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Introducing new ideas into existing rigid social/ political settings - the process of change

By Kaspars Tuters

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Introduction

The following four articles describe the experience of trying to introduce changes in the area of infant and child care in a country that underwent a significant political/social/economic transition from a communist regime to a democratic system. The specific country within which the authors have worked and made their observations is Latvia – the northern European country that was annexed to the Soviet Union after W.W.II. Even though the situation is described from the point of view of the Eastern European republics that were part of the former Soviet Union, the dynamics in many ways are similar to other countries that have been ruled by rigid political or religious regimes. Having recently returned from China, it very much applies to that part of the world.

The first article describes the complicated process of change having to do with giving up previously held beliefs and practices in a long-standing health care system that was so different from the more progressive Western models. Along with that, there was another significant factor to consider – the effect of a political system on the formation of an individual's personality and the effects on child rearing. The second article will describe infant and child care under the old Soviet system and talk about its positive and negative aspects. Then it will comment on some of the changes that have been achieved in the past two decades.

The third article provides examples of successful mental health projects aimed at young children and their parents. These were started as joint ventures when colleagues from the West brought their experience and ideas to Latvia and enabled the Latvian colleagues to adapt these projects to suit their local culture and needs.

The fourth article presents a very successful venture that involved organizing the media (T.V. and internet) to reach out to young families and provide support through information sharing and social networking.

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

WAIMH Central Office
University of Tampere, Medical Faculty, Arvo-building Room C221, 33014 University of Tampere, Finland
Tel: + 358 50 4627379, E-mail: office@waimh.org, Web: www.waimh.org

The Signal is a quarterly publication of the World Association for Infant Mental Health. Address correspondence to Miri Keren (ofkeren@internet-zahav.net).

The Complex Dynamics of Change when a Large Social System is in Transition

By Kaspars Tuters, October 2010

Department of Psychiatry, University of Toronto

Member, Canadian Psychoanalytic Society

In this article I want to share with you my own experience of what happened and is happening when a large system, such as a whole society within a country – in this case Latvia – undergoes a transition from one form of political structure and ideology to another form, that is, from a totalitarian/communist run system back to a democratic system. I think that this applies to almost all the ex-Soviet Republics. It also has parallels in other countries that are run by rigid governments, e.g. the transitional social changes taking place in the world's largest nation – China.

I will describe two aspects that are very important to understand when dealing with a situation such as the above.

> Firstly, what are the effects of a specific political system and ideology on people's mental health. Secondly, the complex dynamics of attempting to introduce change.

I will start by briefly sharing my own experience of observing and learning about the two distinct "national personality types" that emerged in a situation like this. Towards the end of World War II large numbers of Latvians fled from the Communists and settled as refugees in the West. Our family was one of those refugee families that settled in Canada in 1950, and therefore I grew up in a democratic system. In contrast, several of my first cousins remained in Latvia and grew up under Communism. When I first returned in 1989 to the city where I was born – Riga, Latvia, just after glasnost and perestroika, it was a very emotional experience. For 45 years I had had no contact with my cousins. When I now got to know them, it struck me that there were some distinct differences between us, even though we were from the same blood, spoke the same language and shared the same cultural heritage. Now we seemed to be subtly different. I have heard the same comments from some of my German colleagues – the difference between East and West Germany.

As a psychoanalyst, my interest has always been in the personality formation process. Here was an opportunity to observe and learn firsthand – what were the personality differences and what caused them. It really demonstrated to me, how aside from the influences of the immediate family on the development of a child's personality, a political system with its specific ideology can also have a very marked effect on the personality. On top of this dynamic is the fact that Communist rule had the mandate to indoctrinate its people in every possible way into the Communist ideology, and force it on them. I realize that one always has to be careful when making generalized comments to acknowledge that there can be exceptions to these situations.

For example, when I visited a medical museum in Riga in 1990, I saw posters from the 1950's where young mothers were urged to place their babies in day-care, where they would be looked after by "well trained child care workers", so that the mothers could return to work and be productive Soviet citizens. I am also sure that a lot of mothers instinctually resisted this. There was obviously no concept of the crucial part that attachment plays in the formation of a healthy personality in a child. Uniformity and equality was the expected norm. If we look at Western societies, there is the marked contrast, in particular the U.S., where independence and autonomy have always been highly valued or even over-valued. This has its own problems – everyone looks out for themselves and a sense of entitlement and materialism takes over.

The Communist ideology imposed a view of man primarily as a biological/mechanical entity, and as part of a mass to be controlled and suppressed, rather than as an individual in his or her own right, who functions as a complex psychological being who has the right to make choices. This specific mechanistic and dehumanising view of people significantly affected their personal development as well as social dynamics and systems. It also affected the field of psychology and prevented the development of psychodynamic psychotherapy. (Rothstein, 1991). As well it affected health care

delivery in general.

When I first went to Latvia and presented a paper on psychodynamic psychotherapy, a journalist asked me to explain the field of psychotherapy and psychoanalysis. My answer was that it is a field of science and a treatment method whose aims are to help an individual to think and speak more freely, to behave more freely and in general to feel free from the psychological constrictions. The journalist's answer was "This sort of thing was strictly taboo in our society".

Forty or more years of a terroristic and severely repressive political regime had produced several psychological changes, including:

(a.) A damaged basic trust. As we know, trust is crucial for the healthy functioning of a person. It is no surprise that in a political system that used spying and betrayal as its main tools of control, extending even into the privacy of the family unit, that people's natural state of mind would become a constant mistrust and even paranoia. No one dared to speak the truth, or they would risk being imprisoned, or end up as the political dissidents did – locked up in psychiatric hospitals.

(b.) Another personality casualty was a severely lowered self-esteem and self-confidence. Again, when people are constantly being abused, terrorized, deceived and repressed at every level of existence, the end result is a severely damaged self-confidence and self-esteem, which manifest themselves in difficulty in trusting one's opinions, taking initiative, and feeling respect for one's own needs.

(c.) Further to this it produced a state of apathy, general passivity and depression. With the removal of free choice and a lack of ability to participate in achieving personal goals, creativity and initiative wither and die. A state of apathy and hostility sets in. People no longer saw any purpose in improving their life, when they knew that the State could step in at any moment and destroy it. (Henckel, 2006)

The question that arises is – what effect does all of that have on child rearing and family dynamics. Further to that, the lingering distrust and the hesitancy in taking initiative and then ownership of new projects are the severe side effects of emerging from that repressive political system.

This brings us to the other psychological phenomenon – the DYNAMICS of CHANGE. At the conscious or logical level we welcome change and want to incorporate new ideas and new ways, but often there is a strong resistance to giving up the familiar, even though it may not serve us well. For those of us who are psychotherapists or psychoanalysts we know it well from our clinical practices how hard it is to change deeply ingrained patterns. Doctrines that we have been exposed to for decades as the right or the only true ones cannot be shed simply and quickly – whether these are the norms of the "family doctrines" in our own family of origin, or whether they have been imposed on us by "Big Brother", the political system. It will take a generation or more to achieve effective change.

Looking at the dynamics of change from a broader perspective, it would be true to say that no matter which part of the world we're in, the dynamics are fairly similar. From a sociological and psychodynamic point of view – when change is introduced and a period of transition takes place, there is almost always a resistance that is encountered. This is a universal phenomenon. Even though logically and consciously we welcome change with enthusiasm and want to see the old being replaced by the new, there is a strong undercurrent of resistance and resentment to it. The familiar seems safer and easier to maintain, even though we may realize that it is not serving us effectively. I experienced this first hand when I became involved with a number of projects between the West and the newly democratized countries of the ex-Soviet Union. The problem, I feel, stems from both sides – the providers and the receivers. When the process is rushed and handled superficially and naively, even with the best of intentions on both sides, it bogs down after a while. Only a patient and thought through step-wise approach can effectively succeed.

I feel gratified in my frequent trips to Latvia to see that the younger generation has been able to free themselves from the psychological trauma that their parents were subjected to. However, they still live in a system that has not fully undergone the transition. The enthusiasm and appetite of our Latvian colleagues for something new has been very strong. However, when it came to digest the new information and the new approaches and then to metabolize and incorporate them, the projects frequently bogged down. Thus what we learned was that if there was not a continuous follow-up (by the foreign colleagues) built into the projects, they would falter.

Another dynamic that plays a part is the following. When we look at the concept of "best practices", we have to be careful not to "parachute" these ideas and approaches into a new setting whose context may be very different. It is a bit similar to the human body rejecting a foreign substance as part of its defensive system. As a lot of my Western colleagues have agreed, this was a problem because of our own naivety and missionary zeal.

Interestingly, in the context of the overall mental health care delivery system where change and the introduction of new approaches worked better was the field of infant and child mental health. There had been already many younger Latvian colleagues who had been interested in new ideas. They had been attending seminars and training groups run by Western colleagues. This encouraged all of us to organize the first ever WAIMH Regional Conference behind the former "iron curtain". It took place in Riga in 1994. The theme was "Infant and Child Care in a Rapidly Changing Social/Political/ Economic System". Over 1000 participants came form Eastern and Western countries. My wife and I were able to get some of the top professionals internationally who were researchers and clinicians in that field, including Daniel Stern, Serge Lebovici, Robert Emde, Tuula Tamminen, Joy Osofsky, Sarah Landy, Joan Raphael-Leff and many others. This conference acted as a further stimulus towards change, bringing the East and the West closer together. A number of significant programs emerged and were supported actively by the Minister of Child and Family Affairs of Latvia. As a consequence the WAIMH Affiliate was formed a few years ago. Together we organized another successful WAIMH Regional Conference in Riga in 2007. Thus significant change has started and is continuing.

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Overview of the infant and child care system under communism -its positive and negative aspects

By Zaiga Blaua, M.D., WAIMH Latvian Affiliate, Riga's Stradins University

In the Soviet system the health of the infant/child and mother was a priority. However, the emphasis lay heavily on the side of physical health, and much less on the side of emotional health.

On the positive side - during pregnancy mothers had access to prenatal care at least once a month. The expectant mother received paid leave of absence from work 8 weeks prior to delivery, and 8 to 12 weeks post delivery. Beyond that period a mother had the choice to stay off work without pay (12-18 month) and the work place had to guarantee her position when she returned. Pediatricians looked after the infants and children at intervals of 4 weeks or less. The main medical institutions had children's services attached to them where pediatric sub-specialists were available for children who needed more complex health care. All of this was paid for by the State.

