



WAIMH NEWS

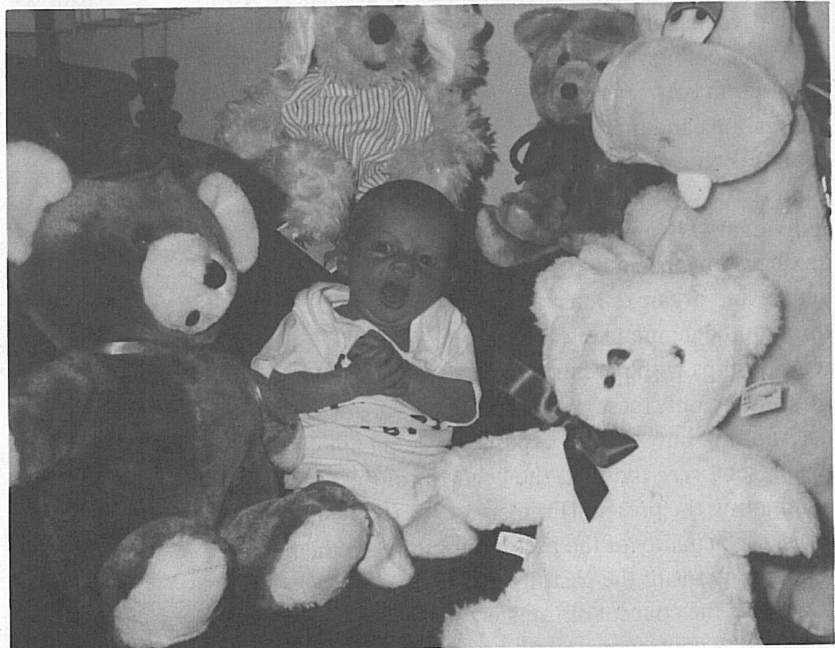
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Why How You Feel Matters: Countertransference Reactions In Intervention Relationships

Stephen Seligman, D.M.H.

The importance of relationships -- especially two-person relationships -- has been highlighted by the wide array of research findings about the infant and its caregivers that has transformed our view of early development in the last quarter-century. Clinicians in infant mental health-related fields are increasingly seeing the infant-caregiver system, rather than any individual, as the focus of their efforts. Similarly, developmental researchers are finding that early relationships are the most powerful predictors of subsequent developmental outcome (Sameroff & Emde, 1989). Along the same lines, there is an increasing consensus that the quality of the intervention relationship is among the most important factors in the success of all interventions (Heinecke, Beckwith & Thompson, 1988; Seligman & Pawl, 1985).

In all their varied fields, professionals who work with infants and their parents are similarly affected by the evocative power of the infant-parent relationship. Even the most ordinary encounters with babies can produce especially strong reactions -- both positive and negative -- in most of us, and these reactions are amplified when the infants are in distress, as in most intervention situations. In addition, strong reactions to parents are common, especially when the parents themselves are in great distress or, as is sometimes the case, appear to be the source of their babies' agonies. The range of reactions in such situations is very broad, including extremes of sympathy, frustration, blaming and even hatred of parents,



and self-criticism when interventions do not have the desired effect. Other professionals may also evoke strong reactions, especially in the face of bureaucratic tangles, puzzling clinical situations, or cultural, disciplinary or

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other differences. It is almost impossible to stay detached when working with babies and their families, and those workers who do are often the least effective. Indeed, the emotional power of infancy is one of the most fulfilling elements of our often disappointing and trying work. But our strong reactions can also impede the progress of our most well-intended and technically sophisticated efforts. Whether these responses become exhausting obstacles or sources of insight and vitality will depend on how we handle our reactive thoughts and feelings. The twin pitfalls of unreflective action or unnecessary self-censorship can be best avoided when we can become aware of our reactions and tolerate and use them as informative data, even when they initially seem negative or inappropriate.

In the face of such challenges, basic concepts drawn from psychoanalysis can be usefully applied in all infant intervention. Psychoanalysis always has focused on the transaction between the inner world of representations and motivations and the outer world of other people and things. Freud proposed the concept of *transference* to capture the omnipresent and dramatic influence of the individual's thoughts, feelings, memories, fantasies and anxieties on current experience and interaction with other people and organizations; all experiences are viewed through the template of earlier ones, especially early relationships with parents and other caregivers. In some situations, these prior experiences are decisive in determining how current experience is felt and lived, as if the present *were* the past; the "ghosts" of the past are dominating the present (Fraiberg, 1975). In other situations, the actuality of the present blends with the internal representations of the past in more balanced ways.

Since the concept of transference was initially proposed, a controversy about its proper emphasis has evolved (Sandler, Dare, Holder, 1973). Some have insisted on a "narrow" definition of transference, regarding it as a special artifact of the psychoanalytic situation as the arena where the most irrational and distortive elements of the mind are given free play. These writers have emphasized the inappropriate and capricious aspects of transference. Greenson (1967), in a textbook of psychoanalysis that is still widely accepted, wrote:

"Transference is the experiencing of feelings, attitudes, fantasies, expectations, etc. toward a person in the present which do not befit that person but are a repetition of reactions originating in regard to significant persons of early childhood, unconsciously displaced onto figures in the present (p.171)."

The hallmarks of these reactions are that they are

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repetitions of the past, and that they are inappropriate, intense, capricious, tenacious, and often, ambivalent. Thus, they are peculiarly powerful, and are not readily altered by explanations or behavior that would normally correct misperceptions or misunderstandings in usual interactions, but instead seem to have a life of their own (Schafer, 1983). Despite its apparent inconsistency with the "actual situation," the sense of the current situation as "replaying" the past is experienced as an objective reality, rather than a subjective feeling.

Other writers have taken a broader approach, emphasizing the ways that *all* relationships are viewed through the template of expectations originating in the past, especially prior relationships; transference, in this view, is a ubiquitous, everyday phenomenon, since the past is always influencing current experience. An integration of these two perspectives will be most useful for most infant workers: While it would be destructive to assume that every client's reaction to every situation and every intervention is a distortion rooted in the past, it would be similarly limiting to neglect the fact that the apparently opaque surface of the present always contains and expresses inner presences and processes that may not be initially obvious. The past and present and the inner and the outer are always in ongoing, dialectical interaction, with the various influences being more or less dominant at different moments.

