The Signal

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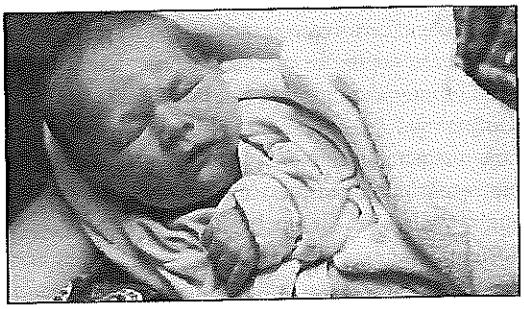
EXPERIENCE FROM THE FLOOR OF ATTACHMENT AND RELATIONSHIP BUILDING

by Kay Karlsson and Anna Skagerberg

"Can you help me survive?" the little boy, aged four months, asked me with his sad face and dull eyes, as he lay on the far edge of mother's lap. "Yes, I nodded, I will try to help you and your mother to survive and become close to one another." Yet another baby had reached our mother-baby unit, Maskan, not knowing whether to live or die, whether to thrive or fade away. Yet another sad mother sat in front of us telling us about her misery of missing feelings of motherhood and her devastating anguish.

Maskan is a special treatment unit for mothers and babies within the Child Guidance Clinics of Stockholm. The English word for Maskan is the Stitch symbolizing a dropped stitch in knitting. If you catch the stitch early enough, no hole or knot will spoil the sweater. Inspired by research into early infant development and Selma Fraiberg's work on mother-baby intervention, Maskan opened in 1989 to meet the needs of mother-baby dyads who needed more help than they could get at the public Health Care Centres or by visiting a psychologist or social worker once a week. The families who come for treatment are mainly referred by Child Health Care Centres because they have severe difficulties in the relationship between mother and baby. Sometimes the baby carries the symptom, sometimes the mother does. Sometimes the family may also have other serious problems. What is common is that most of the mothers are unable to stay at home alone with their babies during daytime because their panic is too overwhelming. Some of them are stricken with unbearable anguish for the first time in their lives, but others have long psychiatric histories. The reality of the problem is a terror of being a failure as a mother, a fear of destroying the child, or of being totally lost as a person facing the task of being a mother.



The staff consists of psychotherapists working psychoanalytically, with four to six mother-baby dyads at a time in a group-setting, three times per week in three hour sessions. Length of treatment can be from two to 12 months long, averaging five and half months.

Time for Evaluation

After seven years of saying good-bye to one mother-baby dyad after another, we realized the need to examine the outcome of our work and evaluate the methods.

In this Issue

Where communication and intervention is often on a nonverbal level it is essential to have continuous critical and professional discussion.

At about the same time, Daniel Stern published, *The Motherhood Constellation*, in which he describes different approaches or "ports-of-entry," to work with disturbed mother-infant relations. The results of research on approaches built on different theories are described, and in short, all the methods seemed to work. Sternàs conclusion is that there must be a common nonspecific factor that is effective. He discusses the impact of factors like the therapeutic alliance and positive transference and links these factors to the mothersà need of support in this special period. Motherhood faces the woman with a task that actualizes feelings related to the responsibility of the baby's life and growth. She is in the beginning of a lifelong relationship and needs the capacity to create a supporting matrix around them. Stern suggests a new concept, the motherhood constellation, for this transition to a new personality organization. Be it a new personality organization or not, the description of what is in focus for the mother is very accurate. So what is required from treatment in this period? Stern calls for further research on a combination of treatment methods.

Combination of Methods

Maskan combines different methods of mother-baby therapy. As well as the group-setting, the mother-baby dyad have weekly individual sessions, which in content and method are adjusted individually to the dyad and to their specific problem. The content varies from interactive guidance with video focusing on what is actually happening, to supportive and to more exploring psychotherapy, the starting point being the mother's question, complaint or history. Still, the baby is our patient. The developing baby is the centre of our attention particularly the baby's attachment behavior and desire to communicate.

The three hour session always follows the same pattern. The group gathers in a large room, squatting on mattresses on the floor. Grown-ups group around the small babies, while older babies crawl around. The babies' behavior and interactions are focused and linked to mothers' feelings. Discussion covers diverse areas—what are children this age interested in, what happens with the playing child when mother suddenly without warning rushes into another room, what happens within a mother when the baby turns away from her, what happens within a child when mother doesn't notice an oncoming uncomfortable state.

After one and a half hours on the babies' level, it is time for lunch. The therapists take turns in making a simple meal. Everyone sits around a large table, and the goal is now how to enjoy lunch all together. How can the mother manage to eat and at the same time feed her child or keep him satisfied if already fed? A nice mealtime is the goal, and a pleasurable interaction is encouraged, although tears are shed occasionally. Lunch is eaten leisurely after which its time for the mothers to pack their belongings together and start their journey home or to have their individual session with their psychotherapist.

This structure of sessions three hours three days a week is repeated week after week for months and forms the frame work within which change takes place. Maskan uses a combination of methods inside this

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definite framework. This contrasts with the treatment methods reported on by Stern that were shorter and less intense.

Questions for evaluation

What we wanted to know in the evaluation was basically:

Did the babies and mothers actually get help?

If so, what in the treatment methods has an effect?

If the mother-baby couples were helped did improvement last in the years to come?

