

The Signal



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TRIANGULATION IN RELATIONSHIPS

As human beings, we constantly experience multilateral relationships. Because they are intrinsically dynamic, triangles help us to understand how these relationships work. For instance, the oedipal triangle organizes psychic life; intergenerational triangles organize family dynamics; relationship disturbances invariably involve a triangle with a coalition of "two against one" (Caplow, 1968). Yet these clinical constructs lack an anchor into normal development: how do relationship triangles normally work and what is their developmental

course? The triangle created by the father, the mother and their infant lies at the base of this matter.

Paradoxically, developmentalists have been slow in approaching the issue. In the face of the theoretical and methodological complexities of triangles, their strategy has been to work, so to speak, from the bottom up, first on the components (Parke, Power & Gottman, 1979). Whereas these studies have unveiled many of the internal workings of a family, they failed to allow for the new, emergent, properties that characterize a complex system as a whole in relations to its components (Emde, 1994; Hinde, 1992; Minuchin, 1988).

Interestingly, family systems proponents have long advocated for viewing the family as a whole, or unit. In particular, they insisted that the third party makes a difference; yet they have not provided the links from the abstract systems notions to their implementation (Thelen, 1989). Neither have they proposed a truly developmental, empirically based, systems theory of the family.

This is not to say that the triad researcher begins in a vacuum. On the contrary, the question is how to bring all the parts together into an integrated whole. Examples of important sources for generating hypotheses, for parsing the sub-system contributions and for elaborating a model follow:

(1) Clinical constructs focused on intergenerational transmission, such as Borzomenyi-Nagy's loyalties, debts and merits (Borzomenyi-Nagy & Sparke, 1973), Reiss's (Reiss, 1989) family practices and rituals and Byng-Hall's scripts (Byng-Hall, 1986); and, in the French

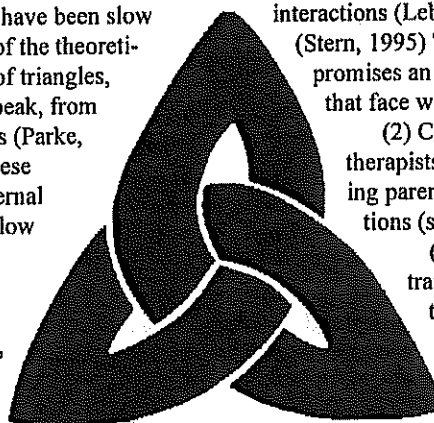
psychodynamic literature, Lebovici's family mandate and B. Cramer's and others' concept of fantasmatic interactions (Lebovici, 1992); and finally, Stern's (Stern, 1995) "motherhood constellation"—which promises an excellent fit to the existential issues that face women around birth;

(2) Clinical models developed by family therapists such as Haley and Minuchin concerning parents and offspring dysfunctional coalitions (see Broderick, 1993, for a review);

(3) the growing documentation of transgenerational patterns of attachment thanks to correspondences between adults attachment recollections in respect to their parents and observed patterns of attachment of their children (Ijzendoorn);

(4) the Cowan's (Cowan & Pape Cowan, 1991), Lewis's (Lewis, 1989) or Belsky's (Belsky, 1989) approaches to the transition to parenthood: what happens to a couple when "the baby makes three";

(5) the effect of marital conflict on child development, such as studied by A. Easterbrooks and Emde (Easterbrooks & Emde, 1988), and by Katz and Gottman (Katz & Gottman, 1993);



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(6) closer to observation, the considerable work by Belsky (Belsky, 1989), Clarke-Stewart (Clarke-Stewart, 1978), Field (Field, 1978), Pederson (Pederson, Anderson & Cain, 1980), Yogman (Yogman, 1982), comparing infants' interactions with their mothers and their fathers in various conditions, or considering the mother-infant interaction in the context of the father's contributions; and Barret and Hinde (Barrett & Hinde, 1988) as well as Dunn's comparisons between siblings' interactions with their mother (Dunn, 1989);

(7) in respect to methodological concerns, Tronick and collaborators' concept of dyadic and monadic phases (Tronick & Cohn, 1989); the pioneering reflections of Parke, Power and Gottman on the triad (Parke, et al., 1979); Parke's own conclusion on writing his research biography (Parke, 1990): we have to study units beyond the dyad and trace again the development of parents-infant interactions from the beginning.

Each of these components involve the triads and compel its study. The momentum seems irrevocable.

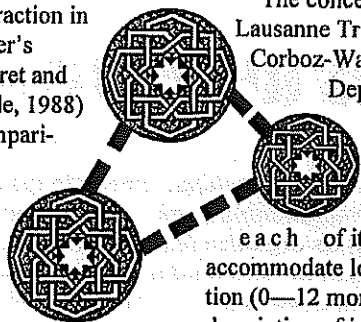
Therefore, proposing a model and a method to observe and describe the father-mother-infant triad in development is one of the most critical steps to be taken at this point in developmental research on family interaction. It will:

(1) recast infant development within a truly family perspective; (2) contribute to empirically derived assumptions about systems of family communication; (3) anchor clinical concepts of triangles in normal triangular processes; (4) provide a model of how triangles work in general; (5) and help bridge different fields, especially, family systems and development, clinical practice and research.

As a step in this direction, the Lausanne team proposes a new concept for exploring the father-

mother-infant triad. We will provide a broad overview of the observations setting, as well as of the models behind it.

THE LAUSANNE CONCEPT¹



The concept operates around the Lausanne Triadic Play (LTP) (see Corboz-Warnery, Fivaz-Depeursinge, Gertsch-Bettens & Favez, 1993). This scenario was designed to observe the triad in each of its permutations, accommodate longitudinal observation (0-12 months), permit detailed description of interactional patterns and fit clinical requirements. Integrating developmental systems theories, it is progressing towards a model of how triangles work as well as towards a method to analyze them.

The LTP

The Lausanne Triadic Play is a "trilogue" scenario which focuses on the family as a group. It is subdivided into successive scenes in which the partners enact the four possible configurations within a triad: "two plus one" (e.g. one parent playing directly with baby, the other one as participant observer, or parents directly interacting and baby as observer) and "three together" (father, mother and baby in direct interaction). Therefore, it fits both the observation of the family as a whole and as a set of interacting parts. It is to be noted that the observation of a triad imposes rather stringent technical constraints if one is to be in a position to systematically describe each of the three

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partners' behaviors in relation to each other (see Fivaz-Depeursinge & Corboz-Warnery, 1993). How to adjust the situation for home-based observation is still an open question.

The scenario is integrated in a semi-standardized clinical consultation which accommodates both clinical families coming with their therapist (therapeutic consultations) and non-clinical families coming for research (research consultation).

The clinical model base

Consider the following vignette: a hospital psychiatrist comes to our center for a therapeutic consultation with a psychotic mother and her baby (hospitalized conjointly) and the father. The LTP observation procedure uncovers a problematic cycle: mother's withdrawal amplifies father's over involvement; the combination feeds into the baby's distress which in turn reinforces the problematic parenting, to the point of disruption.

Note that it is important to interpret this family pattern in the context in which it is observed, namely the research and the psychiatric treatment procedures. This has two important consequences: First, how the family negotiates the inevitable tension inherent in the task—interacting under observation—becomes the focus of the evaluation. Second, the observation is considered an intervention in itself, therapeutic when the family is clinical, prevention-supportive when the family is non-clinical. Therefore, a direct intervention during the procedure may be required in order to make the observation profitable for the subjects. This is not unlike McDonough's procedures in Interactional Guidance (McDonough, 1993).

