

# The Signal



Vol. 3, No. 1

Newsletter of the World Association for Infant Mental Health

January—March 1995

## *Fraiberg in Paris*

by Antoine Guedeney,  
Nicole Guedeney and  
Martine Morales-Huet



In a recent conversation with Charley Zeanah when he visited Paris, we came up with an idea to describe our work, which is based on the work of Selma Fraiberg. So, from a discussion with one American in Paris, we had the idea to discuss another American in Paris, namely, Selma Fraiberg. At the time of the Vincente Minelli film, "An American in Paris," Paris and France were still far from the American way of living. Times have changed; Paris has become increasingly international. The Paris of Willy Ronis, Doisneau, or Henri Miller is slowly vanishing. Nevertheless, it is interesting to compare two very different ways of working in the field of infancy, and two different kinds of public policies. Because there are differences, it is also interesting to see what can be imported from abroad. "Fraiberg in Paris." How can the French state-ruled system make use of the infant-parent program designed by Selma Fraiberg and her colleagues? Can clinicians in the United States derive some of the best aspects of the French system into their work for infant mental health? May professionals in other countries benefit from either?

### **France and the U.S.: Contrasting Systems of Care**

Our first response to the idea of writing a piece on, "Fraiberg in Paris", was to emphasize the differences, not only between the two systems of public health, but also in the philosophy of intervention itself. The most striking difference is probably the status of action and programs since these are the very basis of the U.S. system.

In the U.S., a program is funded with a specific budget for a certain duration and is evaluated in certain ways to determine its effectiveness in attaining certain goals. This obliges applicants to provide a very clear picture of what they intend to do, and how, with a detailed budget and clear objectives that can be evaluated.

These exigences have certainly made the U.S. health programs among the best available in the world. Interventions are designed for achievement of precise goals, with a reasonable chance to give demonstrable results within a short period of time, and with the minimum use of taxpayers' money. Action is the motto, along with effectiveness. Selma Fraiberg's infant/parent program is a good example of one result of this policy.

Let us reconsider its ingredients. The original infant/parent program was "born" from the experience of research with blind children. The original program was very precise in its focus: Is it possible to provide parents of blind born children with a program that could allow for a normal psychological

#### **IN THIS ISSUE**

- |    |   |
|----|---|
| 1  | Selma Fraiberg in Paris                           |
| 5  | Tales from Training                               |
| 8  | Yup'ik Parenting                                  |
| 11 | Stephen's Corner                                  |
| 15 | President's Perspective                           |
| 17 | From the Red Cedar                                |
| 18 | New & Views                                       |
| 19 | Psychoanalytic Association<br>to Create Data Base |

development of the children? It was indeed possible, and the program demonstrated it nicely so that it is now used worldwide. As Selma Fraiberg pointed out, the program was based on very intense collaborative work with parents who were considered unconflicted, rational and helpful. Parents know best; they are in charge. If they do not know, if they feel uncertain, they are the ones to be helped. Eventually, it was necessary to trace the psychological effects of the handicap of their child back into their own childhood so that they could face the handicap and the child without excessive pain.

This approach to parenting proved extremely helpful with parents with severe psychopathology, as well, leading to the concept of "ghosts in the nursery." After the success of the program for blind infants, Selma Fraiberg decided to develop another program, an infant/parent program for unreachable families. The child represents the hope of the parents; they want for the child a better future than what they had. Still, this hope can be altered by the reawakening of the parent's childhood, with a past of deprivation and aggression being reenacted in the relationship with the infant. For those battered families, the child is the only reason to accept professional help. An essential ingredient of the success of the program is of course Fraiberg's outstanding ability to understand infancy, and to make us understand that "infants can't wait."

This is another example of the deep differences between the French and the U.S. systems. As there is no generalized social insurance system, the holes in the network have to be covered by programs, national, federal or locals. The issue of how to reach adolescent parents, drug-addicted parents, immigrants or isolated mothers becomes salient. French society did not have to face this issue until the end of the sixties and the end of the economic post-war boom.

Of course, such problems have

always existed, but they have not yet reached the level of a national health issue. At present, France is faced with a high level of unemployment, with structural causes, shaking the foundations and coherence of French society and the social network. France is also faced with large numbers of immigrants, threatening to overwhelm the limits of the French model of integration through the primary school, the former School of the Republic where any one could learn the language of Moliere and Voltaire, and the principles of the French Revolution.

But what if the immigrants do not want to share the French culture? What if the suburbs grow into shattered places, with only despair and violence? What if classes live in parallel, with no social interchanges and contribute to elaboration of conflicts? The French health care system is rapidly reaching levels of unbearable costs, with relatively feeble efficiency, even if some highly effective domains still remain. The recent, widely publicized incident of HIV contaminated blood has sapped the confidence of people in their medicine and also in the political system. So now, France is facing a confidence crisis, discovering the hidden face of herself: exclusion, poverty hitting 5 to 10% of the population, segregation. Little seems left from our slogan, "Liberty, Equality, Fraternity."

The change is sometimes more difficult in a country of tradition and history, as it is hard to face the fact that we are no more always in the front row, that we have to do more to keep up the pace and high standards of living.

In the early 1960's, an ambitious plan was developed in France for mental health. Each division of 60,000 adult inhabitants was to be assigned to a mental health structure, called the "secteur" (sector) which was charged with prevention and treatment. Some grew and developed very actively, like in the 13th and 14th districts in Paris, but also in the

## Editorial Staff

*Editor:* Charles H. Zeanah

*Editorial Assistant:*  
Dee Bonvillian

*Production Editor:*  
Melanie Smith

*Editorial Board:*  
Susan Berger  
Salvador Celia  
Peter de Chateau  
Mauricio Cortina  
Graziella Fava-Vizzello  
Emily Fenichel  
Elizabeth Fivaz-Depeursinge  
Peter Fonagy  
Cynthia Garcia-Coll  
Bernard Golse  
Antoine Guedeney  
David Lonie  
Tuula Tamminen  
Michael Trout  
Elizabeth Tuters  
Hisako Watanabe

*Feature Columnist:*  
Stephen Bennett

*President's Perspective:*  
Joy Osofsky

*From the Red Cedar:*  
Hiram E. Fitzgerald

*The Signal* is a quarterly publication of the World Association for Infant Mental Health. Address correspondence to Charles H. Zeanah, M.D., Division of Infant, Child & Adolescent Psychiatry, Louisiana State University School of Medicine, New Orleans, LA 70112-2822. All opinions expressed in *The Signal* are those of the authors, not necessarily those of WAIMH's. Permission to reprint materials from *The Signal* is granted, provided appropriate citation of source is noted. Suggested form is: *The Signal*, 1994, Vol. 2, No. 4, WAIMH.

provinces of France. The secteur oversees a network of different activities, ranging from hospitalization, consultations, daycare hospitals, adaption centers, all closely working along with municipalities. The system is entirely free of charge.

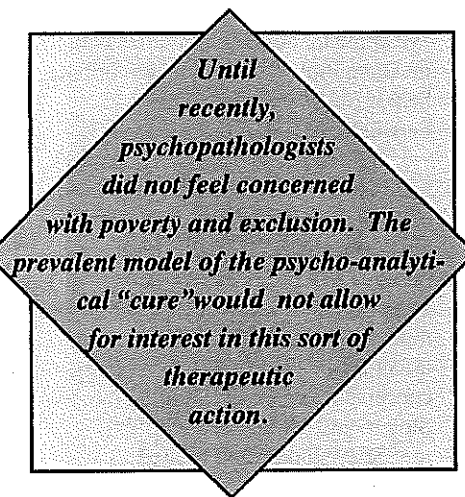
The same kind of organization was launched later on for children and infants. This mental health organization for children is also completely free. It is now well developed, with the public consultation centers in every district or countries. The system is in charge of all kinds of psychopathologies. It is linked with daycare centers for infants, as it is common for infants in France to be put by working mothers in daycare centers as early as three months of age. The Intersecteur, the sector for children, has strong connections with maternal school, which is attended by most French children between 2 1/2 and 6 years. The maternal school is not primarily designed to enhance performance, nor to prepare children to read and write. It is mainly designed, as Rene Diatkine, one of the most famous French psychiatrist and psychoanalyst puts it "to allow the child to become the receptor of a collective message."

Child psychiatry in France has been much influenced by psychoanalysis, and as a result not very focused on specific results or short-term therapies, evaluation, goals, or budget. Action is suspect in French psychoanalysis, where action and initiative are generally considered a form of acting out.

For these reasons, the work of Selma Fraiberg had little chance of being read and understood. People would not understand the necessity of making home visits, for example. They might say one should rather wait for a "real demand" to occur, and in the meantime, to respect other people's privacy.

Until recently, psychopathologists did not feel concerned with poverty and exclusion. The prevalent model of the psychoanalytical "cure" would

not allow for interest in this sort of therapeutic action. One of the best proofs of this assertion is that the book by Selma Fraiberg, *The First Year of Life*, is not yet translated into French, except for the central chapter on "Ghosts in the Nursery," published in "la Psychiatrie de l'Enfant." Even after the 1985 WAIPAD Cannes Congress, which generated enormous interest in infant experimental research and for new kinds of thinking and actions with infants, there remains a reticence about this kind of work. Also, except for great figures of the



past, like Robert Debre, the cooperation between pediatrics and psychiatry for infant mental health has not been optimal.

