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The father-child activation relationship: a new theory to understand the development of infant mental health

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The activation relationship theory is a complement to the attachment theory. According to John Bowlby (1969), attachment consists of two opposing, complementary behaviour systems: 1) the proximity behaviour system that ensures the child's protection and 2) the exploration system that fosters the child's knowledge acquisition and adaptation to unfamiliar environments. Children regularly seek comfort through contact with attachment figures when tired, hungry, sick or afraid or when feeling insecure in the presence of novelty, and this comfort provides them with the necessary confidence to explore their environment further. The Strange Situation Procedure (SSP) developed by Mary Ainsworth and colleagues (1978) has made it possible to assess the quality of the attachment relationship in children ages 12-18 months by focusing more on the secure base than on the parent's response to the baby's need for stimulation in exploratory contexts. Paquette (2004a; 2004b) has theorized father-child attachment by developing the concept of the "activation relationship", the affective bond that permits children to open up to the outside world, focusing primarily on parental behaviour in relation to orduring child exploration of the environment.

The activation relationship theory evolved out of three findings. The first finding was that father-child attachment has a lower explanatory potential than mother-child attachment as assessed with the Strange Situation. The low stability, low transmissibility and low predictability of father-child attachment have led increasing numbers of researchers to question the appropriateness of using this procedure with fathers who have little involvement in daily caregiving (Suess, Grossmann & Sroufe, 1992; van IJzendoorn, 1995; Youngblade, Park & Belsky, 1993). The second finding concerned emerging literature with an increasing focus on the paternal function of opening the child to the world (Paquette et al., 2009). According to Le Camus (2000), paternal roles can be grouped together under the function of opening children to the outside world. Fathers act as catalysts for risk-taking, inciting children to use initiative in unfamiliar situations, to explore, take chances, overcome obstacles, be braver in the presence of strangers, and stand up for themselves (Paquette, 2004a, 2004b; Paquette, Eugène, Dubeau & Gagnon, 2009). This function of opening children to the world is also mediated by language. Studies have shown that fathers play the role of a linguistic bridge to the outside world by using more complex forms of language (by referring to past events, using unfamiliar words and requesting clarification more) than do mothers (Ely et al., 1995; Ratner, 1988; Tomasello, Conti-Ramsden & Ewert, 1990), which causes children to speak more and to use a more varied vocabulary with their fathers (Rowe, Cocker & Pan, 2004). In addition, mothers' verbalizations mostly pertain to emotions while those of fathers refer primarily to actions (Marcos, 1995). Fathers also make more problem-solving related demands than mothers, who tend to solve problems in place of their children (Labrell, 1992). Accordingto Labrell (1996), children must learn to respond to unforeseen events and it is fathers who facilitate such learning by teasing them and destabilizing them with creative, non conventional games. Fathers tend to excite children more and to engage in more physical play with them than do mothers, especially as far as boys are concerned (Dixon et al., 1981; MacDonald & Parke, 1986). Men generally take more risks than women (Byrnes, Miller & Schaffer, 1999), and father-child physical

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play and physical aggression by children represent particular forms of risk-taking (Paquette, Bigras & Crepaldi, 2010).

The third finding concerned human-specific adaptations and especially human fathers' unique status in the species as compared to other primate species. Humans live longer, and human children are dependent on their parents for longer. A large brain and a prolonged period of development (requiring a high degree of parental involvement) allow humans to learn the great number of things necessary to ensure their adaptation to an environment that has become increasingly complex over the course of history (MacDonald, 1993).

There is a relation between paternal involvement, sexual dimorphism, and mating systems in animals. Polygynous primate species are characterized by pronounced sexual dimorphism, with males being bigger and more aggressive than females (e.g.: baboons). This dimorphism can be explained by the strong competition among males for exclusive access to females, and also by the fact that females choose dominant males (Barash, 1982; Fedigan, 1982). Polygynous primate males generally provide no paternal care and are either indifferent to youngsters or attack them as the latter near puberty, but do protect their group of adult females. In promiscuous primate species (e.g.: macaques, chimpanzees), sexual dimorphism is less pronounced than in polygamous species. Malesand females engage in sexual relations with many partners, but dominant males have priority in terms of access to females. Males show tolerance toward youngsters in the group and may sometimes play with them, but provide no paternal care. Finally, there are a few monogamous primate species (e.g.: siamangs, titis); these species show little or no sexual dimorphism in terms of size and aggressiveness and males provide intensive parental care. Humans also display sexual dimorphism in terms of size, strength and aggressiveness, but fossils show that size-related sexual dimorphism is less pronounced in humans today than it was in our hominoid ancestors (McHenry, 1996). Moreover, the human species differs from all other primate species in that while fathers may give very little or no direct basic care to children (Hewlett, 2000), they do adopt parental roles that are distinct from those of the mothers (Le Camus, 2000). Human fathers play, at minimum, the role of provider of resources and protection for their spouses and children and assume various parental responsibilities, generally with boys at the end of childhood, depending on the culture (Paquette, 2004a). This parental specialisation may have occurred phylogenetically with the emergence of the sexual division of labour (hunting for men and gathering for women[1]), fostered, on the one hand, by the extremely high demands of the human infant due to its immature status and, on the other, by the growing complexity of the human societies to which the offspring must adapt.

The extraordinary increase in the volume of our ancestors' brains would have caused problems at childbirth, and natural selection would have favoured women who gave birth prematurely. This would explain why the human infant's brain is not completely developed at birth and continues to develop over the course of the first year oflife. Being more vulnerable and dependent than other primate infants, the human baby would have required more care from its mother, who would thus have had less time available to find food, thus resulting in selective pressure for greater paternal involvement (see Paquette, 2004a, 2004b). A series of evolutionary strategies (greater genital sensitivity; the establishment of continuous sexual activity—due to females being sexually receptive twelve months a year and soon after delivery—; concealed ovulation; female selection of male providers, etc.) would have resulted in males staying with females for as long as possible (Alexander & Noonan, 1979), bonding with them, and eventually becoming involved on both conjugal and parental levels. In addition to protecting the mother-child dyad from predators, the father would thus have developed an important provider role by supplying the mother-child dyad with necessary resources. The literature supports the notion that this provision of resources helped reduce the risk of infant mortality and ensure better physical health for children (Geary, 2000). This type of distribution of labour would also have permitted the human species to increase its population by reducing the interval between births (1 to 2 years in humans versus 5 to 6 years in chimpanzees).

Fathers would have become involved directly with boys especially through their previously mentioned function of opening the child to the world, thus helping boys develop the skills necessary to fight, hunt and explore territory in search of resources; skills they would

[1] — given that our brain today is still the same as that of the hunter-gathers of the Pleistocene Epoch, the period spanning from 1.8 million to 10 000 years ago (Tooby & Cosmides, 1990) —

need once they were adults in order to ensure the survival of their own children (see Paquette, 2004a). Due to the great plasticity of human behaviour, we are currently witnessing increased paternal involvement in Western industrialized societies, especially in middle socio-economic families: fathers are more involved in caregiving than before, with younger and younger children, and progressively more with girls, even in rough-and-tumble play (Dumont & Paquette, 2008; Paquette, 2005; Paquette, Carbonneau, Dubeau, Bigras, & Tremblay, 2003). While fathers involved in caregiving become increasingly important sources of comfort for their children, studies show that such fathers continue to engage in vigorous, physical play with their children (Dumont & Paquette, 2008). Further, humans engage in the most parent-child play of all primates that live in their natural environment (Biden & Suomi, 1993).

The secondary role attributed to fathers in attachment theory is not surprising given that Bowlby's inspiration came from research on sexually promiscuous primate species (rhesus monkeys, baboons, etc.) in which the young are raised by their mothers. However, the activation relationship theory predicts that, under difficult environmental conditions, children will benefit more from the direct involvement of both their parents when the latter play complementary parental roles. It also predicts that, in general, fathers will serve as children's primary activation figures and secondary attachment figures, while the opposite will be true of mothers. The activation relationship theory predicts that the activation relationship will be the result of the interaction of child temperament with parental encouragement to explore (especially to take calculated risks) and parental control (aimed at protecting the child). To a certain extent, temperament is a reflection of the inherited variability of a group of adaptive dimensions tied to our ancestral environment. The activation relationship fosters children's confidence in their own abilities to cope with threats and strangeness in their physical and social environments as their parents stimulate them to push their exploration further while at the same time providing them with the confidence of knowing they are protected from possible danger —hence the importance of discipline. In other words, children have an innate motivation to explore their environment and develop their autonomy, and the role of parents is to channel this energy according to their child's biological predisposition as well as environmental conditions or dangers.

The activation relationship theory also predicts that fathers will activate children more than mothers will, and that boys will be activated more than girls. In addition, the activation relationship theory should predict competition and risk-taking in children. The theory considers aggression to be a form of risk-taking, and therefore predicts that the father-child relationship will be a greater determinant of the development of aggression problems in boys than the mother-child relationship. Indeed, to date, problems of aggression have been linked more to disorganization (Lyons-Ruth & Jacobvitz, 2008) than to the A-B-C types of attachment (Berlin, Cassidy & Appleyard, 2008; Deklyen & Greenberg, 2008). The prediction can be made that over-activated children will have a greater tendency to develop externalising problems while under-activated children will have a greater tendency to develop internalising problems.

