

The Signal



Vol. 5, No. 2

Newsletter of the World Association for Infant Mental Health

April—June 1997

GENDER IDENTITY DISORDER

by Sherryl Scott Heller, M.S.

Knowing one's own and others' gender is essential for our everyday lives. It is one of the first pieces of information that we encode when meeting an individual for the first time, and it can be very disconcerting if that individual's gender is unknown.

There are three conceptually different categories of psychosexuality. The first category, *gender role*, is defined as the individual's adoption of the behaviors that a society or culture defines as masculine or feminine (Zucker and Green, 1992). *Gender identity* refers to the gender that one identifies oneself as being, that is, an individual's sense of him- or herself. Finally, *sexual orientation* refers to "whether a person is more strongly aroused by members of his or her own sex, the opposite sex, or both sexes" (Bailey and Zucker, 1995, p. 43). Gender role and gender identity emerge between the



ages of 2 and 4 years, whereas sexual orientation is apparent only after puberty (Bailey and Zucker, 1995).

When the term gender role was originally introduced by Money (1955), it encompassed all three aspects of psychosexuality. Today, this term refers to those behaviors, attitudes, and personality traits that a culture defines as masculine or feminine (Zucker, Bradley, and Sullivan, 1992). The childhood behaviors that are usually investigated in gender role research include the following sexually dimorphic behaviors: gender of preferred playmate (same- versus opposite-sexed), interest in rough and tumble play, toy choices, fantasy roles, and dress-up play (Zucker, Bradley, and Sullivan, 1992). In adolescents and adults, personality traits that demonstrate gender differences (i.e., aggression, nurturing behavior, or language and math skills) or reports of sex-typed behaviors in childhood, are usually the focus of gender role research (Zucker, Bradley, and Sullivan, 1992).

Some researchers distinguish between observed behaviors and knowledge when investigating gender role (Zucker and Bradley, 1995). Some evidence supports this distinction. As children grow older, they become more flexible in their knowledge of gender role behavior; that is, they are more likely to recognize that males and females can both engage in certain gender stereotyped activities or careers (e.g., soldier or nurse). Their actual gender role behavior, however, usually continues to be sexually-dimorphic (Zucker and Bradley, 1995).

Gender identity is proposed to develop across three cognitive stages; gender labeling, gender stability, and gender consistency (Beal, 1994). The first stage of gender identity, *gender labeling*, begins around the age of 2, when the child learns to discriminate between the sexes (Zucker, Bradley, and Sullivan, 1992; Cross and Markus, 1993). By three years, most toddlers are able to identify accurately their own sex and the sex of other people. This distinction between men and women appears to be dependent on appearance (e.g., hair length, clothing attire) rather than biological information (Beal, 1994). Stereotypical beliefs about gender behavior are also present at this age (e.g., toy preference, color preference, aggression, and job types). In the preschool years, some sex-

IN THIS ISSUE

- 9 Infant Mental Health in Russia
- 11 President's Perspective
- 13 From the Red Cedar
- 14 History of WAIMH
- 17 In Memoriam: J. Noshpitz
- 20 WAIMH survey

typed behaviors, such as same-sex peer preference and aggressive behavior, first appear (Fagot, Leinbach, and Hagan, 1986). More specifically, in boys aggression increases and in girls it decreases, and both boys and girls begin to display same-sexed peer preferences (Fagot et al, 1986). Toddlers who are able to label genders accurately adhere more closely to the sex-typed behaviors of aggression and peer preference, suggesting that the knowledge of gender increases one's awareness of gender role behavior. However, early sex-type learning can occur before the use of gender language. Imitation of same-sexed models, for example, is not dependent upon a child's level of gender constancy—the understanding that one's gender cannot change (Lott and Maluso, 1993).

Around 3 or 4 years of age children begin to recognize that *they* will stay the same sex over time; this is termed *gender stability* (Beal, 1994). However, they still do not recognize that biological sex is permanent across situations (e.g., a change in appearance). Preschoolers at this stage still lack the understanding that one's sex is determined biologically and not by outward appearance.

It is not until 5 to 7 years of age that *gender constancy* occurs (Gouze and Nadelman, 1980; Marcus and Overton, 1978). Prior to the development of gender constancy, children understand that one typically does not change sex, but they do not understand that one cannot change sex. Gender constancy is dependent not only on one's knowledge of the deterministic nature of biology regarding sex, but also on children's increasing cognitive capacities (Beal, 1994). Gender constancy develops in association with a child's general level of cognitive development. More specifically, gender constancy has been found to correlate with performance on the Piagetian tasks that

involve conflict between appearance and reality (Marcus and Overton 1978). In general, once gender constancy develops, a child's attention to same-sexed models and avoidance of opposite-sexed behaviors increases.

According to psychoanalytic theorists, the acquisition of gender identity (i.e., gender discrimination, toy preference, activity level, peer preference, and aggression levels) occurs as a component of separation and individuation and is likely consolidated when object constancy, and thus gender constancy, is achieved (Meyer, 1982).

Sexual orientation appears to emerge in men and women after puberty (Bailey and Zucker, 1995). *Sexual identity* refers to the sexual orientation that one identifies him or herself as holding whereas one's *sexual orientation* is conceptualized as being distinct from one's sexual identity. For example, it is possible for an individual to be primarily aroused by homosexual stimuli but to identify himself as a heterosexual (Zucker and Bradley, 1995).

For most people, these three behavioral categories of gender—gender identity, gender role and sexual orientation—are consistent. Most women, for example, display female gender role behavior, hold a female gender identity, and maintain a sexual orientation toward men. Nevertheless, research on sexual orientation and gender identity has found that in some individuals these three aspects of gender are not consistent. For example, some men who have a female gender identity (e.g., male-to-female transsexuals) may also have a male sexual orientation, that is, they are attracted to women.

In childhood, 2 to 5 % percent of the population exhibit cross-gender behaviors and express the desire to become a member of the opposite sex (Bradley and Zucker, 1990). These

Editorial Staff

Editor: Charles H. Zeanah

Production Editor:
Melanie Smith

Editorial Board:

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

President's Perspective:
Yvon Gauthier

From the Red Cedar:
Hiram E. Fitzgerald

The Signal is a quarterly publication of the World Association for Infant Mental Health. Address correspondence to Charles H. Zeanah, M.D., Division of Infant, Child & Adolescent Psychiatry, Louisiana State University School of Medicine, New Orleans, LA 70112-2822. All opinions expressed in *The Signal* are those of the authors, not necessarily those of WAIMH's. Permission to reprint materials from *The Signal* is granted, provided appropriate citation of source is noted. Suggested form is: *The Signal*, 1997, Vol. 5, No. 2, WAIMH.

children are diagnosed as having Gender Identity Disorder. According to the DSM-IV, the diagnosis of GID requires that a child must "perceive him or herself as of the opposite sex or express dislike about his or her status as a boy or girl and desire to change sex," as well as to display this preference in a variety of domains (Zucker, et al, 1992, p. 76).

Most parents report that the onset of GID occurs during the preschool years, however, the average age at assessment is usually 7 to 8 years (Bradley and Zucker, 1990; Zucker and Green, 1991). By middle childhood, chronic peer conflicts and social isolation occur in children with GID, associated with the general behavioral psychopathology (e.g., depression and social withdrawal) that is part of the GID clinical picture (Bradley and Zucker, 1990). The greatest risk for post-pubertal gender dysphoria is among children whose families have a high tolerance for or actually encourage their child's cross-gender behavior, thereby facilitating the child's fantasy (Bradley, 1985; Bradley and Zucker, 1990; Zucker and Green, 1991).

It has been reported that the degree of family approval of the child's initial cross-dressing behavior correlates with a composite measure of cross-gender behavior at the time of clinical intake (Zucker and Green, 1991). As this disorder is even more rare in females, little research on or description of GID in girls is available (Bradley and Zucker, 1990).

Follow-up studies have reported 75 to 100% of GID or feminine boys become homosexual or bisexual as adults (Bradley and Zucker, 1990; Davenport, 1986; Green, 1985). The occurrence of transsexuality has been lower than would be predicted from retrospective studies, but higher than would be expected based on the prevalence of transsexuality in the normal population (Bradley and Zucker, 1990). Thus, GID appears to be a "necessary but not a sufficient

factor in a transsexual outcome" (Davenport, 1986, p. 511).

Research with this population has focused on the traits or characteristics of the GID boys, their peer relationships, family characteristics (especially parental relations), characteristics of the mother, and the mother-son relationship. Less research has focused on the father, but the need for an investigation of his characteristics and his relationship with his son has been acknowledged in the literature (Coates, 1990). The biological factors associated with GID in children have not been widely studied, although there has been research on transsexualism and homosexuality in this area. For a review of the findings as related to GID see Zucker and Bradley (1995).

Characteristics of GID boys Parental report

Some GID children have been reported to be extremely difficult to manage as infants. This disposition could contribute to frustrating parent-child interactions, and, in turn, a lack of certainty in the child's mind about parental affection (Bradley, 1985). Maternal report, as measured on the Child Behavior Checklist, rate GID boys high on both depression and withdrawal scales (Coates, 1990). Mothers of GID boys also report a high incidence of separation anxiety in their sons (Coates, 1990) and a preference, in their sons, for female playmates (Coates, 1990; Coates and Person, 1985). Parents of GID boys, as well as controls, were also found to be more likely than a normal control group to describe their infant sons as physically attractive (Bradley, 1985; Zucker and Green, 1991; Zucker, Wild, Bradley, and Lowry, 1993).