However, the situation is not the same everywhere in France. Some initiatives, here and there are very close to the practical philosophy of the Selma Fraiberg program. All of these have been initiated by people who have appreciated Fraiberg's ideas and approaches. They have developed a very strong and coherent idea of the work with young infants and parents.

### ***Work with Disadvantaged Parents and Infants in France: Past and Present***

Let us quote first an historical example of a very efficient program, largely unknown in France, as one is seldom a prophet in his own country. In 1894, the first "Goutte de lait" ("Drop of Milk") agency was founded in Fecamp by Leon Dufour, M.D. (Luyer & Sautereau, 1992). Infant mortality rate was very high at this time, especially in the poorest districts, where women had to work from 5 a.m. till late at night. They could not easily find good milk for their children. Most of them worked in the fish industry. Alcoholism and tuberculosis were common.

For all these reasons, breast feeding was very difficult, but artificial feeding was deadly. Dufour first tried to deliver sterilizers freely to the mothers, but he finally decided to open the "Drop of Milk" agency, in order to deliver a sterilized and nutritionally balanced milk. This organization was original because it was a public, secular agency helping destitute mothers without preaching to them. This effort resulted in a dramatic 50% drop in infant mortality in Fecamp after the agency opened. Today, in Beaune, in the heart of the burgundy vineyards, some pediatricians have taken the leadership of an original network of professionals aiming at prevention and intervention within infancy. This effort was judged so representative that it was picked for a special visit by Hillary Clinton when she last visited France (Arfouilloux, in press).

French pioneers in the work with difficult, multi-problem families include Genevieve Appell and Myriam David. Interestingly enough, both are independent people, who searched for training in the U.S. at the end of World War II, and who also worked with John Bowlby. Myriam David has developed several institutions, to help adoption, psychotic mothers, and to promote attention to

the early phases of psychic life.

Michel Soulé has developed early prevention and intervention in the 14th district of Paris, and he eventually succeeded in obtaining public recognition of the efficiency of such a network of professionals. In his former service at the Infant and Child Guidance Clinic, Dr Janine Noel has received and treated a large cohort of families in great difficulties, coming from the nearby poor suburbs. Serge Lebovici and his colleagues have developed a strong research and intervention network in the suburbs of Bobigny, in the north of Paris.

Nevertheless, the key in Selma Fraiberg's approach is to go and see people who are not in a position to come and see you, because of their psychopathology, because they have faith in no one, and because they are without hope. If one intends to help, one goes to them to offer what one can for their infant. Selma Fraiberg's lesson is that you had better be prepared, trained and supported by a strong professional team. Above all, one should know why and what one is there for, and one should be ready to provide support in extremely difficult situations. One should also be prepared to work with people of different cultures, which has not been common among French clinicians. Tobie Nathan, who has opened a center in Saint-Denis for migrants, and Marie-Rose Moro, working in Bobigny, have taught us how effective an intervention can be for those immigrant families, when their vital broken cultural envelope is taken as a starting point.

### **Fraiberg in Paris**

From this perspective, who can be said to work like Fraiberg in Paris? Now, quite a number of public teams conduct effective work with infants and parents, in many difficult situations. Some teams have developed mother-infant full-time or part-time units. A number of teams have home-based intervention as one possibility

in their intervention palette (Dos Santos Brengard, Botbol, Duchateau & Noel, 1992), like the Epernay intersecteur, in the east of France.

In fact, infant specialist nurses do make systematic home visits after the birth of a child, particularly when they are told by social workers of a difficult or potentially difficult situation. Social workers are also entitled to make home visits. So a large array of professionals can detect at risk situations. But there remains a problem of their preparation to administer psychological interventions and the problem of coordinating the relations between different agencies. We know that difficult families tend to make multiple demands and to oppose help if it is offered in a formal, bureaucratic and impersonal way.

Also most of these social workers feel insufficiently trained and in need of more help in the face of the many challenges posed by multi-problem families. They feel in need of supervision, of indirect help and of training for evaluation. The first direct application of Selma Fraiberg concepts was clearly the study by Stoleru and Morales-Huet (1989).

They studied and treated 13 families referred for severe psychological distress during pregnancy, who had refused any psychological help, through home visits and psychotherapy. They insisted on the mediating role of mid-wives. They also emphasized the long-lasting work of protection of psychological boundaries, sometimes simply by having the telephone repaired and the note paid. This early kind intervention should prevent major psychopathology in the child, but needs a rigorous demonstration of psychotherapeutic technique.

Martine Morales-Huet continues this kind work in the Infancy Guidance Center of the 5th and 6th Parisian districts. This team, run by Nicole Guedeney, and linked with the service of Philippe Jeammet, is a direct application of Fraiberg's parent/infant program, albeit on a smaller scale. First, a working network was devel-

oped with diverse professionals working in the field of infancy: mid-wives, following pregnancies in the obstetric wards, and identifying at risk mothers social workers and infant nurses, pediatricians, general practitioners, child judges, social workers working for law agencies (Morales-Huet, Rabouam & Beguier, 1994).

Regular meetings and case presentations take place at the infant unit to decide what should be done for each referred case, letter, telephone call, and home visit. In this Unit, home psychotherapy, by trained psychologists and analysts, has become routine. Evaluation of infant development can be made at the unit, where most of the consultations, teaching and supervision also takes place.

### **Home-Based Infant/Parent Psychotherapy**

The Parisian teams working with infants have developed a sort of club to share their experience of difficult cases, (coordinated by Antoine Guedeney and Bernard Golse), with four meetings a year. A seminar is also held for the third year, common to our two infant teams, centered on the study of Selma Fraiberg's therapeutic concepts. The project of translating "Clinical Studies in Infant Mental Health: the first year of life" is well under way. Fraiberg's last paper, "Early Defenses in Infancy" has been translated and published in French in *Devenir* (Fraiberg, 1993). Discussions include representatives from one or two main centers for home treatments for the most difficult cases, where all the teams could participate in training, and plan research.

So, one could say that Fraiberg is now in Paris, despite the differences in cultural customs and philosophies. Clearly, much remains to be accomplished, however. The teams dealing with difficult situations in infancy have considerable work. This work is demanding, requiring time, patience,

balanced and professionally trained teams and considerable resources. Places in Paris still exist where infants are sent when a separation crisis develops. To avoid the need for separation crises, each intersector is developing infant/parent units, to prevent and treat these families earlier. It may be necessary to develop one or two main centers for home treatments for the most difficult cases, where all the teams could plan, research and participate in training.

### References

- Arfouilloux (in press), Le réseau Beaunois de la petite enfance. *Devenir*, (1995), 6, 2 (in press)
- Dos Santos Brengard, D., Botbol, M., Duchateau, A.V. & Noel, M. (1992), Reflexions sur l'expérience d'une unité de soins à domicile en psychiatrie du nourrisson. *Devenir*, 4, 49-72.
- Fraiberg, S., translated by Congy, G. (1993), Mécanismes de défense pathologiques au cours de la petite enfance, *Devenir*, 5, 7-30.
- Guedeney, N., Morales-Huet, M., Rabouam, C. & Béguier, I. (1994), Un exemple de partenariat entre professionnels de la petite enfance. *Devenir*, 6, 31-35.
- Le Luyer, B. & Sautereau (1992), La goutte de lait de Fécamp: Oeuvre médicale, sociale et pédagogique. *Devenir*, 4, 87-100.
- Stoleru, S. & Morales-Huet, M. (1989), *Psychothérapies mere-nourrisson dans les familles à problèmes multiple*. PUF, Paris.

### Editors note:

Antoine Guedeney is a child psychiatrist/psychoanalyst and head of the Children and Infant Guidance Clinic, Institut de Peuriculture de Paris.

Nicole Guedeney is a child psychiatrist and head of l'Unité de la Petite Enfance.

Martine Morales-Huet is a psychologist/psychoanalyst at the Unité de la Petite Enfance.



## Tales From Training

### Training In Perinatology in Montpellier (France)

by Yvon Gauthier

My purpose in this short paper is to summarize a training experience in which I have been closely involved for the past several years in Montpellier, France. I have chosen to describe it historically, in an attempt to show the natural growth of simple ideas which have gradually led to what I consider an important experience in the development of perinatology.

Towards the end of the 70's, a psychoanalyst colleague, Gilles Lortie, came to work with us child psychiatrists at Ste.-Justine Hospital in Montreal, a children's hospital with a large obstetrics gynecology unit, as full-time consultant in obstetrics-gynecology where the department's Head had for a long time felt the need for psychiatric help. It did not take too much time for this colleague to start telling us rather amazing case histories which were obtained from mothers hospitalized for premature labor, extreme vomiting, complicated pregnancies, pre- and post-partum depressions. We were thus sensitized to the fact that child development, maybe more often than we thought until then, could be influenced by environmental conditions and mothers' problems much before actual delivery.