Indeed, the family pattern described above begins to unravel when the parents accept help from the consultant to team up in order to "frame" their baby together; the baby's ensuing interest in dialogue triggers off the parents' sense of

competence and reinforces their cooperation. The ensuing discussion on their subjective experience, on reviewing the tape, allows them to co-construct a narrative of the family process and to help the parents accept outpatient professional help. On the other hand, the later analysis of the change in patterns following the intervention will provide further information on key variables in triadic process.

The systems approach base

In this model, the triad is considered as a co-evolutionary system (see Fivaz-Depeursinge, 1991; Thelen, 1989). The basics may be spelled out in six propositions:

- 1) The parts: the actions of father-mother and infant are the components of the system.
- 2) The context: the components are assembled by the task, i.e. trilogue.
- 3) The whole: whereas the individual actions are numerous, together they generate simple triadic patterns.
- 4) The emergent property: sustained by triadic patterns, a new property emerges, which characterizes the triadic system as a whole. In trilogue, this property is the type of alliance/misalliance governing the triad.
- 5) The whole-parts relations: the triadic alliance/misalliance in turn commands the individual actions of father, mother and infant.
- 6) Inside the alliance/misalliance: the parent's "good enough" framing is a necessary but not sufficient condition for the infant's "good enough" development.

It follows that the basic construct is the **triadic alliance**: the partners cooperate by narrowly coordinating their movements in order to play and have fun together. As it unfolds, this very dance provides them with an emergent sense of being a threesome; it allows them to proceed together, adjust to each other, flexibly change roles and configurations, repair

missteps, synchronize beginnings, turns, transitions and termination of the play. Smooth alliances are observed mostly in non-clinical families.

In the most rigid **misalliances** (observed mostly in psychiatrically disturbed families), the coordination doesn't work and the attempts to repair missteps are doomed to failure. The partners experience a sense of loneliness, exclusion and failure. The intermediary types of alliances are characterized by **conflict** between the parents: either competition or rigid complementarity between them prevent the dance from taking off and stress the infant.

The interaction model base

As in dyadic play dialogue, the language of play "trialogue" is **non-verbal**: the orientations and distances between the bodies, the establishment of episodes of gaze contact, the exchange of facial-vocal expressions of pleasure, all of these indicate the quality and stability of the trilogue. Configuring the non-verbal displays for triadic interactions implies distinct and interconnected levels, each of them being prominent for a given function (for a model of group formations of non-verbal displays, see Kendon, 1990):

- 1) how the partners localize and orient their bodies indicates their readiness to interact as a threesome;
- 2) how the partners orient their gaze indicates their mutual attention;
- 3) how the partners facially and vocally express their emotions to one another indicates their degree of affect sharing.

To put it simply, the practical questions we ask in order to **evaluate** the triadic alliances/misalliances are: do the three partners succeed in organizing together a frame of 1) interactive readiness (body orientations and distances), 2) mutual attention (gaze directions) and 3) shared affect (expressive displays) which is appropriate? Appropriate

means here sufficient to constitute and remain a threesome across the different "2+1" and "3 together" configurations. If not, is it only the infant who does not cooperate or is the coordination between the parents also in question?

The developmental model base:

As the infant progresses from the core to the social, intersubjective, moral and narrative stages, as described by leading developmentalists (Emde, Biringen, Clyman & Oppenheim, 1991; Stern, 1985), new layers of affect communication are introduced in triogue. Here, the task is to recast these successive layers in the context of the triad. We assume the triadic affective interaction to proceed as follows: 1) sharing feeling tones; 2) sharing social displays; 3) sharing internal feelings; 3) sharing moral emotions; 5) sharing narratives. As an aside proposition, we argue that they form the core emotional tissue of the adult narratives, in particular, in therapeutic interactions.

During the first year of development, the infant takes an increasingly active role in regulating the triadic dance, initially at the behavioral level, then also at the intersubjective level. Observing the genesis of triadic interactions from the very beginning of social life casts a new light on infant development and on the intergenerational transmission of emotional patterns. A case in point is tracing the premises of key intersubjective processes such as social referencing, affect sharing and affect attunement as they naturally emerge within the family; or tracing the premises of family ritualization in play, and of the infant's contribution to this family process.

Take, for instance, **social referencing**, (Klennert, Campos, Sorce, Emde and Svegida, 1983); this is one of the most telling processes of intersubjective communication appearing at 9 months. Its discovery

is to be credited to experimental research, which defines it as follows: an infant faced with a (controlled) difficult to interpret event (e.g. the visual cliff), references his mother's face. She responds positively or negatively, according to her instructions. The infant acts according to her signal. This is taken to indicate that the infant knows about intentions and uses cues about internal states to attribute meanings and guide his/her behavior. Now, take the most simple corresponding phenomenon in everyday life: for instance, during the 3-together play, the father suddenly does something unusual. Uncertain, the baby references his mother's face. She smiles reassuringly; the three smile together, and accordingly, the baby resumes play with his father. Consider the numerous possibilities that exist when conflict is introduced between the parents. For example, instead of smiling reassuringly, the mother may smile in an ambiguous way. In other words, this is a triadic event; from this perspective, it becomes necessary to account for the three parties' responses and their combination into a co-constructed meaning.

The exact same point could be made about other critical affective processes, such as affect attunement (what of mother's response to a particular affect attunement of father to daughter?) Or affect sharing in the threesome (what of infant sharing pleasure with mother and targeting a joyful expression to an unresponsive but physically present father?) Not that these are very rapid processes which escape consciousness and are extremely revealing with respect to intergenerational processes of transmission.

The exploratory research behind it

In previous observational studies of father-baby, mother-baby and stranger-baby dyads in high risk families, we discovered patterns of parental holding and of gaze interactions that pointed to higher order effects, at the level of families (Fivaz-Depeursinge, 1991). Consequently, we set up the LTP and began to explore triadic interactions by microanalyzing the most ethological aspects of these interactions (body-, gaze- and facial formations) in contrasted triads. The observations of clinical families with a psychiatrically ill parent were particularly helpful in generating hypotheses about what to look for.



Our team's effort being focused on exploring and describing, we have mainly worked at designing a method to describe triadic states, initially on the basis of molecular categories, and now progressing to more molar ones. Three small N samples were collected. Two samples of paired clinical/non-clinical

families were observed once, one sample of non-clinical families were observed longitudinally (8, 12, 20, 38, 52 weeks) and followed up at 4 years. At present, a new sample is being collected, beginning before birth (the triad, interactive as well as imaginary, comes into being during pregnancy). To this point, data analysis has remained descriptive. Many challenging issues face us, in particular, the temporal analysis of triadic interactions.

The slow pace of exploration makes all the more valuable the collaborations established with other teams. In particular, the LTP is the "anchor point" of the WAIMH study group on the interfaces between different perspectives: interactive, intrapsychic, intergenerational (see

Emde, 1994; Fivaz-Depeursinge et al., 1994). Furthermore, four research teams have included the LTP in their longitudinal, larger N, studies. Interestingly, they are being conducted within very different theoretical perspectives: psychodynamic (Lebovici & Lamour, Paris; Burgin, Basle), ethological-behavioral (Gottman & Katz, Seattle), and family systems (Hedenbro, Stockholm). Their results will importantly contribute to the testing and validation of the LTP concept, as well as considerably enlarge the perspective on the family triangle.

