

The Signal



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Newsletter of the World Association for Infant Mental Health

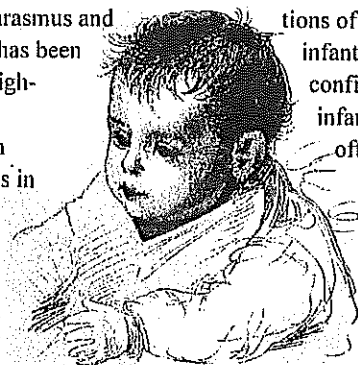
July—December 1996

Failure to Thrive: The Myth of Maternal Deprivation Syndrome

by Dieter Wolke

Historical Background

Poor growth, marasmus and associated mortality has been described since the eighteenth century. The children's hospital on Thomas Coram Fields in London documented that 10,000 of the 15,000 children admitted between 1741 and 1756 died. Early this century, von Pfaundler, at the University of Munich Children's Hospital, was the first to document that children reared in foundling homes under conditions of poor caretaking and hygiene were much more prone to grow poorly (Gedeihstörung - failure to thrive [FTT]). Spitz (1945) and later Provence & Lipton (1962) suggested that lack of stimulation, handling, touch and changing caretaking seemed to explain the poor growth of infants and children in foundling homes. Evidence that toddlers and children showed increased weight gain and recovery after being placed in foster care reinforced the view that failure

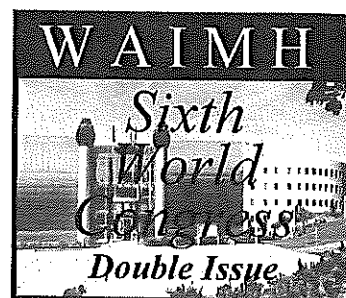


to thrive was due to maternal deprivation.

Case reports and clinical research on referred populations of failure to thrive infants since the 1950's confirmed that mother-infant interaction was often very poor and the parents were reported often to be neglectful. Medical examinations in hospitals indicated that roughly

one third of infants had overt organic reasons for their poor growth while two thirds had no demonstrable organic causes for their growth failure (non-organic FTT=NOFT). Many of the failure to thrive infants were developmentally delayed and this was thought to be caused by poor stimulation.

The clinical research until the mid-1980's was summarized and interpreted in a state of the art book edited by Drotar (1985). The evidence showed that research on FTT was plagued by many methodological problems. Little agreement existed which infants should be considered to suffer FTT (e.g., <5th



The Sixth World Congress of the World Association for Infant Mental Health was held in July in Tampere Finland. Over 1000 professionals from 43 countries attended the meeting and were treated to 530 separate scientific presentations over a 4 day period. These included 40 symposia, 52 workshops, 19 clinical teach-ins, 206 posters, 8 poster workshops, and 22 video presentations. Throughout this special issue are pictures, summaries, derived papers and other references to the Congress as well as the usual articles and perspectives.

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percentile on weight charts, significant drop across weight percentiles independent of where the infant started, weight for height or body mass as alternative definitions; purely psychological indicators of deprivation as diagnostic features, etc.). Furthermore, most studies included preterm infants as well as fullterm infants, others included infants already underweight at birth (small-for-gestational-age [SGA] infants). Some distinguished organic and non-organic failure to thrive, others introduced a third mixed organic group (e.g., NOFT infants who often had infections or other medical problems).

My own review of the literature showed that only 10% of all publications on the topic FTT were based on empirical data. Further, these studies had been conducted on less than 15 empirical samples, including only one study of infants in the community (Mitchell et al., 1980). Much was written about FTT but it was rarely researched systematically. Some papers even made little distinction between different syndromes occurring at different ages: FTT (first 2 years of life), psychosocial or "abuse" dwarfism (>2 years of life), constitutional short stature or pre-pubertal anorexia nervosa.

Still, some of the empirical evidence challenged the maternal deprivation hypothesis. For example, Fryer reported that catch-up growth was up to seven times more likely in organic FTT than NOFT infants, although catch-up growth (in hospitals) was often seen as an indicator of NOFT. The interpretation of findings was often dubious. Few readers would conclude that because acetamenophin reduces fever and flu symptoms, fever or flu is caused by acetamenaphen deprivation. Some clinicians have been happy to accept, however, that because many NOFT infants referred and seen in hospitals

have poor interactions with their mother, this caused NOFT (e.g. feeding disorder) and not vice versa.

The 1980's saw overwhelming acceptance of the thesis that the basis of FTT had to be malnutrition, either because the infant is not given enough food (e.g., neglect), does not take in sufficient food (e.g., food refusal) or does not use what is taken in (e.g., does not metabolize it, quick expulsion due to stress, etc). This suggests that FTT should thus be defined according to anthropometric indices only. This change established a basis for prospective and epidemiological research on FTT and NOFT, something that was urgently needed.

Prevalence of FTT: Epidemiological studies

Epidemiological research or whole population research has distinct advantages to clinical research often conducted in single hospital centers: (1) The prevalence of a condition can be determined with high certainty; (2) Whole population studies are less subject to bias (e.g. selective loss); (3) Prospective case-control comparisons are possible to tease apart which factors are associated, i.e., increase the risk of poor growth.

In 1985, David Skuse, Sheena Reilly and I embarked on the first ever prospective, epidemiological study aimed at identifying the origins of FTT. We monitored the weight gain of all infants born in a geographically defined area in London, Great Britain, during the year 1986. The aim was to identify all infants who were born fullterm, singleton and appropriate for gestational age and whose weight dropped below the 3rd percentile (< 1.88 SD) and this poor growth persisted for at least 3 months and was still present at 12 months of age. Of 1554 fullterm AGA infants, 52 were identified as failing to thrive (3.3%).

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All infants had a thorough anthropometric, physical, neurological and hematological investigation. Only 3 infants were identified to have organic disorder sufficient to explain the growth faltering. All 3 organic FTT infants and only 6/49 NOFT infants had been referred for pediatric or hospital investigation previously. Thus only 9/52 FTT infants were ever referred (17.3%). Those referred (and found in hospital populations) constituted a highly biased group over represented by organic FTT infants and dysfunctional families.

In August 1996, Wilensky and colleagues (Wilensky et al., 1996) reported on a similar community-based study of failure to thrive of a similar sized birth cohort (N=1452) in Israel. Using exactly the same criteria as in our study, they found that 3.9% of infants (54/1452) were failing to thrive confirming the prevalence rate at 3-4%. They also found only 3 cases of organic failure to thrive.

Factors distinguishing NOFT infants: Case-Control Study

To identify the factor associated with NOFT more closely, we wanted to study all 49 NOFT infants. Only 2 parents declined further study participation. The remaining 47 NOFT infants were pairwise matched to 47 normally growing infants according to sex, birth weight, parity, ethnic origin, marital status and neighborhood drawn from the pool of 1507 normally growing infants in the area. All families were visited in their homes for 20 hours for psychological, social interaction, psychiatric, nutritional and toddler oral-motor assessments. Our hypotheses stated that family functioning and mother-infant interaction would be poorer in NOFT than control families. Our findings mostly falsified our preconceptions.

The first set of findings addressed

the question whether NOFT was related to infant functioning. Blind assessments with the Bayley Scales revealed significant differences in the mental development (MDI: cases: 98.2; controls: 108.8) and psychomotor development between the groups (PDI: cases 96.7; controls: 103.6). Nearly identical findings were reported by Wilensky in the Israel sample (MDI: cases: 99.7; controls: 107.2). More detailed analysis of the growth dynamic in the first year of life revealed that those infants who had their onset of FTT in the first 6 months of life mainly explained the poor cognitive outcome while later NOFT (after six months of age) did not significantly affect cognitive development. There was thus

evidence for a sensitive period of early malnutrition on cognitive development likely to be due to detrimental effects on brain development. No differences were found in infant temperament as reported by the parents or the Bayley examiner at 14-15 months. There were also no differences in anemia rates with 25% identified as anaemic in both groups.

