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RAISING THE POST-INSTITUTIONALIZED CHILD

Risks, Challenges, and Innovative Treatment

By Dr. Ronald S. Federici

Adoptions have always been a very important part of American culture. Recently, we have witnessed a higher volume of "international adoptions" and a reduction in adoptions from the United States social systems. Many parents have chosen to adopt a child from another country, because they have found the process cost effective, with reduced waiting time because of an abundance of younger children readily available. Many choosing international adoption believe that adopting an infant or even older child from another country will spare them the pain and hardship of waiting for a child to become available or, more commonly, having the opportunity to "pick and choose" from a large volume of children who the family believes will rapidly "fit in" to their current family structure and whose physical appearance is compatible with their own. Some families also believe they will be spared any possibility of involvement with biological parents if they adopt from another country. This is a sensitive issue because there have been numerous high profile cases in the United States in which biological parents come forward after an adoption in an effort to reclaim their child based on a legal claim of improper adoption, or even because the birth parents experienced a "change of heart."

American families began adopting abroad in substantial numbers almost three decades ago when Korean adoptions became common. Since then, American adoptions of children from other countries have grown at an astronomical rate. Central and South America have always been very prominent countries allowing international adoption. Following the fall of the dictator, Ceaucesceu, in Romania in 1989, and the multitude of dramatic television portraying the plight of Romanian orphans housed in deleterious conditions, thousands of Americans and Europeans went to Romania on their own to adopt these very special children (Kifner, 1989; Battiata 1990, 1991). Romanian adoptions set the stage for other Eastern Bloc countries to open their doors to Americans and Europeans. The former Soviet Union, for example, allowed a great volume of international adoptions beginning in 1993, and many other Eastern European countries followed suit. The most recent surge of these adoptions have occurred in South-east Asia, particularly China and Vietnam.

According to current US INS statistics, Americans adopted approximately 16,396 children from abroad in 1999. Although international adoption has been gradually increasing in the United States since the 1950s, it has dramatically increased over the course of the past decade. For example, from 1992 to 1999 alone, international adoptions in the United States increased from 6,536 to 16,396 children, representing a 250% increase in only 7 years (U.S. Immigration and Naturalization Service, 2000). The principle reason for this huge increase in international adoption has been directly related to the shortage of adoptable children in the Unites States as most families desired young, healthy, white infants, typically resulting in years of waiting or the extensive time it took for the birth parents rights to relinquish. Nevertheless, adopting the child who has been raised in an institution abroad poses some very important "risk factors" which are not always properly understood, disclosed, or explained to families.

The incredible number of children arriving from overseas from post-

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institutional settings has been directly linked to ongoing media attention and the creation of literally hundreds of adoption agencies specializing in international adoptions. The United States has been in the forefront in terms of number of international adoptions, followed closely by Italy, Germany, France, The United Kingdom, and Israel. Many of the countries have tried very hard to promote intra-country adoptions or some type of alternate placement such as foster care programs, but due to the poor economic conditions, international adoptions have continued to be a more viable option. Families from all over the world have offered to provide a stable home and environment for these special and potentially high risk children who have been housed in institutional settings. Although quality of institutional care varies, the majority have deplorable conditions and extremely limited caregiving.

Institutionalization: What Are the Risk Factors?

Many parents ask clinicians, "What do you think it was like for our internationally adopted child?" This is an extremely powerful question as it involves a discussion of the high-risk pre and post-natal factors, genetic risks, poor medical and nutritional care and, primarily, children who have lived without strong maternal bonding and attachment during critical formative years. Commonly, institutional settings have very poor caretaker-to-child ratios with some institutions in Eastern Europe having one caregiver per 15 children. Many people seek out children from countries with more optimal or sophisticated approaches to abandoned children where they are provided better care. For these reasons, South America and Southeast Asia are often looked upon as a better "risk" because of their fostering programs or increased numbers of well-paid caregivers. In the former Soviet Bloc countries, the decades of oppression and neglect, as well as extremely poor medical care and nutrition have been linked to delays in brain and physical growth and development as well as delays in social-emotional development and abnormalities in attachment (Johnson et al, 1992, 1996, 1997; Rutter, 1998).

After Internationally Adopting: What Do We Do?

Children being adopted from other countries come to the United States at varying ages and in varying medical conditions. There are many families who are very much aware of a child's specific physical or emotional disability and chose to adopt anyway. The majority of the children who have been adopted have very little accurate medical information, which leaves huge gaps in understanding the child's early developmental experiences. With this paucity of information, families attempt to set forth and raise their child the way they were raised or in a similar manner should they have biological children.