The Research Design

Of 30 mother-baby couples who came to treatment over a two year period, 10 were sampled at random for a closer examination. An experienced child psychologist was appointed for gathering data. She made two home visits interviewing the mothers, doing a clinical observation of the children's development, and making a short video of mother reading a story to the child in order to assess their current interaction. On average, the evaluation was completed three years after treatment. The interviewer visited seven of the families in their homes and interviewed the other three by telephone. The psychologist also interviewed the therapists and looked through case-records.

We were especially interested in differences between the mothers' narratives and the therapists' descriptions of the processes and between informed and observed data.

Results of the evaluation

What we found was that nine out of 10 mother-baby dyads had made considerable progress during treatment. What does that mean?

The Children Developed

Case records from before treatment showed that almost all the children had severe problems with basic regulation such as eating, sleeping and tension problems, accompanied by a great amount of screaming. This is a description of a two-and-a-half month old baby-girl: "Disrupted daily rhythm, sleeps in 20 second periods throughout the 24 hours, screams a lot, gaining little weight intermittently." Poor interaction was noted. For example, the babies often turned away, avoiding eye-contact. The mothers were too wrapped up in their own problems to really be aware of their babies and help them in their distress. The mother of the little girl above said: "Oh, I feel stupid and silly all dressed up in a pram." Another mother of a seven month old boy says: "He doesn't sleep longer than 30 minutes day or night. When he is awake he cries and I can't stand him screaming. I have constant migraine. I clench my teeth so hard they crack into pieces. I want to get rid of him . . . it's not only that he doesn't sleep—it's what happens inside me . . . I am furious."

What is interesting and can be read from the case records, is the obvious simultaneous development of the children and their mother's new experience of motherhood.

The description of the same little girl three months later when treatment had been completed reads: "She is eating well and gaining weight steadily, sleeps through the night, looks happily around at the other babies and mothers and frequently turns to her mother smiling and babbling."

After treatment, all the children but one had reached their expected level of self-development. That means not only had they stopped screaming, but also that they were eating, sleeping, moving about, smiling, babbling and actively making contact. So, from being far behind, they had caught up in less than six months. The children now had no problems with basic regulation, had caught up with expected development level and interaction both ways between mother and child increased with the one exception. But did this improvement last?

Sustained Improvement

The child psychologist assessed the development of the seven children she visited at home as normal, interaction between mother and child as good and from the videoclips increased interaction was noted. Among the three families interviewed by telephone was one family who did not get help from treatment. The children had developed and interaction was satisfactory.

Mothers' Inner Change

In the interviews, mothers mainly talked about a change within themselves. Their feelings about themselves as mothers had undergone great changes, and they described this in terms of being secure and finding life with the child joyful, words they had not had in mind before treatment. They described feelings of love and tenderness towards their children.

The mother of the boy of seven months now five years old said: "It's

much better but not altogether easy. I can manage . . . it's much better because now, there is a lot of love between me and my little boy."

What is interesting and can be read from the case records, is the obvious simultaneous development of the children and their mother's new experience of motherhood. This process also was described by the therapists.

However, the surprising thing is that the mothers in general did not seem to notice their children's serious condition. In the interviews, they talked about their own anguish and how close they were to becoming failures as mothers, but they did not describe their babies' changes from suffering to sociable children. Their focus was limited to themselves. They were all, with one exception, very grateful for having had the chance to receive treatment at such an early time and highly rated their own development from a suffering woman to a good-enough and enjoying mother. Neither they nor the therapists consider that they would have experienced the positive development that nine of them did, without receiving treatment. Perhaps, a stitch in time saved nine.

Treatment Methods and Effects

Material from the interviews and case records indicates improvement in nine out of ten cases. Seven mothers rated the treatment as having crucial importance for beginning a good relationship with the baby, two rated it as having great importance, and one did not think it had any effect at all.

We wondered whether specific components of the treatment were responsible for the effect. According to mothers' ratings, what was most valued by everyone was the structure of coming 3 times a week and being a member of the group. Some mothers valued individual sessions with the therapists, and others valued the video work the most.

Mothers attended sessions 73% of the time. This high compliance rate is remarkable and is representative of the mean rate for the whole group of mother-baby dyads who came to Maskan.

We inquired about turning points in the treatment process. Four mothers described continuous progress, while four others mentioned events related to a sudden discovery of their developing baby. A typical statement was: "She had started to sleep better and was able to relax. Suddenly she looked up at me watching my face—it was a fantastic experience." Two mothers did not mention turning points.

Reflections

It is difficult to say what promoted improvement in the mother-baby relationship. We acknowledge the fact that time works on our side. Many mothers feel insecure with their newborn child. But families referred to Maskan are families who need more help than they can get at the Child Health Care Centres, even with extra support. All the mothers in the research group had severe difficulties in relation to their own parents. Five of them had no contact at all with their own mothers. Four mothers had psychiatric treatment beside the mother-baby treatment. So, mother-baby dyads coming to our unit do not represent the ordinary insecure mothers.

Holding

The one element in the treatment setting that seems most important for the mothers is simply coming—to come on a special day, at a special time to the group. What makes them come?

