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CAPEDP-Attachment: Parenting Skills and Attachment in Infants: Reducing Mental Health Risks and Promoting Resilience A French Project to Decrease Disorganized Attachment

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The Project Compétences parentales et Attachement dans la Petite Enfance : Diminution des risques liés aux troubles de santé mentale et Promotion de la résilience (CAPEDP; Parenting Skills and Attachment in Infants: Reducing Mental Health Risks and Promoting Resiliency) was developed in Paris in 2006. CAPEDP is a randomised research and action program to promote mental health of young infants, conducted by the infant department of the Hospital Bichat, and the Research Laboratory of the EPS Maison-Blanche. It is funded by grants from the French ministry of Health, through national research grants (PHRC, 2005) and from a public prevention institute (INPES). The goal of the research project is to assess the effect of a preventive intervention in a group of young parents with psychosocial vulnerability. The general project is CAPEDP, A (for Attachment) with CAPEDP being an ancillary study involving closer and specific measures of child disorganization and attachment status and of parental disorganizing behaviour and mentalizing abilities.

The CAPEDP-Attachment research consists in the evaluation of the infants' security and disorganisation attachment, as well as their parents' disrupted behaviour and mentalization skills, in a sub population of the general project CAPEDP. For this we compare the effect of the preventive intervention at home in an intervention and a control group.

PREVENTIVE INTERVENTIONS TO PROMOTE MENTAL HEALTH: THE CONTEXT OF THE RESEARCH

Developmental theories recognize that social and family environment have long-term effects on the psychological functioning of individuals (Bowlby, 1980; Bronfenbrenner, 1979, 1986; Brazelton & Cramer, 1990). The development of good quality early relationships allows infants to explore their environment safely and contribute to the establishment of a broader range of social skills. Moreover, infants are particularly sensitive to precarious contexts that generate significant stress in their families. The psychological suffering of parents (especially depression), and social contexts at multiple vulnerabilities can have a deleterious impact on their development (Brandeis, 2004; Weinberg & Tronick, 1998). Intervention programs targeted on high risk populations have been developed in North America and in other different contexts over the years 1960-1970 (Olds, 2006). In France, since 1945 there is a preventive "universal" system, via the Protection Maternelle et Infantile (PMI, i.e., Infant and Maternal Protection, a network of public free well baby clinics), that offers to all pregnant women the possibility to be assisted. However, if this system of PMI has showed major effects on the public health (especially by reducing infant mortality by 80% in 50 years, along with other systems), it is now limited in its resources to accomplish its mission of prevention and mental

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health, particularly to support the development of parenting in families with psychosocial vulnerability.

The purpose of project CAPEDP, based on the experiences of other cultural backgrounds who have demonstrated their effectiveness, is to strengthen the French prevention system, by implementing a home visiting program to promote mental health and good quality parenting in young mothers waiting for their first infant.

THE CHARACTERISTICS OF THE ACTION-RESEARCH PROGRAM

CAPEDP is a program that aims to evaluate the effect of a preventive early intervention. Families are recruited in maternity wards starting at 6th month of pregnancy. The involvement of professionals starts at the 7th month and continues up to the baby's second year of age. Two hundred twenty families were recruited in a 18 months period in 9 maternity hospitals of the Assistance Publique-Hôpitaux de Paris. This intervention group will be compared with a similar group of 220 families who receive the usual care provided by the French system (maternity, PMI, paediatrician, GPs...). Four hundred forty families have now been recruited. Both groups will be compared on

- Pre-and post-natal maternal depression,
- Sense of parental competence,
- Level of Parental stress,
- Infants' psychological and psychomotor development,
- Infants' attachment,
- Social and medico-social insertion.

Inclusion criteria were:

- Age less than 26 years
- Expecting their first infant,
- Speak enough French to give an informed consent,
- Have at least one psychosocial vulnerability among the three following:
 - Declare to be socially isolated
 - Reach the CMU or AME (i.e., medical assistance for low income families such as MEDICARE in the United States),
 - Have an education level less than 12 years of school.

This is not to say that socio economic risk factors are the main weight on mental health. However, if none of these criteria is in itself a determinant of mental health, we now know that the accumulation of "risk factors" creates vulnerabilities ("it is easier to raise a infant when you are in good health, surrounded and able to assure his needs", or as Mandela puts it: It needs a village to raise a child).

A HOME BASED INTERVENTION BY A TRAINED AND SUPERVISED PSYCHOLOGIST

For all families participating in the study, the first contact is made by a CAPEDP assessment psychologist. These psychologists visit these women at their homes for the first time when they are still pregnant and then, after the child birth, at the 3rd, 6th, 9th, 12th, 18th and 24th months of the baby, in order to assess the intervention effects, by means of observation and a set of instruments. For families receiving the intervention, a psychologist, specifically trained on preventive home-interventions, makes then a contact to begin the home visits since the mothers' 7th month of pregnancy. Visits take place approximately twice a month, but the frequency decreases from the twelfth month of the infant in order to empower the families' competences.

The intervention is adapted to each family. A basic manual was developed in order to ensure uniformity of the established themes: mother and baby's health (psychomotor development, sleep, food), parenting skills (helping parents recognize the signs of the baby), mother-infant's relationship (encourage interaction between the mother and her baby), identifying the needs of the infant (e.g. understand the crying of infants), assistance on the social environment (encouraging mothers to address themselves to the PMI to be guided in the care for their infant).

Two specificities: we do not wait for people to ask for help. We use a promotion of health oriented model:

1. The anticipation of demand. Since CAPEDP is a preventive intervention,

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the ethical issue underlying is whether such an intervention with families who have not made any specific needs is adequate. Two answers are proposed:

The first answer is provided by the scientific data suggesting that these are the people most in need of support but that benefit the less (Hart, 1971) because of their difficulty (physical or psychological) to access the traditional services. The home preventive intervention is now recognized as the most efficient model to meet their needs.

The second answer concerns the choice of the intervention models: CAPEDP is based on a model of health promotion, rather than a psychopathological model: develop skills, not treatment. Our experience shows that families have been able to emotionally invest in the research project, validate the utility of having a professional who answers promptly to their daily defies and to whom they may ask for help in a more regular way when difficult situations arrive.

The risk was to generate a «pathologizing» model of these families. To undergo this risk we have

decided for a non-medical model of intervention, as well as for a weekly supervision of the psychologists-interveners by experienced infant mental health professionals.

2. Home- based intervention. The culture of mental health intervention in France does not focus on families' daily life strategies. This is true especially when it comes to preventive actions. Intervention in the living environment is based on the available resources and proposed solutions that are based on a context that parents can better understand. We hope that this type of format may help to question the traditional framework of psychological intervention and will generate a reflection on the role of mental health professionals.

The project began in December 2006 and the end of the follow-up assessments is scheduled for May 2011. The first data will be available in 2010. Nevertheless, the first families' feedback is quite positive, as well as the feelings of the home visitors of being of enormous help to the mothers in their relationships with the baby. However, we find that some of them, generally the most

vulnerable-are difficult to reach, with all their difficulties in receiving a regular intervention (the visits are still maintained as much as possible). The purpose is for professionals to restore the confidence of these families to newborn and infancy professionals and to help them to formalize their needs.

CAPEDP-ATTACHMENT RESEARCH

Attachment describes the human infant's tendency to seek comfort, support, nurturance and protection from a small number of caregivers. Based upon experiences of regular interactions with adult caregivers, infants learn gradually to seek comfort and protection not from just anyone but selectively from caregivers they have learned they can rely upon. Attachment is considered a vital component of social and emotional development in the early years, and individual differences in the quality of attachment relationships are believed to be important early indicators of infant mental health (Zeanah & Smythe, 2008). The way a child learns to develop relationships is vital for

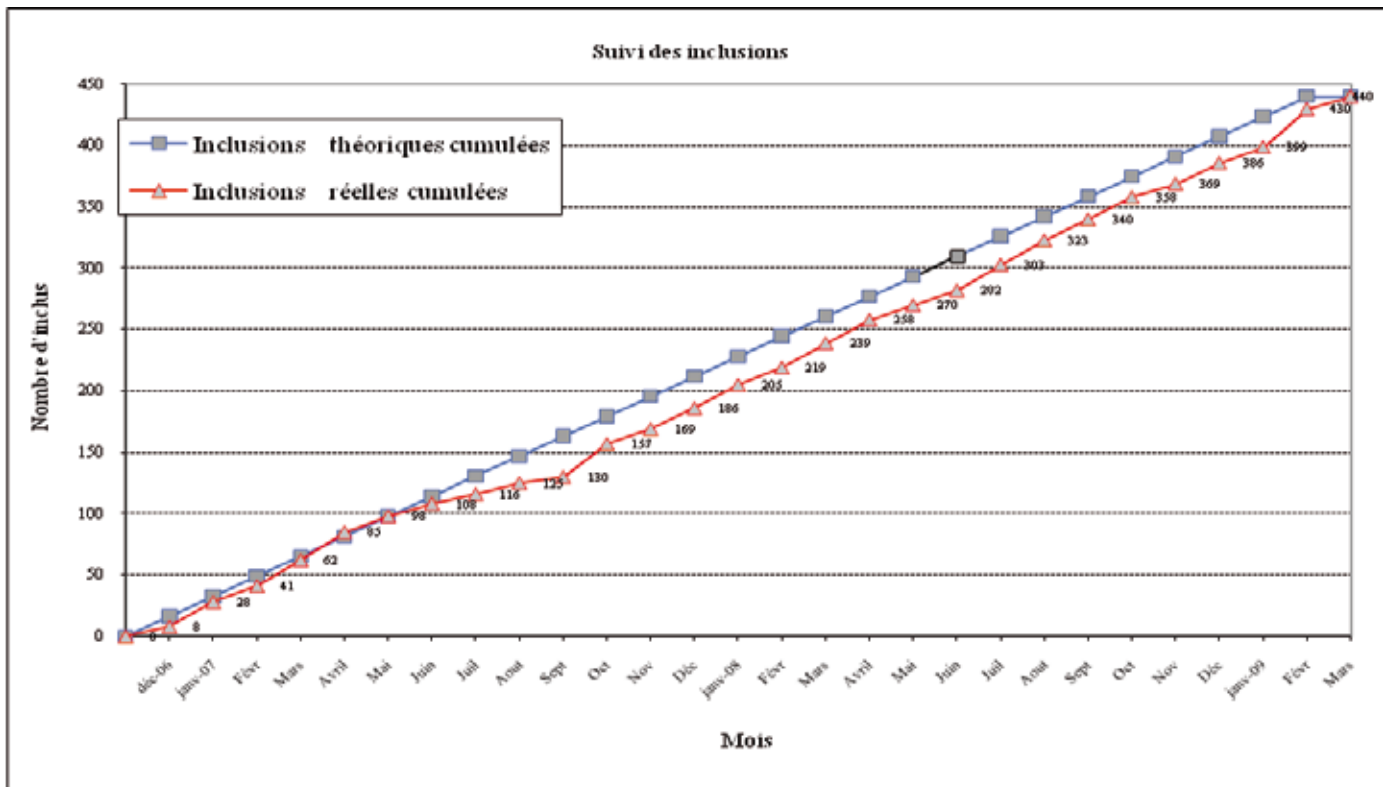


Table 1. Recruitment rate CAPEDP study: 440 women included in 18 months

her subsequent psychosocial relations, since the use of an attachment figure as a secure base allows her optimal development and her ability to explore the world. Many studies have shown that attachment quality influences the ability to manage situations of alarm or distress and the infants' subsequent mental health. Literature also suggests that the mother's attachment organisation may be transmitted to the infant, specifically through the mean of her auto-reflexive skills and by sensitive or disrupting behaviour.

Within this theoretical framework, CAPEDP-Attachment study has four principal aims:

1. There is not, at the present, a French cohort describing the infants' attachment categories nor describing the security or insecurity transmission of attachment from mother to child. The research project CAPEDP-attachment is designed to create such a cohort, in a population with psychosocial vulnerability factors.

2. To test the hypothesis that the CAPEDP home-intervention protocol helps to impede the transmission to the child of the mother's insecure attachment style, and is associated with a lower frequency of maternal disrupting behaviour, as well as with better maternal auto-reflexive skills.

3. Our third goal is the French validation of a number of assessment tools and the setting of a French Attachment Laboratory.

For achieving these aims a sub-sample of 120 mother-infant dyads was selected from the intervention and control randomized groups of CAPEDP general (60 of each group). At their 12 months, infants' attachment is assessed with the Strange Situation Procedure (Ainsworth, Blehar, Waters & Wall, 1978) (ABCD) in our laboratory and later, at infant age 18 months, the Attachment Waters' Q sort (Waters, 1987) is used to assess attachment quality at home. The maternal disrupting behaviours are assessed by the AMBIANCE scale (Lyons-Ruth, Bronfman & Atwood, 1999). Finally, the parental reflexive capacity is assessed by the Insightfulness Assessment interview (Karin-Karen Oppenheim, 2004).

A WORK IN PROGRESS

Since January 2008, the team of CAPEDP-Attachment has progressively organised the following structures: A) Production of intervention documents and manuals for the CAPEDP general intervention team. B) Training of the CAPEDP general intervention team. C) Training of the CAPEDP-Attachment assessment team. D) Training of the CAPEDP-Attachment coding teams.

A) Production of intervention documents and manuals for the CAPEDP general intervention team.

1. Production of the intervention pamphlet entitled *Infants' Emotional Development*, directed to the mothers of the intervention group, to promote their sensibility for the infants' attachment needs.
2. Production of the *Intervention Manual CAPEDP-Attachment*. The manual details the preventive intervention methods, focusing on maternal sensitivity to the infants' signals, and the use of video-feedback intervention at home.
3. Production of the *Intervention Manual on Parental Authority*, for the 12th to 24th months' period, to prevent parental behaviour disruption in the so-called *opposition age*.
4. Organisation of an Attachment Documentation Centre available to the intervention and assessment psychologists (400 articles and documents in paper and digital format).