In Sum

A promising aspect of the LTP is that it can be used in widely differing theoretical and clinical orientations. Among the many questions this new perspective raises, perhaps one of the most challenging, even perplexing, issues at this point is: what about quadrads? As Emde notes (1994), the mere interface with the researchers makes it at least a quadrad, both at the levels of interaction and of representation. Whatever the answer may be, the move to the triad promises to be as productive as the step from the monad to the dyad, with new methods and theories, and an impact beyond the field of infant mental health.

References

- Barrett, J., & Hinde, R.A. (1988). Triadic interactions: Mother-first-born-second born. In R.A. Hinde & J. Stephenson-Hind (Eds.) *Relationships within families. Mutual Influences*, (pp. 181-190). Oxford: Clarendon Press.
- Belsky, J., Rovine, M., Fish, M. (1989). The Developing Family System. In M.R. Gunnar, Thelen, E. (Eds.) *Systems and Development*. Hillsdale, New Jersey: Lawrence Erlbaum Associates, Publishers.
- Boszormenyi-Nagy, I., & Sparke, G. (1973). *Invisible loyalties: Reciprocities in Intergenerational Family Therapy*. New York: Harper and Row.
- Broderick, C.B. (1993). *Understanding Family Process*. Newbury Park London New Delhi: Sage.
- Byng-Hall, J. (1986). Family scripts: A concept which can bridge child psychotherapy and family therapy thinking. *Journal of Child Psychotherapy*, 12 (2), 3-13.
- Caplow, T. (1968). *Two against one: Coalition in triads*. Englewood Cliffs NJ: Prentice Hall.
- Clarke-Stewart, K.A. (1978). And daddy makes three: the father's impact on mother and young child. *Child Development*, 49, 466-478.
- Corboz-Warnery, A., Fivaz-Depeursinge, E., Gertsch-Bettens, C., & Favez, N. (1993). Systemic analysis of father-mother-baby interaction: the Lausanne Triadic Play. *Infant Mental Health Journal*, 14 (4), 298-316.
- Cowan, P.A., & Pape Cowan, C. (1991). Becoming a family: Research and intervention. In E.E. Sigel & G.H. Brody (Eds.), *Methods of family research. Biographies of research projects*. Vol. 1: Normal families, (pp. 1-51). Hillsdale, NJ: Lawrence Erlbaum.
- Dunn, J. (1989). Connections between relationships: implications of research on mothers and siblings. In R.H.J. Stevenson-Hinde (Ed.) *Relationships within Families. Mutual Influences*. Oxford: Clarendon Press.
- Easterbrooks, M.N., & Emde, R.N. (1988). Marital and parent-child relationships: The role of affect in the family system. In R.A. Hinde & J. Stevenson-Hinde (Eds.), *Relationships between relationships within families*, (pp. 83-103). Oxford: Oxford University Press.
- Emde, R. (1994). Commentary: Triadification experience and a bold new direction for infant mental health. *Infant Mental Health Journal* 15 (1), 90-95.
- Emde, R., Biringen, Z., Clyman, R., (1991). The moral self of infancy: Affective core and procedural knowledge. *Developmental Review*, 11, 251-270.
- Fainsilber Katz, L., & Gottman, J.M. (1993). Patterns of Marital Conflict Predict Children's Internalizing and Externalizing Behaviors. *Developmental Psychology*, 29(6), 940-950.
- Field, T. (1978). Interaction Behaviors of Primary versus Secondary Caretaker Fathers. *Developmental Psychology*, 14(2), 183-184.
- Fivaz-Depeursinge, E. (1991). Documenting a time-bound, circular view of hierarchies: a microanalysis of parent-infant dyadic interaction. *Family Process*, 30 (1), 101-120.
- Fivaz-Depeursinge, E., & Corboz-Warnery, A. (1993). Microanalysing father-mother-infant play: Initial methodological and technical requirements. Paper presented at the 60th meeting of the Society for Research in Child Development, March 25-28, 1993, New Orleans, LA.
- Fivaz-Depeursinge, E., Stern, D.N., Burgin, D., Byng-Hall, J., Corboz-Warnery, A., Lamour, M., & Lebovici, S. (1994). The dynamics of interfaces: Seven authors in search of encounters across levels of description of an event involving a mother, father, and a baby. *Infant Mental Health Journal*, 15 (1), 69-89.
- Hinde, R. (1992). Developmental psychology in the context of older behavioral sciences. *Developmental Psychology*, 28 (6), 1018-1029.
- Kendon, A. (1990). *Conducting interaction. Patterns of behavior in focused encounters*. Cambridge: Cambridge University Press.
- Klinnert, M.D., Campos, J.J., Sorce, J.F., Emde, R.N. & Svejda, M. (1983). Emotions as behavioral regulators: social referencing in infancy. In R. Plutchik & H. Kellerman (Eds.), *Emotion, theory, research and experience*, (pp. 57-86). New York: Academic Press.

- Lamb, M.E. (1977) Father-infant and mother-infant interaction in the first year of life. *Child Development*, 48, 167-181.
- Lebovici, S., (1992). A propos de la transmission intergénérationnelle: de la filiation à l'affiliation. *Presidential address, 5th world congress of the World Association of Infant Psychiatry*. Chicago, 9-13 Sept. 1992.
- Lewis, J.M. (1989). *The birth of the family. An empirical inquiry*. New York: Brunner/Mazel.
- McDonough, S.C. (1993). Interaction guidance: understanding and treating early infant-caregiver relationship disorder. In C. Zeanah (Ed.), *Handbook of Infant Mental Health*. New York, London: The Guilford Press.
- Minuchin, P. (1988). Relationships within the family: A systems perspective on development. In R.A. Hinde & J. Stevenson-Hinde (Eds.), *Relationships within Families: mutual influences*, (pp. 7-26) Oxford: Clarendon Press.
- Parke, R. (1990). In search of fathers: A narrative of an empirical journey. In I. Sigel & G. Brody (Eds.), *Methods of family research: Biographies of research projects*, (Vol. I Normal families). Hillsdale NJ: Lawrence Erlbaum Associates.
- Parke, R.D., Power, T.G., & Gottman, J.M. (1979). Conceptualizing and qualifying influence patterns in the family triad. In M.E. Lamb, S.J. Suomi, & G.R. Stephenson. (Eds.), *Social interaction analysis: Methodological Issues*, (pp. 231-251). Madison: University of Wisconsin Press.
- Pedersen, F.A., Anderson, B.J., & Cain, R.L., Jr. (1980). Parent-infant and husband-wife interactions observed at age 5 months. In F.A. Pedersen (Ed.) *The father-infant relationship. Observational studies in the family setting*, (pp. 44-70). New York: Praeger.
- Reiss, D. (1989). The represented and practicing family: Contrasting visions of family continuity. In A.J. Sameroff & R.N. Emde (Eds.), *Relationships disturbances in early childhood*, (pp. 191-220). New York: Basic Books.
- Stern, D.N. (1985). *The Interpersonal world of the infant*. New York: Basic Books.
- Stern, D. N. (1995) *The Motherhood Constellation. A Unified View of Parent-Infant Psychotherapy*. New York: Basic Books.
- Thelen, E. (1989). Self-organization in developmental processes: Can systems approaches work? In M. Gunnar & E. Thelen (Eds.), *Systems and development*, The Minnesota Symposium in Child Psychology, (Vol. 22, pp. 77-117). Hillsdale, NJ: Lawrence Erlbaum.
- Tronick, E.Z., & Cohn, J.F. (1989). Infant-mother face-to-face interaction: Age and gender differences in coordination and the occurrence of miscoordination. *Child Development*, 60, 85-92.
- Yogman, M.W. (1982). Development of the Father-Infant relationship. In H. Fitzgerald, B. Lester, & M.W. Yogman (Eds.) *Theory and Research in Behavioral Pediatrics*. New York: Plenum Press.