In the Soviet Union pre-school teachers had to have a university level education. Children were encouraged to join group activities where they could choose music or ballet or drama, etc. according to their talent. Sports were very important in schools. In socialist countries all children had equal rights -- they were not discriminated by nationality, race, place of birth or financial status. Mother and child protection was provided by many health authorities - women's consultations, maternity hospitals and maternity wards, hospital children's wards, milk kitchen, Mother and Child research institutes. Children's health was promoted in nurseries, kindergartens, boarding schools, extended school days, pioneer camps.

On the negative side – the primary approach to infant and child care was a biological one. There was very little available in terms of psychological education or support. Health issues were looked after in a fragmented way – each sub-specialist attending to a particular problem. There did not exist the notion of a family doctor with whom the patient would develop a mutually trusting relationship and who would guide the patient through the health care system. Newborn infants in the Obstetrical ward were kept separate from their mothers to prevent infections. Parents who had a handicapped child were advised to place the child permanently into children's homes so that parents could return to their jobs. If a newborn died, the medical staff recommended to have that newborn cremated and disposed of as biological waste. The woman did not receive any psychological help. The doctors advised the parents to "be positive and get on with life".

Ninetyeight percent of pregnant women were found to have health problems. The true cause of health problems was poverty, malnutrition, inadequate working conditions. After World War II many women were forced to work. At the end of maternity leave (eight weeks), mothers had to return to work, but they were allowed every 3 hours for one hour to breastfeed their child. The infant was fed every three hours. Night-feeding of infants was not recommended. In the post-war years, this stance was perhaps also justified: "Do not forget to feed the baby every three hours! Accustom the child to sleep at night, because tomorrow you will have a hard day of work! ". Productivity was put ahead of the individual's wellbeing. Later this recommendation became law - not to breast feed their hungry, crying children up to 15 minutes prior to feeding time.

During the Soviet regime there was a significant difference between the official ideology of the State and between the real life situations. Even though the principle of equality was the proclaimed standard, in truth there was no respect

for the individual, and human rights were minimal. Man was of value only if he was of direct benefit to the Communist state. For example, sports schools, which were publicly funded, could admit only prospective athletes who could compete and demonstrate socialism's superiority over capitalism. For others the opportunity to be part of professional sports schools was denied.

Initially in the Communist era the official position was the promotion of State-run Daycares as the preferential way of looking after infants and children. Insufficient knowledge about the child's normal development lead to unfounded requirements for the child and parents:

- A 12 months old child should be able to use the toilet. If the child is unable to control his eliminations, he is denied entrance to kindergarden.

- In the period of emerging sexuality when the child explores his body and examines gender differences, touching his/her genitals was considered as onanismus – sexual perversion (formal psychiatric diagnosis!) .

- Stranger situations with separation anxiety and rapprochement phase with temper-tantrums was seen as a sign of poor parenting of the child.

Soviet times were characterized by a distancing and weakening of the parent - child relationship. Early utilization of child care centers - at already 7 months of age was a common phenomenon. It was common in rural areas to keep the child in day care all week long (24 hour care). Now the pupils of 1970-1980 kindergardens are 30-40 years old. They complaint about a sense of emptiness, anxiety and depression. They have attachment disturbances. Many of them are childless/ childfree, living alone and unable to establish stable relationships with partners. They also have alienated relationships with their parents. However, there are fortunately also exceptions.

Vignettes of life in the Soviet times

A mother tells about her daughter's kindergarden experience: She would take seven 2-year-old children (from her area of residence) and put them in an old army jeep and bring them 30 km to a week-long day care. Chidren spent six days there. Again, there was no understanding of the importance of the parent-child relationship.

1.

2.

3.

(This page) 1. People lining up at the butcher, hoping for a small piece of meat. 2. You had to take what came along -scrawny chicken legs. 3. School-girls being prepared for work and defence 1980. (Previous page) One of the very few lucky children -a party boss's child?

Someone needing a general health check-up (e.g. pre-camp, annual, etc.) would have to go to three or four sub-specialists, each one checking their own narrow area.

Doctors had insufficient knowledge. Not only the lack of knowledge in psychology, but also in the field of modern medicine. Treatment often consisted of shaman rituals - folk healing items, herbal teas etc. Research institutes in the Soviet Union accounted for 10% of medical institutions, but spent 90% of the health budget. However, these institutions worked mainly for the army. These military type of approaches then became recommendations for medical institutions throughout the USSR. I found the following example in a book by J. P. Solsky. "Practical obstetrics" , Kiev, 1977. The author describes "Training of Psycho-prophylaxis" as a method of analgesia during delivery. Here is the described method of making childbirth painless. The physician is instructed that he must work with a pregnant women during the 3rd trimester.

Post-Soviet Years (1990 onwards)

During the Soviet times courses in psychology or mental health were hard to find. There was no scientific literature available from the West. After the collapse of the Soviet Union this type of information was enthusiastically embraced. Psychological teaching then became incorporated into Medical Schools and Teachers Colleges. In Latvia the Faculty of Psychology was founded in 1991. In the last two decades Infant & Child Psychology has blossomed in university settings. There was enough keen interest in the different disciplines to found the Latvian WAIMH Affiliate. It now organizes conferences and work-shops. Nowadays Latvian colleagues have a chance to attend international conferences and establish new contacts. There is also a great public interest in this area, as well as much more awareness of the infant's and mother's psychological needs among young parents. Mothers are able to take a leave of absence from their work of up to 3 years.

Over the past 20 years there has been a genuine hunger to catch up to the Western world. However, this also has its difficulties, because the "professional food" that arrived from the West was often confusing in its variety, and also the "quick ingestion" of this "parachuted professional food" did not have a chance to go through the necessary slow metabolic process.

Training of Psycho-prophylaxis

This method was widely used throughout the USSR and was recommended to be used in the Eastern Bloc countries.

If a woman had pain during childbirth the diagnosis was that there was either, a./ an incorrect history taking; b./ the psycho-prophilaxis had not been carried out properly; or c./ the consultant had inadequate training in the Pavlovian doctrine.

1st session	Doctor's task: to divide women into 2 groups on the following basis: 1st group - women who have balance between 1st and 2nd signal –systems (brain centers); 2nd group – where the 1st signal-system (subcortical centers) prevails, e.g. hysteria prone women;
2nd session	Remove the fear of childbirth. Fear was based on family stories of adverse birth outcomes and in literature which dramatically describes childbirth suffering. The doctors would work individually with women who have "weak" cerebral cortex, or who had a previous negative birth experience
3rd session, 4th session	Birth process, physiology, anatomy
5th session	Promote correct and painless childbirth process through the following proper behavior during childbirth – to sleep quietly , to breath during contractions, to administer herself a "point massage".
6th session	Childbirth is an honorary task of women and should be joyful. Topic: Milk-gland preparation. Hand washing. Timely release of the bladder and bowel. Diet.

The above text was presented as a lecture at the 12th Congress of WAIMH in Leipzig June 30 – July 3 2010: Overview of the infant and child care system under communism - Its positive and negative aspects. Blaua Z. (WAIMH - Latvia, Latvia).

Attachment-based parent and preschool teacher training and research programs in Latvia

By Sandra Sebre and Inga Skreitule-Pikše

University of Latvia, Department of Psychology

Perhaps one of the reasons why attachment theory has gained such acceptance in present day Latvia, especially among students and young parents, is that the message which attachment theory holds was so noticeably missing during the Soviet period. Information about attachment theory came to be generally available in Latvia beginning in 1998 with the publication of "Drošais pamats", the translation to Latvian of John Bowlby's "A Secure Base". The translation of Bowlby's book was sold in general book stores, and upon its reading the following reaction was fairly typical: "If only this book had been available when my children were young, then I would have raised them completely differently."

As mentioned in the above articles by Kaspars Tuters and Zaiga Blaua, during the Soviet period there was minimal opportunity for exchange of information with Western Europe or North America, and the principles of attachment theory were not among those to penetrate this border and to become known in Latvia. However, shortly after the border was opened and the free flow of information became possible, then gradually during the 1990's John Bowlby and other attachment theorists became familiar to practicing professionals as well as students. One psychology student, upon learning the principles of attachment theory in her university studies during the 1990's commented as follows: "During the Soviet period (in Latvia, author's comment) it was not accepted for parents to show love and emotional warmth toward their children. Parents attempted to be emotionally distant so as not to 'spoil' the child".

It became quite apparent that there was a very great need for a parenting program in Latvia, which would include both psycho-educational aspects about the necessity of parental sensitivity and emotional warmth in raising one's child, but also would include an opportunity for young parents to reflect upon their own childhood experience of being raised according to previous parenting principles, and to discuss their willingness to appropriate new approaches to raising their children in the present. Such an opportunity arose in 2003 when Canadian-Latvian psychologist Edīte Ozola brought to Latvia the basis for the first structured parent training program – "Bērna emocionālā audzināšana", referred to in Latvia as the "BEA program", and translated to English as "Encouraging the Child's Emotional Development". This training program for young parents was initiated in Latvia upon the basis of a program developed in Canada by psychologists Sarah Landy and Elizabeth Thomson (Landy & Thompson, 2006). The original program developed in Canada was translated and adapted for use in Latvia by Dr. Ozola, working together with psychologists from the University of Latvia (Lendija & Ozola, 2004). The project has received financial support from the Canadian Embassy, the Latvian Ministry of Child and Family Affairs, and private foundations.

The "BEA program" is a group-based parent training program which involves weekly group sessions of 2 hours in length, with a total of 10 – 11 sessions. Within each group 8 – 12 parents participate. Although both parents are encouraged to attend, usually the groups have consisted mostly of mothers. Each group has two group leaders, most often psychologists who have been especially trained to use the BEA program and who are knowledgeable in early child development, family systems, parenting and group dynamics. The BEA parent training takes place in both local governmental social services centers, non-governmental agencies such as centers against child abuse, and psychologists' private clinics and practices. Although there is no precise data on the numbers of parents who have participated in the BEA program, it is estimated that at least 2,500 parents have received this training.

The BEA program encompasses various goals, including the goal of enhancing parents' knowledge of early childhood development, and an understanding of the need for the child to receive both emotional warmth and appropriate structuring. The program is also organized so as to help parents understand the influence of their family of origin experiences on their current parenting practices, to reflect upon those experiences which they hope to continue or to discontinue in regard to their own children. The program is aimed to encourage parents to develop positive attributions of their child and to reframe negative attributions, with the broader goal of enhancing the parent-child interactions and developing secure attachments. The program provides parents with specific strategies to manage their child's behavioral or emotional difficulties. In turn, the program is geared to enhance both parents' feelings of self-efficacy and also the child's feelings of positive self-esteem.