In one study (Zucker and Bradley, 1995), GID boys and girls between the ages of 6 and 11 were found to display a significantly higher level of disturbance as measured by the CBCL (parent report) than non-referred

children (including siblings). Also, GID boys between the ages of 6 and 11 were three times as likely as GID boys 4 to 5 years of age to have scores in the clinical range and GID girls (6 to 11 years) were three times as likely to have scores in the clinical range as GID girls 4 to 5 years old. Although internalizing symptomatology was the prevalent pattern for the GID boys, the GID girls were found to be high on both externalizing and internalizing behaviors.

Characteristics of GID boys: child report

GID boys often score in the clinical range on depression and withdrawal scales (Coates, 1990; Coates and Person, 1985). GID boys report feeling lonely and not liking themselves (Coates, 1990; Coates and Person, 1985) and that their friendships are usually with girls and do not last long (Coates and Person, 1985). In adolescence, these boys report experiencing verbal abuse from peers (e.g., being called "sissy" or "faggot") and a dislike for athletics due to incompetence and having to expose their body to other males (Coates and Person, 1985).

A high rate of separation anxiety, as diagnosed by the DSM-III-R, has been reported in this population (Coates, 1990; Marantz and Coates, 1991 citing Lowry and Zucker, 1990). These boys have been described by clinicians as being extremely sensitive, having a poor tolerance for anxiety, and displaying borderline or narcissistic personality traits (Bradley, 1985; Bradley and Zucker, 1990; Coates, 1990; Zucker and Bradley, 1995). GID boys have been observed to display extreme anxiety, often expressed in the form of fearfulness regarding new situations (Coates, 1990). GID boys have been observed to express a sense of body fragility, thus avoiding rough and tumble play and other typical male activities (Bradley and Zucker,

1990; Coates, 1990). Investigators also have observed an unusual vulnerability to separation and loss, an unusual capacity to maintain positive emotional connection to others, and an unusual ability to imitate others (Coates, 1990).

Family Relations: Parental characteristics

Fathers of GID boys have been found to be withdrawn, psychologically unavailable, and to have difficulty relating to their sons (Bradley, 1985). Clinically, it has been reported that the fathers of these boys do not intervene to help their sons with the anxiety that they often display (Coates, 1990). One study found that a high number of fathers, in their sample of 12, suffered from some type of psychiatric disorder (Zucker and Bradley, 1995 citing Wolfe, 1990). Projective testing indicated that many of these fathers also demonstrated object relations impairments (Zucker and Bradley, 1995 citing Wolfe, 1990).

Mothers of GID boys have been found to have more symptoms of depression and to more often meet the criteria for Borderline Personality Disorder than do mothers of non-clinical control groups (Coates and Zucker, 1988; Marantz and Coates, 1991). In addition, mothers of GID boys more frequently reported feelings of unhappiness during their pregnancy and the first three years of their sons' life than did mothers of a non-clinical control group (Coates, 1990). Prolonged maternal depression in mothers of GID boys often relates to marital dissatisfaction and/or the father's frequent absences (Bradley, 1985).

Mothers of GID boys have described themselves as impulsively seeking companionship, oftentimes becoming involved in intense volatile relationships (Coates, 1990; Marantz and Coates, 1991). They describe their interpersonal relationships as being dependent, manipulative,

hostile, and devaluing (Coates, 1990). These women's view of men was found to be extremely negative and filled with fear and anger; not surprisingly, these women often characterized both their husbands and fathers negatively (Coates, 1990). On the Diagnostic Interview for Borderline Personality (Gunderson and Kolb, 1978), mothers of GID boys, were found to be vulnerable to transient periods of depersonalization, brief paranoia, and psychotically depressed ideation (Marantz and Coates, 1991).

According to Coates (1990), mothers of GID boys tend to describe

were non-clinical controls. However, these two groups of mothers were not significantly different on self-report measures of their own sex-typed behaviors in childhood (Green, Williams, and Goodwin, 1985; Roberts, Green, Williams, and Goodman, 1987). Although no significant differences were found between the two groups of mothers in social and sexual experiences in late childhood and adolescence, within group differences regarding social and sexual experiences were found. More specifically, the degree of cross-gender behavior in the GID



Overall, GID boys describe themselves as depressed and lonely. They have also been observed to be unusually timid, anxious, and highly attuned to others.

boys significantly and positively correlated with the extent of their mother's report of her own adoles-

cent and young adulthood dating and sexual experiences (Roberts et al, 1987). normal boys as troublemakers, to prevent their sons from playing with them, to reinforce quiet, non-active play and to prevent the motoric activity and exploration typical of young boys. Further, rough and tumble activities are viewed, by mothers of GID boys, not only as dangerous and violent but also as resulting in injury to the boys, the mothers, and/or others.

Half of the mothers in one sample spontaneously reported exposure to a traumatic experience. It is unclear if these women experienced extremely stressful life events or more intense reactions to stressful events (Coates, 1990). In the majority of cases, the cross-gender behavior of these women's sons increased in intensity and consolidated as a disorder after the traumatic events occurred (Coates, 1990).

Other research suggests familial transmission of cross-sex-typed behavior in families of boys with GID. For example, mothers of feminine boys were found to be more likely to describe themselves as tomboys than

cent and young adulthood dating and sexual experiences (Roberts et al, 1987).

Parental psychopathology and marital discord have not been found to differ between parents of GID boys and parents of other clinic referred children (Coates, 1990). The specificity of parental pathology and the development of GID in children has not yet been investigated (Zucker and Green, 1991). Although high levels of depression and borderline personality disorder have been found in this maternal population (Coates and Person, 1985; Marantz and Coates, 1991), no study has compared them to a clinical control group.

Parent-child relationships

Some have suggested that GID boys have an overly close relationship with their mother, who also may have gender identity problems, and a distant relationship with their father (Stoller, 1968; 1975; 1980). Yet clinically, an unpredictable mother-

child relationship has been found in this population (Coates, 1990; Coates and Person, 1985; Marantz and Coates, 1991). On the Interview for the Measurement of Symbiosis (Summers, 1978), mothers of GID boys had a parental style which significantly impaired autonomous development in their sons (Marantz and Coates, 1991). These mothers described themselves as being very dependent on their sons, unable to separate from them, undifferentiated from them affectively, intrusive and controlling with them, and disapproving of their sons' relationships with other people (Coates, 1990).

Interestingly, mothers of feminine boys were found to recall spending less time with their sons than the control mothers (Green et al., 1985; Roberts, et al, 1987). Fathers of feminine boys were found, as predicted, to recall spending less time with their sons from the 2nd to the 5th year than the control fathers (Green et al., 1985; Roberts et al., 1987). Nevertheless, quantity of time spent together is not necessarily reflective of the quality of a relationship between a parent and child.

Clinical studies involving GID girls describe a mother-daughter relationship in which the daughter "disidentifies" from the mother (Zucker and Green, 1991). This is argued to be due to parental devaluation of femininity and overvaluing masculinity (Zucker and Bradley, 1995; Zucker and Green, 1991). It has been suggested that femininity was devalued out of the daughter's inability to connect with her mother because she perceived her mother as weak or helpless. It is believed this perception was due to the mother's own history of sexual abuse or affective disorder (Zucker and Bradley, 1995). Thus, the pattern of parent-child relations with GID children appears to differ for boys and for girls.

The unpredictable relationship, noted clinically, between GID boys and their mothers (Coates, 1990;

Coates and Person, 1985; Marantz and Coates, 1991), appears to induce separation anxiety in the GID boy (Coates and Person, 1985). In an environment containing a depressed, dependent, and controlling mother, a withdrawn father, and family dysfunction, it has been posited that cross-gender behavior develops in an attempt to alleviate anxiety. A young boy who is anxious, timid, and fearful resorts to imitation as an attempt to restore ties with the "absent" mother (Coates, 1990; Coates and Person, 1985; Zucker and Bradley, 1995). In this preoperational phase of development, imitating Mommy becomes confused with having Mommy (Coates, 1990; Coates and Person, 1985). This serves to decrease the anxiety generated by the absence of mother. Stress within the families (e.g., parental fighting, or a single traumatic episode), threatens the child's sense of self (Bradley, 1985) and his self-fusion with his mother alters his gender representation (Coates, 1990). This hypothesis is supported by the finding that about 60% of GID boys meet the DSM-III criteria for separation anxiety disorder (Coates and Person, 1985; Marantz and Coates, 1991 citing Lowry and Zucker). However, most boys diagnosed with separation anxiety disorder do not develop GID (Zucker and Green, 1991). Thus, the exact relationship between GID and separation anxiety remains to be elucidated.

Overall, GID boys describe themselves as depressed and lonely. They have also been observed to be unusually timid, anxious, and highly attuned to others. Mothers of GID boys report symptoms of depression and difficulty in maintaining healthy relationships with their spouses. In self-report measures, they depict themselves as holding negativistic views of men and as wanting to prevent their sons from exhibiting typical male levels of activity. These mother's report being highly dependent on and undifferentiated from

their sons. Their maternal behavior appears to be unpredictable and highly anxiety-provoking for these young boys. Father-son relationships are described as distant.

Treatment

In addressing the treatment of children with GID, there is debate not only on the method of treatment but also about the goals of treatment. Those clinicians who believe that it is appropriate and ethical to treat the child in an attempt to eliminate their cross gender behavior fall into to groups: those who advocate behavior therapy and those who advocate a psychodynamic approach. These two theoretical approaches will be described briefly, followed by a discussion of research questions.

Those who believe that the therapeutic intervention should focus on eliminating the cross-gender behavior argue that this is the ethical choice for several reasons (Zucker and Bradley, 1995): (1) reduction of social ostracism, (2) treatment of underlying psychopathology to which GID is viewed as secondary (e.g., anxiety; dysfunctional family dynamics); (3) prevention of transsexualism, given the emotional distress and physically and socially painful measures often taken by adult transsexuals to alter their biological sex so as to match their gender identity, and (4) more controversially, the prevention of homosexuality.