I had already been sensitized to early age problems through a research I pursued with colleagues at Ste.-Justine Hospital on very young

asthmatics, but I had not given much thought to pre- and post-partum influences. Being granted a sabbatical leave by my university in 1979-80, I decided, under the influence of those recent discussions with this colleague working in obstetrics and gynecology, to do a pilot research project on the possible influence of a high-risk pregnancy on the development of mother-child relationship. I had already decided to go to Montpellier CHU Child Psychiatry Department to spend this sabbatical, for reasons that were closely connected with the quality of the work done in that department, which I had observed in previous visits. But I had then no idea of the quality of relationship that existed in that hospital between obstetrics and gynecology specialists and child psychiatrists—no idea in fact that such a relationship was necessary to conduct such a research!

In theory, there was no problem. I was introduced to the Head of the Maternity who warmly greeted a Canadian professor of child psychiatry choosing Montpellier for scientific reasons. It was important that I could do this project with a local colleague, so Jean-Pierre Visier (Head of Child Psychiatry) assigned Francoise Molenat, who already had been much involved as a child psychiatry consultant in the neonatology unit, to work with me. The choice of this colleague proved to be most fruitful, as history will show.

## **Child Psychiatrists in the Maternity Hospital**

It may sound natural and simple for child psychiatrists to work with obstetricians, since our interests and objectives are close and mutual. The reality is quite different, as probably those who have been involved in this type of liaison know. Obstetricians' resistances to referring their high-risk or normal pregnancy patients, even for a single interview with a psychiatrist, were great, and we saw only a few patients from September to January. At that rhythm, it would have been difficult to complete even a pilot project within the academic year. It was necessary to enlist the Department Head's help again, who was able to put pressure on his staff, so that finally things worked out in time for us to gather our research material.

It is not this small research endeavor which is really important; it is what followed. We can now reconstruct that this research project actually was the first port of entry of psychiatry within this obstetric-gynecology citadel. No psychiatrist was able to work in close collaboration with obstetricians and gynecologists in this specific Maternity, before this "neutral" entry into it, through research. Very slowly at first, but much more after we had presented some preliminary results in May, Francoise Molenat was asked to see patients for various problems, and to be more and more present to the clinical questions raised by obstetricians at all stages of pre- and post-partum. She thus became a regular consultant in this Maternity department. Both through the research she continued to do (specifically around the high-risk pregnancy following a perinatal death in the previous one) and the clinical problems she was asked to be involved with, she actually discovered this new field of psychiatric (and medical) knowledge. Obstetrics has become in the last two decades a very fertile area of research and of high-technology endeavors. All the

new possibilities of both controlling and stimulating reproduction have created a climate of great interest as much in the medical community as in the population. The emotional life of young parents is often much conflicted around those issues of control of fertility and infertility, as much as older personal problems are brought



back to life around a new or expected pregnancy. It is in all these questions that Francoise Molenat was more and more involved in the following years, continuing her research in the midst of her clinical work (Molenat et al, 1988, 1989a, 1989b, 1992) and from this point it is her story which I would like to tell, from my perspective as a consultant who made visits every year to participate in the training sessions that they decided to set up.

To realize all of this, the CHU Montpellier Child Psychiatry Department formed l'Association de Formation et de Recherche sur l'Enfant et l'Environnement (L'AFREE), which has assumed the organization of these training sessions over the years, has produced several films and videos, and publishes twice a year "Les Cahiers de L'Afree" which brings the various papers and discussions of the training sessions to the participants and other interested readers.

### **Development of Training Sessions**

As a good part of Molenat's child psychiatry activities revolved around pre- and post-partum problems, she became aware of a strong interest in the community around all these questions, and of a desire for new knowledge, shared questions and attempted solutions. With the Head

of Child Psychiatry, Jean-Pierre Visier, and a colleague working then as a researcher in the Montpellier INSERM Child Psychiatry Unit, Joel Roy, Molenat developed the idea of training sessions which would be offered to the varied professionals working in or around this new field: PMI nurses and physicians, midwives, psychologists, infant nurses. These training sessions, lasting a week at a time, twice a year, over a period of 2 years, were closely attended by very interested field workers from the Languedoc-Roussillon area (Montpellier can be considered the capital city of this region).

These sessions had a specific characteristic, unusual in the French milieu as I have known it over the years: they were constructed around clinical situations chosen from obs-gyn consultations, and from early pediatric problems. They were not lectures offered as truths coming from above, but as teaching material to be discussed, in a field which is in complete evolution. Films and videos of a high technical quality were developed by the team, which were very helpful in fostering dialogue and personal development of all participants. Obstetricians, gynecologists, and pediatricians were enlisted to work in close alliance with child psychiatrists so that these sessions were multidisciplinary at all levels.

Through these years Molenat was often invited through France where she became known particularly for these high-quality films she was producing, revealing a new approach to these problems around pre- and post-partum clinical situations. She manifestly did not have all the answers, but from her psychodynamic training and experience she always stayed close to the patients' emotions and tragedies and to the professionals who most often had been relegated to a technical role, without a recognition and a valorization of what I would call their "human" role which their work naturally entails.

Through those contacts, it became



clear to Molenat and her team that there was a need all through France to be much more present in obs-gyn departments, to work around all these questions that physicians, professionals and patients were raising in this new age of reproduction. Thus were offered training sessions to French psychiatrists and psychologists who were already involved in their own region with these questions, or were interested in centering more of their energies in this new field. The response was so important that the Montpellier team had to start two training sessions at 6-months intervals, each involving 45 trainees, on the usual pattern: one week at a time, twice a year, over two years. However, the specificity this time was to accept only professionals who were interested in starting in their own area training of professionals already working in the field. A multiplication effect was thus planned in setting up these sessions, which were accordingly called "training sessions for teachers" (formation de formateurs).

I have been able, being personally involved as an "offshore" and consultant, to observe the intensity of involvement of all participants, their coming back faithfully to the following sessions (which often implied personal financial sacrifices), their attempts to be quite active in their own area with obstetrical units, and often meeting the strong resistances we had encountered in our first entry into the Montpellier Maternity.

The success obtained in France led the Montpellier team to organize training sessions for European professionals, coming particularly from Belgium, Spain, Greece, the basic idea still being the same: trainees have the responsibility of setting training sessions in their own country. Greece has already organized such training which gathered neonatologists, nurses, midwives, pediatricians in 3-day periods of training through last year. I had the privilege of participating in the last session with Molenat and Roy at the end of May.

The next step has been to gather in an annual follow-up seminar, those who have now started their own training in their area, to share experiences and to benefit from one another difficulties and successes.

### **Basic Training Objectives**

The objectives of these sessions are several. One important objective is the replication, within training, of the close collaboration which may come to exist between obstetricians, gynecologists, pediatricians and child psychiatrists. These specialists are thus called to come to talk about their practice: echography, in vitro and in vivo fertilization, the discovery of a handicap during pregnancy and

Another objective is a definite attempt to consider all the professionals of the pre- and post-partum units as active and full members of a team, each habilitated to play a support role within his or her specific technique. All professionals involved in these problems around pregnancy and delivery have their own feelings and reactions, as much as they are constantly in a position of receiving patients' anxieties and depressions. It is important to discuss how they handle patients' feelings and how they manage their own emotions. This objective is very tied up with the recognition of other professionals' competencies.

A crucial objective is to become aware of the resistances of obstetri-

---

***A crucial objective is to become aware of the resistances of obstetricians and gynecologists to what dynamic child psychiatry brings into their field; that is, a specific understanding of patients' emotional reactions, and a new language, often hard to understand, to express this understanding.***

---

announcing it to the parents, etc., with all the human implications of such problems. In this process, the child psychiatrist is not seen as the sole possessor of a psychological truth, but rather the obstetrician or the pediatrician, presents himself as living difficult situations with patients, and often needing outside support. We are far here from the "organicist" who immediately dumps all supposedly psychological problems to the psychiatrist who would take them over completely. Another way of expressing this objective is to emphasize indirect vs. direct work: the child psychiatrist is more and more faced with the question of accepting to work through other professionals, and thus to accept that competence is not one's prerogative, that it can be transferred, that it can exist and be used by other professionals, whatever their original training.

cians and gynecologists to what dynamic child psychiatry brings into their field; that is, a specific understanding of patients' emotional reactions, and a new language, often hard to understand, to express this understanding. I do not think that this is a specifically French problem—though the tendency of French analysts to often express themselves at a secondary level of abstraction has certainly increased its importance. It is a specific problem of psychiatric consultants to organic medicine to make sure to use a language which keeps close to the observed realities, and not to launch oneself too rapidly in far away hypotheses. It has been interesting in these training sessions to observe the gradual learning by trainees of a simpler terminology, so as to be and feel closer both to patients and to colleagues of other specialities.

A frequent problem has been brought to the attention of trainees—it may not be a specific objective, but it is certainly a crucial question addressed frequently to our young field: can disadvantaged populations be helped by child psychiatry and allied professionals, and do special techniques have to be developed? I have often brought Selma Fraiberg's experience to our sessions, since it closely discusses this problem. I have as well emphasized the role of therapeutic alliance; that very often it is frontline workers (whatever their original training) who are closer to these patients who have so often been disappointed in their early and later relationships, and who find it so difficult to trust whoever wishes to be close to them. Once a first-line professional has been able to establish a therapeutic alliance with them, how can we think that they can easily be referred to a supposedly "better" therapist?

The problem of mothers who can't take care of their child because

they have never been cared for properly through their own infancy and childhood, has also often been at the center of discussions. A beautiful film has been made by Molenat et al. of the woman who, after she has put her first three children in foster care, is finally able to care for a fourth one herself after the obstetrical team is able to get over its own resistances, and to consider this woman's capacity to develop parental competence, through the development of a therapeutic alliance with her.