During each weekly session the group is presented with a specific topic, such as child temperament, positive body image, secure attachment, language and communication, self-regulation and social competence. Each session includes both psycho-educational presentations by the group leaders, opportunity for reflection and discussion, and weekly homework assignments related to the session's topic.

The effectiveness of the BEA program in Latvia has been studied by Inga Skreitule-Pikše (in print), based upon a sub-group of 60 mothers who participated in the BEA program and 46 mothers who were included in a control group. The mothers were asked to complete questionnaires concerning child behavior and their parenting sense of competence pre and post training, as well as at 6 month follow up. The results of the study showed that mothers' participation in the parent training program led to an increase in the mother's sense of parenting competence and a decrease in child internalizing and externalizing behavior problems. These changes remained consistent at the 6 months follow-up. Additional pre and post training home video observation of 20 mothers showed that mother-child emotional availability was increased at the post-training video observations (Skreitule-Pikse, Sebre & Lubenko, 2010).

The BEA parent training was in 2007 also adapted for preschool teachers in Latvia by Sebre and Skreitule-Pikse. Similarly as with the parent training program, the preschool teacher training program was also structured as a series of 10 – 11 weekly group meetings with 10 – 12 participants in each group and two group leaders. Each session was based upon similar psycho-educational topics as with the parent training. There was also included an opportunity for discussion and reflection upon one's own childhood experience both within the home and one's previous

schooling . Similarly, homework assignments were included, but modified so that the preschool teacher assignments were based upon their interactions with children in their preschool class. Pre and post training assessments of the preschool teachers were administered and the results showed that at post-training the preschool teachers indicted an increase in their sense of self-efficacy within the classroom, as well as a decrease in their personal somatic complaints, anxiety and depression symptoms. The preschool teachers noted that as a result of the training programs they gained not only new information, increased understanding of child development, but also increased self-esteem and greater understanding of themselves.

The interest in attachment theory in Latvia has also resulted in several studies regarding the associations between attachment styles and experience of abuse. It has been shown (Bite, 2003) that in Latvia both men and women who are involved in abusive intimate relationships indicate experience of childhood emotional and physical abuse, as well as preoccupied attachment style. In a study of continuation vs. discontinuation of abusive behaviors which parents experienced as children in comparison to their present parenting behaviors, it was shown that the continuation of abusive behaviors is most prominent for mothers with preoccupied attachment style (Sebre & Lebedeva, 2006). In Latvia attachment story-stem endings indicate insecure attachment representations for those children who report family abuse experience (Pirsko, 2008). The results of this study also indicated that there are socio-cultural differences in regard to specific story-stems which are more or less revealing of negative parent-child relationships within a specific socio-cultural setting.

In conclusion, it can be said that there is now in Latvia a firm foundation and a relatively broad base of professionals, students and young parents who have gained at least an initial understanding of the importance of secure attachment within the parent-child relationship, as well as understanding of the positive parenting behaviors which facilitate secure attachment. Not only is the BEA program each year becoming available to increasingly greater numbers of young parents, but also professionals who understand the importance of secure attachment are incorporating additional programs within their centers, such as the preventive program for young pregnant mothers developed by Karl Heinz Brisch, which is now being implemented in the Center Against Abuse "Dardedze". The importance of secure attachment is beginning to find a secure base in Latvia.

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Reaching out to young parents through the media -Keeping up with the (contemporary) times

By Sandija Salaka ,

Head of Mommies Club

Sandija Salaka, who is a mother of two young children, recognized the need for more effective means to make relevant information available to young mothers and fathers. She realized that Latvia (and so many other countries) were "baby unfriendly" – having very little opportunity for young mothers to interact, to exchange information, or to establish mutual support. In most instances mothers spent their time at home in isolation with their babies. Sandija was aware of two facts about our contemporary society – a./ the frequent isolation of the new nuclear family lacking a support system, and b./ the increasing use of electronic communication and social networking by the younger generation, that has become the preferred mode of keeping in touch.

As a consequence of this, five years ago she organized the MOMMIES CLUB (Maminu Klubs). It started out as a weekly TV program in Latvia, as well as an internet website providing a parents network. It has been expanding successfully and now has TV programs in Latvia, Lithuania and Estonia in the three separate languages and also Russian.

Mommies Club (M.C.) regularly attracts over 200,000 parents in the Baltic States and parts of Russia through the mothers' internet social network, as well as the dedicated weekly TV program about parenting, and also a radio talk show on the national channel. M.C. functions as a hub for parents to parents, parents to doctors and other specialists and caregivers who are involved in child care. It also connects parents with the government agencies that are responsible for the families' social sphere. Thus M.C. works closely with mothers and represents their needs in society. In that way it has an advocacy role and is an intermediary with other media and institutions.

The basic principle of the M.C. network and its success is Parent-Infant Oriented Thinking and Communication which has been built up through its interactive approach and constant feed-back from the parents. The club has 50,000 members at the present – mostly mothers with children from zero to pre-school age, living in different parts of the country. This is the great advantage of the modern media of communication. Cost efficient, highly interactive and fast. M.C. is open to every parent in the country, no matter where they live. There are no membership fees. Financially this organization is able exist by allowing discreet advertising of baby products.

During the past five years Mommies Club has become the largest parents' "community" and a serious opinion leader. It is a real club where parents can participate, get support and information, and a have a feeling that their voice counts. The website provides an opportunity for young mothers to share their daily lives and frustrations, to find moms near their living places, and to establish one-to-one outside contacts.

What the organizers have learned is that the parents need quick answers. This is what they can obtain through the networking with other mothers as well as answers from the specialists who are consultants to M.C. There is also a high demand for visual material such as DVDs showing mothers interacting with their infants, child specialists demonstrating phases of infant and child development, pediatricians commenting on childhood diseases, and many other themes. The following are some of the DVDs – "Playing with the Baby", "The First Edition", "Facts about Immunization", etc. Parents also need to see that parenting a baby can and should be a playful interaction and not just a complicated task to be fulfilled. M.C. uses the notion that children learn best through play with the adult.

Finally, the principles that are used in the Mommies Club media – TV, radio, internet are the following:

- M.C. media cover child development and health from pregnancy to 3 years of age;

- The focus in every material is always the child interacting;

- Presenters in the programs and chief web editors are mothers themselves. This gives a sense of validation.

- M.C. emphasizes that a problematic child is still a good and loveable child and the approach has to be an understanding and empathic one;

- M.C. is not a place of criticism, but it is there to provide advice;

- M.C. as a media and an organization works in close cooperation with a wide range of specialists: pediatricians, child psychologists and psychotherapists, social workers, midwives, gynecologists, and representatives of state institutions for children;

- M.C. works with different cultural and ethnic groups in the Baltic States and pays attention to local child care traditions and language, and tries to integrate these into current infant and child research and recommendations;

For more information you can visit the Mommies Club website:

http://www.maminuklubs.lv

Meeting infants and staff at the foundling home: Introducing concepts of transference and countertransference in an institutional context

By

G. Abatzoglou, Thessaloniki, Greece

The beginning of a collaboration

My collaboration with the Municipal Foundling Home of Thessaloniki (MFH), first in the position of child-psychiatrist and then as director of the Child-Psychiatry Services, starting 20 years ago, has gone over many transformations. During the first years, I was mainly asked to do child psychiatric assessments, upon the request of either the Social Services or the Home director. These referrals were very well welcomed by my team, in contrast with most of our child psychiatry colleagues, who saw them as "mainly psychosocial cases, not "real" psychopathology, therefore as cases that can be dealt by any community worker.

Psycho-social cases and child psychiatry

Here one encounters the following paradox: Those "psycho-social cases", so highly invested by the Social/Welfare Services, are easily turned away by child psychiatry clinics. While not being interesting enough from the clinical standpoint, these same institutionalized infants have attracted scientific interest, and indeed, several famous researchers, such as Rutter and Zeanah, have studied their development. Research is definitely important, but we need to be aware of the danger embedded in measurements and concepts devoid of affective experience and connotations.

On one hand, these case stories are interesting at many levels, due to their existential and social significance. On the other hand, the institutionalized children and even more so the infants, run the risk of becoming alienated while we are in the process of studying them as research targets; they may become abstract entities in the researcher's mind's eyes.

Those psycho-social stories crudely face us, the mental health professionals, with either an absent or an abusive caregiving environment in which the institutionalized infants live. The full clinical understanding of the impact of such an environment must be included in the assessment of these children, regardless whether it is for research or for clinical decision-making. . One of the consequences of this full understanding is the need to apply the French concept of 'institutional psychotherapy', which, by definition, takes into account the multiple facets of parenthood and infant development, and necessitates a lively collaboration between the Home staff and the child psychiatrist. Such a working model lowers the risk of fragmentation, isolation, and alienation in the perception of the infant in the staff's minds.

Collaboration between services is not a given. There are also forms of collaboration between services which may not be beneficial to the service users. One ought to consider whom shall benefit from this collaboration and to what extent will it be useful for service users? Asking these questions and bearing them in mind safeguards against collaboration turning into a bureaucratic process, often to the disadvantage of service users.

The Collaboration framework with the Foundling Home (F.H).

A heightened sense of social responsibility, in my view, ought to be de facto an obvious value of any child-psychiatric public practice, and therefore they should consider this population of abandoned babies as an obvious target of their routine clinical work. Since this is not the case, at least not in my region, we needed to put in place a systemized and multidisciplinary collaboration between the Foundling Home of Thessaloniki and the Child and Adolescent Services of the Psychiatric Clinic of the University Hospital AHEPA. The permanent mental heath team includes a child-psychiatrist, clinical psychologists and an occupational therapist who shares some but not all the activities.

This collaboration has evolved over the past five years and is based on the following format:

1.. Fortnightly meetings with the social workers of the Social Service of the F.H. regarding fostering, adoptions and issues concerning the biological parents.

2. A monthly interdisciplinary meeting that takes place at the F.H. between the Mental Health Team and representatives of the various departments of the F.H., including the director of the institution and a representative of the Board, the paediatrician, the legal counsellor, a representative of the nurses and the social workers. The aim of these meetings is to approach possible unforeseen problems in the F.H. (children who remain for a long time, tension-inducing situations, and collaboration between the services, etc).