Paquette and Bigras (2010) have validated a procedure called the Risky Situation (RS) which allows for assessment of the parent-child activation relationship in children 12-18 months. Gaumon and Paquette (submitted) have adapted this procedure for preschool-age children. The RS is a twenty-minute-long observational procedure that takes place in an unfamiliar room with toys and in the presence of a male stranger. It is divided into six structured episodes during which the child is presented first with a social risk (an increasingly intrusive male stranger), then with a physical risk (a set of stairs), and then forbidden by the parent to climb the stairs. In the RS, under-activated children tend to engage in little exploration, to be passive and anxious and to remain close to the parent. Activated children are confident and prudent in their exploration and obey when the parent sets a limit. Over-activated children are reckless and do not obey when the parent sets limits. The under-activated relationship is linked to parental overprotection, while the over-activated relationship is linked to parental difficulty in obtaining obedience from the child. The coding sheet also provides an activation score between 0 and 5 indicating the extent to which the child is optimally activated (with a score of 5 corresponding to the most positive activation relationship). Results have shown that boys are more activated by mothers and fathers than girls are, and that, depending of the sample, child's temperament (shyness, impulsivity, sociability) may be linked to the activation score. Moreover, and most importantly, the activation relationship reflects the history of parent-child interactions and not only child characteristics: parental stimulation of risk-taking significantly explains the activation score after controlling for child characteristics (sex and temperament). Finally, Paquette and Bigras' (2010) article showed that fathers of activated children tend to have a greater tendency to supervise from slightly more than arm's length than do other fathers. This father-child distance, in which the father is neither too close to nor too far from the child, allows the father to protect the child in case of danger while providing the child with the necessary room to practice abilities independently.

Flanders et al. (2009, 2010) have shown that the association between the frequency of father-child rough-and-tumble play (RTP) in the preschool period and the frequency of physical aggression (which are both evaluated with a self-report questionnaire) is moderated by the father's dominance during RTP (evaluated through observation). When fathers are not dominant over their children, the greater the frequency of RTP, the more physically aggressive the children are and the less they regulate their emotions five years later.

Paquette and Dumont (submitted) have found a positive association between the activation relationship in toddlerhood and RTP frequency at the age of three years only in boys, despite the fathers in their sample engaging in as much RTP with girls as with boys. When fathers encourage their boys to take risks in their physical and social environments, protecting their sons through the use of a combination of supervision and discipline, the boys engage in more risky physical play such as RTP with their fathers. The study's results also support the idea that the Strange Situation evaluates something different when used with father-child dyads (see also Dumont & Paquette, submitted).

Using the preschool risky situation, Gaumon and Paquette (submitted) have confirmed the hypothesis of an association between the activation relationship and internalising disorders (ID) in children (as evaluated with the Child Behaviour Checklist: Achenbach & Rescorla, 2000). The more positively activated children are in their relationship with their father, the fewer internalising disorders they display. The association was found to be significant after controlling for child temperament, parental behaviour and the number of hours worked per week by fathers. Moreover, underactivated children have significantly more ID than activated children. The exploration of links between the activation relationship and ID subscales revealed a unique connection to anxiety. Underactivated

children are more anxious when they receive less encouragement to take risks and explore their environment and when they are overprotected through the use of more control than necessary in light of any potential danger. Dumont and Paquette (submitted) also have found the same results in a longitudinal study with another sample, assessing the activation relationship in toddlerhood with the Risky Situation and assessing internalising problems at three years with the Social Competence and Behaviour Evaluation Scale (SCBE: LaFreniere & Dumas, 1995).

In conclusion, the activation relationship theory has the potential to provide us with a better understanding of the development of infant mental health by taking into account the specific roles played by fathers as a complement to those exercised by mothers in the family system.

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News from the WAIMH Affiliates Council

Affiliates Corner

March 2012

Welcome to 2012 – the year of the WAIMH congress in Cape Town. This congress will include a time to reflect on how we are going in regard to our growing relationships with each other and with WAIMH. This brief letter invites you to join with us in reflecting on a few issues for us all as affiliates.

First, affiliates have the opportunity to create and sustain an interdisciplinary collaboration based on a shared view of infant mental health. While interdisciplinary theory and practice is often espoused, the actual practice of this is more difficult with both academics and practitioners increasingly identifying themselves within specific streams of theory and practice. While the benefit of this trend is potential depth of knowledge, a coexisting risk is creating a world within a stream; a bit like seeing a baby on its own. Yet, as Winnicott would remind us; there is never a baby there is always a baby and someone. We encourage you all to embrace the tensions and struggles that come with growing a shared view within your affiliates – perhaps as our affiliates grow they will do so amidst the ebb and flow of "rupture and repair" – a process Ed Tronick so eloquently has described.

Second, as WAIMH reaches out to its members via the affiliate council it has become increasingly clear that some WAIMH members are not actively engaged with their local affiliates and vice-versa. We are keen to understand this situation more and invite your ideas and experiences of this issue. Your contribution will help to build a broader picture, from which we can meaningfully respond. It is clear however, we have some more bridges to build in this regard with each other. So if you are reading this and you are a member of WAIMH but not linked in with an affiliate, but you would like to be, let us know and we will put you in touch with the nearest affiliate to you – which may be a different country. This capacity within WAIMH is a great strength that we can tap into. Also if you are a member of an affiliate but not of WAIMH and would like to share with us your experience of this, please send us an email. We would be delighted to hear from you.

Third, at the WAIMH congress, we will meet as a council. We are in the process of formulating the agenda. So, whether you plan to be at the congress or not we would very much appreciate any ideas you might wish to have discussed. If you do, you can send these to office@waimh.org or to either of us.

Finally, we wish you all the very best for 2012. We especially look forward welcoming new affiliates from across the globe; and in turn introducing them to you during the year.

Martin St-André
Affiliate Council Chair

Maree Foley
Affiliate Representative

Connecticut Association for Infant Mental Health, Inc.

Affiliates Corner

March 2012

By Grace A. Whitney, PhD, MPA, IMH-E(IV)®, Director, CT Head Start Collaboration Office

Margaret C. Holmberg, PhD, IMH-E(IV)®, President, CT Association for Infant Mental Health

The Connecticut Association for Infant Mental Health, Inc. was formed out of a task force on early childhood development sponsored by our Child Health and Development Institute in 2002. We followed the suggestions from WAIMH for establishing an affiliate and developed By-laws, formed a Board of Directors, established membership dues, and held our first meeting and conference in 2004. We became a 501c3 (US non-profit) organization in 2009 and adopted the Competency Guidelines for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health® in 2009 from Michigan-AIMH. In 2010 we engaged a professional to help us develop a Business Plan following the strategic plan developed by the Board and hired a part time Endorsement Coordinator.

Our membership has grown from 30 to 180 persons from diverse professional and educational fields. Our contact list now numbers 350.

Prior to 2010 we held two professional development activities a year with 80-100 people attending. Since adopting the Competency Guidelines and offering the Endorsement our educational activities have increased. With funding specifically for workforce development we have offered a series of training on infant/toddler and family development related to the Competencies and introductory sessions on reflective supervision. In 2012 with funding from federal, state and local grants we will be offering another training series and will provide four-year-long reflective supervision opportunities for mixed groups of Part C, Early Head Start and child welfare staff.

In addition to membership and conference registration fees, our key funding streams have been federal, state, and private grants. US Department of Health and Human Services funding has come to CT-AIMH a) from the Substance Abuse and Mental Health Service Administration through a local system of care and state work force collaborative, b) from the Office of Head Start through the State Collaboration Office, and c) from the Children's Bureau through our Department of Children and Families. Each of these federally funded efforts includes CT-AIMH in their work plans. Funding from our State Department of Developmental Services was received to support reflective supervision work this year. A private foundation, the Child Health and Development Institute of the Children's Fund, has been a long-time supporter and source of funds. These collaborations have allowed us to move our workforce development initiatives forward, promoting the Competency Guidelines and Endorsement process.

To promote the Competency Guidelines we established a Competency Planning Consortium in 2008. This group has become the Professional Development Advisory Committee and is currently engaged in a visioning process to plan for growing our Competency and Endorsement Activities.

What has worked to get us to our current status? Conneticut Champions who have spoken on our behalf at critical meetings, financial support from federal grants and state agencies as we have been written into their work plans, private foundation support, learning and sharing through connections with other states and the WAIMH¸ and a growing interest in and evidence for the importance of early relationships and emotional regulation.

Our challenges in moving forward are growing from a Board of passionate volunteers to a paid staff, expanding our Board to include people with affluence and influence, finding ways to infuse the infant mental health Competencies into the policies and practices of those agencies and programs that provide services to infants/toddlers and their families, and finding multi-year funding sources that support the infrastructure of the Board and committees.

For additional information please see our web site: www.ct-aimh.org

Obituary
Michel SOULE

Professor Michel Soulé died in Paris, February 2012, aged 85, from a long neurological disease which had kept this very active man confined to a wheel chair for several years. Michel Soulé would have loved to attend his own funeral, but he would have liked it to be a feast, or even better, a 'bal costumé'. Like Huckleberry Finn, he would have loved to hear what was said of him, who was moved, who was not attending. He would have been pleased to see that in this Montparnasse cemetery we were very numerous, even though the temperature was minus 10 C. Almost everyone he had been able to teach, to enlighten and to put to work was there - members of a large, heterogeneous family.

Michel Soulé was a very special figure in the field of French speaking Child and Adolescent Psychiatry. He came from a family of mathematicians and scientists and started by preparing for admission to top engineering schools. He had a clearly organized, scientific mind, as well as a psychologically oriented one. This was obvious when dealing with him as a boss. He quickly moved to medicine, then to paediatrics, then to child psychiatry. He often said that when he did so his mother asked him, " But what have we done to you?.": He had Freudian psychoanalysis with Serge Lebovici, then became a training member of the Paris Psychoanalytical Society. After his residency, he was not named full professor, most probably because he was much too smart for his mentors. He therefore organized doe himself his own place for working , researching and training, as did Serge Lebovici and Léon Kreisler, his friends and colleagues, for the same reasons. The place was the Institut de Puériculture de Paris, in the 14 th district, with a clinic for infants and children, in a paediatric hospital. There, he opened the first day care unit for autistic and psychotic children. He developed liaison work with the NICU, one of France's top ones for very low birth weight premature babies. He was fascinated by the work developed in the IPP with foetuses and family, in one of the earliest foetal medicine department, led by Fernand Daffos, the French pioneer of antenatal diagnosis and intervention. There, he helped the Daffos team reflect on ethical issues in this very new field, and explored the effect of ultrasound echography on parents' minds.

