The Signal

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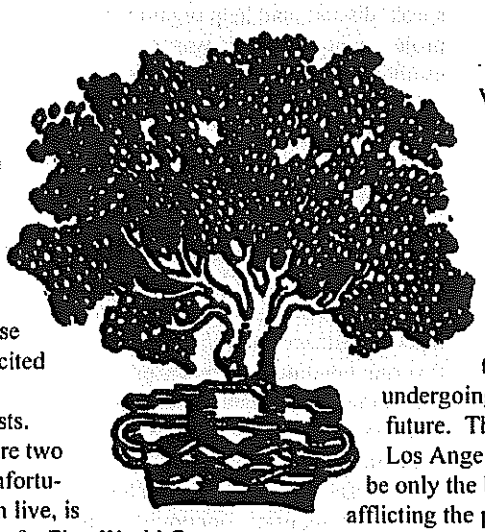
Project Vida

(Project Life)

by Salvador Celia, M.D.



"Yo soy yo y mis circumstancias"

(Man is himself and his circumstances) (Ortega y Gasset) - I begin by describing the living circumstances of these men, these adolescents, these children, these women, these babies, these aged.... (originally cited in [1])

Brazil is a country of contrasts. Actually, we might say that we are two countries. The first, in which, unfortunately, only 5% of the population live, is wealthy and enjoys all resources of a First World Country. It may be compared with Belgium in its quality of life indices. The second, with 95% of the population, sadly, may be compared with India.

The latter Brazil is the country of the malnourished (31% of pregnant women are malnourished--for adolescents alone, this means 500,000 a year), of hunger (32 million people), of abandoned schooling (60% drop out in elementary school), of children working from the age of 10 to 13 in the worst possible health conditions and earning little (over 2 million people). Girl prostitutes (numbering at least 500,000), street children (7 million), raped women and disrespected senior citizens all live in this deplorable Brazil.

As we can see, Brazil has achieved a fantastic "social apartheid" by means of level of income, level of schooling, employment and unemployment, and social level.

Brazil has become the ninth world power, but with a very low quality of life. This concentration of income in the hands of 5 million people is a fantastic House of Masters, while the rest live in the squalor of the Slave Quarters (Herbert de Souza).[2]

All this forms what we call Social Violence, the greatest problem occurring and afflicting not only the Third World countries, but all of mankind, although to a lesser extent in the more developed countries.

John Kenneth Galbraith [3] for instance, in his book, *The Culture of Contentment*, stresses the problems which the U.S. society, a follower of the "Culture of Satisfaction" is now undergoing, and their consequences in the near future. The eruption of violence and riots in Los Angeles in April 1992, unfortunately, may be only the beginning of problems potentially afflicting the populations of large cities in the United States. Such problems result from lack of investment in the social aspects of living such as health, education, leisure, and togetherness (that is, Community Centers).

Man, to me, is a biopsychosocial environment and political being. This defines a broad anthropological and humanistic concept. The vision of the human being lies in what we have decided to call citizenship "the state of being a person."[4]

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To be a person is to enjoy the rights guaranteed by the Constitution of democratic countries. In the case of children and adolescents, it is worthwhile to remember the Children's Bill of Rights of the United Nations, the Brazilian Statute for Children and Adolescents, and the various "pacts" signed by government leaders in favor of the child, the weakest link in this whole chain.

"When one is a person, one knows, one fights, and achieves rights, if one is a citizen and has self-esteem."

Hence, we see that Health Education, Science and Technology, Culture, Leisure, Human Rights are topics which are unified and integrated to improve the quality of life of each individual. As a person, one gathers, forms groups, societies, for company, for discussion, to speak one's mind, to demand, to do, and participate. As a citizen, each individual uses a potential which is often innate, but at other times is acquired or developed in human interaction. He/she forms, or belongs to a group which uses much individual energy, the sum of which leads to social energy, the motivational force that makes individuals use their talents.

Based on these principles, in 1988, we began to create a humanistic project, from within the State Government, aiming to reach the poorer population mentioned above, in order to enable them to have the physical and mental space available to organize, produce goods, and to fulfill their potential. They needed to receive this help from the Government (holding), but the idea was always to have co-participation (autonomy) in co-responsibility to achieve the growth of their citizenship.

From the beginning, over 60 community organizations (residents associations, mothers clubs, service clubs, unions...) were called on to speak, discuss, and help organize the project, whose purpose was to establish centers of togetherness, and centers of humanistic reference for our population.

We know that factors exist which lead to illness, among them hopelessness, frustrations of an amount and intensity beyond people's capacity to adapt, and the lack of bonds. Like a spider web, famous for its characteristics of resistance and flexibility by favoring bonding in a family or a community, we sought to build an emotional web, a network of solidarity, which lends support, which contains and shelters, without choking and, therefore, offers opportunities for the "I" of each person to emerge, increasing his/her self-esteem and quality of life. From the psychological standpoint, an "attachment" center (or secure base) whose aim is "detachment" and in sociological language, to promote individual independence.

According to this humanistic vision, the concepts of physical and mental health, such as the basic areas of health, education, culture, leisure, human rights, and technology should be integrated. We envisioned a center which is sponsored by the "State", yet we wanted the community to take on co-responsibility for management by setting up the "Community Council." This is an organ which represents the community with possibilities and rights of managing, discussing, approving, refusing the various programs, and taking initiatives to

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improve its organization.

The name "Vida," life, was chosen for the project and for the Humanistic Centers precisely to highlight projects, energies, positive talents of each of us and our communities, which are today under great stress due to the great number of projects related to violence and death. Since this project is related to life, obviously the project would have to put in the foreground women and babies, with whom everything begins. We envisioned an intersecting project for all ages with deep roots in prevention and psycho-prophylaxis.

The first Humanistic Center was inaugurated in December 1990 in the Northern suburbs of the city of Porto Alegre. This suburb, one of the poorest in a city of approximately one and a half million inhabitants, is located in the south of Brazil in a region with the highest quality in the country. It is not, however, exempt from serious social problems.

The physical space is highly privileged, but not all the other programs are this size. An old ceramics factory with 32,000 square meters of built-up area, destroyed by time, and originally meant for a model prison had been standing empty for eight years. At this point, the idea arose to install the Humanistic Center there. It was rebuilt in two years.

A public examination was held, with 10,000 candidates competing for 120 jobs as teachers, physicians, psychologists, lawyers, social workers, recreationists, administrative staff, etc. The project was divided into 4 areas: Health Promotion and Prevention of Diseases, Expression and Work (Culture and Job Training), Sports, Recreation and Leisure, and Citizenship.

Each unit has an average of 15 projects or activities, a total of approximately 60. An attempt was made to find the interface between the different sectors, and so specific projects were created such as one for the senior citizen, where an aged person receives attention in the togetherness group (feelings), recreation, sports (specialized gymnastics), culture (theater, singing, dancing), and citizenship (information on senior citizen's rights).

Another project concerns women. There is a center to support women, where they come when they have problems, separations, abandonment and violence. There they receive psychological support, legal support (defense and information regarding their rights), and participate in social, recreational and arts crafts activities.

A program which is truly a philosophy is the promotion of breastfeeding, and is carried out daily, with special emphasis given on International Women's Day, Mother's Day, and Grandmother's Day. Several generations are gathered together and the problems and advantages are discussed using puppet shows, theaters, macrogymnastics, choirs, etc. Since the Center is dedicated to prevention, infant care is stressed with special attention to the more deprived ones, the malnourished.