Mothers who are referred to Maskan range in age from late teens to 40 years old. Socially they represent a variety of women, some living alone, most of them married. What is common is that they left work to have the baby and then lacked a social life being at home with the baby. What they also have in common is a problematic relationship with their own mothers. Sometimes there has been a dramatic break in the family, but most often it seems there had never been a secure relationship. They are often devoid of experience of good mothering or are in great conflict on this subject. Yet, because they are horrified by the troubles they experience with their child, they avoid the parent groups that ordinary families eagerly attend at Child Health Care Centres. So, these mothers who need support most, tend to isolate themselves more and more. These mothers and babies do need a supporting matrix and a treatment group appropriate to their needs.

In the evaluation, there was a great consensus between the mothers' and the therapists' reportings about the importance of the group. They all see the regularity of three times a week sessions as the prime condition for an effective treatment process.

Initially, however, the mothers often hesitated and questioned the need of three times a week before beginning treatment, but afterwards they valued the firm and regular structure. One of the interviewed mothers talked of coming as a lifebuoy. Another mother said: "I think it was the regularity, because once I started to live with routines, it was a new way of living, I was not used to it... but very soon I felt, this is

right." The therapists valued the structure very highly and spoke of it as a basic framework of "holding" wherein change could happen.

The mother-baby dyad who did not improve attended only 49% of the sessions, and this mother expressed clearly in the interview that it was too much to come three times a week. What was most appreciated by mothers who got help was experienced as a demand by this mother.

Of Containment

In coming to treatment, the mothers were desperately in need not only of a place where "being" together with the baby was possible, but also of having someone who saw and confirmed their struggle to become mothers to their babies.

The therapists talked about the arduous work of containment, of containing feelings transferred from the screaming infant, transferred from the missing mother-baby interaction and transferred from the mothers' desperation. They talked about "being without doing," sharing unbearable pain and worry with the mothers, relying on the process and having the patience to wait. Waiting for what? Waiting until the holding and the containing had a gradually calming impact and the mother began to rely on and become attached to the therapist. Then, the mother hopefully would be an ally in the treatment and attention could be more directly focused on the problem.

In contrast, the mothers described their experience of the group like this: "I could relax there for a while. At Maskan you could be yourself, nobody was judged, everybody had problems, I dared talk about my feelings. The therapists didn't do anything special, they just listened, they were always attentive."

What does the contrast between the therapists' images and the mothers' mean? Could it be that the strength with which the professionals hold and contain corresponds to the relaxation the mothers feel?

Holding and Containing — Nonverbal Interventions

There really is something special in a mother-baby treatment—the dominating theme of the therapy is on such a basic level. Any mother has to contain and interpret her baby's needs and to handle him without verbal confirmation. Any baby has to try to make reason out of his mother's behavior. This interaction normally is accompanied by the music of vocalization. In general, they succeed in understanding each other, providing neither of them loses control or panics too much. But this is exactly what happens to mothers who need intensive help. They lack basic trust in the field of mothering, and they panic. Between mother and baby there is silent terror.

> ***To begin treatment together with the baby can be seen as a nonverbal act of hope for the future. The act of the therapist, in receiving the mother and her baby for treatment, can be seen as a confirmation of belief in their relationship.***

Not only the child's, but also the mothers' problem arises from the question of survival. How to survive as a dependent baby and how to survive as a responsible mother of a dependent baby?

When a mother comes in a state of fright and despair with her exposed infant she needs a place where she can "be together with the baby" in security. To begin treatment together with the baby can be seen as a nonverbal act of hope for the future. The act of the therapist, in receiving the mother and her baby for treatment, can be seen as a confirmation of belief in their relationship. In nonverbal language, the routine of coming to treatment can be regarded as questioning and the receiving therapists as confirming. This period, before the mother begins to rely on possible change, is the crucial period of attachment to treatment.

The group functions at an everyday level but allows the underlying theme to unfold and be acted out. Dramas of life and death, love and hate, are there to be seen and experienced.

The suffering mother-baby couple come to the group. The goal is to liberate interaction between mother and child, to stimulate small talk and simple play to cure the frozen standstill. Interactional difficulties are obvious and the group gives time and opportunity to present them. The theme can be enacted on a nonverbal level.

The therapists have to encourage a group climate that promotes development. They have to regulate the level of anguish. In contrast to neurosis psychotherapy, stimulating the uncovering of repressed conflicts, the therapists in a mother-baby group have to handle wounds that often are too open. On the one hand, they have to function as leaders of an ordinary mother-baby play-and talk-group on the other hand most of their work is to contain fright and despair. And

little by little, babies and mother calm down and change begins to take place.

Moments of Meeting— Mother and Therapist

Some mothers put words to their pain and the process of understanding is a task shared between mother and therapist. The work is done step by step and often starts in a dialogue within the individual sessions and then continues in the group-sessions. These mothers are ready to reflect on their problems.

Other mothers present their problems through enactment. They set up a drama in the group, with themselves, the baby and the therapists as the main actors. Feelings are transferred without words and can emerge in the form of headaches or scary fantasies in the therapists. The enactment process is unconscious and the plot is a secret. No words can be shared. Although mother and baby are attached to the treatment they do not cooperate as allies in the treatment process and verbalization of the problem is more than often a mined area. The contained material needs a very patient container who is keen to understand but has to go without confirmation from the mother. Then the worry has to be shared among the therapists and the content of the drama worked through in supervision.

