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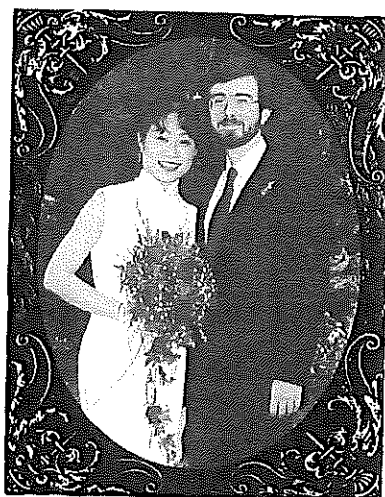
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## The Development of the Parenting Alliance Over the Transition to Parenthood

by Laurie Van Egeren

### Introduction

The transition to parenthood is a major milestone experienced by the majority of married couples. Conceptualized as a developmental stage, it encompasses a multiplicity of changes resulting from the entrance of a third individual into an established dyad. Spousal relationships must be renegotiated, familiar roles must be revised, and new roles must be taken on. The husband-wife dyad is characterized by the marital relationship; yet the new triad is characterized not only by the marital relationship, but also by each parent's individual relationship with the child and the new parenting partnership between the parents. Cohen and Weissman (1984) have termed this unique coparenting relationship as the parenting alliance. From their perspective, derived from family



systems and psychoanalytic theory, the parenting alliance is a relationship between the parenting partners, different from but a component of the marital relationship. Four factors comprise the parenting alliance: (a) investment in the child; (b) esteem for the other parent's involvement with the child; (c) respect for the judgments of the other parent; and (d) the desire to communicate regarding parenting issues. The primary purpose of the parenting alliance is to provide support and affirmation in the intensely stressful situation of parenthood.

To date, research on the couple's transition to parenthood has overwhelmingly concentrated on marital and individual parent-child relation-

ships. Prior studies indicate that marital satisfaction, adjustment, and interactions have significant effects on child-centered concerns such as parenting confidence, parent-child relationships, and child behavior problems (Belsky, Youngblade, Rovine, & Volling, 1991; Floyd & Zmich, 1991; Stoneman, Brody, & Burke, 1989), and much discussion has centered around the association between marital conflict and child adjustment (Grych & Fincham, 1990). However, little attention has been given to the parenting alliance. The few studies that have been conducted suggest that the parenting alliance can be differentiated from the marital relationship. Further support is found in the divorce literature, which indicates that a cooperative parenting partnership is related to more successful child outcomes despite the dissolution of the marital relationship (Buchanan, Maccoby, & Dornbusch, 1991). Given the consistent correlations between marital variables and child adjustment, as well as our emerging understanding of the role of the parenting partnership, it seems likely that the well-documented influence of the marriage on child outcomes is at least partially, if not primarily, an indirect relationship mediated by the parenting alliance. Our knowledge of parenting alliance process

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must be greatly expanded in light of the far-reaching implications for intact and divorced families and for child outcomes.

Research on the parenting partnership is still at the beginning stages. Only a handful of studies have examined the parents' perceptions of the parenting alliance, and those have focused on adolescents and school-age children. Alternatively, a few investigators have explored observations of coparenting behaviors in parents with young children, or have assessed the effects of congruent parenting behaviors, attitudes, and values between mothers and fathers. No studies have integrated these constructs, nor has there been any investigation of the parenting partnership at the point at which it is initiated. The aim of the proposed study is to examine the development of the parenting alliance, as a newly emergent relationship during the transition to parenthood, in the initial months after the birth of the first child. Four questions will be addressed:

- 1) Is there evidence for the construct validity of the parenting partnership separate from the marital relationship?
- 2) How does the parenting alliance change over the initial months of parenthood?
- 3) What pre-birth characteristics predict the initial quality of the parenting alliance as well as individual patterns of change over time?
- 4) What is the interrelationship between the parenting alliance and other variables that may change over time, such as the marital relationship, parenting efficacy, and perception of the child's temperament?

## Review of the Literature

This review of the literature first presents studies focusing on the parenting partnership, then identifies variables likely to predict the development of a new parenting alliance, factors that may affect change in the

parenting alliance, and research on change in marital adjustment over the transition to parenthood that may be affected by the parenting alliance.

## The Construct Validity of the Parenting Partnership

The few available studies of the parenting partnership support the distinction between the parenting alliance and the marital relationship. While correlations between the two constructs have generally reached statistical significance, the magnitude of the relationship has been low to moderate. Specifically, correlations between parenting alliance and marital adjustment self-report measures have ranged from .20 to .38 for mothers and from .44 to .67 for fathers; and correlations between mothers' and fathers' reports of the parenting alliance have ranged from .33 to .50 (Abidin & Brunner, 1995; Floyd & Zmich, 1991; Frank, Jacobson, Hole, Justkowski, & Huyck, 1986). The correlations are substantially higher for men, suggesting that for fathers, the two constructs are interrelated to a greater degree than for mothers. Perhaps the ability to participate in an effective coparenting relationship is more strongly contingent upon having a satisfying marital relationship for men. In contrast, women, working from the traditional context of caregiver, may, to a greater extent, perceive the parenting role as a given, regardless of the state of the marriage. Nonetheless, for both mothers and fathers, a large percentage of unique variance in predicting the parenting alliance remains to be explained.

Measures of the parenting alliance have been shown to exhibit theoretically predicted associations with other parenting variables. For example, in a sample of parents with 4- to 6-year-old children, mothers and fathers who reported a positive parenting alliance were less likely to report high levels of parenting stress (Abidin & Brunner,

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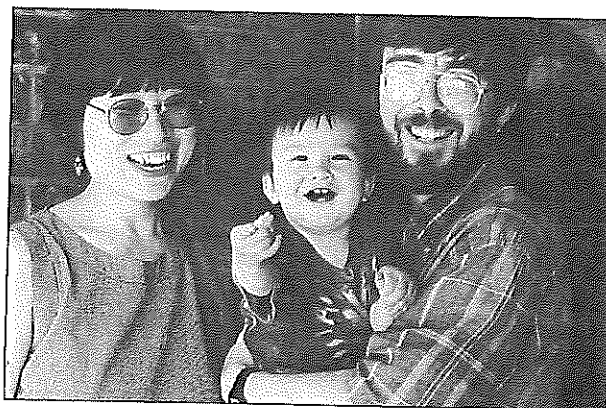
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1995). They were also more likely to endorse a warm, authoritative parenting style; in contrast, marital satisfaction and parenting style were unrelated. Floyd and Zmich (1991) reported that a positive parenting alliance was related to greater parenting confidence and more positive parent-child interactions in parents of mentally retarded children and of typically developing children (ages 6-8).

The above studies, which address the subjective experience of the parenting alliance, have all been conducted with older children. In contrast, the few studies of coparenting behaviors have focused on infants and toddlers. McHale (1995), in an observation of parents with 8- to 11 month old infants, found that in maritally distressed couples, coparenting behaviors were contingent upon the child's gender; parents of boys were likely to evidence hostile and competitive behaviors as they attempted to engage the infant together, while parents of girls showed a pattern of maternal involvement and father withdrawal. Belsky, Crnic, and Gable (1995) observed the coparenting interactions of parents with 15 month old sons. More negative, angry, and critical coparenting behaviors were predicted by greater differences between mothers and fathers in extraversion, sensitivity to others, and comfort with intimate relationships, but not by differences in attitudes toward using discipline and control with the child; this was especially true when parents were experiencing many hassles (although it should be noted that the researchers did not specifically investigate whether marital conflict played a role in these difficulties).