With families who have adopted infants and toddlers (understanding that many countries will not allow a child to be adopted until they reach at least an age of 4-6 months), the natural parental tendency is to provide an abundance of nurturing, stimulation, developmental activities, and active involvement by all immediate and extended caretakers. Although this is certainly the most optimal form of intervention for the infant or young toddler, there may be medical and psychological factors which the family is unaware of and which may complicate the child's development.

For example, the effects of malnutrition on mental development are well known and have often been linked to later learning and behavioral problems (Galler and Ross, 1998; Miller et al, 1995). Fetal Alcohol Syndrome and Fetal Alcohol Effects are common risk factors, which can produce physical, learning, and neurobehavioral difficulties (Johnson, 1997; McGuinness 1998). Additionally, the effects of

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institutionalization on even the youngest child can have profound effects on attachment, safety, security, and coddling behaviors. Failure to Thrive Syndrome and early infant-toddler restlessness, sleep and feeding disorders, and even early onset emotional-behavioral problems have been reported by many researchers who have followed internationally adopted children (Ames, 1997; Zeanah, 2000). Revisiting the profound effects of early maternal deprivation and care as described by Bowlby (1951) and Spitz (1945), clearly have demonstrated that even relatively brief periods of early infant-maternal separation can lead to a combination of cognitive, attachment, and behavioral difficulties.

Most families provide tremendous nurturing and attention for their infant-toddler, but there are select groups who must return to work and place the child in some type of childcare or preschool program at a very early stage of "re-attachment" to the new parents. For the child who may have medical and/or psychological attachment-deprivation risk factors, a placement out of the home for extended periods of time can only further compromise attachment or increase indiscriminant attachment to other caregivers as opposed to the primary parental figures. Zeanah's work on infant-maternal attachment promotes the need for strong and consistent "re-parenting" of the child who has already been deprived during early developmental stages (Zeanah, 1993, 1996). The importance of aggressive re-attachment and re-parenting for a young child coming out of an institutional setting is of paramount importance. These children have had a loss of maternal attachment, stimulation, and developmental experiences ranging from birth through 24 months, with damaging effects of early childhood deprivation expanding exponentially as the child becomes older and remains in institutional care.

Infants and toddlers most certainly require a stable and secure parental-family unit and hierarchy, and an abundance of pure maternal and paternal physical and emotional experiences. Research provided by Cermak and Daunhauer (1997) have consistently shown "sensory defensiveness" in the infant and toddler who has not been exposed to normal child rearing strategies. Therefore, many newly adoptive parents who have infants and toddlers may become shocked and overwhelmed when their affections are rejected. I emphasize that even very young children who have been removed from institutional settings still can be highly sensory defensive. They may reject human contact because their preverbal and sensory-motor experiences do not allow for maternal comfort and nurturing to be so readily accepted. Newly adopted parents must be very sensitive to this issue and adequately prepared for this potential and somewhat provocative experience prior to their adopting an infant or toddler. While many families have extremely positive experiences after adopting the younger child, there are many families who try very hard to force the child into their arms for comfort and nurturing when the child's innate capabilities for this type of infant-maternal attachment are not yet formed.

Other methods which have been found to be extremely helpful for parents who have adopted infant-early toddlers from post-institutionalized settings is to provide a wide range of developmental play activities which involve parent-child involvement. For example, infant toys involving different textures, colors, noises and music in addition to frequent movement activities on the part of the child with the parents physical involvement will allow the child a "safety net" and feel connected to a person and reality as opposed to remaining alone and isolated in a crib by themselves which has been their earliest experiences. There are many infant-toddlers who may be defensive and inconsolable, but parents need to continue to provide constant human contact, warmth, texture, stimuli to all of the senses and work through nutritional problems such as failure to thrive or oral-motor defensiveness. This takes tremendous patience and tolerance from the parent, which is another reason why the child must have only the primary caregivers work consistently on these issues as opposed to ancillary figures such as nannies, childcare providers, or even extended family members.

With gradual and consistent attempts at re-attaching and soothing, along with the ongoing introduction of developmental stimulation, sound and visual inputs, nutrition (which can sometimes be a source of aversion for the new child based on their early "imprint" of poor nutrition), the newly adopted child has a much stronger chance of rapidly overcoming this "defensive pattern" and learning how to become re-attached in a healthy and mutually rewarding manner. Often, parents' frustration over the child's continual crying, lack of accepting soothing and nurturing, or even quasi-autistic tendencies such as rocking and self-stimulation can intensify parents' anger and lead to detachment (Federici, 1998; Rutter, 1999).