### ***The Need of a Common Language***

In the development of a new field like perinatology, we need to realize that it encompasses a period of life where medicine has had a tendency to have several compartments which hardly meet and talk to one another, and where several professionals with very different trainings, have to work together. There is a need to develop a common language around the medical,

familial, social and psychological aspects of those successive phases of the reproduction process: pregnancy, delivery, early child and parent-child development. I believe this Montpellier experience has succeeded in bringing together specialists of very different backgrounds and experiences, professionals of several disciplines, people coming from several regions of France and from several European countries, and have them present to one another and discuss their rich and varied experience. The multiplication effect of such training can be enormous. It has been the privilege of a French-speaking Canadian child psychiatrist to witness this whole development from very close, and I thought important to try to describe it in some detail, since it is certainly replicable.

*Editor's Note: Yvon Gauthier is Professor of Child Psychiatry, Faculty of Médecine, Université de Montréal; member, Canadian Psychoanalytic Society; Child Psychiatrist, Hopital Ste-Justine, Montréal.*



*The following article, reprinted from the Infant Crier, newsletter of the Michigan Association for Infant Mental Health, describes how the Yup'ik People of Alaska view pregnancy, birth and early parenting as told to the author through a Yup'ik woman, Beth. (Names have been changed for confidentiality.) Beth is in her early thirties, married and lives*

## **Yup'ik parenting**

*by Bonnie Young*

*in a village about 70 miles from her family.*

The Yup'ik tradition is to live in family communities. These communities enable the teaching of Yup'ik peoples' view of the world, consisting of people, environment, and the supernatural, all in harmony. Tim, Beth's husband, has employment in

the village, but they hope to move back to Beth's village eventually.

Beth, pregnant for her second child, has a two and a half year old daughter, Amy. Beth has agreed to meet with me and share her pregnancy, birth and parenting experiences.

Tim, a white man, had just finished his lunch and left the house as I arrived. Beth was eating fried fish. Beth invited me to eat with her. The Yup'ik tradition is to share food with whomever is in the home. I told her I had just eaten and wasn't hungry. Beth suggested I talk to Amy who was sitting in the living room. Beth gave me her wedding album to look at. I talked with Amy and Beth. Later, I remembered Yup'iks don't talk during the main meal out of respect for the animal being eaten. I apologized to



Beth and she said she was used to people talking because of her husband's family. She said Yup'iks feel they need to concentrate on enjoying the food. Beth cleaned up her kitchen while we continued to talk. Yup'iks observe and don't ask direct questions. However, Beth was tolerant of my questions. I observed Beth using three stiff feathers tied together to pick up the last pieces of dirt off the floor after sweeping the entire kitchen. I felt Beth's cleaning helped ease any uncomfortable feeling she may have had while I was visiting and asking questions.

Beth's first pregnancy was during her college days. She was away from her family, living with her husband in a friend's home.

Beth's husband was with her throughout the birth experience. Yup'ik tradition dictates women are to let a husband know when labor starts and he will disappear. He is not to be around. Both parents held Amy shortly after she was born. Beth says she was the last of her siblings to be born at home. She said her father was at the hospital when her younger siblings were born.

I asked about the current pregnancy. Beth feels different and says she looks different this time. Both parents are hoping for a son. Beth thinks the differences of how she feels and looks indicate she will have a son. I asked if she followed any Yup'ik traditions to assure a safe delivery. She told me about the custom of getting up quickly in the morning and going outside. She says she doesn't do it because Amy would be frightened if her mother left like that every morning. Living away from her family makes this tradition difficult to do. She follows other traditions, for example, going quickly through a doorway and not linger to assure a quicker delivery and prevent a baby from getting stuck during delivery. Beth doesn't sleep too much so her baby won't be a lazy person. Another tradition she learned from a young mother in this village is not to leave a

dirty spot when cleaning the house or room; this prevents problems of leaving part of the afterbirth during delivery. Beth said she would know more traditions if she lived near her mother and sister. She spoke in a wistful, thoughtful manner. She feels she would be better if she lived near her family and they could tell her things about how to live according to a Yup'ik tradition. However, she said she liked not having people tell her what to do, so living in another village as she does now is good, too. She seems to have some mixed feeling about being told what to do or not. I wonder if this is to help her feel more comfortable away from her family. Beth's family is very important to her and she expressed the desire to move back to their village throughout our visit.

Some traditions Beth didn't mention for a pregnant woman are:

- Lie with your head toward the door while sleeping to assure a head first delivery.
- If looking out a window, don't change your decision about something; this prevents miscarriages.
- Go through doorways head first to assure a head first delivery rather than a breech birth.
- Never back through a doorway.
- Talk to your unborn child about positive things.
- Follow food restrictions during pregnancy or the baby could be born with undesirable characteristics. Each village has its own food restrictions.
- Don't criticize anybody or your child will be like the person you are criticizing.
- The husband carries a little wooden doll in his pocket when he is away from his pregnant wife to keep bad things from happening.

It appears to me that the traditions of the Yup'ik people during pregnancy and birth are for assuring the safe delivery of a healthy baby. A woman concentrates on tradition as

she goes about her daily tasks. The traditions were expressed to me as positive outcomes. The rules keep all the people, especially the pregnant woman, thinking in a positive manner about a pregnancy and birth.

Usually, the woman stays in her house for several days after the birth. She continues to follow the rules on criticism and food restrictions until the child is independent, sometime between 8-10 years of age.

Beth and her husband picked out their daughter's English name. I asked about a naming ceremony and Beth said her mother gave her daughter her Yup'ik name over the phone. It is Beth's grandmother's sister's name. We talked about baptism as a naming ceremony which she observed also. The traditional Yup'ik naming ceremony usually occurs the day after birth. Family members and the extended family come into the home to name the baby. A baby may be given 1-3 or as many as 6 names. Whoever comes brings presents to the baby and food. The food is often the favorite food of the dead person the baby is named after. The name bearer says the Yup'ik name is given assigning many positive attributes to the child.

Some spiritual essence passes with the name, and in an important way the dead are still believed to live again through their namesake.

Small bits of food are diluted with water and put on the baby's mouth as the baby is given his/her name. Then bits of food are thrown into a fire, on the ground, buried or put into cracks of the house depending on village custom. This is so the food will go faster to the spiritual world. The small bits of food sent to the deceased person become full sized when they reach the spirit world. The remaining food is then consumed by the parents. Sometimes, parents have to eat several plates of food in order to accomplish this task.

Eating on the floor which many Yup'iks do is to be closer to the spirits of the dead. The order food is eaten is

traditional and varies between the villages. Observing what people do is important.

If people bring any kind of clothing as a gift to the baby, it is put on the child right away even if it is for two seconds in order to show appreciation for the gift and not insult the giver. If a bowl is given it is used for the infant such as holding the water for diluting the food.

If a baby gets sick, it means that there is a deceased person who wants to be named for the baby. The name of the person will come to the mother or a relative in a dream or some other sign. While the baby sleeps, the Yup'ik name will be given. If the baby lives, the right name was given.

Parenting is a topic we discussed. Amy is potty trained. Beth started potty training Amy when she turned one year old. They had a pot for Amy and she used it right away by sitting on it and going through her panties. Amy had been visiting her cousins with her parents and had watched her cousin use the pot. Amy still wears a diaper but takes it off when she uses the potty. Beth said she didn't start potty training Amy when she was very young because it would be too difficult with cloth diapers. The Yup'ik custom is to potty train at four months; the infant wears a moss diaper and is held over a pot. A mother has to know her child well to sense when he/she has to go.

Beth said she has been meeting Amy's every need. Recently, while visiting her family, Beth's father told her not to be so quick to respond to Amy or she would always feel her every need would be met. Beth is trying to follow her father's advice and feels he has given her important information on parenting.

Beth said she was spanked twice by a teacher while she was in school. She doesn't remember what she did and can't believe it was anything so bad. She was in the sixth grade when teachers were no longer allowed to spank. Yup'ik custom is to never spank a child. Beth's relationship

with Amy is an easy acceptance of whatever Amy wants to do with gentle guidance from Beth. For example, Amy ran around in a little top, bare from the waist down. Beth laid out a pair of panties and shorts for Amy on the couch but never said a word to her daughter. Amy continued to run around and play while we talked. Beth prepared to serve tea at her clean table, and Amy put her clothes on before joining us at the table.

Children go barefoot outside in the summer and inside, for the most part, in the winter to toughen their feet. It is considered healthy and good economics.

Beth doesn't like to visit homes in the village she now lives in because she feels Amy may learn wrong things. The Yup'ik custom is to visit in relatives' homes so a child won't witness or learn improper behavior. Beth feels it is good for a child to be shy.

Other traditions of early parenting include:

- Children are kept close to their mother until 2 to 3 years of age with the infant sleeping in the parents' bed.
- First teach a child to be friendly.
- Infants are sung chants for language development. Teaching games and talking to infants is considered important.
- When a baby starts salivating around 4-5 months of age, start feeding the baby solid foods. Bread is usually the first food and the mother chews it before giving it to the child. Baby food is available today for the children.
- Children don't eat unless they are served. If they help themselves to food, they become inconsiderate and selfish.
- Children are given unsavory food or chores they may not like. They are to eat the food or do the chores right away. This teaches the child to be tolerant and prepared for life. Their survival may depend on this during long winters.