B) Training of the CAPEDP general intervention team.

We are training and supervising the intervention psychologists on the use of home video feedback for the promotion of maternal sensitivity, promotion of maternal mentalizing skills, prevention, detection and reduction of maternal atypical behaviour and infants' disorganized attachment.

Two particular approaches characterise the attachment focus of the CAPEDP intervention. The first one is the use of the pamphlet entitled *Infants' Emotional Development* by the intervention psychologists, which is an idea taken from VIPP, aiming to give knowledge to the parents on babies and infants' emotional life. The French pamphlet was developed as part of this research and is based

on the results of recent attachment longitudinal studies. Our aim is that the mothers work it with the psychologists and then read and reread it when a problem of this area arrives or when they are in doubt. We have decided to introduce the pamphlet to the mother when the baby is 3 months old taking into consideration the sensitive periods for the formation of the attachment relationship. Thus, the possibility to introduce the pamphlet when the infant was six months old seemed to us a bit late and doing it before 3 months of age seemed too early. Especially because first time mothers at babies' 3 months are still involved in a phase of some relevant turbulence or looking for pragmatic ideas. We want to avoid the use of the pamphlet as a guide to parenting, rather than as a tool to help them to face the challenge of raising their first child (Juffer, Bakermans-Kranenburg & van IJzendoorn, 2007). Other arguments in favour of its use at that age are: a) parents are particularly open to suggestions for change in the first year of life of their infant, b) sometimes it's only a bit after the baby is born that they realize that raising an infant creates problems that they can't manage without special attention or extra help, and c) reciprocal interactions of daily life are not yet rigid and we can help with a soft model.

The second one is the use of the video intervention based on the STEEP and VIPP programs. This type of approach is relatively recent in this kind of programs. The reasons for the increased use of this approach are associated with several factors (STEPP):

- Parents need a mirror of their own daily interactions with their child to change their behaviour;
- Video can be a starting point: we regard the current behaviour of the baby and not the retrospective narratives that are so often biased;
- Video offers opportunities to practice observational skills while watching the video together with the parent;
- It also offers opportunities to reinforce the behaviours that the sensitive parent shows, even when they are fluid.

By using the video the parent is his own model of intervention (STEPP and VIPP). This is an opportunity to focus on the baby's signals and

expressions, while stimulating the mother's observation skills and her empathy with her child. It also enables positive reinforcement moments of sensitive behaviour that the parent evidences on the video. The videotape strategy is more successful as it occurs within a supportive relationship that continually recognizes the individuals and the family's strengths within the broader context to which they belong. The strategies of video feedback as been shown to be very effective (STEEP) since it:

- Provides a focus on the parent - child relationship
- Emphasises the expertise of the parents
- Provides a permanent memory (e.g., coming back to the subject, a witness, a gift);
- Offers new perspectives;
- Facilitates the parent to put herself at the place of the baby;
- Helps parents to watch the baby as a third person.
- Increases attention on the real baby;
- Examines better the interactional dimension of maternal perception, signals reading and her interpretation and response to them;
- Shows the difference between what we think and our automatic responses, as well as what we can do to regain control.

In conclusion, we can say that auto-videotaping is an opportunity for parents to get a little bit out of the relationship with their baby and to reflect on what they are learning together. This intervention method allows the professionals to use a new and powerful strategy to strengthen their efforts in the support and promotion of stronger parent-infant's relationships (STEEP).

C) CAPEDP-Attachment coding team.

1. Establishment of a French Attachment Laboratory: two rooms with two remote cameras managed with a remote control device.
2. We pay the mothers 50 euros for participating in the assessment.
3. Formation on attachment theory and research, disorganized attachment and Attachment Clinical Approaches.
4. Training and supervision on the Strange Situation Paradigm administration, and the Insightfulness Assessment Interview.
5. Attachment Journal Club for monthly presentation/discussion on the domain of attachment.

D) CAPEDP-Attachment coding team.

1. Training on the Strange Situation (ABC) in 2005 with Fabienne Becker-Stoll & Karin Grossman of the University of Regensburg, Germany.
2. Training on the Strange Situation (Disorganization) in 2005 with Elizabeth Carlson, University of Minnesota, USA.
3. Training on the Insightfulness Assessment, in 2006 and 2007 with Nina Koren-Karin & David Oppenheim of the University of Haifa, Israel. A French translation of the English manual was done after the training period.
4. Training on the Waters Q-Sort, in March 2008, and November 2008 with Manuela Verissimo, from the Institute of Applied Psychology (ISPA) of Lisbon, Portugal. A French translation of the English manual was done after the training period and the French Q sort was validated.
5. Training on the AMBIANCE scale, in April 2008 with Karlen Lyons-Ruth and Elisabeth Bronfman, of the Harvard University, USA. A French translation of the English manual was done after the training period.

Some reliability tests are still being done by certain coders.

CAPEDP-Attachment invitations and SS and IA assessments have begun in July 2008 and are scheduled until November 2009. There are currently 35 mother-infants' dyads assessed at infants' 12 months. Verbatim Transcripts of Insightfulness Assessment interviews have started in parallel with the data assessment, since July 2008. The SE / AMBIANCE / IA coding teams began their work in February 2009 and are scheduled until December 2009.

CONCLUSION

CAPEDP hopes to offer new perspectives on preventive mental health, as well as the opportunity to develop specific training on the work involving projects of early mental health promotion. CAPEDP-Attachment, by clarifying our understanding of the mechanisms implied in the secure attachment strategies, aims to contribute in a significant way to refine parent-infant early preventive intervention in contexts of psychosocial vulnerability.

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Nés sous X but not “abandoned”

A preventive and therapeutic framework for care in a maternity hospital

For newborns left for adoption

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Les Bluets is an Avant-Garde Parisian maternity hospital, well-known since the 1950s when, founder Fernand **Lamaze**, eminent gynecologist and obstetrician, first introduced the idea of the mother’s active role in her pregnancy and labor, implemented training classes for “painless” labor and birth, while inviting the future father to stand by his wife during labor. At Les Bluets, the staff remains faithful to this innovative spirit and continues to face contemporary challenges (such as medically assisted procreation, the accompaniment of same-sex parents, single parents, couples of varying ethnic backgrounds, etc...) following Lamaze’s inventive path through creative research in various directions (Vamos&Eguillon 2007) Abandoned babies are one of these challenges the staff at the hospital have been asked to cope with.

We wish here, to present the approach that has been developed for them, as a unique combination of the psychoanalytical approach to care giving and the late Hungarian pediatrician Emmi Pikler’s outstanding developmental approach (1979).

BABIES BORN “SOUS X.”: WHO ARE THEY?

Babies born “sous X,” *are* children born to women who have decided, already in the course of pregnancy, to give birth “anonymously” and to leave their newborn child for adoption (Szejer, 2003, Darchis, 2007). What

role can/should the maternity clinic play for these mothers and infants during the first few days?

At Les Bluets, the staff has a dual **goal and ambition**. On the one hand, to offer a “holding”, supportive framework for the mother who is entrusting her child to the care of the State aiming at adoption and, on the other hand, to provide specialized care for the newborn during the time he/she spends at the hospital. Our therapeutic approach focuses on the babies’ daily emotional experiences at the hospital, rather than on the abandonment itself. Nonetheless, the abandonment issue remains at the heart of our preoccupations and constitutes a fundamental question for us, in our approach to the mother. Heightened attention and solicitude are urgent needs for these infants in their first moments of life, in order to facilitate an experience of the world as “friendly enough”, like a buffer against the storm-like experience of abandonment.

French medical circles no longer use the term “abandoned” when speaking of these newborns. The expression in common use today is “an infant having been entrusted to the State with the aim of adoption.” This semantic change conveys a new look at these newborns, focused on planning their future life rather than focusing on the abandonment. Since 2003, a French organization, Coordination des actions pour le droit à la connaissance des origines (CADCO; Organization defending a person’s right to have access to his or her origins), has been attempting to reconcile the interests of three distinct parties: the child and his right to know his/her personal history; the biological mother and her right to privacy; and the adoptive parents and their right to security. French law, although it evolves more slowly than other European countries, recommends a

psychological accompaniment for abandoned infants. We will present here the main components of the psychological accompaniment we have developed, inspired from the combination of our psychoanalytic training, and teachings of the Emmi Pikler unique developmental approach (David & Tardos, 1991).

THE BASIC CONCEPTS OF THE PIKLER-LOCZY INSTITUTE APPROACH

Pediatricians and psychologists at the Pikler Institute have elaborated a **model of adult-baby relationship** within a professional framework, which **differs considerably from the mother-infant relationship**. Myriam David, a child psychiatrist and the 2004 winner of the WAIMH Serge Lebovici award, and Geneviève Appell, psychologist, met the staff of the Hungarian institute and published their findings in *Loczy: an Unusual Approach to Mothering, in the 1970s* (David & Appell 2001, Vamos 2002).

Pikler, through her systematic observation of infants, has taught us a receptive attitude which enables us to recognize and **respect infants potential in any encounter with them**. This receptive attitude also allows us **to preserve** that potential so that a newborn baby can actively participate, at his/her level, in creating his/her own well-being even during the very first days of her life, even in the absence of the mother.

This unusual type of mothering, in a stable environment, that is empathetic but **does not impinge** on the child’s innate capacities, the warm but “professional” treatment, enables the child to create fundamental bonds, in spite of growing in a residential nursery. (Martino 2000) It also incites professionals to develop a better understanding and reorganization of

their own ideas of what is essential for the psychological construction of a healthy and competent individual.

The experience of the Loczy residential nursery has been validated by a longitudinal study carried out by the World Health Organization that showed no signs of emotional deprivation among these babies, nor signs of trauma-repeating behaviors. The study showed that 150 children, who had entered the Institute before the age of one year and spent more than a year there, had social skills comparable to those of other children of their age group and, in the long term, were able to create a stable family life of their own.

CASE STUDIES THAT TRIGGERED THE IMPLEMENTATION OF “LES BLUETS” PROGRAM

The two following case studies show the suffering and dilemmas which led us to imagine a new framework for care. The adults - caregivers and parents - involved in the care of these infants found themselves inevitably dragged into the turbulence of fantasies, projections, and acting-out behaviors. I will not dwell here on the painful stories of the mothers, which mobilized the affects of the staff so intensely, but will rather concentrate on the conditions in which the care of these mothers and babies was initially put in place.

Mrs G. and Betsa

Miss G. is an illegal immigrant in a precarious situation. Her pregnancy is the result of sexual abuse. During the prenatal appointments, she persistently repeats her decision to entrust her baby to the care of the state for being adopted.

Betsa's delivery is uneventful, at term. The baby, healthy, is immediately presented to her mother, who takes her in her arms, and then is taken to the nursery. Everything goes according to the plan which the staff has agreed upon beforehand. In 2002 at the hospital, the collective attitude was to follow the mother's movements of approach towards and withdrawal from the baby.

The definition of my job, as the

psychologist in the team, is to accompany this mother and her infant in this confusing situation...

When I go to the nursery, I find Betsa in her mother's arms; Miss G. is giving the baby her bottle. The baby's brow is creased, her mouth is tense, and her eyes are crossed. I am observing a baby who seems distressed, disoriented in her mother's arms and the mother is obviously at lost and suffering. I notice the closeness of the bond established between mother and baby and I am afraid that if their stay together at the hospital is prolonged the inevitable separation will be all the more painful and destructive for both of them. I learn that the night nurse in charge of the infant has encouraged the mother to hold the child close to her breast, skin to skin. Miss G is coming more and more regularly to care for her baby in the nursery.

It seems to me that mother and baby are caught in a vicious circle that needs to be broken: someone must remind them of the reality of the situation, talk about the initial project of separation while remaining open to the possibility that the situation might evolve at all times. I suggest that mother and baby come and have a talk with me together. The mother accepts. After taking a silent moment to get in tune with the pair, I explain to Betsa the gravity of the moment, and ask her mother if she can say anything to her baby about it. Miss G. sheds silent tears and, in a moment of intense emotion, tells her baby she loves her. She hugs the baby very tightly to her chest but, nonetheless, maintains her decision. She is violently torn. I take the two of them in my arms and I address Betsa and, through her, her mother, recreating the distinct space of their separate futures. Little by little, after a moment of unbearable emotion, the mother gains sufficient calm to leave Betsa in her crib and to return to her own room.

A short time later, the nurse describes Betsa as much calmer, more relaxed. I see Betsa's face transformed by a new glow and vitality. The nurse manages to express the fact that she does not want Betsa to be picked up and held like a doll by every person on the staff who passes through the nursery.

The mother continues coming and going; she is having trouble leaving

her daughter in the nurses' care, as if she thinks that if she takes care of her baby while they are both at the hospital then “they will at least have that.” In the present situation, if the mother and child become any closer it will only add to their mutual suffering and I find it necessary to remind the mother that her desire to care for her daughter goes against her fundamental decision to abandon the baby. I suggest that from then on, Betsa drinks her bottle in the nurse's arms.

On the third day, in order not to drag out the painful process of separation any longer than necessary, we ask the staff of the residential nursery to come and get Betsa as soon as they can. They do and Betsa's departure reassures her mother who leaves the hospital on the same day. In this case, mother and baby felt ever more painfully torn apart because they were experiencing a haze of uncertainty mixed with the more or less unconscious caregivers' wish to reunite them.

Mrs. M. and Boriska

The staff at the hospital meets Mrs M. only one week before delivery and is told about her decision to give up her baby for adoption. The pregnancy happened accidentally at a particularly chaotic time in this woman's life, while she is living in a precarious social environment. The baby, a girl, was born healthy and is named “Boriska.” At that time, at “Les Bluets”, we started the routine to write all the staff's observation about baby's daily activities, emotional states and behaviors, during their stay at the hospital. Boriska's notebook described how she likes her formula, the temperature, the speed with which she drinks, what time she has her bottles, her preferred positions during feeding, how she burps, etc. We are highly attentive to the way she conveys her pleasure and displeasure, any tension, her sleeping/waking rhythms, her ability to be consoled and her explorations.