A number of studies have demonstrated a relationship between an indirect measure of the parenting partnership (congruence between

mothers and fathers beliefs, values, and attitudes) and marital quality. Parental disagreements about discipline have been shown to be related to lower marital satisfaction for parents of girls, but not boys (Stoneman et al., 1989), while congruent child-rearing philosophies when children were 3 1/2 significantly discriminated between couples who were still married versus those who were divorced 10 years later (Block,



Block, & Morrison, 1981). In addition, when mothers reported more frequent disagreements related to childrearing issues, they also reported more behavior problems in their three-year-old boys; in fact, the frequency of childrearing disagreements was a better predictor of behavior problems than marital adjustment (Jouriles et al., 1991). These studies suggest that factors such as child gender and compatible personality styles appear to play an important role in parents' ability to parent together effectively.

The parenting partnership appears to be particularly salient for fathers' relationships with their children. Abidin and Brunner (1995) found that for fathers, the parenting alliance was related to self-reported attachment to the child, while mothers' degree of attachment was independent of the parenting relationship. Furthermore, fathers', but not mothers', experiences of the parenting alliance were related to their child's adjustment across multiple raters (mothers, fathers, and teachers).

Frank et al. (1991) demonstrated that fathers reporting a strong parenting alliance experienced greater stress when their child had frequently been ill, while fathers reporting a weaker alliance reported no relationship between stress and child illness, possibly due to less involvement and investment in the child's well-being. The parenting alliance did not relate to mothers' experiences of stress and child illness. In a home observation study, the frequency with which husbands initiated discussion about their infants was not significantly related to mothering behaviors; however, the frequency with which wives talked about their infants was related to husbands' verbal and physical interactions and affection, both in the presence of their spouses and when alone with the child (Belsky, 1979). These findings also support the greater interrelationship

for men than for women between parenting and spousal behaviors.

In addition, traditional role identification and power may moderate the relationship between the experience of the parenting alliance and outcomes. Laub (1990) found that father-dominant couples reported the most positive perceptions of the parenting alliance, but had the most negative outcomes in a problem-solving task. Conversely, mother-dominant couples reported the most negative perceptions of the parenting alliance, but their problem-solving outcomes were not significantly different from either father-dominant or egalitarian couples.

It appears that for men, more so than for women, a well-functioning parenting partnership is likely to be accompanied by a more positive parent-child and marital relationships. Furthermore, one study indicated that mothers', but not fathers', reports of a weaker parenting alliance were related to reports of fairly severe behavior

problems in typically developing children, but not mentally retarded children (Floyd & Zmich, 1991). Therefore, while the parenting alliance appears especially important for fathers, it is by no means incidental for mothers.

The above review highlights a gap in the existing parenting partnership literature, in that no published research has addressed the relationship between the subjective experience of the parenting relationship and coparenting interactions. However, Laub (1990), in an unpublished master's thesis, found an association for mothers, but not for fathers, between self-reports of the parenting partnership and observations of the couple's problem-solving behaviors. Although the problem-solving discussion centered around a specific child discipline problem, problem-solving and conflict resolution are also an integral component of marital interactions. The researcher did not control for marital quality, so that the parenting relationship and marital relationship may have been confounded.

One goal of this study is to examine the construct validity of the parenting alliance by assessing the subjective experience of the parenting alliance and global ratings of coparenting interactions, and looking at the distinction between the coparenting and the marital relationship. Confirmatory factor analysis using a multi-trait-multi-method framework (Campbell & Fiske, 1969), with the parenting partnership and the marital relationship as traits and the mother report, father report, and observers ratings as methods, provides one way to assess the concurrent and discriminant validity of the parenting alliance. The transition to parenthood is a particularly fruitful period to study this interrelationship, as the new compo-

nent of the couple's relationship is in the initial stages of negotiation.

### Change in the Parenting Alliance

On average, the parenting alliance is likely to be fairly stable within each developmental stage that the child experiences, but may need renegotiation as the child moves between developmental stages (e.g., from infancy to toddlerhood, from school-age to adolescence) due to the different demands each stage places on parents.



Certain factors, however, may contribute to the weakening of the parenting alliance in some families and the strengthening in others within a stage. Instability in the experience of the parenting alliance might be expected to be particularly apparent over the first few months after the infant's birth as the new mother and father engage in the process of negotiating their parenting partnership. Indirect support comes from the marital literature in a comparison of marital satisfaction assessed during pregnancy and at 1 and 6 months post-birth (Wallace & Godlib, 1990). Results revealed that marital adjustment peaked at 1 month, followed by a steep decline by 6 months. This study suggests that an initial "honeymoon period" may occur immediately following the birth of the child, which may or may not be reflected in the parenting alliance.

Growth curve modeling (Bryk & Raudenbush, 1992; Duncan, Duncan, & Hops, 1996; McArdle & Epstein, 1987; Raudenbush, Brennan, & Barnett, 1995; Rovine & Molenaar, 1996, in press; Willett & Sayer, 1994) provides a method of examining the trajectory of change in the parenting alliance over time. A within-person, or *Level 1*, model is comprised of two to three components: (a) an *intercept*, indicating the initial status of the parenting alliance at 1 month after the child's birth; (b) a *slope*, indicating the linear rate of change in the parenting alliance over time; and, if necessary, (c) a *quadratic* function that incorporates the rate of acceleration or deceleration in the change in parenting alliance. The parameters for the Level 1 model are estimated for each person separately and then used to derive an overall average growth curve. Since parenting may be a qualitatively different experience for men and women, it seems reasonable to estimate these parameters separately

by gender, thus allowing the average growth trajectory to be plotted for each sex.

Although the Level 1 model will capture the *average* parenting alliance, it is likely that individual differences will contribute to substantial variation in the initial status, rate, and perhaps direction of change over the first 6 months. The growth curve approach allows individual differences to be evaluated in two ways: (a) *Level 1 predictors* are within-person variables that may also change over time and interact with the parenting alliance (e.g., the marital relationship); and (b) *Level 2 predictors* are between-person variables that do not change meaningfully over the study time (e.g., age, SES). In the Level 2 model, the intercept, slope, and quadratic parameters estimated in the Level 1 model each become the outcomes in

separate equations, and the Level 2 predictors are used to estimate new parameters that might predict these outcomes. This enables us to investigate individual differences in the initial status of the parenting alliance, as well as individual differences in the rate and speed of change. The following section reviews variables that are hypothesized to be meaningful predictors of the development of the parenting alliance.

### Potential Predictors of the Parenting Alliance

All the correlates of the parenting alliance examined to date are concurrent and descriptive, and longitudinal predictors of the parenting alliance itself have yet to be identified. Since the parenting alliance shares variance with the marital relationship and individual parenting abilities, variables that relate to marital adjustment and individual parenting may also predict the parenting alliance; some may even be shown to have no relationship with marital and individual adult variables once the parenting alliance is accounted for. The marital and parenting literature will be used, therefore, to identify potential predictors of the parenting alliance. Belsky (1984) has presented a model of the determinants of parenting which, although directed toward the individual parent, is also applicable to the coparenting relationship. According to this model, parenting quality is determined by individual, contextual, and child characteristics.