Assessing and Treating the Older Post-Institutionalized Child: Challenges, Opportunities, and the Need for Innovative Treatments:

Many families opt to adopt older children from institutional settings from abroad. There are a large group of families who are more comfortable with having a child above the age of 3 or 4 years old, feeling that they can more adequately "identify" physical, cognitive, and personality traits and characteristics. Furthermore, families choosing to adopt older children are sometimes older parents who may not be interested in the "infancy period", but who are more interested in having an older child who may quickly assimilate into their family, particularly

if they have grown children already. Adopting the older child may also make it easier on certain families who must work, as the child can then be placed in a school-based program during the day while the parents maintain their jobs which, in turn minimizes the need for childcare.

Adopting the older post-institutionalized child presents with an even greater risk than the infant-toddler. In remembering how children have lived in institutional settings, the older child has been exposed to even more years of vitamin and nutritional deficiency syndrome, poor medical care, a lack of developmental-educational experiences, in addition to being even further "detached" from maternal-caregiver relationships. The older child often develops a premature sense of independence and autonomy, as they are left to their own devices to explore their institutional world, learn speech and language, toileting and eating habits, and relationships. Most of these developmental experiences occur without proper supervision, correction or effective discipline. These children often are dealt with via harsh discipline, isolation in cribs or beds, or, more simply, placing all of the older children in a room together without toys, games, or recreation under adult supervision. This leads to chaos and confusion and a very skewed sense of a family hierarchy.

These older children learn habits such as fighting, stealing food, hoarding behaviors, indiscriminant friendliness or fearfulness of adults who intervene randomly. Often, the caregiver interventions are no more than isolating the child back to their cribs or beds where they remain depressed, despondent and somewhat confused and disoriented, as the only stimulation they may have is their bleak and impoverished immediate surroundings.

Hopelessness and helplessness sets in rapidly for the older child in an institutional setting and symptoms of "institutional autism" or quasi-autistic characteristics continue to appear, as this is a child's means of providing self-stimulation (i.e., self-soothing via rocking and movement or time-occupying behaviors) (Federici, 1998; Rutter, 1999). The rapid downward spiral of an older institutionalized child can be the precursor to more chronic states of lack of attachment, post-traumatic stress, abandonment depression, fearfulness and anxiety related conditions, and behavioral disinhibition. Children become very angry and frustrated but, without a mode of expression or even an "audience," anger and despair becomes more internalized and "on hold" until the child has the next opportunity for expression.

Speech and language delays along with social-emotional delays are very common as the child continues in the institutional environment. As prospective adoptive parents review pictures, videos, and medical records, this is only a "snapshot in time" as the child's cognitive and behavioral issues typically surface after being adopted. Therefore, prospective adoptive families would greatly benefit by having extensive pre-adoption counseling and awareness of how an older child has grown up in an institutional environment. Providing a "good and loving home" may not be enough, as specialized and practical treatment strategies may bring about a more positive outcome. Many families attempt to love and nurture the older child when, in fact, a gradual treatment process involving "reintegration into the family" must occur first.

In other words, the best interests of the older institutionalized child must outweigh the needs of the newly adoptive parents to give rapid love, affection, and attachment. These are complicated emotional-behavioral patterns and which may be totally foreign experiences to many of these children. If an older child has received a degree of special treatment such as foster care or a especially assigned and paid for caregiver within the institutional setting, this may certainly facilitate a smoother transition to a new adoptive home. Nevertheless, it is so very important that newly adoptive families understand that they are a very different experience to the older post-institutionalized child, who may view them as objects of indiscriminant attachment or people who can be easily manipulated into giving all the things which they never had: food, clothing, toys, games, socialization and unconditional love in the absence of structure or consistency.

Traits and Characteristics of the High-Risk Post-Institutionalized Child

Many of the older children adopted initially will be cooperative, clingy, and indiscriminant. Other reported behaviors described by Ames (1997) in post-placement interviews include a variety of problematic behaviors which tend to surface over the course of time. These behaviors can include engaging or charming behaviors in a superficial way, difficulties with eye contact, indiscriminant affection with strangers, destructive and hoarding tendencies, lying and deceitful behaviors, aggression, demanding, and clinging behavior, and cognitive delays, particularly speech and language deficits.