It might be said that the program begins when the topic of family planning is discussed in women's care, especially attention to adolescent girls. When pregnancy occurs one tries to follow it by holding groups for togetherness, where a woman can tell her experiences, her difficulties during this time of her life. In Brazil, most underprivileged women do not have companions and for Celia et cols, [5] this made the function of a Health Service be to listen, protect, accompany, i.e., "Holding."

At present, we are achieving greater participation of fathers, whenever the situation allows, and the groups meet on weekends, so that they will have easier access to the program. Such activities function as operational groups, and the follow-up can be carried out for several months, or else short duration programs are held, involving only a few meetings, mainly for information and follow-up.

Vida is an integrated program, therefore, pregnant women are referred to gymnastics, which will prepare them better for childbirth. They are referred to the Center for Support to Women where they are informed about the laws which protect them (maternity leave - time for breastfeeding). Their participation is suggested in some activity with cultural expression such as figurative arts, arts and crafts, choir. They can also participate in making clothes for the trousseau of the coming babies.

At the time of delivery, we try to continue care in the hospital, sending the women to those hospitals which are connected to official medical plans, so that she and her baby and family will find it easier to receive care at this important time in their lives.

Once the child is born the mother is invited to participate in operational togetherness groups called parent-infant groups. These meet roughly every two weeks, parents, mothers, grandmothers, and babies participate, playing, discussing the interactions of this age with the assistance of one or two therapists.

These groups help facilitate attachment and also, through observation, help notice any

difficulties with interaction in infant development, and acts as a factor of prevention because when problems are noticed early on, the necessary referrals can be made.

In our experience,[6] these groups have made the psychosocial development of the group of infants easier as compared to a control group of infants referred by the health center pediatricians. These same infants had a better interaction score when their mothers, during pregnancy, received integrated prenatal care. It is clear that these groups have a psycho-prophylactic effect since they operationalize the facilitation of attachment.

At the Center, there is an inoculation program, open on weekends, and thus, of great help in preventing a number of childhood diseases. The Center prepares adolescent volunteers who are trained as health agents, and their help in inoculations, especially on National Inoculation Campaign days, is invaluable.

One of the most necessary programs in Brazil is the care of malnourished children. In Brazil, we have 31% malnourished children up to the age of 6, and in the South, the rate is around 18%. At the behest of a Community located 2 km. from the Center, the Vida team went there to provide care for the children of a Vila (a low income community) which had a number of problems with parasitic and infectious diseases. They ended up installing a small field office. A Census was taken among 300 families, approximately 1500 persons, and we found 21.3% malnourished infants up to 3 years of age.

At this point, with the help of the Community (Association of Residents of Jardim Passo das Pedras III), a hut was built from old lumber and a small house organized in which a Nutrition Center was installed. One of the rooms was the body of an old wagon which was used to provide care.

Our intention, besides helping this Community, was also to find out why these children were malnourished. The research was presented at the Chicago Congress of WAIPAD in 1992 in a plenary session [6].

In studying the group of malnourished mothers and the mothers in the control group, we found that loss of roots, lack of support from the companion, neglect, abandonment and abuse in childhood, the wish to not be pregnant, the wish to abort, breastfeeding time of 51 days (as compared with 200) were very

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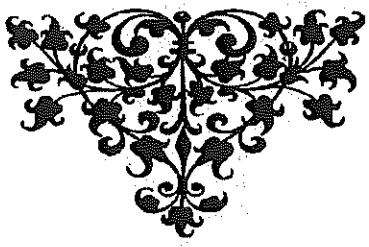

significant factors. Furthermore, all mothers of the malnourished children presented depression as evaluated by the Beck Scale, demonstrating that malnutrition goes beyond economic factors.

Multidisciplinary work involving pediatricians, psychologists, a psychiatrist (coordinator), nurses, a dietician, an agricultural technician, social workers and health agents was established with daily activity. Mother-infant interaction was assessed from the word go, including mealtimes. The changes achieved were remarkable.

Regarding psychological aspects, the mothers were seen individually at the beginning of the program since their emotional burdens, their fantasies, guilt feelings, and low self-esteem prevented group work.

Children who could not stay at home came to the Nutrition Center where they had interaction with the day care center caregivers, and all children came for mealtimes. At the same time as this care, the idea of restoring self-esteem and citizenship was always worked on. A community kitchen garden was established where the women or family members could help; they participated in obtaining food and were able to stop being beggars and helpless. The discrete participation of the fathers improved, and even a clay oven was obtained where once a week bread was distributed by one of the fathers.

Today the kitchen garden still exists and has the participation of some street children from that area. They are followed by the pediatrician who now coordinates the program and uses it to socialize and improve group participation, citizenship and self-esteem.

Besides the recovery of these malnourished children and their mothers, many of them now have jobs as cleaning women, housemaids, seamstresses, or doing small craftwork. An evaluation of their behavior shows that many have learned to be mothers.

As a result of the empathy used by the Centro Vida staff which included collaborators from the Health, Citizenship, Sports, and Expression and Work teams, they began to imitate much of what they observed and picked up a true psychotherapy.

Group participation by the community which helped provide food for the day care center was an important factor in making them feel

supported. As was perceived from the mothers' reports and from observing mother-infant interaction, an important internal change (insight) occurred. These mothers who felt devalued and devoid of expectations of a better life today feel different, relieved, more capable of their life potential since one looked at the other, and they helped each other to achieve what had seemed impossible.

Today some of the mothers who have become pregnant again, besides showing improved interaction, breastfeed their infants for up to six months. Similar programs are being organized in other Vilas close to the Humanistic Center, and they have had repercussions in the State of Brazil, at a time when the country is waging a campaign against poverty, for life, for citizenship, and to improve the life of 32 million Brazilians.

Finally, we see Vida as a program against Social Violence, a real epidemic. A center based on integrated actions, with multidisciplinary actions, and the support of the community, in search of a better quality of life.

It is by means of prevention that this very difficult situation in which we find ourselves will improve. The "anti-violence, anti-gang" culture begins in the young girl, in her care and education so that she knows her status as a citizen. It continues with integrated prenatal care, humanistic childbirth, breastfeeding, rooming in, parent-infant interaction, grandparent-infant care, at the daycare center, in togetherness. It is by integrating knowledge and activities with the community that we can best attain togetherness, bonding.

The people who work at the Humanistic Center, in my mind, can be considered true social operators (Pichon-Riviere), due to the socializing form in which they work. Obviously, integration is very difficult to achieve. Only through team work, through constant meetings, do we build unity and reduce our tendency to feud. In Mental Health, as in any other activity, the quarrel between psychiatrist, social worker, and psychologist is too common. It is easy to forget that we belong to a team, that our goals are achieved only by integrated work.

Centro Humanistico Vida today registers approximately 4,000 persons for various activities. People of all ages, some in extreme poverty, or with psychological needs (such as the handicapped in general, socialized psychotics), come in search of information, culture, sports, leisure, and to strengthen their citizenship. In some months as many as 15,000 persons come to the Center to participate in the Social-Recreation program.