Although not viewed as a mental disorder, it is argued to create social difficulties in an unaccepting culture and by some as immoral. Obviously, this fourth rationale is debated vehemently in the literature.

The behavioral approach to GID follows a social learning perspective and relies on general learning principles to explain behavior (Lott and Maluso, 1993). This perspective argues that children learn gender roles via reinforcement and observation. Furthermore, it is maintained that sex differences in behavior exist because

males and females are differentially reinforced for sex-typed behaviors (Beal, 1994). Social learning theorists view gender as a social category that is constructed via cultural contingencies (Lott and Maluso, 1993). Behaviors known to be differentially reinforced depending on the sex of the child include: toy preference, success and failure, independence, aggression, and verbal communication (see Beal, 1994 for a review). For example, boys receive more positive peer feedback for high-activity play than girls (Fagot, 1984a), and both peers and teachers are more likely to attend to the aggressive behavior of boys than of girls (Fagot, 1984b).

Children can assimilate information regarding gender roles through observing and imitating others. Once acquired, however, the appropriate reinforcing conditions are necessary for the behaviors to be maintained (Lott and Maluso, 1993). Furthermore, research has demonstrated that children are capable of storing information from observation and that imitation is not necessary for information storage (Bandura, Ross, and Ross, 1961). Thus, for social learning theorists, role models are believed to be important sources of information on gender behavior.

Same-sexed parents act as role models, especially in regard to gender-typed behavior. Some research suggest that children who live with their same-sexed parent seem to be better adjusted in their social development (Santrock and Warshak, 1979). Four year old boys who were raised without a father were found to be more likely to play with gender neutral toys, less aggressive, and less likely to engage in rough-and-tumble play (Beal, 1994; Biller, 1981; Stevenson and Black, 1988). This is believed to result from a lack of a role model, and also from differential reinforcement of sex role behavior. For example, single mothers are more protective and less concerned with stereotypic play compared to mothers

who are married (Beal, 1994; Biller, 1981; Stevenson and Black, 1988). Father absence also affects girls' social development. Adolescent girls whose fathers died were observed to be anxious and inept around males, whereas girls without fathers, due to divorce, were sexually assertive (Hetherington, 1972; Stevenson and Black, 1988). This difference may be attributed to the difference in maternal role models: women who are divorced are more likely to date than are widows (Belsky, Steinberg, and Draper, 1991; Booth, Brinkerhoff, and White, 1984; Hetherington, 1972).

Interestingly, mother absence has not been found to have much of an impact on gender role development. However, children are more likely to have frequent and regular contact with their mother even when the father is awarded custody (Beal, 1994; Santrock, Warshak, and Elliot, 1982). Beyond parents' role as models of sex-typed behavior, the way parents relate to each other and other persons provides information on cultural expectations for sex-typed behavior (Lott and Maluso, 1993).

Thus behavior therapists focus on extinguishing cross-sex behaviors and reinforcing same-sex play. It is unclear if one's internal gender scheme is altered or if this treatment generalizes to other situations (e.g., when the parent or clinician is not present) (Zucker and Bradley, 1995). To date there is no long-term follow-up study of the effects of this type of treatment (Zucker and Bradley, 1995). The longest follow-up in the literature is 51 months after treatment (Rekers, Kilgus, and Rosen, 1990) which reportedly accounted for 20% of the variance in the change score.

In the psychoanalytic literature, there are two major theories of transsexuality. One, the conflictual/defense hypothesis (Stoller, 1968; 1975; 1980), argues that this gender dysphoria occurs as a result of an intense childhood conflict with the maternal figure. This conflict is

believed to involve neglect or abandonment, exposure to trauma, or early seductions (Zucker and Bradley, 1995). Most of the psychoanalytical literature on gender disorders involves case reports rather than empirical research, and focuses on castration or separation anxiety (Friedemann 1966; Lihn, 1970; Meyer, 1982; Stoller, 1985). In brief, it is hypothesized that the anxiety created by the threat of maternal abandonment is relieved by creating a closeness to the mother through cross-gender behavior (Coates, 1990; Ovesey and Person, 1973; Zucker and Bradley, 1995). Thus, what once reduced the anxiety related to attachment insecurity/conflict leads to a gender conflict in later life.

Conversely, in the non-conflictual theory (Stoller, 1968; 1975; 1980), the mother is hypothesized to have a very powerful penis envy and views the male child as her phallus. This is believed to lead to a blissful symbiosis between the mother and son. The young boy progresses normally through the separation-individuation phase of development, except in the area of gender identity. The male child's femininity develops out of this symbiosis and is positively reinforced by the mother. According to the non-conflictual theory of transsexuality (Stoller, 1968; 1975; 1980), the young boy does not experience an oedipal phase of development because the relationship with his mother prevents the development of any masculinity, the father is excluded from the relationship, and there is no masculine identification.

The psychoanalyst focuses on the parent-child relationship, and often times on the loss of the mother — due to her death or an emotional withdrawal related to some traumatic experience (Zucker and Bradley, 1995). Although some theorists have described treatment involving a focus on individuation that is necessary due to the overly close relationship

between the mother and son (Zucker and Bradley, 1995), others advocate that the therapist attempt to increase the father's involvement in his son's life. Some argue that it is also important to foster a relationship between a male therapist and the young boy in order to facilitate the development of a masculine identity (Green, Newman, and Stoller, 1972).

Currently, there is debate as to whether it is indeed ethical to attempt to eliminate a child's cross-gender behavior based on the four rationales listed previously. Some therapists and members of the transsexual community argue that attempting to change the behavior will not eliminate the "disorder" and will further damage the individual. These individuals suggest that society be educated on GID and transsexuality and that therapy focus on helping the individual adjust to society's response to their behavior. It is argued that the depression and anxiety seen in these individuals do not lead to the "disorder," but rather result from society's stigmatizing and condemning responses to the individual.

Future Research

Formalized evaluation and long-term follow-up on the various therapeutic models of treatment needs to be undertaken, not only to determine the best mode of treatment (behavioral versus psychoanalytic) but also to determine if attempting to extinguish the cross-gender behavior is indeed the best course of action. At this point, it is still unclear if general psychopathology leads to GID or vice versa or if some third factor is responsible for both. If general psychopathology leads to GID, then treating the cross-gender behaviors would not necessarily lead to a healthy child. Furthermore it is unclear if the psychopathological characteristics noted in this population and the adult transsexual are due, in part, to social ostracism.

From a psychosocial perspective, the maternal and paternal relationships and their dynamics are essential aspects of development, including gender development. However, in regards to the development of both transsexualism and transvestism, the extent and specificity of parental (or societal) influence is not yet fully understood. Further, the transactions of biological, relational, and cultural influences on development of gender and associated disorders need to be elucidated.

An individual's experiences from birth to 48 months of age appear to be uniquely important in influencing one's gender identity and one's attachment to the primary caregiver. How or if these two domains of development relate or interact with each other has yet to be determined. How children who suffer separation anxiety differ from children who suffer from both separation anxiety and GID or GID only also needs to be investigated.

REFERENCES

- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, rev ed 3. Washington, DC, American Psychiatric Association.
- Bailey, J.M. and Zucker, K.J. (1995). Childhood sex-typed behavior and sexual orientation: A conceptual analysis and quantitative review. *Developmental Psychology*, 31(1), 43-55.
- Bandura, Ross, and Ross, (1961). Transmission of aggressive models. *Journal of Abnormal Social Psychology*, 63, 572-582.
- Beal, C.R. (1994). *Boys and girls: The development of gender roles*. NY: McGraw-Hill, Inc.
- Belsky, J., Steinberg, L., and Draper, P. (1991). Childhood experience, interpersonal development, and reproductive strategy: An evolutionary theory of socialization. *Child Development*, 62, 647-670.
- Biller, H.B. (1981). Father absence, divorce, and personality development of the male child. *Developmental Psychology*, 2, 181-201.
- Booth, A., Brinkerhoff, D., and White, C. (1984). The impact of parental divorce on courtship. *Journal of Marriage and the Family*, 46, 85-94.
- Bradley, S.J. (1985). Gender disorders in childhood: A formulation. In B.W. Steiner (Ed.), *Gender dysphoria: Development, research, and management*. New York, NY: Plenum Publishing Corp.
- Bradley, S.J. and Zucker, K.J. (1990). Gender identity disorder and psychosexual problems in children and adolescents. *Canadian Journal of Psychiatry*, 35, 477-486.
- Coates, S. (1990). Ontogenesis of boyhood gender identity disorder. *Journal of the American Academy of Psychoanalysis*, 18, 414-438.
- Coates, S. and Person, E.S. (1985). Extreme boyhood femininity: Isolated behavior or pervasive disorder? *Journal of the American Academy of Child and Adolescent Psychiatry*, 24, 702-709.
- Cross, S.E., and Markus, H.R. (1993). Gender in thought, belief, and action: A cognitive approach. In A.E. Beall & R.J. Sterberg (Eds.), *The Psychology of Gender* (pp. 55 - 98). New York, N.Y.: The Guilford Press.
- Davenport, C. (1986). A follow-up study of 10 feminine boys. *Archives of Sexual Behavior*, 15, 511-517.
- Fagot, B.I. (1984a). Teacher and peer reaction boys and girls play style. *Sex Roles*, 11, 691-702.
- Fagot, B.I. (1984b). The consequence of problem behavior in toddler children. *Journal of Abnormal Child Psychology*, 12, 385-396.
- Fagot, B.I., Leinbach, M.D., and Hagan, R. (1986). Gender labeling and the adoption of sex-typed behaviors. *Developmental Psychology*, 22, 440-443.