We did not detect any differences in psychiatric disorder of mothers and fathers, marital problems or family break-up. Maternal depression and marital problems were frequent in both groups. Wilensky's study replicated these findings also. No differences were also found in maternal IQ. Both case (NOFT: IQ: 83.4) and control mothers (IQ: 86.4) had, on average, low IQ's (WAIS-R full scale score).

Again we investigated whether mothers with infants with early

growth faltering (after 6 months), and the findings were intriguing. Mothers of infants who showed late in comparison to early growth faltering were of significantly lower IQ, had more often anxiety and depressive disorder and social dysfunction and were less socially supported. Mothers of infants with early growth faltering were well

supported and socially well adjusted mothers in comparison to late falterers and control families. Only one difference was detected between NOFT and control families: the households of NOFT families were more disorganized and dirty (YUK-index).

We investigated the growth patterns since birth of all siblings of cases and controls in our study. All information came from child health or

"well baby" clinic records. The search revealed that 54% of siblings of NOFT infants had shown some degree of growth faltering within their first postnatal year, and in 32% it was relatively severe although not necessarily sustained for as long as in the probands. There was thus evidence for a familial pattern of growth failure.

We invested much effort, time and resources in assessing mother-toddler interaction during feeds (FIS, Feeding Interaction Scale) and play situations (POSER, Play Observation Scheme and Emotion Ratings). All analyses were done blindly from videotape and with high inter-observer reliability. We did not find any significant differences in maternal, infant and joint behavior during feeding. In contrast, statistically significant but only small differences in play behavior across five different play episodes were found. NOFT

OUR HYPOTHESES STATED THAT FAMILY FUNCTIONING AND MOTHER-INFANT INTERACTION WOULD BE POORER IN NOFT THAN CONTROL FAMILIES. OUR FINDINGS MOSTLY FALSIFIED OUR PRECONCEPTIONS.

mothers were slightly more controlling and their infants mouthed toys more often and were poorer in communicating their needs. The interactions in both NOFT and control group were very poor and characterized by a lack of verbal communication. Despite these overwhelming similarities in interaction, infants in the control group did show growth failure.

We were puzzled by this lack of statistical difference in family problems and interaction. Furthermore, dietary analysis based on a food diary indicated no differences in food offered between NOFT and control infants. Nutritional diaries can be unreliable. We had also counted every teaspoon offered and every teaspoon accepted during the videotaped feed and scraped off all lost food after the feed to estimate food intake. The detailed video analyses showed that there were no differences in teaspoons of food offered and consumed between groups. However, the food offered to NOFT infants was of lower calorie value in the NOFT group. If calories per kg body weight were computed, all differences disappeared again. Thus the food intake of the NOFT infants did not allow them to show catch-up growth (which requires over-feeding) at the intake level.

There was thus an indication of lowered intake but how could this be explained? The infants received food which was lower in texture (e.g. puree rather than solid food). A newly developed oral motor test (SOMA) consisting of offering different

textures of food in a standard fashion by an examiner was videotaped and analyzed. We found that NOFT infants had highly significantly more often subtle oral-motor problems than control infants. Furthermore, the feeding history revealed that NOFT mothers tended to breast-feed for longer in the first year. The NOFT infants were more often "good babies" who started to sleep through the night already in the first few weeks of life. Detailed analysis indicated that those who slept throughout the night early and were not awakened by their parents for feeds at night, showed particularly poor growth. Wilensky and colleagues also reported that the failure to thrive tended to fall asleep while breast-feeding more often, had slept through scheduled feeds more often and additionally had refused solids more often.

We were still puzzled by the absences of differences in videotaped feeding interactions and thus looked at whether any factors, independent of case-control status discriminated the interactions. We found that maternal IQ and infant developmental status were strongly related to interactional style. The lower the IQ of the mothers or the lower the developmen-

tal status of the infants the poorer (less appropriate, sensitive, more controlling etc.) were the interactions. Maternal IQ and infant developmental status strongly determined interactional synchrony. The interaction rating schemes was highly discriminating and clearly worked. The effect size by maternal and infant IQ was

moderate to large. We wonder how many studies of interactional differences between at risk and controls may be an artifact of differences in IQ and infant developmental status.

To validate or challenge our findings, we invited two graduate students from the University of Regensburg to analyze the tapes according to our and more interpretative coding scheme of quality of interaction developed by Biringen. The analyses were supervised by Gottfried Sprangler of the Grossman attachment research group. The analyses confirmed that there was a lack of difference in maternal and infant behavior during feeding and again, significant but generally small, difference in reciprocity and sensitivity during play interaction. A further interaction assessment at 5 years with the AMCIES-scales which we had pioneered in a different study with 1,500 children, also revealed no interactional differences. Again repeat analysis with the Biringen rating system by the Regensburg group mostly confirmed our findings.

Did we miss any link to parental abuse (i.e. neglect) which would only show up over time? Margaret Lynch, a child protection specialist, monitored the records of the child protection register for sexual, physical or emotional abuse, neglect or grave concern an all minutes on case conferences of all children of our 1986 birth cohort. Altogether 2.5% of children of the 1986 birth cohort were registered and a further 1.2% had case conferences not leading to child protection registration by the age of 4 years. Of the NOFT group, 4 infants were registered (9%) and a further 2 (4%) had been subject to a case conference only. There was thus an increased risk for later serious parenting deficiencies, but previous research has vastly overstated its

WE WERE STILL PUZZLED BY THE ABSENCES OF DIFFERENCES IN VIDEOTAPED FEEDING INTERACTIONS AND THUS LOOKED AT WHETHER ANY FACTORS, INDEPENDENT OF CASE-CONTROL STATUS DISCRIMINATED THE INTERACTIONS.

parenting deficiencies, but previous research has vastly overstated its importance. The small minority of cases that led to grave concern are most likely those who are referred and seen in hospital.

We had also employed the HOME Scale and rated it during the family interview. Using this much coarser instrument to rate the relationship, we did find consistent differences between the groups. NOFT mothers were less stimulating and involved with their toddler during the home visit and less organized. Similarly, less stimulation and verbal and emotional reciprocity were found in the Israel study. Thus while NOFT mothers interacted similarly well during feeds and structured play observations (potential for interaction) there were indications that they were less stimulating and involved during daily routines.

Finally, we investigated using a newly designed instrument (Perception of Body Schema, POBS) maternal preferences for infant body shapes and adult female body shapes. Case reports had suggested that mothers with eating disorders (e.g. anorexia nervosa) may put infants at risk for NOFT. Mothers of NOFT infants indeed preferred slimmer infants. However, this difference in preference compared to controls was not due to NOFT mothers disturbed body perceptions (e.g. eating disorder mothers). Rather NOFT mothers who perceived themselves to be overweight and were overweight preferred slimmer infants. Some of these

mothers commented spontaneously that they had problems controlling their own diet but they could make sure about their infant's diet.

A Myth Dispelled: Where Do We Go from Here?

The most significant finding from a public health perspective originating from our, Wilensky's and other projects (e.g. Grantham-McGregor) is the result that early growth faltering is an indicator of cognitive delay. The risk for later cognitive development has to be taken seriously.

The most surprising findings from our and the Israel study is the evidence that families of NOFT infants are generally *not* different from those of normally growing infants. There was little evidence of maternal deprivation,

neglect and abuse. This is deviating very much from the clinicians (and our own clinical) experience. We get NOFT infants referred who often refuse food and have parents with most inappropriate parent-infant interaction patterns. How can we start to reconcile clinical experience with our empirical findings? Most NOFT cases never reach our clinics. Those that come to specialist services are those *with organic or severe and multiple behavior and family problems* and often are known to social services. Clinical samples are severely biased and do not allow us to make conclusions about etiology! Maternal deprivation is *not* a general cause for NOFT other than in a small minority of cases. It is a myth rather than reality!