The population of the area where the Center is located is over 200,000. Our idea and expectation is that each one who attends will become a multiplier, bringing to his/her community the same experiences, information to enhance potentiality, creativity, and an ability to build a sense of community where each human's personal culture is respected.

Physical space is not the important factor, although the first one installed is exceptionally privileged. The important factors are the philosophy and the integration of the community into an active mobilizing form with helpers who function as true social operators.

Vida can be a sports center, a leisure center, a cultural center, a science and technology center, a health center, a vocational center, a legal support center, or, a center of citizenship and enhancement of self-esteem.

"When we dream alone, it is only a dream... but when we all dream together, it is a sign that we have begun to experience reality." [7]

REFERENCES

[1] Celia, S., Alves, M., Behs, B., Nudelmann, C., & Saraiva, J. (1993). "The effects of violence on infants and young children: International Perspectives on Prevention." Infant Mental Health Journal, 14(2).

[2] "Betinhor quer Mobilizacao contra d Indigencia" Folha de Sao Paulo, 11/3/94, pg. 18, Sao Paulo, Brazil.

[3] Galbraith, K.J. (1992). "The Culture of Contentment." Emece Editores, Buneos Aires, Argentina.

[4] Celia, S., Alves, M., Behs, B., Nudelmann, C., & Saraiva, J. (1992) "Vida Centro Humanistico: una experiencia comunitaria en la formacion de vinculos. La adolescencia, Salud y enfermedad/ 2." Ediciones de la Banda Oriental, Montevideo, Uruguay.

[5] Celia, S., et.al. (1983). "Assistencia Materno Infantil: Analise de uma experiencia. Perspectivas. In, A. crianca e o adolescente brasilerio na decada de 80, pp.13-28, Porto Alegre, Brasil, Artes Medicas.

[6] Celia, S., Alves, M., Behs, B., Nudelmann, C., Saraiva, J., & Saraiva, J.R. (Sept. 1992). "Malnutrition in Infant Development. WAIPAD Fifth World Congress, Chicago, IL, USA.

[7] Pichon-Riviere-Quiroga, A. (1985). "Psicologia de la vida cotidiana," Ediciones Nueva Vision, Buneos Aires, Argentina.

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Postpartum Depression in Native and Immigrant Families:

Dynamics and Psychotherapeutic Approaches

by Fernanda Pedrina, Zürich

Postpartum depression has gained increasing recognition over the past ten years. The depressive mood of the mother and its effects on the baby have been described in numerous studies, which have also given a clearer picture of the significance of this for the later development of the child (Gelfand, 1990). Also, with the development of infant psychiatry, promising therapeutic possibilities have now emerged -- especially mother-infant psychotherapy which is in contrast to traditional approaches more directed towards interaction.

I intend to review briefly the various forms of postpartum depression and corresponding psychoanalytically-oriented interventions, as well as to examine the psychodynamic processes which I consider relevant to the disorder. I would also like to point out some particular features pertaining to treatment of this kind in immigrants.

Phenomenology of Postpartum Depression

The clinical form of postpartum depression can vary. It is sometimes difficult to draw the line between the common, frequent changes of mood, known as "baby (or postpartum) blues," and true depressions. The latter can, at times, alternate with hypomanic conditions, thus complicating their assessment for the person affected, as well as for the therapist. The manifest severe depressions can turn out to be reactive and easily remedied decompensations related to the excessive demands of parental adaptation, to conflicted interaction with the baby, or to the physical exhaustion of childbirth. They can, however, be deeper, comprising the reactivation of previous conflicts or even a previous depression, thus, making them much more difficult to treat. There are also impoverished depressions with few symptoms which are concealed by a lifeless, functional relationship with the baby and are accompanied by disturbances and illnesses in the child. Only after long-term medical treatment of the child, is it possible to gain access to this kind of pathology in mothers.

For an early assessment of depression in these cases, the interaction observations of infant research can be of help. An emotional withdrawal on the part of the mother, if this occurs within a sufficiently good relationship, provokes in the baby wariness and confusion, followed by protest and an attempt to regain affection. In a chronically depressive interaction, the exchange between the partners is generally poorer and more subdued, protest gives way to resignation (Field, 1984). The stages of anaclitic depression, described by Spitz (1946, see also 1965) in emotionally deprived babies separated from their mothers, can in a milder form also be observed when a mother, although physically present, is chronically withdrawn.

The therapeutic possibilities are manifold, according to the diversity of clinical forms of depression just described. A significant factor is how the depression is perceived by the person affected. A mother may complain "I am depressed and cannot look after my child properly," or "My baby and I do not get on, our relationship is disturbed," or "My child is ill, backward, I'm worried about him and I don't feel well as a result of this." Or the family brings along an exhausted mother with her baby, a mother who cannot put her illness into words, and seeks help. In the first sessions, usually with the whole family present, unless the mother expressly requests in the first telephone contact that she come alone, a decision is made as to whether the therapy should be conducted with the family or whether individual therapy for the mother or a mother-infant psychotherapy would be the best possibility. The involvement of the family can also become necessary in later stages of the therapy.

Dynamics of Postpartum Depression

The transition to parenthood, already well described in the 1950's by T. Benedek (1959), provides an indispensable framework of reference for psychotherapeutic understanding. Around the time of the arrival of the first child, the woman undergoes a reactivation of identification with her own mother and other important figures from her past, and this is now extended to include aspects relating to motherhood. This paves the way for her later identification with the child. If the thus far internalized relationships are too conflicted, these developments are overburdened. Unresolved, unconscious conflicts can later manifest themselves in disturbed interactions with the child. Fantasies about the coming baby set in even before the onset of pregnancy and undergo constant change and enrichment. They can be accompanied in this initial stage by ambivalence and grief, or feelings of happiness and wholeness, or fears and worries about the child and the process of childbirth. The confrontation between imaginary and real child after the birth represents

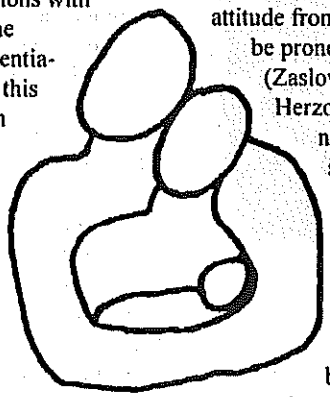
a departure from illusions and at the same time, gain from the exchange with a real person. This can involve great strain and disappointment, which the mother handles with varying degrees of success. Sometimes, she is not conscious of her own wishes until she experiences the first reaction of disappointment.

At the time period surrounding the birth and in the weeks following, the mother experiences a phase of special sensitivity to the needs of the newborn, which enable her to adapt optimally to the still very dependent baby and to confront it only gradually with the inevitable frustrations. This state of primary maternal preoccupation (according to Winnicott, 1965, in 1958) possibly explains the increased susceptibility to psychic decompensation in the immediate postpartum period. A further peculiarity of unconscious fantasies which is closely related to the birth process is primary paranoia, which Fornari (1981) deduced from analyses of the dreams of pregnant women. The pain of childbirth evokes in the woman in labor aggressive impulses and death wishes which can be threatening for the mother-child relationship. As a result, the apportioning of blame and feelings of persecution may be directed chiefly towards the partner. After the birth, they must be retracted in the interests of a more real relationship. However, the pressure to exclude the father, who is experienced from a paranoid perspective, and the trend into an exclusive dual relationship between mother and baby can reinforce each other, forming an insurmountable negative spiral.