It is a difficult task first to understand and then to find a space and words to share some meaning. The therapist has to take in, patiently digest, and go through the process of understanding without recognition from the mother. This process has a parallel to the demands of the containing placed on a mother by her screaming infant. She too has to contain without recognition. She too has to find ways of handling a situation she doesn't understand. The mother puts the therapist to the same test as her baby puts her.

When the process gets to the certain point where the therapist's countertransference is at its peak, and she shares the feeling of being helpless, mother and therapist may experience a very special moment. If the therapist lets go of the desire to push the process forward and allows this feeling to take place and spread within, she can participate in the motherâs state of mind and from her inside feel what it is like to lose hope of being a good mother. The feeling and the knowledge can be shared without words.

After such a moment the feeling is shared. An intermediate space opens where the feeling may be possible to see and be dealt with and the confusion put into words. This work can lead to the understanding that feelings can be shared and acknowledged and that intersubjective meaning can be established.

Meeting between Mother and Baby

From such moments of meeting treatment shifts. What now remains is to further confirm mother's experiences of intersubjective meetings with her baby. This is the time for discovery of the baby. The change can be observed as new attention directed from the mother straight to the child and the child's direct answers back to mother. Lively interaction between the two starts. Special rituals and personal games emerge. Mother is full of stories about the baby's doings, feelings and thoughts. Of course the baby responds to this and thrives in his mother's interest. But even before mother changes the baby has calmed down and developed. Babies get a lot of attention and confirmation in the group.

Developmental Task for Baby and Mother

What does a baby need in order to develop a capacity to reflect? He needs parents who expect the baby to feel, want and think. Without expectations this ability does not develop.

In the mother-baby unit the therapists expect the mothers to feel, want and think. The alternating attention between mother and child and between conscious and unconscious levels facilitates the linking of mother's and baby's minds. These interventions focusing on the relationship slowly helps to build a sense of meaning between mother and child. For the small child this dynamic interchange constitutes the basis for emotional development. For the mother it liberates her mothering capacity.

Stopping History from Repeating Itself

There is an intergenerational concordance in relationship patterns. Troubled mothers often lack an inner compass of good early childhood experience to guide them as they themselves become parents. They see other mothers and babies encircled in love but they do not know how to reach this envied condition.

A shortage of self-confidence drains motherly feelings. Feelings of despair or cold distance may take their place. To have an impact on relationship patterns, treatment has to reach far down into the mothers nonverbal experiences and unlink them from the present baby, their growing relationship and their mutual future.

The evaluation tells us it is possible to help mothers and babies with severe relationship difficulties. The combination of treatment methods, that Stern called for, has proven to have great effect. Our experience is that, within a firm framework of a group-setting on a frequent basis, the psychotherapeutic method, where holding and containing is central, can provide a ground for both the child's self-development and the construction of the mother's ability to mother.

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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. (Some of the Michael Trout videos are available in PAL format.) The shipping/handling fee is $10.00 per video in the US and $20.00 each outside the US for a 3 day use. Users pay the return shipping fee. Videotapes should be scheduled 30 days in advance. To inquire about availability phone: 1-517-432-3793. To order a video, use the attached order form.

★DEVELOPMENT

NEW NEW **A Simple Gift: Comforting your baby.** 10 min. Addresses the development of an infant's attachment relationship with parents in the first year of life. NEW NEW

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.

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.

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.

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

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

Development of Means for Achieving Desired Ends. 20 min.

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

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

NEW NEW **Gentle Touch: Infant Massage.** 47 min. Describes benefits of baby massage and gives step by step instructions. NEW NEW

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

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

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.

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.

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

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

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

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.)

Visual Pursuit & Object Permanence. 27 min.

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

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

★LOSS

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.

★ROBERTSON VIDEOS

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.

★TEMPERAMENT

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: refusual 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 meal-

times 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.

★MICHAEL TROUT VIDEOS (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 re-lationships 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.).

CLINICAL ISSUES

NWORKING WITH FAMILIES

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.

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

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

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

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 PREGNANCY

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.

★ADOPTION: MICHAEL TROUT SERIES (VHS ONLY)

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 re-sources. 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, 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 caregiving 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.

TRAINING CAREGIVERS

★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. 29min.

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.

★SCHOLASTIC: SYDNEY GREENSPAN-BASED TRAINING

NEW NEW NEW

Floor Time: Tuning into Each Child. Parent education and early childhood staff development. Describes the relationship between emotional development and learning. Demonstrates ways to use floor time to best advantage. 35 min. Video plus training materials.

NEW NEW NEW

★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 MI-AIMH 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

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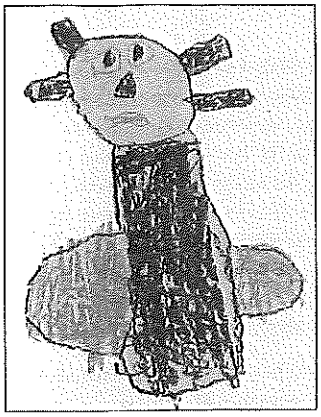

7TH Congress

World Association for Infant Mental Health

July 26-30, 2000, Montreal
Quebec, Canada

Diversity:
Challenges and Opportunities in Infancy

Keynote Speakers

Megan Gunnar, Ph.D.
Brain Behavior Interface

Peter Fonagy, Ph.D.
Developmental Psychopatholgy

Marie-Rose Moro, M.D.
Children in Poverty

Astrid Berg, M.D. & Nomfundo Wolaza,M.A.
Culture and Context

Yvon Gauthier, M.D.
President's Address

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www.med.mcgill.ca/waimh

Invitation

It is with great pleasure that I welcome you to the 7th Congress of the World Association for Infant Mental Health (WAIMH).

