The Signal

Vol. 6, No. 1 *Newsletter of the World Association for Infant Mental Health* *January—March 1998*

Infant Mental Health in the Public Health Setting: Bright Futures for Louisiana

Pediatric professionals have long recognized that psychological and social factors are important contributors to the health and well-being of infants, children, adolescents, and their families.

by Paula D. Zeanah, Ph.D., Geoffrey Nagle, M.S.W., M.P.H., and George Sterne, M.D.

Pediatric professionals have long recognized that psychological and social factors are important contributors to the health and well-being of infants, children, adolescents, and their families. As the diseases that had previously accounted for childhood disability and death became treatable, preventable, or completely eradicated through the use of immunizations, antibiotics, and other accomplishments of modern medical care, the impact of psychosocial factors on children's health has become even more evident. Physical, emotional, and sexual abuse, neglect, domestic violence, community violence, serious accidents and injuries, substance abusing parents, teenage parents, parents with serious mental illness, single parent families, and poverty are among the primary factors associated with child morbidity and mortality in the United States. These situations are all too commonly faced by infants and young children today, and contribute to the "new morbidities" of pediatric health care (Haggerty, Roghmann, and Pless, 1975). For example:

Unintentional injuries are the primary cause of death for children age 1 year through adolescence in the United States (CDC, 1998).

- It is estimated that about 2,000 children die each year from abuse and neglect, although many consider this a low estimate because of problems in accurately identifying abuse and neglect as the cause of death (U.S. Advisory Board on Child Abuse and Neglect, 1995).
- 25-50% of inner city elementary school-age children have witnessed a shooting, stabbing, or rape (Richters et al, 1993; Osofsky et al, 1993). Exposure to violence is associated with a variety of emotional and behavioral consequences, including posttraumatic stress disorder and other anxiety disorders, depressive disorders and self-harmful behaviors, anger and aggression, conduct disorders, social withdrawal, dependence, regression, overactivity, inattentiveness, learning problems, enuresis, nightmares, and sleep disorders (Jenkins and Bell, 1997).
- It is estimated that 22 to 35% of women seeking emergency treatment are battered women (Flitcraft et al, 1992); according to a recent survey, 31% of women reported having personally faced some type of abuse by their spouse (Lieberman Research, 1996). The overlap between domestic violence and child abuse is estimated to be 30-50% (Jaffe, Wolfe and Wilson, 1990; Strauss and Gelles, 1990), and even infants and young children who witness domestic and other violence are likely to show significant emotional and behavioral symptoms (Zeanah, 1994).
- It is estimated that at any one time 8% of mothers are clinically depressed (Downey and Coyne, 1990); the prevalence is higher in adolescent mothers, mothers with young children, and mothers facing significant environmental or social stressors, and those with previous depressive illness (Beardslee, 1989; Zuckerman and Beardslee, 1987). Clinical depression is associated with sad mood, irritability, lack of energy and interest in usually pleasurable activities, hypersomnia or insomnia, feelings of guilt, low self-worth,

IN THIS ISSUE

poor concentration, and recurrent thoughts of death. Thus, depressed caregivers may have little interest in, or energy and patience for the infant. Maternal awareness of fatigue, irritability or hostility directed toward her child may heighten feelings of guilt or self-reproach. Infants and young children of depressed mothers may exhibit a variety of symptoms, including aggressive behaviors, feeding or sleep problems, excessive crying, listlessness and apathy, failure to thrive, and even developmental delays (Beardslee, 1989; Green, 1992; Zuckerman and Beardslee, 1987).

- 6.6 million children under the age of 18 live with alcoholic caregivers (Russell, Henderson and Blume, 1984). Injuries and poisonings occur more frequently among children of substance abusing parents than children in the general population, and 40% of validated cases of child maltreatment involve parental substance abuse problems (Children of Alcoholics Foundation, Inc., 1996).
- In 1996, approximately 21% of all U.S. children were classified as living in poverty, compared to 15% in the early 1970's (U.S. Census, 1997). Poverty and its related effects have a significant impact on an infant's health and development, and young children who live in poverty have significantly higher infant mortality rates than children who are above the poverty level (Kiely, 1995).
- The percent of teenagers who bear children continues to rise in the United States, with an annual rate of 38 births per 1,000 females between 15 and 19 years old in 1994 (Kids Count Data Book, 1997). The numerous short and long term consequences associated with teenage pregnancy, which span health, social, developmental, psychological, educational, and economic problems, have been well-documented (Furstenburg, Brooks-Gunn, and Chase-Lansdale, 1989; Osofsky, Hann and Peebles, 1993).

Identification of these conditions, which jeopardize physical health and have significant impact on short and long term psychosocial functioning, frequently are not identified in pediatric visits, perhaps in part because they present as emotional and behavioral problems. Costello and her colleagues (Costello, Duncan, Burns, and Brent, 1988) have described psychopathology in pediatric primary care as the "hidden morbidity" because it is so infrequently identified. Nevertheless, identification of the underlying etiologies of psychological and behavioral problems in children is complicated because specific symptoms may have multiple etiologies. For example, just a few of the possible etiologies of overactivity in a young child include exposure to violence, maternal depression, a high lead level, poor parenting practices, or the child simply being constitutionally "active." Further, a single risk factor, such as maternal depression, is linked probabilistically to varying symptom patterns and outcomes in children, with increased risks for problems across a number of different developmental domains (Zeanah, Boris and Scheeringa, 1997).

In sum, the problems which most affect children's health and well-being today are complex. The causes and solutions are embedded within the social, economic, political, and moral fibers of our society. Because there are no quick fixes or simple solutions, prevention, recognition, and early intervention are essential.

Pediatric Primary Care

Pediatric primary care professionals have the advantage of being the most universally available group of professionals for children and families. As a result, pediatric primary care has become the natural focus of many new efforts and strategies to address psychosocial problems of children. In addition to the general availability of pediatric care, visits to the pediatrician or pediatric clinic are nonstigmatizing, and often serve to link families to other needed services or programs (Kaplan-Sanoff, 1995). Current efforts range from providing parenting education and support groups, to using developmental and family specialists in practice settings, to intensive home visiting programs for high risk families (see *Zero to Three*, 1995, June/July 1997 for reviews of various programs).

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*, 1998, Vol. 6, No. 1, WAIMH.

Bright Futures

In this article, we focus on *Bright Futures*, a comprehensive approach to health supervision, which considers the physical well-being within the psychosocial context of the child's experience. *Bright Futures* has been developed to address the general health care needs of children from infancy through adolescence, but the philosophy and approach are consistent with supporting and enhancing the development of infant mental health. *Bright Futures* strongly focuses on the development of a working relationship ("partnership") between the family/parent and health professional, recognizes and advocates the pediatric health professional's role in enhancing the relationships between parent and child through reinforcing family strengths and parenting competencies, and identifies contextual influences on the child's health and development. Finally, we describe the use of *Bright Futures* in Louisiana public health clinics, particularly as it is used to enhance attention to infant-parent issues.

A brief history of the development of *Bright Futures*

In 1990, the Maternal and Child Health Bureau of the Health Resources and Services Administration and the Medicaid Bureau of the Health Care Financing Administration initiated the *Bright Futures* project, which had as its goal the development of health supervision guidelines that would address the physical and psychosocial needs of children and families (Green and McCoy-Thompson, 1995). Dr. Morris Green, a pediatrician who had long advocated that pediatric professionals address these issues, provided the vision for the project; over 100 health professionals were convened to serve on the multidisciplinary board of directors, expert panels, and work groups (Green and McCoy-Thompson, 1995). The four expert panels, one each for infancy, early childhood, middle childhood, and adolescence, reviewed and incorporated the relevant literature in order to determine the "best practice" recommendations for the health guidelines. Over 950 professionals then reviewed the recommendations before the final product, *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, was published in 1994 by the National Center for Education in Maternal and Child Health (Green, 1994).

By mid-1997, over 50,000 copies of the guidelines had been distributed to individuals and communities concerned with preventive child health care. Today, it is being used a basis of training in over 250 medical and nursing schools, and the guidelines are used actively in numerous community health clinics, school, and other primary care settings (Palfrey, Mangu, McCoy-Thompson, 1997). *Bright Futures* has garnered the support of numerous professional organizations, such as Zero to Three, American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, American Medical Association, American Nurses Association, Child Welfare League of America, Inc., National Association of Social Workers, and the National Parent Teachers Association (Green, 1994).

Goals and philosophy

Bright Futures extends the traditional approach to pediatric health care to include a strong emphasis on the context of the child's experience. Four basic tenets encompass the philosophy of *Bright Futures*. First, health is viewed broadly, so that the pediatric professional evaluates not only physical growth and development, but also emotional, cognitive, and social development and functioning. Second, the pediatric professional must consider the broader context of the child's experience, including family, cultural, and economic variables. Third, health supervision is considered to be a partnership between health professionals and families. Thus, strong attention is paid to the development of a collaborative, trusting, working alliance between the caregiver and the health professional. The

Bright Futures, [is] a comprehensive approach to health supervision, which considers the physical well-being within the psychosocial context of the child's experience.