#### Individual parent characteristics

One determinant of parenting suggested through this model is the psychological resources of the *individual* parent. For example, mothers' adaptation, competence, and capacity for positive relationships reported before the birth of their child related to their perception of general family adjustment and to their responsiveness

to the infant (Heinicke, Diskin, Ramsey-Klee, & Given, 1983; Heinicke & Guthrie, 1992), and their capacity for impulse control related to less decline in marital adjustment as they became parents (Levy-Shiff, 1994). These studies suggest that *ego development*, a construct discussed by Loevinger (1976; & Wessler, 1970) that encompasses the individual's perspective of the self and world and includes cognitive complexity, impulse control, and interpersonal differentiation, may contribute to the development of a successful parenting alliance. Couples functioning at higher levels of ego development presumably have a greater likelihood of tolerating and working through differences in each spouse's individual parenting decisions. In the growth curve context, ego development is considered a Level 2, or between-person, variable.

A second individual characteristic that may predict the development of the parenting alliance is the degree to which the parent has internally incorporated the *idea* of being a parent. Mebert (1991) conceptualizes the transition to parenthood as a process that, for some couples, begins not upon the delivery of the child, but much earlier, perhaps even prior to the child's conception. Parents who have planned their pregnancy or have strong cultural codes about childrearing roles may have an "internal working model," or a set of expectations that provides a framework for parenting. Parents in this mode (which Mebert terms "assimilation") are likely to have discussed and problem-solved about many of the potentially conflictual issues that parents who are less cognitively prepared (the "accommodation" mode) may find surprising and stressful. Operationalizing the assimilation mode as a high degree of motivation for parenthood, Mebert (1991) found support for her hypothesis as more highly assimilated women had fairly stable perceptions of their marital quality over the period before and after

the baby's birth, and that their pre-birth expectations of their infant's temperament were highly correlated with their post-birth perceptions. In contrast, women who were less assimilated had much less stable perceptions of the marriage and the child's difficulty. It appears that women who have assimilated the parental role may have an "internal working model" or set of preconceived notions that contribute to an experience of continuity over the transition to parenthood. Interestingly, the pattern of correlations was not particularly different for more assimilated versus less assimilated husbands and were generally lower than for mothers, suggesting that the process of becoming a parent may have less of a psychological impact on fathers than mothers. Thus, a Level 2 individual variable that may influence the development of the parenting partnership is the degree of assimilation of the parental role by the partners.

A third Level 2 individual variable that may have an impact on the couple's success in developing an effective parenting partnership is each person's experiences with his/her own parents. Belsky and Isabella (1985) explored the association between retrospective reports of perceptions of parenting styles and marital quality in the family of origin, and change in the marital adjustment in couples by the time the first child was 9 months old. The researchers found that women who experienced more accepting, nurturing relationships with their parents, and men who evaluated their parents' marriages as more successful, reported less decline in their marital quality over the transition to parenthood. Furthermore, when the family of origin was rated as cold and rejecting and the parents' marital quality was judged poor, couples reported the greatest degree of negative change in their own marriages. Similarly, men and women who described the family of origin as more healthy reported better marital adjustment than those who rated the family of origin in a

negative manner (Lane, Wilcoxon, & Cecil, 1988). These findings about the effect of the perceived family of origin on the marital relationship can be extended to the development of the parenting partnership. Individuals who have had the opportunity to observe a competent parenting partnership may have a more functional framework with which to foster their own parenting alliance.

Finally, the individual parent's self-perception of competence as a parent might be expected to reciprocally determine his/her perceptions of the parenting partnership. Parental efficacy can be conceptualized as both an outcome of previous coparenting experiences and a predictor of the subsequent parenting alliance, which would thus suggest a separate but related developmental trajectory (and a Level 1, time-varying variable). Mercer and Ferketich (1995) provide support for this contention in a comparison of inexperienced mothers and experienced mothers over the first 8 months after a child's birth. While experienced mothers showed no differences in their parental efficacy over time, first-time mothers moved from feeling less competent at 1 month to more competent by 4 and 8 months. In a corollary study with fathers, the researchers found that the parental competence trajectory of inexperienced fathers did not differ from that of experienced fathers; both groups of fathers had similar trajectories to inexperienced mothers (Ferketich & Mercer, 1995). For first-time mothers and fathers, parenting efficacy was predicted by a sense of internal locus of control, as well as better family functioning for fathers. A well-functioning parenting alliance might be expected to enhance individual parenting efficacy as each parent receives support for childcare decisions and is validated in his/her parenting role. Furthermore, the importance of family harmony for fathers in predict-

ing more successful parenting is once again highlighted, underscoring the prospect that the parenting alliance is a particularly salient feature of the parenting process for men.

The nature of the relationship between the parenting partnership and parenting efficacy over time is an interesting question; does a successful alliance elicit greater parenting confidence, does a more competent parent contribute to a more effective partner-

**A** well-functioning parenting alliance might be expected to enhance individual parenting efficacy as each parent receives support for childcare decisions and is validated in his/her parenting role.

ship, or is the interrelationship more complicated? Although no study has addressed this question, Teti and Gelfand (1991), in a study of mothers only, determined that maternal efficacy around infant care mediated the relationship between social-marital support and observed parenting competence. However, the association between social-marital support and parenting behavior did approach significance ( $p < .055$ ) in this sample of 89 mothers. It remains to be investigated whether both a direct and an indirect effect might emerge in a larger sample (as well as if the marital relationship were assessed by itself rather than as part of a combined index of marital and other social supports) and the manner in which these effects might evolve over time.

### Contextual characteristics

A second determinant of parenting proposed is *contextual* characteristics, which I suggest may be divided into *demographic* factors (e.g., age, sex, educational level) and *relational* factors (i.e., variables related to the couple's systemic relationship into which the

child enters). Demographic contextual variables that have been shown to relate to marital satisfaction and/or more positive parenting are older parental age, longer duration of marriage, and higher socioeconomic status (Maccoby, 1984; Moss, Bolland, Foxman, & Owen, 1986; Wright et al., 1986). Since these Level 2 variables are likely to relate to more conceptually interesting variables in the study, they will be included in order to control for their effects.

A number of relational factors provide a context within which the parenting alliance can develop. The couple's *marital quality*, both prior to (Level 2) and as it changes after the birth of their child (Level 1), is likely to have a profound impact on the emerging parenting alliance. The marital relationship provides an extremely important context for the parenting relationship, and may function as a barometer of the couple's existing ability to successfully interact and emotionally sustain one another. Intimate marriages have been associated with reports of a positive parenting alliance and sensitive, invested parenting by both mothers and fathers (Cox, Tresch-Owen, Lewis, & Henderson, 1989; Frank et al., 1986). Belsky et al. (1991) found that men who reported decreased satisfaction with marital relationships behaved in more negative, intrusive ways with their 3-year-olds. In fact, when feelings of love had decreased for one or both spouses, fathers were more likely to be intrusive and mothers to be positive when interacting with their child, suggesting the presence of a weak parenting alliance in which mothers attempted to buffer the impact of the fathers' behaviors.

The transition to parenthood appears to be a landmark in the development of the couple's spousal relationship. Both self-reports and observations of marital adjustment reveal consistent small but significant declines over the transition to parenthood, particularly for wives (e.g., Belsky, Lang, & Rovine, 1985; Belsky &



Rovine, 1990; Belsky, Spanier, & Rovine, 1983; Levy-Shiff, 1994; Miller & Sollie, 1980; Waldron & Routh, 1981). However, investigations of patterns of marital relationships over time reveal that while some marriages do indeed grow worse after the child's birth, many maintain the status quo and others actually improve in systematic ways (Lewis, 1988; Belsky & Rovine, 1990). The parenting alliance may, therefore, function as a buffer to minimize or even reverse the post-birth decline in marital adjustment.