- Friedemann, M. (1966). Reflection on two cases of male transvestism. *American Journal of Psychotherapy*, 20, 270-283.
- Gouze, K.R., and Nadelman, L. (1980). Constancy of gender identity for self and others in children between the ages of three and seven. *Child Development*, 51, 275-278.
- Green, R., Newman, L.E., and Stoller, R.J. (1971). Treatment of boyhood "transsexualism": An interim report of four years' experience. *Archives of General Psychiatry*, 151, 84-88.
- Green, R., Williams, K., and Goodwin, M. (1985). Masculine or feminine gender identity in boys: Developmental differences between two diverse family groups. *Sex Roles*, 12, 1155-1162.
- Gunderson, J. and Kolb, J. (1978). Discriminating features of borderline patients. *American Journal of Psychiatry*, 135, 792-796.
- Hetherington, E.M. (1972). Effects of father absence on personality development in adolescent daughters. *Developmental Psychology*, 7, 313-326.
- Green, R. (1985). Gender identity in childhood and later sexual orientation: Follow-up of 78 males. *Annual Progress in Child Psychiatry and Development*.
- Kinsey, A.C., Pomeroy, W.B., and Martin, C.E. (1948). *Sexual behavior in the human male*. Philadelphia: W.B. Saunders.
- Lihn, H. (1970). Fetishism: A case report. *International Journal of Psychoanalysis*, 51, 351-358.
- Lott, B., and Maluso, D. (1993). The social learning of gender. In A.E. Beall & R.J. Sternberg (Eds.), *The Psychology of Gender* (pp 99-123). New York, NY: The Guilford Press.
- Marcus, D.E., and Overton, W.F. (1978). The development of cognitive gender constancy and sex role preferences. *Child Development*, 49, 434-444.
- Marantz, S. and Coates, S. (1991). Mothers of boys with gender identity disorder: A comparison of matched controls. *Journal of the American Academy of Child and Adolescent Psychiatry*, 30(2), 310-315.
- Meyer, J.K. (1982). The theory of gender identity disorders. *Journal of the American Psychoanalytical Association*, 30(2), 381-418.
- Money, J. (1955). Hermaphroditism, gender and precocity in hyperadreno-corticism: Psychologic findings. *Bulletin of the Johns Hopkins Hospital*, 96, 253-264.
- Rekers, G.A., Kilgus, M.D., and Rosen, A.C. (1990). Long-term effects of treatment of gender identity disorder of childhood. *Journal of Psychology and Human Sexuality*, 3, 121-153.
- Roberts, C.W., Green, R., Williams, K., and Goodman, M. (1987). Boyhood gender identity development: A statistical contrast of two family groups. *Developmental Psychology*, 23, 554-557.
- Santrock, J.W., and Warshak, R.A. (1979). Father custody and social development in boys and girls. *Journal of Social Issues*, 35, 112-125.
- Santrock, J.W., Warshak, R.A., & Elliot, G.L. (1982). Social development and parent-child interaction in father-custody and step-mother families. In M.E. Lamb (Ed.), *Nontraditional families: Parenting and child development*. Hillsdale, NJ: Erlbaum.
- Stevenson, M.R., and Black, K.N. (1988). Paternal absence and sex role development: A meta-analysis. *Child Development*, 59, 793-814.
- Stoller, R.J. (1968). *Sex and gender, vol I. The development of masculinity and femininity*. New York, NY: Science House.
- Stoller, R.J. (1975). *Sex and Gender. Vol II: The Transsexual Experiment*. New York: Aronson.
- Stoller, R.J. (1980). Problems with the term "homosexuality." *Hillside Journal of Clinical Psychiatry*, 2, 3-25.
- Stoller, R.J. (1985). *Presentations of gender*. New Haven, CT: Yale University Press.
- Summers, F. (1978). Manual for the measurement of symbiosis in human relationships. *Psychological Reports*, 43, 663-670.
- Zucker, K.J. and Bradley, S.J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York: Guilford Press.
- Zucker, K.J., Bradley, S.J., and Sullivan, C.B. (1992). Gender identity disorder in children. *Annual Review of Sex Research*, 3, 72-120.
- Zucker, K.J. and Green, R. (1991). Gender identity disorders. In M. Lewis (Ed.), *Child and Adolescent Psychiatry: A Comprehensive Textbook* (pp 604-613). Baltimore, MD: Williams & Wilkins.
- Zucker, K.J. and Green, R. (1992). Psychosexual disorders in children and adolescents. *Journal of Child Psychology and Psychiatry*, 33, 107-151.
- Zucker, K.J. Wild, J., Bradley, S.J., and Lowry C.B. (1993). Physical attractiveness of boys with gender identity disorder. *Archives of Sexual Behavior*, 22, 23-36.

Editor's Note: Sherry Heller is a graduate student in Applied Developmental Psychology at the University of New Orleans. She is also an Evaluation Specialist on the Louisiana State University Infant Mental Health Team. She is completing a dissertation on attachment experiences in transgendered adults.

Infant Mental Health in Russia

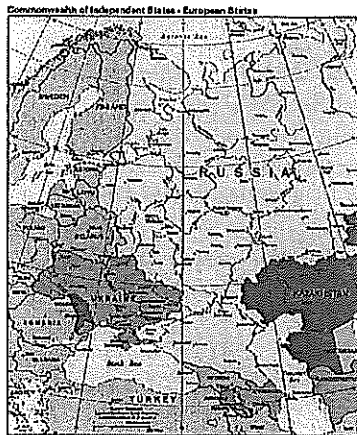
by Rifkat Muhamedrahimov

In 1990, an innovative group of scientific workers under the supervision of Professor L.S. Chistovich at the I.P. Pavlov Institute of Physiology of the U.S.S.R. Academy of Sciences, initiated work on the organization of a social program in Leningrad directed at the diagnosis and training of children at an early age.

In that same year in Leningrad, as in all of Russia, for the first time in post-Communist period, the possibility arose to conduct democratic elections for members of regional and city Soviets. A group of employees from the Institute of Physiology began to support and participate in the work of the association Democratic Election of 1990. The results of the election indicated that a large group of people were oriented towards the implementation of democratic changes in society. Many were elected to be deputies of the Soviets and members of various commissions and committees. These democratic changes included a shift of policy in relation to socially unprotected layers of the population.

In 1991, the mayor's office of the city newly renamed "St. Petersburg," ordered the development of a draft of a social program for disabled infants and toddlers. In June 1992, the status of the city prioritized social program was conferred upon the program of Infant-Toddler Habilitation created by the initiative group under the leadership of Professor Ludmila Chistovich and her daughter, Dr. Elena Kozenikova.

Following this, intensive work was directed at an information search and summary, the analysis of the traditional Soviet system of services for disabled children, and comparison



of this system with foreign ones. Intense collaboration with foreign specialists first led to the appearance of support groups transformed in Sweden into the Friendly Support Association of the Infant-Toddler Habilitation program, and as a result, to the creation of an International Council of Experts on the program. At that time Professor Arne Risberg of the Royal Institute of Technology in Stockholm, Sweden, was the first president and director of the Swedish department of the Council, and Professor Michael J. Guralnick, Director of the Center on Human Development and Disability, University of Washington in Seattle, was the director of the American department.

The initiating group of people began at once creating a social program. They organized the non-governmental creation of a social program, and they organized the nongovernmental Early Intervention Center with Dr. Elena Kozenikova, director and Professor Ludmila Chistovich as scientific director. An interesting work started at the new Centre in terms of standardization of new diagnostic tools and habilitation programs for the Russian society, e.g. an infant and young children assess-

ment system based on the Kent Infant Development Scale (Reuter and Reuter, 1990) and the Child Development Inventory (Ireton, 1992). The BOEL-screening test, developed by Karin Stensland Junker in Sweden was also incorporated in the diagnostic tools. In 1993, the Center was transformed into the Early Intervention Institute with the tasks including continuing the Infant-Toddler Habilitation social program, organizing courses for training and improvement of qualifications for professionals who were going to work in this field, and conducting scientific research on early intervention. During the next several years, the Institute organized a large number of seminars and meetings with early intervention professionals from Sweden, Norway, and the USA.

In July 1992, in the city social program, a Russian-Swedish Lekotek was opened under the leadership of Rifkat Muhamedrahimov. This center was the first of its kind in Russia and provided a district family-centered early intervention program for 0-3 years old children with special needs. Previously, these children had been assessed and diagnosed in the Early Intervention Center. The work of the interdisciplinary team of the Lekotek attempted to combine the main principles of socio-pedagogical programs for disabled infants and their families developed in U.S. early intervention programs (Public Law 99-457, part H, 1986, 1992) and in Swedish habilitation centers and lekoteks (Stensland Junker, 1971; Bjorck-Akesson, Brodin, 1991). In addition, the effort was made to implement the ideas and propositions of the early psychotherapy intervention developed by infant mental health professionals (Fraiberg et al., 1975;

Lebovici, 1983, 1992; Cramer & Stern, 1988; Stern, 1992, 1996).

In June of 1994, a group of people from the Early Intervention Institute and Russian-Swedish Lekotek, took part in the WAIMH Riga Conference on the Mental Health of Infants, Children and Parents. This meeting provided a fortunate opportunity to meet a number of WAIMH professionals, and to learn about new ideas and approaches in the field of infant care. We were able to exchange ideas and approaches with colleagues from Latvia and other Baltic Countries and from different parts of Russia. With the help of the Organizing Committee and its Chair, Kaspars Tuters, we had an opportunity to present the St. Petersburg program to our colleagues.