Boriska has to stay at the hospital for 15 days while she waits for an opening at one of the state-run residential nurseries. The observations in Boriska's notebook are very illustrative of the many pitfalls that caregivers come across while accompanying babies waiting to be adopted, and their mothers waiting for

the separation.

During the first week, whenever Mrs M. makes a brief visit to the nursery, which she does often, but irregularly and for short bouts of time, the caregivers (midwives and nurses) suggest that she feed her baby. . The team in fact persists in believing in the possibility of creating a bonding process between this mother and her infant, creating expectancy of the mother for themselves as well as for the baby, in spite of knowing that she is struggling to give her up for adoption.

Meanwhile, Boriska is described as ever more anxious and irritable, crying a lot and shaking, like a small bundle of nerves. At the end of the first week, Boriska's attitude towards food is described as very bizarre. The mother's behavior is described as very ambivalent towards the baby, and problematic towards the staff. The father, on the other hand, takes care of his daughter, and his visits are becoming more and more regular; the mother's attitude toward the father is very unstable; some days she allows him to approach the baby, other times, she refuses.

During the second week, some quieter moments are observed, but also of times when Boriska swallows her milk like a drug addict. Little by little, we note that a dysfunctional routine has set in, despite our efforts, due to Mrs M.'s erratic comings and goings as well as those of the staff. Most often, when Mrs M. comes for one of her lightning-speed visits, she leaves Boriska crying and in a painful state of excitement. The holes in the continuum of the baby's care routine are reflected in the baby's behavior.

Further on, strong countertransference can be detected through reading the notes left by caregivers. For example: "I brought you some clothes and stuffed animals...I carried you with me all day long wrapped in a carrying scarf." One of the midwives has developed a symbiotic relationship with Boriska. The number of people caring for the baby multiplies: osteopath, pediatrician, trainee nurses and nurses aids, etc. Incapable of envisioning a coherent future for this child, the staff, filled with pity, cares for her in a succession of acts and gestures aimed at comforting her and at dissipating their own feelings

of confusion and disarray. Boriska remains tense and stiff while she drinks her milk, and wants to be held incessantly. Several of the midwives indeed carry her constantly, wrapped tightly to their blossom as they go about their daily activities. Alone in her crib, Boriska is agitated and screams; she becomes ever more disorganized and difficult to console.

Finally, after fifteen days, an opening at the state-run nursery becomes available for Boriska. One of the nurse-aids comes to meet the baby at Les Bluets before her final departure for the residential nursery. When she does leave, the caregivers at the hospital are filled with a sense of emptiness and loss.

This case illustrates the well-too common situation where, in spite of their good will, the team, torn by their strong countertransferential feelings, could not provide the baby a coherent, reliable, and stable setting, based on attention and respect for her own needs and pace. Consequently, Boriska was not able to perceive herself as an active partner in the daily caregiving interactions, nor to develop a sense of self .

DISCUSSION

The two case studies above, triggered our thinking about the uniqueness of the abandonment situation, because of the intensity of the reactions they had evoked, in the baby, the mother, and the team altogether. **It made us realize how the absence of a solid professional framework** within which the staff can care for these adult and baby patients, leaves them to face, alone, their projections and impulses. This, in itself, leads to disorganization at the three levels (the baby, the parent, and the team), with possible detrimental long term effects on the baby's own development and the mother's future functioning.

As a result, we have progressively put in place a new framework for care which helps contain the emotions of both parents and caregivers and which allows us to welcome and protect the new baby in better conditions.

The first step was to wonder about the representations the abandoned baby evokes in us. The idea of an infant who has been abandoned by

his mother is generally unbearable, especially in a maternity hospital, where the sacredness of birth is ever present. It engenders pity, which is, in itself, detrimental to the infant's primary narcissism. The notion of an "infant engaged in the process of being adopted" has made the reality more acceptable for us. Still, it implies a period of waiting: waiting to leave the hospital, waiting for a foster family, waiting for adoptive parents. In this transitory period, the present is overshadowed by the future adoption. Yet close attention to the here and now is vitally important to a newborn infant in his first interactions with the world. At Les Bluets, our representation of a baby "hanging loose," "in transit" must have minimized the importance of the time the child spent with us at the hospital. It must have introduced a sort of blur around this transitional time that the baby probably perceived as a period in which he was suspended in limbo **or waiting in the void.**

In our experience, working in the here and now may lessen the impact of this void. A coherent care routine set up in concert by all concerned, a respect for and the preservation of the baby's personal resources can give meaning to every second of his life. Adopting a therapeutic attitude in which one pays close attention to the details of the present moment is essential; it transforms the way we perceive the baby and the quality of the environment we create for him. As we reviewed above, this is one of the premises of the Pikler approach, which has been taught at the Loczy Institute.

I have been able to communicate to my colleagues my deep belief that if the environment offered to her is good enough then the newborn infant will have the capacity to exist without her mother and my conviction has spread within the hospital. We have been able to contain critical situations in which acting out on the part of the mother or the staff was immanent, and we have managed to second guess destructive impulses due to a generalized feeling of guilt triggered by abandoned infants. The staff has managed to understand that an act will take the place of a feeling that can not be thought through or understood. The importance of having a time and a place for sharing emotions and thoughts is now fully recognized by everyone, as is the importance of

observing the baby and being attentive to its needs. Strong psychological support for the staff is obviously necessary in that challenging task.

THE MAIN FEATURES OF THE THERAPEUTIC MODEL AT “LES BLUETS”

Accompanying the mother

Along the years of **giving support to mothers** who are in the process of giving up their babies for adoption, we have realized that the process is much easier and the outcome more favorable, when started in pregnancy. We accompany the pregnant woman, paying constant attention to her feelings of ambivalence, guilt, anxiety and to the psychological transformations she goes through, as an individual as well as a mother. We try to work out plans for her own future, as well as for her baby's best interest. Our aim is to differentiate the fetus from its mother, making him exist as an individual in the mother's eyes. It is a complex process, but as far as we can judge from our experience, it elicits feelings of empathy from most mothers towards their fetus, together with an understanding that her relationship with her/him, is the very first chapter of her child's future interpersonal relationships.

We aim at giving the mother an active role in this process, and therefore we provide her with detailed information about the postpartum arrangements: how long, where and how (such as knowing she and the baby will be in different wards, their meetings will be in the presence of a **mediator**, and that psychological work will follow these encounters.

When delivery comes, a **referent** caregiver is designated for the mother and the planning for the baby as well as for the mother, goes along what has been decided during the pregnancy. During her hospital stay, the mother's maternal capacities are usually mobilized. We invite her to write for the child elements of her life that she considers important for him/her to know, in any case she/he decides to seek information about her/his origins.

In some cases, we seek for professionals in the community to

provide the mother with support after her return home and during the two months during which French law allows her to reverse her initial decision.

Welcoming and caring for the baby

Our foremost preoccupation is to **get to know** the newborn's own characteristics, and to keep a daily continuous, nurturing, and attentive interaction with him/her. This, we believe, allows the baby to feel as a worthy and welcomed subject. One of the conditions for continuity of care at the hospital, like in any residential nursery, is the transmission of information from one shift to another. We teach the nurses to make detailed reports of their observations. Thus, the major inconvenience of having multiple caregivers is buffered by the sense of continuity and familiarity conveyed to the baby. Also, every baby has one designated main caregiver, and the number of caregivers are kept to the minimum.

The major task of the main caregiver is to respond contingently to the baby's emotional states and behaviors, an interactive experience different from the one with the biological mother, but also different from the expected one with the adoptive parent. Indeed, the place of the baby's future adoptive parents is preserved by keeping the relationship with the baby professional in a warm, contingent, and nurturing context. The daily caregiving tasks (such as feeding, bathing, carrying, and putting to sleep) are privileged times for an intimate exchange with the baby, watching her/his emotions, spontaneous movements, search for and loss of the link to the mother. (Vamos & Csatai 2001) It is believed that in this privileged and respectful space, the baby may develop a vital and competent sense of self.

When time comes to leave, the baby is given a diary, with all the pictures and the notes that have been collected about him/her. This concrete testimony of the beginnings of his/her life is aimed at guaranteeing continuity, and will accompany the baby to the residential nursery and sooner or later, to her/his adoptive home.

Supporting the caregivers

The **medical staff** in charge of these mothers and babies has a complex task to achieve. Each person's role must be well defined; a principal caregiver for both mother and child must be designated. Setting aside specific times in the daily hospital routine for sharing information about these patients as well as allowing for more exceptional, unexpected moments is especially necessary in these situations. Regular institutional meetings and mini-encounters with the psychologist are also required. Each caregiver works out for herself/himself the appropriate professional attitude to adopt towards the baby. This attitude must be different from the one of a fantasized substitute mother's. Thus, the caregivers' demeanor will protect the baby from developing multiple - and illusory - emotional attachments which are destined to a more or less brutal ending. Basically, the suitable attitude is one of professional restraint and reserve concerning one's personal projections while centering one's attention on what the baby is expressing in the here and now. We give the caregivers support for their individual psychological reactions, especially those revealing resistance and defensiveness linked to their personal history (Vamos 2006).

Today, after much collective questioning and thanks to a fundamental change in the way the care providers perceive babies, we have begun to be able to **act** jointly, so that this extremely complex and difficult passage for the mother, the newborn baby, and the staff, becomes a constructing event, with sometimes, unexpected features, as the next vignette illustrates.

ILLUSTRATIVE VIGNETTE

Mrs S. is at her sixth month of pregnancy, after having conceived out of wedlock. She is married and has two children. She does not intend to dismantle her household, and manages to conceal her pregnancy from her family until the eighth month. Thanks to our weekly sessions, she finally decides to reveal the pregnancy to her husband. Together, the couple decides to give the baby up for adoption. During the therapeutic sessions, Mrs S. can sense my concern for her, but also for **the baby as a distinct**

individual. We explore the option of involving the child's biological father, but she does not want to have him informed. While giving her the support she needs for the decision she has made, I mention to her several times the lawful reversibility of her decision during the two-month period after birth.

Nonetheless, my main objective is to help her at maintaining the position she has elaborated during our prenatal sessions, and at avoiding confusion at the time of birth and during the hospital stay. I offer to help her stepwise, along the way she has chosen; I assure her that she will not be left alone during the significant moments of her stay and that she will be surrounded by a staff of supportive staff. Thanks to the well-defined setting put in place for her, she feels relieved, though very sad. This sadness, expressed during our sessions, reflects an inner strength at elaborating her decision.

When time comes, things happen the way she had asked for during the sessions. For instance, *in the delivery room*, her wish not to see her baby immediately is respected. The newborn infant is separated from her mother and installed in the nursery, one floor higher the mother's. Then, the mother understands the rule of being accompanied during all her visits to the baby (twice by myself, and then by other caregivers). The baby is described in the daily notebook as an easy-temperament baby, who eats and sleeps well, and is easy to console.

The mother's farewell to the baby is extremely emotional, but my presence helped her to contain herself. The baby's relaxed face and calm state suggest that mother has managed to avoid projecting her massive inner conflict onto her. While the baby is taken back to the nursery, I stay with the mother until her husband comes and takes her home. The next day, a place in a good residential nursery in the Parisian metropolitan area becomes available for the baby. Members of an Association for Mothers giving up babies for Adoption made regular home visits during the two-month period and provided Mrs S. intensive support throughout that difficult time.

The final separation required a great

deal of courage and determination from the mother. From the staff, too, and many team meetings helped us to internalize the idea that the baby would indeed have a valid existence, in spite of the context of her conception. As a result, the staff acted with the mother and the baby insightfully, instead of being driven by their own impulses and emotional turmoil due to the mother's ambivalent decision. The psychologist's role was a very active one, quite different from the traditional position psychologists have. Indeed, reading Gerda's notebook made it clear that this baby, as opposed to the other two babies described above, had not experienced being in limbo, nor had been exposed to uncertainty, confusion, or conflicted behaviors. Gerda was the first baby to benefit from this change of therapeutic approach at the hospital.

Two months after the baby's departure for the state nursery, I learned via the association that Mrs S. had told the baby's biological father about the child's existence. He decided to take her and bring her up with his own family's help. Mrs S. visits them every fifteen days. The support this mother received from our institution allowed her to build, first for herself and then for her baby, the representation of herself identifying with a baby which she had not damaged. The child was protected against impulsive actions on the part of the adults caring for her; she was protected from unelaborated ambivalence and from massive, collective projections. The intensive, institutional support put in place around Mrs S. and her baby allowed this mother to imagine and build another future for her child.

THEORETICAL FORMULATION OF OUR THERAPEUTIC MODEL AT "LES BLEUETS"

For babies born "sous X", i.e. abandoned babies at birth, the essential question for the maternity staff is **what kind of environment and relationship with mother and baby, will facilitate an overall creative and positive experience for the baby during its first days of existence. The unique challenge, for us as psychologists, is to create such an experience in a regular maternity ward at the hospital.**

Winnicott's work revealed that for a newborn infant, from the moment of birth, the experience of feeling himself impact **on his environment** is fundamental to the development of his psyche. M. Klein showed the fundamental necessity of primary splitting in the ability to separate good from bad for a **good object** to be introjected and thus preserved.

Following the Piklerian concept of **psychological care** expressed through **concrete bodily care** provided by primary caregivers (holding, feeding, diaper change, etc), the baby is able to try his hand at a type of relationship in which he can **discover and create** and even **influence** his environment.

The application of these concepts to the unique situation of a pregnant woman coming in a maternity ward for delivering a baby she intends to give up for adoption, should not be taken for granted at all. It requires from the staff to be willing to reflect upon their daily behaviors, to integrate psychological concepts, and to put aside their judgmental attitudes towards the abandoning mother, as well as their compassion towards the abandoned baby.