An additional relational contextual factor relates to the division of labor, which has received attention from investigators of changes in the marital relationship over the transition to parenthood. Results consistently reveal that regardless of the pre-birth division of labor, mothers shoulder the majority of childcare and household responsibilities after the birth of the first child as roles become increasingly traditional (Belsky & Perlsky, 1988; Belsky, Spanier, & Rovine, 1983; Cowan, Cowan, Coie, & Coie, 1978; Cowan et al., 1985; Hoffman, 1978), particularly in the first 6 months (Cowan & Cowan, 1988), even among couples who were consciously committed to an egalitarian approach (Cowan et al., 1985). In addition, both mothers and fathers perceive their share of household tasks to be greater than their partners give them credit for (Cowan et al., 1985), thereby setting the stage for resentment and conflict.

Actual involvement in tasks appears to be a less salient predictor of declining marital quality than either satisfaction with or violated expectations about involvement. For example, individuals (especially wives) whose post-birth experiences in a variety of domains were more negative than expected reported a greater decline in marital quality and poorer adjustment to parenthood (Belsky, 1985; Kach & McGhee, 1982). Furthermore, different relations are revealed depending on whether the division of labor pertains to childcare or household

chores. Cowan and Cowan (1988) found that men who are satisfied with the household division of labor report higher levels of marital satisfaction, while men who are more satisfied with the childcare division of labor experience less parenting stress. Similarly, among women, violated expectations around the division of housework were associated with feeling less close to their husbands, but violated expectations around the division of childcare did not affect their perceptions of their spousal relationship (Ruble, Fleming, Hackel, & Stangor, 1988). These authors suggest that childcare may be more intrinsically rewarding than household tasks; thus, despite the fact that more time was spent in childcare than expected, it did not elicit the resentment that assuming an unexpected proportion of housework might. Since the division of labor changes over at least the first 2 years after the child's birth (Cowan & Cowan, 1988), assessment of violated expectations at a single timepoint would be misleading. Therefore, violated expectations around childcare and housework are designated Level 1 (time-varying) variables. These variables are especially likely to relate to the association between the parenting alliance and change in the marital relationship.

### Child characteristics

A third determinant of parenting, according to Belsky (1984), is attributes related to the child. First, the literature is inconclusive regarding the effect of the child's gender on the parenting partnership. In the few studies of coparenting, most have either not addressed child gender or have examined only one sex. However, in a study of the subjective experience of the parenting alliance, Floyd & Zmich (1991) found no association with the sex of the child. Alternatively, McHale (1995) discovered differential patterns of coparenting relationships according to child gender and marital distress. Child gender will, therefore, comprise

a Level 2 variable.

Additionally, child difficult temperament has demonstrated a consistent negative association with marital and parenting quality, particularly for women. For example, wives reporting less marital satisfaction have children with more difficult temperaments as rated by both mothers and observers (Sheeber & Johnson, 1992; Wright, Henggeler, & Craig, 1986). More difficult observed infant behaviors have also been related to a decrease in women's marital satisfaction over the transition to parenthood (Levy-Shiff, 1994), although they were no longer predictive once parental interactions with the infant were taken into account. Postnatal information on infant temperament has been shown to improve the ability to discriminate marriages that declined and improved in quality across the transition to parenthood (Belsky & Rovine, 1990). Finally, the child's soothability at one month of age predicted the mothers' responsiveness at one year (Heinicke et al., 1983). A fussy baby is likely to heighten stress levels, as well as require parents to make more judgments about how to care for and soothe the infant. Coparenting may suffer as stress takes its toll and relatively few rewarding experiences enable the development of a supportive relationship. Since perceptions of the infant's temperament may vary over the first few months, and in particular may co-vary with the parenting alliance and parental efficacy, it will comprise a Level 1 variable.

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## RELATIONSHIPS IN COMMUNITY

### *The root sources of health*

by Peter Gorski, M.D.

Six months ago, when I joined the Massachusetts Caring for Children Foundation, I got the opportunity to operationalize and test some fanciful convictions I have been considering over the past decade. During the past twenty years, as a pediatrician and child development specialist, I grew increasingly concerned about two deeply held frustrations. First, I recognized that the most prevalent and serious threats to children's health and development were no longer intrinsically organic conditions, but were the medical consequences of social stress. Low birth weight, infant mortality, growth failure, functional disability, child abuse, school failure, violence, injuries, teenage drug use and problems of behavior and attention were now the major pathogens dimming the bright future of a generation of children across all social classes in the United States. These trends in childhood morbidity correlated inversely with advances in medical science, technology and practice. Instead, the rise in untoward outcomes tracked directly with the accelerating pace of social inequalities in our society. I came to view these contemporary morbidities as nonspecific symptoms of illness in a community, much like fever is a nonspecific symptom of illness in an individual.

Second, and consequently, I appreciated that the medical profession was not designed or prepared to solve the underlying mechanisms that create health problems for children. We have developed the finest disease care system in the world, yet medical professionals have the smallest role to contribute

toward true primary prevention. Indeed, I realized, even if we were to achieve universal access to the current medical delivery system, our children would continue to grow up exposed to high risk for poor health and developmental disability. Health professionals are as powerless to create health as are police to guarantee safety.

Thanks to an auspicious convergence of progress in neuro-developmental biology and social science, we are beginning to identify and understand the causal relationships, starting even before birth, among interpersonal attachment, social cohesion or connectedness and health. Indeed, research across cultures and economies documents that poverty of the spirit is more crippling than is material poverty to the developing soul, mind and body.

Armed with this conceptual framework (and a lingering cache of idealism about human nature), I accepted the challenging opportunity offered by the Foundation to design and test new models of supporting children's healthy growth and development by building the social capacity of communities to foster human resources for promoting healthy functioning and resisting social viruses and carcinogens. While I have sadly tired of the now insipid idiom of the "village," I do believe that it takes a village to support a family in their essential effort to unconditionally love and inspire a child.

The Massachusetts Caring for Children Foundation was established in 1992 by Blue Cross and Blue Shield of Massachusetts, Rep. Joseph P. Kennedy, 11 and area health professionals to improve access to health care

for low income children in Massachusetts. The Caring Program modeled the child health insurance program that last year became the State's official template for legislation expanding Mass Health and the Children's Medical Security Plan. Building on that success and broadening our mission, we are currently developing four active programs.

### **Health Van for Kids**

The Health Van is a mobile health unit that provides free medical and dental exams, dental treatments and referrals for eye exams and glasses for uninsured children. The Van is based in Lawrence, Massachusetts, where children's health is threatened by high rates of parental unemployment, low-paying jobs with no family health insurance benefits, and cultural challenges associated with immigration. Through its volunteer partnership with the Lawrence schools, hospitals, health clinic, businesses and community coalitions, the Health Van also assists children to develop primary health care relationships with established local providers. The Health Van is currently expanding its health services to include reading and literacy programs, neighborhood improvement projects, youth mentoring and health and safety education.

### **Healthy Communities— Healthy Children Program**

Initially collaborating with three communities around the Commonwealth - Lawrence, Mattapan and North Berkshire County—this Foundation initiative aims to provide technical assistance- skill training and small matching grants to enable communities to build their social capacity for solving problems and developing local resources for promoting children's health. Community partnerships supported by the Foundation must involve local government, (continued on page 18)

# Reflections on the Strengths Perspective

By Charles H. Zeanah, M.D.