- Children need to always ask "May I blow my nose . . . go to the bathroom."
- Take a misbehaving child to another situation. Eating with them is positive reinforcement.
- Adults are to present learning to any child who is around.
- In the morning children are roused quickly but gently to teach quickness.
- If an elder is speaking to a child, the child is not supposed to look at the elder to show respect. Grandparents teach good behavior by instructing the children everyday, usually in the morning. If a child misbehaves someone might say, "Haven't the grandparents talked to the child?"
- The morning is the best time for advice because it is remembered better.
- Positive reinforcement is used for good behavior.
- Boys and girls learn each other's duties. There is no division of labor for children.
- Cross cousin teasing is to help minds become strong; the one being teased refuses to show emotion. Mother's brother's children are teasing cousins to father's sister's children.

The Yup'iks believe in living according to the Yuuyaraf, the rules and regulations. There are many more Yuuyaraf not mentioned here.

## References

Fienup-Riordan, Ann. (1983). *The Nelson Island Eskimo Social Structure and Ritual Distribution*. Alaska University Press.

Lower Kuskokwin School District, Bethel, AK. (1981). *Yup'ik Lore*. In *Albuquerque, NM, Educational Research*.

*Editor's Note: Bonnie Young is director of the Doula-Teen Parent Program in Traverse City, Michigan and is on leave in Alaska.*



## Stephen's Corner

Stephen Bennett

### **The Search for an Honest Revolution**

Recently, as I searched for themes for this column, I became aware that there was one individual I really wanted to interview. This was Peter Wolff. Since I had never had any personal contact with him and he had never heard of me, I was delighted when he agreed to see me. Why Peter Wolff? The reason was my own idolatry. Let me be straight out about this—my conviction is that his studies in the late 50's, especially his delineation of infant states, were the conceptual breakthrough that made possible contemporary infant studies. In other words, this infant stuff is all his fault. If this is thought to be an exaggeration on my part, I don't care much. For those of us who came on the infant scene the following decade, Peter Wolff's game was the only one in town. Sure, there were other researchers but none a match for his intensity and clarity. One central idea of his was the primacy of states which led, prior to electrophysiological insights, to a description of the sequence of sleep and wakefulness. His idea, novel at the time, was that you see the world through the window of states; that is, whether you are clear-headed, hung over, drowsy, or spacey, that particular state determines your perceptions and thinking.

Peter Wolff has worked for many years at the Children's Hospital in Boston. At the Harvard Medical School complex, I encountered the usual major construction that is going on in almost every hospital I visit. The scare warnings about reduced funds for patient care appear to be countered

by an explosion of building. Peter Wolff's office is in the old Children's Hospital, a Roman temple next to the new and elegant hospital which has a glass elevator like the Hyatt hotels.

I confess to being a Peter Wolff groupie, and whenever he is on the road, I try to catch his act. This seems to be about every five years. The last time was at the American Psychoanalytic Association in 1989. I have a habit when I take notes on a talk of jotting down a description of the speaker and what I pulled together for him then was—lean and severe, straight and stern, a linear being, talking in a commanding and rich voice with intense logic about stochastic nonlinear dynamics and chaos. Today, he is in his researcher's garb—baggy corduroy pants, sneakers and sweater. Seen close up what comes across is the aging actor's good looks, with his large head and jutting profile, face cut with sharp creases that shift with the wide facial play. But it is the voice that captivates, low and richly resonant, with its melodic qualities constrained by a trace of germanic precision.

Let me describe what I wanted to know about him. First of all, I have a fascination with the pathway to infant work. Also, I wonder about personal influences such as mentors and intellectual obsessions. Although it is not really so, Peter Wolff appeared to have gone off in directions far from infancy, and I wanted to understand the course of his research over the past several decades.

The first thing Peter volunteered was that at the age of 15 he had wanted to be a psychoanalyst. My response was to wonder how he even

had a dumb idea like that. He laughed and thought it had to do with an early fascination with the unconscious and the irrational. This led, after college at Berkeley, to his going to Medical School at the University of Chicago. Before his internship, he spent a year with Ralph Gerard doing neurophysiological research. The first two years of his psychiatric training were at Yale in the early 50's. He remembers that in medical school he found he had a real flair for "smart-ass" psychologizing and this continued at Yale.

However, he began to have questions about the scientific basis of psychoanalysis. He found solace in Piaget who had taken a rigorous look at basic developmental issues.

Next, he went to Austin-Riggs which was just the place for a smart-ass young psychiatrist. At that time it

**For those of us who came on the infant scene the following decade, [1960's] Peter Wolff's game was the only one in town. Sure, there were other researchers but none a match for his intensity and clarity.**

was an institution of elitism and purity during the golden years of psychoanalysis in the United States. Among the teachers and clinicians there were Robert Knight, Erik Erikson and David Rapaport. By his second year, he was wondering again what this was all about. Rapaport asked him what he wanted to do and his reply was research, but just what kind he was not sure. He began a weekly tutorship with Rapaport who was a major creative force and theoretician in mid-century psychoanalysis. The two of them engaged in a critical reading of Piaget which resulted in Wolff's monograph 10 years later. Another work they read with intensity was the *Baghavad-Gita*, the religious classic of Hinduism. Rapaport was considering the issue of activity/passivity and

found insight in the Yoga of Renunciation. "Action rightly renounced brings freedom: Action rightly performed brings freedom: Both are better than mere shunning of action." While we were talking Peter found he had two copies of the *Bhagavad-Gita* and lent me one which I have been carrying around for spiritual consolation.

At the end of his psychiatric training, he decided he wanted to follow the research rather than the clinical route. At that time, ethologists were studying the behavior of animals in depth and while they had constructed ethnograms for animals, for example, Tinbergen and his herring gulls, no one had done ethnograms on humans. Rapaport sponsored Wolff for a career development award. His first studies centered on understanding the human organism by understanding infants under free field conditions without experimental perturbations. The observations consolidated his interest in the temporal organization of motor behavior.

This fascination with timing is powerful, and although he may wander off from infancy for periods, he has never strayed from this interest. Peter believes that Lashley's ideas in his classic paper "The Problem of Serial Order in Behavior" still are gems even though, adding with a smile, he believes that most of them are wrong. Mother-child interaction turned him off because it seemed to him very difficult to understand the complexity of interactions between two independent centers of causality before understanding the capacities and ways of behaving of the infant in its general environment, which obviously includes the mother.

These early studies involved watching an infant 18 hours a day, then having someone spell him off for the other 6. This approach followed from the ethologists and Piaget's clinical method. I remember the injunction that really got to me years ago was that if you were to understand

infancy you must observe through several sleep cycles. I think this has been forgotten, because there are many infant workers around who have never experienced the flow of infant states, have never observed REM or irregular sleep over time, or seen the eyelid flutters and odd expressions that occur, or caught the neonate in the first days during the few minutes of wakefulness when intense eye contact is possible.

Wolff's first studies were done at the Massachusetts Mental Health Center under the help and support of Eleanor Pavensted, and also in various small nurseries around Boston. Also, he did home observations. This is beautifully described in his 1963 paper "The Natural History of a Family." During the decades that followed his 1959 paper "Observations on Newborn Infants", he wrote on visual pursuit and following, the development of attention, early smiling, crying and many other topics including the monographs *The Developmental Psychologies of Jean Piaget and Psychoanalysis* and *The Causes, Controls and Organization of Behavior in the Newborn*.

During this time in the 60's he had not given up on psychoanalysis and completed his training at the Boston Psychoanalytic Institute. Then came an interlude of which I was unaware. While observing infants and their mothers, he was struck by the incredible power of eye to eye contact. He decided to study it in Japan because he had been told by anthropological colleagues that the Japanese consider it impolite to make eye to eye contact. Although this folklore turned out to be wrong, he was able to carry out a six month comparative study of Japanese babies during the early months. During this period he observed by chance that a very large proportion of Japanese adults flush brilliantly within 2-5 minutes after drinking small amounts of alcohol. The observation led him to study the alcohol flushing response among

Japanese, Korean, Taiwan Chinese, North and South American Indians, and subsequently other language-isolated groups such as Basques and Gypsies, as well as North African "Sephardic" and "Ashkenazi" Jews. These studies clearly indicated that the alcohol flushing response has a strong genetic basis, but the vertical transmission of the flushing trait was much greater than could be explained by simple Mendelian mechanisms. In the course of these studies, he noted that mating groups who flush readily to alcohol also tend to blush much more readily in social situations than Western Europeans. This suggested to him that the etiology of the alcohol flushing which aggregates in some mating groups may not be a relatively straightforward genetic variation in an enzyme for alcohol metabolism, but could reflect a more general lability of vasomotor control of the "blush skin."

Because blushing is a socially powerful and dramatic emotional expression that has hardly been studied since Darwin's original description, he also explored mating groups differences of the emotional blushing response, but like others discovered that it is very hard to study blushing experimentally. To provoke blushing under experimental conditions in different cultures he came up with a neat solution, of staring at persons and then asking them whether they blushed.