Such thinking may be especially useful for workers who are not directly involved in psychotherapeutic work with infants and parents, since they are not as likely to be explicitly concerned with the array of emotional reactions that may arise for parents who find themselves in distressing situations with their young children. Even under the most fortunate circumstances, becoming a parent stimulates parents' memories of their earliest experiences, and where these experiences were difficult and even traumatic, the "ghosts" that are evoked may be fearfully haunting (Fraiberg, 1975). In other situations, developmental or bureaucratic factors may interact with such personal experiences to further complicate the situation, as in cases of infants with developmental disabilities (Kalmanson and Seligman, 1992) or where social service organizations have become involved after reported episodes of child abuse or neglect. In situations of bureaucratic transference (Seligman, 1992) parents' reactions to interventions may be especially complex and difficult to manage since they are conditioned by the experience of having been compelled to use services that would otherwise be rejected. A brief vignette from such a situation will now be presented.

An infant-parent psychotherapist was visiting the

home of a young mother who had been required to begin therapy after allegations that she had abused her twenty-eight month old daughter. Herself a resilient and resourceful social worker, she approached the door of the client's apartment in a tough housing project with some apprehension, but expecting to be greeted acceptantly, if not warmly, since the initial telephone call had been surprisingly amiable. However, her knock was met with a long silence, ended by a gruff female voice shouting, "Who the hell are you?" The therapy had begun.

Although the main focus of the work here was not supposed to be the mother's feelings about the worker, this reaction poignantly illustrates the extent to which preconceptions about intervention are central from the first

... it is difficult to function as a "decoder" when one is the target of the same feelings and expectations that one is expected to understand."

moment onward. This mother was fully prepared to see the therapist as intruding on her privacy, accusing her of wrongdoing, and as treating her as an anonymous, bureaucratic client. To her, the therapist was someone to be greeted with aversion, whom she could allow into her home only with an armor of hostility to protect her from the dangers that, in her past experience with her own parents as well as public agencies, always accompanied offers of help. This episode also illustrates one other key point -- that transference reactions usually have important *self-protective* functions. These may not be obvious, especially when these reactions are so intense, don't make good sense, and as they so often do, are implicitly, if not explicitly, hostile. Transference and transference-like reactions are ambivalent in two important and essential ways: they are always expressing something very important about the client's inner worries at the same time that they are concealing them, and they thus invite some form of involvement from we who are their objects as they simultaneously keep us at a distance (Freud, 1914). When these complex purposes can be "decoded" by providers, greater clarity and progress can result. Many of these essential points were made in earliest conceptualizations of transference, but they are often lost in the more technical or jargon-laden contemporary discussions.

Nevertheless, it is difficult to function as a "decoder" when one is the target of the same feelings and expectations that one is expected to understand. The therapist here, for example, felt caught off-guard -- stunned,

discouraged, confused, disappointed, angry and hurt. She was tempted fleetingly to respond reciprocally and rudely to the mother, by getting angry herself or even leaving. Although most situations may not provoke such intense reactions, professionals routinely find themselves confronting their own inner responses to clients' self-protective maneuvers. What kinds of resources--professional, conceptual, and personal--can we call upon to handle such challenges so as to maximize our therapeutic effectiveness?

The psychoanalytic concept of *countertransference* provides a useful tool here. Even more than transference, countertransference is difficult to define rigorously. The

Like infants and parents, intervenors and clients are always involved in processes of mutual influence . . .

broadest definitions refer to all those feelings that arise in the provider in the course of the intervention relationship, while the narrowest are limited to those of the worker's responses to the client that are inappropriate projections -- "transferences" -- of her own prior relationships and inner fantasies, defenses and feelings. Although early conceptualizations of this idea suggested that therapists' emotional reactions to their patients usually impeded the therapeutic work, most contemporary writers now argue that *these reactions are to be treated as data that can provide essential insights about the client's psychology and experience of the intervention, as well as about the intervention relationship itself*. In addition, the psychoanalytic perspective adds the crucial emphasis on *unconscious processes*; that is, that both the client and the service provider are not fully aware of some of the most important elements of their experiences in the intervention situation.

From this perspective, the worker's first task in the face of her own reactions is *self-monitoring*, rather than responding interactionally. Like infants and parents, intervenors and clients are always involved in processes of mutual influence; that families are always affecting our own inner states and actual responses is so obvious as to be neglected regularly. All workers will benefit from adapting an *analytic attitude* (Schafer, 1983), in which self-reflection -- as opposed to unscrutinized reaction -- becomes a routine part of the worker's style. Schafer proposes that the analyst maintain a flexible inner image or "working model" of the analysis and through the data that emerge in the intervention relationship should be

filtered; this model is not always systematic or verbally-organized. While workers in the more pragmatically-oriented infant intervention professions do not have the same secluded, "reflection-promoting" atmosphere of the psychoanalytic consulting room, the basic discipline of the analytic stance can be applied in a modified way to most interventions. Here, I return to the case example introduced earlier.

The infant-parent psychotherapist in the above example was aware of her feelings, but understood that the mother's insult was an indication of how bruised she felt by all that was happening to her, and perhaps much that had happened to her in the distant past. Specifically, the worker drew on a central theoretical postulate to organize her understanding of what was going on in this first stormy minute of clinical interaction: that people in distress will try to inflict the pain that they feel coming at them from the outside on others in their external worlds. Descriptions of such "identification with the aggressor" have been used to account for how frequently parents who have been abused as children will abuse their own children, as well as to explain why so many distressed parents will turn on the same therapists whose offers of help seem so apparently reassuring to them (A. Freud, 1936; Fraiberg, 1975).

With this in mind, in only an intuitive way, perhaps, the therapist said, through the door: "You seem ready for a fight. You must feel very put upon lately."

Relying on a combination of explicit thinking, intuition, and a general position of self-reflective detachment, the therapist used her reactions as the basis for a useful and empathic interpretive comment that got the therapy off on the right foot. Such comments may be useful in a variety of intervention contexts, including those with no psychotherapeutic intent. For example, a physical therapist who feels intimidated as a mother persistently criticizes her by noting the slowness of her infant son's progress may rely on such thinking to interpret the mother's irritation as an expression of her own frustration and despair at her baby's disability. She could then explore the issue of what developmental expectations would be appropriate in the case with a more sensitive awareness of the mother's disappointment, grief and ongoing frustration.

Conceptualizing Countertransference Reactions

Some of the controversy about the boundaries of the concept of countertransference may be clarified by specifying some categories that can differentiate different types of provider reactions. A useful, if somewhat

approximate, schema would differentiate along three axes, mindful of the fact that such differentiations are imprecise continua, rather than rigid distinctions. The three overlapping oppositions proposed here are: 1) those that are rooted in general issues of the working situation vs. those specific to the case; 2) client-based vs. worker-based; and 3) reactions that impede the intervention vs. those that do not.