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But if maternal deprivation or neglect does not explain NOFT in most cases, what does? Our findings suggest that there are several subgroups of NOFT infants and that there are multiple pathways all leading to malnutrition. The risk factors are usually subtle. Our results suggest:

- That those "easy" or "sleepy" infants who start sleeping through the night almost immediately after birth (and may be weaker in their sucking and more often hypotonic) and are not wakened for feeds, learn to go without food for long periods, often 10 or more hours in early life. Their appetite (hunger-satiety) regulation system is reprogrammed. Clinically it always amazed me to see NOFT infants who just did not seem to mind whether they got food or not—they rarely showed hunger.

- Infants with subtle oral-motor problems have more problems of graduating to higher textured food and are more often exclusively breast-fed for longer periods. Exclusive breast-feeding after 6 months is often insufficient to maintain adequate growth.

- Another subgroup, possibly because of oral-motor problems become food refusers (but remember most food refusers grow normally).

- A small subgroup of overweight mothers who practice vicarious dieting with their infants.

- Only a very small subgroup (but mostly seen in clinic) are actually neglected or deprived leading to NOFT.

Our study design cannot answer the question whether the cognitive deficits (if shown to be robust over time) are the result of the effects of malnutrition on brain development (e.g. reduced dendrite branching) or poor stimulation in the parental home

factor (e.g., genetic influences). The later may imply that any behavioral differences in NOFT infants (e.g., missing feeds) are a result rather than the cause of cognitive deficits.

There is still a lot to discover about this mysterious syndrome called Failure to Thrive. As growth faltering is the defining feature and malnutrition the pathway to poor growth in infancy, closer attention to early oral-motor behavior and feeding practices appears to be warranted in future research.

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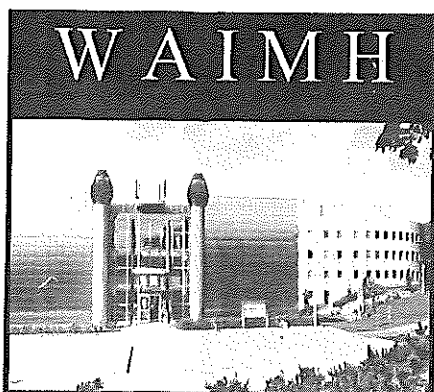
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Editor's Note:

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Sixth World Congress Highlights



Moomintroll

Summer was in full swing in Moominvalley when Moomintroll began to get an inkling there was something special about these tourists he kept seeing around the valley.

As he sat mulling over the difference, he heard a familiar whistle coming from beneath his window. Snufkin! Moomintroll raced down the stairs to meet his friend who was prone to go off wandering whenever the mood seized him, but who always came back to Moominhouse.

"Snufkin, you're back!" He shouted, deeply happy at Snufkin's return.

"Back indeed," said Snufkin. "Let's go exploring."

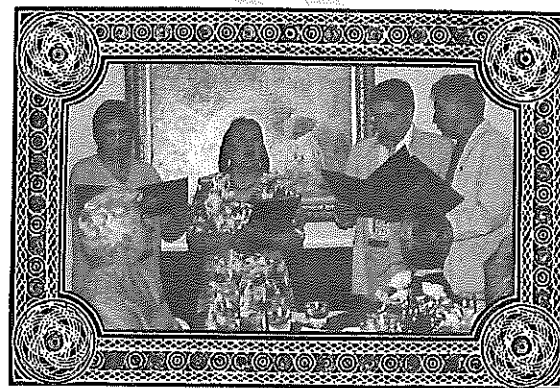
"I was just thinking about all those tourists with babies on their name tags strolling by the River. Let's go take a look. I'll go tell Moominmamma."

He returned a moment later, puzzled. Moominmamma, the heart of a large and 'there's always room for one more needy soul' household, was nowhere to be found. Slightly worried, he wrote a note and off they went. As they neared the crowd, they realized the main activity was in the crystal building. So in they marched following a stream of visitors into a large hall. They sat down in the back and scanned the crowd.

Of all things! There in the front row sat Moominmamma, pocketbook on her lap. Signaling with all his might, Moomintroll finally managed to get her attention. They looked at each other a long minute and smiled. Then she turned her attention back to the speaker who was talking about nurturing relationships between babies and their parents.

"I know why these people are different." Moomintroll whispered to Snufkin. "They're like Moominmamma—they want everyone to feel like they belong to someone special."

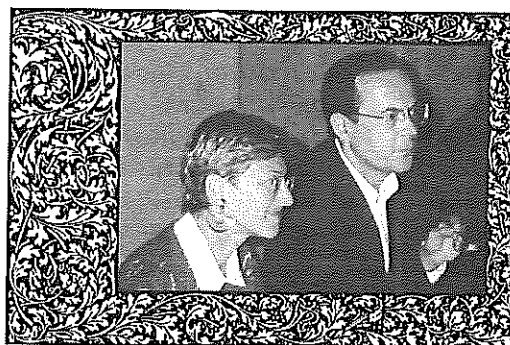
Singing psychiatrists during an evening program



Hisako Watanabe and Eleanor Galenson



Above, L-R, Rifkat Mukhamadrakimov, Joy Osofsky, and Elena Kozhevnikova



Nicole and Antoine Guedeny



Sixth World Congress SESSIONS

Tampere-talo

THEORIES OF INTERVENTION

Plenary: Daniel Stern, Switzerland

Chair: Serge Lebovici, France

Discussants:

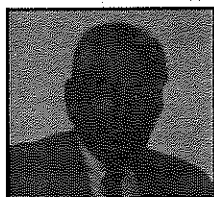
Robert Emde, USA

Peter de Chateau, The Netherlands

Bernard Golse, France

Miguel Hoffman, Argentina

Tuula Tamminen, Finland



In the opening plenary of the Sixth World Congress, Daniel Stern presented his theory of

infant-parent psychotherapy. He proposed that infant mental health has brought forth a new kind of patient (the infant-parent relationship) and suggested that this is inexorably leading to a new kind of treatment. Despite a variety of approaches in infant mental health, Dr. Stern sees a number of unifying features and even suggested that the therapies are being shaped by the populations to whom they are applied. He went further to suggest that the commonalities are more important change agents than the particular or unique features of different types of psychotherapies. Even more provocatively, he asserted that there is probably a rough equivalence of effectiveness among various approaches. A lively discussion of questions sparked by the plenary address ensued, many of which we hope will appear in future issues of *The Signal*.

TECHNIQUE OF MOTHER-INFANT THERAPY

Plenary: Bertrand Cramer, Switzerland

Chair: Hisako Watanabe, Japan

Discussants:

Elizabeth Tuters, Canada

Dilys Daws, United Kingdom

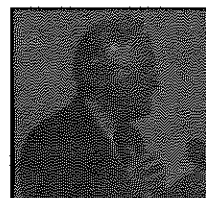
Klaus Minde, Canada

Susan McDonough, USA

Dr. Cramer began his presentation by explaining why an emphasis on technique might seem problematic. First, research has shown rather consistently that outcome differences for different schools of psychotherapy are difficult to find. Second, therapists deviate in their practices from what is described as the orthodox position of their technique. Third, the so-called "non-specific" factors in therapy may be especially powerful.

Nevertheless, given that different technical approaches are employed, it may be useful to explore different techniques as they are practiced and lived rather than as they are described. To illustrate his points, Dr. Cramer showed videotaped excerpts from two different therapeutic approaches used at the child Guidance Clinic in Geneva.

The first was Psychodynamic Psychotherapy, illustrated by a case treated by Dr. Cramer. A 13 month old girl with a severe sleep problem and her mother were seen together by Dr. Cramer. The case illustrated Dr. Cramer's rapid identification of the core conflictual theme, in this case the mother's feeling that "there is no place for me," and linking up this theme



with the mother's past relationships and her current relationship with her daughter.