3. Weekly observation and assessments of the infants at the F.H.

4. Encounter (and support if needed) with the biological parents (mostly mothers), based upon request from the Social Services These meeting usually take place at our hospital but can also be at the Foundling Home, if needed. One of our future steps is to further develop and conceptualize and study this intervention with the infants' biological parents.

5. Foster parents as well as new adoptive parents get counselling and therapeutic interventions, as needed, in collaboration with us.

6. A support group for the nurses takes place at the Foundling Home on a monthly basis.

7. Fortnightly peer group supervision of the mental health team aimed at reflecting upon and organizing the interventions. These meetings function as a kind of self-observation or, better put, self-supervision.

8. Taking care of unstructured events, such as setting up evening activities for the older children, making better use of volunteer workers etc.

Some First Thoughts at that point in time

A burdened institution

The collaboration with the Foundling Home brings various issues to the surface, unsettles many of our vested beliefs and is particularly time-consuming without the prospect of clear results. The Foundling Home is a 'burdened' institution, with set beliefs and practices and resounding tensions. As is often the case in children's institutions, the Foundling Home is torn by never-ending conflicts.

On the one hand there are the conflicts that take place inside its walls and on the other hand denial seems to be a key-mechanism of its functioning. For instance, there is complete denial of the radical changes that have taken place in the population of the FH. At one time, the FH was seen as a place for saving infants who had been abandoned by unknown parents. Today, most of the babies who are left at the FH have parents who are known but unable to provide appropriate care. It is especially difficult because most of the parents,claim parental rights to their young children. Contingently, the conflict between children's rights and parents' "right to have a child," producing aggressive demands for the parental role, largely based on psychological difficulties of the grieving process, involving all parties, with identifications abounding on both sides. Professionals may identify with the biological family or with the adoptive family, with one "good" parent or the other "bad" parent. The FH is in the centre of the storm, thus transformed from a caring home to an Institution of bestowing or refereeing. The FH represents the Power given to Social Welfare, and legitimizes it. Blurring of boundaries is inevitable when the Board becomes the Social Services. Denial of this blurring is striking, especially at times when psychological help and self-reflection are felt as badly needed. How could it be not needed, when the FH finds itself not knowing to whom they should give the child or on which criteria to base their actions. The FH is then transformed into a space which temporarily looks after some children for the benefit of certain adults. The Foundling Home becomes by definition a child-protection service that is mostly interested to its adult service-users.

Clinical vignette: Trust and Respect

D., a 17 years old girl, lives in a very conservative and strict family and becomes pregnant following her very first sexual intercourse. She wishes to keep the baby, but obviously cannot raise it without support. Because her pregnancy must be kept secret, the situation is tense and complex while decisions must be made quickly. Institutions are involved and such involvement evokes excitement and even sexual fantasies (of incest for example). D's mother gets very involved, and becomes the "case manager" for the family as well as the health system. The "case" is referred to us from its start, through the Foundling Home, and there we meet the mother and newborn after delivery. D. is very distrustful, takes a defensive stance and refuses to disclose any information about the pregnancy. She accepts talking only about the care of her baby and refuses to enter any topic that she perceives as intrusive. She goes on living with her parents and her siblings and visits her baby regularly. She tries to insert her motherhood into her adolescence; she keeps on studying at school while wishing to take her baby home.

We are very careful in our contact with her, trying to be patient and accepting the fact that we don't know many details about her. We need to "calm down. " never forgetting" her, especially whenever decisions need to be made concerning her child. We also need to face the intrusive grandmother who wishes to control everything as if the baby belongs to her. After two difficult years, D. explicitly asks us to provide her psychological help, explaining how she became trustful: "Everybody used to ask a lot of indiscrete questions or look at me in a strange way or to talk about me with my mother. You were the only ones who respected my silence, who showed a genuine interest in my child's development and who asked my opinion in the first place".

D. now works and studies hard. She takes care of her child and follows a therapeutic program, having learned to trust us. While we don't know all of her life history, we trust that by following her lead and first meeting her needs, revelations may follow.

Imaginary scenarios in the staff's minds

This double negative that could be summarized as the contradictory request for help and its negation or even denial, may explain many of the phenomena we have observed during the years of collaboration with the FH. One of these phenomena is the creation of "mythical" stories about each child's origins.

In order to understand what this is all about, one needs to remember that the main tenet of the FH is to keep confidentiality at its maximum, to be a "secret" place for abandoned babies. Within the staff, some know about the origins of the babies, others don't, depending on their rank in the hierarchy of the institution. This distinction may nourish fantasies and create arbitrary constructs, based on the devaluation of biological parents. These scenarios will constitute the basic argument of an apologetic rhetoric of the institution, concerning its decisions about the future of children (to whom to give which child).

The challenge embedded in this collaboration between the FH staff and mental health clinicians is the continuous struggle between the FH request for help and guidance, contradicted by its need for denial, splitting and projective identifications. Hence feelings of fatigue and difficulties at thinking that result from this collaboration cannot simply be attributed to case load and tiredness. It seems to us that this fatigue comes from a strange flow of time. Time, at the institution, is either slow or non-existent in terms of its impact on the infants or is suddenly very short when there is an unexpected need to place the child (regardless of the infant's need for preparedness to the change)

Clinical vignette: Our mental health role

Mr and Mrs B., a gypsy couple (a poor ethnic minority in our country), are accused of illegal possession of a six-month-old baby, whom they had declared and registered as their own. The baby's biological mother was an immigrant woman. A financial transaction had been secretly made between her and the couple. The baby was placed at the Founding Home by order of the district attorney, waiting for the court judgment. This cute little baby became right away an ideal candidate for a legal adoption by one of the many childless couples on the institution waiting list. However, Mrs. B. refused to be separated from 'her' child, and she would come, every day, from early morning, to spend as much time as possible with the baby; a beautiful interaction could be observed between the two. The situation became more complicated as the institution decided on a temporary foster care placement. The foster mother, an upper middle class woman, quickly became attached to the baby and made plans for saving him from misery (meaning the gypsy couple). Mrs. B., though, did not give up and the situation became so complex that the director of the FH asked for our advice,

with the expectation that we would solve this impossible situation and avoid the eminent danger of acting out. Our position as a third party made everyone calm down. We proposed a two-step process. First, officially recognize the couple B. as the foster family and second, pronounce them as the adoptive parents of the child. The proposition that we made to the team was simple and logical,. It turned an initially illegal and fake transaction into a normal, legal adoption and plan for parenthood. It is important to understand that this plan could not be made initially by the institutional team while they were feeling so overwhelmed by the situation,

Epilogue

The Foundling Home deals with a 'hot' population, the population of 'left over' infants, which often evokes powerful fantasies on the part of the professionals. A range of unconscious mental representations include images of "unbridled" instinctual activities on the part of the biological parents. These images are transferred to the abandoned children who are unconsciously experienced as "polluted" or "polluting" and lead to unprocessed and emotionally charged reactions, including overwrought rejections or excessive compassions. In any case, it seems that the thought process ceases giving its place to multiple acts of "charity" or "charitable activism". A blind and uncoordinated excitation creates crisis conditions, feelings of panic or emergency which circle in closed circuit. In these cases, the need to refer to a third professional party, outside the Foundling Home, becomes a necessity.

Birthing the World conference on best practices in perinatal care: an interdisciplinary initiative made in Quebec

By

Martin St-André and Catherine Chouinard

Through both its intimate and universal dimensions, the perinatal period marks a key moment in human development. This stage of life has forever demanded that the community give special consideration to mothers to be and their families. The roles of those who provide accompaniment and support and the means and methods that they use have evolved relentlessly as a function of sociocultural context and accumulated knowledge. Today, these roles, means and methods take on a wide variety of forms, as evidenced in the perinatal care policies around the world, including the one adopted by the Government of Quebec (Politique de périnatalité 2008-2018 -Un projet porteur de vie).

On November 25 and 26, 2010, the Birthing the World conference proposed a novel format at once wide-reaching, interdisciplinary and grounded in the major issues of reflection and scientific research conducted here and elsewhere. This event was the result of long months of hard work by the Association pour la santé publique du Québec (Quebec Public Health Association) in conjunction with its principal partners, namely, the Quebec Association of Perinatal Care Family Physicians (AOPQ), the Society of Obstetricians and Gynaecologists of Canada, the Regroupement Les Sages-femmes du Québec (Quebec Midwives Association), and numerous other partner-collaborators from a host of different sectors, including public health, perinatal and early-childhood mental health, community organizations, nursing care, research, the public service, and professional associations.

The goals of the conference were to showcase the latest data and initiatives in the field of perinatal care, to examine the physical and affective dimensions of the interval running from the prenatal period through the first two years of a child's life and, finally, to strengthen and enhance the ability of participants to accompany and support mothers to be and their families in normal situations as well as in others that present particular challenges.

Within the framework of the continuum that is the perinatal period, the conference aimed also to question, provoke, mobilize and influence Quebec society in the aim ultimately of bolstering its collective self-confidence in its ability to bear, deliver and nourish its children from both a physical and mental standpoint.

Three major themes ran through the exchanges at the conference: childbirth, breastfeeding and becoming parents. These were examined and discussed using an interdisciplinary approach, which was conceived not as an end in and of itself but rather as a privileged means of changing and harmonizing the practices of all parties concerned by birth and early childhood. The plenary conferences and the key symposia placed the emphasis on the importance of the emotional aspect of perinatal care, the examination of specific practices regarding childbirth and parenthood support and accompaniment, including the MOREOB program[1], protecting the physiological process of birth, issues regarding the organization of care in the aim of optimizing its continuity and the safety of families, strategies to promote breastfeeding, issues regarding the leveraging of information conveyed to new parents, and the attitudes of different professional groups towards current perinatal care practices.

Birthing the World was made possible thanks to the complicity of scientific and advisory committees composed of practitioners, researchers, managers and clinicians who share the same ideal regarding the well-being of mothers, parents and babies. All the members of these committees stand out in their field of practice for their openness to others and their ability to mobilize the people around them. Over the more than two years that they met, the dynamic within the committees evolved in such a manner as to allow their work to shift from a multidisciplinary effort to an

1 MORE^{OB} (Managing Obstetrical Risk Efficiently) is a comprehensive, three-year, patient safety, professional development, and performance improvement program for caregivers and administrators in hospital obstetrics units.

[2] Infant Feeding Action Coalition

interdisciplinary one. The remarkable dedication displayed by the committee members and their promotion of the event to their respective colleagues allowed creating a similar dynamic within their networks, multiplied by hundreds of participants. The fruits of their labour benefitted from the vitality injected in the project by the executive members of the Quebec Public Health Association, with the support of the event's principal financial partners, namely, the Quebec Ministry of Health and Social Services and the Public Health Agency of Canada.