Table 1 Bright Futures Children's Health Charter

- Every child deserves to be born well, to be physically fit, and to achieve self-responsibility for good health habits.
- Every child and adolescent deserves ready access to coordinated and comprehensive preventive, health-promoting, therapeutic, and rehabilitative medical, mental health, and dental care. Such care is best provided through a continuing relationship with a primary health professional or team, and ready access to secondary and tertiary levels of care.
- Every child and adolescent deserves a nurturing family and supportive relationships with other significant persons who provide security, positive role models, warmth, love, and unconditional acceptance. A child's health begins with the health of his parents.
- Every child and adolescent deserves to grow and develop in a physically and psychologically safe home and school environment free of undue risk of injury, abuse, violence, or exposure to environmental toxins.
- Every child deserves satisfactory housing, good nutrition, a quality education, an adequate family income, a supportive social network, and access to community resources.
- Every child and adolescent deserves the opportunity to develop ways to cope with stressful life experiences.
- Every child and adolescent deserves the opportunity to be prepared for parenthood.
- Every child and adolescent deserves the opportunity to develop positive values and become a responsible citizen in his community.
- Every child and adolescent deserves to experience joy, have high self-esteem, have friends, acquire a sense of self-efficacy, and believe that she can succeed in life. She should help the next generation develop the motivation and habits necessary for similar achievement.

pediatric professional functions as a conduit to strengthen the role of the family and the caregiver, and their role in the provision of healthy practices and health education for the child. The health provider recognizes and reinforces family strengths and supports parental confidence and competence, in addition to attending to the traditional tasks of preventing, identifying, and treating health-related problems. Fourth, *Bright Futures* acknowledges that health supervision requires a partnership between the pediatric professionals and the greater community. It is not expected that the pediatric professional provide all services, but that the professional recognizes that optimum health may require involvement and collaboration with other health care or social service providers. Finally, *Bright Futures* recognizes that the individual, the family, and their environmental circumstances are unique, thus, the goal is to individualize care to the needs and strengths of each family (Green and McCoy-Thompson, 1995). The philosophy of *Bright Futures* is summarized in its charter (see Table 1).

Table 2
Selected developmental achievements, infancy period

Achievements During Infancy
- Good physical health and growth
- Self-quieting behavior
- Sense of trust
- Family adaptation to infant
- Mutual attachment between infant and parents
- Partnership between family and health professional

Tasks for the Family
- Establish regular eating and sleeping schedule
- Promote warm, nurturing parent-infant relationship
- Promote responsiveness and social competence
- Encourage vocal interactions with parents, siblings, and others
- Encourage exploration of the environment

Health Supervision Outcomes
- Formation of therapeutic alliance
- Satisfactory growth and development
- Promotion of developmental potential
- Prevention of behavioral problems
- Promotion of family strengths
- Enhancement of parental effectiveness

From: Green, M. (Ed.) (1994). Infancy developmental chart, *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* Arlington, VA: National Center for Education in Maternal and Child Health, p. 8.

Methods and Materials

Health supervision guidelines. The *Bright Futures* health supervision guidelines are presented in a manual which is organized into developmental sections and by the content of the health supervision visit. There are four developmental sections: infancy (0-12 months); early childhood (1-5 years); middle childhood (5-11 years); and adolescence (11-21 years). In each developmental section, the theme chapter provides an overview of common issues and developmental changes. Charts highlight expected achievements, tasks for the family, and health supervision outcomes for the specific developmental period. Child, family, and community strengths and problems or concerns commonly seen in the period also are listed, so that case-finding and priority issues can be identified. Tables 2, 3, 4, and 5 list selected examples of the content of the infancy period provided for health care providers and for parents.

The health supervision content is presented systematically. For each visit, a "*snapshot*" of common child and family issues provides additional developmental information. The goals of the health supervision interview are to obtain diagnostic data and to facilitate the development of the partnership between the health care provider and the caregiver. Examples of trigger questions to assist the provider in obtaining psychosocial information in a manner that draws upon the parent and child's expectations, concerns, and questions, are provided (Table 6). Important developmental milestones and physical examination priorities are identified.

A unique contribution of the *Bright Futures* guidelines is that attention is specifically given to the observation of parent-child interactions, as well as the behaviors and affect of the individual parent and child. This attention to parent-child interactions underscores the meaningful data which can be derived from observations which naturally occur during a health care visit, which can then be used for both evaluation and intervention purposes.

Age-appropriate screening procedures, including developmental, vision and hearing, metabolic, and other laboratory procedures, and immunizations, based on the Advisory Committee on Immunization Practices (ACIP) of the American Academy of Pediatrics, are identified for each visit.

Table 3
Selected strengths during infancy

Infant
- Is born wanted by parents
- Has good physical health and nutritional status
- Responds to parents and others
- Is adaptable
- Has some self-comforting behaviors
- Plays with toys

Family
- Meets basic needs (food, shelter, clothing, health care)
- Enjoys and feels attached to infant
- Offers emotional support and comfort when needed
- Uses appropriate disciplinary measures
- Has support of extended family and others
- Siblings are interested in and involved with infant in age-appropriate ways
- Parents are physically and mentally healthy

Community
- Provides support to new parents (parenting classes, support groups)
- Provides educational opportunities for parents
- Provides support for families with special needs
- Provides an environment that is free of hazards (e.g., violence, pollution, lead, asbestos)
- Promotes community interactions (neighborhood watch programs, community centers)
- Promotes positive ethnic/cultural milieu

From: Green, M. (Ed.) (1994). Strengths during infancy, *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* Arlington, VA: National Center for Education in Maternal and Child Health, p. 10.

Table 4 Selected issues

Infancy	Family	Community
Prematurity	Dysfunctional parents or other family members	Poverty
Feeding problems	Marital problems	Community violence
Baby bottle tooth decay	Domestic violence	Lack of affordable, high quality child care
Fussing crying, colic, irritability	Rotating parents	Isolation in rural community
Infections, illness	Family health problems	Discrimination, prejudice
Constipation, diarrhea	Family health problems	Poor opportunities for employment
Developmental delay	Lack of knowledge about infant development	Lack of social educational, cultural and recreational opportunities
	Lack of parenting skills	
	Intrusive family members	
	Lack of social support with newborn siblings	
	Neglect or rejection of child	

Finally, anticipatory guidance guidelines are provided. Anticipatory guidance is the provision of health and development education for families so that they may be aware of issues which may arise and need to be addressed before the next health visit. Topics are divided into several broad categories: healthy habits, prevention of illness and injury, nutrition, oral health, sexuality, social development, family relationships, parental health, community interactions, self-responsibility, and school/vocational achievement. Information included in the anticipatory guidance guidelines is age-relevant, so not all categories are listed at each visit. Further, since it is not realistic to talk about all topics at a given health visit, the health care provider and the parent (and child, when old enough) determine those areas to discuss that are most important or pressing. Information provided during the health visit can be supplemented by handouts, videos, books or booklets, as needed and as available. There is a strong emphasis on supporting those behaviors and activities which will strengthen the relationships between the child, caregiver, and family.

Finally, the findings and recommendations are summarized. Referrals to appropriate community agencies or other health or social service providers, recommendations for more frequent visits for high risk families, or other interventions, are determined. In order to be most effective, the provider needs to be aware not simply of the type of services available, but of those services which are family-centered and culturally sensitive. Awareness of the practical issues involved in referrals also is important, such as the cost, need for transportation, hours available, waiting list, and of course, the competence in which services are rendered (Green, 1994).

Table 5 Selected examples, anticipatory guidance for the family, 9 month visit

Promotion of healthy habits

- Injury and illness prevention
- Get down on floor and check for hazards at baby's eye level.
- Do not leave baby alone in a tub of water or on high places. Always keep one hand on baby.
- Recognize early signs of illness (e.g., fever, failure to eat, vomiting, unusual irritability).
- Nutrition
- Encourage finger foods and mashed foods as appropriate.
- Continue to breastfeed or use iron-fortified formula for the first year of the infant's life.
- Continue teaching the infant how to drink from a cup.
- Oral health
- To protect the infant's teeth, do not put him to bed with a bottle or prop it in his mouth.
- Clean the infant's teeth with a soft brush.
- Give the infant fluoride supplements as recommended by the health professional.

Promotion of parent-infant interaction that is mutually enjoyable and satisfying

- Discuss with the health professional the baby's temperament and how the family is adapting to it.
- To set limits and discipline the infant at this age, use distraction, proximal physical presence, structure, and routines. Limit the number of rules and consistently enforce them.
- Consistently provide the baby with the same transitional object so that he can console himself at bedtime or in new situations.

Promotion of constructive family relationships and parental health

- Take some time for yourself and spend some individual time with your partner.
- Encourage your partner's involvement in health supervision visits and infant care.
- Keep in contact with friends and family members. Avoid social isolation.

Promotion of community interactions

- Learn and consider attending parent-child play groups.
- Ask about resources or referrals for good, housing, or transportation if needed.

From: Green, M. (Ed.) (1994). Anticipatory guidance for the family (9 month visit), *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* Arlington, VA: National Center for Education in Maternal and Child Health, p. 72-74.

Supplemental clinical materials

In an effort to enhance the implementation of the guidelines, and to provide more detailed health promotion and disease prevention information, the Maternal Child Health Bureau provided a multi-year grant to the National Center for Education in Maternal Child Health. *Bright Futures* is developing educational materials and tools, and training and evaluation procedures to ensure that the original goals of strengthening the development of partnerships between professionals, families, and communities, improving health care practice, and increasing family knowledge and skills, are implemented.

Table 6
Selected trigger questions for health supervision interview during infancy

- How do you think the baby will change your lives?
- Have things gone as you expected?
- When you have questions about the baby, whom do you expect to ask?
- Have you been feeling tired or blue?
- What questions or concerns do you have at this time?
- How would you describe your baby's personality? How does your baby respond to you?
- How are your other children doing?
- What do you find most enjoyable about your baby? What do you find most rewarding?
- Can you tell when your baby wants to eat? Go to sleep?
- What are your thoughts about discipline?
- Does your partner every lose his temper, throw things, threaten you, or hurt you?
- What do you do when problems seem to be getting to you? To whom do you turn at those times?
- Have there been any unexpected stresses, crises, or illnesses in you family since your last visit?

From: Green, M. (Ed.). (1994) Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. Arlington, VA: National Center for Education in Maternal and Child Health.

Bright Futures has developed a pocket guide for the health supervision guidelines, which includes brief information regarding the interviews, developmental observations, physical exam and screening procedures, and anticipatory guidance. Specific practice guidelines are or have been developed. These implementation guides focus on oral health (developed in 1996-1997), nutrition (expected to be released in early 1998), and mental health (currently being developed). *Bright Futures* has developed separate educational and clinical forms that can be used for health supervision visits and the provision of anticipatory guidance. Parent/patient education materials for anticipatory guidance help parents to prepare for health visits, and other materials which can be used in the office have been or are being developed (Palfrey et al., 1997). There are no copyright restrictions on *Bright Futures* materials; clinicians are encouraged to use them fully and liberally.