This therapeutic model is based on the combination of a psychoanalytical reading of the mother's and staff's inner movements, together with the elaboration of a here and now setting for the baby with its own characteristics. Containing projections, centering work on the provided bodily care (a process that make daily caregiving becoming a narcissistic object to the caregiver), preserves for the baby a space for the "finding-creating illusion" (Winnicott, 1957). This, we believe, has the potential to enhance the baby's capacity to believe in himself and in his surrounding world.

CONCLUSION

It is hard to imagine how a "given up" newborn can grow out of this fundamental negative experience into a healthy individual. Assuming the first days of life are crucial in putting the baby on the right developmental path, we have developed a model aimed at facilitating the newborn's self organization and openness to significant interpersonal exchanges, while focusing on the staff's, mother's

and baby's behaviors **during the few days at the maternity ward, that ultimately aim at the definitive mother-newborn separation**

Following the clinical cases described above, and others alike, we have progressed from an improvised welcome to an organized one, as we have tried to describe along this paper. Though it seems impossible to annihilate the **pain of abandonment**, it does seem possible to avoid its **traumatic** effects.

We have detailed here the specific model put in place to keep mother and staff from being overwhelmed with distress and guilt, feelings inevitably linked to the act of abandonment. We have described the attention we pay to the organization of the daily care which allows the newborn infant to feel protected. The attentive bodily care given to the infant becomes therapeutic: it provides her/him with **a vital and necessary welcoming**. The babies are not **waiting in a void**. While at the hospital, they experience their caregivers' solicitude and lively attention to their "here and now". In other words, the baby is thus encouraged to introject a good and protective object, and leaves the hospital opened to future.

The necessary splitting between care for the mother and for the baby, protects both parties from destructive affects. We focus our attention on creating and protecting the baby's life space from the time of birth on, in order to guarantee the continuity of her/his personal body care history. Each moment spent at the hospital is part of the baby's personal history, and is recorded in a diary.

Moreover, preserving the baby has an organizing effect on the mother. It repairs within her the abandoning part of her self. Something of her parental capacity, initially unthinkable, reemerges and, sometimes, even results in a revision of the decision to give up the child. This revision is not the goal of our accompaniment - each woman has a right to her own life story - yet we allow it to be a by-product of the work we do with the mothers.

To conclude, we have transformed pity for the newborn into consideration for its personal resources and we have grown into

being able to convey greater respect and support for mothers who do not want their babies. The next step for us is to study our model in a systematic research design. We believe it has some unique contribution to our arsenal of intervention for very high risk population of women and babies, such as those presented here, but we definitely need to conduct a well-designed study in the future.

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How long do we need to support parents – results from the five-year follow-up of the Finnish part of the European Early Promotion study

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ABSTRACT

The Department of Child Psychiatry of the Tampere University and University Hospital participated in a European multicentre study, that contrasted the effects of specially trained primary care nurses on newborn and parent-infant relationship outcomes in contrast to regular care delivery nursing practices. In the baseline measurement period, mothers receiving the intervention had more mental health problems and were poorer in their interaction with their infants than were mothers in the comparison condition. At the two year outcome measurement positive changes in Intervention Group mothers mental health and interaction behaviour were seen, and there were no significant differences in child behavior problems between the Intervention and Comparison Groups. In the five-year Finnish follow-up there again were no significant differences in the child behavior problems between the two groups. This suggests that the positive changes gained during the two-year long European intervention study were maintained through the additional Finnish follow-up period, but no evidence of further improvement in the children was seen.

INTRODUCTION

Healthy development of a child is dependent on biological, psychological and social factors. Infants are born with both biologically determined capacities and urge to participate

in human interaction (Emde, 1983; Zeedyk, 1998; Trevarthen & Aitken, 2001). Early parent-infant interaction provides the contextual environment necessary for infants to develop. The quality of parent-infant interaction is affected by the qualities and behaviour of both. Normally parents are sensitized and attuned to meet the needs of their newborn (Emde, 1983; Brazelton & Cramer, 1990), but psychological distress, mental illnesses and drug and alcohol abuse have been shown to impair their ability to engage and interact with their infants in a satisfying way (Murray, Fiori-Cowley, Hooper, & Cooper, 1996; Zeanah, Boris, & Larrieu, 1997; Riordan, Appleby, & Faragher, 1999). Repetitive unsatisfying mother-infant interactions may have long-term consequences for the child, affecting the quality of attachment (Crittenden, 1995; Teti, Gelfand, Messinger, & Isabella, 1995) and restricting the child's cognitive and socio-emotional development (Murray et al., 1996; Crockenberg & Leerkes, 2000; Carter, Garrity-Rokous, Chazan-Cohen, Little & Briggs-Cowan, 2001; Luoma et al., 2001). Since early parent-infant interaction affects the development of an infant (Nelson & Bosquet, 2000; Schore, 2001), it would seem reasonable to try to detect possible problems in the parent-infant interaction and intervene in early infancy.

Prevalence rates of mental health problems in children have been widely studied, and it has been estimated that 12-20 per cent of children suffer from these problems (Anderson, McGee & Silva, 1987; Ghaffer et al., 1996; Offord et al., 1987; Bird, 1996; Puura, 1998). Epidemiological studies on prevalence of mental health problems in younger children are still rare. One of the recent studies by Skovgaard et al. (2007) reported prevalence rates of 4.2% for disorders of affect, reactive attachment and adjustment, and prevalence rate for 8.5% for parent-infant relationship disorder in a sample of 18-month-old infants. Briggs-Gowan and colleagues (2001) found in their community sample of

1,279 children aged one and two years that the percentage of 2-year-olds with CBCL/2-3 scores in either clinical or sub clinical range, was 6.7% for internalizing problems.

Because for some children problems seem to emerge quite early, and because of relative stability of mental health problems during childhood and adolescence (Pihlakoski et al., 2006), the need for preventive interventions is evident. Currently there is evidence that interventions taking place in the perinatal period are most effective, even with high risk groups like prematurely born infants and families with multiple problems (Aronen, 1993; Barrera, Rosenbaum & Cunningham, 1986; Brooks-Gunn et al., 1994; Olds, Hill, Robinson, Song & Little, 2000; Zeanah, 1993). Educational interventions focused on giving guidance to parents have also yielded good results (McDonough 1995). In some studies the effects of early preventive intervention have been seen also in adolescence as less psychological problems (Aronen & Kurkela, 1996; Olds et al., 2000).

In Finland, children's development is followed up in front line services, which for children under school-age means regular check-up visits in well-baby clinics. Each infant is seen monthly during the first year of life, twice in the second year of life and then once a year until the children enter school. The service is well accepted and used by 95% of families with small children, and provides a good framework for both supporting child development and screening for possible problems (Saarelma & Perheentupa, 1998). With increasing awareness of the importance of the early years of child development among Finnish health care professionals, the need to develop health promoting and preventive interventions usable in front line services became clear. For creating such an intervention the Department of Child Psychiatry of the Tampere University and University Hospital participated in a European multicentre study, The European Early

Promotion Project (EEPP, Puura et al. 2002), with the support of the Finnish Ministry of Health and the National Centre for Research and Development of Social Welfare and Health.

The EEPP study was carried out simultaneously in Cyprus, Greece, Finland, Serbia and the United Kingdom. The EEPP aimed at giving nurses working in front line services better skills for supporting families where problems in early parent-infant interaction were found. The initial study lasted two years, and the outcome results from different countries have been reported elsewhere (Davis et al., 2005; Puura et al., 2005). For the Finnish sample the main outcomes of the EEPP were improved maternal mental health with less depressive episodes, less health problems in the children and increased maternal sensitivity in families who had been supported by the trained nurses (Davis et al., 2005; Puura et al., 2005).

In Finland we wanted to continue with a longer follow-up of the participating children and families. Our hypotheses was that the work done by the nurses trained in the EEPP would continue to have an effect on the families in the Intervention Group, resulting in less problem behaviours in children and better mental health in mothers. In this paper we will describe the results of the five-year follow-up of the Finnish sample of the EEPP.

METHODS

First phase of the EEPP- study

The design, material and methods of the original EEPP-study have been described in detail in the main report (Puura et al., 2005), therefore only a short description is given here. The Finnish part of the EEPP study was carried out in Tampere, Finland. A group of 15 primary health care nurses working in well-baby clinics were trained to support mothers with new born babies and to intervene early should problems arise in the care of the infants. These Intervention Group nurses recruited mothers with new born babies to form the Intervention Group (n=93) for the study. A second group of 12 primary health care nurses without the additional training participated in the study (Comparison Group nurses) and recruited mothers with newborns to form the

Comparison Group (n= 72). Nurses in both Intervention and Comparison Groups were asked also to assess the family's need for support as they were recruited for the study.

The training of the Intervention Group nurses consisted of communication skills, infant development and early interaction, basic problem solving techniques and selected infant mental health intervention techniques, like modelling, open wondering (e.g. I wonder what your baby is needing when she cries like that?) and speaking for the infant (e.g. the nurse would say mimicking baby's voice "mom pick me up, I want to be near you"). The skills learned in the training formed the basis for the intervention. The Intervention Group nurses contacted the mothers 4 weeks prior to giving birth and 6 to 8 weeks after delivery. If the mothers expressed any concerns or the Intervention Group nurses observed something worrying, the nurses invited distressed mothers to come to the well-baby clinic once or twice a week until the mothers felt more confident. During the visits the nurse would explore the worries with the mothers, encourage them to think about the infant's behaviour and feelings, and support them in interacting with their infants. The interval between the visits gradually lengthened as the need for support diminished. The Intervention Group nurses also received regular supervision from a child mental health specialist during the two years of the EEPP intervention study.

The Comparison Group nurses received an introductory lecture on the design and purpose of the study, but no further training nor supervision. They were asked to contact the mothers they recruited for the study a month before the birth, 2 to 4 weeks after birth and then continue working with the mothers and infants as they normally would.

All families were assessed when the infants were 6-8 weeks old with a battery of instruments, including a semi structured interview, several questionnaires and parent-infant observation method by independent researchers during a home visit (see Puura et al., 2005). When the children were 2 years old the families (n= 139, 84% of the initial sample) were assessed with the same instruments as in the first assessment.

In addition to the measures used in the EEPP-study, the mothers of the Finnish sample also filled in the Child Behaviour Checklist as a part of the two-year assessment (CBCL; Achenbach 1992).

The follow-up from two to five years

The participating children had their 5-year birthday between March, 2003 and August 2004. The mothers were contacted by mail, and received an information letter about the study, the Child Behavior Checklist (CBCL) questionnaire, and a questionnaire with items concerning the health status of the child and his or her parents, information on child day care, and of the socioeconomic status of the family. All the questionnaires were marked with a research code to protect anonymity. Mothers also filled in an informed consent form, and sent all the forms back in a return envelope to an independent researcher. Ninety two mothers returned completed CBCL questionnaires (53% of the original subjects and 67% of the subjects participating in the two-year assessment). The description of the study sample is given in Table 1. Families who did not participate in the 5 year follow-up did not significantly differ from those who did in relation to socioeconomic factors or CBCL scores at the two year follow up at the T2.

The Ethical Committee of the Pirkanmaa Hospital District gave their permission for conducting the original study and the five-year follow-up.

Measures

The CBCL is an internationally used instrument designed to record children's competencies and problems as reported by their parents. In this study the internalizing, externalizing and total problems scores were used as child outcome variables. The CBCL problem score is a sum score of problem items concerning withdrawal, somatic complaints and depressed/anxious symptoms, whereas the externalizing score is a sum score of problem items concerning delinquent and aggressive behavior. The raw scores of each sum score and the total score have been turned into T-scores. In the analyses we used two cut off points, 60 and 64, with 64 being the lower limit of the clinical range.

Statistical analyses

Differences between groups were tested with Fisher's T-test and chi

Table 1. The comparison of the study sample and drop-out families on Group and Need status demographic variables.

	Study sample T3 (n= 92)	Drop-out families T3 (n=55)	p
	N (%)	N (%)	
Intervention Group	47 (51.1)	32 (58.2)	0.2
Comparison Group	42 (48.9)	23 (41.8)	0.2
Need for support	39 (42.4)	31 (56.4)	0.7
No Need for support	53 (57.6)	24 (43.6)	0.7
Child, boy	46 (50.0)	29 (52.7)	0.4
Mother's mean age (sd) at T1	31.3 (5.0)	30.6 (5.2)	0.4
Father's mean age (sd) T1	33.3 (5.9)	33.0 (5.6)	0.8
Child's mean age (sd) T3	2.0 (0.1)	2.0 (0.2)	0.9
Mother married at T1	64 (63.9)	30 (54.5)	0.08
Family SES			
High	25 (27.5%)	13 (24.5%)	0.5
Middle	44 (48.45)	22 (41.5%)	0.3
Low	22 (24.2%)	18 (34.0%)	0.7

Table 2. Background variables by group status.

Background variable	Intervention Group	Comparison group	p
	(N= 47)	(N= 42)	
	N (%)	N (%)	
Both parents in the family	39 (78.0)	41 (91.1)	0.07
Number of children in the 1-2	33 (70.2)	30 (68.2)	0.5
Child in daycare	44 (88.0)	29 (39.7)	0.006
Mother employed	38 (76.0)	22 (56.0)	0.07
Mother's health good	31 (62.0)	28 (62.2)	0.5
Father's health good	35 (72.9)	29 (67.4)	0.4
Regular visits to a doctor, mother	17 (85.0)	14 (66.7)	0.15
Regular visits to a doctor, father	14 (87.5)	9 (39.1)	0.02
Mother's mental health good	40 (80.0)	33 (75.0)	0.4
Father's mental health good	41 (85.4)	32 (74.4)	0.14
Satisfied with well-baby clinic	23 (47.5)	21 (47.7)	0.6
Satisfied with support from well-baby clinic	29 (58.0)	29 (65.9)	0.3

Table 3. Mean T-scores of the CBCL and proportion of children scoring above or near clinical range by group in the two year outcome measurement.