The second treatment involved a 12 month old boy and his mother who were treated by Sandra Serpa, a therapist at the Guidance Clinic in Geneva, using the Interaction Guidance approach. This boy had bouts of "spastic bronchitis" each time his father went away on a business trip. The treatment involved identification of a pattern of interactive behavior in which the mother made the boy "go his own way." This pattern was used to explore the mother's wish that the boy grow up fast and become independent.

Dr. Cramer discussed similarities and differences in these two approaches. There is rapid identification of a central conflict and communication about this conflict to the mother in each technique. There is careful attention to the facilitation of a therapeutic alliance in both approaches. Nevertheless, there is more attention to negative affect in psychodynamic therapy and more attention to what the mother is doing well (interactively) in the interactive approach.

A lively discussion ensued with panelists highlighting areas of similarities and differences in their own approaches to similar clinical problems. There were also questions raised about the representativeness of the second case as an illustration of typical interaction guidance.

LESSONS LEARNED ABOUT EARLY INTERVENTION

Plenary: Kathryn Barnard, USA

Chair: Miguel Cherro Aguerre, Uruguay

Discussants:

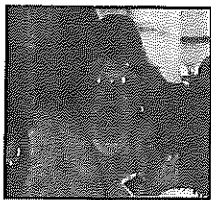
Sonya Bemporad, USA

Joy Osofsky, USA

Yvon Gauthier, Canada

Hisako Watanabe, Japan

Pia Risholm Mothander, Sweden



Dr. Barnard noted that history recounts the plight of children who have suffered from serious

biological and environmental risks. Nevertheless, the field of prevention and early intervention research is barely a century old. In that time there have been numerous studies in which interventions have been implemented and evaluated.

Dr. Barnard discussed several phenomena to be considered in planning successful implementation of early intervention efforts:

1) Parenting Readiness

Appraisal of the parent's capacity, both intellectual and emotional, to understand and to have reasonable expectations of children, as well as provide the necessary nurturing and guidance. She emphasized the need to incorporate an understanding of parents' cognitive and relationship schema when engaging them in early intervention.

2) Generalized versus specific interventions

Identifying a specific target for intervention improves the outcome, asserted Dr. Barnard. She illustrated this point by describing a study in which an intervention to modify preterm infants' states of arousal

during feedings was associated with later differences in parent-child interaction.

3) Specific techniques

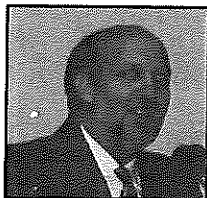
Direct feedback about parent-child interaction may be an extremely important means of changing it. She pointed out the value of video feedback in a number of different studies.

In summary, Dr. Barnard reviewed research documenting important lessons that already can be drawn from extant research in our young field, as well as pointing out important directions for future research. The discussants further elaborated and illustrated many of these points.

EVALUATION AND FOLLOW-UP OF INTERVENTION

Plenary: Peter Fonagy, United Kingdom

Chair: David Lonie, Australia



In the third plenary Dr. Fonagy reviewed some of the findings from a massive analysis that he

and his colleagues conducted of outcome following early intervention. Guildford Press will soon publish this review as a book. Despite major methodological shortcomings in a large number of the studies reviewed, some conclusions about the current state of the art seem warranted. In a look to the future, Dr. Fonagy announced that the age of generic therapies is likely to be over. There will be increasing emphasis on matching treatments and problems, and greater attention to outcomes in a number of different domains of developmental psychology and psychopathology.

PRESIDENTIAL ADDRESS: "ON THE OUTSIDE: INTERVENTIONS WITH INFANTS AND FAMILIES AT RISK"

Presenter: Joy D. Osofsky



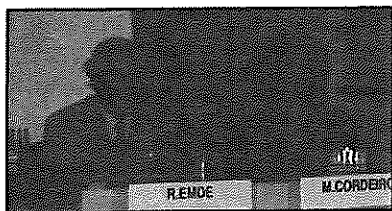
Dr. Osofsky pointed out that preventive interventions begun early in life are the most effective means

of ensuring that a child has a chance for a normal course of development. Interventions will be most effective when they are systems-based, taking into account all of the complex environmental and family factors that can influence an infant's development. She asked us to consider what some of the risk factors are that may keep infants "on the outside" and make them at high risk for problems in development? These include: poverty, adolescent pregnancy and parenting, medical risk, including prematurity and perinatal risk, drug exposure, exposure to violence. In this address, several of these risk factors and preventive intervention programs to address them were vividly illustrated with videotaped examples of programs in Brazil, Russia, Latvia, Japan, and the United States. Different types of evaluations of the effectiveness of preventive intervention programs were discussed including the methodological complexities of carrying out such evaluations. Dr. Osofsky concluded that it is important to build links among research, clinical work, and policy. Further, social policies and individual service programs should be based on an appreciation of the complexity of human development. The most promising interventions are those that are systems-based and

ecological in nature. These programs will target not children in isolation, but rather children in the context of family, and children and families within communities.

DIAGNOSTIC CLASSIFICATION WORKSHOP

Chairs: Robert Emde, USA
Maria Cordeiro, Portugal
Reported by: Robert Emde



*Robert Emde and
Tuula Tamminen chair a panel*

Over 400 interested clinicians attended the Diagnostic Classification Workshop held on the day prior to the Sixth World Congress. Incentives for the all-day meetings were multiple. They included: 1) the publication in North America of Diagnostic Classification: Zero-to-Three that provides coverage for this age group which is not sufficiently considered in either ICD-10 or DSM-IV; 2) the recent activities of a European working group on diagnostic classification; and 3) worldwide interests in applying Diagnostic Classification: Zero to Three, as well as in assessing its usefulness and contributing future experience that will yield an integrated system.

The format, organized by Maria Cordeiro and Robert Emde, consisted of three panels with multiple brief presentations on pre-arranged topics, with each presentation followed by

general audience discussion. The first panel emphasized experience with diagnostic classification in North America, using the published system. It included the following presentations: The Diagnostic Process and the Development of DC: 0-3 (Bob Emde); the Use of the Clinical Record Form and Experiences in Using the System (Jean Thomas); Assessing Relationship Problems (Roseanne Clark); the Application of Diagnostic Classification: Zero to Three in Pediatric and Non-psychiatric Settings (Kathryn Barnard); Assessing Levels of Relationship Disturbance: The Parent-Infant Relationship Global Assessment Scale (PIRGAS) (Charles Zeanah).

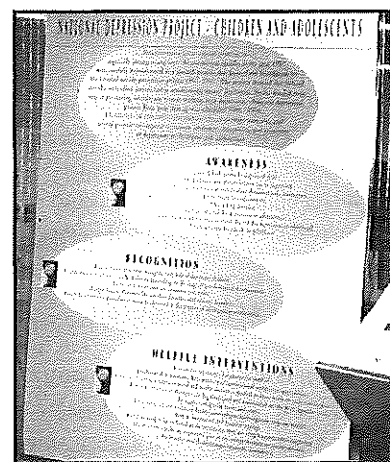
Panel 2 emphasized a European perspective on assessment. Chaired by Maria Cordeiro, it included: "General Issues in Clinical Use of DC: 0-3 (Pedro Caldeiro); An Austrian Field Trial with DC: 0-3 (Marguerite Dunitz); Assessment Tools (Mechthild Papousek). Discussants for this Panel included Philippe Mazet and Martin Schmidt.

A third panel was entitled "Cultural Contexts and Future Directions in Diagnostic Classification." Chaired by Tuula Tamminen, it included presentations by Salvador Celia, Hisako Watanabe, Miguel Hoffmann, Susan McDonough, Joy Osofsky, and Tuula Tamminen.