Birthing the World brought together 722 participants from all sectors connected to perinatal care, from across Quebec, Canada and elsewhere. These included researchers, physicians, nurses, midwives, doulas, professors, social workers, psychologists, and lactation consultants. In other words, converging on one and the same place were people who, while working in the same field, seldom have the chance to share their experiences and interrogations or to report the results of their research and the effects of their practices.

Birthing the World consisted of 148 speakers, 6 plenary conferences, 30 symposia, 25 workshops, 50 oral presentations, 17 poster presentations and an expertise fair spotlighting 20 community organizations from across Canada. All abstracts were evaluated by three scientific sub-committees: the sub-committee on childbirth chaired by Céline Lemay of the Quebec Midwives Association and Dr. Maxine Dumas-Pilon of the AOPQ; the sub-committee on breastfeeding chaired by Carole Dobrich of INFACT-Québec[2]; and the sub-committee on becoming parents chaired by Chantale Audet of the Quebec Public Health Institute. The book of abstracts evaluated by the Scientific Committee is available at www.birthingtheworld.com.

In the opinion of approximately 50% of the participants who filled out the online evaluation after the event, this conference stood apart for its originality and contributed to pool our respective viewpoints and expertise regarding the perinatal period and the first two years of life. Indeed, this gathering constituted a unique opportunity to learn about, discuss and debate current strategies for promoting health, providing accompaniment and support, and carrying out clinical interventions in the field of perinatal care and services. The exchanges and collaborations generated by the event fostered the sharing of knowledge that all too often remains compartmentalized, in addition to advancing the cause of greater integration and continuity of services in perinatal care. Above all, these exchanges contributed to further the process of reflection and to take concrete actions concerning the humanization of care for women, babies and families.

The very positive response to Birthing the World reflects the fact that our capacity to talk to one another has reached a new level of maturity and points to our vital need for collaboration, beginning with our different accompaniment and practice settings. This highpoint for the Quebec perinatal care community paves the way for us to conceive and carry out actions in concert with one another. These include establishing institutional settings for interdisciplinary exchange, offering more targeted training, supporting practice communities through the dissemination of written documents, and resuming our advocacy role on behalf of women and young families, particularly the most vulnerable among them. In the end, this conference leaves in its wake an energized network better inclined to work cooperatively for the better being of families during the earliest years of life.

Martin St-André: Perinatal and infant psychiatrist, CHU Sainte-Justine; Associate Clinical Professor, Université de Montréal; Chair, Birthing The World Scientific Committee; President, Association québécoise pour la santé mentale des nourrissons (WAIMH-Quebec) (martin.st-andreumontreal.ca).

Catherine Chouinard : Project Manager for Perinatal Care Issues, Association pour la santé publique du Québec (Quebec Public Health Association); Birthing The World Scientific Coordinator (cchouinard@aspq.org).

Affiliates Corner Jan 2011

Welcome to 2011.

At the end of last year we invited WAIMH affiliate presidents as representatives of their affiliates to participate in a brief survey.

Most affiliates participated and the responses have been collated into a WAIMH Affiliate profile document that will be readily available to Presidents and will be posted on the WAIMH website afterwards. Inclusive of biographical information and organizational structure variances, there is also information concerning a vast array of training, service and education activities being conducted across the affiliates.

This is a wonderful first working document. A dynamic document that can function as base from which to explore and inspire our relationships as affiliates and with WAIMH.

Thank you to all those who were able to contribute to this document. Special thanks also to Leena Kiuru in the WAIMH office for her enduring editorial support.

Our next key initiative is to run another survey in the first part of 2011. This time the focus will be on the specific needs of affiliates. Responses to this survey will potentially yield a rich cross cultural needs assessment while also highlighting areas of shared concern. Information from this survey will be used to guide issues of affiliate resourcing among the affiliates and in partnership with WAIMH, so we can all engage as fully as possible with the aims of WAIMH.

We also use this opportunity to remind all Affiliates Presidents to renew their WAIMH memberships and to regularly inform the central office (office@waimh.org) about changes in their officers or contact information.

As we are progressively moving towards a more bidirectional communication with the Affiliates, we also wish to encourage Affiliates to use their mailing lists for circulating WAIMH invitations and updates.

Maree Foley, MPhil (Dist)
Affiliate Council Representative

Martin St-André, MDCM
Chair of Affiliate Council

Medical and psychological airport reception and care of children from Haiti adopted in France

By

Hélène Romano, Thierry Baubet, Héloïse Marichez, Charlotte Chollet-Xémard, Jean Marty and Marie Rose Moro

Abstract

Following the earthquake of January 12th 2010 in Haiti, the French government decided to proceed to the emergency evacuation to France of children for whom a legal decision for adoption had been reached. An unprecedented care and prevention operation was established in the Paris airports. Our first objective was to ensure medical and psychological care provision immediately on arrival for these mentally poly-traumatised children, often also affected physically. Our second objective was to ensure satisfactory conditions for the encounter with the adopting parents, while 88% of the children had never met them. This article presents the operation specifically set up for these transfers, and describes the clinical characteristics presented by the first 363 children received, in particular the acute states of stress presented by these very young children. Finally the ethical issues relating to this operation will be broached.

On Tuesday January the 12th 2010 at 16h53 an earthquake registering 7.3 on the Richter scale hit Haiti, causing more than 220 000 deaths. The political context in the country was unstable, with violence and poverty rife in the everyday life of the population. In view of the resulting chaos, France decided to set up an operation for the repatriation of its nationals, with reception organised in the Paris airports comprising medical and psychological care provision. Since 2004, France has systematically organised reception operations in airports by way of the Cellule d'Urgence Médico-Psychologique (CUMP), part of the SAMU (French emergency medical system). This care provision, which has been activated for numerous situations of crisis (the civil wars in Ivory Coast and Lebanon, the tsunami of 2004, the 2006 Lebanon war, the crash of the Rio-Paris Air France airliner etc) [Baubet et al, 2006], provides for separate areas for children and families. From January 16th, following the earthquake, an operation of this type was established in the Paris airports.

Alongside this, the French government also decided to evacuate all the children involved in an adoption process for whom a legal decision had been pronounced, which concerned around 476 children. This led us to design an original, specific care provision operation comprising psychiatric and paediatric care, which will be described below[1].

From January 22nd the operation was in place in the Paris airports: in Orly it was supervised by the SAMU 94[2] CUMP unit, and in Roissy by the SAMU 93 CUMP unit.

Presentation of the operation

The operation was in two stages: first the emergency reception in the airports when the flights landed, and subsequent follow-up of the child and the receiving family, mostly by telephone and email, since adopting families were from all over France. On arrival in the airport, each family received a written document explaining the reasons for our presence and the meaning of our intervention, referring to the emotions and symptoms that they were likely to encounter, both for the children and for themselves; it also gave names, addresses and contacts for subsequent follow-up.

1 This operation for adopted children and their receiving families was coordinated by Hélène Romano in Orly airport, and by Dr. Thierry Baubet in Roissy Charles de Gaulle airport.

2 This figure refers to the Paris-area département to which the SAMU unit belongs

Medico-psychological airport reception operation

The operation mobilised a medical team (paediatricians and emergency physicians) and an emergency medico-psychological team (psychiatrists, paedo-psychiatrists, psychologists and nurses all specialised in catering for psycho-trauma). Each flight arrival required the presence on average of 25 care providers for 45 children.

The operation was designed so as to optimise medical and psychological care provision in the reception setting (airport terminal) with the added constraint of the necessary administrative procedures, conducted by the relevant Foreign Ministry department. Five zones were defined:

- Reception and waiting zone for the children: each child arrived from Haiti (via Guadeloupe or Martinique) with an accompanier (a volunteer, generally healthcare or first-aid worker). When the plane landed French Red Cross volunteers boarded the plane, each becoming the referee for one child. This person established the link between the accompanier and the child as far as the terminal. On arrival the child was settled in a dedicated zone where the Red Cross volunteers relayed until the encounters with the parents (a time lapse of around 2 hours). The zone comprised a play area, a nursery for changing, and a meals facility. The accompanier separated from the child and was able, (if the parents agreed) to meet the parents receiving the child whom he/she had taken care of over the journey.

- Medical zone: advanced medical post set up in two marquees where doctors from SMR 94 and paediatricians from SMUR 92 (Béclère) provided medical care for the children who had been signalled when they boarded the plane, and those who were identified by the Emergency medical services on arrival or in the reception zone. Another marquee was set aside for the parents when referral of their child to emergency department was envisaged, to provide them with a quieter environment away from the other family groups. 42% of the children required medical care, and 6% were hospitalised (denutrition, dehydration, bronchiolitis, injury during the

earthquake).

- Reception zone for adopting parents: this was located at the far end of the setup, in a separate room, visually and phonically apart from the other areas. The parents were invited to arrive a hour before the arrival of the flight. Many of the parents came accompanied (brothers and sisters, relatives, friends), and it was not always possible to find room for all of them in the limited space allocated. For each family, a CUMP professional contacted the parents and any adopting siblings present. They had the task of answering questions and worries. It was also important to assess how much the family new about what the child had been through, and how far they actually knew the child (some had already met the child, while others (88%) had only ever seen photographs. After this interview, a document was given to each family with the contact details for specialist consultations, and a link was established with facilities in their home area (specialised adoption consultations, and local government follow-up departments)

- Administrative zone (local government authority (préfecture), family allowances department, Foreign Ministry international adoption department, ADP) located between the parents' waiting area and the meeting area. Before being able to meet their child, the parents had to go through the different formalities for international adoption. Depending on the advancement of the case files, the time required was sometimes very long on account of the verifications required. To facilitate the different administrative procedures, various government departments were present.

- Meeting area for parents and children: this was materialised by a few armchairs and screens, and aimed to provide parents and children with as much privacy as possible when they met, mostly for the first time. Certain families stayed as long as 8 hours in this area on account of the difficulty in establishing contact between parents and child. The accompanier was not present at the time of the encounter: this was not just for reasons of time (they had to take the return flight), it was above all to avoid conflicts of loyalty for the child between an accompanier he had known for several hours and parents who were frequently complete strangers.

These areas as a whole were set up in a dedicated zone well away from any passenger transit throughout the operation, and protected by police to avoid any intrusion, particularly by journalists.