Measure	Intervention Group	Comparison Group	p-value
2 year assessment	N= 73	N= 57	
CBCL	Mean (std)	Mean (std)	
Internalising T-score	43.8 (8.7)	43.2 (8.2)	0.7
Externalising T-score	48.8 (7.8)	49.0 (8.2)	0.9
Total T-score	47.6 (8.4)	47.2 (8.8)	0.8
	N (%)	N (%)	
Total T-score, clinical range	0	0	
Total T-score above 60	5 (6.8%)	3 (5.3%)	0.4

Table 4. Mean T-scores and the proportion of children scoring above the two cut off points by Group status.

Variable	Intervention Group	Comparison Group	p
5-year measurement	N= 51	N= 45	
CBCL	Mean (sd)	Mean (sd)	
Internalising symptoms T-score	46.5 (9.6)	47.0 (8.7)	0.5
Externalising symptoms T-score	50.4 (9.8)	51.9 (9.6)	0.3
Total T-score	49.2 (10.8)	49.9 (10.3)	0.5
	N (%)	N (%)	
Internalising T-score 64 or above	3 (5.9)	0	0.6
Internalising T-score 60 or above	6 (11.8)	5 (11.1)	0.6
Externalising T-score 64 or above	5 (9.8)	4 (8.9)	0.6
Externalising T-score 60 or above	7 (13.7)	6 (13.3)	0.6
Total T-score 64 or above	2 (3.9)	2 (4.4)	0.7
Total T-score 60 or above	5 (9.8)	6 (13.3)	0.4

square when appropriate, and with Mann-Whitney U- test when variables were not normally distributed.

RESULTS

Comparison of background variables between Intervention and Comparison Group

A comparison of background variables between the Intervention and Comparison Groups revealed three significant differences: A greater proportion of mothers (76%) in the Intervention Group worked outside home, compared to 50% of the Comparison Group mothers ($p = 0.008$); A greater proportion of children in the Intervention Group (88%) were in day care at the age of five, compared to 64% of the children in the Comparison Group ($p = 0.006$); and a greater proportion of fathers had regular visits to a doctor in the Intervention Group (87%) compared to 50%

in the Comparison Group ($p = 0.03$).

Maternal reports of children's symptoms

In the two year assessment with the CBCL no significant differences were found between Intervention and Comparison Group on how much problems or symptoms mothers reported about their children. None of the children scored in the clinical range in the total score of the CBCL at this time point. (Table 3). Five children in the Intervention Group and three in the Comparison Group scored above the cut off point of 60.

In the five-year follow-up no significant differences were found between the Intervention and Comparison Groups children in CBCL T-scores or in the proportion of

children scoring above the two chosen cut off points of 60 and 64. However, in contrast to the two year assessment, at this time point four children scored in the clinical range (64 cut off) on the CBCL total problem behavior score (Table 4).

DISCUSSION

The results reported in this paper pertain only to the Finnish sample within the larger EEP two-year intervention study. The aim of the current study was to see whether the effects of the work of the trained nurses during the EEP could be seen three years post intervention when the children were five years-old.

The main results in the Finnish sample in the outcome measurement of the EEPP-study, when the children were two year-old, were seen in maternal mental health, child health and in mother-infant interaction. Finnish mothers in the Intervention Group had had significantly less mild depressive episodes during the original study, and the children in the Intervention Group families had less chronic and severe health problems (Davis et al., 2005). Intervention Group mothers had become more reciprocal in their interaction with their infants, and offered more variation and stimulation for their infants, whereas no change was seen in the Comparison Group mothers (Puura et al. 2005). At the outcome measurement when the infants were two years-old the Intervention Group mothers were similar in interaction with their children as the Comparison Group mothers, although they had initially been significantly poorer (Puura et al., 2005).

In addition to the measures used in the EEPP, all mothers in the Finnish sample filled in CBCL forms as a part of the outcome measurement at two years. Perhaps reflecting the change in interaction behaviour of the Intervention Group mothers, there were no significant differences between maternal reports of the children's symptoms in the Intervention and Comparison Group families in the CBCL.

In the five year follow-up measurement children in the Intervention Group were not different from Comparison Group children according to maternal reports. Contrary to our expectations, the Intervention Group children were not doing better than the Comparison Group children, meaning that there was no "sleepier effect" as has been seen in some intervention studies. The results may mean that the intervention had no impact on Intervention Group mothers' perception of their children, at least not after the intervention had stopped when the children were two years old. Considering the initial situation where the Intervention Group mothers had poorer mental health and poorer interaction skills, the result can also be interpreted positively in the sense that the improvement seen in the Intervention Group mothers behaviour towards their children at two years was likely maintained, since

the children were doing as well as the Comparison Group children. However, it seems that further improvement of the Intervention Group families would have needed continuing support.

Our hypotheses on better maternal mental health in the Intervention Group was also not supported. In the initial baseline measurement there were more mothers with mental health problems in the Intervention Group (Davis et al., 2005). In the five year follow-up mothers reported how they felt about their own and their spouses mental health. That there were no significant differences between the groups can be interpreted as a positive result of the two year long support from the well baby clinic nurses in the Intervention Group, but again no further improvement was seen after the support ended.

There are some limitations in this study that have to be considered. The size of the study sample was relatively small due to attrition, with 53% of the original subjects participating in the five-year follow-up. In follow-up studies attrition is inevitable due to people migrating to other areas in the country and to people being reluctant to participate in recurrent assessments. In this study a slight majority of the original subject participated in the five-year follow-up measurement. In attrition analyses the drop-out families were not significantly different from the participating families, and the remaining sample represents the original sample well.

Another limitation of the study is the use of questionnaires. Although the CBCL is internationally widely used and well validated, the information it yields is limited compared to more intensive interview methods. The use of mothers as respondents limited the information to maternal reports, giving only mothers' perception of their children and of children's fathers. Some of the questionnaires also had missing answers limiting the amount of data on these variables.

CONCLUSIONS

The initial intervention carried out in the EEPP-study supported mothers who were poorer in the interaction with their infants while it lasted and none of the mothers in the initially poorer Intervention Group reported

their children having problems at clinical level at the age of two (Puura et al., 2005). However, no sleeper-effect was found after the end of the intervention, and in the five year follow-up the rate of children scoring above or close to clinical range had increased and was similar in the Intervention and Comparison Groups. In conclusion, it is likely that preventive interventions support better parenting under their duration but do not necessarily provide long-lasting help for parent-child problems.

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Addressing Challenging Behavior in Infants and Toddlers: The Center on the Social and Emotional Foundations for Early Learning

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Jamal, age 17 months, began attending the Bright Baby Child Care Center 8 weeks ago. In these initial weeks at the center, Jamal has spent much of his time crying. He frequently hits and bites other children and the caregivers. He has had difficulty falling asleep; often he does not nap at all. Jamal's primary caregiver, Ms. Gatson, doesn't know what to do. Nothing she has tried seems to help. Ms. Gatson is particularly worried about him biting other children. She is also worried about her ability to provide sufficient attention to the other children while trying to help Jamal. Ms. Gatson has been thinking about talking to her supervisor about telling Jamal's mother that the Bright Baby Child Center might not be a good fit for Jamal. Ms. Gatson knows she needs to talk to her supervisor, but she is worried her supervisor will think she is a bad teacher.

Prior to coming to the center Jamal was cared for by his grandmother while his mother worked full time. Jamal had little prior contact with groups of young children, but he had never bit or hit other children. Since attending the center Jamal has been having difficulty eating and sleeping at home. His mother, Malena, asked her pediatrician for guidance; the pediatrician responded that Jamal might be "stressed" and suggested child care may be too much for him. Malena is not sure what to do. She needs care for Jamal, yet she is concerned about the toll it seems to be taking on him.

THE IMPACT OF CHALLENGING BEHAVIOR

In the absence of focused support, Jamal may be asked to leave his child care center. If he stays in the child care program and his behaviors persist, his relationships and his development may suffer. Jamal's peers may begin to ostracize him, or perceive him to be a poor playmate that they would rather avoid, or both. Jamal's teacher may become overwhelmed by his behavior and begin to treat him with impatience, frustration, or harshness. In addition, Jamal may likely experience his mother's stress in the way she interacts with him, cares for him, and speaks about him.

The potential impact of Jamal's challenging behavior on his social-emotional development is significant. He may come to believe relationships are stressful and difficult. Jamal may develop negative associations with other caregivers, child care, or school. He may develop an idea that the world is an unsafe and unsatisfying place where he does not fit in. Jamal may develop negative thoughts about his self-image and identity such as, "I cannot be soothed," "I have needs that cannot be met," "I am a person others cannot understand," and, perhaps, "I am not worth being treated well or of having satisfying relationships with

others." Jamal's behavior problems contribute significantly to his mother's worry, her level of stress, and the general quality of family life.

It is unclear from this brief scenario whether Jamal's behaviors represent developmental or transitional issues, issues in the care environment or relationships, or issues internal to Jamal. Jamal's experiences likely reflect a combination of all of these interactional experiences. Although there is increasing consensus that social-emotional and behavioral problems exist in infancy and toddlerhood (Zeanah, 2000), relatively little is known about the course and persistence of such early emerging social-emotional and behavioral problems (Briggs-Gowan, Carter, Bosson-Heenan, Guyer, & Horwitz, 2006). What is clear in this scenario is that Jamal, his teacher, Ms. Gatson, and his mother, Malena, need support and strategies to navigate this complex situation.

PREVALENCE OF SOCIAL-EMOTIONAL AND BEHAVIORAL PROBLEMS

Unfortunately, situations like Jamal's are all too common. The Michigan Child Care Expulsion Prevention

ZERO TO THREE Corner

The Center on the Social and Emotional Foundations for Early Learning (CSEFEL) is a federally funded national resource center designed to support early care and education (ECE) providers in addressing the social-emotional needs of children birth through age 5. Recent research has found that an extraordinarily high number of young children are being asked to leave early childhood settings because of their behavior. In the article below, the authors describe the Pyramid Model, a framework of recommended practices to help ECE programs support the social-emotional competence of young children and address challenging behavior.

Initiative, one of the country's few programs dedicated explicitly to the prevention of expulsion of very young children, reported that 67% of referrals they received in 2006–2007 were for children birth through age 3 years (Mackrain, 2008). Additional data suggest that an estimated 10%–15% of 1- and 2-year-old children experience significant social-emotional problems (Briggs-Gowan, Carter, Skuban, & Horwitz, 2001; Roberts, Attkisson, & Rosenblatt, 1998). Other data similarly suggest that 12% to 16% of the total population of children from birth to 3 years old exhibit challenging behavior (Boyle, Decouflé, & Yeargin-Allsoop, 1994; Campbell, 1995). Yet, fewer than 8% of 1- and 2- year-olds with social-emotional problems receive any developmental or mental health services (Briggs-Gowan, Carter, Wachtel, & Cicchetti, 2004). From an early intervention perspective, Danaheer, Goode, and Lazara (2007) found that in 2006 only 2.41% of the national population of children from birth to 3 years received services and supports through the early intervention system.

Perhaps the fact that so few young children with social, emotional, and behavioral problems are identified and receive services offers partial insight into why 4-year-olds in Pre-K programs are expelled at a rate three times that of all children in grades K-12 (Gilliam, 2005). In most cases, challenging behavior develops over a period of time in the context of children's relationships and environments. On the basis of prevalence data, it is possible that many of the children expelled at age 4 could have been identified with proper screening and assessment tools in earlier years of their development.

NEED FOR ADDITIONAL INFORMATION FOR PARENTS AND TEACHERS

Despite an increasing trend in the number of young children with challenging behavior, many teachers of young children feel ill-equipped to meet the needs of children with challenging behavior (Fox, Dunlap, Hemmeter, Joseph, & Strain, 2003). Early childhood teachers report challenging behavior to be their number-one training need and

report that challenging behavior negatively affects their job satisfaction (Hemmeter, Corso, & Cheatham, 2006).

Similarly, parents are often unsure how to respond to their children's challenging behavior. Frequently parents worry about how to meet their child's needs while also meeting work responsibilities and other family and personal obligations. Parents may be put in a position where their child's needs are at odds with their work responsibilities. Parents rely on family, friends, pediatricians, and their child's teachers for guidance and advice; however, information and services for very young children with challenging behavior are not widely available. In fact, in a study exploring the experiences of parents of young children (from 25 to 43 months of age) with challenging behavior, many of the parents considered information provided by pediatricians to be inadequate; parents reported that pediatricians often suggested that the children's challenging behavior reflected a normal range of functioning for the child's age, and/or that the child would grow out of the behavior (Worcester, Nesman, Raffaele Mendez, & Keller, in press).

THE CENTER ON SOCIAL EMOTIONAL FOUNDATIONS FOR EARLY LEARNING

The Office of Head Start and the Child Care Bureau recognized the need for a national resource center to support early educators in addressing the needs of children expressing challenging behavior in the classroom. The Center on the Social and Emotional Foundations for Early Learning (CSEFEL) was initially funded in 2001 to develop materials and resources to assist teachers in supporting the social-emotional development of children ages 2 to 5 years and addressing challenging behavior. In 2006, CSEFEL was funded again with an explicit focus on expanding the model and materials to address the needs of early educators working with children from birth to 2 years old.

The CSEFEL approach to understanding and addressing

challenging behavior in young children is designed to build the capacity of teachers and parents to support the social-emotional development of all young children. The Pyramid Model for Supporting Social-Emotional Competence in Infants and Young Children provides a conceptual framework for organizing effective practices for promotion, prevention, and intervention. The four levels of the Pyramid Model are, from bottom to top: Nurturing and Responsive Relationships, High Quality Supportive Environments, Targeted Social Emotional Supports, and Intensive Intervention. The base of the Pyramid, Effective Workforce, reflects the importance of providing support and training to providers in order to support them in implementing the Pyramid practices.