Stephen's Corner

Stephen Bennett

MERE CHAOS



Health issues vital to women and infants can find expression in political and ideological battles.

One controversy that was played out in the summer of 1994 in the New York State Legislature and the New York Times concerned the disclosure of newborn H.I.V. testing

results to mothers and clinicians. This was portrayed as a fight between the health needs of infants and the privacy rights of mothers. What made this struggle fascinating for me then was the fact that the medical authorities invoked by the various sides came from the hospital where I work. A city hospital usually makes the paper only when there has been a scandal or

disaster, and so it was refreshing to find ideas of substance presented.

This story is complex and enfolding. As I poked about and interviewed, a neat ending never arrived, so I dropped and picked up this narrative several times. I can see now from where I write — the spring of 1995 — what an extraordinary shift has taken place. My goal when I started was to center on the ideas themselves, but to catch, as well, their leavening by the vivid personalities who voiced them, as if ideas and people possessed a primacy and political intrusions were only external events to heighten the interest. What I can see now is that mean and vivid changes have lurched forward so quickly that within a season the issues

of practical consequences for patient care are heralded on the front pages as one program after another is discarded. Rather than be determined by need and clinical worth, the new politics prune programs and people — myself in time, no doubt — to meet its own vision of what is economically and politically expedient. What I want to attempt now is to catch the complex currents of real life. I will start with the disputes about H.I.V. testing for mothers and infants that drew me in a year ago, describe the struggles over these issues, try to give them a human dimension by weaving in portraits of the real people involved, but then show the impact of the massive political shift.

First of all, let me describe the battles that made the papers. For the past 8 years in New York State all newborns have been tested for H.I.V., but neither the parents nor the clinicians are informed of the specific results. The purpose of this testing is for the tracking by the State Health Department of the prevalence of the virus. In the spring of 1994 an Assemblywoman put before the New York State Assembly a bill to disclose the test results. The stated purpose was that if the testing results were unblinded, early treatment could occur. Identification of newborn H.I.V. status would allow Bactrin treatment to ward off PCP. New York would have been the first of the 45 states with H.I.V. testing of newborns to disclose the test results. This proposal aroused bitter opposition from AIDS groups, gay rights groups, women's organizations, and civil libertarians because a positive test identifies the woman as infected and so new mothers would be the only group subject to mandatory testing. This bill ran into trouble and another, competing bill was put forth that called for mandatory counseling.

The next dispute centered on the effectiveness of counseling with the successful results of such programs at my hospital used to justify this approach. However, the pediatrician in

charge of our successful program raised doubts about the effectiveness of large scale counseling programs. By the end of the summer neither bill had gotten through but it was clear that sometime after the election this issue would resurface.

At the same time in the spring of 1994, the results of the 076 H.I.V. Maternal/Child Transmission study were reported openly and appeared at first to resolve the issue, but instead the report poured kerosine on the flames of the testing debate. This double blind and placebo controlled study showed a reduction in H.I.V. infection

among infants born to women treated with AZT. The rate of perinatal infection for the placebo

group was 25.5% and 8.3% for the treated group, that is, two thirds of the children were saved from infection. The study was stopped earlier than expected because of the strong support for the effectiveness of AZT in reducing prenatal transmission.

Here, for the first time, recognition of HIV status during pregnancy had real consequences for the infant. Prior to this time such knowledge did not mean much. The naive observer, myself as an example, would have thought that this would wrap up the testing struggle. Not at all so. What it did do was cause those opposed to mandatory testing to double their efforts because of concern that the results of the study would be used to resurrect this issue.

Let me now go beyond the disputes to the people actually spending their professional lives working with women, infants and AIDS. My first visit was with Janet Mitchell, an obstetrician and gynecologist. She is the person most quoted around here by anyone against

testing and reporting. I had seen her about the hospital, and my main impression was of her tininess. However, the impact of my long discussion with her was that she is huge because the energy and force of her personality filled the room. She is extraordinarily articulate and persuasive. All is said with a grace and even funniness, the charm of her "y'all" disarming amidst her surety and conviction. She has that gift of intimacy possessed by successful politicians who allow you into their thinking, so that you feel it would be ungracious not to accept their ideas. It



... IN THE SPRING OF 1994, THE RESULTS OF THE 076 STUDY WERE REPORTED OPENLY AND APPEARED AT FIRST TO RESOLVE THE ISSUE, BUT INSTEAD THE REPORT POURED KEROSINE ON THE FLAMES OF THE TESTING DEBATE.

is easy to see why she is in demand at public forums because in a dispute she would outclass everyone. I wouldn't want to get into a knock-out fight with her, especially if I was convinced that I was in the right.

Dr. Mitchell is from Kentucky and describes that, unlike Clarence Thomas, she is a product of affirmative action. This got her into Mount Holyoke. Her first choice for medical school, then in the 70's at the height of the civil rights movement, was Howard University because she knew it was politicized with an emphasis on what they called "cultural competence." She trained in ob/gyn at Harlem Hospital, then in maternal and fetal health in Boston followed by obtaining a MPH at Harvard.

Let me be clear about the ideas about testing and reporting that I carried with me into my discussion with Dr. Mitchell. These ideas came mainly from pediatricians who are usually crisp and curt in their pronouncements concerning the need for early identification and prompt treatment of any major illness.

Dr. Mitchell feels that there was a gross misunderstanding of the facts of the mandatory testing and reporting controversy and that few people want to get past emotions. It needs be said that of all the people I have talked to she is the most passionate. The jargon expression used is 'newborn screening' but the public perception misses that what is measured are the maternal antibodies. A positive result identifies 100% the mother's H.I.V. status but only 20% for the baby. In other words, only 1/5th of the babies will prove to have the H.I.V. virus. There can be seroconversion for the child but never for the mother.

The tragedy, Dr. Mitchell feels, is that she does not hear anyone talk about the infected mother and the brute fact that a positive test is the announcement of a fatal diagnosis. In this focus on the baby, she feels the overt message to the mother is that she is not worth anything.

Until recently the main funding and interest was for the baby and little attention was paid to the mothers. Dr. Mitchell feels she must make up for that neglect by being the advocate for poor and minority women in this inner city community.

The main advocacy for individuals with AIDS has been gay rights groups. They have been strongly against mandatory testing because they feel that such public knowledge would lead to discrimination. Their approach has been to change community attitudes, specifically concerning safe sex, but their assumption has been that all communities share their values. Since they have been in charge of the AIDS programs that assumption has had power. However, Dr. Mitchell points out that the face of AIDS has changed from white to black, but also women have gotten lost. The gays say that as soon as drug users see their friends die, they'll change their behavior. This is just not so in the inner city where friends are always dying. For the women here who must cope with enormous trauma, AIDS is just one more thing on an already full

plate. She feels when the issue is a fatal diagnosis that women have a right not to know—they should only know when they wish to.