The impression and influence of the Riga-WAIMH Conference to the work that followed in St. Petersburg was outstanding. It had a beneficial effect on the understanding of the infant mental health issues (especially the possibility for using new early psychotherapy intervention ideas and approaches in the program for disabled infants and their families), as well as on the organization of a new professional association. For the successful development of Infant-Toddler Habilitation social program in St. Petersburg, it was necessary to create model early intervention services and to organize their interaction with one another in the framework of a single program. This was largely completed by the Spring of 1994. It was also necessary to prepare employees for work in model services and to prepare new professionals, as well as to create a new association, uniting professionals of various spheres of early intervention. After the Riga Conference, we decided to approach this goal by trying to organize in St. Petersburg a regional professional association for infant mental health.

In the spring of 1994, the work of the St. Petersburg Early Intervention Institute and Lekotek was approved by the American Association for the Advancement of Sciences (AAAS) and the American Psychological Association (APA). In July of 1994, after the Riga-WAIMH Conference, with the help of Elizabeth Tuters, Rifkat Muhamedrahimov was invited to join the Canadian Group for their Study Week at the Anna Freud Centre. In August, as the AAAS/APA Fellow, he visited the United States. The Fellowship Program outside of the APA offered the possibility of traveling to and becoming familiar with faculty at the Louisiana State University Medical Center, Division of Infant, Child and Adolescent Psychiatry, and the Louisiana Infant Mental Health Association; the University of Colorado Health Sciences Center, Department of Psychiatry, Program for Early Developmental Studies; the University of Washington Child Development and Mental Retardation Center; and to participate in the Continuing Education Program, "The World of Infant Research and Adult Psychotherapy" with Daniel Stern. Local hosts, WAIMH President, Professor Joy D. Osofsky, WAIMH Vice-President, Professor Robert N. Emde, CDMRC Director, Professor Michael J. Guralnick, and Professor Daniel N. Stern were very kind to provide the opportunity of getting to know first-hand up-to-date studies and information in the sphere of infant development and early intervention.

As a result of one year Post-Fellowship activity, the St. Petersburg Association for Infant Mental Health was approved and received the legal status of a professional non-profit association. In June of 1995, WAIMH President, Professor Joy Osofsky, and Chairperson of the Local Organizing Committee of the WAIMH Sixth World Congress, Professor Tuula Tamminen, visited St. Petersburg to meet people from EEI,

Lekotek and the new regional AIMH, and present about WAIMH and infant mental health issues. This was another turning-point — the acceptance of the St. Petersburg AIMH as a WAIMH Affiliate group and participation in the Sixth World Congress was discussed. Very soon, with the support of Joy Osofsky and Tuula Tamminen, the proposals to the Program Committee of the Sixth World Congress for organizing a symposium entitled, "Early Intervention in the New Independent State (NIS) of the ex-Soviet Union" and a video presentation, "Infant Interaction in the Orphanage" were made.

In the autumn of 1995, WAIMH Past President, Professor Serge Lebovici, WAIMH Francophone President, Professor Bernard Golse, with the group of people from WAIMH in France visited St. Petersburg to get to know the situation with child care, to meet professionals from different Institutes, and to present on mental health issues. Having the very busy schedule with many meetings and visits to institutions, they kindly found an opportunity to observe the early intervention program in Lekotek. In December of 1995, Rifkat Muhamedrahimov and Elena Kozenikova were invited to Paris by the "Central and Eastern Europe Commission" (Professor Dominique Cupa-Perard) to participate in the Group WAIMH Francophone Conference and together with colleagues from Eastern and Central Europe to be acquainted with the French child mental health professionals and their work.

In 1995-1996, the group of people, including psychologists of the EEI Child Psychotherapy Department and the staff of the Lekotek completed the Foundation Course in Psychological Development and Disorders of Childhood, organized in St. Petersburg by professionals from the Anna Freud Centre (London) and the EEI Child Psychotherapy Department. The Course Coordinator in

London was Dr. Rose Edgcombe and in St. Petersburg — Dr. Nina Vasilieva. The course provided an opportunity for former soviet professionals to look into the new psychoanalytic theory of normal emotional development of children and pathology, as well as for the first time to present and analyze the cases, especially the cases of infants with special needs, disabled infants.

In May of 1996, St. Petersburg AIMH held a city conference concerning different aspects of infant mental health problems, briefly presented by the leaders of AIMH: "Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (The Zero to Three Diagnostic Classification)," "Infants in the Orphanage," "Mother and Fetus," "Psychoanalytic Concepts of Infant's Inner World,"

"Pedagogical Services in Early Childhood," "Infants Habilitation — St. Petersburg Early Intervention Program." It was very interesting and fruitful to combine and discuss all these themes in one conference, and to examine the different sides of the same multidisciplinary infant mental health issues. Living in the same city and sometimes working in the same place, presenters referred to different theories of infant development and argued the necessity to develop different early intervention approaches. For example, early parent education program or early parent-infant interaction oriented psychotherapy. These differences are very important for the development of early intervention in St. Petersburg and Russia, reflecting the multitude of early intervention approaches. This kind of activity also provided an

opportunity for every professional to select from the large stream of the new child development and early intervention information available in western literature (or seminars and workshops provided in St. Petersburg by the wide range of professionals from different countries).

It is our hope that the experience of the EII, Lekotek and St-Petersburg AIMH will be helpful for professionals and initiative groups to start and develop new programs of care, intervention and prevention for infants with special needs in Russia and other New Independent Republics of the ex-Soviet Union.

Editor's Note: Rifkat Muhamedrahimov is head of the Habilitation Department and Head of Lekotek at the Early Intervention Institute in St. Petersburg.



President's Perspective

Yvon Gauthier

In a workshop in which I was recently involved, the two following cases were presented for discussion:

Case #1. A young woman arrived in a state of panic to a maternity ward, bearing in her a womb a dead child. She has learned this awful news five days before on a Friday, from an obstetrician whom she did not know because her own doctor was on vacation. She was told to come back to see her own obstetrician on Monday, and that her child would be delivered "next week." Following this, she tried unsuccessfully to get help from professionals (psychiatrist, family physician) who did not seem to understand her anxiety of carrying

within her a dead child and rather tried to minimize the importance of what was happening to her. Her husband, however, had tried to provide her with some support.

A midwife greeted her at the hospital and succeeded in calming her anxiety by explaining gradually all the steps leading to the delivery of her child. When the patient expressed her fear of seeing her dead child after delivery, which had been presented to her as a necessity so that she would really mourn him, the midwife decided to ask the child psychiatrist for a consultation. Work done with this patient in the following days revealed that the warm support received from the whole team all

throughout this experience awakened the emotional deprivation of this woman in her relationship with her own mother, who was present all throughout the postpartum but could only talk in terms of, "You will get another one; it is not so serious."

Two very specific problems are tied to the birth of a dead child and have to be delicately approached: to see or not to see the dead child, and how to have the child put in the grave. It is around this second problem that the mother realized that she did not want her child to lie near her father, thus revealing the ambivalent relationship that she had with him. Psychotherapeutic work was mostly centered on the clarification of what belonged to the mourning of the lost child, and what rather belonged to a conflictual past awakened by this event. The midwife was seen as playing the essential role of "container" of the anxiety, whereas the child psychiatrist allowed the emergence of a conflicted and unresolved past.

Case #2. Another young woman, mother of a first child, was pregnant again. Her history revealed four previous episodes of delirious outbursts, and she was being followed by a psychiatrist. Nevertheless, her obstetrician was most anxious that this new pregnancy would disrupt this patient's equilibrium. On her own, this patient went to an "Early Infancy Unit" to obtain help in becoming a mother for this new child. She had much difficulty in describing what went on in her mind, particularly around her personal history. It was only when her therapist took the initiative of a meeting between the obstetricians, the patient and herself, that the patient was reassured by this "containment" by the team. Then, she could finally approach the problem of her relationship history, specifically, her parents' divorce when she was 12. She learned to differentiate between this new child and these parental images that she otherwise was tempted to project upon him.

This is the kind of clinical material that infant mental health professionals who work in obstetrical wards expected to encounter. Several experiences have been published, whether they were research or clinical endeavors, showing the importance of a psychological presence in obstetrics. Around 1975, in Montreal, at Ste-Justine Hospital where I work, I believe it was unusual, and probably before its time, that the chief of obstetrics asked the help of a full-time psychiatrist as consultant, to help them understand not only postpartum depressions and psychoses, but clinical situations such as threatened premature labor, severe vomiting, death of a child or hypotrophy. The experience of Monique Bydlowski in Paris is another instance of a close collaboration between obstetrics and psychoanalysis which started some 20 years ago. Francoise Molenat in Montpellier (France) is also conducting a most interesting experience of close collaboration

with obstetrics (cf. *Signal*, vol 3, no. 1, 1995).

Such a psychological-psychoanalytical presence in obstetrics already has brought several interesting results. Our knowledge has certainly considerably increased rather than staying at the level of reconstructed theory. Mothers' verbalizations which were felt by early clinicians to be expressions of borderline pathology have now come to be seen as unusual, but normal accessibility to unconscious processes, to affects and memories which are not usually available to the conscious mind—a phenomenon observed by several clinicians and described under different names: "transparence psychique" (Bydlowski), "permeability of the unconscious" (Raphael-Leff), "inconsent a fleur de peau" (Lortie), "fluidity of deeper layers of affective life" (Molenat). There also seems to be a capacity for change which is quite different from other periods of life. The regression to the image or to the reality of the mother has also been observed, as a source of conflicts which have never been completely resolved and now come back to the surface, as for a definite resolution.