Michel Soulé will be remembered for a lot of reasons, but the one of organising prevention and early services for infants in the community is a very special one indeed. He was able to recruit the help of a brilliant, young magistrate, Simone Veil, who became a very prominent politician and health minister to help him organize the first district based prevention and early intervention network for infants and families.

In addition, ,Michel Soulé organized a yearly meeting for infant, child & adolescent mental health professionals, over 25 years ago. He meant it as a crossroad between disciplines, where people came to learn, to reflect on new issues, to share resources , as well as to be amused and distracted from daily clinical work. What he established was beautiful - a special mixture of pleasure and work, with around 800 people attending each session. Many of these "Journées de la Guidance" were memorable. The first one was in 1973, focused on infant's functional syndromes. It led to the writing of a still famous book by Michel Soulé, Michel Fain and Leon Kreisler on early psychosomatics. Another meeting was about parents in the NICU; another introduced T. Berry Brazelton 's work to the French public; another examined foetal medicine issues; and yet another was one on the effect of an autistic child on the parent' s mental life. Michel Soulé was definitely the first psychoanalytically oriented child psychiatrist to raise the issue of autism in France.

In summary, Michel Soulé was quite a leader, a fantastic teacher, and a great organizer. He wrote a classic teaching book on child psychiatry, gathering contributions from all over France. He organized the first course in infant and child mental health, which was followed by legions of paediatrician, psychologists and child psychiatrist. At last, in 1985, he was named honorary Professor of Infant Psychiatry at René Descartes University (Paris V). He was extremely pleased with this recognition, even if it was quite late in life. He had a great ability to connect with children and adolescents, as he had kept something from his own childhood. He was curious and playful, loved to listen and to tell stories, to make jokes. He could not live without reading, without learning, and without music, particularly opera. He loved to travel, particularly in Italy, where he went as often as he could. He was a close friend of Graziela Fava and many Italian child psychiatrist and psychoanalysts. He stayed quite often in Trento to teach and work with the Fava's, and he went more than 40 times to Venice.

Of special importance, Michel Soule was particularly helpful with the young child psychiatrists of my generation or a bit older. He told us how to teach and enlisted us in his clinical and scientific adventures. Though he did not speak English, he was very interested in the international landscape and was well known in South America, as well as in all French speaking countries. Michel Soulé took great interest in WAIPAD and was a member of the organising committee in the Lugano WAIPAD congress, along with Bob Emde, Bertrand Cramer, Hiram Fitzgerald, Serge Lebovici, Charley Zeanah, Kathryn Barnard.

We will remember his strength in front of his increasing handicap, of his willingness to live, to understand, to learn, without abdication. I miss him, we miss him.

Antoine Guedeney

Reflections on filicide

By Sam Tyano and Miri Keren
Tel Aviv University Medical School,
Geha Mental Health Center, Israel

"A four-year-old girl had disappeared for two months and was found dead in a suitcase at the bottom of a river. The girl's father admitted to having killed her and, the girl's mother is suspected of having asked him to do so."

"A three-year-old boy was drowned by his mother, a single parent. Until then, this boy filled the mother's world. She had planned to commit suicide, but did not do so."

"A one-year-old infant girl was killed and hidden in a forest by her father. Her parents were divorced. "I knew this would be the solution for all my problems," the father said.

Introduction

The interdiction to kill one's own child is not a universally shared value.
The first published "near-filicide" of our ancestor, Abraham, was ready to sacrifice his son, Isaac, as the ultimate proof of his unconditional commitment to God. But God did not allow it to happen…

To most Western minds, the thought of a parent killing his/her child evokes a deep sense of horror and outrage, as it is viewed as a betrayal of the assumption that parental love is one of the tenets of civilization. Therefore, parental, and especially maternal, filicide is regarded as a crime committed by "crazy" people. While reviewing the literature, it turns out that many societies have practiced infanticide, including Greeks, Chinese, Japanese, India, Brazil, England, Italy, and France, among others. Infanticide has been the most widely used method of population control during much of human history (Harris, 1997) and fully reviewed by Brockington (1996). "Legitimate" motives for infanticide include the desire to control the size and composition of the family, maximize reproductive success, and ensure social stability (Mull & Mull, 1987). Indeed, cultural-bound priorities, still in the early 21st century, give legitimization for filicide (Oberman, 2003). For instance, in parts of Northern India, adults prioritize the well-being of family rather than the survival of individual members (Miller, 1981). In some societies, infants with visible deformities and twinships are legitimately killed (Mull & Mull, 1987; Larme, 1997). Female gender is also a culture-bound risk factor for infanticide (Fuse & Crenshaw, 2006). Some societies, such as in rural parts of India, seem to prefer sons, but the reason behind this preference is economic: "Too many girls, too much dowry" (Diamond-Smith et al, 2008). Culture-bound beliefs, such as evil spirits that can grab the souls of newborns, may make infanticide a legitimate act, as it has been described in Bolivia (DeHilari et al, 2009). Other common reasons for killing infants were social, such as family size and poverty. These authors found that both communities of their sample gave legitimization to infanticides that were the result of biological and social reasons. Killing infants because of social reasons only, was rarely justified.

While the rationale for engaging in infanticide varies widely by culture, commonalities emerge, especially among less-industrialized places. Contrary to current Western thinking and studies (that will be reviewed below), filicide is not always an unpredictable crime committed by mentally ill parents: Oberman (2003) showed that parents who commit filicide often cannot raise children under the circumstances dictated by their specific position in place and time.

Besides the cultural and socio-economic motives, little is known about the circumstances and factors that lead to filicide. This lack of knowledge makes prevention difficult. While it is obvious that filicide is one of the rare conditions where prevention is the only treatment, this lack of knowledge is especially disturbing.

Prevalence of filicide among western societies

A recent survey in the United States (Hatters-Friedman et al, 2005) reported that homicide was the fourth leading cause of death among children from ages 1-4 years, and the third one among children from ages 5-14 years. The first year of life is the most prone: among children and adolescents, homicides are most likely to occur in the first year of life; the second peak is during later adolescence (Overpeck et al, 1998). Abuse and filicide are on the same spectrum: more than 80% of homicides in very young children were actually fatal child abuse.
Among those under the age of 5 years, 61% were killed by their own parents, half by their mothers (30%), and half by their fathers (31%). The majority of homicides of children older than three years are committed by a person unrelated to the child. Based on these statistics the conclusions reached are that filicide is a real problem and that the first three years are critical for early detection of infants who are at high risk for death at the hands of their parents.

Risk factors for filicide

Early detection necessitates knowing the risk factors.

- Age of child

In the late 1960's, the author, Resnick (1969), suggested differentiating between "neonaticide" (within the first 24 hours of life) , "infanticide" (within the first 12 months of life), and filicide (older children). Neonaticide being typically committed by young, poor, and unmarried mothers with little or no prenatal care. A more recent review (Hatters-Friedman et al, 2005) reported a high frequency of denied or concealed pregnancies (in spite of the fact that these mothers tend to live with their own parents) among maternal perpetrators of neonaticide. Mothers who committed infanticide were described as young, unemployed and having a high frequency of psychiatric disorders (Haapasalo & Petaja, 1999).

- Child's characteristics

A study which took place in Japan (Haapasalo & Petaja, 1999) found not only a high frequency of psychiatric disorders among mothers who murdered their infants, but also a high frequency of physical anomalies among the child victims. This is consistent with the well-known link between physical handicap and child abuse.

- Gender

Among the children who were murdered under five years of age in the United States in the last quarter of the 20th century, 61% were killed by their parents, equally by mothers and fathers (30% by mothers, 31% by fathers). Twice as many fathers as mothers committed filicide-suicide (Hatters-Friedman et al, 2005). In a Quebec sample (Bourget & Gagne, 2005), paternal filicide was found to be more common than maternal filicide after the age of one year (neonaticide is very rarely committed by fathers and most infanticides are committed by mothers).

Despite these findings, paternal filicide has attracted limited research and is even less well-understood than maternal filicide. Also, 60 cases of male parent filicides were investigated : 23% of the children were under the age of 1 year, 26% between 1 and 5 years, 22% between 6 and 10 years, and 29% were more than 10 years old. Siblings were murdered in 23% of the cases. 60% of the homicides committed by fathers were followed by suicide, especially in the instances involving multiple sibling victims. 18% of the sample also killed their spouses at the time of the filicide. The most common means of homicide was the use of a firearm (34%), followed by beating (22%). The use of knife, strangulation, blunt instrument, intoxication, and drowning were much less common, in decreasing order. Recent rupture of the marital relationship had occurred in 40% of the cases; family violence was indicated in 40% of the cases; drugs and/or alcohol use were uncommon. The presence of severe psychopathology was observed in 60% of the fathers: major depression (52%), schizophrenia and other psychoses (10%), and acute substance intoxication (5%). Fathers are often perpetrators of fatal-abuse filicide, with a childhood history of abuse, especially in paternal filicides involving infants under the age of 1 year. These fathers are rarely psychotic. Retaliating filicides are rare among mothers and typically reflect personality disorders with a high incidence of suicide attempts.