In recent years, the early interaction between parents and baby has been more closely studied. The surprising success of therapy centered round the mother-child interaction motivated Cramer (1993) to ascribe this a specific role in the dynamics of postpartum depression. Interactions run circularly and are extraordinarily effective both in the positive and negative feedback loop. A baby can have characteristics that touch conflicted areas and trigger anxieties in one parent, which negatively influence his or her reactions. Examples include perinatal complications or physical handicaps, but also simply an appearance reminiscent of a certain person who is associated with negative experiences. As a result of their own character traits the parents may pursue interactions which severely limit the development possibilities of the child. Here, it is a good idea to regard the baby as a transference object of the parental projections, as described by Fraiberg (1975). In these cases, tracking down the parents' unconscious fantasies is of great clinical significance.

Fathers and Postpartum Depression

As regards the development of fatherhood, the question is the degree to which it retards or helps to shape a depressive disorder in the woman. In an expectant father, the reactivation of previous identifications with his own parents and the personal further differentiation of these is part of this process. Identification with the pregnant woman, and reactions of jealously can also be observed. These can dissolve in the emotional cathexis of the child experienced as pertaining to both parents. They are often the motivation behind larger projects at work or new training programs which are suddenly taken up during pregnancy and which the mother later perceives as an abdication of responsibility for the baby. An ambivalent attitude at the beginning of pregnancy is common in many fathers; if it is too pronounced and remains insurmountable, there is an increased risk of postpartum depression in the woman (Cowan & Cowan, 1992, quoted in Cramer).



The father's function in the perinatal period is described by Winnicott as the "holding" of the mother-child dyad, which lies in a variable deep regression. A disconcerted father may not be able to do this satisfactorily and can therefore himself become dependent on the support of others. A significant specification has been added by Bion's thoughts (1968), which examine the relationship between the holding environment and the projective identification. Bion describes the mother's reverie as a kind of mental digestive process, which converts the projected elements of the baby and returns them at times "decontaminated." Infant therapists have attributed this reverie to the father (and also the therapist) if he can respond to aggressive projections of the mother with anything but pure counter-aggression. Negative images about the child can also be defused by his participation. However, one should not only expect a caring attitude from fathers. They too, may be prone to postpartum "blues" (Zaslow & Pedersen, quoted in Herzog & Lebovici, 1989) and need the emotional support of the mother in the approach and emotional cathexis of their baby.

The whole process of adaptation to new conditions related to the biological, psychological and social development, necessitates constant departure from the preceding situation. The mourning process accompanying these losses is a "normal" component of the evolving of feelings in early parenthood (for which Manzano [1990] recently proposed the rather nice term "deuil dévelop-pemental"). It has its counterpart in the gratifying identification with the progressive achievements of the baby and in the attainment of a new identity.

Postpartum Depression and Immigrant Families

With reference to therapy with immigrant families one should bear in mind the fact that the psychological working through of immigration involves similar dynamics. Departure and grief, distress and depression, the search for an extended identity as the result of oscillating between the pre-migratory identity and the challenges and experiences within the new culture are processes which sometimes take years to complete. It is important to understand the biographical timing of the new life event of the transition to parenthood with this background in mind. The arrival of a baby often triggers a crisis in coping with immigration - and similarly later beginning school or choosing a profession. The immigrant must once again ask himself if he sees a future for this child and family in these new surroundings, or rather, in his home country, whether he wishes to educate his child in the new language and culture, etc.

The change in the woman's role and the loss of the supportive function of the extended family compared with traditional society are often the cause of strained relations.

In the process of approaching the family of origin, which often takes place in beginning parenthood, comparisons between the person's own childhood situation and the new circumstances can arise. The status of gender, the relative position in the order of brother and sisters, the mother's and father's role distribution in the care and upbringing of the child, the involvement of the extended family among other things, are reconsidered and must find a personal answer on the part of the mother and father. Often the surfacing of ideas and values presumed dead takes young parents by surprise. In immigrants, the confrontation with culture differences can be renewed in these interrelated topics, and the therapist should familiarize himself with these (Moro, et al., 1989). The change in the woman's role and the loss of the supportive function of the extended family compared with traditional society are often the cause of strained relations. In the first months of the child's life, cultural influences with regard to child care and upbringing are especially important. The question of breastfeeding and the search for a balanced attitude between devotion and frustration lie in an area of tension, to which fathers, grandmothers and sometimes also social or ideological standpoints contribute. Later family conflict often revolves around the question of authority or the use of punishment and threats in the child's upbringing. In mixed marriages with partners of different cultures, this search can proved to be especially difficult. In the traditional upbringing an initially very permissive, orally satisfying attitude often changes into an exceptionally repressive one. Both attitudes may be difficult to tolerate for a partner of other convictions.

Generally one can say that the central motif in psychotherapies of postpartum depression is the support of the depressed woman (and to a varying extent, the whole family), in her resumption and continuation of the interrupted process of identity extension which comes with the transition to parenthood.

References

Benedek, T. (1959) "Parenthood as a developmental phase." *Journal of the American Psychoanalytic Association,* 7:389-417.

Bion, W.R. (1968) *Learning from experience.* London, Heinemann.

Cramer, B. (1993) "Are postpartum depressions a mother-infant relationship disorder?" *Infant Mental Health Journal,* 14:283-297.

Field, T.M. (1984) "Early interactions between infants and their postpartum depressed mothers." *Infant Behavior and Development,* 7:517-522.

Fraiberg, S. (1975) "Ghosts in the nursery: a psychoanalytic approach to the problems of impaired infant-mother relationships." Journal of the American Academy of Child and Adolescent Psychiatry, 14:387-422.

Fornari, F. (1981) "Il codice vivente." Torino, Boringhieri.

Gelfand, D.M. (1990) "The effects of maternal depression on children." *Clinical Psychology Review,* 10: 329-353.

Herzog, J. & Lebovici, S. (1989) "Le père." In: S. Lebovici & F. Weil-Halpern, *La psychopathologie, du bébé,* Paris, Presses univ. de France.

Manzano, J., & Palacio-Espaza, F. (1990) "Concepts théoriques fondamentaux à propos des psychothérapies mères-bébés." Paper read at the Symposium de psychiatrie infantile, Geneva.

Moro, M.R., Nathan, T., Rabain-Jamin, J., Stork, H. & Ahmed, D. (1989) "Le bébé dans son univers culturel." In: S. Lebovici & F. Weil-Halpern, *La psychopathologie, du bébé,* Paris, Presses univ. de France.

Spitz, R.A. (1965) *The first year of life.* New York, International Universities Press.

Winnicott, D.W. (1958) *Through paediatrics to psychoanalysis.* London, Tavistock.

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Stephen's Corner

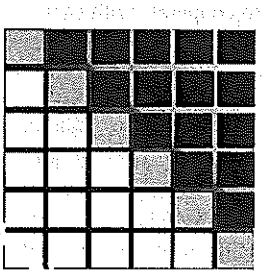
Stephen Bennett

NORTHERN EXPOSURE

It is mid-March in Montreal. The grey rain let loose by the fog is dissolving the leftover snow, dissolving distance, so the very fact that a city exists is lost in the watery greyness. The reason I am in this northern city is that Klaus Minde has invited me to come up and see his program. His home is a townhouse that is part of a row of hundred year old buildings, each with its unique shape and color. Klaus's place has been identified as the one with the yellow door. It is good to come inside and sit in his living room with its large, stark spaces splashed with bright pictures and deliberate clutter, such as a grand piano with music left about, as if there had just been a performance.