“General vs. specific”

Many situations recur in interventions with infants and their families that routinely generate strong feelings in providers. For example, many workers--at least in the United States--are routinely frustrated by the difficulties of the legal and social service bureaucracies set up to protect children who have been victims of abuse and neglect. Similarly, the poignant problems of children with chronic and severe developmental disabilities may bring grief, anger and even despair to those who work with them on a daily basis. These reactions may not vary much across cases, but can affect a workers' emotional state and conduct in important ways.

Other evocative factors vary from case to case. For example, a mother may be especially competitive with the worker's competently offered developmental guidance and defend against her sense of humiliation and failure by criticizing trivial details of the worker's style. Alternatively, a pediatric practitioner who may be exasperated by an extremely difficult-to-soothe infant thwarts his efforts to help the baby's parents find effective soothing strategies.

Worker-Based vs. Client-Based

There is wide variation in how different workers will respond to the particular intervention situation. With the competitive mother just described, a worker who is herself prone to competition might become quite irritated and even become actively competitive with the critical mother, while another with fragile self-esteem might feel like there was indeed something wrong with her. A third might be less susceptible to the mother's defensiveness, and might more immediately adapt or bring the issue to the mother's attention.

But some things that clients do can be expected to evoke strong reactions in almost anyone, although the nature of these reactions will vary from person to person. Most of us would be vexed when a mother with whom we thought we achieved a beginning alliance offers, "Who the hell are you?" as her initial greeting. Similarly, outrage at extremes of sexual or physical abuse is routine

in those who work with infants and their families.

In general, the specific nature of these reactions always will be the product of the transaction between the workers' own personalities and the intervention situation. Workers must always be vigilant about their own personalities and reactivities. In addition to personal issues, cultural and class-based preconceptions should be scrutinized.

Countertransference Impediments vs. Countertransference as a Routine Part of Everyday Work

Reactions to the infants and families with whom we work are inevitable, especially in the presence of the uniquely evocative infant-parent relationship. It is difficult to imagine therapeutic efforts going forward without such reactions. But even those feelings that are usually most important in promoting the positive working atmosphere can have negative effects.

For example, our feelings of concern for a victimized infant will propel us to work harder on his behalf. But when an identification with that infant makes it impossible for a social worker to make an accurate assessment of whether the abusive parents have responded to treatment enough to provide a secure home for their baby, the feelings of concern must be examined and placed in a proper perspective. When such dynamics do occur, workers should resist the temptation to condemn themselves (or one another), since such condemnations can lead to further impediment. Such dynamics are extremely common and can occur with any of the wide array of reactions that occur in the difficult and evocative situations that usually accompany interventions with infants and their caregivers -- in whatever discipline.

Conclusion

This paper calls upon infant intervention workers in all fields to pay careful attention to the array of reactions that are evoked for them as they work with infants, their families, and social agencies. These reactions should be approached with acceptance, rather than as a basis for quick action or, alternatively, self-reproach; there is much to be gained from an emphasis on reflection, decoding and understanding how clients' provocative behaviors often include concealed protective maneuvers. Such thinking is by no means simple and requires that the worker know herself well; analysts, for example, are required to complete their own personal analyses, and workers in many other helping professions feel that analytic therapies have been helpful to them in their own work. Overall, the

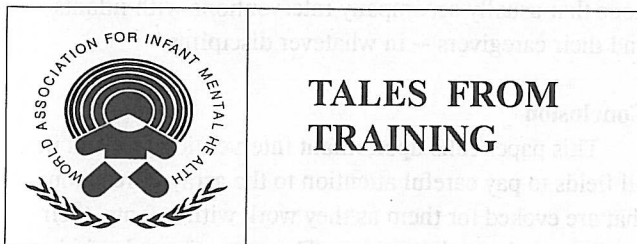
combination of a general awareness of transference-like and countertransference-like reactions will help intervenors to avoid "taking clients' reactions personally," and instead use them as data to learn more about the clients, themselves and their intervention strategies. ❖

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Editor's Note:

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Editor's Note: *This is the inaugural column in a new feature of the Newsletter entitled, "Tales from Training." This column will present descriptions of especially important, difficult or memorable training experiences in infant mental health. All current or former trainees are encouraged to submit a column directly to me for consideration. I am pleased that Dr. Fritsch agreed to write the first entry in this new section.*

A Clash of Perspectives: The Triple Board Residency

Sandra L. Fritsch, M.D.

Introduction

My training in infant psychiatry was unusual in that I was trained as part of a new initiative, the Triple Board Residency Program, co-sponsored by the American Board of Psychiatry and Neurology and the American Board of Pediatrics. This training provides a five-year integrated program in pediatrics, general and child psychiatry. Through my participation, I experienced several developmental curves for identity formation. The first two years involved mainly pediatrics, and in my role as a pediatric

resident I was trained to be a staunch child advocate. Years three through five of training focused more intensively on general and child psychiatry training, and here I found the perspective of child in the context of the family rather than as an isolated individual. During years three through five, I also continued to serve as a pediatrician, primarily through a pediatric continuity clinic where I provided primary pediatric care to children.

I became dimly aware that my own identity was changing as I began to recognize how family issues and parents' individual psychological issues impacted on their children's health and development. Still, contextual influences were important in affecting my attitudes and behavior. My own developmental changes are depicted in the following vignettes.

Vignette #1

As a fourth-year resident, I was moonlighting in pediatrics in a small community hospital. Although well into my psychiatry training at this point, I was in a thoroughly pediatric setting and frame of mind when I was called to attend a delivery at 2:00 a.m. I was called because the pregnant mother had ingested a large quantity of aspirin and had made superficial cuts on her wrist at the onset of labor. By the time I was called to the delivery, it was already several hours after the ingestion, and the mother had a significantly toxic aspirin level.

The baby was vigorous and active at birth, but he had a significantly toxic aspirin level. As part of managing the newborn, I made calls to the Poison Control Center and to a pediatric toxicologist which aided me in managing the newborn, and the child eventually did well. Further social history revealed the mother to be a single, unwed mother of three other children, with few outside supports. Onset of labor had triggered intense, sudden suicidal ideation in her, followed by the subsequent attempt. Child Protective Services was called, as is standard in cases of drug-exposed newborns.

When discussing the case later, my supervisor remarked about how much pain and anguish the mother must have experienced in order to precipitate her suicide attempt during pregnancy. I was startled to realize that I had had little interest in the mother's internal state, and had responded purely as an advocate for the newborn. "How could this mother care so little about her unborn child to risk hurting the child?" "Something clearly needs to be done to prevent this woman from causing further harm to her newborn." These were the only thoughts I had entertained at the time of delivery. As I was only involved peripherally with the case through my moonlight-

ing role, I had no further contact with mother or child.