Parental motivations for committing filicide

The major motivational factors for filicide include (Gagne, 2002; Resnick, 1972; d'Orban, 1979; Pitt & Bale, 1995; Farooque & Ernst, 2003):
a. Mental illness
b. Retaliation
c. Rejection of an unwanted child
d. Mercy killing
e. Chronic abuse that lead to accidental death (i.e. the "Shaken Baby syndrome)
Empirical studies have made clear the fact that in most cases of filicide, multiple factors act together to cause the parent to kill his/her own child (Saisto et al, 2001; Schwartz & Isser, 2000). These include financial difficulties, social isolation, single motherhood, work-related stress, housing problems, and a childhood of abuse and/or trauma, marital problems and jealousy, alcohol abuse, physical illness, depression, mood disorders, psychosis.

Filicidal parents who are not defined as mentally ill

Neonaticide is caused mostly by this group of mothers, usually very young mothers who cannot cope with social stress factors Haapasalo et al, 1999; Stanton et al, 2000; Bourget et al, 2007). The absence of mental illness, as defined by the law, meaning psychosis or affective disorder, does not imply the existence of a healthy personality. As has been shown (Putkonen et al, 1998), there is a high rate of personality disorders, with very low ego organization, among these mothers who commit neonaticide. Similarly, among 16 cases of neonaticide (Spinelli, 2001), nearly all of the women reported symptoms of belle indifference, depersonalization, dissociative hallucinations, and intermittent amnesia at delivery. Most of the cases reported were preceded by denial of pregnancy and 56% of of the sample had a history of sexual abuse. Accidental filicides, i.e.fatal abuse, is more frequent among parents with personality disorders and intense psychosocial stress at the time of the fatal abuse, than psychosis and depression (Stanton et al, 2000). Among the psychopathic, narcissistic, retaliatory individuals, the aim is sadistic (Glasser, 1986). The child was never really wanted and is killed either as an accidental result of severe abuse or in the parent's deliberate, vengeance towards his/her spouse. This group of parents, though psychologically disturbed, but not mentally ill (Pappietro et al, 2005), are typically found guilty of murder.

Filicidal parents who are defined as mentally ill

In this second group of parents who suffer from schizophrenia, bipolar disorder, or psychotic depression, the violence is very different in nature. It is self-preservative, aimed at protecting oneself and/or the child from perceived threat (Fonagy & Target, 1995). There is a suggestion of a distinction between two types of psychotic women (Kunst, 2005):

1. The disorganized type, characterized by extreme personality fragmentation that is the combined result of a biologically-based chronic mental illness and a destructive early environment (such as severe neglect and abuse). This parent's crime is the result of bizarre acting out where the infant is not perceived as human, but rather as a lifeless part-object into which the mother projects unwanted, threatening parts of her fragmented ego.
2. The organized type, distinguished by a premorbidly more integrated ego (reflected in quite good educational achievements, work and interpersonal functioning), that becomes temporarily but severely fractured. The crime is organized into "logic", though pathological and distorted. Their childhood history is less chaotic than the disorganized group's one, but, based on Kunst's sample of filicidal mothers, all the women had a history of intrafamilial sexual abuse and depressed, inconsistent maternal care. Unlike the first group, these filicidal mothers are very invested in their child, but in a pathological way. They look to their children to be for them objects of transformation, of repair of themselves (Bollas, 1987). Such women seek a mother in their own child. Again, the filicidal act comes when environmental stresses, such as marital stress or separation, severe financial problems, and poor support, combine with the mother's psychological vulnerability and lead her to feel increasingly alienated from the world around. The mother's unbearable anxiety turns into depression and fantasies of ultimate annihilation where the child is entrapped because of her enmeshed, undifferentiated relationship with him/her. It is in that state of mind that these mothers start to build "the" plan. A mother's statement, illustrates this catastrophic dynamic very well: "I didn't kill my son, I killed myself" (Kunst, 2005, p. 36).

This distinction of the two groups of women is important in terms of understanding the phenomenon of filicide and in planning for intervention. Indeed, in Kunst's experience, the women described as "organized" are often treatable patients who can use psychotherapy to understand the core complexities and fantasies that led them to commit the crime.

Clinical implications

Early detection

The knowledge of motivating factors causing a parent to kill a newborn, a

toddler, or an older child, is a prerequisite for any early intervention planning. The above reported data imply, for instance, that a psychotic mother is at heightened risk of killing her newborn, especially if other factors add to the burden of motherhood, such as being a single parent, having a low IQ and a history of drug abuse. For these women, there is a specific need for social and psychiatric support during pregnancy and the first year of life. The same stands for teen-agers, isolated, and poor first mothers. Psychiatrists also need to remember that a very depressed woman may be at risk of killing an older child, especially if she has other risk factors. Thoughts of infanticide should be directly probed by general practioners and other health professionals, among non-psychotic, postpartum depressed mothers because they tend to spontaneously disclose their suicidal thoughts, but not their infanticidal ones (Barr & Beck, 2008). In spite of the high proportion of child homicides committed by fathers, the tendency to overlook filicidal risk among men, is still high. The possibility of homicidal tendencies in depressed fathers, especially when suicidal ideation is present, should be assessed systematically. Almost half of the filicidal women and men had had previous contact with health professionals before the time of offense (Bourget et al, 2005).

To-date, the most effective early detection is still a case-by-case approach which necessitates a high degree of vigilance and general awareness of homicidal risk. The findings of the above cited Finnish study (Putkonen et al, 2009) suggest that prevention of filicide is not the task of psychiatry alone; health care and society must work together.

Existing programs

In the USA and other Western countries, programs usually center on

1. Developing comprehensive reproductive health programs, including giving access to family planning and abortion
2. Improvement of social support networks
3. Targeting at-risk families, such as those with high levels of domestic violence
4. Clinical interventions
5. Legal sanctions

One of the evidence-based efficient interventions is home visitation by trained nurses during pregnancy and the first two years of life reduced rates of child abuse and neglect among first-born children of unmarried adolescents of low socioeconomic status (Olds et al, 1986).

Conclusion

Obviously, only a minority of parents who become psychiatrically ill and/or have environmental stressors kill their child. Similarly, most parents who experienced neglect and/or abuse in their own childhood do not kill their children, in spite of their deficient parenting skills. Therefore, one must try to comprehend the phenomenon of filicide as a complex one, where psychodynamic factors should be included in the constellation of risk factors identified in individuals at risk for filicide [28].

"The eye sees only that which the mind is prepared to comprehend", has brilliantly announced Henri Bergson, French philosopher and recipient of the Nobel Prize for Literature in 1927. The central task for those who seek to eliminate filicide is first to understand the lives of those who commit this crime and the unspoken messages conveyed by their society and culture. It is important also to recognize the serious nature of perinatal mental disorder, its link to abnormal personality and to consequent relationship problems with the parent and infant and to plan risk reduction strategies in primary and secondary services where staff are trained in infant and perinatal psychiatry.

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Membership meeting

World Association for Infant Mental Health
WAIMH 13th World Congress
Cape Town, South Africa

Thursday April 19, 16.45 – 17.30
Chair Antoine Guedeney, President of WAIMH

Agenda

1. Call to order
2. President's remarks
3. Approval of Minutes of the 2010 Membership Meeting, Leipzig, Germany
4. Financial Report
5. Report on Board Activities since Leipzig, 2010
6. Central Office Report
7. Action plan for 2012 – 2014
8. WAIMH 14th World Congress, Edinburgh, Scotland
9. AOB
10. Closing of the meeting

Welcome to the WAIMH Membership Meeting

Antoine Guedeney
President of WAIMH

Honorary President Distinction

President's Perspective

By Antoine Guedeney

WAIMH is on the Move!

WAIMH really is on the move, and on all extend. We have implemented major by-laws changes, as well as the transfer of the WAIMH office from East Lansing, Michigan USA to Tampere, Finland. This is by now fully realised and efficient. We have also revised and updated the WAIMH website.

The Signal is on the move. Revitalized by Editor and President-Elect, Miri Keren (Israel) and with assistance from Deborah Weatherston (USA), The Signal is becoming an important member benefit. Members are invited to submit articles for the readership at large. We invite all affiliates to use The Signal to disseminate information about the history of their associations, as well as special trainings, conferences or advocacy events. The Signal is also a place where WAIMH can celebrate the life and work of colleagues who have made important contributions to the field, but who are no longer living, such as Salvador Celia from Brazil, arguably the first WAIMH member to be statued in the city where he organized la 'Semana do Bebe', the week of the infant or Michel Soulé, a great figure of infant mental health in France (see his obituary in this issue). It is the place where members can publish original clinical work, specific experiences or book reviews.

WAIMH members recently held an important board election. As President, I want to thank the candidates who were nominated and congratulate the selection of Karlen Lyons-Ruth. Because this is a member-based organization, we hope that each WAIMH member will participate with enthusiasm in upcoming elections. The next important vote will take place in Capetown. Miri Keren will step up to her role as President of WAIMH. At that time, the board will select a new Present-Elect. We have sent a tentative inquiry to all WAIMH members so that candidates be known and give their programs and presentation so the members of the board will be able to vote select the new President-Elect at the April 2012 board meeting.

The position of President-Elect is an important one. The WAIMH Presidency is an honour as well as an exciting and demanding responsibility. Generally, candidates have been on the board for some time and are very familiar with the organisation. Quite often, they have successfully organised a world congress or a regional conference in connection with WAIMH. They have had leadership experience as head of an academic department or research team and have international experience and respect. The President-Elect sits on the board for 4 years before becoming President, allowing for a great deal of collaboration with the current president and insuring continuity for the leadership of the association.

Of additional interest and showing that WAIMH is "on the move," we have used video conferencing for our board meetings, allowing us to have meetings when needed at low cost to the association.