*In our previous issue we introduced the idea of self-reflecting, as a profession, on the meaning of the words by which our field is known: infant mental health, and by extension, then, with our identity: who we are and what we are about. Over the course of upcoming issues we plan to publish the thoughts of various members on these important concepts. Furthermore, we invite you, as readers of The Signal, to submit your reflections as well.*

*The first article in the series (see The Signal, January–March 1998) was written by Alicia Lieberman, Ph.D. The following thoughts are presented by Charles H. Zeanah, M.D., Professor of Psychiatry and Pediatrics and Director of Child and Adolescent Psychiatry at the Tulane University Medical Center, and for the duration of this century, editor of the Signal.*

Much of my professional efforts these days are focused on infant psychopathology and psychiatric symptomatology, and even aberrant parental behavior, especially maternal behavior. Though this is perhaps not so surprising for a psychiatrist, I do feel a bit self-conscious at times about what is known in our field as “the strengths perspective.” I would like to use the occasion of this new feature of our newsletter to say a few words about the strengths perspective, as I understand it, and to offer some thoughts about it in light of my interests and efforts.

Increasingly, I hear about and read about the importance of and need for the “strengths perspective,” which must replace the “deficit model.” As we know, the former emphasizes family and parental strengths and capabilities, while the latter focuses on symptoms, psychopathology, and disorders. The strengths perspective is considered to be especially important with trainees and young clinicians. Nevertheless, all of us may find the urge to name and label irresistible, the guiding principle being, “If you can diagnose/label/name it, then you understand it.”

Still, I believe that there is another equally problematic danger—namely, that in our zeal for communicating this important perspective to students and trainees we may oversimplify the focus on strengths. At the risk of offending some by challenging an important guiding principle, and for others for overstating the obvious, I feel compelled to reflect a bit about how I understand this conceptual framework.

The first person in the infant mental health community whom I remember passionately emphasizing a need to focus more on the inherent strengths of the help-seeking individual rather than merely on weaknesses was Berry Brazelton. For as long as I can remember hearing and watching Berry, his profound and earnest hope for the best in those who consulted him always was evident. Watching him work in clinical settings, as many of you know, is a special and unique treat. Like a heat-seeking missile, his energy and optimism and belief in the capacity of the individual seems to find some often obscure, small pocket of hope amidst considerable despair or frustration or bewilderment in a parent. Having found that hope, he then nurtures and supports and sustains it, seeming to help people see themselves in a new way as parents and as people. At center stage in his magic show, of course, is THE BABY. This exotic creature comes to life for parents in a way that most of us would not have believed possible. And following that beacon of hope and change and possibility allows many parents to become someone other than whom they have been.

Susan McDonough’s interaction guidance is another well-known clinical approach that emphasizes making contact explicitly with the strengths of a parent. Identifying what goes well, commenting on it, ignoring what does not go well—all of these approaches are, as you know, central components of interaction guidance. Furthermore, she engages in these approaches while watching with parents videotaped

replays of them interacting with their children. This marvelous technique allows her to underscore what she finds interesting, important, and salient about the often conflicted, disturbed, or flawed parental behavior she is watching and to use this observation of kindness, or interest, or support that a parent offers to a young child, or perhaps the child's eager response to this behavior, to increase the parents' awareness of their own positive response. "Did you see how much she liked it when you smiled at her when she showed you the doll?" Susan might say. Implicit in this statement and the context in which it occurs are the following messages: "I have seen your problems clearly and unmistakably, and yet I have also seen your strengths. With regard to changing, which is why we are meeting, I believe that you can build upon those strengths and become a more effective parent for your child."

As a psychotherapist, I know that one of my jobs is to believe that my patients are capable of and worthy of more than they sometimes believe themselves to be capable of and worthy of. Much as mothers and fathers lead their infants developmentally by attributing to them motives, intents, and capacities that are probably well beyond the infants' current developmental level, therapists must relate to and believe in the future and possible patient as much, if not more than, the present and actual patient. That is, therapists believe in whom the patient may become rather than who the patient is or feels like now. Many would argue that it is this sustaining belief and the way that it is communicated that is as responsible for change as any specific technical maneuver for change in psychotherapy.

With all of this as a long preamble, I would like to offer the following reflections:

1. Following Michael Rutter and Bob Emde, I remind myself and all of us that disorders are diagnosed—not people. Diagnoses disorders are useful as ways of facilitating communications

among professionals, of making it possible to learn about course, prevalence, risk and protective factors, and especially treatment of specific patterns of symptomatology. People, on the other hand, are assessed for disorders, symptoms and other problems, but also for their strengths.

2. A strengths perspective that does not include a good hard look at liabilities as well as assets is no strengths perspective at all. I believe that a true strengths perspective means looking the Medusa of psychopathology right in

can strengths be used as allies in our efforts to change weaknesses? Without a full appreciation of both, it is impossible to understand either as fully as we need to.

4. Transcending deficits is not the same thing as ignoring deficits. Sometimes serious problems in parenting must be faced squarely and directly, as when Jerree Pawl, in a carefully chosen moment, told a mother whom she had worked with for a long time, "Spanking's no good for either you or your daughter — you



What we have to offer as clinicians is hope for change—an alternative perspective that makes it possible not only to see a situation differently but also to behave differently.

the eye without allowing our hearts or ourselves to turn to stone. The reason that Susan McDonough's intervention is so powerful, I believe, is because she has looked directly and unflinchingly *with the parent* at their own undesirable/terrible/flawed parental behavior. She saw all of this and neither fainted, nor gagged, nor rejected them. Instead, she conveyed acceptance and hope for change.

At any given moment, Bruno Bettelheim used to say, people do the best that they can, given their view of the world at that moment. Sometimes the best that they can do is not good enough, for themselves or for others, especially their babies. What we have to offer as clinicians is hope for change—an alternative perspective that makes it possible not only to see a situation differently but also to behave differently.

3. It is vital that we not only identify strengths and weaknesses, but that we also appreciate their interrelationships. How do problems obscure and render strengths useless? And how

must stop it?" Knowing when and how to focus on strengths and/or weaknesses is the essence of the art of clinical work in infant mental health.

5. Those of us in infant mental health must be ever vigilant not only against a tendency to label and to pathologize but also against a tendency to idealize babies so much that we find it too uncomfortable to discuss and describe their experiences of serious psychopathology. Similarly, much as we must guard against mother-blaming and parent-blaming, we must also guard against an unwillingness to face serious shortcomings in parents. When faced with these shortcomings, the questions that we must ask are: How did this come to pass? How can I understand this mother sufficiently to help her change her behavior? How can I help this father become a better father for his baby than his father was for him?



## President's Perspective

Yvon Gauthier

In our field, a dialogue is more and more necessary between the numerous specialists who work on the early development of the child. For too long each specialty has been working on its own, developing ideas and theories, and too often, when communication was attempted, it was a "dialogue de sourds" (as we say in French). But the picture may be changing. I was recently involved in a symposium (in France) which brought together specialists of the brain, and specialists of pregnancy and of early development, around the theme of individual differences at birth. A tendency away from unilateral doctrines towards a more open acceptance of theories coming from another field of inquiry is stirring. A colleague even spoke of a honeymoon between infant specialists and neurobiology. The term may be too strong yet, but the attraction that this meeting had for pediatricians and other infant professionals is an indication that a tendency in that direction exists. I will try to summarize several conclusions which occurred to me after this meeting.