Vignette #2

Later in the fourth year of my residency, I met two-week-old, Jamie. He and both of his parents attended the initial newborn visit in my pediatric continuity clinic in a large, tertiary health care center. Ordinarily, the clinic serves indigent, poverty-level, single-parent families from a variety of ethnic origins. This infant visit was notable because both parents attended the first visit, because the parents were married, because the father was employed full-time and because they had third-party health-care insurance.

At the initial visit, the parents seemed to be nervous, first-time parents. They were anxious to be reassured about the health of their child. Pregnancy and delivery had been unremarkable and weight at the first visit was above the birth weight. Mother displayed a fair bit of anxiety, and because of that I arranged follow-up in two weeks rather than the usual two months of age.

During the next four months, Jamie made appropriate weight and developmental gains, and I saw him and his mother frequently, usually every three to four weeks. His mother remained noticeably anxious. She described, for example, watching him breathe at night because she was afraid he might stop breathing. She also said that she had found pregnancy easier than she was finding parenthood, because she was trapped at home with the baby without outside supports. She voiced many worries about the baby in the first four months, but she seemed to be reassured after each visit with me. Her husband worked full-time

Even as I was horrified and saddened by Jamie's death, I could appreciate his mother's anguish. I recognized she must have been left without sufficient supports to raise her child.

and also frequently worked additional overtime, but he discouraged her from finding babysitters and was not interested in taking care of the baby himself so his wife could have some time for herself.

My psychiatric antennae were up at this point, but beyond a sense of the mother as anxious and unsure of herself, I did not really understand what was going on. I was concerned about the possibilities of the mother having postpartum depression or possibly an anxiety disorder. At the time, I was receiving supervision from the same supervisor mentioned in Vignette #1.

By four months of age, the mother seemed to be doing better, and the child was developing appropriately in all

spheres. I changed the frequency of visits to a standard pediatric schedule with a follow-up at six months of age. At his six-month check, Jamie had gained no weight, was irritable, and he had otitis media (an ear infection). I discussed the situation with the attending pediatrician in the clinic, who felt treatment of the ear infection and close follow-up were warranted. It was clear at this point that the mother had developed no outside supports (no friends, and no help from family), and she had been housebound with the exception of clinic visits. I arranged an appointment for her with the clinic social worker for further evaluation and supportive therapy.

Jamie underwent numerous rounds of antibiotic therapy for recurrent ear infections. With weekly or every-two-week visits, he began to show improvement of weight, irritability, and mood. His mother received support from the clinic staff, including the social worker, several nurses, and me. On two occasions, he had a single bruise which was not easily explainable and once he had petechiae (red spots resulting from rupture of small blood vessels) on his forehead. His blood tests were all normal, suggesting that he did not have any sort of medical problem to explain his bruises or petechiae.

At nine months of age, I received a call from an investigator from Child Protective Services. The worker was investigating a report about Jamie "having a broken arm" two months previously and "looking skinny." The investigator also mentioned to me that the parents' had had contact with Child Protective Services with a previous child. In that case, the parents' rights had been terminated after their infant was treated for multiple fractures and a cerebral contusion (brain injury). A strong suspicion that the parents had abused him had led to the termination of parental rights.

Both parents came to the next pediatric visit after I had spoken to the Child Protective Services investigator. The father was enraged and felt I was responsible for the placing the call to the investigator. I told him and his wife that I would never have contacted Child Protective Services without notifying the family that I was going to do that. The father angrily reported that his lawyer advised changing pediatricians, and he demanded a copy of his son's records from me. I urged both parents to reconsider changing doctors, explaining that Jamie needed close monitoring. I even pointed out that he had received excellent care through our clinic, and I cautioned the parents about seeking care from other facilities that could not provide the time and attention to the issues of the child's problems gaining weight. Although I didn't emphasize it, I also mentioned that I thought that Jamie's

mother needed attention for her concerns also. Still, they fired me and the clinic and went elsewhere. Unhappy, I made a follow-up call to the Child Protective Services investigator to emphasize how crucial I believed pediatric follow-up care was for Jamie and for his mother.

As I thought about it later, I realized that, inadvertently, Jamie's mother had been receiving weekly therapy through the context of the clinic and her appointments with me. I had been discussing the case in supervision on the same morning of their clinic appointments before I saw them.

I had no further contact with the family and heard nothing more about them until six months later. I awoke to the morning news which reported the arraignment of the mother for the murder of her child. He was 15 months old at the time. My immediate reaction was, "That poor woman, she must have been in terrible pain." Even as I was horrified and saddened by Jamie's death, I could appreciate his mother's anguish. I recognized she must have been left without sufficient supports to raise her child. I later found out that Jamie had gained no weight in the intervening six months, and that his father had refused all services offered by Child Protective Services.

Conclusion

For me, these two cases epitomized several develop-

Through these cases I began to recognize that the relationships with our patients also set us up for our own personal pain and anguish.

mental changes for me as a trainee. The first "lesson" I learned was that many times while working with family members it is easy to pass judgment quickly and thereby to threaten the treatment alliance. In order to best meet the needs of the child, there must be a therapeutic alliance with both parents and child. However, even the best attempts at a therapeutic alliance may not withstand the challenges of life stressors or parents' personality conflicts, as in the case of Jamie. At a minimum, it is important to attempt to appreciate the family's situation and perspective. Also, a relationship with the family must develop in order to appreciate the larger treatment issues of growth and emotional development of the child.

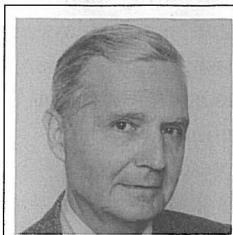
These two cases also helped me to confront my own biases. As a pediatrician, I had assimilated the belief that I was an advocate for the child, but residency training in pediatrics did little to help me see the child as part of a

family with its own needs. I am sure my pediatric colleagues will have to grapple with some version of this issue on their own as they enter private practice. I had the luxury of exploring them in psychiatric training with ongoing supervision.