The Infant Mental Health Journal (IMHJ) is also on the move. Hiram Fitzgerald, Editor-in-Chief, has moved the IMHJ into one of the more important publications in the field with a large panel of Associate Editors from around the world and streamlining submissions electronically. The new format and cover are really attractive and, of real importance, the IMHJ can accommodate more papers in each issue and can plan for special issues. WAIMH members are invited to submit ideas for special issues and, if accepted, will undergo the same peer review process as the regular issues. Hope is high that the IMHJ will soon get into Medline; the mean rejection rate now is 69%, which is about the same as Child Development. The IMHJ is the official publication of WAIMH and is owned by the Michigan Infant Mental Health Association (MI-AIMH). MI-AIMH, with assistance from a selection committee, will choose the next Editor-in-Chief by 2014 when Hiram Fitzgerald steps down from that position.

Development of training within WAIMH is also "on the move," with several new initiatives. One is the first WAIMH Training Village to be carried out in Capetown, just before the Pre-Congress day. It will be one-day training, offered by Kaija Puura, Palvi Kaukonen, Deborah Weatherston and myself, at the Children War memorial paediatric hospital. Astrid Berg and the South African Affiliate organized a test meeting last year during the WAIMH Conference committee's site visit and it was quite successful. The idea was to use the WAIMH Congress as a way to attract and support infant mental health workers who may not be able to attend the WAIMH Congress in Cape Town, but would be able to attend a Training Village. It is one way that WAIMH can give back to the growing infant mental health community. In the future, we could look for sustained sponsorships for such events.

A second training development was the invitation extended to Miri Keren and myself to participate in the perinatal section of the World Psychiatric Association WPA. Together, we used our attendance at this conference in Buenos Aires to respond to the invitation of the Argentinian affiliate association (SAPI), to participate in a 2-day meeting at no cost to the affiliate. In the past, WAIMH board members have largely done this work as missi dominici, offering their expertise and training abilities to groups who requested it. WAIMH leaders will take every opportunity to participate in other societies meetings (Marcé, IACAPAP, etc), increasing our training opportunities within our world or regional congresses. Our next goal is clearly to continue to expand training in India and China as they develop affiliates groups or societies committed to infant mental health.

This is my last presidential address and offers me the opportunity to tell you how pleased and privileged I have been to work with such an incredible group of people who are now long time friends. I have had constant help from Miri Keren, President-Elect (my almost sib as we were born same day in the same city!) and I will continue to work with her and with the board with great pleasure as Past President. I had the constant support and help from Past President, Tuula Tamminen, from Honorary President, Bob Emde and previous Executive Director, Hiram Fitzgerald, benefiting from their experience and wisdom. Palvi Kaukonen, WAIMH Executive Director, is a great asset for WAIMH, assisted by Kaija Puura, Associate Director, with both of them carrying high level responsibilities as they carry out the work of WAIMH. The WAIMH office in Tampere is fantastic, with Minna Sorsa, Administrative Assistant, always ready to assist even in "off" hours. The board has been extremely hard working, during congress meetings and in between. I do thank all of them for their work. It was with particular pleasure that we greeted Martin Saint André and Maree Foley as representative of the affiliates to the board and we have appreciated their responsiveness and initiatives to strengthen the bonds between WAIMH and affiliates societies. Thanks to Kai von Klitzing for organizing a very successful congress in Leipzig, which puts us in a good financial condition and to Neil Boris and the whole program committee who made it so scientifically and clinically pertinent and so attractive.

Finally, I must say how much I learned in being a WAIPAD then a WAIMH member for 23 years now. I started as executive at large for Serge Lebovici, my mentor and the first French president of WAIPAD. I barely could speak fluent English then and I had to follow and transcript the conversation between impressive people like Bob Emde, Joy Osofsky, Hiram Fitzgerald, Peter de Chateau, and many others all of whom were quite helpful and became close friends. Being in the board of WAIMH has helped me a lot in my personal career and lead me to high responsibilities in research and university as well as allowing me to visit extraordinary people and places around the world, and I am very grateful to the organization for all this.

Now, get ready for the next WAIMH grand rendezvous! See you all in Cape Town or, if not, in Edinburg, 2014.

Editor's Perspective

By Miri Keren, M.D.

When cry becomes lethal…

In the literature review on the filicidal parent's motives to kill their infant, as it has been described in this Issue, "accidental death due to abuse" is mentioned. Baby Shaken Syndrome is one of the causes for such accidental death.

By chance, in parallel to the preparation of this Issue, two cases of Baby Shaken Syndrome, one of them lethal, were reported in the news, and created very strong reactions in the Israeli media. It reminded me of a similar case we had at our Infant Mental Health Conference last year. A 26-year-old father could not stand his baby's inconsolable cry in the midst of the night and shook her so badly the baby was left with mild to moderate brain damage. He was discharged from the police under the condition that he participate with his wife in our unit for intensive treatment. There were no indicators of chronic abuse towards the baby.

As opposed to the public "black and white" reaction, we had no choice but to try to overcome the almost automatic identification with the victim…a 4 month- old beautiful baby, the first child of a young, immigrant couple… and to develop a more complex view of the case. Not surprisingly, the team member who volunteered to be their therapist was our social worker (Selma Fraiberg was indeed a social worker…)! We enrolled both parents and their baby in an intensive treatment plan we have put in place for neglectful/ violent parents. The plan includes two weekly sessions. The first is a parent-infant group interactional therapy and the second is an individual triadic (mother-infant-father) session. Our adult psychiatrist diagnosed the father with impulsive and antisocial traits, but did not see him as a violent man.

Within the parent-infant group sessions, as a sense of basic trust slowly emerged among the parents, the father felt confident enough to tell what happened. As opposed to the usual horrified reactions heard in the general public, the other parents identified with the father's extreme reaction to the baby's persistent cry. Each of them started to tell the group how much they fear their baby's cry. Almost by definition of the reason for their enrollment in this high risk parents' group, all of the parents have complex childhood attachment histories. The persistent cry, a central attachment signal, evokes in all of them helplessness, followed by anger and rage, as they perceive the baby ias persecutory. Shaking the baby in despair and rage becomes the end-point of this psychological chain of events.

The therapist's ability to sort out parental despair and fear as separate from the violent act, is, I think, the first step in our duty, often imposed on us by the court, to try and treat violent parents. We do not have the luxury to simply put them far away from us, by labeling them "simply crazy" or "horrific" as the media has. It seems to me that we as infant parent therapists are trained to treat these parents as victims of trauma and domestic violence rather than perpetuators of abuse. As the baby's cry may become the trigger for a filicidal act, the parent's treatment can start only with the establishment of a secure base that will give him/her tools for regulating his/her strong negative affects engendered by fear, loneliness, and helplessness in face of their crying infant, exactly what they missed in their own past. At the end of a two-year therapeutic process, the father who participated in treatment with us concluded by saying: "Only now I understand how much being a parent is not something to take for granted". He and his wife have decided to have their second child.

Book review

Clinical Skills in Infant Mental Health:
The First Three Years, 2nd Edition (2011)

Authors: Sarah Mares, Louise Newman, and Beulah Warren
ACER Press, Victoria, Australia

As interest in infancy and early parenthood grows, professionals who work in a variety of ways with very young children and their families are eager for practical information about the relatively new field of infant mental health. It was not so long ago that Selma Fraiberg coined the phrase, "infant mental health" and introduced developmental and clinical practitioners to the early identification and treatment of the parent-child relationship (Fraiberg, 1980). Fraiberg understood that an infant's capacity for love and learning begins in the first years of life. She also understood that how a parent cares for a very young child has a significant impact on the emotional health of that child. Most importantly, she helped us understand that history is not destiny. Parents have the capacity to change the ways in which they relate to and care for a baby; babies have the capacity to change, too. From Fraiberg's perspective, it is our shared responsibility as professionals to support parents during pregnancy and in the first years of life to promote healthy social and emotional development and to reduce the risk of relationship disturbances, disorders of infancy, abuse and neglect.
Clinical Skills in Infant Mental Health: The First Three Years, 2nd Edition, written by Sarah Mares, Louise Newman, and Beulah Warren, Australian clinicians well-known for their work in Sydney, offers a guide to professionals all over the world who with families in effort to reduce the risks that Fraiberg described and to restore emotional health in infancy and early parenthood. The knowledge and skills addressed should be seen as "a treasure that should be returned to babies and their families as a gift from science" (Fraiberg, 1980, p. 3). It is a volume offering theoretical and skill-based information to inform research and practice with children birth to three and their families.

The first chapters introduce the reader to the multi-disciplinary field of infant mental health, with attention to both research and clinical practice during pregnancy and in the first three years. The authors offer a theoretical framework within which infant mental health principles and practices may be considered- psychoanalytic theory, object relations theory, attachment theory, neurobiology and brain research. Of additional interest, there is a succinct overview of infancy, including the exploration and significance of early emotional and psychosocial experiences to development, the identification of disorders of infancy and disruptions to the parent-child relationship, as well as discussion of current models for early intervention. There are also references for further reading and vignettes that illustrate key concepts.

Later chapters introduce a bio-psychosocial and developmental perspective for infant mental health assessments. The approach invites careful consideration of infant, family and contextual factors. Principles to keep in mind include the assessment of both capacity and risk; the understanding that parents want what is best for their babies or toddlers; that a relational approach is essential; and that development is transactional. The invitation to consider effective clinical assessment includes practical guidelines for interviewing families, observing parent-infant interactions, and carrying out. developmental assessments of each infant to assure an understanding of the risks and the strengths of those referred for services. The authors include many examples from their clinical experiences with very young children and their families that enrich the reader's capacity to consider a broad range of things when assessing risks in infancy and early parenthood.

In later chapters, Mares, Newman & Warren discuss problems that are often arise in infancy and result in referral to a professional for assessment, consultation and intervention services. The most problematic include regulatory difficulties (sleeping, feeding, crying), relationship disturbances, and trauma that place development and caregiving at high risk. The authors offer guidance to practitioners to help them determine what therapeutic approaches might increase parental confidence in caregiving and strengthen the quality of the infant-parent relationship.

