects of maternal depression on children. Clinical Psychology Review, 10, 329-353.
- Hopkins, J., Marcus, M. & Campbell, S.B. (1984). Postpartum depression: A critical review. Psychological Bulletin, 95, 498-515.
- Jennings, K.D., Wisner, K.L. & Conley, B.A. (1991). Serving the mental health needs of families with children under three: A comprehensive program. Infant Mental Health Journal, 12, 276-290.
- O'Hara, M.W. & Zekoski, E.M. (1988). Postpartum depression: A comprehensive review. In R. Kumar & I.F. Brockington (Eds.), Motherhood & Mental Illness 2: causes & consequences, London: Wright, pp. 17-63.
- O'Hara, M.W., Zekoski, E.M., Phillips, L.H. & Wright, E.J. (1990). Controlled prospective study of postpartum Psychology, 99, 3-15.
- Puckering, C. (1989). Annotation: Maternal depression. Journal of Child Psychology, Psychiatry & Allied Disciplines, 30, 807-817.
- Weinberg, M.K. & Tronick, E.Z. (in press). Maternal depression and infant maladjustment: a failure of mutual regulation. In J. Noshpitz (Ed.), Handbook of Child & Adolescent Psychiatry. New York: Basic Books.
- Zuckerman, B.S. & Beardslee, W.R. (1987). Maternal depression: A concern for pediatricians. Pediatrics, 79, 110-117.
-

WITH EVELYN AND DAVE

Stephen Bennett

Evelyn pushes her way down the drab hall of our Child Psychiatry Clinic, a swirl of people dancing around her, grabbing at quick consultations. Her ebullience and humor, sunny in a crowd, sardonic when we are alone, possesses a crackling energy that is palpable and inexhaustible, even though she gets only 4 hours of sleep at night. She is on her way to one of the many places she spends her time, such as the Pediatric Clinic or our Therapeutic Nursery.

A military trope captures my sense of her. Evelyn would make a good field commander. Clear, on-the-spot decisions made on the run, she pushes her way into the heart of the action. To paraphrase Ulysses S. Grant's maxim on war, she finds her patients right away, hits them with everything she's got, and keeps moving. Now that I think about it, the battle metaphor is tired and boring amidst the realities of a city hospital. Physical and emotional crises of patients we are trained to handle, but the city's financial and managerial chaos defeat us. Still, layoffs, forced furloughs, and dilapidated surroundings strengthen the spirit because they are a startling confrontation with the real and ugly world our patients experience every day.

Evelyn Davis is a developmental pediatrician who is a member of our Child Psychiatry Staff. I have a right to congratulate myself on her presence here because I found her. About 10 years ago, right after her pediatric residency at Babies Hospital, I had supervised her on a child psychiatry treatment case when she was taking her fellowship in developmental pediatrics. One of the better things I have done was to bring her along with me to Harlem Hospital when I came here. At first, her existence in Child Psychiatry was innovative, but now it is a necessity. Before she worked with us, we were only vaguely aware of fetal alcohol syndrome, but now all of us in Child Psychiatry can spot it in the elevator.

I know better than try to compete for her attention during the struggle of the working day, so I get to her first thing in the morning. At this time, the stark space of our clinic which used to be a surgical floor is missing its only color, that is, people. Years ago, we tried to brighten it up by putting up children's pictures on the bare walls, but they were pulled down because they were contrary to the fire code. I enter her small office with its ripped furniture and desk piled high with charts and tell her about the neonatologist from Boston whose lecture circuit routine is to show a picture of a scrawny and sickly infant and ask the audience what drug is most likely to be the cause? Evelyn knows the punch line. The neonatologist shows a cigarette ad to answer the question she has posed. It is highly effective

showmanship. We both smile in enjoyment of this splendid propaganda and feel a lofty tolerance in our amusement, but then we wonder whether neonatologists should ever be let out of their intensive care nurseries.