My question as to how he got from infancy to his other areas of research took the form of a remembrance of going to hear him speak in the mid-70's with the expectation of something on infancy, but instead heard about his research on dyslexic children and their tapping behavior. What went through my mind was how in the devil did he get off onto tapping? The answer is in the notes which I kept. The underlying and basic theme that made him turn to motor coordination was the problem of serial processing and sequential organization, which also runs through-

out his infant and all other work. Peter's response to my question why he stopped watching babies was that he was increasingly put off by the sentimental slush dressed in scientific jargon that masquerades as research but was muddying the whole field because it tells us more about the observer's fantasies than the infant's behavioral organization. Since then, he has studied motor coordination using the new paradigm of nonlinear dynamics rather than psychology's traditional assumption that human beings can be studied by linear causal mechanisms and deterministic laws. The question he hopes to clarify is what are the intrinsic processes of motor control.

In one set of studies he focussed on motor coordination in developmental dyslexia, which he agrees may be a curious approach to the study of learning disabilities. Studies on dyslexia by others have concentrated on the related language defects but until recently have ignored the possibly more basic variable of impaired timing control. Like other investigators, he finds that dyslexia aggregates in families. However, people in large numbers have been reading for less than 400 years, therefore it seems highly implausible that selective pressure would have operated on the ability to read printed text.

One question that now preoccupies him is the behavioral phenotype that might be vertically transmitted in dyslexia pedigrees. At the same time, he is skeptical about current endeavors in the genetic investigation of complex human conditions that look for simple major gene variations, simply because that is what we can do with the current technology of human molecular genetics. His studies indicate that impaired timing control appears to be the behavioral phenotype vertically transmitted in about half of dyslexia pedigrees.

Although Wolff's study of the coordination of motor behavior

represents a major research effort, my impression that he had abandoned infant research was wrong. He would say that timing and control of behavior have always been his interest whether it be in infancy or school-age children. In a recent paper "Behavioral and Emotional States in Infancy: A Dynamic Perspective" he returned to his old love of infant states, but was able to describe them from a dynamic systems perspective gained from his studies of coordinated behavior that continued his earlier work on infant states. The ideas are heady. Rather than follow an arousal continuum, his view is that the states are discontinuous and represent low-dimensional ensembles, are marginally stable, possess potentials for self-correction, and have a propensity for spontaneous pattern formation. These ideas can be applied to adult states such as the cycles of a manic-depressive illness or dissociative states. Possessed with these ideas he is currently working on the dynamics of state organization in an infant population with a colleague. I wish that he would hurry up with this.

After an intense burst of ideas, I usually ask about other interests. This

turned out to be just as complex. His answer was these people, and waved his hand to some pictures on the wall. The people are Eritreans with whom he has worked for about 15 years. The answer to my question as to how he had gotten involved was that during the Vietnam war he had acquired some experience in purchasing "black market" medical equipment and was able to offer Eritreans some advice in their 30 year long liberation struggle. I commented that this was an ability to be esteemed but wondered how he had acquired it?

In the 60's he had seen a film on the violence inflicted by the American advisors on the Vietnamese people which broke his heart and left him with the tormenting question of how he could sit still in an office and not do anything. At first he worked with an organization of American physicians—the Committee of Responsibility—that arranged for the location and evacuation of children burned by napalm. However, in order to get children into this country, the Committee had to collaborate with the U.S. State Department, the C.I.A. and the U.S. Air Force. Moreover, once the



### *From the Works of Peter Wolff*

- *During alert inactivity the infant seems to be able to attend for brief periods of time and respond to external stimuli by complex pursuit movements. (1959)*
- *Alert-inactivity and its developmental derivatives are the optimal states for a "true assessment" of the environment, and that with fluctuations from this state, the assessment is impaired because the adaptive behavior patterns function less adequately. (1965)*
- *We should consider, at least for speculative purposes, that even for the baby there are different ways of "being in the world," and would explore whether stabilization in the relation between organismic state and state-specific patterns results in quantitatively distinct ways of structuring experience. (1985)*

children arrived in the U.S. for treatment, they were sometimes exploited for antiwar propaganda purposes. Finally, many of the children (who all had at least one parent) refused to go back to Viet Nam, although the Committee had promised to return all the children to their parents. Therefore he looked for a more effective means of opposing the war by joining with other colleagues to form a U.S. Medical Aid Committee for Vietnam that took the more extreme step of sending medical equipment and supplies to the civilian war victims in North Vietnam, who were even more severely affected by the daily bombing than the civilians in the South. By chance, this organization received a gift of nearly \$3 million dollars in private donations to rebuild and resupply the Bach Mai Hospital in Hanoi, the largest tertiary care civilian hospital in North Vietnam that had been totally destroyed by U.S. bombing raids. This was not only as gesture of help, but also a protest. So, Wolff got into the business of buying medical equipment.

However, the events in Vietnam after the "reunification" of South and North, and the ruthless political repression of the National Liberation Front in the South by the North disturbed him greatly, and so he continued to search for an "honest" revolution. He laughed here, breaking up the intensity and emotionality of the recounting of his Vietnam experience, and said again that indeed what he was searching for was an honest revolution. He felt that he had found one in Eritrea.

The Eritreans had sought him out for help during their battle against the Ethiopians. They wanted to build up their medical system. While the war was still very active, he went to Eritrea for the first time. While there, he visited a large orphanage which had been hidden in a deep canyon surrounded by steep mountains so the children would be safe from the almost daily Ethiopian air attacks, but the physical and social conditions

were terrible. After spending several days at the orphanage, Wolff and a Norwegian pediatrician, made concrete suggestions how the conditions might be improved. With a minimum of advice from outside "experts," the orphanage staff worked tirelessly for two years to implement the recommendations according to their own needs. When Wolff returned to the orphanage two years later, there had been a dramatic change in the social climate. The orphans were now more peaceful, socially integrated, felt free to interact with the staff and one another. Whatever it's worth, psychological testing also indicated that cognitive development and skills of the orphans were now superior to those of refugee children in a neighboring camp.

Since the end of the war, the orphans have been moved to the capital of Asmara, raising the vexing problem what kind of permanent solution can be found for over 9,000 unaccompanied children. The Eritrean Social Affairs Authority is currently making a heroic effort to reunite the orphans with their extended families, and Wolff is helping them to study the effect of this reunification on the child and its new family. The description of his Eritrea experience was immensely upsetting for him, and he had to turn away twice because he was choked with tears. He thought that perhaps he felt a kinship with these people because he had himself been a refugee, fleeing Germany in 1938 with his family, and getting away relatively unscathed. He added that he probably suffered from a lot of "German guilt," then joked that actually he valued it because it kept him more or less honest.

A little afraid to ask, I wondered what Peter felt about the current state of infant psychiatry. His quick answer was that much of it was "absolute hokum": the presumption that infant psychiatrists can read a baby's mind seems to him preposterous. Most of the conclusions on which the experts base their gratuitous advice is unpreju-

diced by any evidence; some of the "therapeutic" recommendations are embarrassingly banal; many are likely to be wrong and actually harmful. Wolff thought that most experts haven't a clue about the real problems of everyday life with which many parents have to cope; and even when carefully worded, such advice leaves parents who are already confused in this "heartless world" with the impression they must follow the advice of the experts if they are to do right by their children. This, he thought, robs them of confidence in their own good sense, undercuts their sense of autonomy; and it also weakens their self-reliance and resolve to take control of their own lives.

I lamely commented on the creativity of some researchers and Peter's response was, "and so are astrologers." After my burst of laughter, I relaxed and enjoyed the old revolutionary as he inveighed against vanity and presumption.

Peter's current ideas will find expression soon in an article for the *Journal of the American Psychoanalytic Association* titled—"The Irrelevance of Infant Observation for Psychoanalysis." I am eagerly awaiting the response. What this stirs up should be a lot of fun to watch. As I walked back through the maze of hospitals to the train to Logan Airport I was aware of having had one of the most exciting and appealing interviews I have yet conducted. My old hero was thriving. The conviction I was left with was that the revolution Peter had helped create truly needed him now more than ever so as to keep it honest.

*Editor's Note: Dr. Stephen Bennett is Chief of Child Psychiatry at Harlem Hospital and Assistant Professor 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.*





## President's Perspective

Joy D. Osofsky

I was delighted to read Miguel Hoffmann's article on social and community issues in the last issue of *The Signal* and pleased that he raised this issue for WAIMH. I was planning in this column to invite a dialogue about issues of infant mental health—what is it?—how does it fit into various disciplinary viewpoints?—what is appropriate research for the field?—what clinical work is appropriate?—and what are the policy implications? Based on Miguel's thoughtful article, we might add, what is our role as an organization and/or as individuals in relation to social and community issues?

I would welcome response from readers regarding the issue of "what is infant mental health?" that we might include in subsequent columns of *The Signal*. The interview in this issue with Peter Wolff might be starting point for some to begin the dialogue. I also will take the opportunity to share in a subsequent column what I envision to be the important goals and issues in the area of infant mental health. But to do it now would foreclose dialogue—so I will wait.