Bright Futures consultants conduct workshops with professionals, administrators, policymakers, parent advocates and others to orient them to the philosophy, goals, and methods of *Bright Futures*. Specialized training on interviewing skills, child development, and anticipatory guidance has been developed.

Implications for infant mental health

A task force on infant mental health, organized by the Louisiana State Office of Mental Health (1993) defined infant mental health as: the presence of age-appropriate social, emotional, and behavioral competencies which develop within supportive family relationships and ethnic and cultural contexts. In examining infant mental health, professionals and families, ***working together as a team***, should, at a minimum, consider: 1) the infant's age and developmental status; 2) the infant's uniqueness, gender, genetics, strengths, sensitivities, vulnerabilities, and specifically identified problems in the areas of temperament, responsiveness, and interactions; 3) qualities of interaction between the infant and primary caregiver; 4) direct environmental influences on the infant occurring prenatally and postnatally; and 5) the qualities of the caregiving environments, including societal, cultural, and ethnic influences on the infant and family."

The overlap between this definition of infant mental health and the goals of *Bright Futures* is striking. Since pediatric professionals are those most likely to come into contact with infants, children, and families on a regular basis, they can serve an extremely important role in providing support and education to families, as well as identifying risk factors and situations. A number of pediatric primary care intervention programs which focus on infant mental health have been described recently (e.g., see *Zero to Three*, August/September 1995, whole issue, and *Zero to Three*, June/July, 1997, whole issue). What makes *Bright Futures* unique is the use of the traditional pediatric primary care visit to integrate the physical with the social, cognitive, and emotional health care needs of children and their families. Enhanced support for the development of positive working relationships between the provider-caregiver provide a model for, and thus hopefully strengthen, caregiver-infant and family-community relationships as well. Because factors overlap which are detrimental to, or which can improve, infant health, development, cognition, and developing attachment and social relationships, a comprehensive approach to primary health care is necessary. Thus, implementation of *Bright Futures* may provide one of the best types of primary prevention available for infant mental health for many of the factors currently associated with morbidity and mortality in infancy and early childhood.

Bright Futures in Louisiana

Louisiana, located in the gulf south region of the United States, is routinely ranked at or near the bottom of indicators of child health and welfare in the country. In 1997, Louisiana had the highest child poverty rate in the United States, with 34% of children living in poverty; 18% of Louisiana's children live in extreme poverty (income below 50% of poverty level). The state ranked 50th out of 50 states in percent of low birth weight babies, infant mortality, and percent of families with children headed by a single parent (33%) (*Kids Count Data Book*, 1997). As in the U.S. in general, unintentional injuries are the leading cause of death in children after the neonatal period (Mel Kohn, M.D., M.P.H., Medical Director, Injury Research and Prevention Section, Louisiana Office of Public Health, personal communication). The exact percentage of injury-related deaths directly attributable to abuse or neglect is unknown; however, in 1996, there were 14,863 validated cases of child abuse and neglect, affecting 11,000 children (3%) in Louisiana. 180 children, approximately 30 per year, died as a result of validated abuse or neglect between 1989 and 1995; 79% of these victims were under three years of age (Louisiana Office of Community Services, 1996). The high rates of child abuse, poverty, low birth weight infants,

and infant mortality make these a major focus of current public health efforts.

Because Louisiana is a poor and mostly rural state, access to adequate medical care is problematic; availability of support services, including mental health services for young children, is sorely lacking, often completely unavailable. Public health nurses in Louisiana, like public health nurses elsewhere, traditionally have provided numerous direct and preventive health care services for preventable medical conditions, such as tuberculosis, sexually transmitted diseases, and childhood communicable diseases. Although they primarily work with those who have few health care resources, public health nurses interact with children and families across socioeconomic lines. It is estimated that public health nurses have at least some contact with 56% of all the children under the age of one in Louisiana (*Louisiana Office of Public Health Statistics, 1998*). Most services are provided in a clinic or school settings, however, public health nurses frequently make home visits to families deemed to be "at risk" for a variety of reasons, such as children with chronic or other special health problems, lack of attendance for scheduled clinic visits, or worrisome or suspicious findings during a health visit.

Most public health nurses work within the communities in which they grew up; they are personally familiar with their clients' mores, beliefs, and values, as well as the systems and resources available in the area. Because they see clients for health and preventive care, often provided in multiple settings over time, public health nurses have the opportunity to get to know immediate and extended family members. They are highly regarded by their clients (Sackoff, 1996). They are positioned ideally to support and educate parents, to identify early potential problems, and to refer and coordinate with other agencies and providers. By virtue of their immersion in direct care, the nurses are aware that many of the behaviors and interactions they observe between parents and children reflect the need for preventive interventions. In a recent state-wide survey, nurses identified further training in the assessment of parenting behaviors and high risk parents, as well as more parenting education and support for clients, as two of the major needs in dealing with parenting-related problems (Zeanah, 1997).

As part of the efforts to address the high morbidity and mortality rates of children in Louisiana, the state Office of Public Health, Maternal and Child Health Section (OPH-MCH), is making a concerted effort to strengthen nurses' assessment and intervention skills regarding parenting, to provide more and better parent education materials and tools, and to improve collaborative efforts between agencies and services serving young children. Because *Bright Futures* addresses all of these goals and can be integrated easily into existing services, it has been selected to serve as the primary guideline for the provision of child health care in the public health units.

Copies of *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* have been distributed statewide. Selected state-level consultants, regional administrators, nursing staff, and private-practice pediatricians recently were trained by *Bright Futures* staff in the goals of the program, the use of the manual, and improved skills for interviewing and providing anticipatory guidance. This training currently is being provided to public health nurses across the state. However, simply having access to and knowledge about the guidelines cannot address all of the issues of implementation; fortunately, adoption of the *Bright Futures* guidelines coincides with several related efforts of the MCH division.

Updated procedures

As documentation procedures can enhance the use of the guidelines, we redesigned child health record forms to be consistent with the parameters identified in the *Bright Futures* health supervision guidelines. These one-page, age-specific forms will be used for all types of child health visits (e.g., health screening, follow-up, and certification for WIC). In addition to recording results of the physical examination, brief cues assist the nurse in the assessment and documentation of infant/child behavior, parent-infant/child interactions, parent/family issues, and in identification of specific, relevant areas for anticipatory guidance. We hope that use of these forms will improve identification of actual and potential problems, referrals to other services both within and outside of the public health system, and will ease follow-up of previously identified problems at subsequent visits.

Infant mental health training

A 25-hour pilot training program in Infant Mental Health, developed by the Office of Public Health, Maternal and Child Health Section, in collaboration with the Louisiana State University Department of Psychiatry, recently was completed in one southern Louisiana parish (county). The goal was not to train nurses to become infant mental health professionals *per se*, but rather to help them formulate the rich data to which they have access, to boost their confidence in using their observations, skills, and knowledge to provide assessment and interventions for parenting issues, and to reinforce their roles in physical and mental health prevention.

The specific objectives of the training were three-fold: 1) to improve nurses' knowledge and skills in early recognition of factors and conditions which place the infant and caregiver at risk for immediate and long term problems in social, emotional, and cognitive growth and development; 2) to develop a repertoire of preventive interventions specifically aimed at enhancing parent-infant relationships and decreasing the incidence of child abuse and neglect; and 3) to develop and strengthen working relationships with local agencies which provide services and support to families and children. Most of the sessions were didactic, but we also used clinical videotapes to illustrate concepts, including healthy and problematic behaviors and interactions. We provided supplemental readings, and allowed adequate time for the nurses to raise questions about cases, and to discuss their own values, biases, and concerns about parenting. Representatives from local outside agencies, including a substance abuse clinic, a battered women's shelter, child abuse services, and a counseling and parent

education agency, helped the nurses to be more informed about the agencies to whom they refer, and to work on improving referral and communication patterns.

The formal evaluation of this program is now underway; informally, the nurses have been extremely enthusiastic and receptive. They reported that it did, in fact, help them to "see things differently," and it increased their confidence in their clinical skills. The nurses were eager for more training, and we have continued to provide follow-up and case supervision on a periodic basis. Once the initial evaluation is completed, the program will be implemented in additional regions throughout the state.

Development of referral services

Better assessment and brief intervention skills are essential, of course, in any type of preventive effort. However, a major concern is that once problems are more clearly identified, sufficient referral sources must be available. Most communities have parenting classes available, but these classes typically are not adequate to address the pervasive, overwhelming, and often chronic problems facing many of Louisiana's children and families, especially those that affect parenting ability most directly. We are working with state and local agencies to improve collaboration with and availability of social, mental health, and early intervention services, but this is a slow process, dependent upon funding priorities and sources, and more important, the vision, energy, and determination within local communities to develop appropriate supports for families and children.

Home visiting programs

OPH-MCH currently funds four paraprofessional home-visiting programs, based on the Healthy Families America Model (NCPCA, 1997), which target specific high-risk populations. The specific criteria for admission to the programs vary, but all aim to provide early enrollment (prenatally or within the first few weeks of life), and long term (up to five years) intervention. A number of advocacy groups are now pushing Louisiana legislators to provide funding for broader implementation of home visitation programs, as such programs show great promise for reducing child abuse and neglect and childhood injuries, and decreasing unwanted subsequent pregnancies (Kitzman et al., 1997; Olds et al., 1997). In a fiscally poor state, such as Louisiana, obtaining funding for programs such as these is an uphill battle. Nevertheless, we are encouraged by the level of support these programs have generated by individuals and groups with disparate interests, all of whom share a stake in the well-being of children in Louisiana.

The goals of Bright Futures and the preventive intervention efforts such as those taking place in Louisiana appeal to our hopes and desires for ensuring a bright future for our youngest citizens.