Audience discussion was active and vigorous following each panel's set of presentations. A final session of the workshop had general discussion on proposals for the future. Participants emphasized the need for assessing reliability of our diagnostic classification categories for sharing such information. Discussions also concerned needed studies of validity. In addition to documenting the usefulness of the system, we need to do studies of prediction, as well as

convergent and divergent validation, using a variety of assessment devices. Concerns were expressed about not "mother blaming" or encouraging unwanted labeling effects in our classifications. We need to remember we are classifying disorders, not people. Most of our work involves assessment of individuals and then diagnostic classification for disorders. Others emphasized the desirability of using multiple contexts for observation and reporting. We are often dealing more with identifying risk than we are classifying disorder. Moreover, we are often assessing individuals for strengths, as well as vulnerabilities.

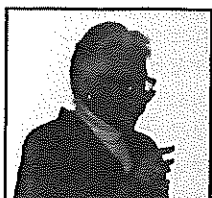
Still others in the discussion emphasized the importance of cultural values in diagnostic assessment. The use of our multi-axial system can help us to realize that there is a bi-directionality of effects between the developing infant and the environment, as well as between social factors. Others emphasized that every diagnostic assessment is an intervention; multiple contacts are often important for assessment and can prove beneficial in terms of "being with" young children and families.



*One of the many well-designed
posters displayed at the Congress.*

SOCIAL AND PUBLIC POLICY STUDY GROUP WORKSHOP

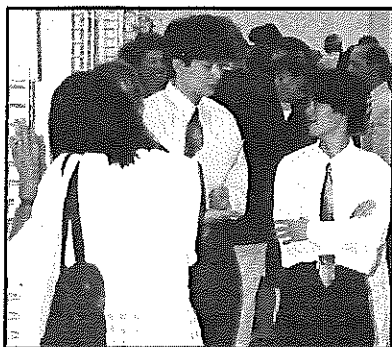
Chair: Sonya Bemporad



A pre-meeting workshop organized by Sonya Bemporad, a IAIMH past-president and

current Chair of the Study Group on Social and Public Policy, was attended by over 75 infant mental health professionals. This workshop afforded the opportunity for clinicians from vastly different (and similar) settings around the world to attempt to prioritize the social and public policy issues most important to them. In an ambitious group exercise, Dr. Bemporad had participants generate and organize the issues most salient to them. A complete collation and prioritization of these efforts will be distributed to members of the Social and Public Policy Study Group soon.

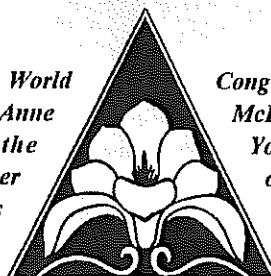
It became clear to the participants in this exercise that despite many differences in culture and setting, there are universal struggles for infants and their families and for the mental health professionals who work with them.



Poster sessions provide time for informal interactions.

YOUNG INVESTIGATOR AWARD

*At the Sixth World
Congress in Tampere,
Finland, Dr. Anne
awarded the
Award for her
achievements
her doctoral*



*Congress in Tampere,
McDonald Culp was
Young Investigator
outstanding career
since receiving
degree.*

Dr. Culp is currently an associate professor in the Department of family Relations and Child Development at Oklahoma State University. The award was given in part for her work in implementing and evaluating a parenting intervention program for low income adolescent mothers. The intervention program was designed to improve knowledge in parenting skills and child development and ultimately to prevent child maltreatment. The recently completed five-year program was supported by grants totaling \$ 1.1 million from the US Department of Agriculture, the OSU Cooperative Extension Service and the Oklahoma Department of Health, Office of Child Abuse Prevention.

PROGRAM DESCRIPTION

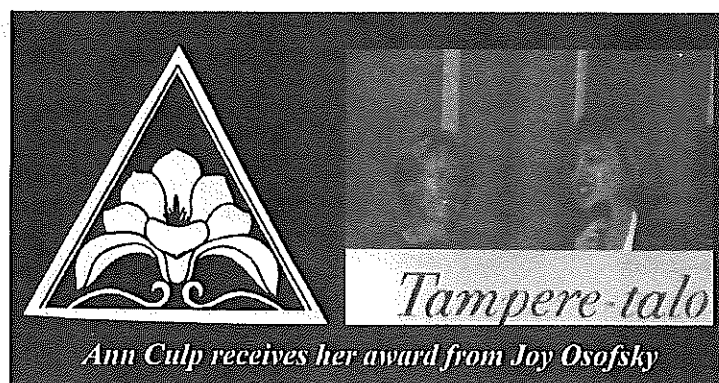
For the first year of life, each family was visited in the home for one hour each week. When the child became one year of age, the visits were every other week until the child was 18 months of age. After the child was 18 months of age, the visits were once a month and continued on a monthly basis until the child entered an Evenstart or Headstart program.

Parent Educators provided weekly in-home education using a manualized, yet individualized, curriculum on parenting skills, child development, home safety and information on available community resources. Prior to being assigned a family, the Parent Educators received a minimum of 30

classroom hours of training. Training sessions were conducted by Coordinators, holding masters degrees, and additional members of the Community Parenting Coalition. The Parent Educator devoted two hours a week per family. The two hours included time for preparation, travel, making the in-home visit and supervision. The curriculum's goal was to enhance both the parent's and child's development and to foster a positive parent-child relationship. Specifically, the curriculum was designed to help parents: link to community agencies, develop parenting and guidance skills, learn ways to enhance their child's development, develop reasonable expectations for their child, and to arrange a safe environment for their child.

The one-hour in-home visit was composed of four parts: a parenting lesson, child development lesson/modeling, parent time, and selection of next visit's parenting topics. The Parent Educator strove to complete all four parts at each in-home visit. Most importantly, the infant was part of each in-home visit. The curriculum was designed for first-time parents and was used by a Parent Educator as she met individually with the mother and her infant in their home. The parenting topics were numerous including expectations, discipline issues, teen parenting, financial management, finishing school, getting a job, and transportation to name a few. The child development topics included crying, bathing, sleeping, feeding, exploration, talking, toilet training, child guidance and discipline. Over thirty specific topics on child development/parenting were in the forms of lessons, such as "Your Baby Likes to Be Talked To," and "Your Baby likes to be Held," and "Your Toddler Likes Limits."

Each mother's needs were assessed individually. The Parent Educator asked the families what services they were currently using and what services they were interested in using. Following this needs assessment, the Parent Educator facilitated linking the family with available community services. Ongoing training and supervision occurred weekly for at least one hour. Half of each



weekly meeting was set aside for each Parent Educator to report on each family. The other half of the weekly meeting was devoted to training on specific issues, such as cultural sensitivity, separation anxiety, toilet training, and child

guidance and discipline and available community resources. At least one community professional (social worker from Department of Human Services or nurse from the Health Department) attended the meetings at least twice each month. This was extremely important because of the program being community based requiring more than one agency's involvement. In summary, after the mothers agreed to participate in the program and had signed an informed consent form, her Parent Educator was introduced to her. The Parent Educator met with each family assigned to her individually on a weekly basis. At each session, the Parent Educators provided teaching activities, modeled parenting interaction activities, and provided referral sources to the mothers.

Findings—After six and twelve months in the program the mothers improved their knowledge of infant development, improved their understanding of empathic responsiveness, improved their understanding of child and parent roles in the family, improved the safety of their homes, and increased their involvement in the number of agencies in the community. Prior to intervention, the adolescent mothers compared to the nonadolescent mothers had significantly lower scores on infant development knowledge and parenting skills knowledge in the areas of empathy and child/parent roles.