Since, however, I have made some important personal decisions regarding my role as a professional, academician, researcher, clinician, and psychoanalyst regarding social and community issues which speaks to the concerns raised by Miguel Hoffmann and encouraged for discussion by Charley Zeanah, I feel that it is important for me to address the issue directly in this column. Recently, I was asked to write an article for the Newsletter of the American Psycho-

analytic Association on the psychoanalyst in the community. I must confess, when asked to write the article, that I hadn't thought much about the fact that I might be doing something unusual as a psychoanalyst working in the community. I saw what I was doing as a continuation of my commitment to learn more about and help infants and families at high psychosocial risk with the goal being prevention of more serious problems that might develop at a later developmental period. I recognized in doing work in the community either with agencies, as was mentioned by Miguel, or directly with community residents that sometimes you are welcomed and sometimes you are not. Further, at the community level, the response is not always predictable. Academicians, researchers, and clinicians are often viewed with scepticism. Community residents wonder why you are there and whether your motivation is to work with people in the community according to the community needs or, as is often the case, to follow your own agenda. I, personally, feel a strong commitment to working at a community level and using my skills to deal with real problems in the society as well as trying to help facilitate systems changes that will improve conditions for all people within the society. I believe that my professional skills may be helpful in these efforts in important ways. Some academicians would not agree with this position believing that working in the "real" world with "real life problems" is not really science and

cannot be considered scientific.

Interestingly, while many scientists and clinicians do hold to that position, a growing number are recognizing the importance of moving out of the laboratory or consulting and treatment room to apply their knowledge and skills to real life problems.

Let me give you an example of what we have done in this area and then return to Miguel Hoffmann's question about the role of an organization such as WAIMH in these endeavors which includes taking public stands on issues. As many of you know, I have been deeply concerned about the amount of violence that our children are being exposed to and have been studying and writing about the effects of violence exposure on young children. This is a problem world-wide although it is more of a problem in some countries and areas than others. Besides doing research and writing in this area, I have been deeply involved in developing an intervention program with the police in New Orleans concentrating on one of the areas of the city with a high level of violence as well as poverty and subsidized housing developments.

Our program involves a collaboration between the police, community residents and the mental health community including my group at Louisiana State University College of Medicine and a community service agency, the Children's Bureau, which for several years has had a program with the goal of serving children who have been exposed to homicide. Some people might rightfully ask, "What is the appropriate role of an infant mental health specialist or a psychoanalyst in such work?" And I would reply that we have to use all of our skills to come together with people in the community to build an equal partnership that respects our differences and our strengths.

Through such a collaboration, we can better define the issues and work together to find solutions for many of the most pressing problems in our society today. What happens if we

stay in our "ivory towers" or "laboratories?" We will make significant contributions of a different kind. However, by working together with some of the other systems in our community, we are more likely to find solutions that will be more effective for the people to whom we are accountable and be longer lasting because an impact has been made at a systems level.

For example, as we work together with the police in our community to try to decrease the violence and help children who are exposed, we are learning a great deal that we would not have known. As I have listened to the police officers and talked with them about the effects of violence on children and the need for preventive intervention strategies to try to reach the children early, I have become more aware of children as the "invisible victims" who are exposed to a great deal of violence in their homes every day. Little attention is paid to this exposure except when a child is abused or something dramatic happens. We have found by working

with police officers that they can be helpful to the children when responding to domestic violence calls and can also play an important role in referring them for preventive services earlier. As a preventive mental health person involved with them, I am able to offer support and advice regarding many of these cases through a 24 hour hotline that we have established as well as gain increased sensitivity to the issues facing police officers.

What might be some of the differences between one's role as an individual and as a representative of an international organization? As an individual doing a particular project, I can involve myself to the extent that I desire with community and social issues. As an employee of the State of Louisiana, I can take positions as an individual but cannot attribute them to my position as an employee of the state. That restriction inhibits my activity very little as I work for an institution that is very community-oriented in its goals. As President of an international organization, the World Association for Infant Mental

Health, I should not be taking positions that are not endorsed by our executive committee. However, if there is agreement that the organization should take a public stand on behalf of children, we can do it as we did for the United Nations Resolution on the Rights of Children or other issues of concern. I believe that as an organization, we should be ready to support efforts that are undertaken internationally on behalf of children if the leadership of our organization feels it is appropriate and if we can do so legally within our structure as a non-profit organization. I feel that WAIMH has an important role to play on behalf of children internationally and seek to broaden that role as much as possible. I welcome the inclusion by our Editor of the column on community and social issues. I would also welcome comments and suggestions from our members by fax (504) 568-6246 or mail (Department of Psychiatry, LSU Medical Center, 1542 Tulane Avenue, New Orleans, LA 70112, USA).

## WAIMH

## 6th World Congress

July 25—28, 1996

Tampere, Finland

### First Call for Papers

The first call for papers for the 6th World Congress is now going out. The co-chair persons of the Conference, Peter de Chateau and Antoine Guedeney offer the following information and guidelines for those considering the submission of a paper.

The overall theme of the Congress is "Early Intervention and Infant Research: Evaluating Outcomes." Each of the four days will have a similar structure, with a plenary session in the morning, followed by a symposium, and in the afternoon

parallel activities such as poster presentations, audio-video presentations, workshops, etc.

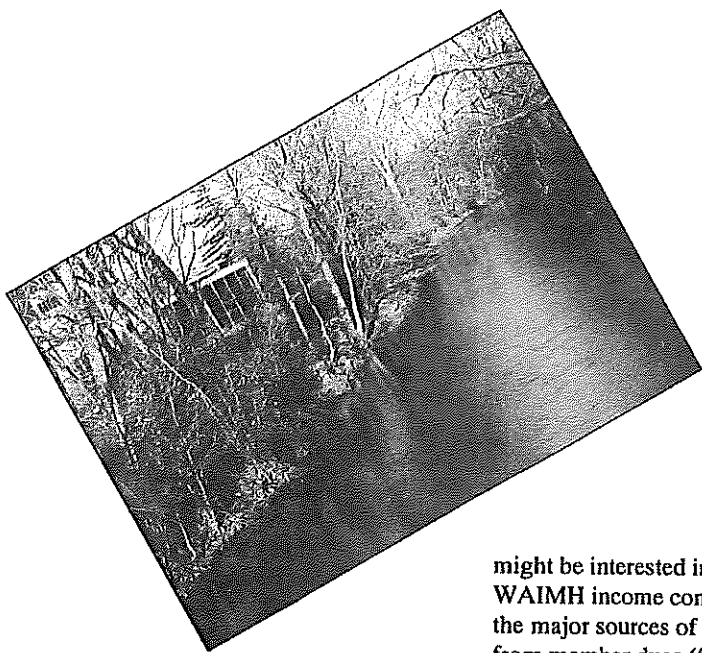
A *symposium* is considered to be a group of presentations on a related topic, generally the latest thinking about a particular subject. Investigators should keep in mind the multidisciplinary and international nature of WAIMH when organizing symposia.

A *workshop* has fewer presenters and the goal is to teach a particular body of knowledge.

Suggested topics for the symposia and workshops reflect the overall theme of the conference:

- Theory of intervention: does early intervention work and how?
- Intervention in different cultures
- Techniques of intervention
- Difficult to reach populations: how do we reach them?
- Evaluation and follow-up of interventions
- Teaching and learning intervention

Date for submission of papers is September 30, 1995. Preliminary responses can be made to: Tampere Congress Partners, P.O. Box 693, FIN-33101 Tampere, Finland.



## From the Red Cedar

*Hiram E. Fitzgerald*  
Executive Director

In the previous *Signal* I shared with you the relationship between WAIMH's purposes, as described in the by-laws, and its programmatic objectives. Similar material formed the basis of the first part of the Annual Report, submitted to the Executive Committee. The second part of the Annual Report consisted primarily of information about the annual budget. I believe that all members should be aware of some of the practical information related to operating our association.

### **The Budget**

Total income for 1994 was \$83,972, which represents an \$11,921 increase over 1993. Most of this increase is attributable to increases in dues, journal subscription fees, and the San Francisco workshop. Total expenses for 1994 were \$89,262, which represents a \$3,509 increase over 1993. So, increases in income were greater than increases in expenses, but the budgeted \$5,800 shortfall for 1994 was very much on target (the shortfall was \$5,290). One way to look at the overall implications of the budget, the so-called "bottom-line" is that WAIMH lost \$5,290 in 1994. That is the amount of money that had to be taken out of reserves to pay our bills. I thought that members

might be interested in knowing where WAIMH income comes from: in 1994 the major sources of income came from member dues (50%), journal subscriptions (30%), regional conferences/workshops (10%), grants received (4%), workshop registrations (4%), and Beacon Club (1.5%). The remaining sources collectively are less than 1 percent.

### **Where do we spend money?**

During 1994, the major line items for expenses include: journal subscriptions (32%), salaries and fringe benefits (16%), regional workshops and conferences (13%), planning for World Congress VI (12%), printing (8.5%), and postage (5%).

Printing and postage costs will increase for 1995 inasmuch as the United States Postal Service has increased rates for all classes of mail. We take advantage of bulk rate mailing for both the domestic and international markets so we are at the least holding postage costs as low as

possible. Nevertheless, the increased mailings related to the Sixth World Congress will add substantially to the postage costs for 1995. In an effort to reduce our printing costs while simultaneously increasing quality, we are using a new service that should help to maximize the low-bid, high-quality margin we constantly seek. Salaries also will increase slightly, depending on the University increase negotiated for employees. Technically, Melanie Smith is an employee of Michigan State University so we must pay her according to the university schedule. A side note; if WAIMH continues to expand over the next three years as it has during its first three, a half-time administrative assistant will not be able to handle the workload. The possibility exists, therefore, that sometime in the near future there will be a substantive increase in the salary category.