I got a chance to see Dr. Mitchell in action during her monthly Special Prenatal Clinic meeting. The purpose of this clinic is to provide prenatal care to a group of women who would get lost in the usual clinic. These are women with major problems with addiction. Over the past year, 140 women were seen. Although most are multiple drug users, crack is the drug of choice. H.I.V. testing is voluntary and 90% agree. Dr. Mitchell was tough and funny, raising hell at sloppy workups, declaiming "send in the troops" when intervention was urgent, all the time making clear that these women needed their clinic's control and protection, including admitting them to the hospital for social reasons. She characterized this population as highly manipulative, playing stupid, but nevertheless socially and conceptually sophisticated. They were Darwinian survivors. Her comment on their drug of choice was that it was men and babies.

Janet Mitchell's dedication to women forced me to reexamine my own attitudes. Certainly, in my secret heart I am convinced of my own attentiveness to the rights and needs of parents. However, I do share with pediatricians a special obligation to the child. Anyone who has spent years dealing with child abuse cases does not have a lot of problems with superseding parental rights for the welfare of the child.

Elaine Abrams is in charge of the Pediatrics AIDS Program and the Maternal Transmission Study. If Janet Mitchell softens her knockout punch with the velvet 'y'all', Elaine uses an ebullient funniness. She boasts that she is from Brooklyn as if this gives her an ingenuousness and power. I was raised in Queens myself and have been always a little afraid of people from Brooklyn. Her growing up in that borough includes attending James Madison High School where, as she

points out, Ruth Bader Ginsburg was a graduate. After Princeton she attended Columbia College of Physicians and Surgeons, trained in pediatrics at Babies Hospital and Harlem Hospital. As with Janet Mitchell, she is committed to the idea of providing health care to the underserved of the inner city.

She began her interest in AIDS and children in the middle 80's at the start of the epidemic when the first anti-body tests were done. A major attempt was made to identify newborns with a positive H.I.V. status. Early efforts at identification were about 30% in their yield. At first risk factors, such as drug use and promiscuity, were used as criteria for testing, but because all women in this community were felt to be at risk, they were dropped. In other words, they concluded that everyone should tested.

Elaine described the rapid progress made in the treatment of AIDS. Only 10/20% of the children they follow have died in the past 2 years. She thinks of AIDS in children as more like leukemia, not overwhelming. As with most pediatricians I listen to, she is curt and morose in her comments about testing. She feels that we must get away from social reasons dominating testing and center on medical reasons. She comments that she has seen too many babies die and adds that she has a drug — Bactrin — that will counter PCP if given early. With Elaine, I hear a bitterness and disgust over what she sees as the politically correct attitude influencing identification of AIDS in children.

The way to sidestep the blandishment of the quick fix of mandatory reporting of H.I.V. testing has been voluntary testing. Elaine's view is that voluntary testing in this state has been an "abysmal failure." Why then has Elaine's program been a success? What I see is solid financial support, a vigorous staff who believe in what they are doing and work within a clinical setting, and Elaine herself as the driving force. Some hospitals have had increasing success. However,

these programs have, as in our hospital, centered on the postpartum period when, as Elaine says, it is too late. For there to be any prevention, the maternal H.I.V. status must be determined during pregnancy. There is an abortion rights resistance, she feels, to testing during pregnancy for the sake of the Baby-to-be because abortion rights advocates do not wish anything that defines the fetus as a baby.

A public forum Columbia-Presbyterian Medical Center on the results of the 076 study sponsored by the N.Y. Task Force on Women and AIDS gave me a sense of how these ideas were played out in the community. The theme of the presentations was that clear information would

hands but was the principle investigator of a project that investigated the acceptance of testing by women enrolled in family planning and prenatal care programs. In addition, her group has put together a clear and simple brochure that disseminates information about the 076 study.

Dr. Heaton possesses the direction and drive that appears necessary for survival in the AIDS world. Several weeks later when I talked to her in her office, I let on that I was wary of the effectiveness of voluntary programs she responded with a relish and delight. Stating that as a teacher she needed a blackboard she enthusiastically drew and lectured for over an hour in an intense private tutorial. Later on she described

working on a major legislator who had been for mandatory testing and that it had taken her 4 hours to convert him to becoming



SHE CHALKED OUT THE REASONS GIVEN FOR UNBLINDING THE NEWBORN TESTS AND FOR MANDATORY TESTING DURING PREGNANCY AND ONE BY ONE DEMOLISHED THEM.

strengthen the absolute right of the women to make choices. A passionate statement about the meaning of treatment came from one H.I.V. positive woman who had been given AZT. With bitterness, she described that what had been ignored was the harmful effects of the AZT and the fact that it may work less well the second time. She felt that doctors were only trying to save the babies and were just watching women die. This statement caught, I feel, just the surface of the suspicion and anger towards the medical establishment.

A forceful presence at the meeting was Cheryl Heaton who is Associate Dean of the Columbia School of Public Health. She was straight out about her concern that the positive results of the 076 study would be used to support mandatory testing. However, she is not just wringing her

its major opponent. I confessed all my sins after only an hour. She chalked out the reasons given for unblinding the newborn tests and for mandatory testing during pregnancy and one by one demolished them. The idea is that all positive babies would be identified and by this the both mother and baby could get treatment. Knowing the positive HIV status during pregnancy would allow treatment to prevent transmission to the infant. In addition, this information would help reduce transmission to the mother's partners. Also, women could be advised about breast feeding.

Now came the counter-punch. Mandatory testing, she feels, just doesn't work because it drives women away. They fear the result. She has tons of data to support this contention. Good voluntary testing obtains 95%.

Civil rights are a major issue in mandatory testing. So far all men are free, but it has been open season on women. Also, she is clear if there must be mandatory testing and treatment that men must be included. It's clear that such a demand would stop it cold. Attempts at mandatory treatment would not withstand any legal challenge. For example, C sections to save the life of the baby have occurred in some states but after the fact, they have always been overturned in court. You cannot make someone do something invasive.

There is no clear evidence that transmission among partners would be influenced by mandatory testing or that knowledge of H.I.V. status constructively influence the behavior of those who are positive. A negative result causes a promise to God of good behavior for awhile, and those who are positive are sometimes seized by a "what the hell, who cares attitude."

The issue of breast feeding is tricky. The virus is transmitted through the mother's milk. Someone who tested negative during pregnancy may well become infected right after birth. The initial infection produces a great outpouring of the virus. Her advice is that here in the U.S. any of those in at-risk groups should not breast feed nor should any mother in developing countries where a safe water supply exists.

An issue of concern to her was that the 076 study was terminated when the child was 6 months. Heaton has successfully advocated for a follow up protocol. It has been hard to get the participants back in again. Of concern to her is what will be the long-term effects of the drugs given to these women when in the future they need AZT for their own health.

Taking a chance, I teased Heaton about the public health approach. I commented that every person I talk to invokes it but the funny thing was that she and Mitchell who really were trained in it did not sound anything

like the quick search out then treat approach that I had been taught and everyone else expresses. Heaton answered that she was taking a contemporary view of a unique disease. It does not come out of the water or air but is based on consensual sexual activity or needle sharing. The old solutions don't work. There is not an easy way of rendering the infected person harmless.

A view on this is provided by Ron Bayer, who is from Columbia University and writes on the trends and ethical issues created by the AIDS epidemic. In the 80's, rather than responding according to the traditional authoritarian public health approaches to sexually

transmitted diseases, the gay rights people and liberals initiated what he calls "HIV exceptionalism." AIDS was to be thought of differently. However, the thrust of exceptionalism has eroded over the past years and there has been a resurgence in the demand for the traditional methods of reporting and treatment. Bayer argues that a return to the old ways would lose the chance to revitalize public health and find creative ways to meet the challenges of the future. For example, the requirement of informed consent demanded by HIV testing ought to be applied to all clinical tests. In addition, the involvement of the populations who are "at risk" in campaigns of public health education should be extended to all diseases and dangers.