Many authors are now describing this period as a developmental crisis, a "reamengement d'identité." The birth of a child is a very special time, for the mother and for the couple, and we seem to begin to realize that we should much more use this opportunity for the kind of therapeutic and/or preventive work that can be done during these sensitive months.

Several methods and techniques are being explored for efficacy. Of course, a classical psychotherapeutic approach can be used. Usually, it is a brief-term therapy, conducted before the birth of the child, preventing the projection on him or her of these unsolved conflicts, as seen in these two vignettes previously reported. It can also take the form of a beginning awareness that there are unresolved

problems which have never really been worked on, which will lead the patient to come back later, after the birth of the child, once the child leaves her some leisure!

I have been able to observe that very often work can be achieved only after a close collaboration of the infant mental health professional has been developed with the professionals who are taking care of pregnant women at all stages of the procreation process. In many cultures, it is not the obstetrician who is the front-line worker, but a nurse, a midwife, and it is these women who can be the main instrument for reaching mothers whose pregnancy has awakened some unsolved psychological difficulty. The obstetrical world is a very complex one, and if one can function in a classical way in some places, one has to be aware that often one has to lean for a long time on front-line workers, whose intervention can be sufficient in itself or necessary to open the door to a deeper approach later.

This is especially true of vulnerable women whose traumatic childhood or adolescent experiences make the approach to motherhood very difficult. With them, it is particularly important to offer a milieu which is most "containing" (in a Winnicottian sense), without necessarily offering a direct psychiatric intervention.

How long can all of this continue to be done, in the midst of hospital reforms which in many countries try to decrease at the most minimum the length of stay of women in obstetrics? This is a threat which certainly decreases possibilities of early detection of problems, or follow-up in hospitals of major anxieties. We will have to make sure that prenatal and postnatal teams, working with outpatients are sensitive not only to problems of physical health and development, but also to old and recent conflicts which may easily lead to failures of interaction with the new child.



from the Red Cedar

WAIMH WORLD CONGRESS: How Often?

Enclosed in this newsletter is a survey authorized by the Executive Committee. The survey asks for your advice on an important decision that the Executive Committee must make in the coming months. The decision concerns the frequency with which WAIMH conducts its World Congress.

When WAIMH was organized from its two parent organizations, it added 2 (IAIMH met biennially) and 3 (WAIPAD met triennially) and came up with 4. In Tampere we ran into a difficult situation concerning the bylaws that regulate election of the officers of the association. Our by-laws require the members of the Board of Directors to be elected by the membership of the association. The Board of Directors, then, is required to elect the officers of the association. For an international organization of over 1000 members from 30-40 countries, the by-laws assure democratic election of the members of the Board, while simultaneously assuring an organizational structure that allows business to be conducted in a timely and efficient manner. In Tampere, however, we

discovered a problem with the by-laws that prevented voting on the officers until after the business meeting. But the business meeting took place late in the congress and did not allow adequate time for the new board to elect its officers. This fall you will receive a ballot requesting a change in the by-laws that will correct the sequence of events and will assure broad based member input to the election of Board members. The by-law essentially allows for the elections to take place months prior to the World Congress, via mail ballot, and, therefore, will allow election of the officers to take place at the meeting of the Board during the World Congress. So, look for the ballot in *The Signal* this fall.

As the By-laws committee discussed WAIMH's organizational structure it became unceasingly clear that the committee sensed that the world infant mental health community needed to meet more frequently than every 4 years. The advances in clinical research and the need to keep policy makers alert to infant mental health issues, requires that the infant mental health clinical and scientific community assemble more frequently than every 4th year. The by-laws committee strongly favored a biennial (every 2 years) schedule, but also wanted to have a sense of the members' preferences before making a recommendation to the Board of Directors. The survey is enclosed with this copy of *The Signal*.

I support the biennial schedule for the reasons noted above, but also because it will allow WAIMH to become more directly involved with scheduling of Regional Congresses during the off years. Arguments that having biennial meetings will interfere with other society meetings just do not hold up because other societies do not restrict the frequently with which they hold conferences in order not to conflict with WAIMH. Our society exceeds 1000 members. We attract 1200 plus to our world congresses, with approximately 40% of that total consisting of WAIMH members. The need for clinical training, for exchange of clinical research, and for discussion of policy implications of our work requires more frequent attention if we are to move the agenda of infant mental health world-wide. Please respond to the survey and share your opinion with the WAIMH Board of Directors so that they can make a decision that is in the best interests of WAIMH members and the world's infants. If we move to a 2-year cycle, this means that we will issue a call for site proposals for 2002 and 2004 immediately. Moreover, it means that the Board of Directors will begin assertive planning for Regional meetings as early, perhaps as 1998. Please take a few minutes to send your opinion to the WAIMH office via mail, e-mail, phone, or FAX.

The survey is found on page 20.

History of WAIMH



by Hiram E. Fitzgerald

The text that follows is that of an after dinner talk that I was invited to give at the 1997 annual meeting of the Michigan Association for Infant Mental Health. It is a personal rendering of historical events related to the origins of WAIMH and the Infant Mental Health Journal. As many of our readers may know, Joy Osofsky and I have agreed to co-edit a four-volume handbook of infant mental health. One of the chapters I am preparing concerns the history of infant mental health. This is a chapter that requires broad interdisciplinary and international input. I invite every member of WAIMH to send anything to me that he or she considers to be of historical significance. History is composed of events; but all events have a personal, subjective story and I would like to include this story as much as possible so that the historical record is more than a dispassionate log of events. So, if you have any comments, any issues, any perspectives or point of view that you would like to see represented in the history of infant mental health, please send your materials to me via regular mail (WAIMH office), FAX 517 355-4565 or e-mail Fitzgerald9@pilot.msu.edu. Of course, I bear final responsibility for what eventually is included and what is excluded from the historical record. I look forward to receipt of all of your suggestions. In the meanwhile, here are my dinner comments sans the really snazzy overheads that I used to illustrate the events described.

WAIMH's World

On this the occasion of your 21st annual conference, I bring greetings and warm wishes to you from Yvon Gauthier, President of WAIMH, the members of the WAIMH Board of Directors, and my personal greetings, both as Executive Director of WAIMH, but also as a long-standing member of WAIMH. It is especially fitting that I offer greetings from WAIMH, because I was asked to speak this evening on WAIMH's role in the internationalization of the infant mental health movement.

WAIMH's role of course, is the

direct result of decisions made by two pioneering women in infant mental health, a duo that exemplifies one of WAIMH's historic concerns, namely, the link between clinical infant research and public policy. Of course, I am speaking of Selma Fraiberg and Betty Tableman.

In 1972, Fraiberg had established the Child Development Project at the University of Michigan in order to develop a home-based intervention model designed to enhance the quality of the mother-infant relationship. In 1973 and 1974, Tableman, via her position in the Michigan Department of Mental Health, persuaded Fraiberg

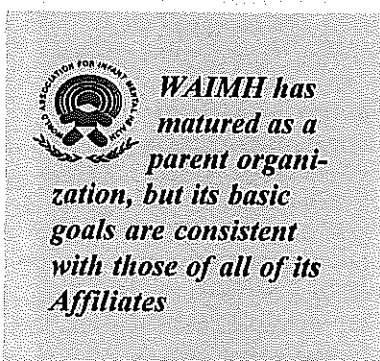
to train selected employees of community mental health agencies as part of her goal to implement infant mental health services throughout Michigan. Thomas Taflan-Barrett was a member of the second class to train with Fraiberg--he was also a graduate student at Michigan State University in the clinical psychology program. One day in 1976, Tom dropped by my office--he was shopping for a faculty member to chair his dissertation research. Tom had been working with a pediatric cardiologist trying to understand failure to thrive among infants who had received corrective heart surgery. Tom's description of the problem fascinated me, and I agreed to chair his dissertation research, which he completed in 1997. Tom often channeled our discussions about causal influences on non-organic failure to thrive to Fraiberg's work and it was from those discussion that I first learned about her training programs and the group of clinicians who organized WAIMH. By 1978 Tom successfully persuaded me to become a candidate for the WAIMH board. Well, I was elected to a two-year term of office and in 1979 attended my first meeting of an infant mental health board of directors--little did I know then how many infant mental health board meetings were in my future!

That meeting, held on April 27, 1979, was historic because the WAIMH Board approved two proposals offered by Jack Stack. The first proposal was to establish the International Association for Infant Mental Health and the second was to establish the *Infant Mental Health Journal* as WAIMH's official publication, with IAIMH having co-sponsorship as well as ownership of the logo that has appeared on the cover of the IMHJ since 1980. Human Sciences Press was selected as the publisher with Jack Stack as founding editor. Michael Trout was selected by the organizing IAIMH Board as its first President. Members of the WAIMH

Board who voted to create both the journal and the international association were Michael Trout (President), Ruth Szabo, Jack Stack, Ann Safer, Judith Evans, Mary Scoblic, Stan Garwood, Tom Barrett, Mary K. Peterson, Barbara Banet, Alice Marie Carter, and Hiram Fitzgerald.