EFFECTIVE WORKFORCE

The foundation of any effective organization is an effective workforce. A well-supported, well-qualified workforce is even more critical in programs serving infants and toddlers where the quality of children's care and education is largely based on their interactions and relationships with their caregivers (Kagan, Tarrant, Carson, & Kauerz, (2006). Working to promote children's social emotional development and to prevent and address challenging behaviors requires that programs have a number of systems and policies in place to support the adoption and maintenance of evidence-based practices (Hemmeter, Fox, Jack, & Broyles, 2007). Programs should develop formal and informal strategies that are individualized to promote each staff's ongoing professional development. Staff members should know the specific procedures to request support and share concerns, and they should have access to timely and qualified support in response. Staff members should have regular opportunities to reflect on their practices and their own sense of well-being, and to offer feedback and suggestions.

There are a number of leadership strategies that support developing an effective workforce to support young children's social-emotional development. A leadership and administrative team should

- Demonstrate a commitment to promoting all children's social and emotional development;
- Regularly recognize and acknowledge staff efforts and contributions;
- Involve staff in shared decision making;
- Articulate the program's expectations and goals;
- Work to ensure that staff at all levels of the organization are accountable;
- Use data to make continual program improvements;
- Recognize that changing practice is challenging; and
- Maintain enthusiasm, passion, and direction for enhancing staff competency and quality children's services.

NURTURING AND RESPONSIVE RELATIONSHIPS

The foundation for promoting social-emotional development in young children is characterized by responsive relationships and high quality environments. Very young children learn what relationships look and feel like by participating in and observing relationships with others. Interactions between children and staff, parents and children, staff and parents, and among staff are all critical to consider when thinking about promoting children's social-emotional development. Young children develop their self-image and their beliefs about the world and the people in it based on their early relationships with their caregivers. Children who have positive relationships, self-confidence, and social skills are less likely to engage in challenging behavior. Similarly, very young children are more likely to respond to caregivers with whom they have developed a positive trusting relationship.

Caregivers who have nurturing and responsive relationships with children in their care often engage in practices such as

- Maintaining frequent and close eye contact with children;
- Acknowledging children's efforts;
- Providing praise and encouragement to children and their parents;
- Smiling and warmly interacting with children, using positive language at all times;

PRACTICES TO SUPPORT AND ENHANCE RELATIONSHIPS WITH CHILDREN AND FAMILIES

- Ask parents about their child's needs, interests, routines, and preferences.
- Talk frequently with the child's parents about their caregiving practices at home (e.g., how do they feed the infant? How do they put her to sleep?).
- Communicate with children and families in their home language.
- Communicate daily with families about the child's activities and experiences (e.g., display photographs of each child's family at the children's eye level).
- Welcome families and encourage them to stay or visit anytime.
- Develop rituals with families and children at "drop-off" and "pick-up."
- Encourage breast-feeding and offer private, comfortable spaces for breast-feeding.
- Conduct home visits.

- Responding to children's vocalizations and communication attempts;
- Frequently using language to talk about emotions, experiences, and the environment;
- Using significant amounts of physical closeness (e.g., holding children, sitting next to children at their level, rocking children);
- Holding infants while feeding them a bottle; and
- Spending time on the floor with children.

Organizational practices such as continuity of care, primary caregiving, using everyday experiences and routines to guide the curriculum, and low caregiver-to-child ratios set the stage for caregivers to form close and secure relationships with children and their families. Individualizing care by uniquely responding to each child's temperament (e.g., allowing a child who is slow to warm up more time to watch an activity before he joins in), interests, strengths, needs (e.g., carrying an infant who is used to being held frequently in a baby carrier or sling), and individual sleeping, feeding, and playing rhythms helps caregivers get to know each child and be responsive to his individual needs.

When providers make an effort to communicate and develop relationships with each child's family, they demonstrate that they understand and respect the key role the family plays in shaping how their children learn about themselves and their emotions and develop their own way of interacting and relating to others (National Research Council & Institute of Medicine, 2000). Establishing a trusting relationship with each family early ensures that if a child does exhibit challenging behavior it can be addressed openly in the context of an existing trusting relationship. In addition, systems that serve infants and toddlers and their families have the opportunity to positively contribute to a family's social support network and to reduce the level of stress families may experience (Gowen & Nebrig, 2002; Seibel, Britt, Gillespie, & Parlakian, 2006).

There are a number of concrete practices that can assist caregivers in developing and maintaining responsive nurturing and supportive relationships with families (see box, Practices to Support and Enhance Relationships With Children and Families).

HIGH QUALITY ENVIRONMENTS

High quality environments facilitate children's ability to safely explore and learn. High quality environments facilitate positive interactions among children and between adults and children. In addition, physical environments that are well designed (e.g., changing tables placed where caregivers can see other children, sinks next to the changing tables, child-sized toilets in the restroom, ample space for children to move and play, sufficient storage) and well-supplied (e.g., adult-sized furniture and child-sized furniture, plenty of materials) facilitate caregivers' ability to successfully care for children and help caregivers feel comfortable and valued (see box, Characteristics of High Quality Environments).

TARGETED SOCIAL EMOTIONAL SUPPORTS

Essential social-emotional skills include cooperating, sharing, turn taking, engaging with and getting along with others, regulating/managing emotions, expressing emotions, listening, recognizing emotions, taking the perspective of another, empathizing with others, and using words and gestures to resolve conflicts. The development of these skills starts early (infants as young as 7 months can recognize a discrepancy between a caregiver's tone and facial expression (Grossman, Striano, & Friederic, 2006). Responsive flexible routines and systematic approaches to teaching social-emotional skills can have a preventive and remedial effect on young children's social-emotional development.

There are many ways to support young children in learning and developing social-emotional skills. Caregivers who are intentional and purposeful provide multiple and diverse opportunities throughout the day for young children to observe, experience, and practice their social-emotional skills. Children with strong social-emotional skills have fewer challenging behaviors

USING ROUTINES

Caregivers can use routines such as feeding and diapering to provide each child with one-on-one time for interacting, bonding, and engaging in relationships (i.e., demonstrating relationship skills). Caregivers of older toddlers can engage children in developing social skills by sitting with them during eating and encouraging conversations about the food or experiences (versus hovering over them). Toddlers benefit greatly from predictable yet flexible routines that help them to feel safe and secure in knowing what is coming. As children feel comfortable in their routine and in their surroundings they are able to explore and learn.

DEVELOPING SELF-REGULATION

Through relationships with their caregivers very young children begin

CHARACTERISTICS OF HIGH QUALITY ENVIRONMENTS

- Safe and free from hazards
- Clean and free of clutter
- Inviting, interesting, and aesthetically pleasing
- Natural light with windows
- Comfortable spaces for adults to sit with and/or hold children (e.g., adult-sized couch, rocking chair, mat with large pillows to lean up against)
- Quiet soft spaces for children to be alone and/or interact with one other child (e.g., a nest with a blanket over it, a loft space or box for two children to crawl in)
- Children's art work at eye level
- A space for developmentally appropriate toys and manipulative items at children's level so they can reach them
- Mirrors at children's level so they can see themselves
- A space for reading to children and places for infants and toddlers to reach books and look at them
- Space and materials for sensory exploration
- Space and materials for development of gross motor skills (e.g., floor space so children can move freely about, ramps and short climbers, balls of all sizes, rocking boats, tunnels to crawl through, a bar fastened to the wall at various levels to accommodate multiple children attempting to stand, slides and climbers that invite peer interaction)
- Space and materials for dramatic play (e.g., hats, scarves, purses placed at children's levels; child-sized kitchen furniture and utensils; multi-ethnic dolls, baby bottles, bed and blankets)
- Spaces and materials appropriate for children's ages (i.e., developmentally appropriate, individually appropriate, and culturally appropriate)

to recognize and regulate their own feelings. As caregivers respond when children are hungry and when they indicate they are satisfied or want to stop eating, children learn to recognize and respond to their own feeling states. When caregivers tune in to a child's cues for how much stimulation he may need and respect when he is uninterested in interaction, a child begins to learn how to regulate his own emotions and interests. When caregivers respond to children's attempts to communicate individual needs consistently over time, children learn that their communication is

meaningful and effective in getting their needs met. Picking up a crying baby, offering soothing touches, rocking, singing, or providing calming words sets the stage for him to develop his own ability to self-soothe. Encouraging older toddlers to notice their feeling states (e.g., "you look so angry right now"), engage in deep breathing, experiment with different feeling expressions and different bodily states (e.g., tense, stiff, loose, relaxed) provides children practice in identifying their own feelings and learning how to calm themselves.

Infants and toddlers also learn about emotions when their caregivers and parents label children's emotions as well as their own throughout the day. Children learn turn-taking when caregivers encourage children to imitate their actions such as putting a block in a bucket. When caregivers offer opportunities for young children to help (e.g., set the table, clean up toys and spills) and provide specific praise for helping, children learn social skills of cooperating, being responsible, and contributing to their surroundings. Peek-a-boo and other social games offer children engaging and fun opportunities for give and take in social interaction. Regularly offering children choices (e.g., asking which book they want to read) helps children feel powerful and independent. Following a child's lead in play is another strategy to support children's social-emotional development. When adults allow a child to direct the play, the child learns that his ideas are valued and he is more likely to further initiate, explore, and interact. When problems or conflicts occur between children, caregivers can teach children to problem solve by offering alternative solutions and gradually helping them use problem solving steps on their own.

INTENSIVE INTERVENTION

Even when teachers establish positive relationships with children and families, design and implement supportive environments, and intentionally offer multiple and varied opportunities for children to develop their social-emotional skills, a small percentage of children will continue to need more intensive

and individualized intervention.

One approach to developing individualized plans is called Positive Behavior Support (PBS). PBS recognizes that children's behavior has meaning. "In the last decade research has demonstrated that *positive behavior support* (PBS) is a highly effective intervention approach for addressing severe and persistent challenging behavior" (Fox, Dunlap, Hemmeter, Joseph, & Strain, 2003). It has been described and used successfully with young children including toddlers (Dunlap, Ester, Langhans, & Fox, 2006; Dunlap & Fox, 1999; Fox & Clarke, 2006; Fox, Dunlap, & Cushing, 2002; Powell, Dunlap, & Fox, 2006).

The focus of PBS is to understand the meaning of the child's behavior and help the child and adult discover together more effective means for communicating needs, wishes, and desires. As a result of using a PBS approach, adults develop new ways of responding to children and children develop more effective strategies for communicating what they want or need. Using PBS reduces challenging behavior, enhances relationships between adults and children, and generally helps caregivers and children experience an improved quality of life. Steps in implementing a PBS process include:

- Conduct observations and collect data on the child's behavior and the context in which it occurs in order to identify the function of the behavior.
- Respond immediately to any unsafe behavior.
- Meet with the family to collect information about the child's behavior at home and in the community, share information, and demonstrate a commitment to working together to address the child's needs.
- Convene a team meeting (including family members) to collaborate and design a behavior support plan based on an understanding of the child's behavior in everyday activities and routines.
- Provide support to the caregivers to implement the plan at home and at school.
- Continue to conduct observations and collect data in order to evaluate the plan and ensure the plan is being implemented consistently.
- Set a timeframe and method for

SAMPLE INDIVIDUALIZED BEHAVIOR SUPPORT PLAN

Dean is a social, engaging, active 22-month-old boy. He has just started a group child care program for the first time. When his parents first brought him to the center, they talked with the teacher about their concerns about his behavior at home. His language is delayed. When adults can't understand what he is saying he gets frustrated and starts crying and screaming. He often does not follow directions, especially when he has to change activities. When changing activities (e.g., from playing in the classroom to going outside), he often has temper tantrums and falls to the ground crying. The teacher, center director, and parents are all committed to developing a plan to help him be successful. On the basis of several observations, they determine that Dean has challenging behaviors most often when (a) he is asked to transition to another activity; (b) he is engaged in an activity that is difficult; and/or (c) he is asked to follow directions to do something he does not appear interested in. The team hypothesizes that when tasks are challenging and/or when he doesn't want to do something he attempts to avoid the activity. The team works together to develop a plan based on their observations and discussions. The strategies below address Dean's difficulty with transitions. Similar plans are developed for following directions and engaging in difficult tasks. These plans can be used at home or at child care.

Goal: To improve Dean's ability to transition from one activity to another.

Prevention Strategies

- Provide him with a picture schedule to help him understand the transition.
- Use a timer to help him prepare for the transition.
- Use simple language to warn him that a transition is about to happen.
- Include times on the schedule when he can do the things he really likes to do.
- Write a short story about what he should do during transitions and read it to him each day. Include photos of Dean and the classroom to provide illustrations of what he should do during transitions.

New Behaviors

- Teach him to use the visual schedule (i.e., turn over the photo of one activity in preparation for the next activity).
- Teach him to transition when the timer sounds; practice transitioning at times when he is not upset.

Adult Responses/Support

- Provide positive descriptive feedback when he uses his schedule and when he transitions without having a tantrum.
- Validate his feelings.
- Refer to the schedule to help him through transition.
- Stay physically close to provide support and encourage him through small steps of the transition.
- Have a peer bring him something related to the next activity (e.g., a ball for outdoor time).
- Use "first, then" statements, (e.g., "first we change your diaper, then we can go outside").

evaluating the plan and changes in the child's behavior.

- If challenging behavior persists,
- Determine whether the plan is being implemented as designed.
 - Conduct additional observations to determine whether the team correctly identified the meaning of the child's behavior.
 - Determine whether the plan needs to

be revised.

- Determine whether additional evaluations, assessments, supports, or professional expertise are needed. Individualized plans are developed based on a comprehensive assessment process that includes observation, interviews with significant others, and the reviewing of records. The assessment should include:
 - Information from the family

- The parent's view of the behavior and parents' current responses to the behavior
- Family history
- Significant changes in family composition and/or other relationships
- A review of the child's developmental and medical history
- Family circumstances
- Level of stress, etc.
- Information and data on the behavior
- Frequency, intensity, and duration; function of the behavior
- What happens before and after the behavior
- The setting and context in which the behavior occurs, etc.
- An assessment of the child's interests, strengths, and development
- Observations of the child in multiple environments
- Results from any screenings or other assessment

The goal of the assessment process is to identify the function or purpose of the child's challenging behavior. Individualized plans should be designed based on an understanding of the individual child's behavior and should include prevention strategies, new skills to teach the child, and strategies for changing or modifying the way adults respond to the challenging behavior. Plans can be designed for the child care center and/or for the home. The most effective plans are those that are consistently implemented by all the caregivers in a child's life. A sample of a behavior plan for a toddler is provided (see box, Sample Individualized Behavior Support Plan).