Through these cases I began to recognize that the relationships with our patients also set us up for our own personal pain and anguish. The first case was one in which I had no qualms about contacting Child Protective Services, with the likely outcome of foster care for the baby. I gave no thought to the mother's own needs or pain. Even though the outcome might have been the same, I feel that not appreciating the context led me into

an overly narrow and therefore distorted view of the situation. With the development of a relationship with Jamie and his mother, I empathized with her pain and solitude, as well as questioned my role in the child's death. Reflection in both cases has afforded me personal and professional growth. ❖

Editor's Note: Dr Fritsch is currently Instructor in Psychiatry at the Brown University School of Medicine and Director of the Pediatric Inpatient Program at Rhode Island Hospital. She graduated in the first class of Triple Board Residents at Brown.



STEPHEN'S CORNER

The Conferencegoer

I am a conferencegoer. Several times a year the attraction of a strange city and new ideas pulls me out of the rhythm of my life into days without familiarity or demands. The Society for Research in Child Development meetings in New Orleans at the end of March pushed me to think about such experiences. A meeting for me may be minor in its importance for real life, but its uniqueness make it stand out in episodic memory. For many of those attending this conference, professional survival rides on the impact made. Now and then I have been a player. Last September, I spoke at the WAIPAD meeting in Chicago as part of a symposium on mothers' internal representations of their children. A special sense of belonging comes from participation. For reasons that elude me, most of the representation people at that meeting were Italian. Lunch with them was an ebullient experience. This time I am just one of the audience and so view this conference as theater.

I try to convince myself about my commitment to developmental ideas as the basic science necessary for any rich clinical understanding. The staff back in our clinic count on me for this. I think now about what ideas will be

useful. What my staff does not need is more outré developmental concepts but what it does require is immediately serviceable stuff. However, I must be honest about one of my motives for attendance. Just as important is that these days out of time offer a feel for a new place and culture. I have a friend who touches base with the important themes of a conference, then spends most of his time in art galleries and in the evening procures tickets for the local ballet or symphony. I get a little guilty about so much pleasure, but when I have tried it, I have found that these experiences tend to stay with me.

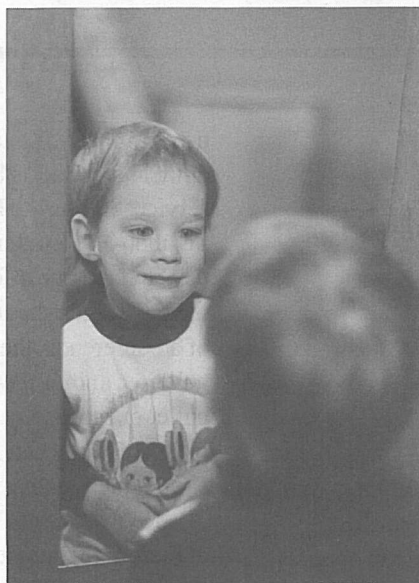
My wife is not too happy with New Orleans. Her view of it from the movies is of dread and evil; *Angelheart* and the remake of *The Cat People*. I do not feel that way and remember that Walker Percy's novel *The Moviegoer* used New Orleans as setting for soliloquy and fantasy. One appeal of this novel is that Percy was a graduate of the medical school with which I am affiliated. I feel more comfortable with a physician's daydream. This novel catches the palpable reality of the movies. I am a true moviegoer as well as a conferencegoer, and I feel that real commitment to either identity is the willingness to experience ten not so good ones in hopes of something great. As a matter of fact, often the bad movies or conferences create the best musing and fantasy and allow new ideas to blossom.

This conference schedule draws on greed, then anger when two good sessions are scheduled simultaneously. Which to choose? One way to go is to follow the superstars -- a Carroll Izard or a Gerard Edelman -- and indeed I enjoy these dramatic interludes, but this time I decide to pick a theme instead.

In previous years, attachment theory has grabbed hold of me. Its great appeal at first was that it could be turned to clinical use. I am of mixed mind about this because some ideas are lovely in themselves. As Emerson said, "Beauty is its own excuse for being." The excitement from the mid 80's was provided by Mary Main who showed us how to look into the interior world of infants, children, and adults and also gave us a sense of how the contents of the mother's head might get inside her child. This look inside is refreshing now because you can go to a week long meeting of the American Psychiatric Association and never get past the external. But by now I know the attachment doctrine well enough to give a pretty good lecture on it. The take home gifts to my staff are easy to come by because my old friend, Arietta Slade, who was the discussant at a symposium on Attachment and Emotional Regulation emphasized how you could transform findings from attachment research to clinical use. The new understanding of the place of emotions in attachment helps illuminate clinical phenomenon. It is the difficulty integrating negative affect that can lead to either exaggeration or muting of feeling.

Just after I typed my first draft of this in my hospital office, I heard from down the hall a mother scream at her child, "If you can't say anything good, then don't say anything at all." Parents who are uncomfortable with negative emotions avoid them and those who cannot contain them are flooded by feelings. These styles of affect regulation are passed on by the parent to their children. This sense of knowing what is going on in attachment was substantial and satisfying and so, should have allowed me to take off to a bar or a museum. However, I possess an obscure sense of mission.

Having obtained in my small study of material representations a feel for a mother's ability to describe her subjective world and to time travel between the future and past, I had wondered when children were able to approach the same. It had become clear to me that the children I had used were too young and my technique of interview inappropriate. I feel that these meetings should provide me with some better understanding and so I decide to place my bets on children's "theories of mind." This seems to be the hot topic this year, and there was an enter-



tainment on this subject almost every hour.

Before committing myself to a specific session, I take a short walk through the French Quarter. The hero of *The Moviegoer* floats around New Orleans having imaginary conversations with movies stars. I seem to require a target for my soliloquies and so, I choose Robert Emde, not just because his square-jawed, rugged good looks would be great in Westerns, or because he is the president of SRCDC this year, but because with him, I feel a special affinity.

Now that I have a companion, I wander back into a poster session, a noisy fairground of hawkers of ideas. The title of one, "Children's Understanding of the Stream of Consciousness" pulls me in. To my surprise, I find that the host is a genuine superstar playing a cameo role. John Flavell does not know me from anyone, but with a graciousness and enthusiasm he acts out in high style a little scene: first, an adult sitting there as if in puzzled thought, and then he plays the child who is asked what is in that person's head? Are thoughts seen as on/off phenomenon or continuous? The conclusion is that the preschoolers' conception of another's inner world is different from the older child or adult. It is as I had suspected, a child needs to be several years older than the 5 or 6 year olds I had been working with to be able to talk about such mental states.