Evelyn has acquired her ideas on the issue of newborn drug exposure from having seen for the past 8 years most of the developmentally-delayed young children identified around here. What became clear to her over time was the strikingly high incidence of language and relationship problems in children exposed to cocaine prenatally, including classic autism! She is well aware of those who argue that she has an exaggerated view of the scope of the problem because she sees only symptomatic children who are referred. Sure, she says, but she has seen 300 of the 3,000 children exposed to cocaine over the past 5 years at our hospital--not a small number. What about the other 90%? Evelyn doesn't know. An old maxim in child psychiatry, that may not be at all true, is that we usually see only the families of young children who are sturdy enough to seek out help before the school system identifies them.

I try to sit with Evelyn a morning a week while she sees patients. It is quite a switch from the old days in which I supervised her, but I enjoy it. Today, we watch an 18-month-old girl who is so wildly active that I am surprised, even though overactive young children are familiar to me. She scrambles deftly to the top of a filing cabinet. "She's just like a squirrel," her 69 year old grandmother comments, which is something that other caregivers also have described. The infant has no words and needs only six hours of sleep a night. Her appetite is voracious, but she remains small. When enticed down finally, she becomes intensely interested in the water in the sink.

Each family is an exciting puzzle to Evelyn. She is alert to prenatal issues, reading hands and faces for evidence, since those systems are formed at the same time as the nervous system is laid down. In a review of 70 children exposed to cocaine prenatally, 94% had delays in language skills and 54% delays in personal-social skills. Most striking was the finding of autistic disorder in 11% of the cases. Autism is an extremely rare neurobehavioral syndrome occurring in 4 children per 10,000 live births. The affected children also had specific and fascinating signs and symptoms, such as abnormalities in the sleep-wake cycle, excessive eating with poor weight gain, and temperature dysregulation. Evelyn has felt this to be a stunning lead to the specific mechanism for the action of cocaine on the developing nervous system. She bristles at the stereotypic depiction of the "dysfunctional" African-American family as the major explanation for the troubles of the children she has followed. She is well aware of the impact of family disorder, but 80% of her children have been in

reasonably good foster and kinship foster care since an early age.

We walk now from the clinic building to the main hospital. She is stopped many times by patients. Very much at home here, Evelyn lives across the street and was born and raised in Harlem. After attending City College, she spent three-and-a-half years as a Peace Corps worker in Liberia setting up mother-child health care facilities. It was after this experience that she decided to follow her lifetime ambition to be a physician, and so worked her way through New York University Medical College.

A question to tangle with now, beyond offering a personality sketch, is why am I writing this? As someone who has hung around researchers for a long time, I know that past experience and quirky personal vision are major determinants in what an investigator investigates. Carefully designed studies reported in the literature have their own unique histories. Within this medical center, where people reside determines their experiences and leads to different ideas on the same issue. I want to capture this.

Some pediatricians wonder if Evelyn is spreading scare stories about a generation of doomed children. Evelyn's response is that she spots problems that come her way and that early identification and treatment is the only appropriate course. I decided that now is a good time to visit Dave Bateman before I am completely captivated by Evelyn. He is the Chief of Neonatology at our hospital. To get to the obstetrical floor, you must pass a guard who prevents people from carrying off babies that don't belong to them. Dave is a lean, bearded man, and to carry on the military metaphor, he has the look of a World War I submarine commander. I think of the First World War because he possesses an anachronistic dignity and handsomeness. I don't think he gets much sleep either, and on him it shows. It is nice to visit with him here, because on the phone, and in brief meetings, he gives the word laconic a new austerity. If 3 words just manage to convey a meaning, he uses 2. However, on home ground, he reveals a playful funniness while interacting with his staff. His office displays a disheveled hominess, which makes sense because Dave and his co-workers hang out there 24 hours a day. Indeed, he looks like he lives there, which I suppose is possible because his wife is also a neonatologist on the staff. I am exaggerating, I realize, because he shows me pictures of his two young children. He and his wife believe that an advantage of their work situation is that they can alternate child care. Dave was late this morning because his boys ran around in the rain and mud and he had to find a second change of clothes before school.