During the fall of 1994, especially after the election, this article was put aside because I was trying to cope with the intrusions of the real world. One after the other there have been cut-backs, re-engineering, layoffs,

down-sizing, job freezes and buy-outs. The horrendous best of these terms is desubstitution. What this means is that one level of professional will be replaced by another who is less well trained and therefore cheaper. At-risk populations are the bane and horror of the new business approach to health care. They are the "undeserving" and noncompliant, those who have brought their problems upon themselves — the addicts, alcoholics, homeless, and the poor women who keep having babies. One example of



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the dismantling of health care for at risk groups is that out of about 30 city programs that serve addicted women who are pregnant, more than half were cut suddenly with the likelihood that the rest would not last long. Mitchell and Abrams are strong enough so that they are likely to make it, a few showpiece programs will be politically necessary, but there won't be much else left. In January the kick-in-the-teeth economic forces leapt out of the papers. Both city and state are intent to hugely cut health care benefits. Also, again front page stuff, there was warning about closing or selling off the city hospitals, our own at the top of anyone's list. To illustrate the marvelous confusion, let me catch the events of the end of January. The week before the head of the hospital quit. At least he had lasted two years, where before there had been five directors in as many years. The public statement was that he had gone onto a better job while the undercurrent was that he had failed to plan for the future

in this new world of health care austerity and so had been pushed out. One thing for sure continues and that is that no one around here seems to have a clue as to what is going on.

The best event in January was when Princess Di visited. Of interest for this article is that she spent several hours playing with the children in the Pediatric AIDS Program, a follow up to a visit 6 years before. However, what should have been a rather sweet episode became a tabloid front page story because the hospital's publicity person had not told the city bureaucracy and so was fired. The primacy of publicity was ascendant.

A startling turn occurred in the beginning of May 1995 when the Centers for Disease Control and Prevention decided to suspend its anonymous AIDS testing of newborns. One morose interpretation of this decision was the Government's discomfort — the Tuskegee experiment specter hovering about — with information about thousands of infants and mothers kept secret when it could be used for the planning of treatment. A question is, why now? Legislation in both Washington and New York State had been proposed that would make known the testing results. The transcendent solution to the dilemma about what to do with this information was not to have it at all. I do not believe that the tensions will lessen but rather the battle lines will shift. A major issue will be the demand for mandatory testing the same as for syphilis and P.K.U. Also, there will likely be a struggle over the amount of funds necessary to create a solid voluntary testing program. At this time, as I am holding onto this column, awaiting the next chapters of this unfolding story, the editors of this column are after me to turn it in. I will do so but plan a follow up in the next year or so.

Also, at this time, the talk of selling the hospital has decreased to be replaced by the threat of a greatly decreased health care system.

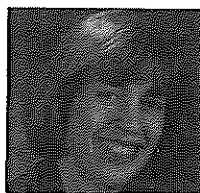
Managed care with its "providers" turning out "products" will overturn what is felt to be an anachronistic and socialist approach to the health care needs of poor people.

My mood now has become direfully apocalyptic and so I turned naturally to Yeats — "Things fall apart; the center cannot hold; mere anarchy is loosed on the world." The trope of mere anarchy caught me. Anarchy and chaos are similar in popular use today with the latter really in nowadays, very fashionable to quote. Other than a few mathematicians no one really seems to understand it, so I have no problem with invoking it myself. One of the ideas is that within chaos self organizing structures emerge. There is no center to the chaos of health care but islands of stability are in place and some of these are the special clinics and projects I have described. They are the strength of the hospital—the parts stronger than the whole—as if they could keep the structure from falling apart. The three women portrayed—three fates, norms, witches—more currently put, strange attractors, create unique hurricanes that touch everything and cause multitudes of butterflies to flutter.

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

Correction:

Last issue's column on Peter Wolff erroneously reported the date for the quote "different ways of 'being in the world' . . . results in quantitatively distinct ways of structuring experience" as 1985. It should have been 1965.



President's Perspective

Joy D. Osofsky

In the last issue of *The Signal* (January-March, 1995), I invited 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? Several articles and columns in the *Signal* have addressed this topic as is appropriate since our organization's commitment is related to infant mental health—and we can certainly accomplish our goals better if we are clear about what they are! It is also crucial, however, to acknowledge that infant mental health means different things to different people and will be influenced by the cultural traditions within geographic regions and even various cities within those regions.

Let me reiterate the goals of the World Association for Infant Mental Health:

- promotes education, research, and study of the effects of emotional development during infancy on later normal and psychopathological development
- promotes research and study of the mental health of the parents, families, and other caregivers of infants
- promotes the development of scientifically based programs of care, intervention, and prevention of mental impairment in infancy
- encourages the realization that infancy is a crucial period in the psychosocial development of individuals

- facilitates international cooperation among individuals concerned with promoting optimal development of infants and their families.

Clinical and research work in the area of infant mental health is developmentally oriented. We are interested in pathways of development which include positive features that facilitate development as well as negative aspects that may interfere with development. Infant mental health includes interpersonal and cross-generational features as well as an understanding of the psychological features of the individual.

Infant mental health is also crucially concerned with the prevention of problems as well as the treatment of current problems. A major objective is to help families "get back on the developmental track" in an effort to prevent later problems. In infancy, biological factors that lead to strength in development and offer a "developmental thrust" are often on our side. As Selma Fraiberg, one of early leaders who provided inspiration to our organization, said so poignantly many years ago speaking of the recoveries that one sees in infancy, "It's a little bit like having God on our side." (Fraiberg, 19XX). Through WAIMH, there has been a strong interest in understanding infant mental health in context—in families and cultures. There has been a strong emphasis on understanding strengths and problems that might arise in different cultures.

Miguel Hoffmann, our Treasurer from Buenos Aires, responded to my invitation for feedback. His ideas are interesting and should provoke thought and discussion. His letter follows in which he has shared his ideas about infant mental health. I would welcome your comments and suggestions related to additional infant mental health perspectives.

Miguel Hoffman: Some thoughts on Infant Mental Health

This is a new field. I think our president is right in trying to find a better definition for something that is still in the making. I propose three concepts for this debate: First, the idea that "There is no such thing as an infant," which is a frequently used quotation from Donald Winnicott. By this, he means that there is no infant alone, without a mother, without a care giving environment. And how far do we go when we think of environment? Do we stop at the door of the family house; the township border, or the national border? Let us take poverty for example, which could be seen either as a family or a community issue. Yet, another way of looking at poverty would be to define it as a "lack of" something and specify the items to be considered as such. What would these be just food or shelter? In Latin America, we have huge problems and a few good ideas about how to understand them. The CEPADUR, a group working in Chile, produced a document after years of research called "Human Scale Development."

In this document, we can find six different types of poverties (p21);

1. *poverty of subsistence* (food and shelter);
2. *poverty of protection* (due to bad health systems, violence,);
3. *poverty of affection* (exploitative relationships, authoritarianism, oppression);
4. *poverty of understanding* (poor education);
5. *poverty of participation* (marginalization of women, children, minorities);
6. *poverty of identity* (due to forced migration, exile or imposed foreign values).

If there is no such thing as an infant by itself and we have to ask into account the environment, to speak of six categories of poverty introduces many complications. Who said that it is an easy task to define infant mental health? This is not a proposal that mental health be limited to external issues. *Participation*, for example, is a topic that I have personally taken to do research in the mother-infant system, based on the space the mother makes and the great deal of attention she gives to the infants' initiatives at age 4-12 months. In my understanding, participation is essential for the development of creativity (Hoffmann, 1994, 1995).