Montréal is well known for its hospitality, and the Local Organizing Committee has worked with much enthusiasm in these last four years to allow all of you to fully experience the mid-summer charm of this great city. We used to think of Montréal, this city on an island at the juncture of two great rivers, as a meeting ground of French and English cultures. In fact, peoples from all around the world enrich Montréal's cultural environment.

The theme which has been chosen for this Congress, "Diversity: Challenges and Opportunities in Infancy," expresses our urgent desire to create a working atmosphere where professionals from around the globe can talk about their experiences, learn more about the conditions that promote growth in the crucial early years, and become better equipped to intervene in an environment which is in constant and rapid change.

I sincerely hope that the Scientific Program will allow each of you to take part in creative discussions while also enjoying this beautiful city, its people and its surroundings.

Yvon Gauthier, MD
President
World Association for Infant Mental Health

Message from the Chair

Historians remind us that migrations have occurred since the earliest times and that, consequently, intercultural contacts are as old as our world. For example, we could summarize the history of Canada (and of Montréal) as a series of six migratory waves, from the first that involved the Amerindians coming from Siberia many millennia ago, to the last, which during the past thirty years has included Africans, South Americans and Asians.

If migrations are ancient, there is, however, a new phenomenon now happening, which is the co-existence of many very different cultural groups in small territories, in particular in varied large cities across our planet. The Swedish anthropologist Ulf Hannerz (*Cultural Complexity: Studies in the Social Organization of Meaning. New York: Columbia University Press, 1992*) studied this phenomenon in many places, especially in Vienna, Calcutta and San Francisco. He showed how most contemporary societies are now subdivided into "varied zones of meaning," where multiple cultural communities not only are located very near each other, but above all penetrate each other. Almost everywhere individuals are confronted with an increasing diversity and ambiguity of multiple identificatory models in an environment that is noteworthy for its great unpredictability. This new reality compels us to draw our attention to the impact of these complex cultural systems on persons and societies.

These persons also include children, especially the very young children with whom we are involved in our work. Early in their life, in their neighbourhoods and their daycare centres, children are now often exposed to children of differing languages, cultures and colours. There are compelling reasons to observe systematically these early interactions in order to better measure their varied impacts, either positive or negative, on children's development and to better adapt our interventions.

Montréal is an ideal location in which to meet at the turn of the century and discuss one of the main themes of our meeting: the impact of cultural diversity and complexity on very young children. Here in Montréal, very different cultural communities, including an Amerindian one, are situated near each other. Many of these communities also have their own academic and medical institutions. The most unexpected interactions, and occasionally some negative ones, are continually taking place at the borders of the varied "zones of meaning."

You and the other participants of the meeting will feel very much at ease in holding your discussions here. I wish you a most hearty welcome.

Jean-François Saucier, MD, PhD
Chair
7th Congress of the World Association for Infant Mental Health

Submission of Abstracts

Your abstract must reach the Congress Secretariat no later than September 10, 1999.

Submission

Abstracts must be submitted in English. Abstract for Publication Form A1 and Abstract for Evaluation Form A2 (see page xx) must be submitted together in order for an abstract to be accepted for evaluation, irrespective of the method of submission.

Submission of Symposium Presentations

The symposium organizer must gather and submit all the abstracts for the symposium in one package. This includes:

- Forms A3 and A4, the Symposium Abstract Forms
- Forms A1 and A2 for each abstract proposed for the symposium

Evaluation

Abstracts will be peer-reviewed in a blind evaluation process.

Notification

We will mail you notification of acceptance in early 2000. However, your presentation category will not be confirmed until a later date. All authors whose abstracts are accepted will be eligible to register at the early registration rate.

Publication

Abstracts accepted for presentation will be published in English in the Infant Mental Health Journal, which will be available during the Congress.

Presentation

Oral: In each room designated for oral presentations there will be one standard 35-mm slide projector and one overhead projector. Multimedia presentations are discouraged. If special equipment is required it may be at the expense of the presenter.

All overheads and slides must be in English.

Those presenting in French must arrange for a delegate to provide interpretation into English during the session.Those presenting in English may, if they wish, arrange for a delegate to provide interpretation into French.

Poster: In the room designated for poster presentations, each presenter will be provided with a 4' x 8' (121 cm x 243 cm) panel. Push-pins for mounting material will also be provided. Posters will be displayed for one entire day and the author is required to be present between 14:00 and 17:00.

Posters may be English only, or English and French, within the space allowed.

Presentation Categories

Clinical Teach-In (Forms A1 and A2)

Once abstracts have been selected for a Clinical Teach-In, presenters will be asked to identify a discussant who will comment on their detailed presentation of a clinical case. The audience will then be invited to comment. Note: the Clinical Teach-Ins are on Wednesday, July 26, the Pre-Congress Day.

Poster (Forms A1 and A2)

Posters are best suited for presentations from a single empirical investigation or of a clinical, educational or intervention program.

Poster Workshop (Forms A1 and A2)

Drawing on Abstracts accepted for poster presentation, Congress organizers will assemble selected posters around a common theme. Poster workshops based on these groupings are scheduled for 75 minutes. A discussant will provide a 15-minute general overview, followed by an open discussion for 60 minutes. Presenters must be present at their poster for the full Poster Workshop session.