Children with these patterns of neurocognitive difficulties often struggle greatly both at home and in school. They should be assessed immediately. Coming out of an institutional environment already has placed the child at risk for developmental delays. The child's entering a new family and educational system, with intensified demands and expectations, may be grossly unprepared. In turn, this may begin an "acting out cycle," which can produce a tremendous stress and burden onto newly adoptive parents, particularly if they have not had experience in child rearing.

Even the most experienced family can be challenged by the older post-institutionalized child. The temptation to give love, affection, and an abundance of stimulation is so tempting due to the parents' own desire to "make up" everything the child has lost in their years of institutionalization. Often, the more the parents give immediately upon arrival, the less they get in return in the long run. Families are often counseled to provide "love, nurturing, and stimulation" which may not necessarily be the best advice, given the fact that that these are all experiences that the older post-institutionalized child never has experienced previously. Therefore, providing this level of basic indulgence or traditional parenting often promotes a mindset in the child that they will have anything and everything they want and will use "institutional behaviors" such as being demanding, yelling, aggressiveness, or self-stimulation as a means of obtaining a new set of stimuli which they are unable to adequately process or organize in a meaningful way. For the child who is cognitively delayed or impaired (i.e. mental retardation, autism or multi-sensory neurodevelopmental disorders), the ability to handle a flood of new experiences and relationships makes little sense, due to processing deficits or an inability to comprehend what is actually required of them in terms of behaviors and emotional-social reciprocity.

I emphasize strongly that there is almost always a degree of lack of attachment, post-traumatic stress, and abandonment depression in the older post-institutionalized child beyond the age of 3-4 years. Many people will hold onto the belief system that they can "cure" the effects of institutionalization quickly when, in fact post-institutionalized children can show very intense patterns of childhood depression and anxiety through the manifestations of irritability, low frustration tolerance, lethargy and despondency, coldness and aloofness, indiscriminate behavior, or even rage and severe behavioral dyscontrol. There are many children who respond extremely well to their newly adoptive family environment which is most likely related to their having at least some developmental experiences of attachment, nurturing, and maternal-caregiver involvement. This may be the exception as opposed to the rule but, nonetheless, Rutter (1998), has found that developmental catch up following adoption after severe global privation will, in fact, occur in the younger child as long as families remain involved and provide developmental-psychological interventions.

Innovative Treatments for the Post-Institutionalized Child: A Guide for Families and Mental Health Professionals

The most important intervention which families and professionals can provide to the older post-institutionalized child is an immediate and comprehensive medical and neurodevelopmental assessment. Understanding deficit patterns very early, particularly speech and language delays, cognitive-intellectual deficits, sensory-motor impairments and a rough estimate of the "stage of psychological development or trauma" will help plot out the most appropriate treatment interventions.

In expanding upon innovative treatment methodologies in dealing with the older post-institutionalized child, I have strongly advised against a "wait and see model" (Federici, 1998), as it is important continually to revisit the reality that the child has lived basically "detached" from proper maternal affection and caregiving. These are issues which need to be assessed and addressed early on, with the main recommendation being for the older child is to arrange for a gradual "introduction" into a new family system, culture, and language which is so foreign to all of these children a strategic and systematized plan of action should be undertaken to minimize later problems.

The following ideas and concepts may seem extreme to many families who have adopted the older child, but it is amazing how many parents who have sought psychological treatment years after adopting an older child and stated, "If we could have done it all over again, we would have done it much differently." Therefore, the concept of gradually "de-institutionalizing" a child at the onset of adoption makes the most sense. I believe that this will provide a true blueprint for families, a plan that is organized, strategic, and operates at the level of the child's development. Notwithstanding noble and nurturing impulses in adoptive parents, incongruous efforts to connect with the psychosocial and cognitive stage of the child are doomed.

For the child who has been institutionalized approximately three years or more, I recommend the following treatment approaches:

1. Prior to adopting their child, the family should prepare for potential difficulties ahead. Preadoption counseling should be sought so that parents will become aware of potential high risk medical and psychological factors and the strong probability of cognitive delays, particularly speech and language. Teaching parents about "quasi-autistic" or "institutional autistic" characteristics is very important, as many children from institutional environments self-stimulate, and this may cause parents great distress.
2. Parents should be prepared for the initial "meeting and greeting" with the child. An immediate act of indiscriminate attachment does not mean that the child automatically loves the parent or really understands the concept of attachment and affection. Parents fall in love with their adoptive child much quicker than the adopted child falls in love with their parents. Advising parents that attachment is a

developmental process and not an immediately occurrence may prevent serious misunderstanding.