Second concept: What is exactly the space we are willing to allot to infancy in general, not only to its mental health? How much space do we make for infancy inside our heads, in our minds? From our clinical experience, we often wonder how much an infant or a child exists in the mind of his/her parent? Lebovici (1988, 1991) proposed two infants. One is the fantasied infant, the unconscious resolution of the maternal Oedipus and the child of imagination that develops out of the pre-conscious and conscious thinking of a mother and of both mother and father exchanging projects for the newborn or the one to come. To this idea we have added the child of perception, the one that emerges out of personal contact, with sensory stimulation of parental minds (Hoffmann, 1995). Difference between expectation and realization in the newborn may produce extreme frustration in both mother and father, with concomitant aggression and violence, attempts to subdue, and other forms of suppression running under the title of "educational process."

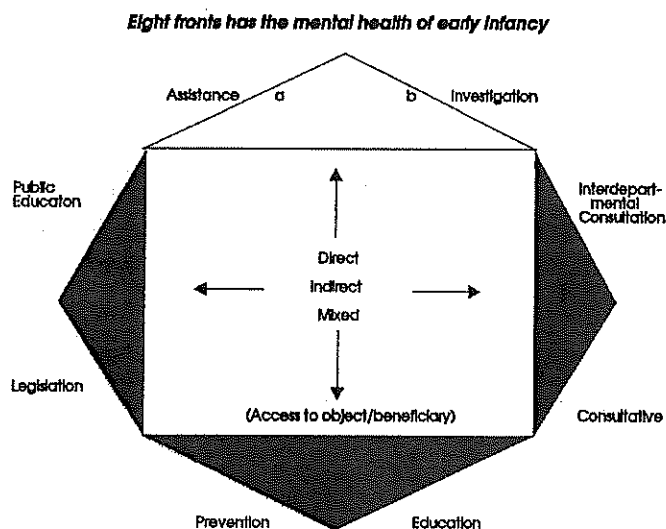
Children can be used at the community or social level as well. Totalitarian regimes have always made use of youth to impose their ideas upon society, often through confrontations between the youth and the elder in the same family. Children are used as carriers of ideologies. Now, children are used as consumers through media advertising, aimed specifically at the youngest. What has the community in mind when it proposes Day Care? Is Day Care aimed at the best interests of developing infants, or is it a more or less convenient way of making space for the mother's or the community's best interest? How much of the curricular requirements in early and in primary education are aimed at the child and how much at the interests of society? The so called "cultural values," strongly enforced in some societies through laws, the media, or religious activism (fundamentalism) violate fundamental rights of infants every minute. Take for example, clitorrectomy in young female babies. Or the selling of infants from underdeveloped countries to the first world, depriving them of their right to have roots, a culture and an identity of their own. Just simply think of the prohibition against having some form of birth control, with the consequences of unwanted pregnancies.

How much space do we make for infants as parents, professionals, societies, cultures?— meaning by "space" something much closer to the individual destiny each one of us would wish for him/herself. We all carry a national, family or cultural destiny. But we all aspire to a degree of freedom to perform some shaping of that destiny. And as mental health specialists, we should know that the greater the degree of individual development, the greater the capacity to become a creative, participating, respectful "citizen." And here we often fall into the trap of confusing individuality - which is a developmental achievement- with individualism

that is a deviant, pathological compensation for lack of fulfillment of one's own possibilities.

Third, a few years ago I was invited to describe infant mental health as a field for a journal in my country. From that paper, I am reproducing the octagon that represents the eight different fronts this new field has in my understanding:

Eight fronts of the mental health of early infancy¹



Two fronts (a,b) are directly connected to the infant: research and clinical treatment. Two other fronts (c,d) are related to the collaborative activity with other professionals; one is through interdisciplinary combined action (we go to the surgical ward, or the neonatal intensive care unit and work on the infant and his family together with the colleagues). In the second one, we receive the colleague and answer his questions regarding procedures directed onto infants and small children. The latter might be in the educational field, consulting with day care or school system. Another

two (e,f) are more educational. We teach our ideas for prevention or share educational purposes, but still within the area of infants, parents or professionals. The last two (g,h) are even more indirect as we go to government officials, and lawmakers to consult, or inform them on social policy issues, new legislation, and definition of rights for infants and children.

A surgeon might be consulting with law makers regarding tobacco and cancer, a nurse has a role in prevention, or a statistician has important ties with public education, in most of these eight fronts almost permanently. Similar to the new role of pediatricians,

infant mental health specialists share the concern for health more than the involvement with pathology. And health is so much more complicated than pathology that we just start to feel how much stress is put upon us in this new field! Infant mental health wasn't a field in the last century, mainly because infants weren't regarded as individuals in their own right. Infants have always been the property of their parents, their communities and their culture. Now that infants are emerging as independent beings, with some scant rights, they also require specialists who do not renege on their complex roles as attendant, adviser, researcher, advocate, or educator.

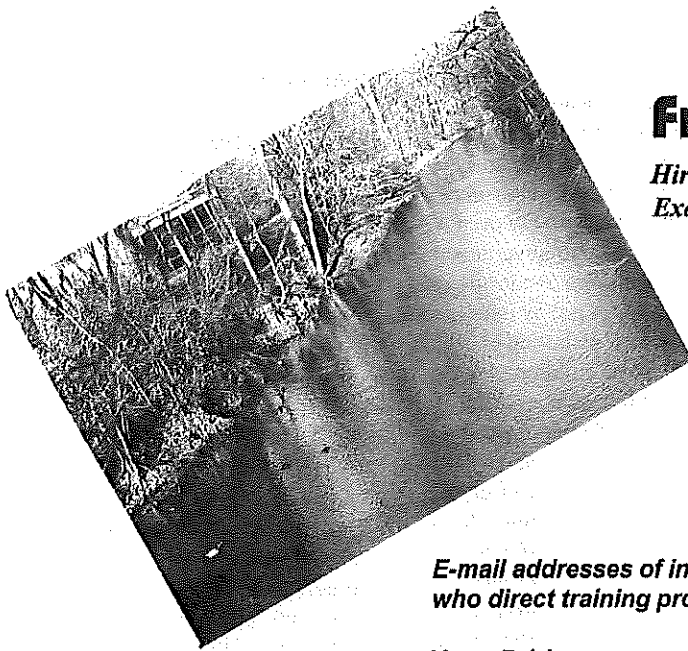
References

- Lebovici, S. (1988) Fantasmatic interaction and intergenerational transmission. *Infant Mental Health Journal*, 9, 10-19
- Lebovici, S. (1992) Una nueva patologia: Disarmonias en las interacciones tempranas. Curso dictado en simultáneo con el II Congreso Latinoamericano de la WAIPAD, Buenos Aires, Argentina, Julio de 1991. Edición en castellano CIAD WAIPAD, Buenos Aires, 1992
- Hoffmann, J. M. (1994) L'Initiative dans le developpement emotional precoce; organization du deuxieme semestre. *Psichiatrie de L'Enfant*, XXXVII, 1, 179-213. Paris: P.U.F.
- Hoffmann, J.M. (1995) Making Space. *Infant Mental Health Journal*, Vol. 16 (1).
- Hoffmann, J.M. "Missing Spontaneity" book chapter, edited by Robert Tyson, in process.
- Max - Neef, M.; Elizalde, A.; Hopenhayn, M.; with the cooperation of: Herrera, F.; Zemelman, H.; Jatabá, J.; Weinstein, L.; "Human Scale Development: An Option for the Future" in *Development Dialogue*, 1989. (available in English & Spanish)

Back to the question

Now let me return to our original question. What is infant mental health? The purpose of opening this dialogue is to provide the opportunity for each of us to think further—and share ideas if you wish—about how infant mental health may be understood, broadened, or implemented in our clinical work, research, teaching, and for those who are interested, public policy. We have outlined our broad working understanding for the organization. Each of us in our own settings will come up with ways to work most meaningfully in this area. Let me hear from you!