1. It is evident and well accepted that individual differences exist and can be observed at birth and soon after, and may play an important role in the outcome of the child. Geneticists will tend to ascribe such differences to genetic influences, and they can evidently be right in many situations. Without negating such factors, ethologists and specialists working with parents emphasize from their observations the role played by parental representations, coming from their personal history, in rapidly giving a sense to their child's characteristics. For example, a mother will immediately attribute a specific quality to one of her

twins who will look exactly alike to any other observer. As much as one can see the importance of specific handicaps or characteristics diagnosed by the geneticist at birth or soon after, we also have to be impressed by the importance of the parents' history in their early characterization of their child, and the possible influence of such on the outcome of the child's personality.

2. We are often asked to what extent emotional stress experienced by a mother during pregnancy will affect the child's state after his (her) birth, without knowing how to answer such questions. There are now attempts to correlate the state of a mother's emotional life during pregnancy with the neonatal state of the child. This may lead to a better knowledge of such influences on the newborn who has been the passive object during 9 months of a mother's anxiety or depression, just as we know better how toxic factors may impede the development of the brain during its development in pregnancy.

3. Media frequently convey the impression that everything is already decided by genetic and organic factors once a child is born. Such notions evidently satisfy many who dream of easy solutions to difficult problems.

Happily, simplistic thinking was not the case in this meeting. Work done on ties between attachment and temperament show that temperament is but one factor in the development of quality of attachment. There is no doubt also that brain plasticity through postnatal synapto-genesis is an important factor in gradually compensating for an organic insult which may have occurred during pregnancy or at birth.

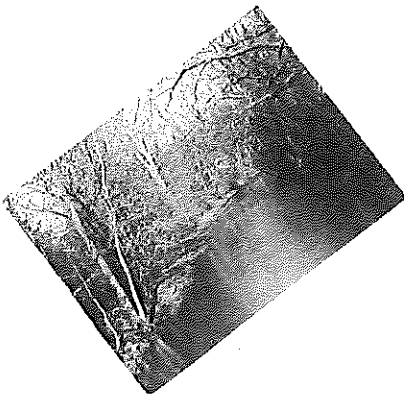
4. This whole question of

differences at birth opens the possibility of predicting with a fair amount of certitude the outcome of a child. Several participants emphasized the limits of prediction, and brought out the problem of possible stigmatization of women at risk by an inept or untactful early psychiatric or psychological intervention. This is a serious problem. Mothers' narcissism during pregnancy and postpartum has to be supported and protected. It is during this period that professionals, like nurses or midwives, can be particularly useful, as they are seen as natural companions to the mother through this whole period where it is so important not to be isolated. The role of midwives (I know of them particularly in France—this profession hardly exists in Canada) is well suited to create a working alliance which can be of much benefit in at-risk situations. The idea was finally suggested that what is needed is more a "culture de prévoyance" (a culture of careful foresight) rather than a "culture de surveillance" (culture of surveillance, in the sense of inspection).

Such ideas may all sound very abstract, an ensemble of good intentions. The same approach makes sense to me in a clinical milieu where obstetricians, pediatricians and child specialists, for example, meet on difficult situations such as around the birth of a child. A spirit needs to be put in place, a dialogue needs to be established between specialists and researchers who can no longer stay in their own field and hold to their unilateral theories. Symposia like the one I attended, as well as clinical settings, serve as essential venues for the meeting and exchanging of ideas and theories.

The Montreal Congress in the year 2000 should be a very convenient place to discuss and confront the development of new ideas and theories from all fields of science working on pregnancy, infants and parents and their many clinical applications.





### *Thoughts Flowing from Transition:*

As many of you know, the WAIMH Central Office overlooks the Red Cedar River on the Michigan State University campus. Therefore, I have a particularly advantageous vantage point for watching the return of some of the 43,000 students for Fall Semester. Roughly 6,000 of these students are first year students at the university, all of whom are required to live in residence for their first year. Despite the increasingly sophisticated travel experiences of many young adults, for many of these 17-18 year olds, this will mark the first extended living experience away from home. It is a time of transition, a time of change. For many students this is the first sustained separation from the home; placement into a living situation with new roommates, new responsibilities for personal conduct, new demands for self-motivated study and scholarly work, and new challenges to emerging identities. Many individuals seem to make life transitions with ease, others have great difficulty leaving the stability of past life and embracing the unpredictable future.

This was a summer of transition for me as well. After 30 years my wife and I moved to a new home. What's more, we acquired new home-mates, my wife's mother and father, which instantly changed the multi-generational composition of home life. For 30 years we were the parents, we oversaw the development of three children, acquired three in-law children, and, currently, 3 grandchildren.

## from the Red Cedar

*by Hiram E. Fitzgerald,  
Executive Director*

Oftentimes, this raucous group of nine (along with their godparents) were at home together, their laughter, arguments, empathy, and love seemed part of the structure and fabric of the building. "That's where we use to have Steven's crib." "That is the wall that Katie fell into that gave me my first experience at repairing dry-wall." "There are Stephanie's oil paintings of Huey's (little bee-like creatures), that now must be painted over for the new owners." These are memories that will forever be disconnected from their anchor because they are linked to the sights, sounds, and smells of that old house.

But moving means transition and change; we still are parents, but we now also are children living with parents. We are building new memories of home life and putting "that old house" into its place in family history. Our separation from home and reunion with parents has been accomplished with few real problems, because we have the advantages that accrue from careful planning, life experience, and positive family support. We differ most from students, it seems in the dimension of life experience. We have survived many errors of judgment that students have yet to make. We survived them in part because our values were grounded in stable family backgrounds (continuity of family dynamics), rich experiences with parents and relatives (attachments), respect for knowledge (educational achievement), and key mentors at various critical times during development.

We did not have to live in war or poverty, we did not suffer the indignities of racism, we have not had to struggle with disabilities. However, it is a truism, that millions of the world's children are victims of the inabilities of adults to live in peace, friendship,

mutual respect, and hopefulness. I cannot imagine what it is like to spend infancy, toddlerhood, or childhood in circumstances that exacerbate ways that may kill or maim me. I cannot imagine what it is like to live in circumstances where some members of my species do not consider me to be included. I cannot imagine circumstances where adults would view me as chattel or as an object for their sexual gratification. Understanding man's inhumanity to man seems increasingly to be an impossible task. Which of the students I am watching will become community leaders who will support family life, who will fight against racism and poverty, and who will attempt to make life better for themselves, their loved ones, and their communities? And which ones will not?

Theories and polemics of infant mental health point to interpersonal dynamics as a potential immunization against inhumanity. If our science is on the right track, and if our theories are sound, what is our social responsibility to advocate against inhumanity, injustice, poverty, and abuse? Who will speak for infants and toddlers, if we do not? What is WAIMH's responsibility to improve the early experiences of millions of the world's children?

Our move is complete, our transition to our new home is done. I will forever bask in the warm memories of family life and child development that were generated from life in that old house. I look to the future with great anticipation, perhaps with a bit less uncertainty than the first year students outside my window, and I will continue to search for deeper answers to why the killing fields are so attractive to so many members of my species, and why our immunizations do not seem to work so well.