From ideas to implementation

The goals of *Bright Futures* and the preventive intervention efforts such as those taking place in Louisiana appeal to our hopes and desires for ensuring a bright future for our youngest citizens. Of course, such efforts are easier to discuss than to implement. Lack of skills or knowledge, lack of time, "higher priority" problems, role conflict, fears of negative consequences of labeling parents and children, as well as transference and countertransference issues between caregivers and providers are common barriers to providing comprehensive care to children (Burns and Burke, 1985; Sharp, Pantell, Murphy, and Lewis, 1992). There are no easy answers to these problems. *Bright Futures* provides education, materials, and a basic format to help health care providers to address some of these issues, but as the developers acknowledge, the best health care must be provided within the context of partnerships between clinician and caregiver, parent and child, family and community, clinician and community (Green, 1994).

It is essential to determine if our efforts are accomplishing our goals. Though education, prevention, and partnerships make good clinical sense, we need empirical support to inform and guide what we do. Exactly how can the clinician best use the brief time available in a child health visit to address not only the urgent health care needs but also provide prevention and health promotion interventions for the child and family has not been determined. Rigorous research, whose methodologies include large sample sizes, comparison groups and interventions, long term follow-up and appropriate statistical analyses, needs to be conducted. Plans are underway to determine the efficacy of *Bright Futures* in practice and to determine if the practice guidelines make a difference in health outcomes for children and their families, an essential beginning.

Summary

Psychosocial problems of infants, children, and families are among the major public health problems of today. Many experiences during infancy and early childhood can enhance or significantly deter later physical, social, emotional, and cognitive development. Multiple strategies, implemented by professionals, families, and the larger community are required if we are to have any hope of eradicating the ills which affect so many of our children now, and which have such long term consequences on functioning. *Bright Futures* provides an approach to assessment, prevention, health promotion, and clinical interventions in pediatric settings. *Bright Futures* sets forth an ideal that may seem impossible to attain for many pediatric clinicians. However, as *Bright Futures* shows us how to teach parents to have reasonable expectations of their children by showing empathy, compassion, and support for parents themselves, we would do well to heed the advice ourselves. By developing reasonable expectations for families, by working with other professionals who supplement and enhance our efforts, and by acknowledging even small accomplishments, pediatric health visits can provide us all with bright futures.

[1]Barry Zuckerman, M.D., Chair, Infancy Panel; George G. Sterne, M.D., Early Childhood Panel; Judith Palfrey, M.D., Chair, Middle Childhood Panel; Elizabeth McAnarney, M.D., Chair, Adolescent Panel

For more information on *Bright Futures*, contact:

Pamela Mangu, M.A., Senior Project Director
Bright Futures Project
National Center for Education in Maternal and Child Health
2000 15th Street, North suite 701
Arlington, VA 22201-2617
(703) 524-7802
(703) 524-9335 (fax)
brightfutures@ncemch.org

References

Anon. (1996). *Collaboration, coordination, and cooperation: Helping children affected by parental addiction and family violence.* New York: Children of Alcoholics Foundation, Inc.

Anon. (1997). *Kids Count Data Book: 1997*, Annie E. Casey Foundation, p. 21.

Beardslee, W.R. (1989). Children of parents with affective disorder. *Pediatric Review*, 10, 313-319.

Burns, B.J. and Burke, J.D. (1985). Improving mental health practices in primary care; Findings from recent research, *Public Health Reports*, 100, 294-300.

CDC (April 29, 1998). *Ten Leading Causes of Death, United States 1993-1995.* (Electronic data base-On-line). National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control. Available Internet: www.cdc.gov/ncipc/osp/leadcaus/ustable/htm.

Costello, E.J., Edelbrock, C., Costello, A.J., Dulcan, M.K., Burns, B.J. and Brent, D. (1988). Psychopathology in pediatric primary care: The new hidden morbidity. *Pediatrics, 82*(3), 415-428.

Downey, G. and Coyne, J.C. (1990). Children of depressed parents: An integrative review. *Psychological Bulletin, 108*, 50-76.

Flitcraft, A.H. (1992). Diagnostic and treatment guidelines on domestic violence. American Medical Association, Chicago, IL, p. 8.

Furstenburg, F.F., Brooks-Gunn, J., and Chase-Lansdale, L. (1989). Teenaged pregnancy and childbearing, *American Psychologist*, 44, 313-320.

Green, M. (1992). Maternal depression: Bad for children's health, *Contemporary Pediatrics*, 10, 28-36.

Green, M. (Ed.) (1994). *Bright Futures; Guidelines for health supervision of infants, children and adolescents.* Arlington, VA, National Center for Education in Maternal and Child Health.

Green, M., and McCoy-Thompson (1995). Bright Futures: Health supervision guidelines and their implementation, *Zero to Three,* Washington, D.C.: National Center for Clinical Infant Programs.

Haggerty, R.J., Roghmann, K.J., and Pless, I.B. (Eds.) (1975). *Child health and the community*, New York: John Wiley and Sons.

Jaffe, P., Wolfe, D. and Wilson, S. (1990) *Children of battered women.* Newbury Park, CA: Sage Publications.

Jenkins, E.H. and Bell, C.C. (1997). Exposure and response to community violence among children and adolescents. In J.D. Osofsky (Ed.). *Children in a violent society*, New York: Guilford Press.

Kaplan-Sanoff, M. (1995). Pediatric pathways to success: The power of pediatric practice to support families, *Zero to Three*, 16, 12-17.

Kiely, J.L. (1995). Poverty and infant mortality-United States, 1988. *Morbidity and Mortality Weekly Report,* Centers for Disease Control and Prevention, 44, 922-927.

Kitzman, H., Olds, D.L., Henderson, C.R., Hanks, C., Cole, R., Tatelbaum, R., McConnochie, K.M., Sidora, K., Luckey, D., Shaver, D., Engelhardt, K., James, D., and Barnard, K. (1997). Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing. *JAMA, 278*, 644-652.

Louisiana Office of Community Services (1996). Data on child abuse/neglect fatalities, 1989-1995, Unpublished data.

Lieberman Research, Inc. (1996). *Domestic violence advertising campaign tracking survey,* Wave 3, November 1995. San Francisco, CA: Family Violence Prevention Fund and the Advertising Council.

National Committee to Prevent Child Abuse (NCPCA, 1997). *Healthy Families America: Community Planning and Site Development Guide*, Chicago, IL: National Committee to Prevent Child Abuse.

Olds, D.L., Eckenrode, J., Henderson, C.R., Kitzman, H., Powers, J., Cole, R., Sidora, K., Morris, P., Pettitt, L.M., and Luckey, D. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect: A 15-year follow-up of a randomized trial. *JAMA, 278*, 637-643.

Osofsky, J.D., Hann, D.M. and Peebles, C. (1993). Adolescent parenthood: Risks and opportunities for mothers and infants. In C.H. Zeanah (Ed.) *The handbook of infant mental health*, New York: Guilford Press.

Osofsky, J.D., Wewers, S., Hann, D.M., and Fick, A.C. (1993). Chronic community violence: What's happening to our children? *Psychiatry, 56*, 36-45.

Palfrey, J., Mangu, P., and McCoy-Thompson (1997). Building bright futures, *Zero to Three*, Washington, D.C.: National Center for Infants, Toddlers and Families.

Richters, J.E. and Martinez, P. (1993). Children as victims of and witnesses to violence in a Washington, D.C. neighborhood. In L. A. Leavitt and N. A. Fox (Eds.), *The psychological effects of war and violence on children*, Hillsdale, NJ: Lawrence Erlbaum Associates.

Russell, M., Henderson, C., and Blume, S.B. (1984). *Children of alcoholics: A review of the literature.* New York: Children of Alcoholics Foundation, Inc.

Sackoff, D. (1996). Summary, health units client satisfaction survey (Unpublished data, Louisiana Office of Public Health.

Sharp, L., Pantell, R., Murphy, L, and Lewis, C. (1992). Psychosocial problems during child health supervision: Eliciting, then what? *Pediatrics*, 89, 619-623.

Strauss, M. and Gelles, R.J. (Eds.) (1990). *Physical violence in American Families.* New Brunswick, New Jersey: Transaction Publishers.

U.S. Census Bureau (1997). *Poverty rates by age: 1959-1996*, U.S. Census Bureau, Housing and Household Economic Statistics Division.

U.S. Advisory Board on Child Abuse and Neglect. (1995). *A nation's shame: Fatal child abuse and neglect in the United States.* Washington, D.C.: U.S. Advisory Board on Child Abuse and Neglect.

Zeanah, C.H. (1994). The assessment and treatment of infants and toddlers exposed to violence, in J. Osofsky and E. Fenichel (Eds.). *Hurt, healing, hope: Caring for infants and toddlers in violent environments.* Washington, D.C.: Zero to Three/National Center for Clinical Infant Programs.

Zeanah, C.H., Boris, N. & Scheeringa, M. (1997). Psychopathology in infancy. *Journal of Child Psychology, Psychiatry and Allied Disciplines, 38*, 81-99.

Zeanah, P. (1997, May). *Parent training and support services survey*, Unpublished data, Office of Public Health, Maternal and Child Health Section,

Zuckerman B.S. and Beardslee, W.R. (1987) Maternal depression: A concern for pediatricians. *Pediatrics*, 79, 110-117.

***Editor's Note:** Paula Zeanah, Ph.D., is Assistant Professor of Psychiatry at the Louisiana State University School of Medicine in New Orleans. Effective July 1, 1998, she will be Associate Professor of Psychiatry and Pediatrics at the Tulane University School of Medicine in New Orleans. She will remain a Child Mental Health Specialist in the Office of Public Health of the State of Louisiana.*

Geoffrey Nagle, M.S.W., M.P.H., is Child Health Manager in the Office of Public Health of the State of Louisiana. George Sterne, M.D., is in the private practice of pediatrics, and a Clinical Professor of Pediatrics at the Tulane University School of Medicine in New Orleans.

In Memoriam

Norma Miller Ringler, Ph.D.
March 22, 1924—March 22, 1998

Norma Miller Ringler's passion and deep commitment for enhancing the quality of life of infants and young children was evident in every facet of her professional and personal life. Her research spanned cultures and developmental issues, with a special interest in language development as it occurred within the context of mother-infant interaction. For example, Norma was among a small number of investigators who identified differences in maternal speech when directed toward infants and toddlers in contrast to that directed toward adults. This work, which others eventually labeled "motherese," paved the way for greater precision in understanding how caregivers altered the young child's language environment in reaction to their perception of the child's level of competence. Norma's scientific work appeared in such distinguished journals as *Child Development*, the *Journal of Pediatrics*, and the *Infant Mental Health Journal*. Over the course of her professional life, she taught at Case Western Reserve University (where she did work with Marshall Klaus and John Kennell), Cleveland State University, Nova Southeastern University in Florida, and as recently as 1995, was engaged in research with Tiffany Field at the Touch Research Institute.