The many talks I hear on theories of mind give comfort by repetition. These studies, including Flavell's, use tricky tasks to reveal what a child knows about his own or another's mind. The "false belief paradigm" is a joke and trick which, in one version, a child is shown a bandaid box and asked what he thinks is inside of it. It is then opened revealing its contents --pennies! The child is asked then what another child would think is there. It is the ability to invent these clever and revealing tasks that allow some understanding of the child's inner world. I know that I have to return home and re-think my own approach. "Theories of mind" is attractive to a developmentalist because it suggests that big concepts come early, appearance and reality, desire, deception, and belief. A woman next to me squirms in her seat and whispers that she is a cognitive psychologist and feels that these concepts are pretty shallow. Maybe so, but still, I go for deception and desire.

One strong source of consolation is the fact that several speakers have referred to Mikhail Bakhtin's

dialogic conception of language and thought. This gives me the security and freedom to continue talking to myself. I find substantiation in a wonderful poster, "Private voices; Dialogues in Children's Solitary Play." Gloria Mitchell, with a quiet excitement, describes a blend of Vygotsky, Freud, and Bakhtin in young children's inner life. She lets me listen to a stunning tape where a little boy playing by himself holds conversations with his father, a ghost, and Chuck Norris. I am also a great fan of Chuck Norris, the action movie star, but still, I am more comfortable talking to Bob Emde, having seen him in many more roles and over several decades.

The first time I saw Bob Emde perform was in the mid-sixties at the first SRCD meeting I ever attended. It was at the Waldorf Astoria in New York. I was the sixth and last name on a paper concerning the autonomic nervous system response of newborns at that meeting. The hope was to discover basic patterns that served as a backdrop to personality formation. It was a great idea, but it never got anywhere. This was the odd way I first became interested in babies. I was not long out of a child psychiatry residency and was searching around for some sort of research opportunity with children, and this was the only game in town. I was picked up because in the army I had learned to read EEG's, not very well, but good enough. The project needed someone to tell the difference between REM and NREM sleep. There was little written on this then and, at that time, after a few tries, I could do it as well as anyone else.

I am recalling this so as to explain that it prepared me to understand a wonderful paper by Bob Emde on the newborn REM smile. I did not understand much of the other child development papers -- the language was strange and the subjects were foreign -- but for Emde's paper, I was better prepared to catch on than most people there. I remember that the chairman of the meeting made dumb jokes about his name. M.D.'s were even less well represented in SRCD in those days than they are now. An odd coincidence was that I was sitting next to another M.D., David Levy, who, to my knowledge, was the first psychoanalyst to have been president of the SRCD. He was a friend of our project leader, and I remember that although he was pretty old then, his ideas were still most vibrant.

Every several years I would see Bob Emde at a meeting, one of those curious relationships where you only see the person in a hotel conference room in some strange city and so you wonder about their existence outside of this setting. Someday I should try visiting him in Denver to see if he is real, has a grounding in place. Bob Emde, I

trust, would have no trouble with my imaginings because he has placed such an emphasis on context.

His presidential address, "Individuality, Context, and the Search for Meaning," offers a reprise of his research over three decades. He has achieved a synthesis and perspective that comes with long-term research and its demands for productivity, publication, and commentary at conferences. There are only a few physicians who have made such rich contributions to the developmental world. These are the people that child psychiatrists and psychoanalysts really listen to. I could not help think during the Academy Awards two days later that Hollywood would have done a better job of introducing Emde because much of his work has been recorded on film. I remember his comments on Spitz's anaclytic depression in a Nova video and the sadness communicated that this horror still exists. Another video that was shown for a while at conferences displays the playful inventiveness it took to demonstrate the social referencing between toddler and mother when a toy mobile robot was aimed at the child. I think also of the unrecorded live theater of analytic meetings where he described his concept of the affective core.

I note with delight here in New Orleans that Emde is turning mystical, although he calls it reflective. Starting with the oracle at Delphi whose pronouncement was "know thy self" he extends it to "know that all you know is relative." I really like the latter one, and although I am not too sure just what it means, it has a fluid quality that seems just right in New Orleans.

He ends his address with the caution that in research and therapy values cast a powerful influence. My own take on this is that the construction of values over the flow of development is as complex a process as any other, most likely more so. Two of the examples of values he gives are caring and love of learning. I think now that I want to chuck most DSM-III diagnoses and stay with values which, in a sense, I have done in any successful treatment I have ever conducted.

I am home now where boundaries are clear, schedules demanding, Delphic insights rare, and I am cautious about my soliloquies. Still, as I look over my meager research tapes, I find myself murmuring--hey, Bob Emde, where are you now that I really need you?❖

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

Joy D. Osofsky

In my second column in the new WAIMH Newsletter, I want to share with our members some of the activities planned for 1993 and 1994 as well as some of my goals, hopes, and aspirations for our new organization. WAIMH held a Regional Meeting in Graz, Austria, May 14-16, 1993, and will sponsor a one day workshop in Amsterdam in July, 1993, and a Regional Meeting in Punta del Este in Montevideo, Uruguay in November, 1993.

The meeting in Graz, enthusiastically planned by Peter Scheer and Marguerite Dunitz, focused on **Infant Psychiatry in Central Europe**. Plenary addresses were presented on psychoanalysis and infant mental health, research challenges for infant mental health, especially as we approach the end of the 20th century, and intergenerational and cultural aspects of children's exposure to violence. Workshops provided an opportunity for WAIMH groups in Central and Eastern Europe to present ideas and clinical data concerning the impact of changes in society for childrearing and family development. The workshops also dealt with the broader political systems and the many changes that are occurring and their impact on infants, children and families. Coming out of this Regional meeting are plans for the future that include a European group that will meet to discuss diagnostic classification in infancy and will relate to the Diagnostic Classification Task Force in the United States organized through Zero to Three/National Center for Clinical Infant Programs.

The Amsterdam meeting planned by Serge Lebovici, Peter Fonagy, Peter de Chateau and Joy Osofsky will be a one-day workshop held on July 25, 1993 before the International Psychoanalytic Association meeting in Amsterdam. The theme is: **Origins of Mental Representations: Enlightenment through Clinical Presentation**. Clinical cases will be presented by colleagues from Holland, France, and Japan. The discussants will also be international coming from England, Holland and the United States. Both of these meetings provide opportunities not only to share ideas in different parts of the world, but they also provide an opportunity to meet with European colleagues to discuss objectives and goals for our

international organization. We hope through these regional meetings to stimulate interest and involvement in the 6th World Congress to be held July 25-28, 1996 in Lahti, Finland.

The Montevideo meeting planned by WAIMH members, Miguel Cherro Aguerre, Salvador Celia, and Miguel Hoffmann will be a four day Regional meeting jointly planned by colleagues from Uruguay, Argentina and Brazil. It is also jointly sponsored by WAIMH, IACAPAP (International Association for Child and Adolescent Psychiatry), and ISAP (International Society for Adolescence). The theme is: **Change and Development: The Infant, the Child, and the Adolescent in the 21st Century**.