After six months of intervention, the adolescent mothers improved their scores but continued to score lower, not significantly, on infant development knowledge, understanding alternatives to corporal punishment, and parent/child roles. Clearly, from these data, the adolescent mothers start out with less knowledge on infant development, empathy and child/parent roles than nonadolescent mothers; however, they increased their knowledge following intervention approaching the level on

nonadolescent mothers. The adolescent mothers did not differ from the nonadolescent mothers on the safety of their home. Both groups of mothers started with low scores on safety and improved their scores following intervention. In addition, the adolescent mothers did not differ from the older mothers on their use of community resources.

The Parent Education/Home Visitation Program model used paraprofessionals to make weekly home visits to the mothers and to link the mothers with community agencies, to explain the needs of children; to teach appropriate parenting responses and to model the role as parent being separate from and different from the needs of their child in the family. The model seems to help both adolescent mothers and nonadolescent mothers even when the adolescent mothers begin the program with less information on child development and parenting than nonadolescent mothers.

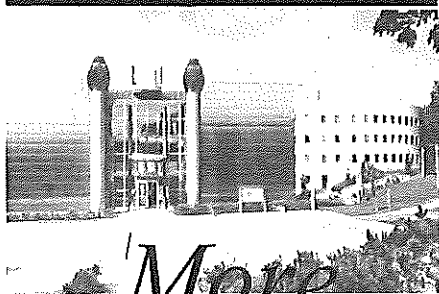
Currently, Dr. Culp is involved with research teams at the National Center for the Prevention of Child Abuse and the Oklahoma State Department of Health Office of Child Abuse Prevention; is actively involved with the Oklahoma state legislators, and is a co-principal investigator with Dr. Laura Hubbs-Tait and Dr. Rex E. Culp on two federally-funded projects one by the National Institute of Mental Health and one by the Administration of Children, Youth and Families. The two grants will help determine the parental characteristics and parenting practices that promote good cognitive, social and emotional adjustment of 4-year old Headstart children as they enter kindergarten and the first grade.

Previous to her current position at Oklahoma State University, she had the privilege of being mentored by Dr. Robert Harmon while at the University of Colorado School of Medicine, Dr. Joy Osofsky while at The Menninger Foundation, and Dr. Marion O'Brien while at The University of Kansas. In addition, she has had the honor to work with Dr. C. Henry Kempe, Dr. Lucile Ware, Dr. Lula Lubchenco, Dr. Mabel Rice, and Dr. Aletha Huston.

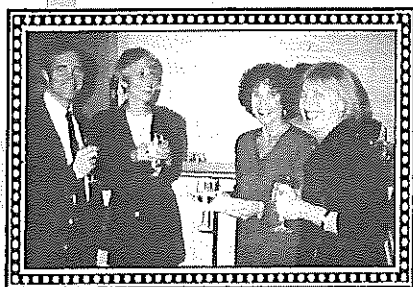
Dr. Culp has published in the areas of premature infants, adolescent parenting, adolescent depression and self esteem, and infant language development.

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WAIMH



More Congress Highlights



*Charley Zeanah, Susan McDonough,
Tuula Tamminen and Joy Osofsky*



Poster workshop attendees



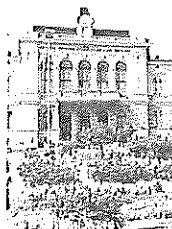
Justin Call (left), recipient of the WAIMH award as Founder of the World Association for Infant Psychiatry and for his lifetime contributions to infant mental health, chatting with Yvon Gaulhier, newly elected President of WAIMH.



Tuula Tamminen, Planning Committee Chair, addresses the Congress



WAIMH Awardees: Hiram Fitzgerald and Sonya Bemporad (past Presidents of the International Association for Infant Mental health), Robert Emde and Serge Lebovici (past presidents of the World Association for Infant Psychiatry and Allied Disciplines), with Joy Osofsky (first president of the World Association for Infant Mental Health).



Serge and Ruth Lebovici in Tampere





President's Perspective

Yvon Gauthier, MD

I am writing this first President's Perspective as I contemplate the flamboyant colors of our magnificent Canadian autumn. I am remembering the long evenings of Finland's summer and the majestic red pines of that beautiful Northern country. This is the background of my attempt to summarize here some of the thoughts that have stayed with me ever since this most successful 6th Congress and to reinforce the need to use *The Signal* as an important tool for international collaboration.

Evaluation of Early Interventions

The theme chosen by the Program Committee was brilliantly treated by the four plenary speakers. I am awaiting the opportunity to read at leisure their written texts to reach a clearer mind on such complex questions. But I can say that I came out of the Congress with a rather positive feeling. Geneva's research team findings (Robert-Tissot et al., 1996) are most important. The theory of the "motherhood constellation" and of the several ports of entry into the system that Stern has developed out of this research opens fascinating perspectives. Peter Fonagy's and Kathryn Barnard's presentations were the result of vast experience in early intervention with disturbed and disadvantaged populations, and appeared to me to bring a lucid appraisal of the difficulties and constraints involved in treating such populations.

It seemed rather clear to me that positive results are to be expected with more socially advantaged families (Cramer's population) than with disadvantaged ones in which more variables have to be taken under consideration simultaneously, and longer periods of intervention are necessary.

Non-Specific Factors of Change

Evaluation of results brings out the question of specific versus non-specific factors of change. I am one of those who have come to think that those factors called "non-specific," such as emotional availability, empathy, continuity and consistency of the therapist, are also very specifically essential. The creation of a relationship between a therapist and a mother, father, or couple, into which enough continuity allows trust to develop, is a very specific process. From this relationship and trust, change begins to occur, much like a child starts to explore once he has developed a trusting relationship with a mother and an environment that responds with regularity to his basic needs.

Barnard's work strongly suggests the importance of such a factor, particularly with disadvantaged populations, who have so often felt betrayed in their early relationships, and too often also in their earlier attempts to seek help in the system. Their pattern of avoidance can be modified only with patient efforts to rebuild trust.

More Involvement in Public Policy?

A new experience took place this summer in comparison with previous congresses: a group of 75 participants spent an afternoon putting together their thoughts and preoccupations about child protection and child care under the expert leadership of Sonya Bemporad. Evidently, problems are not exactly the same in each country, but it was interesting to realize that concerns about the "best interest of the child" were very close despite varied legislation and legislators who often seem to place the interests of adults before those of the child's. Over the coming years this public policy group will work to identify and build a consensus of opinion around principles that apply to all children, whatever their origin and culture.

Personally, I can't help seeing links between those children raised outside of the continuity of parental ties and those who are profoundly traumatized by the brutal loss of their parents in one of those countries still caught up in civil wars. Infants and young children of Bosnia and Rwanda, or of Algeria, are not usually seen in the tragic images that the media show to us, but we all know that they are somewhere, suffering and incorporating images and affects of grief, of withdrawal, of aggression and violence which are certainly stored in their fragile minds, until the time that they will come alive again, probably in a very threatening manner. We are not a political organization. But we have to wonder to what extent we should become more involved in these problems and use the power that we may have to convey the principles which are at play.

Parentless Children In Hospitals

This question has been brought to our attention through activities at the Congress, and in the paper published in a recent issue of *The Signal* (see April-June 1996). I was particularly moved by Dr. Ertem's study of these children in her own country of Turkey, and it brought to my mind memories of a very similar situation in which I was caught when I returned to my own pediatric hospital after years of training in the USA.

Teachers' and hospital administrators' attitudes and reactions described by Dr. Ertem are very similar to what we had to live through in Montreal in the early 1960's. I must say that it took us a good 10-15

years to change mentalities which are deeply ingrained and much reinforced by high technologies and can't be changed rapidly. But I can testify that change is possible: Parents are all over the place in our hospital now. They often sleep in the hospital close to their child; they participate in the child's treatment; and they can touch and hold their premature infant. Such presence and participation were gradually won over strong resistances.