Providing care to children with challenging behaviors is hard work and can be stressful for caregivers. Any individualized planning efforts should consider the stress level and emotions of the caregivers. Caregivers implementing individual behavior plans need and greatly benefit from opportunities to: reflect on their experience, share concerns and beliefs, gain support, and receive positive recognition for their efforts and accomplishments.

PUTTING THE PYRAMID MODEL INTO PRACTICE

The following is an example of how

TRAINING MODULES FOR PROMOTING THE SOCIAL AND EMOTIONAL COMPETENCE OF INFANTS AND TODDLERS

Module 1: Social-Emotional Development Within the Context of Relationships

Module 2: Responsive Routines, Environments, and Strategies to Support Social-Emotional Development in Infants and Toddlers

Module 3: Individualized Intervention with Infants and Toddlers: Determining the Meaning of Behavior and Developing Appropriate Responses

Each of the three modules includes a presenter's script, PowerPoint slides, accompanying handouts, and video clips. A facilitator's guide is available. The training modules as well as additional resources are downloadable (www.vanderbilt.edu/csefel) and may be copied and distributed freely.

the CSEFEL Pyramid Model can be used in an infant toddler classroom to support social-emotional competence.

Ms. Little, the administrator at Palm Tree Child Development Center, helps Ms. Powell, an infant toddler teacher, warm a bottle and set out food for the children. It is the beginning of the year and Ms. Little wants to ensure that the infant and toddler teachers have the help they need to communicate effectively with each child and parent upon arrival (Effective Workforce).

When Theo, age 6 months, arrives at the center, Ms. Powell gently takes him from his mother. She nuzzles him close and smiles at him, telling him how much she missed him over the weekend. As she holds him close to her she asks his mother, Tori, how her weekend was. She asks Tori about Theo's sleeping and eating patterns and the progression of his teething. Ms. Powell then talks a bit to Theo about the classroom and his favorite areas to play in. As Tori leaves, she smiles to herself thinking how lucky she is to have Theo cared for in such an interesting environment by a teacher who really loves him (Nurturing and Responsive Relationships and High Quality

Supportive Environments).

Ms. Powell holds Theo on her lap while she feeds him a bottle. With Theo on her lap she sits at a child-sized table with two toddlers who are practicing feeding themselves. As she feeds Theo, she engages all the children in conversation about what they are eating. One of the children, Lizzy, pushes her food away and makes an angry face. Ms. Powell says, "Lizzy, you look angry. Are you finished with your food? Can you say, 'all done'?" Lizzy imitates Ms. Powell's words. Ms. Powell responds, "Great job trying to use your words, Lizzy. If you are done eating you can go ahead and play with the toys from the shelf" (Targeted Social Emotional Supports).

Ms. Powell has been a bit worried about the behavior of another child, Sarah. Lately she has noticed a change in how readily Sarah has been hitting and biting to try to get what she wants. Ms. Powell, Ms. Little, and Sarah's parents have been keeping in close communication about Sarah's behavior and may soon develop an individualized behavior plan for home and school in order to try to strategically prevent and address the behavior. They all agree that a plan will help them better understand Sarah's behavior and find the most effective ways to prevent and respond to it (Intensive Intervention).

Three training modules have been developed to support caregivers in addressing the social-emotional needs of infants and toddlers. These modules reflect the three tiers of the Pyramid, with Module 1 focusing on the bottom tier, Module 2 focusing on the second tier, and Module 3 focusing on the top of the pyramid. (see box, Training Modules for Promoting the Social and Emotional Competence of Infants and Toddlers).

SUMMARY

I am so frustrated by these behaviors. Some days I feel so incompetent, I just want to quit!

Sometimes I cry, not because he is hurting me but because I don't know what to do for him.

Although these quotes are from teachers with whom we have worked, they are not unusual. In our work with early childhood providers in a variety of settings, we hear these kinds of comments on a regular basis. Teachers are frustrated by infants and toddlers with challenging behavior and feel that they lack both the direction and support to help them respond appropriately. Their frustrations affect their job satisfaction and no doubt affect their interactions with children and families. In this article we have described a model that addresses teachers' need for effective practices and supports teachers in implementing those practices. The Pyramid Model offers a set of practices for promoting social-emotional development and addressing challenging behaviors in all young children. Implicit in the model is the recognition that program policies and procedures must be in place to provide supports to teachers in implementing these practices. In this model, addressing the social, emotional, and behavioral needs of young children is a program responsibility rather than only the teacher's responsibility. Staff whose programs have fully implemented the Pyramid Model have described changes in the day-to-day operation of the program. In the words of one teacher, "The pyramid model was difficult at first, but the more you use it, the better it is—and it is life-changing."

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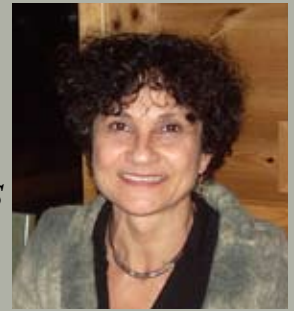
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EDITOR'S PERSPECTIVE

*Interventions outcomes in Infant Mental Health:
Using deceptions and failures to think and understand more and do better...*



By
Miri Keren, M.D.
Editor, *The Signal*

Our field of Infant Mental Health is, basically, almost by definition, led by optimism and conviction that early therapeutic acts will prevent psychopathology in the child, through targeting maladaptive parental behaviors and distorted caregivers' perceptions of their infants. It is therefore not surprising to read more about positive outcome studies than negative or inconclusive ones.

When we start with a preventive, comprehensive and well-designed program, such as the CAPEDP (Guedeney et al, in this issue) with isolated high-risk mothers in Paris, or with new adoptive parents in Montreal and in Tel-Aviv (St-André & Keren, Yokohama WAIMH conference, 2008), we may be *a priori* convinced we will find a significant difference between the control and intervention groups. We actually may, but we may not, as the Finnish team (Hermans and Puura in this issue) have not.

While looking at continuities and discontinuities of psychopathology, one may need to look more at the continuity and discontinuities of the risk and protective factors, instead of at the psychopathology itself. In that sense, when we design intervention outcome studies, we may benefit from looking at the course of the risk and protective factors as themselves, and not only at the children's and parents' behavioral outcomes. The intervention is supposed to act as a protective factor, but still it is one among others, and it may be counterbalanced by on-going or new risk factors in either the child, the parents and/or their environment. For instance, preliminary results of an 6-8 years follow up of children who have been treated at our Unit in Tel-Aviv, show that the only factors that seem to differentiate between the better and worse outcome groups, are maternal self-esteem and somatization levels.

This result, if final, may lead to the conclusion that we do need to continue our early childhood interventions, but not necessarily with the child, and may be more targeted at identified parental risk factors.

Long term follow-up and comparative studies of our various primary, secondary and tertiary types of interventions, like those described in this double issue, are, in my view, a crucial step in the development of our growing-up domain of infant mental health. This is a main requirement for going on advocating for investment of public resources in these times of wide financial cuts in health care.



Literature Monitor

BOOK REVIEW

*Finding hope in despair:
Clinical studies in infant mental
health, Edited by Marian Birch,
Zero to Three, Washington D.C.,
2008*

Reviewed by Margaret Rossoff

Despite the potential of infant-parent psychotherapy to modify distorted projections and reset skewed developmental trajectories, early childhood mental health therapists frequently find ourselves in situations where such change is unlikely despite our best efforts. "At times, we find ourselves working with children whom nobody wants or even sees, and with parents whose capacities for attachment are mortally wounded, in communities with few if any appropriate services for the families of infants," (p. 8) writes Marion Birch in her introduction to this extraordinary book, an exploration of six treatments that were "heartbreaking failures."

Tackling the taboo of clinical failures, naming the odds against success for many at-risk families, this is an important book for clinicians working with families of very young children. Experienced therapists will appreciate the complexities tackled by the authors, while new therapists will benefit from the book's realistic assessment of difficulties as well as its demonstrations of clinical self-awareness at its best.

Six clinicians each write a chapter about their work with, and feelings about, a family they tried to help with disappointing outcomes. Susan Sklan's work with a 16-year-old mother had a promising beginning; the mother asked for therapy while pregnant. But Sklan's and mother's good intentions were not enough in the face of the mother's history of unresolved trauma, the instability of her living situations and Sklan's professional isolation.

Marion Birch worked for four years with Ben, a two-year-old boy who, after a sadistically deprived infancy, was lucky to have sensitive, caring

adoptive parents. Many clinicians will resonate with Birch's response to Ben's incessantly aggressive play scenarios, "grafting themes of rescue and comfort onto his dramas." (p. 89) Ultimately, however, Ben did not adjust to his new home. Birch wonders whether she, as well as Ben's parents, lacked "the courage or wisdom to go with Ben into that terror-filled world he came from." (p. 94) If she had gone there, could the outcome have been different for this family?

Richard Ruth describes the vicissitudes of a White therapist working with a Black family whose children are in foster care. For Julie Stone, a mother's projections onto her child lead to the question: "Do we, and did I, flinch from thinking about hate because I was afraid of my own hate and destructive potential?" (p. 171) Martin Maldonado-Duran's work invites thinking about cultural clashes between the expectations of family members and the therapist. Toni Vaughn Heineman faces her sense of responsibility for a child in the foster care system who has no one caring for her. Heineman writes, "When we are confronted with the vacuum of maternal care that engulfs children in foster care it surely stirs a primitive panic in us." (p. 242)

These brief introductions may convey some of the range of this remarkable volume—the variety of clinical challenges and the integrity with which the contributors examine their work and their feelings about the work. Each chapter is followed by a reflection written by another contributor to the book, adding additional layers of understanding to the complex dilemmas of the treatment. In her masterful concluding chapter, the editor, Marian Birch, extracts eight "threads" that run through the cases and explores the impact of these issues on the six therapies. The thoughtful reflections, first by the clinician, then by the colleague offering commentary and finally by the editor, implicitly invite the readers to think deeply about our own work and to share our reflections with our colleagues.

It may seem paradoxical that a book about well-intentioned and experienced therapists doing hard work with disappointing outcomes is ultimately encouraging rather than disheartening. In part, this is because of the relief at having our challenges named and assessed for what they are. Just as our clients may feel supported by empathic identification of their troubles, we are strengthened by the acknowledgement of the difficulties we face.

Finding hope in despair is also reassuring because of its perspective that countertransference reactions are inevitable. As Birch points out, "[t]he emotional responses that we as therapist have, when we are exposed to infants in states of activated attachment need, are rooted in our biology and our personal history." (p. 5) The authors in this volume model ruthless honesty in their exploration of their responses, demonstrating how countertransference, when acknowledged, can point to new directions in our work.

The impact of countertransference is only one of many elements that can undermine therapy, including systemic and institutional forces beyond our control, and including the severe disorganization of some of the families we see. A theme in this book is the limitation of a strengths-based approach. In many of these chapters the therapists acknowledge the disservice to their clients of underestimating the depth of their trauma, hatred or internal chaos. An important corollary is the disservice to therapists when we have unrealistic expectations of what is possible for us to do to support a family to change.

Finding hope in despair examines six times when the combination of risk factors in the family, limitations on the therapist and scarcity of social supports lead to therapy with painfully disappointing outcomes. It is both an analysis of the difficulty of therapeutic efforts in such conditions and an example of how reflection leads to understandings that can change future practice. An extremely rich volume that will bear many re-readings, *Finding Hope in Despair* should be in the library of all therapists providing parent-child therapy to at-risk families—and in the curriculum of all training programs for this work.

President's Perspective

Votes for the EC and the Affiliates representative, Editorship of the Infant Mental Health Journal and the next WAIMH congress sites



There is a lot going on in WAIMH now. The first thing is clearly the vote of the membership for nominated people to stand in the EC of WAIMH. This is a major step in our Association, giving the membership more grips to name the Executive committee. We have three people beautifully elected: Kai von Klitzing, from Leipzig, Germany, Campbell Paul from Melbourne, Australia and Deborah Weatherston from Michigan, USA. Kai is currently in charge of the next WAIMH congress in Leipzig, in the summer 2010, and was already in the current EC, thus providing continuity. Kai made several important studies on attachment, has both a psychoanalytic culture and does evidence based clinical research. Campbell Paul is well known by WAIMH members, having organized the Melbourne world congress and several other meetings; he is working on a book on Parent Infant Therapy, has done several works on liaison work for babies in hospital and on transcultural issues. Debbie Weatherston is the current MI-AIMH Executive Director; she took a major role in the process of MI-AIMH putting up an endorsement process which will take more and more importance within WAIMH in the coming years. She was also responsible for editing the WAIMH handbook of infant mental health, which is a robust compilation of knowledge about how to work with infants and family, in continuation with Fraiberg's famous 'Kitchen Table' therapy. Thus, we have three excellent colleagues of us on board, reflecting WAIMH vitality. I wish to thank here the other candidates who ran for the EC and could not get in since only 3 places were available. They are all prominent figures at WAIMH and other associations. They have expressed their willingness to contribute their skills to our association, which we definitely will

keep in mind.

The Affiliates presidents will have to nominate their representative in the EC and this will be done in the coming weeks, after some adjustments are made. The delay is due to the novelty of the process.