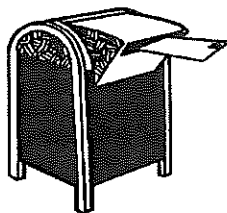
The following table provides an overview of WAIMH's assets over a period of time. Note the fluctuations that occur. This is a fairly typical pattern and reflects a number of factors related to when we solicit membership renewals and publish newsletters. One way to try to dampen these fluctuations is to increase the orderliness of our

Account	April 1993	December 1993	March 1993	May 1993	June 1994	Dec. 1994	March 1995
Checking	14,713	8,815	19,204	14,511	19,268	7,806	12,642
Savings	10,160	10,385	10,447	10,447	10,506	5,603	5,603
Investment	35,100	35,791	36,030	36,030	36,323	36,323	37,135
University	9,161	1,577	(509)	2,512	941	2,540	5,691
President	—	—	—	—	—	2,320	2,320
Total	69,135	56,569	65,174	63,502	58,039	55,406	63,393

calendar. So the office is implementing a business calendar that hopefully will reduce the degree of fluctuation in our assets and, simultaneously, make things happen in a more orderly fashion. By the way, these are the data that I scan monthly to keep a watchful eye on WAIMH's financial status.

In the opening paragraph I alluded to the WAIMH Annual Report submitted to the Executive Committee. Next year I will include an Executive Summary to the annual report and distribute it to the membership. Preparation of an annual report is a way of drawing together all of the activities of the year so that the Board of Directors (in WAIMH, the Board of Directors and the Executive Committee are the same) can review the relationship among the purposes of the organization, its programs and objectives, and their relationship to the annual budget. Thus, the annual report provides a way of assessing past performance (the past year), short-term planning (the current and perhaps next year), as well as long-term planning (say, five year plans). Over time I believe that effective use of the annual report will improve the overall program planning for the association.

Well, I have provided much information in this short note "from the Red Cedar." If there are any concerns or questions about operational or policy issues, please do not hesitate to contact the central office. Be sure to read "From the Red Cedar" in the next issue of *The Signal* for important information about a new electronic communication system for WAIMH.



## News & Views

Dear Dr. Zeanah,

The PIC (Parent Infant Clinic) is happy to announce that the School of Infant Mental Health is carrying out its fourth year of training for professionals working with children under five and their parents (from pregnancy). Its trainees are already qualified professionals in psychology, other therapies, general medicine and pediatrics. They take part in a rotation involving different settings (e.g. special care baby units, nurseries, and prisons). The minimum period in each setting is 6 months which provides a broad experience, essential in enabling the trainees to help parents in situations of significant risk or severe deprivation.

A new group of 18 are undergoing full training, and four are training for the year's conversion course for adult and child psychotherapists who wish to specialize in Infant-Parent Psychotherapy.

Short intensive weekends have been requested from different and sometimes remote areas in South America, North America, Europe and Africa, and we have been able to provide them with follow-up research projects and further courses.

Experience in preparing and evaluating the training has made us aware of issues and experiences that are important for professionals working with infants and their parents. We would welcome contact with other similar institutions and would be happy to be part of any committee formed for this purpose.

Furthermore the fortnightly FORUM continues with its open evening of talks on interdisciplinary issues in infancy. National and internationally renowned speakers contribute with relevant themes on infancy and provoke interesting discussions. The clinic is now able to offer subsidized places and a sliding scale as well as home treatments for house-bound mothers and babies.

Last, but not least, we would like to thank Hisako Watanabe, Joan Raphael-Leff, Colwyn Trevarthen, Mara Sidoli, adult and child psychotherapists and psychoanalysts, research neurobiologists and psychologists for their continued support in teaching, research, attending events, conducting public relations and giving time generously for other purposes.

As a member of WAIMH I would like its members to know about the work I have been involved with in England.

Yours sincerely,  
Stella Acquorone

### Upcoming Conferences

**June 30-July 1995 in Buenos Aires, Argentina.** A conference sponsored by the Department of Children and Adolescents of the Psychoanalytical Association of Buenos Aires. "Fantasy, Creativity and Action". Registration cost is \$50. For information contact: Dr. Luis Mario Minuchin, Part. Mansilla 2431 9 "A" (1121) Buenos Aires. Tel/Fax: 54 1 961 4122

**Saturday, July 29, 1995 in San Francisco.** WAIMH will hold a one day workshop before the International Psychoanalytic Association meeting. The topic is "Reality and Early Trauma: Developmental Pathways". For information and registration materials contact Dr. Joy Osofsky, Department of Psychiatry, Louisiana State University Medical Center, 1542 Tulane Avenue, New Orleans, LA 70112, USA. Fax: (504) 568-6246.

**July 28 and 29, 1995 in Seattle, Washington.** A twelve hour seminar conducted by Dr. Daniel Stern and sponsored by the Seattle Institute for Psychoanalysis. "Infant Psychotherapy: An Overview and a Unifying View." Dr. Stern will discuss his research, highlight major issues in psychoanalytic theories of infant development and offer new understanding of therapeutic approaches effective in preventing the development of psychopathology in children.

For information contact Lola Richards, Executive Secretary, The Seattle Institute for Psychoanalysis, 4020 East Madison St., Suite 230, Seattle, WA 98112. Tel: (206) 328-5315.

#### **Call for Papers**

The Administration on Children, Youth and Families, Department of Health and Human Services, in collaboration with Columbia University and the Society for Research in Child Development, announces Head Start's 3rd National Research Conference, "Making a Difference for Children, Families and Communities: Partnerships Among Researchers, Practitioners and Policymakers," to be held June 20-23, 1996 in Washington, D.C. Direct inquiries to: Dr. Faith Lamb Parker, Project Director, Columbia University, School of Public Health, CPH/MCH, 60 Haven Avenue B3, New York, NY 10032. Tel: (212) 304-5251. Fax: (212) 305-7024.

## **International Psychoanalytical Association Seeks Creation of Database**

The Standing Committee on Psychoanalytic Research of the International Psychoanalytical Association would like to create a database of active psychoanalytic researchers involved in systematic research in various fields of data gathering relevant to psychoanalysis.

The aim would be to: 1) provide a channel to publicize upcoming events of relevance to the field of psychoanalysis and 2) facilitate the exchange of information and research interests

and projects by publishing and distributing a directory of those in the database.

To participate, fill out the following form and send to:  
Professor Peter Fonagy  
Chair, Standing Committee on Research  
International Psychoanalytical Association  
"Broomhills"  
Woodside Lane  
London, N12 8UD

NAME \_\_\_\_\_

CONTACT ADDRESS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PSYCHOANALYTIC SOCIETY \_\_\_\_\_

FAX NUMBER \_\_\_\_\_ EMAIL \_\_\_\_\_

YEAR OF JOINING IPA \_\_\_\_\_ QUALIFICATIONS \_\_\_\_\_  
(BA, MD, etc.)

PROFESSIONAL AFFILIATION \_\_\_\_\_

PROFESSIONAL BACKGROUND \_\_\_\_\_  
(Please indicate the principal discipline(s) in which you received your scientific training, e.g. medicine, psychology, etc.)

AREAS OF RESEARCH INTEREST: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TITLE(S) OF CURRENT RESEARCH PROJECTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PRINCIPAL FUNDING SOURCE: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## WAIMH 1995 MEMBERSHIP APPLICATION

Date \_\_\_\_\_

Renewing Membership \_\_\_\_\_

New Membership \_\_\_\_\_

Please print or type

NAME \_\_\_\_\_ DATE \_\_\_\_\_

TITLE \_\_\_\_\_ PROFESSION \_\_\_\_\_

MAILING ADDRESS:

TELEPHONE:

Work: \_\_\_\_\_

Fax: \_\_\_\_\_

Do you belong to a WAIMH Affiliate?

If so, which?

### 1995 DUES

Membership, no Journal: \$50.00 \_\_\_\_\_ Student: \$35.00 \_\_\_\_\_

### Membership with Journal:

US Address: \$85.00 \_\_\_\_\_ US Address Students: \$70.00 \_\_\_\_\_

\*Canadians: \$100.45 \_\_\_\_\_ Canadian Students: \$85.45 \_\_\_\_\_

\*\*International: \$98.00 \_\_\_\_\_ International Students: \$83.00 \_\_\_\_\_

\*Includes 7% GST + \$13.00 international postage for IMHJ. \*\* Includes \$13.00 international postage for IMHJ.

### METHOD OF PAYMENT:

\_\_\_\_ Check (Must be drawn on a US affiliated bank or it will be returned.)

\_\_\_\_ Charge VISA/Mastercard Number \_\_\_\_\_ (Check accuracy please)

Expiration date: \_\_\_\_\_ Signature for charge \_\_\_\_\_

### WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

Institute for Children, Youth & Families

Kellogg Center, Suite 27

Michigan State University

East Lansing, MI 48824-1022

NON-PROFIT ORG.  
U.S. POSTAGE PAID  
PERMIT 199  
EAST LANSING, MI

Tel: (517) 432-3793

Fax: (517) 432-3694