Norma's service to the field of infant mental health was full service from the outset. When the International Association for Infant Mental Health was formed in 1979, Norma was among its first members, a regular contributor to its biennial conferences, and a contributing member of its Board of Directors. She was secretary of IAIMH at the time it merged with the World Association for Infant Psychiatry and Allied Disciplines, and had the merger not occurred, was in line to become IAIMH President following Sonya Bemporad's term. The merger occurred of course, and Norma was among the first to send a letter of congratulations. She always held advancement of the field of infant mental health as the highest priority, was extraordinarily supportive of efforts to build a strong scientist-practitioner professional association to support training, research, and clinical studies of families with infants, toddlers, and preschoolers. No one provided me with stronger encouragement over the years than Norma; always encouraging, always sympathetic, always offering a listening ear, always patient, and absolutely always sharing her wisdom about interpersonal dynamics, and almost always with her husband Albert by her side. Her resolute, positive dedication to the field of infant mental health and to the infants and families with whom she worked, challenges every infant mental health specialist to reach just a bit deeper, to go just a little bit further, in order to strengthen the quality of the infant's caregiving experience. I, and the field of infant mental health, will miss her deeply.

—Hiram E. Fitzgerald

From the Editor . . .

Infant Mental Health, Infant Mental Health, Wherefore Art Thou Infant Mental Health?

Increasingly, as I talk to people interested in our field, I hear more and more agonizing about the term, "Infant Mental Health." "We really need a new name for this," they say. "Is this really capturing what we want?" they ask. "What would be a better way to say what we mean?" they ponder. These and other comments suggest to me that we are struggling not only with our name, but more profoundly with who we are and what we are about.

Are we about disorders and psychopathology? Or, are we about risk and protective factors that moderate disorders and psychopathology? Are we about social competence? Are we about brain development? Are we about parent education? Psychopharmacology? Psychoanalysis? Nutrition? Massage? Chaos Theory? Motor development? Are all of these related to mental health? Or, as Jeree Pawl challenges us, "What is it that we really want to teach people? What is it that we want them to know?" All of this questioning is a healthy endeavor for a new field, and it provides an occasion for assorted reflections on our name and our field.

In the next few issues of *The Signal,* I will publish the reflections of a number of WAIMH members on some aspect of these questions. Please feel free to submit your thoughts to me unsolicited—hardly anything is more exciting than an unsolicited manuscript for publication in *The Signal* from a member of WAIMH. I will call this new feature, "Reflections on Infant Mental Health."

To begin the process, I requested and received permission from Alicia Lieberman to include some remarks she made on another occasion. I invite all of our members to respond to these pieces with letters, commentaries or full-length papers on the general topics of who we are and who we want to be. I will be happy to include them in "Reflections" in future issues.

A PERSPECTIVE ON INFANT MENTAL HEALTH

Alicia Lieberman, Ph.D.

Sigmund Freud said that mental health consists of loving well and working well. We can quibble with what this really means, because there are so many ups and downs in the quality of our loving and of our working, but who can ask for more than loving well and working well as emblems of a life well lived? If this is so, we can define the mental health professions at their best as disciplines that aim at helping people love well and work well by alleviating rigid patterns of thought, feeling, and behavior that result in damage and pain to the person and/or to those who come in contact with him or her.

The joy and vibrancy of babies, as they relate to others and master new skills, seem an embodiment of the mental health landmarks of loving well and working well. Still, it is essential to understand the origins and the course of mental health disorders in the first years of life, both for appropriate intervention in the moment and for successful preventive efforts.

When we look at the field of infant mental health specifically, it seems to me that there are five main principles that define this point of view and transcend specific theoretical frameworks. The first three principles have to do with looking at external behavior as an expression of inner, subjective experience. The final two principles have to do with how we frame and carry out interventions.

External behavior as an expression of inner subjective experience

1. Babies are by nature social creatures. They exist and develop in the context of relationships, and their functioning needs to be assessed and understood within the framework of these relationships. These relationships are always dyadic at one level, in the sense that they involve the baby and a specific other person, but this does not mean that babies have meaningful relationships with only one primary caregiver. On the contrary, deep emotional bonds develop between the baby and a variety of people who have a regular role in his or her life. These emotional bonds influence each other and come to form a matrix of interpersonal connections that in normative conditions build the earliest foundations for mental health by helping the baby feel loved, valued, and competent, as opposed to feeling unwanted, burdensome, and ineffective.

When one of the baby's primary relationships does not support the baby's developmental needs, the baby's confidence in himself and others is undermined, but he can continue to maintain a basically sound developmental course if other appropriate and satisfying intimate relationships are available. The adults support each other in supporting the child, and compensate for each other when one of the caregivers falters. This is why committed family networks and other social supports are important in child rearing. Adults, like babies, are social creatures by nature, and they need each other in every important facet of their lives, most particularly in demanding emotional endeavors such as raising a child.

Straightforward as it may sound, this principle that babies are social creatures functioning within the matrix of relationships is also deceptively simple. While it is true that several people may have a central role in caregiving, it is inaccurate to assume that these relationships are interchangeable from a baby's point of view. A baby can love several people, but each of these loves has a specific quality and a unique place in the baby's internal landscape. Being a social creature does not mean being an indiscriminate creature, and it is the passionate "only you" sustaining power of intimate relationships that is at the core of the baby's capacity to love well and to grow well.

2. Individual differences are an integral component of babies' functioning. The specific terms that we use to describe babies' individual differences may differ, depending on our professional discipline and theoretical prefer-

ences, but we share a recognition that each baby and each parent is unique in many different ways. This means that while we can understand important aspects of the baby's functioning by relying on developmental principles, we also need an appreciation of each baby's individuality along a variety of dimensions. Each parent is also unique. To understand the baby and her relationships in depth, we need to become acquainted with each partner's temperamental style, skills, areas of vulnerability, motivations, fears, and wishes and how each partner's characteristics interact with one another. Only then can we appreciate fully the areas of goodness of fit and the inevitable areas of mismatch and tension in every baby-parent dyad and in every family constellation.

3. Every individual exists in a particular environmental context that deeply affects the person's functioning. When we think of a baby in the context of her relationships, we often make the unconscious assumption that parents can control their circumstances and what they offer to their children. But parents are not independent agents. How they raise their children is influenced not only by how they were raised themselves and who they become, but also by the everyday circumstances of their lives, the resources to which they have access, and the quality of life they can provide, materially and psychologically. As the Spanish sociologist Jose Ortega y Gasset put it, "Yo soy yo y mi circumstancia" (I am myself and my circumstances). Humans exist only in the context of their life situations; there is no "me" independent of the circumstances of my life.

We usually think of support systems in human terms—a spouse, a parent, a friend. But support systems consist also of community networks of supplies and services that keep us safe, able to take daily survival pretty much for granted, and therefore free to devote a considerable portion of our energy to relationships and to work. For a child raised in the middle-class circumstances that are still the norm in this country, life tends to unfold in a concentric series of circles that support each other—her resourceful parents, her decent house, her good school, her safe neighborhood, her access to adequate and affordable medical care. American society is not classless, however. Social class is one of the most important predictors of developmental outcome, as it molds the child's identity by shaping the specific circumstances of his life.

We must also consider culture as a shaper of children, defining culture as the sum total of a group's ways of living and being, including language, ethnicity, religion, moral values, rules for relating in social situations, expectations of oneself and others and, most basically, the question of what meaning people find in different aspects of life. Cultural differences are to groups what individual differences are to individuals. Understanding a child, therefore, needs to involve an understanding of the psychological and sociological configurations created by the parents' culture and specific circumstances.

The framing and implementation of infant mental health interventions

4. Infant mental health practitioners make an effort to understand how behaviors feel from the inside, not just how they look from the outside. This means asking ourselves: What is this father's motivation, what is he thinking and how is he feeling when he yells at his child? What is this mother's experience when she does not respond to her baby's crying? How does this toddler feel while having a tantrum? In other words, what inner states made these behaviors come about. How do these behaviors reflect the person's frame of mind and ways of perceiving the world and her place in it?

The same effort to understand how behaviors feel from the inside applies when we look at external circumstances and their impact on children and families. This means asking ourselves: How does this 10-month-old feel when she is switched from one caregiver to another without any transition time? How does this mother feel when her toddler runs away from her and refuses to come back when called? How does this father feel when he come home unexpectedly and finds me there talking to his wife? This attunement to the subjective meaning of behaviors and external circumstances makes the mental health practitioner search for answers to these and many other questions. Our intervention is shaped by the tentative answers we find.

5. The intervenor's own feelings and behaviors have a major impact on the intervention. We need to keep a sharp eye on how we are feeling towards each of the family members with whom we are working, how we are responding, and how we are coming across to them. We then use our own emotional responses to what is happening as a way of deciding whether to intervene and how to intervene in a particular situation. A corollary of this principle is that, as Robert Emde has observed, every relationship affects every other relationship. This means that what happens between the parent and the intervenor affects what happens between the parent and the child. A parent who feels supported and understood by a gesture from us is more likely to do something kindly for her child; conversely, a parent who feels judged by us is likely to behave in a harsh and critical way towards her child. Similarly, our relationship with the child affects our relationship with the parent. If the child has so much fun with us that he begins to prefer us to the parent, a competitive struggle is likely to follow over who owns the child. Conversely, if we help the child look at the parents with more accepting eyes, this will strengthen the parents' confidence in our good will towards them. This parallel process is an excellent built-in mechanism for testing out the efficacy of our interventions.