An invitation to observe how another area responds to the needs of infants and mothers brings out, first a jealous sense of competition, then a curiosity about just what is going on. Anyone who attends meetings and is in touch with the literature knows Klaus as a vividly articulate but subtle searcher into the ways of infants and mothers. He is chairman of the Division of Child Psychiatry of McGill University and chief of psychiatry at the Montreal Children's Hospital -- L'Hopital de Montreal pour Enfants -- which is part of McGill University.

Although McGill used to be the English speaking or Anglophone system, now both English and French speaking families attend the hospital. The parallel organization is the University of Montreal. Francophone. Here are two juxstaposed organizations, cultures, and languages. Perhaps, the only way to find out how these systems work and compare would be to experience them over time. In my first visit, eventually I did get a sense of the differences through the drama of a dialogue.



On this first evening, Klaus has invited over what he calls "some of the local infant mafia." Among those present in the group, huddled around the wine and cheese, is Yvon Gauthier. He is a large, handsome man with white hair and solid stance, just the kind of person you would like to be the leader of your organization. And indeed, he just happens to be the President-Elect of WAIMH. He was also Dean of the Medical School at the University of Montreal from 1981 to 1989. The mannerisms of Yvon and Klaus would baffle anyone looking for cultural clues. Yvon presents an amused dignity and charm, and even with a subject strongly felt, there is a quiet, off-hand sense of the basic humor of things coming through. Klaus is tall and supple, his grey hair parted in the middle and tossing with the explosion of his gestures. His balletic footwork, and the musicality of his voice remind me of a philharmonic rehearsal. Indeed, music plays an important part of his life and his brother is the conductor of the Portland Opera.

Listening to Klaus and Yvon talk and argue is the delight of the evening. They start out by describing their hope that after the 1996 meeting of WAIMH in Lahti, Finland, the next meeting would be in Montreal. I ask Yvon how the two language systems co-exist? He answers that they have had more to do with each other in the past 5 to 10 years, are always collegial in meetings, but otherwise there is little contact. I get the impression that there is no great hostility, as in other aspects of the English and French rivalry, but here there is an amiable indifference.

Klaus describes the French system as hierarchical, with tradition taken seriously. There is a resistance to change, a fact that he feels has slowed reorganization of structure. The McGill system is now beginning to amalgamate all their diverse hospitals into one. This, Klaus feels, is evidence of their flexibility. Yvon, with quiet firmness, states that he just doesn't agree with Klaus. That the English community would get rid of their five hospitals to build one big one is for him a crazy idea. He is against megacenters and feels that "smaller is more beautiful." There is laughter as Klaus says that at least McGill has the flexibility to do something crazy.

I ask Yvon about the relationship of Montreal with France, as regards infant psychiatry. Montreal is very different from Paris, he replies. In their approach to infancy, for example, they respond to the work of Selma Fraiberg, and are in tune with the Americans. The French system in Montreal, Yvon says, is closer to pediatrics, while the English is more in touch with psychiatry. Since the early 1960's, when he started child

psychiatry, Yvon has been very interested in pediatrics and involved with pediatricians at Ste. Justine's, which is the University of Montreal's obstetrical and children's hospital. Although this is a mother-child hospital, Yvon acknowledges that there is an institutional reluctance to the creation of a new structure that would integrate services to mothers and infants. He intends to push this.

Yvon works with the frontline General Practitioners and other professionals in the C.L.S.C. -- Centre Local de Services Communautaires -- which is the primary care structure for mother-child programs. The second line is the child psychiatrists, and he feels that they should make their presence and ideas felt where mothers and young children and the disadvantaged come together.

Yvon was trained in psychiatry and child psychiatry in Philadephia from 1955 to 1960. As soon as he returned to Montreal, he became involved with pediatrics. His interest in very young children came through research on asthma. The hypothesis in the literature centered then on the early mother-child relationship, but the striking fact was that there was no direct research with young children. In 1972-73, he saw 40 children between the ages of 14 and 30 months. Since that time he has continued his involvement with young children. All through the 1980's, when he was the dean of the medical school, it was only through the developmental clinic at Ste. Justine that he maintained direct clinical contact. He knew that some day he would come back to infant work.

His powerful remembrance of the first meeting of the World Association for Infant Psychiatry in Portugal in 1979 echoed my own memory. At that meeting, for him an amazing event, he felt that psychiatric infant work really started with force and dignity.

That previous afternoon I had followed Klaus about his busy work schedule at the child psychiatry clinic of the Montreal Children's Hospital. He has a large staff which includes 20 child psychiatrists, and 20 more in 3 other hospitals. The staff is divided into teams responding to a particular age group. The infant team, which cares for children under 3, consists of at least five professionals of various disciplines. They spend about two days a week evaluating young children and their parents. Luckily, they were meeting that afternoon, and so I got to watch an interview through a one-way mirror of a 2 year old who had signaled distress. The situation is sad. His mother who is 19 is obviously upset because the father of the child, aged 20, has decided to move with his own parents to the United States.

Klaus voices pride in his efforts to get all senior people who work with babies to cooperate with each other. He does this in other areas as well, such as adolescent teams. He admits he is forceful about helping his staff to see the advantages of collaboration. His command of resources allow him to do this, or as he puts it, use blackmail. It is easy with the infant people because they reach out for contact. They serve as a support group for each other and see about 200 cases a year. There is an active lecture program. Last fall they had Bertrand Cramer, and this spring, Alicia Lieberman will come.

Raised in Leipzig, Germany, Klaus attended medical school in Munich and London and trained in pediatrics at Bellevue Hospital in New York. He had wanted to understand normal children and learn about development and so, on a Fulbright scholarship, studied developmental psychology under Jersild at Columbia University. The rigor and methodology of this discipline is intensely important to him. In the 1970's he spent 2 years in East Africa as a child psychiatrist.

There were several routes to his interest in infancy. An early and vivid experience in his career was a resident who had a baby, took the 3 weeks off she was entitled to, but then came to Klaus in tears saying that she needed more time with her new baby. Klaus was able to come up with sick leave. This incident was his first inkling of how powerful a baby could be. A personal experience came from his first child who was premature. At that time parents were allowed little contact. This was an immensely traumatic time for his wife and himself. His clinical experience came from following 250 premature infants until they were 4. It was here that he learned about babies but also about the importance of a team. In 82/83, during a sabbatical, he spent 6 months with John Bowlby, and another 6 months in Yale where he had frequent contact with Sally Provence.

On the second day, I get up early to accompany Klaus as he purchases bagels and croissants for his monthly infant group breakfast meeting. I discover that Montreal bagels are thin and chewy, and I would think, more authentic than the puffy New York bagel. During this trip he relates that every three months he spends two weeks with his wife Nina, who is a psychologist, working with the Cree Indians of James Bay. The stories he tells about this experience are so vivid that I hope he will sometime turn them into an article for this newsletter.