I bring this question to the fore, as a good example of how *The Signal* can be used to bring our attention to questions and problems at the core of infant mental health and affective development but which are lived differently in varied countries and cultures. I strongly hope that mem-

bers of WAIMH will use this bulletin to bring to light their problems and preoccupations. WAIMH certainly can thus play the essential role of promoting communication across cultures on infant mental health problems, and of helping one another find the best solutions for infants, young children and families.

Reference

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President's Retrospective

Joy D. Osofsky, Ph.D.

Reflections on my Presidency

Being President of WAIMH for the past 4 years has been a major highlight of my career not only for the honor, but even more for the relationships and friendships with colleagues from around the world that have become an on-going part of my life. The culmination of this wonderful adventure was the outstanding Sixth World Congress in Tampere, Finland. I still have very warm feelings when I think about the meeting and look at the photos in this issue.

During my presidency, I had the opportunity to travel widely, to learn about infants and families in different cultures, and to see our concerns about

infant mental health from many diverse perspectives. What has been striking to me, perhaps surprisingly, has been the similarities across cultures even more than the differences. People concerned with infant mental health issues around the world seem to think in similar ways and "speak the same language," despite linguistic and cultural differences.

Approaches to intervention and treatment are similar. Thus, infant-parent psychotherapy done in Switzerland, France, or Japan looks very similar. Although language and cultures differ—the affect shown, patterns of interaction, and ways to help that infant and parent are very comparable. Intervention strategies in

different countries are tailored to the needs of the people and countries; yet, again, the efforts look more alike than different. I have seen evaluations and assessments of infants and parents from countries such as Argentina, Brazil, or Uruguay that looked similar to those done in European countries and in Japan. In the United States, patterns of evaluation and treatment are comparable. Even efforts to diagnose problems in infancy and in the early relationship can be done in a similar way across these different regions.

So, what does this teach us about infant mental health? Infants communicate their needs in very particular ways. We learn how they are feeling by their affective expressions, by the way they relate and interact with others, and by their behaviors. We can interpret what may be going on in a relationship based on observations that cross over cultural borders. We certainly need our interpreters from different cultures to help us understand what a particular behavior or

pattern of interaction may mean within that culture; however, there is a special "language" of infancy that transcends many differences.

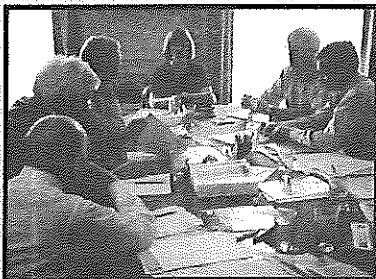
WAIMH is growing and thriving and I look forward to working with President Yvon Gauthier and the Executive Committee to continue its expansion. I anticipate new and innovative ways to communicate electronically in the future so we can grow closer despite the distances. I look forward to sharing infant mental health concerns with colleagues around the world over the Internet on the List Serve and on our Home Page. I will continue efforts to facilitate regional activities at the request of the President as I did during my tenure as President. I will also be continuing as Editor of the *Infant Mental Health*

Journal, soon to be expanding with more emphasis on clinical perspectives in addition to scientific, research, and intervention work. I anticipate exciting activities for WAIMH. The Congress in Finland gave a boost to the evolution of affiliate groups and I know that plans for the Seventh World Congress are already well underway.

Many thanks to my Executive Committee (Yvon Gauthier, Serge Lebovici, Sonya Bemporad, Bertrand Cramer, Miguel Hoffmann, Charley Zeanah, Hisako Watanabe, Hiram Fitzgerald), my Special Advisors (Bob Emde and Peter Fonagy), to my Regional Vice Presidents (Peter de Chateau, Miguel Cherro Aguerre, David Lonie, Keigo Okonogi, Michael Trout, Elizabeth Tutters), and to the 1996 Sixth World Congress Commit-

tee—Program Co-Chairs Peter de Chateau and Antoine Guedeney and Local Arrangements Chair, Tuula Tamminen. A very special thanks to several people who worked very closely with me: Serge Lebovici, Past President; Yvon Gauthier, President-Elect, and Hi Fitzgerald who provides the "glue" to keep WAIMH going and growing in an extremely organized and efficient way. In the meantime, I hope to still hear from many of you and will enjoy working with Yvon Gauthier, our President, and Peter de Chateau, our President-Elect as we move toward the 20th Century.

My warmest wishes and heartfelt thanks to all of you.



In September 1992, the respective memberships of the World Association for Infant Psychiatry and Allied Disciplines and the International Association for Infant Mental Health voted to merge into a single entity, the World Association for Infant Mental Health. Thus did Joy D. Osofsky become the "first" president of WAIMH. Joy not only accepted the mantle of leadership for the newly formed association, but she wore it proudly, with confidence, and forceful enthusiasm for the development and expansion of the organization. During the past four years it seems as though

Ode to Joy: A Job Well Done

Joy D. Osofsky, WAIMH President 1992-1996

there were never more than two consecutive days that I failed to receive an e-mail, telephone, FAX, or mail correspondence from Joy. Joy brought a leadership style to WAIMH that was perfect for the infant organization, thoughtful and caring of the theoretical, cultural, and political diversity that characterizes WAIMH's membership, sensitive to the financial realities of the organization, and deeply committed to extending the infant mental health concept to a wide and variable international audience. When necessary she executed the authority of her office with decisive decisions that seldom left any uncertainty as to the meaning of the message. Joy was an untiring advocate for WAIMH and was especially interested in facilitating establishment of Affiliate organizations throughout

the world. Mailing Joy packets of membership materials and Affiliate applications was almost a routine office activity and WAIMH can point to Affiliate organizations in Russia, Germany-Austria-Switzerland, France, The Netherlands, Great Britain, and Louisiana as proof positive that her efforts were successful. Joy's creative, decisive, and dynamic leadership was precisely what WAIMH needed in its period of infancy. It was nurtured well. I am sure that I speak for the Board of Directors and the membership when extending thanks and appreciation for her contributions to WAIMH and, therefore, to the field of infant mental health.

—Hiram Fitzgerald
Executive Director



From the Red Cedar

Hiram E. Fitzgerald
Executive Director

are extended to a group of medical students who donned their "blue stripes" daily to provide gracious assistance to presenters, exhibitors, and accompanying persons. Thank you and we hope to see many of

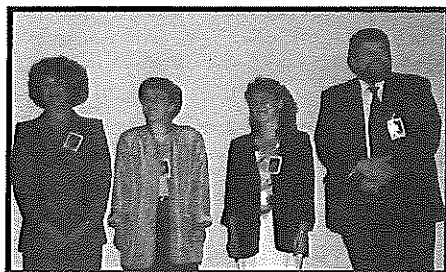
Kiitos Paljon

There are many people from Finland who settled in the northern part of Michigan, known as the Upper Peninsula, as distinct from the Lower Peninsula (a sort of Näsijärvi-

Pyhäjärvi distinction somewhat like Tampere's two lakes). The Michigan Finns are known to be honest, efficient, unpre-

tentious, hard-working people, seemingly bound to the ecology of the *jarvi* (lake) and *metsä* (forest), who know how to celebrate the joys of life without reducing them to the frivolous and commonplace, and who absolutely understand the importance of the *savusauna* (smoke sauna). Perhaps they are mostly descended from the Finnish tribes of the Häme region, whom some historians describe as the most reserved of

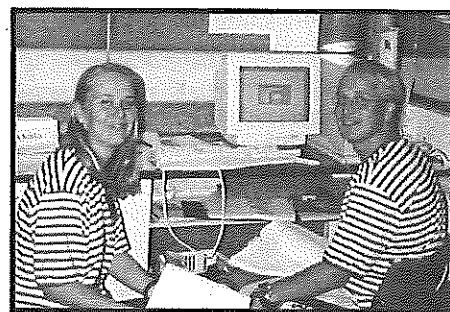
Finland's historical tribes. Because they migrated to the United States in more recent historical times, it is more likely that Michigan's Finns represent an amalgamation of the Savonian peoples' easy going nature, the Karelians' hospitality, and the reserve of the people of the Häme region, which, you see, is the region where one finds Tampere! After working so closely with Tuula