Over the entire operation, which lasted as long as 10 hours for some families, a child mental health professional accompanied the child and the family, preparing and accompanying the encounter, and intervening where necessary.. The task of these professionals was to detect states of mental distress, and to provide emergency care measures for the infants and children. Each professional took charge of three families, and all were supported by a senior clinician (H.Romano or T.Baubet). We noted that the presence of professionals had a containing role that was very reassuring for the families, and parents questioned us a lot about the meaning of what was happening for the children: "why do you think he did that?"

Provisions for follow-up

On account of the specific features of this care provision (multi-trauma, precipitated international adoption procedures, and families from all over France) from the outset we established a follow-up system for these children and their adopting families:

- A telephone contact within the week following, and then envisaged at one, three and six months, and one year

- Availability for any parent wishing to call the coordinators of the two operations (worries about the child, consultation relays, difficulty obtaining appointments with specialists, etc)

- An information letter to specialised departments and facilities (COCA, local government, education authority) explaining the context so as to raise their awareness towards these young children and their new families.

- Debriefing of the teams who had taken part: an intervention of this sort is not easy for those taking part, and requires an elaboration of counter-transfer effects, sometimes felt particularly strongly (words of the adopting parents, refusals on the part of certain children to leave with their new parents).

Clinical observations

Thus 363 children were cared for, brought in on 9 flights, and 240 of them were under the age of 3. All the families (parents, brothers and sisters, close relatives), amounting to 1105 individuals, were also attended to.

Psycho-traumatic impact among the children

This intervention in the airport terminal environment used to receive these children is quite specific compared to other operations that have been organised in other airport crisis situations, on account of the numerous trauma, and the young age of children :

- certain children already had a traumatic past, prior to the earthquake – abandonment, violence

- the confrontation with a major traumatic event, the earthquake and its consequences: chaos, disorganisation of the adult world, loss of all landmarks and references

- different levels of exposure: certain children were in places that were spared, while others had been buried under rubble

- numerous losses suffered in the space of a few days: their attachment figures, their references, their roots, their habits, and also the actual death of attachment figures or other children

- very young children with great difficulty expressing their distress

- the language barrier (most spoke Creole)

- cultural shock: leaving a world of black people for a world of white people; shifting from living in a group to situations where the child was cared for individually by numerous different people; and also thermal and dietary shock, and so forth

- a violent confrontation , not allowing for the individual pace and ability of each to elaborate this new world and new family.

It is not so much the catastrophe of the earthquake, as the way in which the consequences were managed that is liable to leave an enduring traumatic mark on these children's histories. Adoption will not cancel out this traumatic debt, and particular vigilance is required for these children and their parents. The risk is that the parents, encountering serious difficulties, will not feel able to seek assistance because of denial, fear, embarrassment or guilt.

Disturbances presented on arrival

All the children received in-depth psychological attention (Romano, 2006), from their arrival up to the meeting with the parents. Prior to this in transit in Guadeloupe and Martinique medico-psychiatric teams had assessed the children and commenced care provision. Two thirds of the children were under three, 52% were girls and 48% boys.

There were 21 sibling pairs, including 7 cases of twins and 4 where the siblings were not biological: children adopted at the same time by the same parents, but not brothers or sisters and not necessarily from the same orphanage.

On arrival the children mainly presented disturbances specific to children having experience traumatic events. In particular we noted:

- inhibition of affects: 72% of the children were hypotonic, prostrate, with a blank look, and without any manifestation of emotion. They remained completely absent, not responding to solicitations from the people taking care of them. These children did not explore their environment, they did not play, chatter or babble. 32% of these children presented reactive hypersomnia (they had slept for the 9 hours of the flight and did not then wake despite numerous solicitations).
- disorders of attachment behaviours: for 85% of the children we noted difficulties in establishing interactions with the adults around them (first aid staff, adopting parents). They were either excessively compliant in the face of adult solicitation, allowing adults to take them in their arms, treat them like dolls, feed them with water and biscuits (15%) or, for the majority (85%) withdrawn and defensive, refusing any bodily contact, adopting avoiding behaviours and rendering any holding function (carrying) impossible (stiffened body, aching backwards, or too floppy, with major risk of injuring or dropping the child.
- control reaction: 66% showed constant hyper-vigilance, startled by any new event; these children struggled not to fall asleep, while they were obviously exhausted
- re-living: 35% manifested traumatic play sequences (Romano, Baubet, 2008), nightmares when asleep in the waiting area, and distressed reactions in case of reactivation (loud noises)
- regressive states: numerous children seemed to have lost abilities that were assumed to have been acquired – walking, speech, toilet training.
- manifestations of severe distress: on arrival all the children who were awake demonstrated extreme sadness, over and above control reactions, withdrawal and reliving described above. During the receiving period 11% of the children expressed their distress by screaming in desperation, some inconsolably for more than an hour. 8% cried quietly for the complete duration of the operation.
- traumatic contamination of the adults taking charge: the confrontation with these very young children mentally harmed by their many trauma and presenting signs of acute distress was difficult to endure. We noted, among both emergency staff and adopting parents (when they met their child) behaviours that indicated the traumatic contamination that was underway. The adults mostly remained silent, unable to find words in the face of the child's distress. They were overcome with feelings of powerlessness at their inability to soothe, reassure and console, or merely take the child in their arms. Some (25%) reacted by compulsive hyper-stimulation (tickling, forced play). They had great difficulty in apprehending the child's traumatic history, and this suggests that it is likely that, when confronted with post-traumatic manifestations, they will over-react or deny them. For example, such symptoms that can be interpreted as "tantrums" or "naughtiness", rather than as the signs of the mental trauma that these children have undergone. When confronted with post-traumatic manifestations, they will over-react or deny them. These symptoms that can be interpreted as "tantrums" or "naughtiness", rather than as the signs of the mental trauma that these children have undergone).

Psycho-traumatic impact among parents and siblings

The time spent with the parents in the waiting area enabled numerous questions to be answered reassurance to be given them as to their parenting abilities. 835 interviews were conducted. It also enabled us to detect distress among certain parents as well as their degree of perception of what their child had just been through.

- widely differing levels of elaboration of their parenthood: 12% had already met their child, 63% only knew the child from photos, and 25% had not even had a photo
- guilt expressed by 25% to be receiving child while for others the child had died in the earthquake: the risk is that they will minimise their difficulties and not dare to "complain" in case of difficulty
- some had thought that their child was dead: risk of tramautic encapsulation
- since the earthquake, these families had all been in an atmosphere of great insecurity and anxiety as to what had become of their child; this anxiety was compounded by statements by certain orphanages managers undergoing financial pressure : risk of vicarious traumatization disturbances relating to traumatic contamination
- all were in a state of extreme fatigue: little mental availability or energy, despite the fact that this was important to take over the children in the best possible conditions.
- 65% of the parents were adopting on an individual basis, 22% via associations, and 13% via OAA
- 32% of the parents were single
- certain parents stated they were "not ready", or "had not had time to get organised" to receive the child
- certain parents (15%) presented worrying mental disturbances: intellectual deficiency, immaturity, personality disorders, or acute disorders related to the context.

Clinical discussion

Despite the massive nature of the symptoms observed, it seemed to us that is was not easy to make a pronouncement on their clinical significance. The situation was indeed acute, and the clinical observation occurred at the time of a relational breaking-off, and at a time when the child was coming into contact with a new universe. In addition, we did not know exactly what events the children had experienced at the time of the earthquake (one to four weeks before examination), nor if there were pre-existing disorders. It is likely that the significance of the symptoms observed varies according to the child: acute stress disorder, post-traumatic stress disorder as defined in DC:0-3R (Zero to Three 2005Fenichel et al. 2005), affect disorder or again the evolution of a pre-existing condition as deprivation/ maltreatment disorder (Zero to Three 2005). Developmental and growth delays we observed in many cases supports the latter hypothesis.

Recent research concerning acute stress disorder in preschool children suggests the need for caution, beyond the emergency setting: it seems that acute stress disorders far more often evolve towards chronic states in preschoolers than they do among older children and adults; in addition, it also appears that these symptoms are often unrecognised by parents of preschool children (Sheeringa 2008).

Ethical issues

The emergency situation occurring in the aftermath of the earthquake led to the implementation of this operation (Balsari, Lemerey, Williams, Nelson, 2010). Providing care for these very young children enabled us to see the intensity of their mental distress. The risk of compoundede victimisation by hasty transfer and adoption is very real, entailing potential damage for both the children and the adopting parents and siblings. This risk of compounded victimisation should of course be weighed against the dangers that the child is liable to encounter if he stays where he is, as a result of destruction, lack of care and social disorganisation. In the chaos of the first days after the catastrophe, the balance was certainly in favour of the evacuation of these children.

The psycho-traumatic consequences are often minimised among the very young, and the risk is to think that these children are too young to realise, and that they will forget – this opinion being shared, as we sadly noted, by some professionals.

The trauma-generating consequences of this traumatic event and precipitated adoption process will depend on what the child can be told, and on the ties that the parents are able to establish with him to re-appropriate this history. If the parents, when they experience difficulties, try to cope on their own (for reasons of fear, embarrassment, guilt or shame) the outcome does not look good for these children.

It is for this reason that a close supervision of these families seems to us to be essential so as to be able to detect any individual distress (whether in the parents or the child) and family distress (siblings, parents/children)

Conclusion

The earthquake in Haiti led France to set up a completely new airport medico-psychological operation. The particular focus on very young children who had suffered numerous traumatic events went had in hand with the need to ensure a presence at the time of the first encounter between the child and his adopting parents, with whom he was frequently little or not at all acquainted.

This unprecedented care provision operation finds its place within a global approach to psycho-traumatic consequences for child victims, and also in the transmission of the trauma in the adoptive filiation procedure. The follow-up over several years of these children and these families will be necessary in order to evaluate the intensity of traumatic repercussions of a transfer in these conditions on filiation.

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Hélène Romano – AP-HP, Hôpital Henri Mondor, CUMP 94/SAMU-SMUR 94, Université Paris 12, 94010 Créteil Cedex, France.

Thierry Baubet – AP-HP, Hôpital Avicenne, Service de psychopathologie de l'enfant et de l'adolescent et CUMP 93/SAMU 93, EA 3413, Université Paris 13, Bobigny, France.

Héloïse Marichez, Chollet-Xémard, Jean Marty – AP-HP, Hôpital Henri Mondor, Service d'Anesthésie-Réanimation chirurgicale SAMU-SMUR 94, Université Paris 12, 94010 Créteil Cedex, France.