After focusing on infancy, the authors present developmental changes throughout the second, third and fourth year of life. They examine emotional and behavioral milestones and challenges, offering many examples of emotional processing, the development of symbolic capacities and empathy. Essential tasks of parenting are clearly presented, with attention to the challenging behaviors that toddlers may present and the need for careful developmental and family assessments and supportive interventions.

Careful discussion of special issues appears in the final chapters where the authors address trauma, gender identity, perinatal mental illness, parental substance abuse, and high-risk caregiving environments that threaten the social and emotional health of infants and young children. There are levels of intervention that practitioners can provide to reduce these risks, from prevention to early intervention and long term care. The authors discuss a range of evidence-based practices and conclude with a discussion about training and the preparation of professionals to provide an array of infant mental health services.

In sum, the book is an extraordinary guide for those who want to build infant mental health services into their local or state systems. It is beautifully written and offers vignettes to illustrate theory and clinical practice. Most importantly, the authors offer hopefulness for change through supportive interventions that take into account, the infant, the parent and the early developing relationship.

Reference

Fraiberg, S. (Ed.)(1980). Clinical studies in infant mental health. New York: Basic Books.

Mothers with Severe Psychiatric Illness and their newborns: a hospital-based model of perinatal consultation

By Ana Almeida and Gaëlle Merminod, University Hospitals of Geneva

Daniel S. Schechter, University Hospitals of Geneva and Columbia University College of Physicians Surgeons

ZERO TO THREE Corner

Women with severe psychiatric illness face numerous risks and challenges during pregnancy and as parents. Mental health professionals can help these mothers and their infants by supporting the attachment relationship and by providing the external supports that are necessary for successful parenting. In this article from the Zero to Three Journal (Vol.29, No.5), the authors describe a hospital-based intervention in Geneva, Switzerland, and contrast the stories of two mothers with schizophrenic illness in terms of the risks and resilience of each mother in her capacity to care for her infant.

Women with severe psychiatric illness, such as schizophrenia, experience increased risks and vulnerability during pregnancy and the postpartum period. The risks are particularly high if the woman has had to stop taking her stabilizing medications because of the risks to the baby and if she lacks sufficient social supports (Miller, 1997). A recent epidemiologic study of over 1 million live births in Denmark over a 25 year period supported the theory that women with psychotic disorders are at substantially higher risk for perinatal loss and morbidity (King-Hele et al., 2009) than are women without psychotic disorders. This increased risk was not necessarily due to their psychiatric illness itself but rather to psychosocial impairment that is associated with chronic psychiatric illness and that results in insufficient prenatal care, unstable living conditions, and lack of integration into social support networks including a medical home (King-Hele et al., 2009). In addition, women with chronic psychotic disorders are more prone to lead unhealthy lifestyles that often involve nicotine dependence, poor nutrition, and greater risk for violence exposure (Hauck, Rock, Jackiewicz, & Jablensky, 2008).

The problem is not as rare as one might hope. Every year in the U.S., 4,100 to 8,200 women experience postpartum psychosis. New onset psychosis during the peripartum period is most commonly associated with bipolar disorder (Sharma & Mazmanian, 2003). Careful evaluation, diagnosis, and treatment of maternal psychiatric illness together with family planning counseling prior to any conception would be optimal in an ideal world. In reality, this is often not possible. And so, preventive intervention and sensitive alliance-building with psychiatrically ill parents, baby, and other caregivers from the first moments of presentation is paramount to provide the newborn with the opportunity for optimal development (Hauck et al., 2008).

At the University Hospitals of Geneva, we foster alliances between infants and their parents, medical staff and parents, and medical staff and infants with a developmentally and relationally focused perspective. These human bonds are the most precious, yet vulnerable lifelines for mothers, many of whom who have experienced disturbed attachments, abandonment, violence, lack of social support, or immigration stress. Because these women often feel abandoned and burdened, if not menaced, by the world around them, it is hard to let their own babies connect to them, even though those babies are hardwired to try (Stern, 1985). In addition to these social risk factors, chronic psychiatric illness may involve psychosis (i.e., loss of reality testing, thought disorder, gross disturbances in affective responsivity, poor social functioning), medications to treat their psychosis and other difficulties, and the potential side effects of those medications. Given these vulnerabilities and risks, women with psychiatric illness face enormous challenges to succeeding as parents in a complex urban society (Hipwell, Goossens, Melhuish, & Kumar., 2000).

For women with severe psychopathology, a key part of the treatment involves recognizing their capacities and their desires, however ambivalent, to form relationships that can at the least reduce stress, and at best, save lives (Schechter & Willheim, 2009). Another component of treatment involves helping to contemplate and interpret their baby's communication. It is important to note that this psychotherapeutic work is distinct from child protective services and should be clearly presented as such. This is to say that we as clinicians attempt whenever possible to maintain a therapeutic alliance with mothers that holds their and their baby's perspectives in mind while not neglecting safety issues. To maintain this longer-term investment in the mother and baby's well-being, we recommend that a separate team of mental health/child protection specialists, whose job it is to report over the short-term to the family court system directly, do a distinct forensic evaluation to determine whether parental rights should be upheld, suspended pending observation, or terminated. At times, we do find it essential to offer our clinical opinions one way or the other to the forensic evaluators. When this is necessary, as it often is, we often have one member of our team who is known to the mother discuss this frankly but sensitively with her, with an attempt to ally with her fundamental wishes to keep her child alive and protected from danger. Another member of our team known to the mother remains available should the mother decide that the therapist who spoke with the forensic evaluators can no longer be trusted. This is an advantage in working

in therapist-pairs with these families. We also try to continue our therapeutic work beyond the time when court decisions are made—which itself is often a period of enormous stress for parents, extended family, and baby. If a mother and baby are separated, often one member of the therapist-pair will continue to follow the baby in her new setting and the other, will work with mother on issues of separation, loss, and planning for her own future.

In order to assess an infant–parent relationship at high risk, it is important to try to elicit the strengths and capacities of the parent and infant, and the family's internal and external supports over multiple visits. The discovery of mother and baby's ability to form a loving attachment is a treasure to guard. But the ability to form a loving attachment within a structured hospital setting does not necessarily mean that a psychiatrically ill parent will be able to manage without a substantial network of resources upon discharge. Her baby may even need to be placed, temporarily or permanently, in a child protective center and/or foster family (Hipwell et al., 2000). Our work involves establishment of a sense of continuity and coherence in the lives of psychiatrically vulnerable mothers and the thoughtful integration of multiple points of view by members of various professional disciplines: the obstetric team, social workers, mental health professionals, pediatricians, nurses speech/occupational/physical therapists, vocational skills educators, and others.

In situations when termination of parental rights seems imperative, we again want to emphasize that it is still beneficial to work with parents and infant to prevent subsequent tragedies. Indeed, parents often "replace" a removed child, and many infants grow up with the scars of adverse early experiences in the child protective system. The efforts of the mental health professional , whether or not the parent remains active in the daily life of the child, should include mental health outreach, family planning, and violence prevention/safety planning as important treatment goals (Miller, 1997) Working with foster parents and their infants, and assessing their tolerance of an ongoing relationship between the child and biological mother when she is stable, can optimize the subsequent development of the child (Marshall, Reeb, Fox, Nelson, & Zeanah, 2008). To illustrate, we present below two contrasting situations involving mothers with chronic disabling psychiatric conditions.

Raiza and Yousef

In the Maternity Hospital, the neonatal staff requested an evaluation of a mother–baby relationship 1 day postpartum because of the staff's concern regarding the mother's erratic behavior. Nurses had noticed that Raiza, a 44-year-old Algerian woman, had appeared to be overly intrusive with her baby boy, Yousef, one moment, and very "odd" and elusive to the staff the next. Yousef was placed on the Developmental Pediatrics Unit pending further evaluation. A colleague in the adult psychiatry liaison service diagnosed Raiza with schizoaffective disorder, a form of psychotic disorder typified by delusions, hallucinations, profound ambivalence, mood swings, and erratic behaviour. Raiza had been stable for several years without any treatment—yet to maintain this level of functioning, she had a very routinized life with little social contact. She was on long-term disability and had a city-appointed case-manager to manage her finances. Behind inconsistent interaction with hospital staff was clear mistrust to the point of "paranoia." Raiza at certain points believed that the Swiss medical system was robbing African mothers of their children to make the children "Swiss" and work for the "white people." She denied any mental illness or need for treatment.

Raiza was not married to Yousef's father, Boris, who was an illegal immigrant and did not speak the local French language. Yousef is the only child of this couple, but Raiza had previously had an 11-year-old son out of a relationship with a man who had long since disappeared from her life. Boris had three children living in war-torn Bosnia whom he had left behind to seek political refuge in Geneva. The couple knew each other for less than 1 year. The pregnancy, while unexpected, went well despite the fact that mother had completely avoided obstetric care.

Raiza had been painfully rejected by her family for having had her first child as a single-mother and so moved to Geneva. Raiza remained guarded about her family. Yet she suggested that she had nothing good to say about her parents or siblings. A history of verbal and possibly physical abuse was suspected but never completely confirmed by Raiza.

She was hospitalized at the main psychiatric hospital in Geneva when her older son was only 2 years old. At that time, she was diagnosed as having a schizophrenic disorder. Raiza was assigned a case-manager, and this older son was given to his father who at that point assumed full-custody and legal guardianship, and the son had weekend visits with Raiza.

During meetings with the multidisciplinary team, Raiza had consistently appeared to be easily irritated, often talking nonstop without taking a breath, and showing signs of physical agitation that caused her to leap up from her chair, dramatically leave the room, and then return. She tended to jump from one subject to another often with vague, idiosyncratic references that were difficult to follow despite her excellent command of the French language. In the relation to Yousef, she seemed to confuse herself with Yousef, speaking of dry skin and lathering her own arms and face with skin cream but also applying it to Yousef's behind and legs tin such large quantities that a white visible layer that oozed from the diaper. At times, it appeared that she forgot about her baby, relinquished eye contact with him, and focused with his nurses only on her own grievances.