3. Parents absolutely should not try to fix everything right away, as recovery can sometimes take years, and it may not be complete for some children who have experienced profound damage. Parents need to remain calm and practical, with the initial focus being on taking care of transporting the child from the country of origin to their home and addressing any urgent medical needs which may occur during the in-country adoption process. Again, careful counseling with the parents regarding how the child may react in their presence upon first meeting and on the plane ride home is very important to prevent catastrophies. Consulting with a pediatrician and possibly considering some conservative medication to ease the child's anxiety and promote sleep can be beneficial, in addition to being prepared for common medical conditions such as nausea, vomiting, diarrhea, and infections. Getting the child home and into medical care is a priority.

4. Upon arrival home, it is very important for families absolutely and unequivocally not to over-stimulate the child at any level. The child's room should be kept extremely basic (if not stripped). Providing an abundance of colors, sights, sounds, and toys surely will promote chaos, as these are experiences the child may never have had. It is important to remember that children who have resided in an institutional setting are very accustomed to having little, if any, stimulation. As time passes, families can gradually expose their child to new things, but **gradual** is the key. Primary caregivers should handle the gradual increase in exposure. Having a "family reunion" surely will be overwhelming for the older post-institutionalized child.

5. Institutionalized children are used to a very rigid routine. Initially, this should be maintained after arrival to their new home. Keeping a well-structured routine involving eating, sleeping, activities, and parental attention is necessary, otherwise the child will become "random and confused" due to their inability to process everything their new home has to offer.

6. It is important that parents stay at home with their newly adopted child as much as possible and have only a few people around, preferably just the immediate family. Having extended relatives and numbers of friends, may exacerbate indiscriminate attachment. Well-meaning as these efforts may be, they may be counterproductive. If at all possible, the primary caretaker should remain home with the child, attempting to ascertain and monitor any and all nuances of cognitive and emotional characteristics. A team of developmental experts may be helpful in understanding puzzling behaviors. Before placing the child in any type of school-based program or childcare, it is important to help the child re-adapt to the radically different environment. In my opinion, childcare should be avoided for at least 12 months, as childcare is just another institutional setting for the child who needs instead to attach and adapt to a family.

7. Over the course of the first 2-to-3 months, parents should try to find a way to communicate with their child in his or her native language, even if it is very basic. The child will learn the parents' language very quickly, but will feel more comfortable if the parents are able to communicate basic commands and directives in their native language. Even poor Russian or Romanian is better than speaking to the child in an unfamiliar language, which they absolutely do not understand, let alone if they are speech and language delayed. Using visual-graphic techniques, basic sign language and gesturing, or direct training methods (i.e. showing them how to do something with the parent being right there) is recommended.

8. Most children coming out of an institutional environment have significantly deviant emotional development. Therefore, they require constant training via repetition, role playing/rehearsal about most everything they do, including bathing, toileting, eating, dressing, and dealing with both human and animal relationships. Many children become very aggressive and demanding and take it out on others or family pets. These are additional reasons why it is important to keep stimulation to a minimum and direct supervision to a maximum.

9. Avoid taking newly adopted children to places which are totally overwhelming, such as grocery and department stores, parks and recreational activities, or anyplace in which there is likely to be "sensory overload". games such as Nintendo, videos or electronic games should be avoided as this will only promote social detachment and a new set of preoccupations.

10. A gradual introduction into socialization should occur over the course of months as opposed to being crammed into the day after emigration. Sending the child to daycare or school right away often results in disaster, as the post-institutionalized child will play and socialize almost exactly the same way they did in their institution. This will usually take the form of indiscriminate attachments, aggressive play, and/or remaining aloof and isolated.

11. Many families attempt to provide the child with foods that are contraindicated. Remember, children in the institution lived on a very narrow and regimented diet. If at all possible, maintaining a similar food regimen at first is recommended. New foods can be introduced gradually under strict supervision, as children will often begin to hoard food or eat without any proper manners. Strict adult supervision and restriction of food intake will lead to better eating habits later on, as food can often be another form of self-stimulation and self-soothing in the place of human relationships.