There are a dozen people around the breakfast table, mostly psychiatrists, who meet for the purpose of discussing the research and administrative aspects of infancy work. I cannot imagine this happening now in New York City. It would take a Klaus to blast through the claims of busyness and overextension, and dig people out. I think about the qualities of leadership, what goes beyond research and academic credentials, beyond charisima -- that special dynamism that it takes to charm and force people to work together. Also, a fascinating to consider is that there is a parallel system doing the same thing.

Mid-morning I follow about Dr. Lee Tidmarsh, who is a child psychiatrist interested in primary care. I get

to experience first hand the mental health aspect of early intervention that has been described to me. Dr. Tidmarsh is just finishing a Zero to Three\National Centers for Clinical Infant Programs fellowship. This sponsorship encourages research, makes possible contact with senior clinicians, and above all provides entry into a network of others with similar interests in infancy. Her research project, predominately a descriptive field study, is to evaluate the mental health assessment done by community-based nurses and doctors for mothers and their newborn babies. She accompanies the mother during her visit with the nurse when the baby is about 10 days old. Two weeks later, when the baby is about one month old, she is present during the mother and infant's first visit with the pediatrician. A follow-up assessment is conducted at 18 months. Preliminary findings are that very few issues are raised by either the mother or the professional about the mother's emotional life, such as her feelings about her baby or whether she is depressed. Klaus's comment was that it seems amazing for a pediatrician to begin a 16 year relationship without asking the mother how she feels. Nurses score a little better. Such a study is an essential prelude to any large scale plans for responding to the mental health needs of mothers and their young children.

Dr. Tidmarsh's long road to infancy work began with animal behavior. In her work in Germany with Konrad Lorenz, she had occasion to imprint ducks and geese and saw Lorenz in action with his own family of geese. (Among the life experiences I regret not having is being a goose mother.) Dr. Tidmarsh attended medical school at McGill and did three years of pediatrics at the Montreal Children's Hospital. Neonatology was an area of interest, but she found she was more interested in what went on between the mother and her new baby so she left pediatrics, and still at McGill, she trained in psychiatry. She had her first child during her psychiatry residency, then finished training, and had two more children. Klaus made his appearance in Montreal in 1989, and she joined him in starting an infancy program.

On a personal note, Dr. Tidmarsh related that recently her five-year-old daughter had asked her what she was going to do when she grew up, and she answered that she was going to be an artist. She joked that watercolor courses are preparing her for her real career.

On this morning, Dr. Tidmarsh is making her regular visit as consultant to the CLSC at Notre-Dame-de-Grace/ Montreal West. The edge of this area consists of middle class housing that borders on a section of great poverty. Although there is a large Carribean population it is widely multi-ethnic with Arabic, African, and Russian immigrants. The center is on the ground floor of a sturdy apartment building. I mention this because in my experience the organizations that serve poverty areas are most often found in crumbling buildings. There are a dozen social workers and nurses sitting around a table. Three women are presented. All of them, as was the woman the day before, are fragile, left alone without the father of the child, and possess only slender family resources. All three presented at the center are having serious problems with immigration. The staff, in the best tradition of social work and nursing, are actively searching out family and neighborhood resources. One woman had just delivered a child the weekend before and the social worker was present during the delivery. I am struck in the histories by the predominant theme of abandonment and betrayal by the men around them. Is this an older European, out of fashion view, that derives from a sense of male responsibility? Where I reside, men seem to have been written off.

I ask the group how they feel about the allocation of resources for young mothers and children? My own sense is that excellent services are being provided, at least compared to my own backyard where mental health resources for mothers and infants are sparse. The answer is that the programs available were one step above being seriously inadequate. Montreal has the highest rate of poverty and low birth weight children in Canada, and, although there are services in place, they are not nearly enough. Such commentary by professionals who respond to the mental health needs of mothers and young children is usually viewed by government agencies or insurance companies as a nightmarish and greedy desire to provide this population with endless and costly support.

My own sense where I reside is that the new legislation encouraging early intervention shows promise, but it will take time to get beyond basic pediatric care, and then address the mental health needs of infants and their parents. I come to this morose view as a result of close questioning of the people involved at a local, city, and state level. There is frustration -- although no one will stop trying -- over the difficulty in breaking into the new bureaucracy.

The Infant-Mother Unit of the Douglas Hospital, one of the four

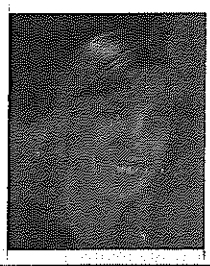
Three women are presented. All of them . . . are fragile, left alone without the father of the child, and possess only slender family resources. . . . I am struck in the histories by the predominant theme of abandonment and betrayal by the men around them. Is this an older European, out of fashion view, that derives from a sense of male responsibility? Where I reside, men seem to have been written off.

hospitals in the McGill child psychiatry system, is my final stop. It is in southwest Montreal and touches the St. Lawrence, but the heavy snow allows me only one grey glimpse of the river. The wide expanses of lawns in an area surrounded by urban clutter reveal its origins as an old state psychiatric hospital. Although serving an Anglophone population most of the bilingual staff appear more comfortable in French. The talk at lunch concerns the city's decision to move social workers out of the downtown centers into the community. The population they serve at Douglas is not only the community, but also the psychiatric hospital. They are well placed to offer care to expectant mothers and mothers with newborns who are psychiatrically ill. They can be referred to the infant unit while continuing to receive adult psychiatric services. The director, Suzanne Dongier, a gracious woman with a melodic voice, is a child psychiatrist and psychoanalyst. The focus for this unit's therapeutic efforts is the morning program that provides a place where mother, father, and infant can, through play, enjoy each other. Group sessions with the parents are part of this. Their work and that of the other hospitals in the McGill Child Psychiatry system, as they state clearly in their brochure, is influenced by Fraiberg, Stern, Greenspan, Emde, Lebovici, Cramer, and Winnicott. These are not empty names -- but rather -- powerful ghosts in their nursery. I am struck by this acknowledgment of their psychoanalytic lineage, but also that in their sorties into the world outside they make presentations to all the tough, no-nonsense acronyms -- SRCD, WAIMH, ICIS, and NCCIP. In particular, I admire one piece of research by this unit which addresses an issue endemic to clinical settings. It seems that there is always someone who defends not doing research by claiming that it gets in the way of clinical work. The findings of this group are that in a population renowned for their ambivalence about treatment and failure to keep appointments that participation in research, if parents were really made part of it, aided greatly the therapeutic efforts and improved attendance.

While sitting in the plane on the runway waiting for the snow to be hosed off the wings, I think of the complex confluence of factors it takes to get major programs going for mothers and infants. Even a Berry Brazelton doesn't get very far unless the local political system provides money. What I had seen in two days was best put in a winter image and that is a snowballing effect of Provincial support, strong old pros as leaders, opportunity for younger people to explore, all as part of a vital team who are in touch with the larger clinical and research world and eager to make changes.

Editor's Note:

Dr. Stephen Bennett is Chief of Child Psychiatry at Harlem Hospital and Assistant Professor of Clinical Psychiatry at Columbia University. He has been a baby watcher for many years. At present, he straddles the ivory tower concerns of academe and the pressing real world problems of the inner city. His column is a regular feature of this newsletter.