An awareness of inner feelings—children's, parents', and our own—allows infant mental health practitioners not to focus only on outer behavior. This flexibility in moving back and forth from a focus on inner experience to a focus on behavior is, I think, the hallmark of an infant mental health perspective, and its most useful contribution to other disciplines.

Editor's Note: The author is Professor of Psychiatry and at the University of California at San Francisco and Director of the Child Trauma Program at the San Francisco General Hospital in San Francisco, California. *This article first appeared in Zero to Three January/February 1998 and is reprinted with permission.*

INFANT MENTAL HEALTH VIDEOTAPE LIBRARY

Videotapes from the library of the World Association and the Michigan Association for Infant Mental Health are available in 1/2 in. VHS to WAIMH and MAIMH members. The shipping/handling fee is $10.00 each in the US and $20.00 each outside the US for a 3 day use. Videotapes must be scheduled **30 days in advance.** To inquire about availability phone: 517-432-3793. To order a video, use the attached order form.

ROBERTSON VIDEOTAPES:

Lucy, 21 Months: In Foster Care for 19 Days. Documents the gradual acceptance of very young child to substitute mother because she cannot maintain for long a clear image of the absent mother. 35 min.

John, 17 Months: Nine Days in a Residential Nursery. Documents responses of a 17-month-old child to nine days of residential nursery care while his mother is in hospital for birth of a second child. 45 min. B&W.

Jane, Age 17 Months: In Foster Care for 10 Days. The reactions of a young child in brief separation from the family. 37 min. B&W.

Thomas, 2 Years, Months: In Foster Care for 19 Days. Thomas defends against anxiety during the first few days by over activity and pseudo-cheerfulness, then more appropriate feelings emerge.

Right from the Start. 55 min. Looks at relationship between parent and child which begins at birth.

Beginnings. 51 min. Study of parent-infant interaction.

Benjamin. 42 min. First 6 months in the life of a normal infant using split screen techniques to show interactions between mother and infant.

A Better Beginning. 38 min. Identifies social and emotional components of failure to thrive by examining clues from two babies and their parents.

Early Learning. 29 min. Jean Piaget's theory of development.

Learning to Talk. 26 min. Infant's early attempts to imitate sounds of others begins purposeful attempt to communicate with adults.

Visual Pursuit & Object Permanence. 27 min.

Toot'n Tub: Object Concepts During Sensory Motor Stage. 20 min.

To Have and Not To Hold. 20 min. Parents speak about events surrounding their baby's early birth and stay in neonatal nursery.

Discussions with Parents of a Malformed Baby. 37 min. Intended for medical & other professionals; illustrates how parents learn about and adapt to child's special needs & learn to cope with their feelings of grief, anger, and blame.

Development of Means for Achieving Desired Ends. 20 min.

Causing Events to Occur: Development of Causality. 24 min.

Baby Basics. 110 min. 8 chapters: the newborn at birth, caring for yourself postpartum, your first days at home, daily care, feeding, health and safety, crying and sleeping, growth and development.

Babies Like Attention. 13 min. Several mothers discuss using different forms of praise and encouragement with their infants.

Building a Relationship with Family Members. 25 min. Home visitor explains how to build relationships.

Building a Relationship with Mother and Child. 18 min. Specific roles and skills needed by home visitor.

Focusing on the Baby's Action and Development. 16 min. This program deals with basic ways of observing & interpreting babies' actions.

Infant Health Care: A First Year Support Guide for New Parents. T. Berry Brazelton. Part of Johnson & Johnson Parenting Series. Designed to increase confidence and enhance the parenting experience during baby's first year.

Interdisciplinary Teamwork: A team in Name Only and Becoming an Effective Team. Training re-source for professionals, parents & students. Effects of team process on young children with disabilities and their families.

Journey into Life. From moment of conception through birth. 30 min.

Journey Through the First Year of Life. From birth to 1st birthday gives key developmental milestones. (Burton White/Judith Nolte) 45 min.

Prematurely Yours. 15 min. Focuses on the strengths and skills of premature infants; encourages parents to play an active part in infants' early development.

Observing Kassandra: A Transdisciplinary Play-Based Assessment of a Child with Severe Disabilities. (50 min.)

On this Journey Together: Parent/Professional Partnerships. (25 min)

Resistance to Change. Chadem. 1993. (30 min.)

Sensational Baby - *Part I: From the Beginning to Birth.* Deals with fetus' sensory abilities as it grows in the uterus and during labor and delivery. (22 min.)

Sensational Baby-*Part II: From Birth On.* Birth to first four months of life outside the womb.(22 min.)

Supporting Families: Current Practices in Early Intervention Services. Provides professionals working with young children and families with a clear understanding of key concepts which guide early intervention service provision. Merrill Palmer Inst. 26 min.

Teen Mother Peer Educators Talk to Professionals. Three part sequence highlighting the issue of enhancing communication between teens and professionals.

Teens Having Babies. 20 min. Shows teen couple having their baby in a supportive hospital setting.

When Teens Get Pregnant. 18 min. Young girls speaking openly about their families, school, peer pressure of have sex, of the reality of sex as opposed to the fantasy. Explains what happens to each girl after delivery.

Growing into Parenthood. 29 min.

Women, Drugs and the Unborn Child. A two-part series on prenatal drug use.

Psychological Birth of the Human Infant. 48 min. Produced by Margaret Mahler Foundation.

Infant Development: First Year Guide to Growth & Learning. D-emonstrations by T. Berry Brazelton and other child-care professionals

Reflective Supervision in IMH Practice. Created by 0-3. Tape and booklet

Using Temperament Concepts to Prevent Behavior Problems (4 tapes)

Kaiser Permanente series is based on original research of Drs. Stella Chess and Alexander Thomas and research conducted at Kaiser Permanente Northern California.

Tape #1: Describes and illustrates the nine temperate concepts: Thresholds, intensity, adaptability, persistence, mood, rhythmicity and distractibility.

Tape #2: Describes the high intensity, slow-adapting child: refusal to obey adult requests; hitting, biting and fighting with other children; difficulty getting to sleep and waking up; and returning to forbidden activities.

Tape #3: Describes high activity, slow adapting child: difficulties at mealtimes and bedtime; "running wild"; bossing other children; and resisting toilet training.

Tape #4: Describes the sensitive, intense, withdrawing child: difficulty separating from parents; rejection of new foods, clothing or people; difficulty making new friends; and strong reactions to routine medical procedures.

PROGRAM FOR INFANT/ TODDLER CAREGIVERS

Developed by the Center for Child & Family Studies with California Dept. of Education (also available in Spanish--VHS)

Respectfully Yours: Magda Gerber's Approach to Professional Infant/ Toddler Care. 58 min.

Space to Grow: Creating a Child Care Environment for Infants and Toddlers. 22 min.

First Moves: Welcoming a Child to a New Caregiving Setting. 27 min.

Together in Care: Meeting the Intimacy Needs of Infants and Toddlers in Groups. 30 min.

Getting in Tune: Creating Nurturing Relationships with Infants and Toddlers. 24 min.

It's Not Just Routine: Feeding, Diapering, and Napping Infants and Toddlers. 28 min.

Discoveries of Infancy: Cognitive Development and Learning. 32 min.

Flexible, Fearful, or Feisty: The Different Temperaments of Infants and Toddlers. 29 min.

The Ages of Infancy: Caring for Young, Mobile, and Older Infants. (Spanish only) 26 min.

Essential Connections: Ten Keys to Culturally Sensitive Child Care (Spanish only) 36 min.

Protective Urges: Working with the Feelings of Parents and Caregivers (Spanish only) 27 min.

MICHAEL TROUT VIDEOTAPES: PAL and VHS available

The Nature of Human Attachments in Infancy. Historical overview of infant mental health, with current thoughts on the process by which human infants and their primary caretakers develop a bond. 56 min.

The Psychological Dimensions of Pregnancy and Delivery. Describes intense but quite normal psychological work engaged in by a pregnant woman, how it changes her relationship with her mate, etc. 56 min.

Conducting an Infant Mental Health Family Assessment. Methods used to elicit material from families regarding the nature of their relationship with the baby and the etiology of the breakdown in their bond with the baby.

The Newborn, the Family and the Dance. Discusses ways in which real or imagined characteristics of the newborn affect integration into family and the nature of his relationships with primary caretakers.

The Birth of a Sick or Handicapped Baby: Impact on the Family. Examines struggles engaged in by parents and siblings to integrate a handicapped or sick newborn into the family. 56 min.

Infant Mental Health: A Psychotherapeutic Model of Interventions. 95 min. 3 parts. For clin-icians working with infants and their families. Part 1: Opportunities for Intervention (23 min.). Part 2: Principles of Intervention (49 min.). Part 3: Issues in Clinical Infant Mental Health (23 min.).

VHS Only: (Both for $10)

Gentle Transitions: A newborn baby's point of view about adoption. (10 min.)

Multiple Transitions: A young child's point of view on foster care and adoption. (16 min.)

EARLY ON PERSONNEL DEVELOPMENT SYSTEM : LISTENING TO FAMILIES. This 16-tape **close captioned** series is designed to meet the need for training early on interventionists to work effectively with families. ***

INTRODUCTORY TAPES:

Created for use with providers working with families in a variety of settings. The tapes focus on the provider's role of engaging families in building partnership based on family strengths. ***

Building a Family Partnership. 50 min. Viewers Guide. Contains unedited excerpts from conversations with 5 diverse families. Highlights generic communication strategies helpful in joining with a family and building a collaborative partnership. All income levels.

Exploring Family Strengths. 30 min. Viewers Guide. Highly focused presentation of the rationale, examples and strategies for engaging families in conversations about their strengths as well as their problems.

*INDIVIDUAL FAMILY VIDEOS****

Conversations with individual families explore the issues of raising a young child or children with special needs. Families are from diverse cultural, linguistic and economic backgrounds with children representing a wide range of disabilities. They are shown talking with experience family therapists who demonstrate how to listen to a family's story and focus on family concerns, priorities and resources. Discussion guides included.