Plenary sessions, papers, posters, and workshops will focus on strategies in mental health including risk factors and prevention, recent approaches and new knowledge about development and relationships, psychopathology, and training in infant mental health. Much progress has been made in the past 5 years related to clinical research in infant mental health in several countries in Latin America and we look forward to seeing more progress at this meeting.

Our organization is going through a new "growing phase" that involves the formation of Affiliate groups in countries around the world. Since the presidency of the organization is currently in the United States, it is particularly important to emphasize our commitment to building a strong international base in Europe, Latin America, Asia, and Australia. As other regions are identified, we are hoping that they too will consider forming Affiliate groups or participating actively in our organization. In the United States, since the formation of our organization in September, 1992, three new affiliates, one in Louisiana, one in Kansas, and one in Wisconsin are in the process of forming. Michael Trout, the Regional Vice President from the United States has expressed interest in encouraging different workshops in various parts of the states where there is much interest in infant mental health but the need for some stimulus and encouragement. In Europe, the Nordic Affiliate currently has over 100 members. Also colleagues in England with Peter Fonagy's leadership have expressed interest in forming an affiliate group (coinciding with a one day workshop in March, 1994 in London) as have our members in Japan with the leadership of Keigo Okonogi and Hisako Watanabe (coinciding with a Regional Meeting next April, 1994). At the Regional Meeting in Punta del Este, Uruguay in November, 1993, one of the issues to be discussed is the formation of a regional Affiliate group in Latin America. Colleagues in

Greece have been working with Bertrand Cramer and Serge Lebovici to build an Affiliate group. The formation of an Affiliate group allows a structure for more communication and activity among the membership without the need for a large organized meeting. In the future, we will be working with the affiliate groups in different parts of the world to develop meaningful activities for these groups. One of our first requests will be to identify a corresponding member for each of the affiliate groups to facilitate communication.

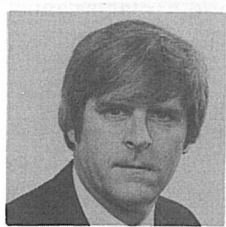
Unfortunately, we will have to be resourceful financially in the next phase of our activities as we have a very limited budget to keep communications and activities going around the world. Our plans to accomplish the objectives for our organization will depend on Regional Meetings supporting themselves--we have found that this is not too difficult if a registration fee is charged and expenses are calculated carefully. If this is the case and the meeting is especially successful, then extra monies after all expenses are paid will be split between the regional group and international organization to continue activities in that area. Usually, this situation can work as it did recently with a one day meeting in New Orleans held in March, 1993, if expenses are kept down (we were able to use the room without cost because it was held one day before a large convention) and translation is not necessary. Another possibility is for some of the costs of

translation, meeting space, audiovisual equipment, etc. to be donated by the region. We must be creative in order to accomplish our objectives of communication, education and training. With the strong commitment of our members to growth in the field of infant mental health, I am sure that we will see many exciting activities emerging.

Another issue that we must keep in mind and I know is being followed carefully by Serge Lebovici and his colleagues is the deprivation and destruction that infants, young children and families are facing in many war-torn areas in Europe and Africa.

The devastation in these areas is outrageous and the consequences of such violence for infants and their families almost beyond imagination. We will continue to try to help in any ways possible.

It would be wonderful if we had the economic and personal resources to address many of the pressing issues for infants and families around the world and to help to educate, train and facilitate the treatment of high risk infants and families. Unfortunately we are not in such a position financially. However, as our membership grows, so does our enthusiasm and our ability to reach out to many more regions. Therefore, we encourage you to continue to contact us and we will work together to build activities around the world. ❖



FROM THE EXECUTIVE OFFICE

Hiram E. Fitzgerald

What do THEY do with the dues I pay? This is a question that just about every member of an organization asks when it is time to pay annual dues. I hold membership in 14 scholarly associations and so it is a question that I ask 14 times annually. I also find that many associations do not provide much information about how member dues are tied to member benefits. So from time to time I will provide information about WAIMH's budget and how member dues are related to member benefits as well as to WAIMH's overall mission.

Although an individual can join WAIMH for \$50, 99% of our members select the \$75.00 dues in order to receive a copy of our flagship journal, the *Infant Mental Health Journal*. So I will restrict my comments in this issue of the *WAIMH Newsletter* to the rate selected by nearly all members. The publisher of the *Journal* negotiates a member rate with WAIMH biennially. The current subscription rate for members is \$31.50. In addition, the publisher adds an additional \$10.50 for international air mail. This is necessary to assure prompt delivery of the journal, usually within 2 weeks of publication. Because of the Canadian use tax, all subscriptions to our Canadian colleagues require an additional 7% fee. For 1993, the WAIMH Executive Committee fixed the cost of the journal to members at \$25.00. Note that this is \$6.50 short of the rate charged by the publisher and does not include any of the postage costs. Thus, WAIMH absorbs these costs and pays for them from the \$50.00 dues; for 1993 this will amount to approximately \$4500.00. In

addition, WAIMH contributes \$2000.00 annually in support of the editorial offices of the journal. (The Michigan Association for Infant Mental Health provides \$6000.00 annually in support of the journal for a total editorial office budget of \$8000.00. This must cover all secretarial support, postage, FAX, phone, etc. expenses of the editorial office.) So WAIMH must budget \$6500 annually to support operation of its journal (the 4500 subsidy and the 2000 grant to the editorial office).

Each member receives a quarterly newsletter. Each newsletter requires approximately \$1200.00 for printing and postage. Of these, postage is the larger cost because we use air mail for international distribution. So just for printing and postage, the newsletter has an annual cost of \$4800.00. So adding costs of the journal subsidy and the newsletter, results in a budgetary need of \$11,300.

WAIMH has one part time employee at the central office to handle all of the business activities of the association. Estimated annual costs are \$12,500. In addition, from time to time graduate students are hired for special jobs on an hourly basis. Estimated total staff expenses for 1993 are around \$15,000. So adding the journal, newsletter, and staff expenses together produces an annual budget requirement of \$26,300!

Currently WAIMH has 460 members, which produces an annual revenue from dues of \$23,000 (\$50.00 times 460).

Now if you have been following this rundown of budget, you have arrived at the same conclusion that I have and that is that the annual dues do not produce enough revenue to support the most basic services that WAIMH provides for its members; namely, its scientific/clinical journal and its networking newsletter.