I try the neonatologist/cigarettes story on him, but he does not think it is very funny and tries to persuade

me to take more seriously the critiques of the question of the effects of prenatal drug exposure. He believes that these effects have been overstated. I am thinking that a neonatologist sees an infant only at one discrete moment in time, and I wonder how much they can tell about the future neurological development. What you need to find is a measurable outcome, says Dave. The easiest variables to measure are the things we ordinarily pay attention to: birth weight, gestation, sickliness, and obvious neurological symptoms. Looking at these data does not indicate that prenatal exposure to cocaine is much worse than a lot of other variables, such as poverty, violence-ridden neighborhoods, and other miserable living conditions.

There may be some answers to the question of the effects of prenatal drug exposure coming up in the near future. At our hospital, a study has been funded to follow-up 350 children who were exposed to cocaine over 6 years ago. They will be compared with a cohort of children who were not exposed. A multivariate analysis will be conducted, meaning that the weight of different factors such as cigarettes, alcohol, lousy environments, and lots of other things can be determined. Evelyn will be one of the people seeing these children at 6 years of age. I rather imagine that the results will end up confirming both Evelyn and Dave's views. One finding will be that many children who were prenatally exposed do well if their environment is half-way decent, and another finding will be that a lot of the children have neurodevelopmental damage.

Dave describes himself as coming from the mid-western United States, then attending medical school at Tufts in Boston. A product of the radical movements of the 70's, he ended up, as he describes it, a "fellow traveler" at the Lincoln Health Collective which was an experiment in social medicine in the Bronx. The experiment and the Collective folded after bitter internal battles over Marxist ideology. From there, he went on to pediatric training at Babies Hospital in New York and then into neonatology. He was several years ahead of Evelyn.

It is interesting to me that both of them have in their background a commitment to helping that goes beyond the usual in medicine. George Vaillant describes altruism and humor as lifetime defenses that really work. Dave and Evelyn both have need of such strengths for their intense and difficult professional lives.

I return for another visit with Dave and find him tinkering with a borrowed blood gas machine. In the many rooms, his staff also work over their pieces of equipment, the life support systems that maintain the tiny babies that are housed in plexiglass containers. The bad joke is that the contest is to see who can insert the

most tubes. Dave has had my own experience here which is that you rarely get anything you really need. He points out that after waiting several years for chairs, he bought his own. Working on the machine is a survival skill for him, because if he doesn't fix it, no one else will for months.

I am here to attend the psychosocial rounds in Neonatology. We sit around a table eating bagels. Lynn Adams, the senior social worker, has a wacky sense of humor. She forces us relentlessly to discuss the resources of each family, but especially their ability to care for an infant with special needs. I am on familiar ground as a child psychiatrist now that we leave the high-tech space of the intensive care nursery and look at the world of scant resources to support these fragile mothers and babies. There are some solid and skilled agencies such as the Visiting Nurse Service and a few drug treatment programs that also offer parenting. However, my judgment is that there is a need for a powerful and integrated care for these mothers and infants that would carry them along for several years. In every other case, issues of H.I.V. status and major drug use arise. We shudder collectively, but then we eat another bagel and move on. The appalling environment of shelters and deteriorated housing, Dave believes, determines these infants' fate as much or more than anything the mother ingests during pregnancy.

The juxtaposition of advanced and hugely expensive hardware in the intensive care nursery and the horrendous social environment just outside is a direct mirror of the immediate surroundings of the hospital. Just across the street to the south are elegant apartments and to the north are abandoned buildings. Plane trees grow on the roofs of those abandoned buildings. Though it is a testament to the endurance of life, it is a sad one. The Marxist tensions that Dave experienced several decades ago are still very much with us.

I feel that while both Evelyn and Dave have their own separate intellectual pursuits and convictions, both come together in shared determination to search out troubles and to tangle with them as best they can using their own resources--indeed--with all the other resources they can muster!