Colton Family: A Family Fighting for Its Vision of Carissa; Colton Family: One Year Later 60 min. ea., two-tape set. Two parents, three children. The one-year-old daughter

has Down's syndrome; the boys are six and eleven. Focuses on the family hopes and vision for Carissa, the family's decision making and interactions, the needs of the older children, the role of brothers in caring for their little sister and strengths from religious faith and extended family. Family is middle-income, African-American.

Dutton Family: Two Wise Women Demonstrate Strengths of Intergenerational Parenting Team; Dutton Family: One Year Later. 60 min. ea. Two-tape set
Mother and grandmother, and three children, two-, three-, and four-years-old. The three-year-old boy has cerebral palsy. Focuses on the strengths of shared caregiving, the family's hopes for the child, the tensions between mother and grandmother over discipline and family rules, the difficulties with getting EI services and making the transition from Part H to public schooling. The family is limited-income, African-American.

King Family: When Support Isn't Enough; King Family: One Year Later. 60 min. ea., two-tape set.
Mother, father and two children, a girl, two-and-a-half and a boy, four. The younger child has C-H-A-R-G-E, a syndrome with multiple birth defects affecting major organ systems. Focuses on parenting roles, stress on the parents and on their relationship from caring for a medically fragile child, the needs of the older sibling, interactions with medical and EI providers, conflicts over diagnosis and treatment and on financial and future concerns. The family is middle-income, European-American.

Andrews Family: Parents Set Aside Differences and Work Together for the Sake of Their Child. 60 min.
Mother, father, one child. The son is two-years-old and was born with multiple congenital malformations, including Dandy-Walker syndrome, cerebral palsy, hydrocephaly. Focuses on parents' commitment to their child and efforts to cooperate (although they are now separated), difficulties in getting respite care in a rural area, and the attitudes of the family and its town toward a child with severe disabilities. The family is working class, European-American.

Bernardo Family: Parental Intuition Makes the Difference for Child with an Ambiguous Diagnosis. 60 min.
Mother, father, two children, two- and four-year-old. The oldest boy has speech delays and possible diag-nosis of A.D.D. Focuses on the parents' difficulties and stress in decision making when the diagnosis is uncertain or ambiguous, the parents' sensitivity toward their child's needs, parental differences over advice not to use native language (Spanish) in the home because of speech difficulties and financial concerns due to mother working only part-time in order to meet child's needs. Family is middle-income, Latino.

Bond Family: Love Changes Everything: A Young Couple Forms a New Family. 60 min.
Mother, father, and five children. Only the two-year-old son, born prematurely with hydrocephaly and development delays, is present. Focuses on the development of a couple bond, family-of-origin relationships and acceptance, medical and EI services and hopes for the future. The parents, young working couple, are middle income, African American.

Espinoza Family: Keeping the Diagnosis from Taking Over the Family. 60 min. Mother, sister and mother's best friend, with only child, a boy, six-years-old (husband/father was working and could not be present). The boy was diagnosed with autism at four after diagnosis of PDD in infancy. The focus is on the family value of inclusion in family life and in education, the differences in parents' roles in child-rearing, support from sister and friend in providing care, family attitudes toward diagnosis of autism and confronting attitudes within Latino culture toward children with special needs. Family is middle income. Latino.

Johnson Family: Love Across the Generations: Grandmothers Caring for Grandchildren. 60 min.
Grandmother, great-grandmother and three children. The children are two, three and four, born to a drug-abusing mother who no longer lives at home. All three children have developmental delays; one had seizures. Their EI home visitor and a family neighbor/friend also join in the conversation. Focuses on family strengths, differences in child-rearing philosophy across generations, impact of drugs on family life and continuity, importance of extended family, friends, social services and spiritual values. The family is limited income, African American.

Rivas Family: Hopes of a Strong Immigrant Family on Fragile Ground (in Spanish, with subtitles). 60 min. Mother, father, four children. The two boys, five and seven, have sex-linked mental retardation; the girls are 14 months and four years old. The parents are from rural EL Salvador. Focuses on the family's hopes for the children, the parents' understanding of the boys' disabilities and abilities, EI services, the parents' employment difficulties and support from extended family and church community. Family is limited-income, Latino.

Thompson Family: Hanging in There: Two Generations with Altered Priorities. 60 min.
A single father and his parents. The child, a boy of 18 months, has serious asthma. The father has returned to live with his parents, who share in care-giving for their grandson. Focuses on the boy's medical condition, attitudes of medical staff towards the family, financial difficulties, communication, and tensions over shared responsibilities and altered priorities of grandparents. The family is middle-class, European-American.

Williams Family: Strength and Vulnerability in a Family with Many Concerns. 60 min.
Young mother, her mother, two children, four and almost three, and mother's niece, seven months. The three-year-old son has been diagnosed with neurofibromatosis. The focus is on family strength and vulnerabilities, multiple caregiving demands brought on by the mother's worsening sickle cell anemia, the three-year-old's special needs and EI services, custody issues with niece, strengths and support of African-American family, community and church, the mother's hopes for future

for herself and her children. Family is limited income, African-American.

*ON THIS JOURNEY TOGETHER****

In this series parents speak about their experiences in raising a child with developmental disabilities. The series was developed for parents, support groups and professionals in health care and human services fields. Co-produced by Family First in Columbus, Ohio, a project of the Arc of Ohio and the Ohio Department of Mental Retardation and Developmental Disabilities.

The Early Days. 22 min. Parents discuss diagnosis of developmental delay and offer suggestions to other parents.

Building Brighter Futures. 23 min. Interviews with parents discussing the future for their children with special needs.

Parent/Professional Partnerships. 25 min. Parents discuss the value and difficulties of working with professionals. Suggestions are offered to facilitate partnership.

Resources for Families. 25 min. Parents describe the challenge of finding resources for their child and for themselves. Suggestions are offered to support the process of seeking resources.

*FAMILY CENTERED HOME HEALTH SERVICES FOR YOUNG CHILDREN****

Four-tape series with Training Guides

This video series was designed for home health staff and other personnel working with young children with special health needs. The series addresses issues in the areas of developmental needs, family concerns, and care coordination. Each video includes strategies for home health personnel and others working with families who have children with special health needs. Individual guides for each video include program objectives, a synopsis of the video content, supplementary information, related objectives, and references. Closed Captioned. Produced by Judith L. Pokorni, Ph.D., of the Georgetown University Child Development Center.

Parents & Professionals: Partners in Co-Service Coordination. 20 min. Presents a model of service coordination for families with an infant or toddler with special needs. The model is CO-SERVICE COORDINATION where parents and professionals work together as partners to find, access, arrange and monitor services that the families need. Highlights the requirements of the Individuals with Disabilities Education Act, Part H requirements for service coordination. The model is based on the premise that parents know their child's strengths, needs, likes and dislikes; how the child learns and what works best for their family.

Responding to Families. 24 min. Families receiving home health services describe some of the stress they experience from lack of privacy, disruption of normal family living, inconsistent nursing personnel, etc. Also, family members and home health personnel discuss important considerations for caregivers.

Encouraging Communication and Play. 20 min. Describes strategies for integrating activities that promote communication and play skills into everyday care. The first half discusses communication skills and shows strategies for encouraging communication during routine nursing care. The second half focuses on play and includes suggestions for engaging in interacting play and for using toys appropriately.

Encouraging Motor Development. 16 min. Illustrates the sequences of fine and gross motor skills that typically develop in the first few years of life. Techniques for using each principle throughout caregiving routines are illustrated.

Building Family-Centered Care Coordination. 23 min. Describes the role of care coordination in serving young children with ongoing health needs.

RIGA, LATVIA, 1994 WAIMH CONFERENCE

His Name is Today. Award winning film combines scientific presentations from the conference with footage of cultural exchanges and images of the streets, orphanages and day care centers of Riga, to provide powerful insights into the issues of mental health for the international community. VHS.

Audio Tapes of Conference Presentations. (10 tapes.)

ADDRESSES FROM MAIMH CONFERENCES

The Promise of Fatherhood: Fathers in their Relationships with Infants, Toddlers, and Service Providers. Phillip B. Davis, Ph.D. 90 min. 1991

Strong Families, Strong Children: Lessons from Longitudinal Research. 63 min.

The Roots of Love and Commitment in Childhood. Margaret Morgan Lawrence, M.D. 1991.

Relationships from an Infant Mental Health Perspective. Jeree Pawl, Ph.D. 54 min. 1991.

Loss of a Baby: Understanding Maternal Grief. Margaret Nicol 1991.

Helping Adolescent Mothers: What Works & Why 74 min. Judith Musick. 1992.

The Impact of Violence on Infants and Their Families. James Garbarino.1993.

Changing the Way We Think About Change. Larry Edelman. 1994

Mother/Infant Attachment Theory: From Research to Practice. Mary Jo Ward. 1994

How to Develop Culturally and Linguistically Competent Services. Gloria Johnson-Powell. 1994.

A Unified View of Different Approaches to Infant-parent Psychotherapy. Daniel Stern. 1995.

Baby Signs: Opening a Window into the Infant Mind. Linda Acredolo and Susan Goodwyn. 1997.

Infant-Caregiver Relationships: Broadening our perspectives. 1997 Annual conference. Audio tapes of conference plenary addresses and workshops.

Infant Mental Health Video Library Order Form

Videotapes from the library of the World Association and the Michigan Association for Infant Mental Health are available in 1/2 in. VHS to WAIMH and MAIMH members (the tapes by Michael Trout are also available in PAL). Audio tapes are $10 per set. The shipping/handling fee is $10.00 per video in the US and $20.00 per video outside the US for a 3-5 day use. Videotapes must be scheduled **30 days in advance.** To inquire about availability phone: 517-432-3793, or fax: 517-432-3694 or email: smithm40@pilot.msu.edu. To order a video, fax or send us the following form.

Billed to: **Mailed to:**

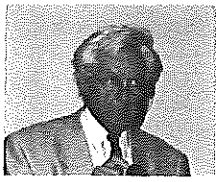
Contact Phone No:

Purchase Order No.:

Name of Video(s): **Dates of Use:**

Send to:
Infant Mental Health
Kellogg Center #27
Michigan State University
East Lansing, MI 48824-1022
USA

Fax: 517-432-3694



President's Perspective

Yvon Gauthier

Many of us are involved in intervention with parents of infants and young children, or with professionals who are themselves working with young families or expectant mothers. We often have a feeling of discouragement about the tendency to regress to old patterns perhaps transmitted from previous generations and in seeing the time it takes to break those patterns.