Another important issue is the Editorship of the Infant Mental Health Journal. Joy Osofsky made a fantastic job in this position for more than 10 years; she accepted in Paris 2006 to continue and to help at making the transition smooth. The journal under her leadership has become one of the most respected and read in the field, with a fairly good impact factor and inclusion in several major databases. Michigan Association of Infant Mental Health owns the journal, which is published by Wiley & sons and is of course the official journal of the association, whereas the Signal is its newsletter. A search committee was launched under the leadership of Debbie Weatherston for MI-AIMH and received the candidates. Finally, the candidature of Hiram Fitzgerald got all votes and Hiram accepted a three-year term as editor, starting next September, with Neil Boris, Mark Tomlinson, Kai von Klitzing, Holly Brophy Herb, Rachel Schiffman, Tammy Mann and Kim Kelsay as associate editors. Ann Culp will continue the book review part of the journal. Medline inclusion has been submitted by Wiley and we expect to have on line submission fairly soon. Lisa Deveraux will serve as managing editor of the IMHJ. Emphasis will be kept on contributions linking innovative work in neurobiology with infant mental health issues and on increasing visibility for clinical case studies.

Finally we have several important choices to make as soon as possible. We need a Chair of the program committee for the Cape Town congress, with sensitivity to the situation in the country and in Africa. This PC has to start working soon,

as there will be a short time period between Leipzig, in summer 2010 and Cape Town, in March 2012.

For 2014 we also have to make a choice between Jerusalem and Edinburgh. Planning of a world congress is a tricky issue, which needs decisions being taken as soon as possible, for both central office and LOC to start working. We now have quite an expertise in doing so, based on experience and now the central WAIMH office in Tampere is settled and effective. We have two excellent bids. Both are in famous attractive cities, both in Europe or Middle East, very well known all around the world. Both bids are brought up by an active group, backed by a strong WAIMH affiliate organization. The Jerusalem bid has been presented to us by Miri Keren in Yokohama. Sam Tyano is a key person in this LOC, with great experience of world congresses; the LOC is supported by a private foundation which may help effectively. Edinburgh bid is backed by WAIMH UK, a long standing and a major affiliate in our organization. WAIMH UK has organized a very successful conference in Oxford, 10 years ago. Shirley Gracias the past president of WAIMH UK has presented us with the WAIMH UK bid in Yokohama and Catherine Lowenhoff is ready to follow on the bid, with a LOC benefiting from the experience and influence of Colwyn Trevarthen.

The next regional WAIMH congress will take place in Acre, in Israel, next September, organized by Miri Keren, Sam Tyano and the Israeli Affiliate Board (See the WAIMH web site for the program), followed by a 2 days EC meeting with both the 'old board' and the 'new board' in Jerusalem, with minimum expenses for WAIMH. So WAIMH is on the move. We'll keep you posted through the Signal.

Antoine Guedeny

Invitation

It is with great pleasure that we invite you to participate in WAIMH's forthcoming world congress.

The central theme of the Leipzig congress will be „Infancy in Times of Transition“. Transitions are essential to the lives of young children. For the individual infant, there are transitions from intra-uterine to extra-uterine life, from early forms of relatedness to more specific object relationships, from the preverbal to the verbal self, and many others.

Within the family, there are transitions from dyads to triads and to broader family relationships. The city of Leipzig, where I live and work, has seen a major transition of the political system over the last 25 years, from the collective system of a communist dictatorial state to a free market economy and democracy. This change was hard won by the people, but it has also brought some insecurity into family lives. Young children are the first to be influenced by these kinds of social transition. And we, as mental health professionals, try to help families and infants to cope with these changes, which involve opportunity and risk at one and the same time.

We are looking forward to welcome scientists and infant mental health experts from all over the world, in an exchange of scientific research, clinical experience, theoretical thinking and social political ideas. And we promise: because of its great tradition of liberal open mindedness and scientific curiosity, Leipzig will be a good place to meet.

We look forward to seeing you soon

Kai von Klitzing, MD
Professor of Child and Adolescent Psychiatry,
University of Leipzig
Chair of Local
Organizing Committee



12th World Congress of the World Association for Infant Mental Health

WORLD ASSOCIATION FOR
INFANT MENTAL HEALTH

**SECOND
ANNOUNCEMENT**

“INFANCY IN TIMES
OF TRANSITION”

JOHANN
SEBASTIAN
BACH

June 29 – July 3, 2010
Leipzig, Germany
www.waimh-leipzig2010.org

Photos on pages 28-29 © LTS Schmidt

Program Highlights

Plenary Presenters

Louise Emanuel (UK), Hiram Fitzgerald (USA), Alison Fleming (Canada), Kai von Klitzing (Germany), Michael Tomasello (Germany), Mark Tomlinson (South Africa), Charley Zeanah (USA)

Plenary Interfaces

Nicolas Favez (Switzerland), Monika Hedenbro (Sweden), Reija Latva (Finland), James McHale (USA), Vibeke Moe (Norway), Kaija Puura (Finland), Pia Risholm-Mothander (Sweden)

Master Class Presenters

Karl Heinz Brisch (Germany), Sybil Hart (USA), Robert McCall (USA), Mechthild Papousek (Germany), Heidi Simoni (Switzerland), Charley Zeanah (USA)



Local Organizing Committee

Chairs

Kai von Klitzing, Karl Heinz Brisch

Members

Thomas Fabian, Siegfried Haller, Peter Hiermann, Wieland Kiess, Annette Klein, Gabriele Koch, Michael Kroll, Ulrich Milde, Margot Refle, Edelhard Thoms

Program Committee

Chair

Neil W. Boris (USA)

Members

Hiram E. Fitzgerald (USA), Kai von Klitzing (Germany), Pålvi Kaukonen (Finland) and Kaija Puura (Finland).

Scientific Advisors

Mechthild Papousek (Germany), Michael Tomasello (Germany)

Plenary Interfaces

Elisabeth Fivaz-Depeursinge (Switzerland)



Abstract Submission

Go to the Congress Web site at www.waimh.org for detailed instructions and to submit your abstract electronically. The online system opens in August 2009.

- Abstracts (2500 characters) must be submitted in English
 - Abstracts are peer reviewed in a blind evaluation process
 - Accepted abstracts will be published online as a supplement to the *Infant Mental Health Journal*
 - Submission of an abstract constitutes a commitment by at least one of the author(s), if accepted, to present, register, and pay the Congress registration fee
 - Abstract acceptance will be communicated to the senior author and/or primary contact person via email by 15th February, 2010
- Deadline for abstract submission of October 30, 2009.**

General Information

Leipzig

Due to its rich cultural heritage, Leipzig presents itself as a confident and genuinely international city at the heart of eastern Germany. Famous musicians like Johann Sebastian Bach, Robert Schumann, and Felix Mendelssohn were active in Leipzig.

You can still see their influence in the city, for example in St. Thomas Church where Bach – director ‘musices lipsiensis’ – worked as choirmaster of the church’s Boys Choir between 1723 and 1750. During recent years, Leipzig has also become a center of modern art in Europe.

Furthermore, Leipzig’s reputation as a city of trade fairs looks back on more than 500 years of history. Leipzig’s Old Town Hall is one of the most beautiful Renaissance town halls in Germany and Leipzig’s Central Station is the largest terminus train station in Europe. Founded in 1409, the University of Leipzig has produced numerous notable individuals like Johann Wolfgang von Goethe, Gottfried Wilhelm

Leibnitz, Richard Wagner, Friedrich Nietzsche, Werner Heisenberg, and Wilhelm Wundt.

How to get to Leipzig

You can reach Leipzig by plane with direct flights from the cities Frankfurt and Munich (approx. 1 hour). Furthermore, Leipzig is easily accessible by train from Berlin main train station (1 hour), Hamburg main train station (3 hours), Frankfurt Airport (3,5 hours), and Munich main train station (4,5 hours).

For further information on WAIMH 2010, please contact:

Congress Registration, Exhibition, Organisation:

INTERPLAN

E-mail: waimh2010@interplan.de

Website: www.waimh-leipzig2010.org

Scientific program & submitting abstracts:

Contact congress@waimh.org or visit www.waimh.org



Information and news from the Central Office

This is a special issue of the Signal, since it will be posted to all current and former members of WAIMH. The Signal has a new editorial board, you can see members at page two in this Signal.

The WAIMH Central Office is also proud to bring you news of two members being honored. MI-AIMH has honored Hiram Fitzgerald by naming their recently announced award for emerging scholars and researchers the "Hiram E. Fitzgerald Emerging Scholar/Researcher Award". Past-President of WAIMH, Professor Tuula Tamminen received a medal of honor from the Finnish President Tarja Halonen.

The election for the new Board members was carried out, for the first time, electronically. The system worked well and was cost-effective. Altogether 297 out of 925 members 2008/09 took part. The office wants to thank everybody involved.

WAIMH hosts a World Congress every two years, each in a different country. Our 12th World Congress will be in Leipzig, Germany in 2010. The abstract submissions will be open from August 2009 until the end of October 2009. The theme of the Congress is "Infancy in Times of Transition". For more information, please visit <http://www.waimh-leipzig2010.org/>. You can also contact the Associate Executive Director for WAIMH World Congresses, Dr Kaija Puura, at congress@waimh.org. See pages 28-29 for more information.

WAIMH also hosts Regional Conferences. Our next Regional Conference will be in Acre, Israel in 8-10 September 2009. The theme of the Conference is "Updates on Interventions in Infant Mental Health".

For more information, visit WAIMH web-site or e-mail i-doron@zahav.net.il.

For more information see page 31.

We have altogether 930 individual WAIMH members in 2008 or 2009. Yet, only about 450 have registered for this year. Please go to www.waimh.org and renew your membership online.

WAIMH also has affiliate members. For the affiliates we plan to update the affiliate web-pages after the summer season. We also plan to develop a calendar of events on the web-pages.

And last but not least, the new Central Office has been very busy! We receive e-mails to office@waimh.org. We are sorry if responding to some mails is prolonged due to the transfer and summer vacations. All e-mails will be replied to in due course.

Päivi Kaukonen
Executive Director of WAIMH

Minna Sorsa
Administrative Assistant



Photo: Past President of WAIMH, Professor Tuula Tamminen received a medal of honor (16th Feb 2009).

Programme

Tuesday 8/9/09

09.00 – 10.00
Registration

10.00 – 12.00: Parallel Teach-Ins:
Teach-In 1: Circle of Security Group Therapy, Neil Boris (USA)
Teach-In 2: Treatment approaches for severe feeding disorders in Infancy Dalya Benbasa (Turkey)
Teach-In 3: Using a modified Wait, Watch and Wonder therapeutic approach in a pediatric setting Michael Zilibowitz (Australia)

12.00 – 13.00: Light lunch

13.00 – 15.00: Parallel Teach-Ins:
Teach-In 1: Update on therapies during pregnancy, Miri Keren (Israel)
Teach-In 2: Promoting resilience of mothers and infants in a war zone Shlomit Kanotopsky & Najla Asmar (Israel)

15.00 – 16.00
Coffee, Posters,
Free Communication: Vicissitudes of implementing Infant Mental Health services in Morocco Ghizlane Benjelloun (Morocco)

16.00 – 18.00
Opening Ceremony
Greetings: Acre Mayor
Ministry of Health Deputy
Miri. Keren, WAIMH President Elect
Eli Alalouf, Rashi Foundation

Introductory Lectures:
Antoine Guedeney, WAIMH President: New directions of WAIMH
Sam Tyano: Implementing a National Network of Infant Mental Health
Guest Lecture:
Dorit Hopp: "Fairies and Witches in the Nursery"

Wednesday 9/9/09

09.00 - 10.15
Chairperson: Shlomit Kanotopsky, Israel WAIMH president
Opening Lecture: Evidence-based interventions in infancy, Hiram Fitzgerald (USA)

10.15 – 11.30
Maternal Insightfulness into the emotional experience of the child: Its

significance for children's development in normative and high-risk conditions
David Oppenheim (Israel)

11.30 – 12.00: Coffee Break

12.00 – 13.15
Chairperson: Tuula Tamminen (Finland)
The era of video: Uses in Infant Mental Health, Antoine Guedeney (France)

13.15 – 14.15: Lunch & Posters

14.15 – 16.15: Parallel workshops

1. Update on interventions for sleep disorders, and debate around a clinical case, Avi Sadeh Israel, Case presenter: Still to name
Moderator: Mark Tomlinson (South Africa)

2. Bringing in the father, Hayuta Kaplan, Gal Meiri (Israel)
Moderator: Kai von Klitzing (Germany)

3. Direct observation versus video observation, Elisabeth Tuters (Canada)
Moderator: Gary Diamant (Israel)

Optional tour in Acre for guests from abroad

Thursday 10/9/09

09.00 – 10.15
Chairperson: Palvi Kaukonen (Finland)
Ways of how psychological interventions are perceived in the Arab society.
Shafiq Masalha (Israel)

10.15 – 11.30
The Biological Basis of Parent-Infant Bonding: Normative and High Risk Conditions and Implications for Early Intervention
Ruth Feldman (Israel)

"Updates on Interventions in Infant Mental Health"

Regional WAIMH Conference
Acre, Israel
8-9-10/9/2009

11.30 – 12.00: Coffee break

12.00 – 13.15
Chairperson: Sam Tyano (Israel)

From Past to Present: The history of Interventions in Infant Mental Health, Peter de Chateau (Sweden)

13.15 – 14.15: Lunch & Posters

14.15 – 16.15: Parallel Workshops

1. Choosing the modality of treatment, and debate around a clinical case Neta Gutman-Avner, Yehudit Harel (Israel)
Moderator: Rachel F. Schiffman (USA)

2. In-patient units in IMH, and debate around a clinical case Kaija Puura (Finland), Case presenter: Still to name
Moderator: Miri Keren (Israel)

3. From research to clinical work in pregnancy and debate around a clinical case Massimo Ammaniti (Italy), Case presenter: Still to name
Moderator: Iris Berent (Israel)

16.15 – 16.30: Closing Session
Antoine Guedeney, Miri Keren

There will be simultaneous two-way translation English-Hebrew.

Registration for foreign guests before Aug 1st, 2009 (including program, workshops, hotel):

WAIMH members: \$520-\$685

Non WAIMH members: \$555-\$720

For more information please visit: www.waimh.org
or e-mail i-doron@zahav.net.il.