By 1984 I had served a term as president of MAIMH and of IAIMH, had committed to serve as Executive Officer of MAIMH and Executive Director of IAIMH, and was deep into infant mental health organizational activities. One of those activities was to serve as the linchpin for organizational change. During the first few years the IMHJ subscription list grew rapidly and the number of submissions to the journal increased proportionately. Jack Stack turned the editorial duties over to Sharon Bradley-Johnson and things continued to progress well. Then we encountered difficulties with the publisher. Quickly publication of the journal fell more than a year behind schedule, galley proofs came to the editor with portions of one article appearing in another, pages missing, and typos rampant. Sharon resigned in frustration and mid year in 1984, I took on editorial responsibilities for the journal. We also began negotiations with Human Sciences Press to take copyright control of the journal. With the help of a small publishing company in Vermont, Clinical Psychology Publishing Company (CPPC), we were successful in securing copyright control of the journal, and CPPC, Inc. became our new publisher with a five-year contractual commitment that was renewed continually until Wiley's recent purchase of CPPC. Coincidental in time to the problems with the journal, I had invited Bob Emde to present a colloquium to the Psychology Department at Michigan State University. I knew Bob from my graduate school days at the University of Denver when he was a resident in psychiatry at the University of

Colorado Medical Center. After the colloquium we had an active discussion about all of the infancy action of the day, IAIMH, National Center for Clinical Infant Programs, International Society for Infant Studies, and the World Association for Infant Psychiatry and Allied Disciplines (WAIPAD), for which Bob was about to become President. We discussed the possibility of having both IAIMH and WAIPAD co-sponsor the IMHJ and also discussed the amazingly similar mission and objectives of the two organizations. We also discussed the possibility of Joy Osofsky as



editor of the journal. We planned a follow-up meeting to take place at the biennial meeting of the Society for Research in Child Development in Toronto. So the courtship between IAIMH and WAIPAD had begun.

The planning committee that met in Toronto consisted of Bob Emde (President of WAIPAD), Richard Barthel (President of IAIMH), Joy Osofsky (future editor of IMHJ), Dolores Fitzgerald (IAIMH Administrative Assistant), and me. Needless to say, our discussion went well and not only did Joy agree to a five year term as editor, I agreed to serve as program chairperson for WAIPAD's triennial congress in Lugano, Switzerland. Bob Emde played an especially key role in bringing the merger message to WAIPAD. Everything was in place for board members in both organizations to get to know one another. Moreover, a committee was

in place to review possibilities for merging the two organizations into a strong interdisciplinary and international force for infant mental health. We had a conception!

Prenatal development went smoothly: During the first trimester (1988) Joy was announced as editor of IMHJ (which I think she will remain forever). During the second trimester (1989) I was announced as program chair for Lugano. During the third trimester (1990) the by-laws committee (Bob Emde, Joy Osofsky, Hiram Fitzgerald, Sonya Bemporad, Serge Lebovici, Yvon Gauthier, Justin Call) presented its recommendations to a joint meeting of the IAIMH and WAIPAD in Chicago and the boards and members of each association ratified establishment of the World Association for Infant Mental Health. And I agreed to a 10 year stint as Executive Director, with central offices located at Michigan State University! The merger retained the Affiliate structure of IAIMH. During its 11 years of existence, MAIMH's child, IAIMH organized Affiliate associations in Texas (1980), Delaware Valley and Illinois (1981), Mexico, Ontario and Iowa (1982), Virginia and North Carolina (1983), Quebec and Maryland (1985), Minnesota (1986), Maine (1987), Australia (1988), New Jersey (1990), Oklahoma (1991), and Nordic Countries (1992). WAIMH has added Louisiana and Greece (1993), France (1994), Kansas and Russia (1995), United Kingdom, Netherlands, and Germany-Austria-Switzerland (1996) to the fold. In sum, WAIMH has affiliate connections to 19 countries and individual memberships in excess of 30 countries. Currently we are working closely with colleagues in South Africa, Italy, Finland, and Israel to develop Affiliates in those countries.

WAIMH has matured as a parent organization, but its basic goals are consistent with those of all of its Affiliates. Specifically, WAIMH

- 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,
- Facilitates international cooperation among individuals concerned with promoting optimal development of infants and their families.
- Maintains with MAIMH a video library of films about infant development, infant mental health, and family relationship issues,
- Sponsors the Infant Mental Health Journal and provides members reduced rates for subscriptions,
- Sponsors regional and world congresses devoted to scientific, educational, and clinical work with infants and their caregivers.

So, the pathway that began as a study group of Selma Fraiberg trained students, employed in Betty Tableman supported community mental health settings, bumped into convergent pathways, merged with them, and played a key role in shaping what has become the pre-eminent professional association for clinical infant studies in the world, WAIMH. We look forward to many, many years of continued strong relationships with MAIMH and we wish you well as you address issues of concern to infants and their caregivers in Michigan.



INFANT MENTAL HEALTH JOURNAL

Changes are brewing for the *Infant Mental Health Journal* (IMHJ). Established 18 years ago, IMHJ is going to get a face lift. When John Wiley & Sons purchased Clinical Psychology Publishing Corporation and gained publishing rights to IMHJ it was clear that transitions were in store. The first transition involved a 25% increase in the number of pages allocated to the journal, which, in turn, allowed IMHJ editor, Joy Osofsky, to implement structural changes to the contents of the journal. Now the Michigan Association for Infant Mental Health, copyright holder of IMHJ, has approved additional changes. The most dramatic of these changes will involve the cover of the journal which will no longer be yellow, although the final color(s) and design of the cover are still under review. Less noticeable, perhaps, will be changes in the

font used to typeset the articles. The final transition, not scheduled for 1998, but soon to occur, will involve movement to 6 issues per year. Although WAIMH is the official sponsor of the journal, the founder and owner of the journal is the Michigan Association for Infant Mental Health. Publication committee members are Hiram Fitzgerald, chairperson, Joy Osofsky (IMHJ editor) and Susan McDonough (WAIMH World Congress program committee chairperson). Although many individuals already believe that IMHJ is the premiere journal in its field, these changes should help to broaden that opinion and result in increased submissions to the journal and increased subscriptions for the journal.



In Memoriam:

Professor Joseph D. Noshpitz, MD

by Natalia Trenchi and
Miguel Cherro Aguerre

We had known him for many years. We had read his books and articles since we were studying to become Child and Adolescent Psychiatrists. Then in 1994, during the IACAPAP Congress in San Francisco, while attending a pre-congress activity organized by WAIMH, a conspicuous white-haired man sat beside us. We noticed that everybody heard his opinions with evident respect. Natalia read his name badge and asked me: "Could he be 'our' Noshpitz?"

She meant the Noshpitz we had read so many times: the one of the books and articles. In fact, we had just read his *Pathways of Growth*. Precisely, he was, "our" Noshpitz.

When we introduced ourselves, he showed great surprise at being read so much in our country. Being so polite and friendly, he became interested in Uruguay, our work, and in us personally. We asked him to visit and he accepted right away.

During the IACAPAP Congress, we kept talking as we shared different events. During the farewell party at the Museum of Asian Art we had the chance to meet Charlotte, his wife. They made a charming couple, lively and joyful.

In 1995 Joseph and Charlotte came as guests to the Psychiatry Congress in Uruguay. "The Uruguayan Adventure" had it all, even annoying misfortunes that were overcome with his excellent sense of humor. He even made some keen remarks about our reality and the way we perceive it.

We spent many unforgettable moments with them and Aida and Floreal Loy. Joe loved life and took

pleasure in what it offered him every moment. He made us stop to enjoy a sky full of stars in spite of the cold, and he dared to touch the sand with his feet defying the severe Uruguayan winter. We all appreciated his joviality, his fine sense of humor, his culture, his fraternity.

We became friends sharing stories, confidences, and jokes in English, French and Yiddish, the language he rescued from his memory in order to communicate with Floreal. We were so close that we could even call him "Pepe," the way all "Josés" are called in Spanish.

After this visit, we corresponded extensively, and found a sensitive, communicative, and warm Noshpitz. We enjoyed every letter we received. He communicated in a spontaneous and simple way, with a fine poetic register full of precision, warmth and humanity.

We were really happy when we met again in 1996 in Tampere, Finland, at the WAIMH Congress. That would be our last time together. Joseph participated with us in the ISAP Symposium and presented his topic "Idealization." He was so kind that he gave it to us to be published in Spanish in one of our scientific journals.

The Noshpitzes invited us to have dinner with them, and we set our agendas aside to share that moment of being honored. We met at the door of the Tampere Hall, and we video recorded Joseph sending an enjoyable greeting in Yiddish for the Loys in Montevideo.

We walked together to the Lutheran Cathedral where we appreciated the decoration and enjoyed an organ concert. After the concert, while we were looking for a restaurant, Joseph perceived that Charlotte

was cold. He automatically took off his coat and offered it to his sweetheart, who accepted it, knowing she was well cared for.

That last dinner we could rejoice once again with Joseph's great stories. As usual, there was good humor, the pleasure of being together, and Joseph's wise remarks. In the midst of anecdotes, jokes, and laughter, he made this reflection about Infant Psychiatry. "It is the most relevant of all the sciences. What would all advances of other sciences, computers, and space travels be worth without the human being? Our discipline deals with obtaining better human beings...and we are closer to achieving that goal each day."

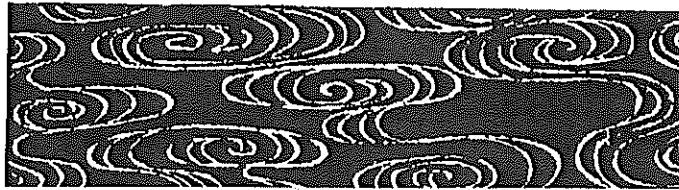
After dinner we all walked to their hotel. When we arrived, they insisted on walking with us to the corner so they could see us get to ours. We laughed at the absurd idea of accompanying each other forever. Then we said good-bye with fraternal love.

Today, February 5, 1997, we are on vacation some miles away from Montevideo. We almost never go back to our hometown, but, as if it had been predetermined, we had to return to find out the sad news: Joseph had died some days before.