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. I am pleased that his column will appear as a regular feature of the Newsletter.

MESSAGE FROM THE PRESIDENT

The formation of the World Association for Infant Mental Health is a "new beginning" like many that we have in infancy. WAIMH, continuing the traditions of the two organizations from which it was formed, WAIPAD and IAIMH, is committed to promoting positive beginnings for infants and families world-wide. We blend research, clinical, educational, and intervention interests in an effort to optimize the quality of infant development, the kinds of caregiving that infants receive, and the environments in which infants are raised. We are an international organization with strong emphasis on cross-cultural and cross-national work. Our reach is to both developed and developing countries. We recognize that different approaches and strategies may be needed depending on the region of the world, the problems, and the goals to be accomplished. With these different perspectives, we have the opportunity to take many different approaches to problems of infants and families.

We are a multidisciplinary, interdisciplinary, and transdisciplinary organization (as emphasized by WAIPAD Past-President, Serge Lebovici). To meet the interests of our membership as well as to address the many needs of infants and families, we will hold different types of meetings including World Congresses, Regional meetings, study groups, and affiliate group activities. We are committed to cooperation and collaboration with other societies and groups to accomplish our goals. At the same time, we will maintain our own important commitment to clinical work, research, and interventions with infants and families.

We have made enormous strides in the past decade in stimulating growth in the field of infant mental health in important regions of the world not previously so involved including Latin America, Asia, and Eastern Europe. Yet much more needs to be done and we will continue these efforts in addition to identifying other regions where our work would be helpful. Serge Lebovici, WAIPAD Past-President, will be continuing the efforts that he and his colleagues have initiated in Eastern Europe. I plan to follow his fine lead in encouraging activities in this area as much as possible. We will see growth of affiliate activities following the lead of IAIMH Past-President, Sonya Bemporad, with the help of WAIMH President-Elect Yvon Gauthier. Through our affiliate organizations, we are hoping to address more directly pressing domestic issues including poverty and violence that affect infants and families. In the United States, these collaborations will include such groups as Zero to Three, National Center for Clinical

Infant Programs in these efforts. For other parts of the world, we will look to Affiliates.

As we enter this time of a new beginning for the World Association for Infant Mental Health, I want to emphasize to the membership that your participation is critical to the success of our organization. We not only need your membership, but that of your colleagues in order to accomplish our objectives. The world-wide activities we are planning, that I have briefly described above, require financial resources. Previously, we have sustained our organization from World Congress to World Congress with the Regional meetings supporting themselves. Affiliate activities and study groups that outreach to developing countries require some financial support from the organization. In order to encourage individuals to join WAIMH, the dues have been kept relatively low and they include a subscription to the *Infant Mental Health Journal*.

Our redefined organizational structure will help us communicate better with members but also will require new financial resources. Let me share this structure with you. I welcome communication with you directly from the President's office about ideas you have for WAIMH, initiatives that are of interest, fundraising ideas, etc. Our Executive Director, Hiram Fitzgerald, will be in charge of all of the administrative activities of the organization including memberships, subscriptions to the *Infant Mental Health Journal*, overseeing of budget with the Treasurer, Miguel Hoffmann and myself, and handling all of the mailings, tax and legal issues, and accounting. We will organize the mechanics of the organization including World Congresses, Regional Meetings, and Affiliate Activities through that office with the personal contacts in the regions being carried out through the Regional Vice Presidents in collaboration with the Executive Committee. We will have a part-time administrative secretary working with Hiram Fitzgerald at the office in East Lansing, Michigan. Under my Presidency, we will have fewer Regional Vice Presidents than we have had in the past with increased responsibility for larger regions of the world. We will be working closely with these individuals to promote membership, affiliate groups, and other regional activities.

I am delighted that Charley Zeanah, our Secretary, has agreed to become the first Newsletter Editor. As you can see, his energy and creativity is paying off already in this new, exciting product.