# meet your regional vice-president

*Regional vice presidents play an important role in WAIMH. They are responsible for Affiliate development and are liaisons between Local Affiliates and WAIMH. They have major responsibilities for membership expansion, regional congress promotion, and inter-country advocacy of infant mental health. They also are encouraged to provide input to the Executive Committee apropos of the goals and issues that WAIMH should be addressing. We are delighted to be able to begin a new feature of The Signal in an effort to acquaint WAIMH members with their Regional Vice Presidents.*

## Campbell Paul, M.D.



*We begin our series with Dr. Campbell Paul, Regional Vice-President for Australia and New Zealand. He is a child psychiatrist affiliated with the Mental Health Service of Royal Children's Hospital in Victoria, Australia. Additional activities to his education and work in Australia include research with the Winnicott Research Unit, Cambridge, studying the development of infants whose mothers suffer from depressive illness, and completing a diploma course in Infant Psychiatry at the University of Paris under the direction of Professor Serge Lebovici.*

*He writes the following about his life as a psychiatrist deeply committed to the evolving field of infant mental health.*

**M**y imagination was captured by exposure to child psychiatry when a medical student at the Royal Children's Hospital in Melbourne. This was in a

hospital where there was a rich tradition of close work between pediatrics and

psychiatry so after a period of general psychiatry training in

Edinburgh I returned to continue Child Psychiatry training at the Royal Children's Hospital.

Consequently I have worked for a long time in the Pediatric Consultation Liaison Psychiatry context. This has been a particularly rich and challenging one and fertile for the development of an Infant Mental Health Service. The Children's Hospital is a place where infants are brought by their parents readily and with confidence in the institution. This has meant that it has been possible to build a very healthy service for babies and their parents.

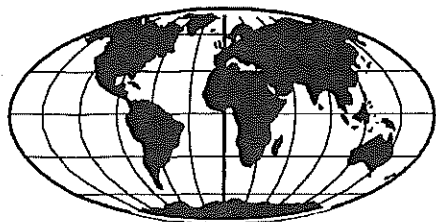
I have been honored to be able to work closely with many of the general and specialist pediatricians and staff from many disciplines at the hospital. We have built up a particular connection with general pediatricians, neonatologists, gastroenterologists and

many other groups in the hospital. We also have ongoing community liaisons with mother/baby/units and parenting centers in the city. Within the hospital our multidisciplinary group has built up special interests in areas such as infant irritability, failure to thrive and feeding difficulties and infants with disabilities and medical and surgical problems. We have worked closely with child protective services and social work departments. We also have been fortunate in Melbourne to be able to cooperate in a healthy collegiate way with the other Infant Mental Health Programmes in the city.

I have a particular interest in the role of gaze aversion as an early symptom in infancy and am fascinated by the dramatic changes that apparently simple interventions can produce when working with infants directly when in the presence of their parents. The further development of the concept of the infant's own mind provides exciting prospects for further therapeutic possibilities in infant psychotherapy. Our group was able to establish the first Graduate Diploma and soon to commence a

Masters Course in Infant and Parent Mental Health within the University of Melbourne. This has been a very exciting venture made possible by the cross disciplinary nature of Infant Mental Health.

The Australian Association for Infant Mental Health has branches in a number of states and are currently forming one federal organization. We've held two Regional WAIMH congresses and many other conferences. Again we are always encouraged by the capacity of an Infant Mental Health conference to draw together people from a wide range of disciplines. Planning is well under way for the 1999 National meeting. Colleagues within WAIMH have been extremely generous of their time and support for me and for our Australian organization. I have enjoyed and benefited from the links with colleagues in Paris, London, United States, Japan and many other countries making me realize what a small world it is. The Antipodes are not so far from the other Hemisphere. WAIMH is truly a global association where there is a very healthy respect for colleagues as well as our communities of babies and families.



# WAIMH

## *Affiliate News*

### **German-Speaking Association for Infant Mental Health**

From May 21st to May 23, 1998, the German Speaking Association for Infant Mental Health (GAIMH) held its annual meeting in Graz, hosted by Marguerite Dunitz-Scheer, MD, and Peter J. Scheer, MD. The main topic was interdisciplinary relationship. Since participants came from three German speaking countries (Austria, Germany and the eastern part of Switzerland) with very different modes of thought, the opening lecture was given by the host using examples from musicals and operatic arias to explain the pros and cons of teams in their relation within and to the client. This session was headed by Hanus Papousek, current President of the Association for Child Research.

One whole day of the annual meeting was devoted to current research in the field, for example, psychotherapy research by K.H. Brisch and his group from Ulm, Germany, as well as long-term studies of the role of the father in the developing infant being conducted by K. Grossmann, of Regensburg, German.

Dr. P. Bartmann, a neonatologist, currently head of the department for neonatology at Bonn, Germany, gave the key note address on the topic of "The Baby-Friendly Hospital." Papers were presented on topics such as chronic diseases in infancy, children born to serve as bone marrow donors, and long-term psychotherapy in a hospital based program. Presentation of three case-histories from all partici-

pating countries made the conference lively. The next annual conference is scheduled for May, 1999 in Cologne, Germany. WAIMH members from other countries are warmly invited to participate.

—Marguerite Dunitz Scheer, MD  
and Peter Scheer, MD

### **Illinois Association for Infant Mental Health**

Members of ILAIMH are eagerly anticipating their upcoming annual conference in October (see page 20 for more details.) The theme of the conference is entitled "Constructing Meaning in Relationships: Working with Infants, Toddlers and Families." Jeree Pawl, well-known author, clinician, infant specialist, and director of the Parent-Infant Program at San Francisco General Hospital, will be the keynote speaker.

### **Kansas Association for Infant Mental Health**

Two conferences were held recently in Kansas. In April, Joann O'Leary, MS, Parent Infant Specialist at Abbott Northwestern Hospital in Minneapolis, Minnesota spoke about prenatal cycles of parenting during pregnancy and in unexpected outcomes such as termination of pregnancy and babies who die.

In May, Kathryn Barnard, RN, Ph.D., from the University Medical Center in Seattle discussed her method of assessment of relationships at risk between parents and baby in the neonatal period, and in a second session

addressed the methods of intervention to promote sensitive caretaking in mothers of very young infants and the empirical results of this program in Seattle, Washington.

—Kansas Association for Infant  
Mental Health Newsletter, January  
1998

### **Maine Association for Infant Mental Health**

The Maine Association for Infant Mental Health anticipates offering a three-day introductory course on the issues and practice of infant mental health offered at various locations around the state. The basic curriculum has been developed and appropriate resources, support services, consultation will be provided to the instructors.

—*Everyday's Child*, March–April 1998

### **Michigan Association for Infant Mental Health**

The annual conference sponsored by the Michigan Association for Infant Mental Health hosted its biggest crowd ever—over 500 people showed up to hear talks centering around research in brain development and its relation to the power of human connections. Keynote addresses were given by Elizabeth Muir, Child Psychotherapist of the Watch, Wait and Wonder Program at the Hincks Center in Toronto, Canada, Arnold Sameroff, Ph.D., of the University of Michigan, and Megan Gunnar, Ph.D., from the Institute of Child Development at the University of Minnesota. Videos of

these presentations are being prepared and should be available through the video library in early 1999.

Outgoing President, Kathleen Baltman, reminded participants that the message of infant mental health is not just about what we give to our clients, but it something that begins within us, as an organization. She summed up the essence of the life giving force responsible for infant mental health's continued growth by stating: "We take this relationship business pretty seriously don't we? The warmth and friendliness that has been and continues to be developed by each and all of us; greeting by greeting, training by training, conference by conference, year by year. It is what we bring, share and give [to one another] that has made MAIMH what it is today."