Tuula Tamminen, Pälvi Kaukonen, Kaija Puura and Pekka Antilla

Tamminen, Kaija Puura, Pälvi Kaukonen and Pekka Antilla over the past 3 years, the connection between the Finnish people living in Michigan and those residing in Finland is evident. Key members of the

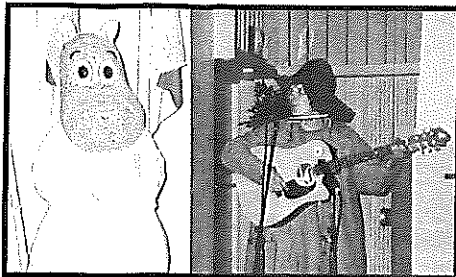
Local Arrangements Committee, this foursome provided attendees with perhaps one of the most outstanding World Congresses WAIMH has yet seen. It takes great energy and investment from many, many people to coordinate the diverse components of a World Congress. And while our thank you's are extended collectively, they are directed to every individual who assisted in any way to help make the congress a success. Special thanks



Blue Stripes assistants

Finland's future pediatricians and psychiatrists attending future world congresses, not as aides, but as presentors of their own scientific and clinical studies of infants and their families.

I especially want to draw attention to the fine work of the Local Arrangements committee. Tuula, Kaija, Pälvi, and Pekka, you simply did a marvelous job in every facet of the congress. The meeting events were on schedule, the food was wonderful, and the evening activities were simply extraordinary. You achieved a perfect blend of Finnish culture with congress activities from the historical photos in the congress booklets, to the concert in the Cathedral of Tampere, a reception by the Mayor and a greeting by the Flower Girl, a Finnish barbecue on the Island Viikinsaari, the wonderful visits by Moomintroll and Snuffkin, and, of course, the delightful exercise routines by the mothers and infants of Majja



Mommintröll and Snufkin entertain

Salo's Children's Music and Play School as well as Ms. Paula Rautakorpi and the mothers and infants with their song and dance routine! Such delightful *Sylimikrot* (laptops). I think that sometimes the scientific and clinical program occupied a back seat to the cultural events, thus reminding us that at the foundation of our work is the mothers, fathers, and infants whom we touch and who touch us, however briefly that may be in the span of life.

I would be remiss if I did not draw attention to the superb program that Peter de Chateau and Antoine Guedeney assembled with the help of their program committee. *Kiitos* for a job well done. I cannot remember a congress where so many people felt compelled to comment positively about the program content, plenary speakers, and overall scheduling of events. Peter and his committee processed over 500 abstracts, a sign of the fact that WAIMH is maturing as a scientific and clinical association. Over 600 non-members attended the meeting and each earned a free membership for 1997 as part of the non-member registration fee. So in one five-day period, WAIMH literally doubled its membership. Hopefully, many of these individuals will continue to be associated with WAIMH over the years after their trial membership ends.

While I am handing out cudo's, Robert Emde and Maria Cordeiro are to be congratulated for organizing an

extraordinarily successful pre-congress workshop on diagnostic classification, as is Sonya Bemporad for organizing WAIMH's Social and Public Policy Study Group and holding its first international meeting. These are the events that will transform WAIMH and guide it toward and into the 21st century.

Miguel Hoffmann's historical committee continued to develop video interviews, thus utilizing modern technology to make a "living" history



Mothers and infants sing and dance

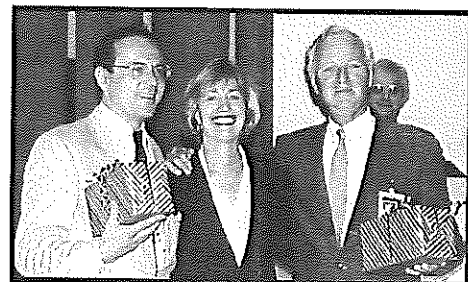
of WAIMH's historical development as well as the field of infant mental health.

While all of these activities were dominating the scene, WAIMH did manage to elect a new Board of Directors (Yvon Gauthier, President; Peter de Chateau, President-Elect; Miguel Hoffmann, Vice President; Elizabeth Tuters, Secretary; Tuula Tamminen, Treasurer; Joy Osofsky, Past President; Hisako Watanabe, Executive at Large; Hiram Fitzgerald, Executive Director), and to set its agenda for the coming years. Joy Osofsky provided exciting news about changes in the *Infant Mental Health Journal*, not the least of which is that its page allocation will increase about 25% but the annual subscription fee will only

increase about 4%. Our new publisher, John Wiley & Sons, seems committed to helping expand the distribution of the journal as well as to supporting its continued development as the seminal journal in the field of infant mental health. Joy also announced that Wiley has asked her and me to co-edit a four-volume *WAIMH Handbook of Infant Mental Health*. The Executive Committee approved the project and with a bit of luck and much hard work, it will be published in 1999 or 2000 at the

latest. I will provide an overview of the agenda in the next issue of *The Signal* as well as the 1996 financial report and 1997 proposed budget. Importantly, we now turn our attention to planning World Congress VII to be held in Montreal, Canada, July 26-30, 2000. I do hope that I will have the pleasure of seeing everyone from Tampere again as well as all members who were not

able to attend the congress this year.
SEE YOU IN MONTREAL.

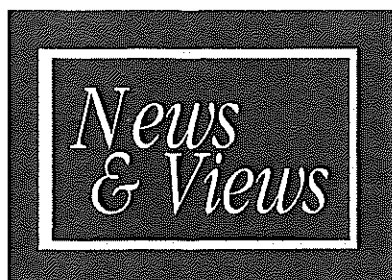


Joy Osofsky presents gifts of appreciation to Congress co-chairs Antoine Guedeney and Peter de Chateau



**WARMEST
HOLIDAY
GREETINGS**

from
**HIRAM FITZGERALD &
MELANIE SMITH**



CONFERENCES

Michigan

The Michigan Association for Infant Mental Health is sponsoring its annual conference, May 18-20, in Ann Arbor, Michigan. Theme for the conference is "Infant-Caregiver Relationships: Broadening Our Perspectives." For information call: 313-764-4276 or fax: 313-764-1557.

Brazil

International Conference of Mental Health: Infant, Child, Adolescent and Family. May 1-4, 1997, Canela, Brazil. Conference theme is

"The Impact of Studies on Prevention and Abuse on Neglect of Infants and Adolescents." Sponsored by WAIMH, IACAPAP, ISAP, FLAPIA. For information call: 55 51 335 1933 or fax: 55 51 330 1134.

SYMPOSIUM

Continuing Care of the Child with Special Needs, April 24-25, 1997, Oakbrook, Illinois. Sponsored by Lutheran General Children's Hospital. For information contact: David Sheftel, MD, Lutheran General Hospital, 847-723-5313.

CERTIFICATE COURSE

Journey of the Next Pregnancy and Parenting of the Subsequent Child. A certification course for professionals working with parents in their child-bearing years. May 5-8, 1997, Abbott Northwestern Hospital, Minneapolis, Minnesota. For information fax: 612-863-4860.

FACULTY POSITION

A full-time, tenure track, graduate faculty position in infancy and early childhood is open at the Erikson Institute in Chicago. The position includes teaching a human development sequence and courses in infant studies, supervising students, and developing an Infant Mental Health component in a well-established Infant Studies Program.

Applicants for this position should send a curriculum vitae, reprints and preprints of their scholarship, a statement of teaching, clinical and research interests, and arrange for three letters of reference to be sent to: Linda Gilkerson, Ph.D., and Robert Halpern, Ph.D., Co-chairs, Faculty Search Committee, Erikson Institute, 420 North Wabash Ave., Chicago, IL 60611. USA

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