The Noshpitzes had invited us to visit Washington, their beloved hometown, but reality changed our plans abruptly. However, love and memories bring us the hope that in some blooming spring we will be there and meet Joseph again, "our" dear Noshpitz, "our" dear Pepe, to continue a dialog that should never be interrupted.

Editor's Note:

Atlántida, Canciones, Uruguay, 1997. Miguel Cherro Aguerre is Psychoanalyst and Professor of Child Psychiatry at the University of Montevideo. Natalia Trenchi is a Cognitive Behavioral Therapist in Montevideo.



Centering Expertise

by Carol Harding

The current emphasis on client-centered or family centered practice, research, and service acknowledges the importance of the client/family for the successful outcomes of our efforts. Our attempts to place those with whom we work in the center of the work acknowledges that they offer a necessary expertise. However, it is unclear that we or they understand the role of their expertise or how best to collaborate in our joint enterprises. A better understanding of expertise and the ways we think about its function in the service of families may assist us in strengthening our well intentioned approaches to centering expertise around them.

"Expertise" can be assumed to be a human construction and, similar to the ways feminist scholars talk about "doing gender" (Lorber & Farrell, 1991), humans can also be assumed to "do expertise."

Humans, over time and within our societies, construct what is meant by expertise (and lack of expertise) and construct ways to recognize it, label it, and evaluate it. In addition, we begin to act as if power and privilege are assigned on the basis of constructs such as expertise and over time, come to think about and act as if a phenomenon such as expertise exists as part of some external reality.

With the development of professions such as physician, psychologist,

teacher, social worker, and lawyer, expertise has come to be situated in "the expert"—the professional who has a set of skills and a body of knowledge ready to be dispensed to those who seek her services. Recently, however, many of our professions and the disciplines underlying those professions have begun to consider expertise as an activity rather than as a person or a characteristic of a person. Post-structuralist thought provides examples of the limitations of the role of the expert and the ways in which the activity of expertise must change as the disciplines of social science undergo paradigm shifts away from the certainty, abstractions, and universals of modern, positivist science.

Ingram (1994) describes a primary activity of expertise as one of discovery: "The discovery of what is meaningful in relationship is not what is normative, standard, correct, prescribed, coded, approved, or experimentally reproducible" (p. 191).

Rather than validating the standards and norms that "experts" have employed in diagnosing and remediating the "problem" we now find our disciplines calling for methods of discovery and dialogue within the context of the lives and relationships of people—clients and families—who see themselves as needing to work on their "problem." Sometimes, in fact, it becomes clear, that we—the experts—are viewed as

"the problem" or at least part of the problem. Bogdan and Taylor (1992) pointed this out in their article titled *The social construction of humanness: Relationships with severely disabled people*:

The [caregivers] report that they have often been bombarded with specialists' judgments that, in their eyes, underestimate their partners' capabilities. They argue that specialists are not privy to the long, day-by-day, hour-by-hour observation of the person Unlike the [caregivers], professionals are not intimately familiar with their clients and therefore, are not attuned to the subtleties of their sounds and gestures. (Bogdan & Taylor, 1992; p. 283).

Most of us acknowledge that we don't and can't know everything and usually we can recognize the limitations of the objective, neutral, abstract knowledge base that has been the foundation of our expertise. We can agree that clients and families must contribute to our knowledge of them and their situations and that they should be at the center of our attention. However, what it means to be at the center and who gets to determine that meaning are questions that must be addressed.

Some families have reported that family-centered approaches indeed put them at the center, but that at times it feels like the center of a bull's-eye. Professionals use them as

the "target" of their services, expecting parents to know how to coordinate the multitude of professionals working with them, to identify priorities, and schedule varied and often unrelated treatments. Services are "aimed" at the family, bombarding the center. Some miss the mark; others pierce the heart. Families may feel that they have been placed at the center of someone else's target shooting. Neither the choices nor the power are vested in the family.

In a proposal written to seek funding for a parent driven support network for families and children with complex chronic illness, one parent wrote of her experiences: "Unlike formal education, parents of children with chronic illness didn't have a choice of what field of study they are interested in or what school they want to attend. We didn't choose to be educated experts in the field of chronic illness—we had to be." A second parent wrote: "I am developing an information resource database to provide referral information to help families navigate through the maze of services and programs Since I was a constant in my child's life, I felt I could do a better of and have more control over the quality of care he received while dramatically reducing costs" (Goldberg, 1994).

Expertise is an activity taking place at the center of the family-centered approach, just as it occurs as an activity engaged in by the professionals serving the family. In addition, and this is the important point of this brief essay, expertise must be viewed as an activity of discovery and engagement occurring at all points in the interaction. Dialogue is critical to discovery and engagement and this dialogue cannot occur only as prescriptions or advice directed at the family, but as conversations (listening as well as speaking) engaged in among all the players—including dialogue occurring between professionals.

For Ronald Heifetz (1994), a psychiatrist by training and a teacher

of leadership at Harvard University's Kennedy School of Government, the activity of leadership and/or expertise is "adaptive work," which builds on our personal and collective resources. Adaptive work, for Heifetz, "requires a change in values, beliefs, and behavior" (p. 22). As Heifetz (1994) describes:

For many problems, no adequate response has yet been developed No clear expertise can be found, no single sage has general credibility, no established procedure will suffice.... We look to our authorities [experts] for answers they cannot provide. What happens then? Authorities, under pressure to be decisive, sometimes fake the remedy or take action that avoids the issue by skirting it The flight to authority is particularly dangerous for at least two reasons: first, because [it] often occurs in response to our biggest problems and, second, because it disables some of our most important personal and collective resources for accomplishing adaptive work" (pp. 72-73).

As a reflection of "our most important personal and collective resources," we must keep our families at the center of practice, research, and service. However, that center must feel less like the center of a bull's-eye and more like the center of an embrace—both caring and supportive. To ensure that this embrace is based on our best knowledge and our best practices, we must educate people to "do expertise" as adaptive work, a shared activity of many players engaging in complex, thoughtful, and on-going dialogues. Just as parents must be helped to develop expertise in playing their roles at the center of the "embrace" so must professionals be helped to develop and practice expertise as one part of that embrace.

REFERENCES

- Bogdan, R., & Taylor, S.J. (1992). The social construction of humanness: Relationships with severely disabled people. In Ferguson, P.M., Ferguson, D.L., & Taylor, S.J. (Eds.). *Interpreting Disability: A Qualitative Reader*. NY: Teachers College Press.
- Goldberg, A.I. (1994). COACH: A proposal for Coordinating Action for Children's Health. Loyola University: Chicago.
- Heifetz, R.A. (1994). *Leadership without easy answers*. Cambridge: Harvard University Press.
- Ingram, D.H. (1994). Poststructuralist interpretation of the psychoanalytic relationship. *Journal of the American Academy of Psychoanalysis*, 22, 2, 175-193.
- Lorber, J., & Farrell, S.A. (1991). *The Social Construction of Gender*. London: Sage Publications.

Editor's Note: This article is reprinted from the Summer 1996 newsletter of the Illinois Association for Infant Mental Health.

WAIMH Member Survey

Question: how frequently should WAIMH hold its world congress?

Dear Member:

The WAIMH Executive Committee seeks your opinion about the frequency of WAIMH World Congresses. Prior to the merger of WAIPAD and IAIMH into WAIMH, WAIPAD met every three years and IAIMH met every two years. When the merger took place, a decision was made to meet every four years. The by-laws committee expressed concern that the volume of scientific and clinical research in infant mental health justifies more frequent meetings of the world community concerned with infants, their caregivers, and the contexts within which infant development takes place. This is particularly true if we expect our work to have public as well as scientific and clinical impact. Movement to a more frequent schedule for world congresses also would enhance the impact of regional congresses, enabling WAIMH to plan regional meetings more strategically as part of its overall training and technical assistance outreach. If the schedule for World Congresses changes, we will have to seek host

sites during 1998 because of the need to secure possible sites, hotel accommodations etc. as early as possible. To this end, the Executive Committee seeks your opinion about the frequency of World Congress meetings.

I would like to see the WAIMH World Congress held:

Every 2 years _____

Every 3 years _____

Every 4 years _____

Other _____

The results of the survey will be published in *The Signal*.

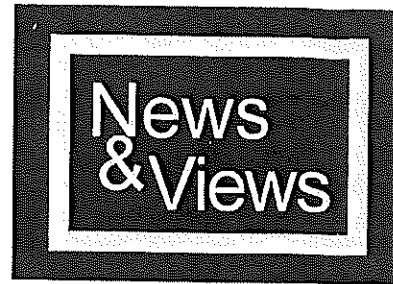
Return your opinion by mail, fax or email:

WAIMH
Kellogg Center #27
MSU
East Lansing, MI 48824-1022

Fax: 1-517-432-3694
email: waimh@pilot.msu.edu

Deadline: August 15, 1997

World Association for Infant Mental Health
ICYF, Kellogg Center #27
MSU
East Lansing, MI 48824-1022



Headstart Program, USA

The National Head Start Bureau is expanding its pool of peer reviewers and consultants who will assist with the review of current and future activities, policies and research. Contact Dakota Technologies Corporation, Head Start Reviewers and Consultants, W-A37, Fair Oaks Commerce Center, 11320 Random Hills Road, Suite 105, Fairfax, VA 22030, Fax 703-218-2483, email dakatacorp@aol.com

Call for Papers

Gaza Community Health Programme, 3rd International Conference on Health and Human Rights. Oct. 13-15, 1997. Contact: Mr. Husam El-Nounou, PO Box, Gaza City, Palestine, 972-7-865-949, fax: 972-7-824-072, email: gcmhp@baraka.org

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