Workshop (Forms A1 and A2)

The goal of a workshop is to exchange information about a particular body of knowledge, clinical treatment, teaching technique, assessment, or research instrument or methodology. Active discussion between audience and presenter(s) is essential.

Video Presentation

Video presentations are used to demonstrate or teach about new clinical or research evaluation tools and methods. If a substantial portion of your material is illustrated through video, or if you have developed an edited video presentation, you should submit your abstract in this category. Presenters must be present for the video presentation session and must allow time for discussion.

Symposium (Forms A3 and A4, plus Forms A1 and A2 for each abstract proposed for inclusion in Symposium)

A symposium is considered to be a group of two or three presentations under a related topic, generally the latest thinking about a particular subject (for example, a clinical issue, research findings, or a debate). You should try to identify contributers from different parts of the world with differing perspectives on your topic. In addition to two or three presenters, you should identify a discussant who will be prepared to respond to the presentation before the open discussion period. A symposium will last 90 minutes.

Submitting Abstracts Electronically

Abstracts may be sent via fax, e-mail or our Website to meet the abstract deadline. However, you must simultaneously mail an original of Forms A1 and A2, and, for Symposiums, Forms A3 and A4, along with the applicable Forms A1 and A2, to the Congress Secretariat in order for your submission to be published in the Journal. See Congress addresses on Page XX.

WAIMH New Investigator Award

The purpose of the WAIMH New Investigator Award is to recognize and encourage promising new investigators in infant mental health. The applicant must be a member of WAIMH or must be sponsored by a member of WAIMH and must have earned a university degree no more than eight years prior to the application deadline, which is **September 10, 1999.**

The applicant must submit the following to Peter de Chateau, Chair, Award Committee, WAIMH Congress Secretariat (see Congress Addresses, page XX):

- one copy of the applicant's CV or résumé in English
- one copy each of the Abstract Forms A1 and A2 which you have submitted to the WAIMH Congress Secretariat
- three copies of the original complete paper. A paper may consist of empirical or clinical studies, integrative or scholarly reviews, or a special methodological or theoretical contribution.

Accommodation

The organizers have reserved accommodations for Congress participants at The Queen Elizabeth Hotel and at the McGill University Residences.

The Queen Elizabeth Hotel

The Queen Elizabeth is a spacious hotel located close to the attractions of downtown Montréal — the museums, galleries, elegant shopping areas and first-rate restaurants for which Montréal is famous. Not far away are the historic and wonderfully restored Old Montréal and Old Port.

Delegates may stay for additional nights at The Queen Elizabeth at reduced Congress rates. Note that The Queen Elizabeth Hotel room rate is the same for single and double occupancy:

Single / Double: $138.00

The Queen Elizabeth Hotel
900 René Lévesque Boulevard West
Montréal, QC, Canada H3B 4A5

Telephone: (514) 861-3511
Fax: (514) 954-2256

McGill University Residences

The McGill University Residences are nestled in the side of Mount Royal overlooking downtown Montreal.

Single Registered Delegate	$ 35.50
Single Student Delegate with ID	$ 29.50

McGill University Residences
3935 University Street
Montréal, QC, Canada H3A 2B6

Telephone: (514) 398-6367
Fax: (514) 398-6770

How to Reserve a Room

The deadline for guaranteed reservations is May 23, 2000.

After May 23, 2000, special Congress rates are not available and accommodation cannot be guaranteed.

- You must reserve in advance to ensure a room on arrival.
- Complete Congress Registration Form B, including the Accommodation section.
- A valid credit card number and expiry date must be indicated in the Accommodation section on Registration Form B in order to guarantee your first night's accommodation.
- Indicate late arrival time, if applicable.
- Accommodation will only be booked upon receipt of Registration Form B with the correct Congress fee.
- Do not enclose payment for accommodation; you will pay for your accommodation when you leave.
- The 7% Goods and Service Tax (GST) and 7.5% Québec Sales Tax (QST) will be applied to hotel or residence rates.
- Accommodation will be booked and confirmed directly to you by mail by the Congress Secretariat.

Congress Addresses

Please address all correspondence to:

WAIMH Congress Secretariat
1110 Pine Avenue West
Montréal, QC, Canada
H3A 1A3

Telephone: (514) 398-3770
Fax: (514) 398-4854
E-mail: waimh@ums1.lan.mcgill.ca
www.med.mcgill.ca/waimh

All Congress sessions will take place at:

The Queen Elizabeth Hotel
900 René Lévesque Boulevard
Montréal, QC, Canada H3B 4A5

Telephone: (514) 861-3511
Fax: (514) 954-2256

For further assistance regarding accommodation or tourist information, contact:

The Greater Montréal Tourist and Convention Bureau
1555 Peel Street, Room 600
Montréal, QC, Canada H3A 1X6

Telephone: (514) 844-5400
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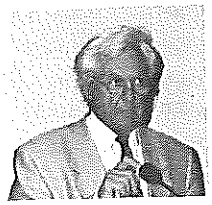


President's Perspective

Yvon Gauthier

All through the years, reading about the Holocaust, I tried to imagine how such cruelty could be done by human beings to human beings. How many of them were children? And how many stayed behind, forever separated from their parents? La Bella Vita, (Life is Beautiful) the marvelous film that Roberto Benigni recently made about a family in a Nazi concentration camp in Italy, shows how a father could not leave his son behind; how he constantly imagined scenarios to help him mask the reality of what was going on around them. Although Benigni's humor succeeds to some extent in denying the awful misery that he is reconstructing—still, I came out of this film crying for a long time.