I have appointed two special advisors and want to describe their respective roles in the organization. Bob Emde is a Past-President of WAIPAD and is currently President of the Society for Research in Child Development, the major English-speaking organization for child development research. He will be our Senior Scientific and International Advisor. He has played a

major role in enthusiastically encouraging the development of clinical science in developed and developing countries. Under his leadership, our organization has made major advances in both Latin America and in Japan in both clinical work and research for infants and families. I am very pleased that he has agreed to continue these international efforts in collaboration with the Executive Committee and Regional Vice Presidents. Peter Fonagy, the other special advisor, has just been installed as the Sigmund Freud Professor at University College London, is a leader of clinical research at the Anna Freud Centre, and serves as Treasurer of the International Psychoanalytic Association. He has agreed to work with WAIMH as a Consultant for Psychoanalysis and will continue our commitment and interests in that area.

In closing, I want to express my personal enthusiasm about having the opportunity to lead this exciting new organization committed to helping infants and families world-wide. I encourage you to continue to work with our new organization, WAIMH, and to help us to "grow our organization" as we address some of the pressing problems of infants and families on which the future of the world depends.

Joy D. Osofsky, Ph.D.
President

FROM THE EXECUTIVE OFFICE

Although the Red Cedar River flows through Michigan State University's campus, WAIMH's new Executive Office has the misfortune of being located far enough away from the river that we cannot enjoy its scenic beauty. Nevertheless, we do have a view of a lovely courtyard and I invite any member of WAIMH who is passing by East Lansing to stop by and visit, especially in the spring and summer months.

By the time this Newsletter is in the mail, the move to new office space will have been completed. Richard Lerner, Director of the Institute for Children, Youth, and Families, has generously provided space for a wide variety of infant programs, including executive offices for WAIMH and its Michigan Affiliate (MAIMH). MAIMH not only founded the *Infant Mental Health Journal* and holds copyright, it helps to support the office's administrative operations. Finally, this also is the home of Michigan State University's graduate program in infant studies, as well as the Michigan Infancy Network, an information, communication, and advocacy network being nurtured as the outreach arm of the graduate program in infant studies. If you have the feeling that the 500 square feet we occupy is bustling with infancy programs and staff, you are absolutely right.

Speaking of staff, allow me to introduce you to Ms. **Melanie** (pronounced Melawnie) **Smith**, WAIMH's new Administrative Assistant. Melanie earned her MA in reading from Central Michigan University, has been a high school teacher, has worked as a trainer for a diversity management consulting firm, has co-authored six books during the past seven years, and recently has established connections with medical and rehabilitation professionals in Ukraine. She will be returning to Ukraine during 1993 and this time perhaps we can persuade her to take the infant mental health message with her as well. When you call the executive office and no one is there, you will hear Melanie's voice on the answering machine. Melanie currently is busy trying to cram all of the office operations into an intense two-week training period, and she is holding up well to glitches in our new computer and new software.

We have tried to make communication with the executive office as easy as possible. The following list provides all the information necessary to contact either the executive office or the Executive Director.

Executive Office

Office hours: Monday and Tuesday:
9:00 am - 1:00 pm (13:00)
Wednesday and Thursday:
11:45 am - 2:45 pm (14:45)

24 hours per day:
FAX 517 336-3694 WAIMH office
FAX 517 336-2476 Fitzgerald
Tel 517 336-3793

Electronic Mail: 10983HEF@MSU.EDU

Address: WAIMH
Institute for Children, Youth, and Families
2 Paolucci Building
Michigan State University
East Lansing, MI 48824-1110
USA

The executive office was established to facilitate central coordination for WAIMH's worldwide activities, and to regulate all of the business affairs of the association. In this way we hope to be able to be of greater service to WAIMH members and to WAIMH Affiliate organizations. For example, to date WAIMH has two sponsored regional congresses well underway, one in Graz, Austria and one in Punta del Este, Uruguay. Additional regional congresses are planned for Tokyo, Riga, Sydney, and perhaps Amsterdam. We hope that other Affiliates will develop similar plans for regional meetings.