President's Perspective

Joy D. Osofsky

In the summer of 1994, WAIMH held two very different types of workshops that were consistent with the overall objectives of our organization. The Regional Meeting held in June, 1994 in Riga, Latvia was the first regional meeting that we have had in an Eastern European country with a strong effort made to reach out and include participants from other Eastern European countries. The second was a more held in San Francisco in July, 1994 during which clinical approaches to working with infants and families were presented and afternoon workshops were held before the meeting of the International Association for Child and Adolescent Psychiatry and Allied Professions. In this column, I will discuss highlights from each of these meetings and prospects for the future that may result from these efforts.

Riga, Latvia 1994

Riga was such an exciting adventure and uplifting experience for all who attended thanks to the careful planning, dedication, and thoughtfulness of Kas Tuters. WAIMH, with our European colleagues taking the lead, has been reaching out to several countries in Eastern Europe. However, having a Regional Meeting in Latvia had special meaning since it was developed and organized by a Latvian, Kas Tuters, who had to leave the country as a young child, grew up in Canada, and came back to his country of origin when it was finally

possible to both learn and teach. He brought together colleagues from Latvia to join him in the organization of the conference. Thus, there was special inspiration for this meeting from the initial planning stages. Many people who attended the meeting, not just the Westerners coming from a long distance, had never been in this region of the world. Several of our colleagues from the Nordic area mentioned how very meaningful this experience was for them living such a short distance away but never having traveled to these countries. For many people attending from Western European countries, meeting in Latvia with strong presence from the participants from the Baltic Region and Russia made a deep impression. This meeting was truly unique in many ways. A longer description of the meeting and its content written by Kas Tuters is being published in an upcoming issue of the *Infant Mental Health Journal.*

The conference was organized in a different way from other regional meetings. Two days of preconference activities and meetings were planned to help the participants to become better acquainted with the culture and setting before presenting to the group. We had the opportunity to hear about local programs and perspectives, visit mental health, ambulatory, and orphanage care settings for children, and, participate in special cultural activities including much charming musical entertainment planned by the Latvian people. The overall content of the meeting included material on the psychosocial development of the infant and child, direct clinical work with infants, children, and their parents, and theoretical and practical applications to institutional work with infants and children, all applicable to the overall theme of: "Adaptive Changes to Infant and Child Care in a Rapidly Changing Social-Political-Economic System: Which Models Apply Best?"

I want to share some of my personal experiences and impressions in addition to the general comments and report of the meeting.

As many people know, I have been working intensively for the past few years on the effects of violence on children with particular emphasis on the effects of violence exposure, both acute and chronic, and also the effects on parents and caregivers in the home and community. In Latvia, as in many both developed and developing countries, there is a high level of violence within the society. Latvia, like many countries (including the U.S.) has not yet come to deal directly with what such violence exposure may mean for the later development of children. There is also a different way of dealing with problems within families and with parenting. For example, on the second afternoon, we had the opportunity to choose among several different orphanages, hospitals, or ambulatory care facilities for children. I chose to visit one of the better orphanages, a place that was taking care of about 140 children most under the age of 5 years. Some of the children had physical problems, others had emotional problems and some had neurological problems. Many of the children were healthy but without families. Some showed appropriate affect and seemed "attached" while many more showed indiscriminate attachment -- they would go to anyone to receive attention. Apparently, although many are adopted, if the mother visits every 6 months, they cannot be adopted. I had forgotten what an orphanage looked like for very young children as our country has gone much more in the direction of foster care homes for children who cannot be cared for by their families. While the caregivers in the orphanage were very caring (though at times overwhelmed), I was saddened by this visit because I wondered what the longer term outcomes would be for these children institutionalized at such an early age. And yet, just as in our country, many children receive less than optimal care, so in this country, this was the only choice for many children and families.

We were struck in many different ways with the high degree of hopefulness within the people who were living in this newly created free society within the Republic of Latvia. So many people saw a future for themselves that had not previously been possible. Despite the overwhelming obstacles, there was a spirit of trying to rebuild and create a new life that previously had not been possible. This spirit was shown vividly not only through words, but even more clearly through music and dance and the many children who participated.

Another highlight of our meeting in Latvia was a separate meeting that was held with representatives from the Baltic and Nordic Regions, including among others the countries of Lithuania, Latvia, Estonia, Russia, Finland, Sweden, and The Netherlands. The purpose of the meeting which was chaired by WAIMH's Regional Vice President for Europe, Peter de Chateau, was to discuss the general interests within the different countries and regions and future directions including whether there was the possibility for WAIMH affiliates to be formed to continue the enthusiastic work that was represented at this meeting. It was a lively meeting with many different perspectives and viewpoints being presented and discussed.

The Nordic Affiliate group agreed to be available and helpful in facilitating future activities as did Peter de Chateau. The message was presented very clearly to our group by a woman from the Baltic Region who said, "We have much to give as well as much to learn and it is important that you listen to us." We listened and heard and will try to be helpful and supportive to efforts to develop infant mental health activities in this region of the world.

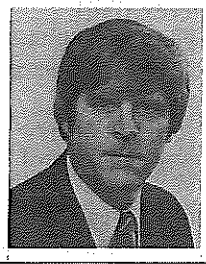
San Francisco, California, July, 1994

The Regional Meeting in San Francisco, organized by our Executive Director, Hiram Fitzgerald, was held on Saturday, July 23, 1994 before the meeting of the International Association for Child and Adolescent Psychiatry and Allied Professions. (WAIMH members also presented an invited symposium during the IACAPAP meeting). It was well attended with representation from the U.S., both Western and Eastern Europe, South America, and Japan. The focus for the plenary sessions presented by Stephen Seligman of the Infant-Parent Program in San Francisco and myself was to discuss different approaches to clinical work with infants and families. Steve's presentation focused on infant-parent psychotherapy in varied situations and my presentation discussed post traumatic stress disorder in very young children by presenting case material from two year old twins in treatment with one of the child psychiatry fellows at LSU Medical Center who had witnessed their mother's death by shooting. The cases were then discussed by a distinguished panel of WAIMH members including Miguel Hoffmann, Charley Zeanah, Bob Emde, and Antoine Guedeney, with Hi Fitzgerald moderating. The discussion by both the panel and audience was lively with many good interchanges.

In the afternoon, we broke into smaller groups for workshop discussions on the following topics: infant depression: diagnosis and assessment; attachment disorders in infancy, assessment of early initiative and willfulness from birth to one year; transference and countertransference in infant-parent intervention, and the IFEEL Pictures technique.

The workshops were well attended and benefited from the rich interdisciplinary and international representation. In the workshop that I co-chaired with Bob Emde on the IFEEL Pictures, we had participants from around the world coming from both research and clinical settings, some of whom were familiar with and had used the measure and others who came with little background but much interest.

By holding regional meetings in conjunction with other larger meetings, we find that we have the opportunity to meet new people with interest in infant mental health and expand our network of communication as well as our own perspectives. The next regional meeting to be held in a similar context is one with the theme, "Reality and Early Trauma: Developmental Pathways," which is being planned for Saturday, July 29, 1995, in San Francisco before the meeting of the International Psychoanalytic Association meeting. An update on the program will be provided in the next edition of the *Signal*. For more information and registration materials, please contact my office (Joy D. Osofsky) at Department of Psychiatry, Louisiana State University Medical Center, 1542 Tulane Avenue, New Orleans, Louisiana 70112, USA, Fax (504) 568-6246.