We thought we were out of such human agony. We are not. And it is not afterwards any more that we become aware of such tragedies. Television brings us, in the here and now, very painful images of infants and young children who at least have not been separated from their mothers. It is striking to see mostly older people with them, as if most younger men have disappeared, either killed or staying behind to fight; we don't really know.

Of course we are reminded of Bosnia, and of Rwanda, and if we go back further, of Palestinians who are still living in camps.

I have been asked several times: what can WAIMH do? We have been mostly a group of professionals doing research and clinical work who have tried since the early 1980's to develop and communicate new knowledge about the early years. Several of us may have been involved in addressing the social problems of our own country and in influencing the development of social policies to foster optimal development. In talking and e-mailing with colleagues, I find that very few of us seem to be involved in trying to help families and infants caught in tragedies like Bosnia (I know specifically of Lebovici and his team who initiated some work in Bosnia some years ago).

> Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it's the only thing that ever does.
>
> Margaret Mead

Such a function has not been part of WAIMH's objectives, and we evidently do not have the financial resources that would be necessary to accomplish the tasks that are implied in caring for families and young children in acute stress. On the other hand, we have the human resources. Our field goes back to the pioneers who studied infants' reactions to separation from their mother and loss of their caregiver. We are frequently asked as consultants by protective services who have to deal with often extreme situations.

We could certainly be part of missions that will have to be set up once the conflict reaches a settlement. It is difficult, it seems to me, to imagine a direct role particularly in this acute phase we are living through. But there should be a time where infant mental health professionals could play a role as consultants to the organizations which have the responsibility of refugees.

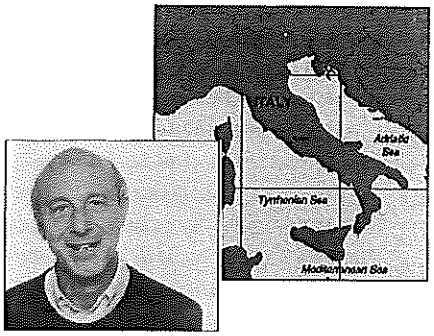
Those are the thoughts and feelings with which I have been dealing in recent weeks, feeling very helpless in front of all those images. Could we, at a certain point, feel more useful? I would much appreciate your thoughts and suggestions as to a possible role that we could play in the aftermath of this new tragedy.

You can contact me at: Fax: 514 345 4635; e-mail: gauthiey@magellan.umontreal.ca

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.

Massimo Ammaniti, M.D.



Our column today takes us to Italy to meet Dr. Massimo Ammaniti, Regional Vice President for Southern Europe. Dr. Ammaniti lives in Rome where he is professor of Developmental Psychopathology at the University "La Sapienza." The following text is Dr. Ammaniti's introduction to himself and his work.

I am a medical doctor and was trained in Child and Adolescent Psychiatry at the University "La Sapienza" in Rome. At the beginning of my professional career I began to work at the Child Neuropsychiatric Institute of Rome. I became especially interested in inherited inborn errors of metabolism associated with mental retardation. Later my interests moved to developmental psychopathology and psychodynamics. I went through psychoanalytical training becoming a full member of the International Psychoanalytical Association. At the same time I moved to the Faculty of Psychology at the University "La Sapienza" of Rome, where I am now Full Professor of Developmental Psychopathology.

In my clinical work I stress the importance of the complex interrelationship between parents and children in infancy, childhood and adolescence in improving the resources of the family. In the past few years I have focused on interactions between mother and infant, trying to define psychotherapeutic strategies, while also supporting such interventions as home visiting.

As for theoretical and research interests I have worked in the area of maternal mental representations in connection with a group consisting of Daniel Stern, Charles Zeanah, and Graziella Fava Vizziello. To explore maternal representations in pregnancy more systematically, I have created an 'Interview for Maternal Representations during Pregnancy' (IRMAG), which I have standardized in an Italian sample but used also in other countries.

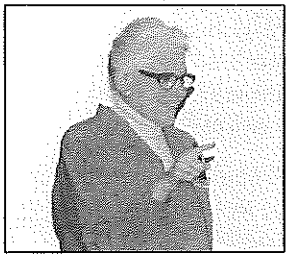
Another area of interest is Attachment Theory and research. I have organized a Training Institute for Adult Attachment Interview (AAI). This initiative has stimulated a growing interest about attachment among researchers and clinicians here in Italy. I have started studying attachment in infancy in the Italian population, with a particular focus on disorganized patterns. I am comparing and contrasting Attachment Theory and Psychoanalysis, with the belief that psychoanalytical theory needs revision in the light of recent neurobiological and developmental research.

For these reasons it was quite "fateful" that I should get in touch with WAIPAD* and later WAIMH, both of which have always placed theoretical as well research and clinical issues into a systemic and interactional perspective.