When an Affiliate or any other group of WAIMH members wants to plan a regional congress, they should contact the Executive Director. He will send a packet of information detailing how the local group should organize its affairs and the necessary steps to take in order to obtain the approval of the WAIMH Executive Committee. If co-sponsorship is not an issue, Affiliates may hold conferences without approval from the Executive Committee, however, we still would like the central office to be notified of all conferences, workshops, training programs, and the like. In addition, I urge everyone to communicate with Charley Zeanah, editor, so that he can include announcements of activities in the newsletter.

If an Affiliate association does not exist in your local area and you are interested in starting one, please write to us for a packet that provides guidelines for forming an Affiliate. During 1992, the Nordic Association for Infant Mental Health and the Oklahoma Association for Infant Mental Health were accepted as Affiliates by the general membership. To prevent the possibility that new Affiliates would have to wait until

1996 for acceptance, the WAIMH Executive Committee has agreed to allow a smaller set of its members to act on affiliate proposals.

The MAIMH Infant Mental Health video library also is housed in the executive office. During 1993 each WAIMH member will be receiving a description of the video library along with information about rentals. Unfortunately, to date we only have a series of videos donated by Michael Trout, Regional Vice-President, that are in European format. All other videos are U.S. Standard VHS. Perhaps as time goes by we will be able to convert other videos to non U.S. formats, although in some cases we cannot do this without securing copyright releases from the companies that hold copyrights. In any event, the videos have been hot rentals in the U.S. and Canada during the past 10 years and will continue to be useful to many infant mental health professionals in their training programs.

The executive office also will be the repository of materials being compiled by the history committee chaired by Miguel Hoffmann. This committee, assisted by other WAIMH members, is compiling a history of the infant mental health movement. One of the more exciting aspects of the project involves the development of video and/or audio interviews with many individuals who were "in the movement" during the early days, as well as those who have helped to give definition to infant mental health over the years. This is an exciting project and the hope is that it will provide additional materials for use by WAIMH members as more and more training programs are developed worldwide.

I will continue to keep the membership informed by reporting in each newsletter about WAIMH resources and activities. If anyone has any questions at all about WAIMH, I invite you to contact the executive office and if we do not have the answer at our fingertips, we will direct you to the person who does.

*Hiram E. Fitzgerald, Ph.D.
Executive Director*

TO THE EDITOR

I would like to let the members of the WAIMH know that the London PARENT INFANT CLINIC, started by Dr. Stella Acquarone in 1989 to offer clinical services, has now incorporated The School of Infant Mental Health, creating a two year training for professionals of different disciplines who work with under fives. The training consists of three modules:

1. **INFANT PSYCHIATRY I** -- given Hisako Watanabe, M.D., an update of normal and deviant development in infancy and illustrations of different psychotherapeutic interventions covering pregnancy, gender identity, malformations, and disorders in infancy.
2. **CLINICAL SEMINARS I** -- led by myself, involving discussion of the students' experiences with under fives in their normal work settings and in two added voluntary settings.
3. **INFANT OBSERVATION I & II** -- led by Dr. Etchegoyen, M.D. and Psychoanalyst.

The second year of INFANT PSYCHIATRY (II), led by a team of psychoanalysts (theory) and myself (practice) will cover the theory and practice of mother-infant psychotherapy from pregnancy to three years; while the second year of CLINICAL SEMINARS will revolve around discussion by the students of their practice of mother-infant psychotherapy. Sadly for us, Hisako Watanabe is leaving for Japan, but she will continue to represent INFANT PSYCHIATRY I in three weekends of ten seminars each over the coming year.

The ten trainees currently taking the course divide into the following disciplines: (4) four Child Psychiatrists, (2) two Clinical Psychologists, (1) one Art Therapist, (1) one Social Worker specializing in adoption and fostering, and (2) two Psychiatric Nurses. They form an enthusiastic and dedicated group which has been meeting four hours weekly in the evenings from November to July.