¹From "Salud Mental: El Area de la Primera Infancia" *Rev Arg de Psicopatologia* (1991)



From the Red Cedar

Hiram E. Fitzgerald
Executive Director

Recall that last year we circulated a survey that attempted to assess infant mental health resources and the extent of infant mental health training programs? Well, to date there have been 65 responses to the survey and Melanie Smith is busy entering all of the information into a data base, which eventually will be accessible through regular mail and through electronic mail. We are testing World Wide Web as well as a number of other bulletin board systems to see which would be best for our situation. The dedicated computer is available and now it is just a software decision and a management strategy to keep the bulletin board up to date. In the interim I thought that I would share some of the information gained via the survey and facilitate WAIMH networking.

NETWORKING VIA ELECTRONIC MAIL (add these to your member directory)

I tried my best to read printing and handwriting correctly. If there are errors, please send us the correction, but do type them with accurate spaces etc. Thanks).

E-mail addresses of individuals who direct training programs:

Nancy Balaban
nbalaban@bnk1.Bnkedu
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Marija Radojevic
PS-radojevic@hope.ocs.mq.edu.au
Joyce Hopkins
PsychHopkins@iit.edu

We were delighted to receive so many additions to our slowly increasing electronic mail address list, but the big surprise was the number of training programs that surfaced. Since we receive so many inquiries about formal training programs, I thought that *The Signal* would be an appropriate outlet to begin the dissemination process. In some instances we did not have complete addresses, so we have listed a contact person, either the program director or the individual who brought the program to our attention in the survey.

Infant and Parent Development Program
Bank Street College
Contact: Nancy Balaban, Ed.D.
50 Circle Drive
Hastings on Hudson, New York
10706 USA

Baby-Kurs
Univ. KinderKlinik
Contact: Marguerite Dunitz, MD
Univ. KinderKlinik
A-8036 Graz
AUSTRIA

Parent-infant Development Service (PIDS)
University of Chicago
Contact: Lauren Nakschlag, Ph.D.
Department of Psychiatry
5841 S. Maryland
Chicago, IL 60637
USA

- Infant Psychiatry Program
University of British Columbia
Contact: Prahbha N. Reebye MD
1453 Laurier Ave.
Vancouver, British Columbia
V6H 1Z2 CANADA
- Residency Program
Department of Child & Adolescent
Psychiatry
Martin J. Drell, MD
Louisiana State University Medical
Center
1542 Tulane Avenue
New Orleans, LA 70112
USA
- The Blake Newborn Family Unit
Harvard Medical School
Contact: Peter A. Gorski, MD, MPA
Massachusetts General Hospital
Boston, MA 02114
USA
- Infancy Clinic
Department of Psychiatry
Contact: Robert Harmon, MD
University of Colorado Medical
Center
4200 East 9th Avenue
Denver, CO 80262
USA
- Training Program for Para-Child-
Psychiatric Personnel
Yonsei University
Contact: Helen Lee, MD
16-1 Daeshimdong, Seodaernmgu
Seoul 120-160
KOREA
- Child Development Unit
Harvard Medical Center
Contact: Edward Z. Tronick, Ph.D.
Children's Hospital
300 Longwood Ave.
Boston, MA 02115
USA
- Interdepartmental Graduate Program
in Infant Studies
Michigan State University
Contact: Hiram E. Fitzgerald, Ph.D.
27 Kellogg Center
Institute for Children, Youth and
Families
East Lansing, MI 48824 USA
- Infant-Parent Program
University of California, San Fran-
cisco
Contact: Jeree Pawl, Ph.D.
UCSF-SF 6H
2550 23rd Street (9-130)
San Francisco, CA 94110
USA
- Infant Psychiatry
George Washington University
Contact: Irene Chatoor, MD
Children's National Medical Center.
11 Michigan Avenue, N. W.
Washington, DC 20010
USA
- The Infant Parent Institute
Contact: Michael Trout
328 North Neil Street
Champaign, IL 61820
USA
- Crisis Intervention of Mother-Infant
Relationships
Tokai University, School of Health
Science
Contact: Rynji Kobayashi
Bchesidai, Isehara, Kanagawa
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- Quality Infant/Toddler Caregiving
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- Children of Drug-Addicted Mothers
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University of Michigan
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- Infant Mental Preventions and
Cognitive Development
Contact: Eliana Bensusan
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URUGUAY
- Mother-Infant Interaction-Psychoso-
matic Disorders
Facultad de Medicina
Contact: Marina Altmann de Lituan
J. M. Montero 3096
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URUGUAY
- Drug Exposed Infant Project
Leake and Watts Services, Inc.
Contact: Pickens Moore, MSW
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Yonkers, New York 10705
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- Prevencion Interacciones tempranas-
prematuros-trastornos de
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Clinical Psychology Program
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Cross Cultural Studies on Infancy
Universite Rene Descartes Paris V
Contact: Prof. Helene E. Stork
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FRANCE

Infant-Parent Psychotherapy
Monash University
Contact: Frances Thomson-Salo
12 Powderham Road
Caulfield North, Victoria 3161
AUSTRALIA

Therapeutic Approaches to Parents
and Infants
Tavistock Clinic, London
Contact: Paul Barrows, M. Phil.
Knowle Clinic, Broadfield Road
Knowle, Bristol R54 2TT
ENGLAND

Center for Infancy Research and
Assistance in Developmental Issues
Contact: Miguel Hoffmann, MD
Mansilla 3766
Buenos Aries 1425
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So, as you can see, training in infancy is available at many locations around the world. As our information data base expands, I am certain that additional training programs will be identified. We welcome any information about such programs, but we must have complete addresses and a contact person identified in order to add program descriptions into the data base. Current plans call for completion of the data base project by the end of 1995. So, enjoy NETWORKING with your colleagues in infant mental health throughout the world. This is one way to help to build cultural competence and respect for cultural diversity among the WAIMH membership.

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UPCOMING CONFERENCES

The Royal Australian and New Zealand College of Psychiatrists, Conference, Christchurch, New Zealand, September 6--9, 1995. Theme: 'Early Intervention and Treatment. Contact: Margo Lukes, Tel: 64-3-372-0404, Fax: 64-3-372-0407, email: mlukes@chmeds.ac.nz

Assoc. of Child & Adolescent Psychiatric Nurses, Conference, September 20-23, Orlando, Florida. Includes psychopharmacology institute and train-the-trainer for HIV education. Tel: 1-800-826-2950.

Illinois Association for Infant Mental Health, Annual Conference, Friday, October 27, 1995. Chicago, Illinois. Gloria Johnson Powell, M.D. will speak on understanding culturally diverse families. Information: Barbara Byer: (708) 634 1141

WAIMH 6TH WORLD CONGRESS, July 25--28, 1996, Tampere, Finland. 2nd Call for Papers out in July, 1995 with registration details.

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