*The Infant Crier, April—June, 1998*

### **Texas Association for Infant Mental Health (TAIMH)**

The annual meeting of TAIMH, held in August, focused, on an issue receiving much attention recently in the US—welfare reform. As more mothers are required to seek employment as a condition for receiving financial support, the issue of finding quality child care poses new challenges for many families and communities. This is not an easy task. Evidence continues to mount in regard to the importance of the first three years of life. These early years are not only impacted by the child's home environment but also by his child care situation. . . . Parents need information that helps them make informed and responsible decisions in selecting care for their babies. . . . We want families to be proactive and not reactive where child care is involved. The success of these families depends largely on how prepared they are for maneuvering their way through our systems. . . . As

professionals we can help by becoming aware of the different avenues available and by empowering parents to take the lead in their child's life. . . . What's needed to reach our goals of addressing and improving the quality of life for our communities and families is to combine our efforts and energies in collaborative plans and action.

—Gail Surlles, President  
*TAIMH Newsletter, July 1998*

Besides the annual conference, TAIMH sponsored a study course on Psychopathology in Infancy: Selected topics. Five sessions in the spring of 1998 included such issues as sensory regulatory disorders, sleep disorders and feeding disorders. Among fall session classes are topics of traumatic stress disorders, and the father's role in infant mental health. These reading and discussion courses take place in the city of Dallas and are offered to a wide range of professionals. Their focus is on early childhood disorders with a special emphasis on the parent/child relationship.

### **Northern Italy Association for Infant Mental Health**

Organized through the efforts of Dr. Graziella Fava Viziello the Northern Italian Association for Infant Mental Health has been granted provisional status as a new Affiliate of WAIMH. Many of the 15 members became interested through a graduate course in parenthood and development taught at the Università degli Studi di Padova by Dr. Viziello.

### **Quebec, Canada**

Through the initiative of Dr. Lee Tidmarsh and other colleagues, the Quebec Association is revitalizing itself as a viable Affiliate after several years of dormancy.

*(continued from page 11)*

businesses, schools, religious leaders and health providers. The community-led health coalitions will determine the programmatic target and focus for improving the health status of their children. Projects include neighborhood clean-up, health care access, facilitating literacy, and building social cohesion across generations, races and cultures.

### **The Hunger Project**

The Foundation is co-directing a major survey and policy initiative on food insecurity among the children of the Commonwealth. Teaming with Project Bread, Tufts University Center on Hunger, Poverty and Nutrition Policy, U.S. Representative Joseph P. Kennedy II and Suffolk County District Attorney Ralph C. Martin III, this project will conduct a comprehensive study of the extent and causes of hunger among children in Massachusetts. It will also list resources currently available for eradicating this primary cause of poor health, stunted growth, limited intellectual development and school achievement, emotional despair and learned hopelessness. Physician Task Forces and community focus groups with consumers, providers, advocates and policy makers, will develop a humanistic database to connect the unacceptable statistics with real faces and personal stories. Achievable strategies for public action to eliminate childhood hunger will be presented and promoted to State officials, communities and organizations throughout the Commonwealth before the end of 1998.

### **Learning is Healthy Program**

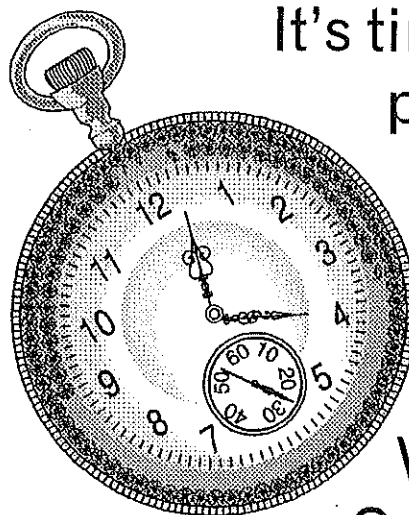
This represents the Foundation's emerging collaboration with the Massachusetts Teachers Association, the Massachusetts Federation of Teachers and the Massachusetts

*(continued on page 19)*

Department of Public Health, Division of School Health. Health should never interfere with a teacher's efforts to educate or a child's energy to learn. We hope to test new statewide models for maximizing the opportunities for schools to support the work of parents and health providers in providing children with quality health prevention, health education and clinical services. Schools are based in communities, are central in the lives of children and families, and should have special insight into how to foster the strengths, resilience, performance and dreams of young individuals. Again, we hope to create innovative service partnerships between the public and private sectors, schools, health care providers and health care funders.

Transferring a model that has long inspired my clinical practice, teaching and research onto the plane of social action for children's health, I continue to operate from the conviction that all individuals and communities possess strengths, talents and resources that they can use to promote health and healing. Inspiring, mobilizing and supporting the growth of such attributes and ultimately increasing a community's capacity to prosper and contribute, represent the central objectives of our work at the Foundation.

*From the Newsletter of the Boston Institute for the Development of Infants and Parents, May 1998. In addition to his Foundation directorship, Dr. Gorski serves as Director of Professional Education of the Brazelton Institute of Boston Children's Hospital. Active on several national Boards of child health and welfare, he was the Immediate Past President of the Society for Developmental and Behavioral Pediatrics.*



## It's time to start planning for the great beyond.... WAIMH 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.**

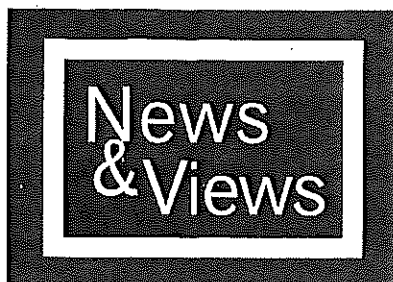
### **Bids should include:**

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

**To request further information  
or to send your bid  
contact:**

**Hiram E. Fitzgerald, Ph.D.  
27 Kellogg Center  
Michigan State University  
East Lansing, MI 48824-1022  
USA  
email: fitzger9@pilot.msu.edu**

**DEADLINE FOR PROPOSALS: MARCH 30, 1999**



## Training Opportunities

### Canada

November 12-15th, 1998. The Hincks Center for Children's Health, Toronto, Ontario. *The Long Shadows of Trauma: Traumatized Parents and Infants—Developmental and Clinical Issues*. An international conference for clinicians whose clients have experienced a variety of traumatic events in their early years. Faculty includes David Finkelhor, Allan N. Shore, Nathan Fox, Pamela Sorensen, Joy Osofsky, John Marcellus, Elizabeth Waites, David Conrad, and Charles Zeanah.

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  
fitzger9@pilot.msu.edu  
waimh@pilot.msu.edu

For information, contact: The Hincks-Dellcrest Institute at 1-416-972-1935 x 3345 or 3341; fax: 1-416-924-9808; email: enerlich@cmhincks.cn.ca or hincks@interlog.com

### United States

October 30, 1998. Chicago, Illinois. Annual Conference of the Illinois Association for Infant Mental Health. *Constructing Meaning in Relationships: Working with Infants, Toddlers and Families*. Keynote speaker is Jeree Pawl, Ph.D. For information: Pat Husband at 312-909-4210, or Marsha Hawley at 312-259-2242.

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, 1998. Washington, D.C., 0-3, *National Training Institute*. For more information call (703) 486-0675, or visit web site at: [www.zerotothree.org](http://www.zerotothree.org)

February 27, 1999. Chicago, Illinois, Institute for Clinical Social Work, *Relationships Matter: Rethinking Development*. Key speaker is Alan Sroufe, Ph.D. For information: The Institute for Clinical Social Work, 312-726-8480, email: [ecsw@icsw.com](mailto:ecsw@icsw.com)

### 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.

### New Web Site:

Michael Trout's Infant-Parent Institute, in Illinois now has a web site: [www.infant-parent.com](http://www.infant-parent.com)

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