Marie Rose Moro – AP-HP, Hôpital Cochin, Maison des Adolescents / Maison de Solenn, INSERM U669, France.

Book review

By Zack Boukydis

Recently the book Nurturing Children and Families: Building on the Legacy of T. Berry Brazelton (Barry M. Lester and Joshua D. Sparrow, Eds.) was published by Wiley-Blackwell (West Sussex, UK, 2010). The book is a collection of chapters written by former students, colleagues and friends of the eminent American pediatrician T.Berry Brazelton following a tribute to Dr. Brazelton in Boston MA USA in 2008 marking his ninetieth birthday.

T. Berry Brazelton is known to millions of people worldwide as a clinician, scientist, advisor to parents; and major promoter of policy to support children and families.

When the copy of this book arrived at our flat in Budapest, my six year old daughter saw the book and heard it was about "Dr. T Berry" (as he is known in our household). She left the room and arrived a few moments later with her copy of Going to the Doctor. We read this book a number of times, before and after visits to my daughter's pediatrician. The book was also special for my daughter because Dr. Brazelton and his grandson, Alfred (who drew the pictures in the book) had signed it when I was at the tribute conference for Dr. Brazelton in Boston. I told Alfred (and his grandfather) that my daughter 'got a great deal' from the pictures in the book and Alfred wrote: "I am glad you like my pictures, Anna, keep on drawing." My six year old daughter feels her own connection to Dr. Brazelton (and his grandson).

The book is an astounding collection of thirty-one chapters that reflect Brazelton's influence on many fields including child development, pediatrics, infant mental health, nursing, psychology, child psychiatry, social work, physical and occupational therapy, and policy. Each chapter was written by a colleague who has been influenced by Brazelton over the years and includes three generations of students, collaborators and colleagues. The book begins with a thoughtful tribute to Dr. Brazelton by Geoffrey Canada, President/CEO of Harlem Children's Zone in New York City, USA.

A partial list of contributors include people surely known to readers of the Signal in a section of the book called "Infant mental health and the treatment of early trauma" [Charlie Zeanah & Paula Zeanah, Alicia Lieberman & William Harris; Joy Osofsky & Howard Osofsky; and Dante Cichetti & Sheree Toth]; and many who have contributed centrally to connections between infant assessment and infant mental health practice ;(J. Kevin Nugent; Kathryn Barnard; Heidi Als, Tiffany Field; Rose Bigsby; Amy Salisbury); others who have studied parent-infant interaction either developing Brazelton's ideas (Edward Tronick; Tiffany Field) or reflecting on them (Daniel Stern). Also included is a chapter by Brazelton's professional peer the late Stanley Greenspan.

I highly recommend this book to anyone - but especially to practitioners and teachers of infant mental health. The work of Dr. Brazelton on seeing, assessing and understanding infant development is integrated into many chapters in this book. In developing training in infant mental health, one can never 'bring in' enough experience and perspective on infant/child development and the effects of individual differences in infants on the developing infant-parent relationship; including:

(a.) Careful 'differentiated' observation of infants. From Brazelton and colleagues' contributions in the seventies and eighties onward, no longer were babies seen as passive recipients of environmental input but they were shown to have active, organized ways to seek out and respond to stimulation from parents and the environment. Brazelton and colleagues were the first to develop an infant assessment (eventually called the Neonatal Behavioral Assessment Scale (NBAS) that took into account not only reflex functioning and muscle tone; but 'organized' responses to sensory input and ability to regulate or stabilize internal states of arousal. Included in this perspective was an appreciation of individual differences in newborn behavior (first described in Brazelton's book Infants and Mothers) which brought the study of temperament in child behavior into the earlier period of infancy. Part of the generativity of this perspective on infant neurobehavior includes the development of other systematized assessments of different populations of infants and 'prenates': (the Assessment of Preterm Infant Behavior APIB; the NICU Network Neurobehavioral Scale (NNNS; for at-risk drug-exposed and preterm infants) and the Fetal Neurobehavioral Scale (FENS).

(b.) Knowing how knowledge of infant development effects one's understanding of the interactions between infants and parents. Included in Brazelton's focus on individual differences in infant behavior was an interest in how individual infants contributed to developing interactions between themselves and their parents. In the seventies, Brazelton thought that there were cycles of attention and inattention which were influenced in sustained interactions by both infants and parents. This perspective evolved into the mutual regulation model articulated by Edward Tronick and others and which contributed the still-face paradigm which allowed researchers and clinicians to observe the infant's efforts to regain (or repair) active, mutual interaction with their parent. In the book, Daniel Stern provides a fresh look at parent-infant interaction reflected in the perspective of infant arousal dynamics. Others such as Tiffany Field used dimensions of infant neurobehavior aseessed by the NBAS to study interactions between infants and mothers struggling with depression.

(c.) Enabling practitioners to develop more differentiated and complex models of development as they learn to see and support relationships with parents and infants. Joshua Sparrow's chapter describes the move in thinking about development from one-way causality to systems theory. Also, with Brazelton's emphasis on touchpoints in development, there was a central emphasis on periods of development where there was disorganization followed by reorganization that included new abilities in the infant. The touchpoints perspective and the emphasis on individual differences in infant behavior provided a huge challenge to existing models of development which needed to assume continuity from early infant behavior to later developmental attainment. Brazelton's contributions were aided by other developmental theorists and advanced methodologists, especially Sameroff (the transactional model) and others which have indicated that it is not 'biological status' alone, but complex interactions between infant and environment, and infant and parent which help to predict later developmental status.

As part of his opening chapter, Barry Lester provides perspective on how behavioral epigenetics (interaction between fetus and prenatal biobehavioral environment) can contribute to an understanding of how the infant "arrives' in the postnatal world with the individual differences in newborn behavior seen and assessed by existing infant neurobehavioral assessments. Three sections of the book: Regression and reorganization in relational models of development (chapters by Mikael Heimann and Frans Plooj); Relational and contextual developmental models (chapters by Stanley Greenspan and Robert Levine) and Neuroscience perspectives on relational

and developmental models (chapters by Allan Schore and Jerome Kagan) provide advanced understanding of connections between developing infants and their developing relationships.

(d.) Knowing how to build on solid models of development and parenting when building programs and services for families with young children. Brazelton and colleagues influence on the translation from infant development to models of care evidenced in chapters by Kathryn Barnard on the Nursing Child assessment Satellite Training (and Keys to Caregiving);Heidi Als and Rose Bigsby on care in the NICU for preterm infants and their parents; and three chapters on nurse home visiting programs (Kristie Brandt & J. Michael Murphy; David Olds; as well as Ann Stadtler, Julie Novak & Joshua Sparrow).

Joshua Sparrow as co-editor contributed a chapter which provides a central perspective on Brazelton's emphasis on forming relationships and collaborative consultation. These ideas have grown through the evolution of the Touchpoints program; evidenced in a chapter by Jayne Singer and John Hornstein on the Touchpoints approach to early childhood care. Separate chapters indicate Brazelton's influence on infant mental health training in early intervention and early head start (the late Libby Zimmerman); innovations in behavioral/developmental pediatric fellowship training (Constance Keefer); child life (Myra Fox); early child care and education (Francine Jacobs, Mallary Swartz, Jessica Dym Bartlett & M. Ann Easterbooks); and a thoughtful chapter by Daniel Pederson and Jack Shonkoff on translating the science of early child development into policy and practice. The book concludes with a chapter by Sara Lawrence-Lightfoot called Respect and Healing.

(e.) The conduct of research in applied development, early intervention and evaluation of infant mental health programs. Combining an emphasis on the importance of individual differences with one on complex interactions between the infant and environment has placed a demand for new methods and new models of development. Barry Lester's opening chapter and several others in the book detail how researchers have worked to translate Brazelton's contributions into sound research protocols.

To sum up the connection between the new book and infant mental health training and practice, I can but quote WAIMH's own Hi Fitzgerald in his tribute on the back cover of the book: "Those who want to bask in and relive the exciting engagement with infants and families throughout the second half of the 20th century can do so in these chapters. Those who want to engage in the transformations required in the 21st century, read, imagine, and take action, know that Brazelton's footsteps, though wide and encompassing, move quickly."

The book is a valuable resource for training, for practice - and for reading and reflection. When I was preparing to write this review, I tended to read one chapter and then spend some time afterward reflecting on what I heard that was new; what confirmed my experience; what I disagreed with, and so on. Therefore, you could say I also recommended the book as a source of 'daily' reflection – and inspiration.

Post script. When I was a young Ph.D. at Dr. Brazelton's Child Development Unit, at Children's Hospital, Boston, I was astounded at his fellowship program. It was developed for clinicians from pediatrics and other disciplines, at the fellowship level, to study and experience what a colleague called 'typical child development and parenting." Brazelton, I think, was concerned that pediatric residents (and others in allied disciplines) had learned about diagnosing problems and treating known illnesses but this learning was not often balanced by learning about child development and the everyday concerns of parents. Early on, I asked: "Why would people at this stage of their career return for two years of sitting on the floor in day care centers; participating in the Early Childhood Service and learning to join with colleagues in many other disciplines in seeing and then, supporting children and their parents?" One simple answer was that Brazelton himself, and those around him; had created what one fellow called "A hotbed of child development." The curriculum included how to learn from research and develop researchable questions in an applied context. All of the fellows have moved on to noteworthy careers as faculty, (often forming developmental/behavioral pediatric and applied child development training programs); researchers (in first rate applied research protocols); clinicians and policy advisors. In a similar light, this book is itself a "hotbed of child development and issues central to infant mental health practice."

Two of the 'Brazelton fellows' have passed on recently. This review is a tribute to Dr. Brazelton and is also dedicated to the memory of Stephen Parker, M.D. and Bob Gatson, M.D .

Zack Boukydis, PhD, Visiting Professor, Fullbright Fellow, Department of Pediatrics, Semmelweiss University Medical School , Budapest Hungary and University of Turku, Turku, Finland. E-mail: zboukydis@gmail.com.

Editor's Perspective

By Miri Keren, M.D.

Challenges in representing the infant in new contexts

Introducing new ideas and concepts into well-established and often rigid systems, is a task that most of us, as infant clinicians, have been faced with, each within his or her own country and health or mental health facilities or networks. Indeed, the idea that infants perceive, understand and react to their surroundings, is so obvious to us, and still so strange to many of our colleagues, especially whatever discipline they come from "Well, he's too young to understand," is still a very common statement among many lay people and professionals.