It has been hard to organize a timetable for our busy team of staff and students, but the effort has borne fruit in requests to us to extend our activities to Europe, Latin American and the USA, so that professionals in those places who work with under fives can have access to similar information and support.

Dr. Stella Acquarone, Director

IMPORTANT ANNOUNCEMENTS

Workshop sponsored by WAIMH

The Origins of Mental Representations: Enlightenment through Clinical Presentations

Amsterdam, The Netherlands
Rai Congress Hall
Rooms E & F

Sunday, July 25, 1993
8:30-5:30

Introduction:

Joy D. Osofsky, Ph.D.
New Orleans, U.S.A.

Presentations:

Serge Lebovici, M.D.
Paris, France

Dirk De Raeymaecker, M.D.
Rotterdam, The Netherlands

Hisako Watanabe
Yokohama, Japan

Discussion:

Peter Fonagy, Ph.D.
London, England

Paulina Kernberg, M.S.
White Plains, U.S.A.

Peter de Chateau, M.D.
Nijmegen, The Netherlands

Cost: \$70.00 advance registration by July 1, 1993
\$80.00 at door, space permitting

Cassette recordings of a number of sessions from the **Fifth World Congress of Infant Psychiatry and Allied Disciplines** held in Chicago in September 1992 are available for purchase. To order contact:

WAIPAD Audio Cassettes
c/o Foto-Comm. Corp.
P.O. Box 5316
Oakbrook, IL 60522-5316

Tel. 800-252-4358
Fax: 708-575-2910

Program Abstracts from the Fifth World Congress of Infant Psychiatry and Allied Disciplines held in Chicago in September 1992 also are available for purchase. The cost is \$15 (U.S.) if you attended the meeting and \$20 (U.S.) if you did not. Send requests and payment to:

WAIMH: Program Abstracts
Institute for Children, Youth & Families
Michigan State University
East Lansing, MI 48824-1110

REGISTRATION FOR AMSTERDAM WORKSHOP

NAME _____

DEGREE _____

ADDRESS _____

PHONE _____ FAX _____

PAYMENT: CHECK ENCLOSED (do not send cash)

VISA/MC No. _____ Expiration date _____

Signature for VISA

Send to:

Dr. Joy Osofsky
WAIMH/IPA Conference
L.S.U. School of Medicine
Department of Psychiatry
1542 Tulane Avenue
New Orleans, LA 70112-2822
Phone: (504) 568-3997/Fax: (504) 568-6246

UPCOMING WAIMH ACTIVITIES

REGIONAL CONFERENCES

<p>MAY 14-16 1993: Graz, Austria</p> <p>Contact: Peter Dunitz/Maguerite Scheer Univ.-Kinderklinik Auenbruggerplatz 30 A-8036 Graz, AUSTRIA FAX 43/316 385-32 64</p> <p>JULY 1993: Amsterdam, The Netherlands</p> <p>Joy Osofsky Division of Infant, Child & Adolescent Psychiatry L.S.U. Medical Center 1542 Tulane Ave. New Orleans, LA 70112-2822 USA Fax (504) 568-6246</p> <p>NOV. 24-28 1993: Punta del Este, Uruguay</p> <p>Miguel Cherro Aguerre Libertad 2348, Pt. 202 Psiquiatria de Nonos y Adolescentes Psicoterapeuta--Psicoanalitico Montevideo, URUGUAY Fax: 598-474786</p>	<p>APRIL 1994: Tokyo, Japan</p> <p>Keigo Okonogi Keio University School of Medicine Neuro-Psychiatric Department 35 Shinanomachi Shinjuku-Ku Toyko, JAPAN Fax: 813-5379-0187</p> <p>JUNE 1994: Riga, Latvia</p> <p>Peter de Chateau University of Nijmegen Department of Child & Adolescent Psychiatry Postbus 9109 Kun-Reiner Poshan 10 6500 HC Nijmegen, THE NETHERLANDS Fax: 318-054-0561</p> <p>JULY 1994: Sydney, Australia</p> <p>David Lonie Box B7 Boronia Park, NSW 2111 AUSTRALIA Fax 61-2-879-7305</p>
--	--