12. What is extremely difficult for

families to do is to reign in a child's indiscriminate friendliness. Again, many parents hug and hold their older child very tightly, and the child may reciprocate, but this behavior may represent indiscriminate behavior on the part of the child without any substance or depth of emotion or attachment. Parents need to maintain strict hierarchical boundaries and gradually teach the child when, where, and whom to touch, hold, or hug. Most older post-institutionalized children immediately will reciprocate a parental affection with their own version of affection, but this may not be genuine as again, this was not a practiced behavior in the institution. The needs of the child must outweigh the needs of the parent to "fix everything" through love and affection, which they are inclined to deliver immediately and with good intentions, but out of synchrony with the child's unique developmental needs.

13. Many children are cognitively or linguistically delayed. Parents must understand that the "wait and see model" may not be best. If a child is showing a pattern of impairments in their native language and behaviorally, that immediate special educational and behavioral interventions should be implemented. Examples of effective interventions would be providing increased structure, consistency, effective discipline, and developmentally appropriate therapies. The more structure, firmness, and behavioral modification techniques applied early will help the child feel safe and secure even when they rebel against the limits placed upon them. Rage and aggression should be dealt with directly by providing safe and nurturing holding techniques so no one becomes injured. Unconventional therapies, including "rage reduction" or immediate "attachment therapy" should be avoided for these children. Children who have not had typical attachment experiences should not be prematurely diagnosed or treated psychiatrically when they are in the midst of re-equilibrating.

14. Families must learn to rehearse and practice with their child methods of understanding personal space, boundary issues, eye contact, voice tone and pitch, self-control, and the ability to delay gratification and impulses. Most older post-institutionalized children have very little understanding in the recognition of facial expressions and body language which are an extremely important part in the development of proper attachment. These are skills to be taught as the child will not learn on their own or may learn from inappropriate role models.

Summary, Conclusions, and Points to Ponder

To appreciate fully the dimensions of an institutionalized orphan's medical, cognitive, and emotional difficulties, we need to understand the road traveled by such a child and what has happened along the path of decline.

Let us imagine how this child came into being. Imagine the child in the mother's womb, exposed to malnutrition, environmental poisons, nicotine, alcohol, and perhaps life-threatening medical conditions. Imagine the child born into a totally impoverished family, without sufficient food, shelter, clothing, or medical care. Imagine that child abandoned, without the love and affection of a mother and father. Imagine the child placed in a stark and sterile hospital-like setting, with little human contact or stimulating activity, often kept tied to the crib. Obviously, such neglect can lead to psychological problems, but health problems also are a serious threat. As with any baby or young child left unattended for too long, these neglected orphans are exposed to so many pre- and postnatal risk factors that it is difficult to imagine that the brain is not compromised.

After newly adoptive parents have brought the child home, the idea is to help them transition gradually into the dramatically new environment, by recreating some aspects of their institutional setting and lifestyle. This vital initial stage of transition may even communicate to the child that parents understand where they have come from. A gradual transition to a new and very complicated home life takes time, effort, consistency, and a willingness on the part of the newly adoptive parents to implement innovative assessment and treatment strategies which violate many maxims of traditional parenting. If parents are able to view objectively and to maintain in focus how their child was raised and what their true needs are, then they may be able to keep their own immediate need to create a family in check. Under these circumstances, long-term constructive changes and sustained emotional stability of the child will be more rapidly developed.

We must never underestimate the power of the family structure and hierarchy for proper re-development of a child who may have been deprived and cognitively and/or emotionally damaged during formative years. These children need supervision, support and education in a non-threatening and consistent manner. I tell parents that post-institutionalized children need about 50% more parenting than one had intended to give. Offering this level of intensity can be a challenging and at times overwhelming task, but it is the deep commitment that parents make to their child, whether biological or adopted, that facilitates the most optimal outcome.

Early assessment is the key, and ignoring problems or seeing what happens is a serious impediment to improving problems. In our society, we often view children as being able to "learn on their own and become independent." We are reluctant to impose too much control. The post-institutionalized child has experienced a serious overdose of learning on their own and independence. Therefore, teaching parents how to work at the level of the child and in tune with the child's adverse experiences is of paramount importance. Success in parenting these children is driven first and foremost by proper understanding, and by building gradually upon successful experiences.