And yet at other moments Raiza clearly had a capacity to share an admiring glance with her baby, speak sweetly to him, or sing him a song. However, she described Yousef (i.e., "her mental representations of him") with a paucity of detail, and with no regard for his individuality: "What can I say of him… he is a baby and all babies that age are alike." She also described Yousef via attributions that one would normally apply to the description of an older child: "He is a wise young man—he knows what you are all up to." She had a definite idea that was unmovable regarding her baby. When we tried to introduce a bit of curiosity about him, she was not curious with us. It was as if the discovery of her baby from any other perspective was too threatening.

Another worry among hospital staff was the sudden panicked thoughts Raiza could have about her baby. A nurse could be talking with her calmly when suddenly the sleeping Yousef's gurgle would be interpreted by Raiza as evidence that he was suffocating. She would jostle him and hoist him up in her arms abruptly to make sure he could breathe, startling him and making him cry. When we tried to reflect with Raiza on these moments, she denied that she had really thought he would die, saying, "He was waking up and I just wanted to help him by holding him." We understood but did not interpret to Raiza that these incidents likely marked Raiza's own sense of suffocation by her baby's needs and the closeness he required.

Ten days postpartum, Raiza became increasingly anxious about why the Developmental Pediatrics Unit would not let her take her baby home if he was not physically sick. After not visiting all day, Raiza showed up in the evening on the unit and abruptly took Yousef out of his bassinet. She covered him in a blanket and stormed out of the unit. When the nurses tried to stop her, she screamed loudly in a threatening way at them. As Boris approached her to keep the elevator door open so she would have more time to talk to the nurses, she shoved him back and pulled the door closed. Hospital security was called but could not arrive quickly enough, and the mother disappeared into the night with the baby. The staff called the police and an adult psychiatrist to make an at-home crisis evaluation. At the time of the assessment, Raiza was calm and Yousef, sleeping, remained unharmed. Raiza reported that if police said that Yousef must go back to the hospital, she trusted that there was a real medical reason for it. She allowed the police to remove the baby and was not brought to the hospital herself. It was as if Raiza had been reassured by the police intervention and remained calm.

Following this event, Yousef was moved directly in front of the nurse's station and monitored when his mother visited. Raiza seemed more compliant with nursing requests and apologized for her rash judgment. Nevertheless, after a day or two, she again began to resist nursing suggestions that her baby might be crying for reasons other than hunger—even as she could keep her baby on her breast for exceedingly long periods, beyond nutritive sucking. She also had the need to awaken her baby to change him and lather his bottom with diaper cream.

By the third day following the police event, Raiza again seemed mistrustful of the nursing staff and easily irritated. Yousef was more dysregulated, hypervigilant, and frequently spitting up due to excessive feeding. The pediatricians limited visiting hours to allow time for Yousef's own sleep and feeding rhythms to develop without Raiza's intrusion. Raiza seemed more organized and focused on Yousef when she visited. As with the limitations imposed by the police, she seemed to rise to the challenge during the briefer visits. She, nevertheless, continued to deny any difficulties and refused psychiatric care even though this was a condition for increasing her visiting hours.

A law guardian was appointed for Yousef by Child Protective Services, to whom a report had been made when Raiza took Yousef from the hospital against medical advice. Meetings between this law guardian and Raiza ended with Child Protective Services deciding to place Yousef in foster care and terminate Raiza's parental rights. During the multidisciplinary meeting at which this decision was announced, Raiza hurled insults at the medical staff, became agitated, got up to leave, and then sat down again spontaneously and remained quiet and preoccupied, muttering to herself.

It was painful for us as parents to see Raiza's suffering in these circumstances. The countertransference was one of guilt, as we if we indeed had done exactly what Raiza feared. We felt helpless for lack of our capacity to appeal to logic or for this parent to exercise insight and invoke problem solving. Using this awareness of our own reaction to her, we reassured Raiza in this intense and disorganizing suffering that we understood how much she loved her baby and that we would do everything possible to help her maintain a link with Yousef no matter what the outcome would be.

Boris meanwhile, was in a precarious social situation since he was in Switzerland illegally. He visited often at first, with an attitude of total support for Raiza (perhaps either with ignorance of or denial of the degree of her psychiatric disturbance and thus colluding with her in the denial of her pathology). But after Raiza shoved him and took Yousef out of the hospital as nurses pleaded with her, he little by little showed understanding of Raiza's difficulties and, simultaneously, greater estrangement from her. At the same time, he too had a strong tendency to mistrust the medical staff and remained angry and abrupt. He seemed unaware that his temper was intimidating. He refused categorically that the baby should be placed out of his care—even though in Switzerland he had no paternal rights as an illegal immigrant with no proof of paternity. He threatened members of the medical team, causing security to be called when he visited. The presence of the the security officers in response to both parents' behaviour made them more hypervigilant and suspicious of the medical team's intentions. However, Raiza remained responsive to limits set—almost as if she had been reassured by the presence of security; while Boris tended to become agitated and provocative with guards and staff alike. Not surprisingly, the day Yousef was transferred to the Child Protective Services residence, the parents separated, and the residence's staff reported that Boris made no further visits to Yousef.

Yousef was placed in an attachment-sensitive center that is meant for temporary shelter, but in fact becomes often a placement for several months. Raiza did not show up for her outpatient visits with us. Follow-up at Yousef's shelter indicated that Raiza had visited initially on a sporadic basis but stopped after several weeks and that Yousef was waiting adoption.

As a postscript to this story, 2 months later Raiza was wandering around the lobby of the Children's Hospital one morning appearing agitated and lost. She was hardly recognizable, with a new hair color and style, wearing large glamorous sunglasses and fashionable, flowing, and colorful, if not somewhat mismatched clothes. She approached Dr. Schechter saying, "Doctor, I am so glad to see you… I don't know where my baby is. I heard he was adopted but they tell me nothing. I just want to know where he is and that he is safe." She proudly pulled out her cell phone and showed Yousef's picture. "This is the last picture I have… see that he can sit by himself now! He is so handsome, no?" Just as Raiza had disappeared, she had reappeared in a new guise and engaged the doctor to cope with her loss, receive confirmation that she had produced a lovely child, and to assist her communication with the city social services department so that she could find out that her baby was indeed in safe hands without compromising the foster family's right to maintain anonymity.

Rose and Europa

A local gynecologist worried that this Italian-immigrant mother whom we shall call Rose had presented for care in her 22nd week of pregnancy. A midwife noted that she seemed "odd and hard to follow." The gynecologist referred Rose for evaluation by the Adult Psychiatry Consult-Liaison Unit at the Maternity Hospital, which led to Rose's immediate hospitalization where she remained until the delivery. After an uncomplicated birth, her baby girl, Europa, was hospitalized in the Developmental Pediatrics Unit. Rose returned to the Adult Psychiatry Inpatient Unit.

We learned that Rose's own mother suffered from a psychiatric illness that required intermittent hospitalization. However, Rose had very positive early and consistent contact with her maternal grandmother until she was an adolescent and began to "have fun with boys." Rose herself had never worked. She was 34-years-old. Despite a history of multiple sexual pursuits since age 14, she denied

physical or sexual abuse. She did not know with any certainty the identity of Europa's father.

We observed that during visits with her daughter Rose appeared adjusted, attentive to Europa's signals, respectful of her sleep rhythms and feeding needs. The pediatric nurses noted that Rose was very careful with her daughter during bathtime, speaking and singing appropriately to her little girl throughout. Europa was a quiet baby who cried when hungry but calmed quickly in Rose's arms. When awake, Rose appreciated her attentiveness.

Rose, in contrast to Raiza, idealized her daughter and saw herself in her daughter. Yet Rose was also able to see her daughter as an individual: She was delighted to discover Europa's face, and to acknowledge that her daughter was nonetheless unique. Rose said, "She has her mother's feet but her hands are all her own."

During the second postpartum week, Rose awakened on the psychiatric ward crying for the nurse. She told staff that she "had nightmares that Europa is crying and calling for [me] but [I] cannot get there… [I] cannot tell her it will be all right." We viewed this as further evidence of an evolving attachment—of what Winnicott called " primary maternal preoccupation" (Winnicott, 1956/1958, p. 300) even though mother and daughter were not allowed to sleep in the same room. Staff decided to bring Europa's crib over to Rose's ward. The nightmares stopped. Europa woke up twice per night to feed and fell quickly asleep again along with her mother.

One concern that remained was that Rose continued to wonder whether in fact she might have produced Europa without a father because she did not know who the father was. During the pregnancy Rose had said that a man she passed on the street on the way to her obstetric appointment might have been the father, but after Europa's birth Rose said that maybe she "alone conceived the baby like the Madonna." This statement was made despite the fact that Rose was taking anti-psychotic medication, and as with many such women, sacrificing breastfeeding to do so.

On the positive side, Rose seemed to rally and become more organized when she spoke about her baby than when she spoke about her own life history. In particular, Rose disorganized around discussion of her tendency to fall in love quickly, passionately, and prolifically with a number of men whom she did not know well, thereby placing herself and her baby at considerable danger. Despite the hurdles of coming to accept that Europa had a father but that the father would likely never recognize Europa as his child (and that Rose would likely not recognize the father by appearance!), 2½ months of mother–baby hospitalization allowed us to build a very positive and reciprocal alliance with Rose and Europa. In contrast to the case of Raiza and Yousef, Rose accepted that "something was not right with her mind" (officially termed "schizoaffective disorder"). She thus gladly accepted psychiatric follow-up for herself and dyadic psychotherapy, home visitation, and case management with a law guardian in the interest of Europa. Until a suitable housing arrangement could be found for Rose in a supervised living facility, she allowed Europa to move to the same attachment-sensitive child protective unit where Yousef had been sent. Yet Rose maintained daily regular contact and demonstrated that she could keep her own mental health appointments. We thus felt confident that Europa and Rose would benefit from the best each could contribute to their mutually satisfying relationship. In addition, we believed that Rose and Europa's emerging attachment would lay the foundation for openness to subsequent attachments with others such as case managers, early childhood staff, or mental health professionals, who would further nurture and enrich Rose and Europa's development as a new family..