6TH WORLD CONGRESS: WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

July 1996: Lahti, Finland

Tuula Tamminen
Elvankatu 12 D
33 270 Tampere
FINLAND
FAX 335-8-31-156164

AFFILIATE NEWS FROM AROUND THE WORLD

Affiliates, we need contributions to turn this into a quarterly feature column.

Michigan Association for Infant Mental Health: Statement of Mission and Organizational Beliefs

*The mission of MAIMH is to promote and to support
nurturing relationships for all infants.*

MAIMH believes that each infant needs to be nurtured and protected by one or more consistent and stimulating caregivers who enjoy a permanent and special relationship with the baby. This relationship is not just a luxury over and above the basic physical necessities of life, but is the essential and necessary context within which every human infant learns basic emotional, cognitive and social attitudes which will influence all later development.

As a consequence of this basic position, MAIMH further believes that the failure to provide or to maintain such a nurturing relationship during infancy inflicts a primary developmental insult which is likely to solidify over subsequent years, with resulting damage to the individual, and thus, to society.

Therefore, MAIMH espouses the following four positions:

1. Early intervention is an essential social policy important from both a fiscal and a moral point of view.
2. Early intervention can be effective for the individual infant only if offered in a manner which promotes and supports the infant-caregiver relationship as both the primary locus of need and the primary source of strength.
3. Early intervention can be effective for society as a whole only to the extent that it is offered to all segments of society, in a manner which is culturally sensitive to each.
4. Support, training and advocacy for early intervention must become a cooperative venture which crosses all traditional cultural, disciplinary, administrative and political boundaries.

Michigan Association for Infant Mental Health
17th Annual Conference, **The Diversity of Infant Experience: Awareness and Action**, will be held on April 25-27. To our knowledge, this is the longest running annual conference exclusively devoted to infant mental health issues in the world. What a challenge. Historians dig into those records. Is our claim correct? In any event, this year's meetings will feature plenary sessions, workshops, and poster sessions addressing issues related to what in the United States is referred to as 99-457 IDEA. This and other public laws address issues related to the provision of comprehensive services for infants at risk for poor developmental outcome. In the United States, the "education of the handicapped" public laws have involved the creative talents of thousands of individuals from a great many disciplines in an effort to devise the most efficient and most comprehensive way to deliver services to at-risk infants and their families. The excitement of much of this activity is that the definition of at-risk includes psychosocial risk as well as biological risk. Anyone interested in attending the MAIMH annual conference in Ann Arbor, Michigan, please contact Penny Tully (313) 936-0379 at the University of Michigan or contact: Melanie Smith, MAIMH Central Office, Institute for Children, Youth, and Families, 2 Paolucci Building, Michigan State University, East Lansing, MI 48824-1030 Tel: (517) 336-3793; FAX (517) 336-3694

WAIMH

1993 DUES STATEMENT
DUES AND SUBSCRIPTION: \$75 US

NAME _____

MAILING ADDRESS _____

DEGREE _____

METHOD OF PAYMENT:

_____ CHECK ENCLOSED (Checks must be drawn on US affiliate banks. Checks not in US funds will be returned.)

_____ VISA/MC Card no.: _____ Expiration Date _____

Signature for VISA/MC _____

**WAIMH
INSTITUTE FOR CHILDREN, YOUTH & FAMILIES
2 PAOLUCCI BUILDING
MICHIGAN STATE UNIVERSITY
EAST LANSING, MI 48824-1110**

NON-PROFIT ORG.
U.S. POSTAGE PAID
PERMIT 199
EAST LANSING, MI