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Postpartum Crisis in Migrant Families

Dealing with Cultural Differences in Situations of Special Distress

By Fernanda Pedrina

Recent work on psychotherapy with immigrants concentrates on two main topics. The more sociologically oriented studies focus on psychodynamic working through of the migration process, including grieving for lost relationships, establishing new relationships, allowing identification with new objects, and sometimes, overcoming traumatic experiences. Other studies, closer to ethnological thinking, consider psychodynamic implications of living in a different cultural environment and describe the further development of cultural identity. Many factors – reasons for migration, experiences before leaving the country of origin, acceptance in our country, length of exile – influence the kind of psychic distress of our patients and will determine the focus of therapy. My paper will address the meaning of cultural differences in situation of special distress for migrant families (beyond migration herself) and their implications for psychoanalytical technique. The clinical examples will focus on postpartum crisis.

The Accentuation Of Cultural Differences as a Coping Strategy and the Development of Intercultural Identity

In his classic article, Garza-Guerrero (1974) described the psychic process of overcoming culture shock resulting from the migrant's confrontation with his novel and very different surroundings. The first phase is dominated by grief, despair, and the attempt to keep lost inner objects and values alive. Gradually, identification with new objects widens the cultural identity and thus facilitates detachment from the old and integration into the novel environment.

Various authors have established that certain life events confront the immigrants again on a new level with questions of cultural assimilation and integration. These are typically sending the children to school for the first time, choice of profession, marriage, the birth of a baby (Moro, 1993). These events bring about new social contacts and open new social perspectives. But to which society — that of the original or host environment? The problems which occur in these situations have been termed re-enactment of the culture shock, whereby temporarily a reactivation of traditional habits can be observed (Molinari, 1995). The immigrants initially fall back on problem-solving patterns from their culture of origin. This represents an anchor in the new, uncertain phase of life, even though the solutions seem inappropriate by our standards. Only gradually can they contemplate more suitable solutions, which incorporate traditional and modern ideas.

Traditional behavioral patterns and judgements are therefore not constant during the course of migration. Their accentuation can possibly be understood as a reactivation of the process of coping with the foreign world and has therefore an assimilative and defensive character. The perception of the defensive character naturally influences our therapeutic stance.

Within and Without: Cultural Differences as a Given Condition or as a Cause of Intrapsychic Conflicts

How should we as psychotherapists deal with the elements which we recognize as foreign, as part of another culture (beliefs, perceptions, values, behaviors)? The most important aspect is to observe what psychodynamic meaning these elements have for the immigrants themselves. This is not always easy in view of the fact that the intrapsychic developments enhanced by the change of cultural surroundings and the establishing of an intercultural competence are manifold and long lasting processes.

A crucial precondition for psychodynamically-oriented psychotherapy is that patient and therapist have the same conception of a subjective internal world. However, the line between what is perceived as pertinent to the external world and what is perceived as intrapsychic is culturally influenced (Nathan, 1986). Ethnopsychoanalytical works have shown that patients from traditional cultures generally blame difficulties and symptoms that we would see as the result of an internal conflict on external factors (malicious activities of

others or even magic powers). If the therapist looks at the problem set forth on a personal level irrespective of cultural views possibly based in the external world he is in danger of putting the patient's nose out of joint. The latter would feel misunderstood, rejected or even under attack, and the therapeutic relationship would be jeopardized. This often results in premature termination of relationships. I find this experience also to be relevant for work with migrant families from neighboring countries with less foreign background. It is important to ascertain the true external difficulties and acknowledge their implications. With reference to the delineations and accusations, which we perceive as projective defense, we must remember that these are additionally legitimated by the correspondence with a cultural discourse and reinforced in their status as external truth. For this reason, interpretations of defense must be especially carefully considered.

In my own practice, I treat many patients from the Mediterranean region. The most striking cultural element which renders these therapies different is the evident, sometimes extremely pronounced nature of the patriarchal family structure, which manifests itself in many details of social intercourse and ways of thinking. These features are in some cases presented as given conditions. They are undiscussable, even if someone is experiencing problems for these very reasons. In other cases the patients themselves make problems out of them and they can be included early on in a psychodynamically-oriented therapeutic process. Our skill lies in understanding the outlook of the person seeking advice as exactly as possible so as not to dismiss him with an over hasty questioning and in order to find ways with him to widen the intersubjective communication in the context of our different cultural references.

I will try on the basis of two opposing examples to make people sensitive to this question. I will focus attention on the different conceptions of family roles and the crucial significance of these at the birth of a child.

1. Vignette: Family K.

A man with a strong foreign accent called me firmly requesting an appointment for his 3-month-old son. The baby always looked to the same side, the right. The man would not be dissuaded from his request for help by the fact that I am a psychotherapist, and that possibly, there had been a misunderstanding. He was advised to come to me by his pediatrician and said that he would accompany his wife and baby for the appointment as she did not understand German and was dependent on him to translate.