Research has shown the importance of an "affective alliance" which needs time to get established and to work through layers of mistrust laid down over time (Heinicke et al, 1988). The research of Olds et al (1997), recently replicated in Memphis, shows that intervention needs to start during pregnancy and continue up to the age of 2, with monthly visits to mother and the family. This type of intervention shows the necessity for continuity in establishing a relationship where problems can be brought out, worked on and maybe solved enough to prevent pathogenic projections on the child.

Interventions of a less intense nature were also shown to bring interesting results. Cramer's team in Geneva, working in brief psychotherapeutic sessions, whether of a psychodynamic type or of interactional guidance, obtained positive results of a lasting nature 6 months and one year later. They were working with a middle class population so one wonders whether they were touching the most disturbed kind of patients, but we note that the mothers who were predicted to have more negative results were eventually the ones most helped by the brief intervention (Cramer et al, 1990; Robert Tissot et al, 1996).

Van den Boom's research in Holland is definitely striking since she obtained positive results of a lasting nature with only 3 interventions made between age 6 and 9 months in a disadvantaged population, with children diagnosed as having difficult temperaments. At age one, and at follow-up ages of 18 and 36 months, children were seen as more secure, and as developing quite well within an "adequate" mother-child relationship, in comparison to a control group which did not receive such minimal intervention (Van den Boom, 1994, 1995).

The research of our Canadian colleague Sarah Landy and her team, described in the last issue of the *Infant Mental Health Journal* (IMHJ Spring, 1998), goes in the same direction. Public health nurses were trained to care beyond the usual post-natal intervention. A cohort of children whose families were seen from birth up to 18 months (3-4 home visits, clinic visits, to which were added various assessments, follow-up visits and referrals when necessary) were seen to be much better in self-regulatory behavior, developmental level and social competence than 2 other groups who were seen later (18 months to 3 ½ years, or 3 ½-5 ½ years) and less intensively.

The research was done with a clearly defined transactional framework where public health nurses did not concentrate only on information to families, but also discussed family dysfunction, parents' own history of being parented and parental depression. It seems to confirm what other researchers have found before: that the therapeutic relationship is the most critical variable in assuring the success of early intervention programs.

I believe we are all living in societies where public policy is much influenced by success of investments, and that we have to prove that our ideas are not just "beliefs," but have a demonstrable efficacy based on observable facts. Landy's research is not perfect— they themselves indicate their weaknesses—but it brings out once more the importance, in a context of minimal new resources, of using public health nurses for early intervention. It is interesting to see the results which are obtained when a "transactional model" is added within the methods traditionally used in a public system of care.

References

Cramer, B., Robert-Tissot, C., Stern, D.N., Serpa-Rusconi, S., De Muralt, M., Sesson, G., Palacio-Epasa, F., Bachmann, J-P, Knauer, D., Berney, C. and d'Arcis, LJ. (1 990). Outcome evaluation in brief mother-infant psychotherapy: A preliminary report. *Infant Mental Health J,* 1: 3, 2 78-300.

Heinicke, CM, Beckwith, L & Thompson, A (1 988). Early intervention in the family system: A framework and review. *Infant Mental Health J,* 9: 2, 111-141.

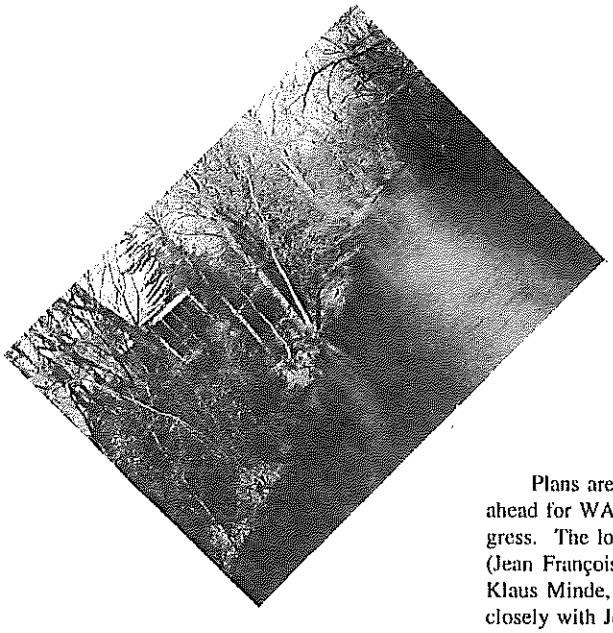
Landy, S., Peters, R.DeV., Arnold, P., Allen, B., Brookes, F. and Jewell, S. (1 998). Evaluation of "Staying On Track": An early identification, tracking and referral system. *Infant Mental Health J.,* 19: 1, 34-58.

Olds, DL, Eckenrode, J, Henderson, CR, Kitzman, H, Powers, J, Cole, R, Sidora, K, Morris, P, Pettitt, LM & Luckey, D (1 997). Long-term effects of home visitation on maternal life course and child abuse and neglect. *JAMA,* 278, 637-643.

Robert-Tissot, C., Cramer, B., Stern, D.N., Serpa, S.R., Bachmann, J.P., Palacio-Epasa, F., Knauer, D., De Muralt, M., Berney, C. and Mendiguren G. (1996). Outcome evaluation in brief mother-infant psychotherapies., Report on 75 cases. *Infant Mental Health J,* 17(2), 97-114.

Van den Boom, DC (1 994), The influence of temperament and mothering on attachment and exploration: An experimental manipulation of sensitive responsiveness among lower class mothers with irritable infants. *Child Dev., 65,* 1457-1477.

Van den Boom, DC (1995). Do first-year intervention effects endure? Follow-up during toddlerhood of a sample of Dutch irritable infants. *Child Dev.,* 66, 1798-1816.



from the Red Cedar (by way of Montreal)

by Hiram E. Fitzgerald, Executive Director

WAIMH 7th World Congress

Diversity: Challenges and Opportunities in Infancy

Montréal, Canada July 26-29, 2000

Plans are proceeding full steam ahead for WAIMH's 7th World Congress. The local arrangements committee (Jean François Saucier, Chairperson; Klaus Minde, Co-chairperson) is working closely with Joan Gross (McGill University Conference Office) to assure a well-organized congress as well as opportunities to share in Montréal's rich and colorful history. The program committee (Susan McDonough, Chairperson; Hiram Fitzgerald, Co-chairperson) has proposed six subthemes as organizers for the congress events, with diversity issues generic to each of the subtopic areas: **Brain-Behavior Interface; Developmental Psychopathology; Culture in Context; Environmental Health Concepts; The Caregiving Context; and Special Babies/Special Caregivers.** Innovations in program format are being planned with emphasis on participant involvement in ongoing daily events.

Beginning with this issue of *The Signal* we will review aspects of program structure and content, as well as Montreal's charm, cuisine, arts, and entertainment. The congress hotel is Le Reine Elizabeth, located within easy access to shops, museums, St. Catherine stress, and Old Town, with its many absolutely fabulous restaurants. Speaking of gracious dining, Le Reine Elizabeth's Beaver Club, is a culinary treat. For the adventurous diners, I bear witness that the Petite Marmite de Bison et sa Moëlle aux Pépites de Ble D'inde Fume et au Chou Rouge (Buffalo consomme with smoked corn niblets, marrow, and red cabbage) is delicious. Filet de Caribou en Venaison au Porto Canadien sur Canapé de Riz Sauvage et Compotée de Chicoutais (Fillet of caribou venison style with Canadian port wine on wild rice canapé and chicoutais compote) was a fantastic combination and just a little invitation to heaven on earth. Coffee is a final delight, with grapes, chocolates, and other good things to nibble on while sipping a heady cup of regular brew.

The Beaver Club was founded by French Canadians and Scots, with membership by invitation and unanimous vote only. The Club met at Beaver Hall for banquets during the winter when ice closed island waterways and prevented trappers from plying their trade. Tradition required all diners to smoke from a pipe of peace, survive a minimum of five formal toasts, and feast long into the morning hours. Trappers, woodsmen, explorers, and members of the Beaver Club helped to found modern Canada. As far as WAIMH is concerned, none of the members was more important than James McGill, founder of the University that bears his name, and is providing conference coordination for the 7th World Congress.

News & Views

Training Opportunities

United States

November 20-23, 1998. New Orleans, Louisiana, ***International Early Childhood Conference on Children with Special Needs.*** For information call 1-407-628-3602.

December 3-5, Washington, D.C., 0-3, ***National Training Institute.*** For more information call (703) 486-0675, or visit web site at: www.zerotothree.org

United Kingdom

The Tavistock Clinic and United Bristol Healthcare NHS Trust are offering a Postgraduate Diploma/MA in Infant Mental Health. This is a part-time 2 year course requiring day-time attendance on Wednesdays and about 8/9 hours per week for observational work, reading and writing. Flexibility is available for those who need to take the course over a more extended time. For information call Angelique Halliburton in London at 44 171 447 3717, or Sharon Baker in Bristol at 44 117 914 5526.

ATTENTION AFFILIATES!!!

send us:

- News and photos of your activities.
- Current officers with addresses, telephone and fax numbers

After Montreal 2000, what then ???

Time to make bids for World Congresses 2002 and 2004. If your affiliate is interested in hosting one of these upcoming congresses, form a local conference committee and make a bid. Bids should include:

- chairpersons of the local conference committee
- list of members of the committee
- hotel site
- preliminary budget

Send your bid to:
Hiram E. Fitzgerald, Ph.D.
27 Kellogg Center
Michigan State University
East Lansing, MI 48824-1022
USA

WORLD ASSOCIATION
FOR INFANT MENTAL HEALTH
Institute for Children, Youth & Families
Kellogg Center, Suite 27
Michigan State University
East Lansing, MI 48824-1022

Tel: (517) 432-3793
Fax: (517) 432-3694

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