From the Red Cedar

Hiram E. Fitzgerald
Executive Director

Membership and Affiliate Development

I have mostly good news to report in this issue of *The Signal*. First, let me extend cordial welcome to **Groupe Francophone d'Etudes et de Recherches en Matiere de Sante Mentale de l'Enfant de la Conception Jusqu'a Trente Mois**, WAIMH's newest Affiliate. Prof. Bernard Golse is President of the French Affiliate, Prof. Michele Maury and Prof. Philipe Mazet are Vice Presidents and Serge Lebovici is Secretary. Welcome to WAIMH and best wishes for continued success.

In addition, WAIMH continues to work with individuals from around the world to establish new Affiliate organizations. Currently, Affiliates are in development in Canada (British Columbia), Germany, Israel, Japan, Netherlands, Russia, and the United States (Ohio, California, Wisconsin, Kansas). Moreover, members of the Australian Affiliate are working to establish chapters of their organization in various cities throughout the country. The net benefit of all of this activity, is that WAIMH membership continues to grow. As of the end of August, we have slightly more than 650 members.

Subscription Rate Increase

This increase in membership has helped to boost subscriptions to the ***Infant Mental Health Journal*** to its highest subscription rate ever, 1,112 as of August 31, 1994. This is truly remarkable growth in the subscription rate since 1985, when there were approximately 400 subscribers. This growth rate reflects the excellent work

of the journal's editorial staff and consulting editors, under the leadership of Joy Osofsky, as well as the continuing strong support of Clinical Psychology Publishing Company, our publisher. Recently, the Board of Directors of the Michigan Association for Infant Mental Health (founder and copyright holder of the ***Infant Mental Health Journal)***, voted to accept a new five-year contract offer from CPPC, Inc. to continue publication of the Journal. However, since subscription rates have not changed since 1993, there will be an increase in both to offset inflation related increases in paper, ink, and production costs. Similarly, postage rates for international mail have increased substantially and so there also will be an increase in these costs for our international subscribers. See column 3 for new rates. Costs in subsequent years will be based on inflationary trends and will be negotiated between CPPC, Inc. and the MAIMH Publications Committee (Hiram Fitzgerald, Chairperson). There will be no increase in WAIMH dues for 1995.

1995 Regional Congresses

The Australian Association for Infant Mental Health has issued its call for papers and registration of interest for the April 21-23 Pacific Rim Regional Meeting, to be held on the campus of the University of Sydney, Australia. The theme of the conference if "The Baby, Family and Culture: The Challenges of Infancy Research and Clinical Work." Invited speakers include Serge Lebovici and Antoine Guedeney (France), Hisako Watanabe (Japan), Charles Zeanah and Hiram Fitzgerald (United States). For registration information contact: WAIMH Meeting, PO Box 214, Brunswick East, Melbourne, Victoria 3057, Australia. For information about the program, contact Dr. Campbell Paul, Program Convenor, Mental Health Services, Royal Children's Hospital, Flemington Road, Parkville, Victoria 3052, Australia.

The Texas Association for Infant Mental Health

On April 7-8, 1995, the WAIMH Regional Conference, ***Babies Can't Wait: A Collaborative Approach to Planning for Infants and Toddlers in the Legal System*** will be held in Arlington, Texas. Conference hosts are the Texas Association for Infant Mental Health (TAIMH) and the Tarrant County Junior College Child Abuse Prevention Project. The conference will explore issues affecting infants and toddlers who are drawn into the legal system and are adversely affected by it. Speakers include Alicia Lieberman, Jeree Paul, Bruce Perry, MD, and Michael Trout.

Watch for details in later issues.

Conclusions

So, it seems self-evident that WAIMH continues to mature as an organization. At the San Francisco meeting of the Executive Committee it was decided to conduct a survey of world training and education programs in infant mental health as well as begin to identify resources that may be available to educators. Development of the survey is underway and should be in the mail with your membership renewal notices Nov. 1. Bob Emde is chairing the resource assessment effort, assisted by Joy Osofsky and Hi Fitzgerald. The first WAIMH membership directory will also be included in the Nov. mailing.

Finally, planning for the 1996 **WORLD CONGRESS** in Tampere, Finland continues to go smoothly because of the efforts of Local Arrangements Chair, Tuula Tamminen and Program chairs, Peter de Chateau and Antoine Guedeney.

1995 WAIMH Membership Rates and Infant Mental Health Journal

(all figures in U.S. Dollars)

United States addresses:

Journal Only Rates:
- Institutional: ***$109.00***
- Personal: ***$57.00***
- WAIMH Member: ***$35.00***

WAIMH Membership Dues:
- Membership only: ***$50.00***
- Membership plus Journal: $50.00 plus 35.00 = ***$85.00***
- Student Dues: ***$35.00***
- Student Dues plus Journal: $35.00 + 35.00 = ***$70.00***

Addresses outside the US:

Journal Only Rates
- Institutional Rate: $109.00 plus $13.00 postage= ***$122.00***
- Personal Rate: $57.00 plus $13.00 postage = ***$70.00***
- WAIMH Member Rate: $35.00 plus $13.00 postage =***$48.00***
- Canadian Residents add 7% value added tax.

WAIMH Membership Dues:
- Without Journal: ***$50.00***
- Membership Plus Journal: $85.00 plus $13.00 postage = ***$98.00***
- For Canadians: add 7% value added tax = **$100.45**
- Student Dues: ***$35.00***
- Student Dues plus Journal: $70.00 plus 13.00 postage = ***$83.00***
- Canadian student residents add 7% value added tax= ***$85.45***

News & Views

EDUCATION OPPORTUNITIES

Advances in Psychiatry VI, 1994. George C. Curtis, MD, Professor, Director of Anxiety Disorders Program and Continuing Medical Education in Psychiatry, Department of Psychiatry, University of Michigan. Sponsored by the University of Michigan Medical School Department of Psychiatry. November 4-5. Towsley Center, Ann Arbor, Michigan, USA. 14 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association. An application has been submitted to the American Osteopathic Association for accreditation.

The instructional objectives are to update the psychiatrist in the diagnosis and treatment of psychiatric disorders, ranging from the circumscribed to the pervasive.

For information call Vivian Woods: 313 763 1400.

ZERO TO THREE/National Center for Clinical Infant Programs is holding its 9th National Training Institute on December 1-4, 1994, in Dallas, Texas, USA. Conference Theme is: Frontiers and Front Lines in Infant/Family Practice, Policy, Research, and Training. For information, call, write, or fax: ZERO TO THREE, NTI, PO Box 7270, McLean, VA 22106-7270. Tel: 703-356-8300 Fax: 703-790-7237.

REPORT AVAILABLE

The Violence Study Group of **Zero to Three** has issued a new report, *Caring for Infants and Toddlers in Violent Environments: Hurt, Healing and Hope.* Edited by WAIMH members Joy D. Osofsky and Emily Fenichel, the report presents research findings and case studies illustrating what is known about the impact of early experiences of violence on children's development. It suggests ways for adults to cope successfully with their own experiences of violence, so they, in turn, can help very young children cope successfully with potentially devastating trauma.

The cost is $4.95 for one copy plus $2.50 for shipping.

To order, send your payment, name, mailing address and phone number to: Zero to Three, PO Box 25494, Richmond, VA 23260-5494.

By phone (credit card orders only) 703-528-4300. By fax (credit card orders only: 703-528-6848.

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