What do each of these vignettes teach us?

As infant specialists, we are relationship-based and attachment-focused. We understand the potential effects of protection and risk conferred by a particular attachment relationship (Coates & Schechter, 2004). And, in fact, psychiatric patients often have histories of interpersonal violent trauma, as in the case of Raiza, with compromised early attachment. Such a background often predicts a mistrust of caregivers, medical or otherwise. Yet, when we hear that a mother has paranoid schizophrenia, schizoaffective disorder, bipolar disorder, or has a "severe personality disorder," do we sometimes assume, based on a worst-case scenario stereotype, that an infant and mother with such difficulties are best separated? Indeed, the case of Rose and Europa illustrates that a psychotic mother with supports in place can fulfill her infant daughter's developmental needs sensitively and enjoy her own maternal competence.

This is not to say that we should ignore the elevated risk and perinatal stress implicit in becoming a mother while having one of these chronic disabling psychiatric conditions. Rather, we hope that we can learn to see what prevents Raiza and Yousef from developing a good-enough attachment despite the external supports and constraints that are imposed. And we hope that we can learn to se see what permits Rose and Europa, despite the mother's significant psychiatric morbidity, to maintain a loving attachment and make the most use of external supports and constraints that are imposed. Rose's lack of judgment in her relationships with men poses a risk for Europa in terms of potential trauma such as sexual abuse. And yet, Rose is able to accept that, for this reason, it may be best not to live alone with her baby at this time—while still maintaining a positive relationship with her under the guidance and supervision of professionals.

A secure attachment to her maternal grandmother surely provided a foundation for Rose to accept and make use of help and to pass this appreciation of human relationships on to Europa even as a newborn. In contrast, Raiza's early deprivation, and repeated trauma in the context of having no secure attachment, together with the particular nature of her subsequent psychopathology, prevented her from working with others and with Yousef for their mutual benefit.

Another very common and unfortunate fear for prospective adoptive parents of infants such as Yousef is that these babies may share the schizophrenic or bipolar genetics of their parents. As much as the complexity of modern medical science seems to bring us toward greater uncertainty rather than less, one helpful trend is the realization that caregiving environments matter very much and that genetics are not the only determinants of behavior (Caspi et al., 2003; Meaney & Szyf, 2005). The genetic risk of developing schizophrenia in adoptees whose biological mothers had schizophrenic-spectrum disorders compared to a control group of adoptees of nonschizophrenic mothers was slightly elevated but not statistically significant in a large Finnish epidemiologic study (Tienari et al., 2003).

For mothers such as Raiza and Rose, it is to the greatest advantage to their infants and subsequent generations to reduce their burden of stress during and following pregnancy because stress as been shown to play a role in the vulnerability to and exacerbation of at least some schizophrenic-spectrum disorders (Corcoran, Mujica-Parodi, Yale, Leitman, & Malaspina, 2002; Malaspina et al., 2008). Infant mental health specialists need to further research the effects of

our preventive interventions in terms of reducing toxic stress, improving outcomes, and interrupting cycles of trauma and psychiatric illness. The development of inpatient mother–baby units and transitional programs that provide support upon discharge and that are staffed by infant mental health experts, can play a crucial role in an cost effective and successful intervention for the benefit of all concerned (Hipwell et al., 2000).

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The authors wish to thank Professor François Ansermet and the staff of the University Hospitals of Geneva and of Piccolo for their unwavering support of the work described in this article. We also wish to thank the patient–families, including those anonymously described in this paper, for what they have often so poignantly taught us about their experiences, needs, wishes, and fears.

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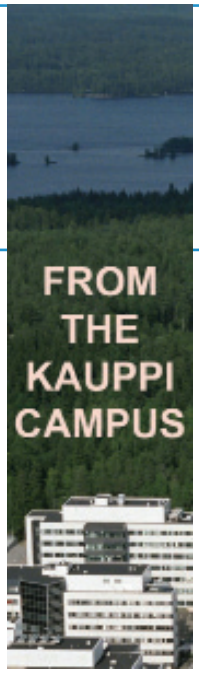
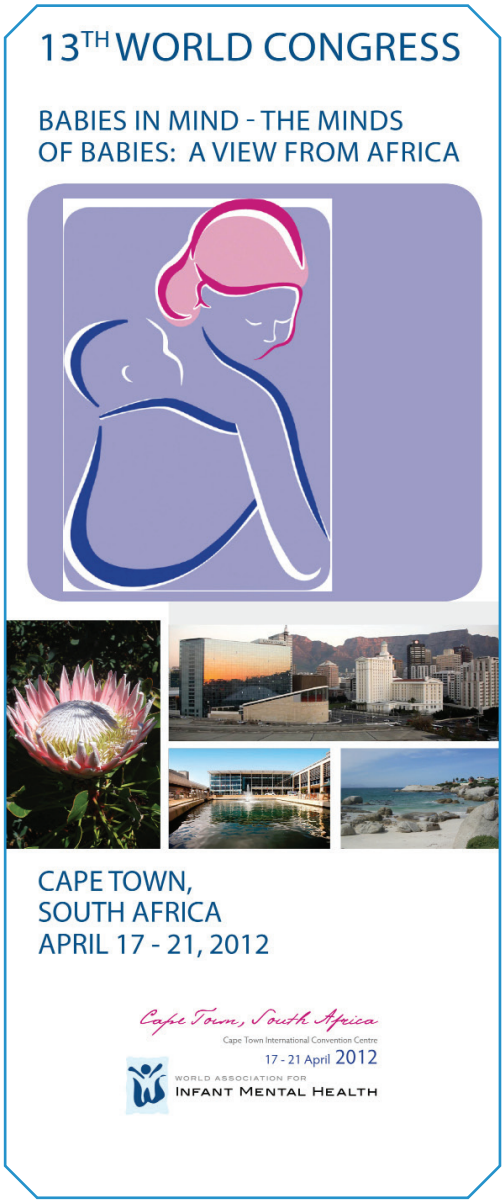


From the Kauppi Campus -News from WAIMH Central Office

By Pälvi Kaukonen, Kaija Puura and Minna Sorsa

Dear WAIMH members, we will meet each other soon at the 13th World Congress of WAIMH in Cape Town, South Africa. This is the first WAIMH congress ever spanning to Africa. We are looking forward to the congress and the beautiful Cape Town!

The congress programme will be a rich one that caters for all needs with 67 symposia, 58 workshops, 18 clinical teach-ins, 8 video presentations, 14 Master Classes, 150 posters and 13 poster workshops from all over the world. There will be two Pre-congress Workshops, one on Diagnostic Classification for Infant Mental Health and one on Infant Rights. Additionally, before the WAIMH Congress two Training Village seminars will be arranged for local practitioners.



An important part of the Congress is the biannual WAIMH Membership Meeting. All WAIMH members participating in the Congress are welcomed to join the meeting on Thursday 19th April, 16:45-17:15. The Agenda of this meeting is included on page xx in this Signal.

The new Board member elected to the WAIMH Board of Directors is Professor Karlen Lyons-Ruth from Harvard Medical School, U.S. Congratulations to Karlen!

Altogether 18,5% of eligible WAIMH members voted in this election. The vote tally is consistent with previous experiences since 1992. It would be good, if the members' participation rate was higher. Ideas for improving the voting activity may yield out of discussions at the Board and Membership Meetings and discussion with Affiliates at the Affiliate Council Meeting in Cape Town.

The current President Antoine Guedeney is stepping down to the position of Past President and the current President-Elect Miri Keren will commence her presidency in Cape Town.

A new President-Elect will be elected from among the Board of Directors. Two Board members, Kai von Klitzing and Campbell Paul, have expressed their interest in becoming a new President Elect. We have sent all WAIMH members a tentative enquiry in order to find out the support each candidate has among the members. The Board will then elect the new President Elect in Cape Town, taking into account the tentative enquiry and the opinion of the Nominating Committee.

You have received an e-mail with a link, which redirects you to the enquiry, and just tick your favourite President-Elect candidate, and submit your vote.

Last but not least, please renew your 2011 membership into a current membership online at the WAIMH website www.waimh.org.

Cape Town 17 - 21 April 2012

Of The World Association For Infant Mental Health

Babies in mind - the Minds of Babies: A view from Africa

Cape Town, South Africa

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

Dear Colleagues

The first WAIMH congress to be held in Cape Town, South Africa is only a few months away with the central theme of Babies in Mind – The Mind of Babies. In this flyer we wish to inform you of two additional training events taking place just prior to the Congress.

9-11th April PDI Training

Administering and coding the Parent Development Interview

12-14th April Supporting bonding between careers and babies

Individual Group Interventions

16th April Pre-WAIMH Congress Training Villages

We warmly encourage you to register and join the Congress to your knowledge and experiences with the presenters and delegates in our World Congress. This time there is also a unique opportunity to combine work with holiday in the beautiful South Africa.

We look forward to seeing you in Cape Town and giving you a warm African welcome!

Antoine Guedeney, Paris, **President of WAIMH**
Kai von Klitzing, Leipzig, **Chair of the Program Committee**
Astrid Berg, **Chair of the Local Organizing Committee**

ONSCREEN CONFERENCES & EVENTS

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