I have attended various Congresses in Kyoto, Lugano, Chicago and lastly, Tampere, where I was elected Regional Vice-President for Southern Europe. Recently I have worked to create an Italian Association that brings together researchers and professionals who work in the area of infancy. In 1998, the Italian Association of Infant Mental Health affiliated with WAIMH. I am President. We have exchanges with Giosur WAIMH, another new Italian WAIMH affiliate.

In the future we will be working with the French Affiliate to plan a meeting of all the European groups affiliated with WAIMH. Next November our Association is organizing a Conference on Traumatic Stress and Psychopathology in Infancy with featured speakers who are experts in the field.

**World Association for Infant Psychiatry and Allied Disciplines. In 1992, WAIPAD and the International Association for Infant Mental Health merged to become WAIMH.*



In Memoriam

Sonya Bemporad

Sonya Bemporad, a long-time member of WAIMH, died on March 20, 1999 in Dallas, Texas, after a long illness. The following is a memoriam written by Hiram Fitzgerald, WAIMH's Executive Director.

Devoted does not capture the intense emotional investment that Sonya Bemporad made in making the early years of life better for infants and toddlers in Dallas, Texas, and internationally. Fueled by the needs of infants and toddlers for quality care and incensed to the depth of her being by the senseless violence and abuse of young children, Sonya promoted her call for loving, relationship based quality care for children, whether reared at home or in supplemental care settings. For example, in one of her articles in *The Signal* Sonya wrote, "For a baby to develop a sense of the importance of close relationships, she must experience them. A baby must learn to love." Thus, the need for relationship based child care settings.

Sonya was an active member of the International Association for Infant Mental Health (IAIMH) from the time it was organized in 1980, until 1992 when IAIMH merged with the World Association for Infant Psychiatry and Allied Disciplines and formed the World Association for Mental Health (WAIMH). She was President of IAIMH at the time of the merger and played an important role in bringing the two major infant mental health associations into collaboration. She was instrumental in forming the Texas Association for Infant Mental Health, an Affiliate of WAIMH.

Sonya was always focused on social policy issues related to young children. She chaired WAIMH's Social Policy Committee and at WAIMH's 1996 World Congress organized a day long meeting devoted to articulating policy issues related to the right of infants. Individuals from nearly 30 countries attended the session and plans were laid to develop a document that would define the rights of infants with the goal of submitting the document to the World Health Organization. Although Sonya's illness delayed progress on this document, work of the committee continues and will be motivated to be even more persistent in its efforts to achieve the goal that Sonya had for healthful environments for all infants and young children. In 1996 the WAIMH honored Sonya for her personal and professional lifetime commitment to infants and their families with the WAIMH Award for devoted service to infants and their families.

There are many infants and toddlers in Sonya's extended family, they will miss her deeply. Sonya was always a source of comfort, reassurance, and support for me during my work in infant mental health, and although I too will miss her dearly, I am ever so fortunate to have known her and to have learned from her that work for infants and young children requires more than just intellectual commitment, it requires a bit of the soul as well.

News & Views

Training Opportunities

England

The School for Infant Mental Health in London is offering the following short courses in July, 1999: ***"Home Intervention—The art of the home visit", "Early Intervention: What works best."*** In September of 1999, a 4-week certificate program is scheduled: "Intervention Support: Workers, Staff and Organization."

For information call: (44) 171 433 3112, or email: acquarone@aol.com

Infant observation courses and parent-infant psychotherapy courses are now being offered in the US in Denver Colorado, and Santa Fe, New Mexico by London's School for Infant Mental Health. For information contact Sara Lincoln in Colorado, at (303) 691-6140.

Germany

March 28-April 5, 2000 and September 7-15, 2000. University of Cologne, Germany. ***Training in the Adult Attachment Interview*** (AAI) directed by Patricia M. Crittenden (Ph.D.)

March 30-April, 20000. University of Cologne, Germany. ***Training in the "Care-Index"*** directed by Patricia M. Crittenden (Ph.D).

For information on either program call or write: R. Kissgen (Dip. Paed.) University of Cologne, Frangenheimstr. 4, 50931 Koeln, Germany. Phone: 49 221-470-4684. Fax: 49-221-470-4684. Email: ruediger.kissgen@uni-koeln.de

United States

June 14-18, 1999. Syracuse, New York. ***23rd Annual National Quality Infant/Toddler Caregiving Workshop***. Directed by Alice Honig. For information call: 315-443-3273 or email: mshin02@syr.edu

June 22-24, 1999. Bank Street College, New York City, New York. ***12th Annual Bank Street College Infancy Institute.*** Keynote address by Joy Osofsky, Ph.D. Special panels on advocacy and leadership. For information call 212-875-4728.

October 18-19, 1999. Chicago, Illinois. ***The Loyola Forum on the Child.*** "Reclaiming Childhood: Shaping Policy for the Future." For information call: (312)-915-8567 or visit their web site: www.luc.edu/childforum

October 29, 1999. Illinois Institute of Technology, Chicago, IL. ***Annual Conference Illinois Association for Infant Mental Health.*** "Engaging the Overburdened Family: Theory and Practice." Keynote speakers are Susan C. McDonough, Ph.D., and Arnold Sameroff, Ph.D. For information contact: Lynn Liston (815) 971-5184

Graduate certificate program in Prenatal and Perinatal Human Development. St. Mary's University, Minneapolis, Minnesota. Dr. Thomas Verny, director. For information contact newins@aol.com, truerny@idrect.com, or www.smumn.edu

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