Please keep in mind that I have not given a full run down of all of our expenses either; total budgeted expenses for 1993 are \$90,000!

How do we do it! What magic does WAIMH use to operate a deficit operation and continue to exist? If we relied exclusively on member dues to operate the association, for 1993 our annual dues would have to be \$196.00. There is no magic. WAIMH historically has survived from overages generated by its World Congresses. Although the final figures have not yet been released by the accountant, the Chicago Congress generated a slight deficit. Thus, our next four-year budget is based on cash reserves generated by the 5th World Congress in Lugano in 1989.

What are our choices for dealing with budgetary problems?

As is the case for all professional societies, our

options are limited. We can try to optimize our investments to produce the maximum yield possible without endangering the security of our cash reserves. We can increase dues; a \$50 increase in dues produces an additional \$23,000. We can reduce the amount of subsidization provided for the journal by having members pay the actual member rates for the journal. (Keep in mind that the nonmember rates for the journal are considerably higher than those available to members.)

OR, we can increase membership!

Every 100 new members generates \$5000.00. **If every current member of WAIMH recruited 1 new member this year, we would have 920 members and total member dues of \$46,000. So this is an appeal to each member of WAIMH--support YOUR association by recruiting one new member for this year. All new members will receive all copies of the journal and newsletter and receive all other benefits of membership.**

I hope that I have not provided too much detail about budget, but I believe that members need to know more about the business side of the association. WAIMH exists because its members wanted an international and interdisciplinary organization dedicated to promoting infant mental health. Our work is only just beginning and we need to dramatically increase our membership worldwide. Joy Osofsky notes in her column that we have 5 new Affiliate associations being developed; let's get 25 new Affiliates. And, after we double our membership this year, let's double it again next year. The world's infants cannot wait. Given the theoretical traditions that provide the very foundation of our association, we cannot in good conscience allow the needs of families with infants to go unfulfilled. Help WAIMH fulfill its mission, recruit a member!

Erratum:

Our apologies to Hisako Watanabe, in the photograph published in Vol. 1, No. 1, we incorrectly identified her as Keigo Okonogi. Although Hisako and Keigo are equally strong advocates for infant mental health in Japan, the individual in the photograph is unmistakably, Hisako.

Similarly, we extend apologies to Maria Cordeiro. We incorrectly identified her as Graziella Fava in the same photograph. Maria has been extremely active in infant mental health in Portugal for many years as has Graziella in Italy.

Our thanks to Bob Emde's detective skills and sharp eye for pointing out these errors to us.



ANNOUNCEMENTS and AFFILIATE NEWS

New WAIMH Regional Affiliate

The Louisiana Infant Mental Health Association (LIMHA) approved its by-laws and elected its officers and Board of Directors on May 5, 1993. Robin L. Harwood, Ph.D., a faculty member in Developmental Psychology at the University of New Orleans, was elected as the group's first President. The New Orleans-based group begins with nearly 40 members, including pediatricians, psychiatrists, psychologists, social workers and nurses. Activities planned for the first year include a monthly lecture series, a quarterly newsletter, training workshops, and a regional conference. For further information, contact Julie Larrieu, Ph.D., LIMHA Secretary, Louisiana State University School of Medicine, 1542 Tulane Avenue, New Orleans, LA, 70112-2822.

To the Editor:

The NFSU (Nordiska Foreningen for Spadbarns Utveckling, Nordic Association for Infant Mental Development) is a very active affiliate. We have 111 paying members from Sweden, Norway, Denmark, Finland and Iceland. Forty-nine of the 111 NFSU members are also paying members of WAIMH. The NFSU Association was formed in 1991. We meet twice a year and discuss scientific and clinical topics within the field of early childhood. The aim is to create a network of researchers and clinicians in the region all of whom work in infancy and/or pregnancy.

In March 1993, a scientific meeting of the group in Copenhagen attracted 72 participants. The theme of the meeting was "Developmental Psychopathology and Diagnostic Issues." It was hosted by Lene Lier, M.D., Marie Gammeltoft, M.A., and Jesper Pederson, M.D. They presented their work at the Child Psychiatric Department at Bispebjerg Hospital, where an outpatient ward for mothers and infants has opened recently in a nice separate building in the hospital area. The group's work with the Early Relational Assessment Scales (ERA) in combination with more ethological analyses of parent-infant interaction was presented.

After presentations and a sight-seeing tour of the hospital we were taken by buses to a hostel in the woods, near an old royal hunting castle, for a nice evening with food and wine to be followed by more clinical presentations the following day. The weekend was a nearly perfect blend of intellectual stimulation and meetings with friends that we want our organization to offer. The meeting also permitted exchanging ideas for next year's regional meeting in Riga, Latvia. Our next scientific meeting will take place at the Nic Waal Research and Clinical Institute in Oslo, Norway, at the end of October, 1993.

Pia Risholm Mothander, Ph.D.

Infancy's Infancy

Miguel Hoffman, M.D., of Argentina, is chairing an Historical Project Committee for WAIMH to assemble the archives of infant mental health. Joined by Justin Call, M.D., Hiram Fitzgerald, Ph.D., Peter de Chateau, M.D., Serge Lebovici, M.D., Keigo Okonogi, M.D., Yvon Gauthier, M.D., and Michael Trout, M.A., Dr. Hoffman has titled the group's effort, "Infancy's Infancy." Committee members are organizing interviews with infancy pioneers, attempting to find film or videotaped recordings of historical figures, and meeting with students of Bowlby, Winnicott, Spitz, Anna Freud and other historical figures.

Interviews will appear in a forthcoming Special Issue of the *Infant Mental Health Journal*, edited by Dr. Hoffman.

Anyone who has access to material of interest to the group is encouraged to contact one of the Committee members directly or the Executive Director's office in East Lansing.

Name The Newsletter Contest: Last Call For Nominations

To date no suggestions have been received for the Name the Newsletter Contest. The deadline is September 1, so get your nominations in as soon as possible. Send them by FAX, call and leave a message on the answering machine, or send a letter. The winner receives a full subscription to the *Infant Mental Health Journal* for 1994, plus a moment in history as the individual who gave WAIMH's international networking publication its name!

1993 WAIMH MEMBERSHIP APPLICATION

Date _____

1993 DUES

Name _____

_____ \$75 U.S. With Journal
Subscription to IMHJournal: New or
Renewal

Title/Degree _____

_____ \$50 U.S. without Journal

Mailing Address, including country:

_____ \$35 U.S. Student, no Journal

_____ \$60 U.S. Student with Journal

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_____ Check and amount (*funds must be drawn
on U.S. affiliate bank*)

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