Each of the papers in this issue describes how this "obsession" of ours, pushes us to represent the infant (The French psychoanalyst would say "Talk the infant") in contexts where his/her emotional needs are at potential risk. The context may be a natural catastrophe, such as the Haiti earthquake; a society where psychological thinking is just starting to grow, such as in Latvia or Hungary; or even an orphanage where the adults' needs predominate. Although the contexts are different, the idea is the same: to introduce and disseminate our understanding of infant mental health, by "talking about the infant".

Our challenge is not only to share knowledge, but also to hold the infant in our minds, so that the question, "Hey, what about the infants?" should be automatic, whenever we hear about severe and adverse events hitting communities. For instance, we could not take for granted that the trauma experienced by Haitian infants would be considered after the earthquake. If the child psychiatrist, Marie Rose Moro, did not have "babies in her mind," I wonder whether the medical force from "Physicians without Borders" would have thought about them as a target population at risk for developing post-traumatic reactions. More often than not, we cannot count on health policy leaders to initiate actions on behalf of babies following a traumatic event. We have to remind them to think about the infants' psychosocial needs. We are definitely the ones who represent them.

In order to do so, we do not necessarily need to work for big changes in systems or infrastructures. We can speak for the babies as individual situations arise. I had occasion to do this two months ago when a huge fire spread over the Carmel forest in Israel and people were evacuated from their houses in the middle of the night. In the midst of thick smoke and red blazes, police spokesmen shouted in the streets: "Life is in danger, life is in danger, you must leave your house immediately!". The media described how Hebrew-speaking Ethiopian children woke up their non-Hebrew speaking parents and how Holocausts survivors re-experienced the smell of the smoke. Some were found by the firemen holding old suitcases, re-traumatized, as if ready to go to the camp. Obviously, no one mentioned infants' reactions to the trauma experienced by the fire. I, together with the local child psychiatrist, called the director of the Early Childhood Center of the town that had been the most exposed, to ask her whether measures had been taken to detect those infants and parents at risk for developing post-traumatic symptoms. Her reaction was of keen surprise mixed with a bit of guilt. She said, "I did not even think about it. I thought about the school children and the adolescents… though I work with toddlers myself!" The next step was quite simple. She and I met and we formulated an easy to use questionnaire to screen for symptoms of post-traumatic stress disorder (PTSD) in both the infants and their parents, to be distributed in the Well Baby centers where all Under Three's come for immunizations and developmental follow up. An indirect, yet immediate, effect was the community health professionals' request to have more information about PTSD in infancy. They realized that the main reason for not having thought about it was the fact that they did not know what a post-traumatic stress disordered infant looks like.

Talking about or representing the baby is not always that easy; the resistance we often face is very well described in Grigoris Abazoglou's paper. He, like the Latvian Infant Mental Health team, had to find creative ways to introduce basic concepts, such as attachment. I was just talking the other day, with Zack Boukydis, who reviewed the book about T. Berry Brazelton for this issue of The Signal, and who has recently moved to Budapest. He told me how much he needs to start from zero to convince the local neonatal care unit staff of the real need to give psychological counseling and support to the premature babies' parents, to work through the traumatic delivery and the stay at the neonatal care nursery.

I believe these difficulties we face when speaking about the psychological needs of infants to other professionals and health policy makers, do not come only from a lack of knowledge. No matter how much evidence-based information we bring them, we often face a basic resistance to the idea that infants do develop psychopathology when not cared well enough by their caregivers, and do develop post traumatic reactions with long term impact on their development when faced with traumatic experiences, directly or indirectly. , . Many adults with whom we speak have never thought about the infant in these ways before. We, as individual clinicians as well as members of WAIMH, seem to be the ones who can mediate between them and the infants.

President's Perspective

By Antoine Guedeney

What's new since our last WAIMH Congress that was held in Leipzig in July 2010? Well, the news is that the Congress was a scientific success as well as a financial one, thanks to the efficacy of the local organizing committee (LOC) headed by Kai Von Klitzing. Kai was able to obtain financial support from the City of Leipzig, as well as from other sponsors. Thus, he kept expenses under control and made a profit for WAIMH, which is the first time that a congress made money in many years. In fact every congress brings WAIMH 50 USD per registered participant. Then the profit- if there is any- is divided between the LOC and WAIMH. In 1989, the Lugano Congress made a profit, thanks to a large contribution from the city, and the Stockholm Congress was a great success, due to Peter de Chateau , even though it occurred in the middle of a petrol crisis. The Chicago Congress lost money. The Tampere Congress made quite a good profit, but the following Congress in Montreal was a loss for WAIMH. The Paris Congress brought no extra money to WAIMH nor did the Yokohama Congress. Therefore, the Leipzig Congress is the first one to bring extra money to the organization in a very long time. The success in Leipzig makes WAIMH financially secure. This is crucial to the stability of our organization since our next Congress is- as stated in our by-laws- outside Europe, i.e. in Cape Town, South Africa, a smaller affiliate organization. There is greater fiscal risk in hosting a Congress in a smaller infant mental health community.

We have asked every participant about his or her feelings about the Leipzig congress. The analysis of the feedback will be sent to you in the near future. What we already know is a general feeling of satisfaction with the scientific content, the ambiance and the organization.

One reason for the success of the Leipzig Congress was the leadership of Kai von Klitzing, with strong teamwork from the (LOC) and WAIMH Program Committee (PC), along with an excellent conference organizing company, Interplan.

Over the years, the WAIMH Central Office has gained experience in organizing and running world congresses. We can help the LOC with budgeting, sponsoring and abstract handling. Still, there are clear advantages in having a long-term contract with one conference organizing company that gets to know the structure and goals of our organization. This is the reason why we have launched a bid for a long term contract between WAIMH and an international Conference Organizer. The WAIMH Board will make a choice within a month from now between the bids received and this will be applicable to the WAIMH Congress in Scotland, 2014 that follows the Capetown Congress in 2012.

We have the first results of the major changes we made in the structure of our WAIMH Board by including two delegates who represent the affiliates, Martin St André and Maree Foley. They have initiated a survey of all the affiliates, as described in this issue of the Signal, so that we know much better "Who is Who and Where" in WAIMH and that every affiliate delegate can be in direct contact with another affiliate. This is a major step and I thank Martin, Maree and our office staff for accomplishing this task effectively and in due time.

As one of our major goals of sharing knowledge and experience, our next step is to launch another survey among all the affiliates in order to define local needs and wishes in terms of training. This will be the basis on which we will organize Training Institutes, in the format of one or two preconference days of world and regional congresses. For instance, our first Training Institute will be held in June 2011, just before the ESCAP conference in Helsinki, Finland. This will be the occasion for local professionals who come to the ESCAP conference to have a training day about infant mental health assessment and intervention. We will do the same in September 2011 in Buenos Aires around the dates of the World Psychiatry Association conference, and again at the WAIMH Congress in Capetown in 2012.

Last but not least, plans for the Capetown Congress are under way. We will have a site visit there in April, with minimal costs to WAIMH. The Program Committee has already started to work, with Kai von Klitzing as chair, Neil Boris, Mark Tomlinson and Kaija Puura as committee members, together with the Local Organizing committee with Astrid Berg as chair.

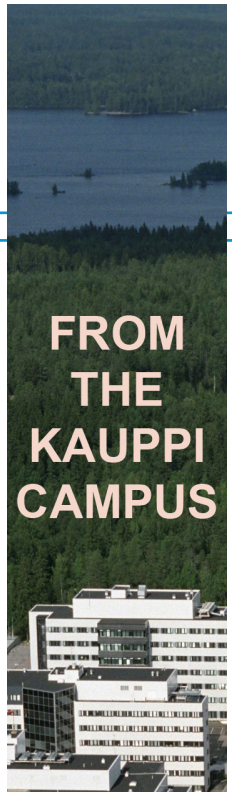
So start preparing your presentations for the 2012 WAIMH Congress in Capetown!

With best wishes Antoine Guedeney, President

Last minute note: The earthquake in Christchurch devastated parts of the city. WAIMH is a family and every board member, as it seems, has spontaneously sent an email to Maree Foley, representative of the Affiliates societies on the Board. She gave news the day after, but was still worried about her in-mother- in-law's fate. She described how some local WAIMH members very courageous as they tried to help many young children. The WAIMH network provided an immediate resource of existing programs to help infants in traumatizing situations, such as those that have been developed in New Orleans, New York, Haiti, and more. This is what is great about WAIMH...

From the Kauppi Campus -News from WAIMH Office

By Pälvi Kaukonen, Kaija Puura, Minna Sorsa and Leena Kiuru



Dear WAIMH members,

2011 is a year between our world congresses: Leipzig is past and Cape Town approaches. As before the WAIMH Office sent an email to all Leipzig congress participants asking them to fill in an evaluation form in the web. The office received answers from approximately 13% of participants. The respondents were quite satisfied with the content of the congress: 80% of respondents rated the Congress as excellent or good on the whole. According to the feedback, the highlight of the Congress seemed to be the playful and humorous plenary of Michael Tomasello. Two thirds of the respondents felt there were too many events, and having to choose between so many good presentations was one of the most frequent complaints given. Even with the huge difficulties in the beginning with the new web based submission system, half of the submitters rated the system excellent or good. This indicates that we were able to correct the faults according to the constructive feedback from the submitters as we went along.

For the next WAIMH Congress in Cape Town the respondents wished to hear more about Africa, attachment, treatment, neuropsychiatry and how to make societies more infant friendly. Training courses on both assessment methods and treatment interventions, and multicultural discussions were suggested by many respondents. In short, people wished events with more interaction and discussion.

After Leipzig congress we have had time to focus on membership issues and improving the WAIMH website. The membership register has been cleaned of multiple ID´s many of the members had. Now each member should only have one ID for updating the WAIMH membership.

We have also updated the current WAIMH Affiliates' list with www-addresses and contact emails to the WAIMH website. There is also a new subpage for the WAIMH Affiliates' "Upcoming courses and meetings". The office (office@waimh.org) will add affiliates' new training and congress information on the page. There is also a new "Resources and links" page for international infant mental health congresses and trainings on the WAIMH website. So do go online and check the website from time to time see what is happening.

The preparations for the 13th World Congress in Cape Town are well on their way and the Call for Papers will be sent out soon. Finally, we want to remind you about RENEWING YOUR MEMBERSHIP FOR 2011. Go online to www.waimh.org.

Enjoy your autumn or spring – whichever season one is coming up on your side of our globe!