Before our meeting, I learned from the pediatrician that Mr. and Mrs. K are Kurdish refugees, who had been living in Switzerland for the last 8 years on a provisional residence permit. Four months previously, they had been informed by the authorities that their application for asylum had been denied. Since that occurred, they had been engaged in desperate and hectic activities in order to appeal against the ruling. The baby was born during this period. The baby had temporary nutritional and weight problems. Critical, however, was the mother's condition; she had been crying inconsolably for months. At the first appointment, attended by both parents and the baby, Mr. K dominated the situation. He took the baby out of the carrycot, held it in his arms and began to explain to me that his wife was afraid of returning to Turkey, as some of her relatives were politically vulnerable there. He said that he was in the process of looking for alternatives. Mrs. K meanwhile sits next to him crying incessantly. Mr. K's arguments escalate. At the point at which the hopelessness of his situation became evident, he didn't see his thoughts through, and constantly he brought up new arguments. It was difficult for me to interrupt him and to address his wife. From her I learned only that she had a headache and that she would like me to give her a certificate which would entitle her to remain here. In this initial scene, Mr. K assumed the role of protector of his family. He actively sought solutions and had no assignment for me. It was clear to me that I could not challenge his self-image at that time.

After I had discussed in detail with Mr. K that all possibilities of appeal were for the moment exhausted and that a certificate was not necessary, I tried to draw his attention to other factors which could be of significance for his wife's crisis. I mentioned the possible stress caused by the isolation of a young mother, which in my experience is often an issue even with unproblematic births. Mrs. K suddenly listened, and for the first time during our talk, she stopped crying.

Mrs. K was a totally different person at our second meeting. She was fully alert and partially joined in the conversation. As at the first meeting, Mr. K held the baby in his arms while he reported at length about plans that were not as yet concrete. There were four weeks remaining until the date set for them to leave the country. I picked up the thread of my conversation at the point where I had seen possibilities of development and formulated further needs of a young mother here or in another country. Mr. K added that her sister-in-law had visited the week before. His wife hadn't cried then, and it

seemed that the visit had done her good. I asked how the baby was. Mr. K reported that he had been diagnosed as having a harmless case of torticollis. He was more concerned about the fact that the baby didn't drink much and occasionally vomited. Mrs. K corrected him: "The child is better, he doesn't cry so much." Previously, when he cried so much she didn't know what was the matter. Recently, she had been able to console him and felt more confident about his nutrition. It turned out that the father had previously watched over and insisted upon a sufficient food intake. Mrs. K felt backed up by her sister-in-law's attitude when she came to visit: "You mustn't force the child to drink, otherwise it will vomit," she maintained. Mrs. K continued to voice her own worries for the child. "The boy is 'too soft, and that is not normal," Mr. K intervened. First of all, he wanted to know if I am cognizant of such things. When I affirm this, he allowed me to examine his child for hypotony.
My examination of the child showed that his tone was normal. I could, however, observe that he withdrew and became limp during interaction with his depressed mother. I was able to reassure the mother that her child had a normal constitution and that he was capable of switching between various tone states. Our working alliance was too insecure for me to be able to address the depressed interaction. Mrs. K seemed reassured.
Five weeks later, I heard from Mr. K that the appeal had been accepted and that everyone was in a better state of health. Since our meeting, his wife regularly attended the child health clinic in her area in order to meet other women.

What did I do regarding the intercultural communication? I refrained from showing Mr. K that it was unreasonable for him to insist on coping with the family's psychic crisis on his own and that his strategy was ineffective. I considered it inappropriate and too dangerous to question his authoritarian attitude directly, which actually rendered my task impossible and distressed his wife in her relationship with the child, but was, in fact, the basis of the family's survival strategy in this emergency situation. I did, however, refuse to simply fulfil the function he saw for me, namely to support his scheme by issuing a certificate. I didn't totally submit to his logic. Instead, I tried to incorporate overlooked resources, that is, those from the woman's culture of origin (resources present both in Switzerland and in his home country). This opened ways for unexpected triangulation processes and enhanced changes in the marital relationship.

2. Vignette: Family R.

The meeting with family R which revolved around a similar problem as Family K took a totally different course. In this case, the mother also suffered from the restrictive orders of the family head. She, however, had a longer history of motherhood and could put her need for help into words. As often in the cases of families shaped by patriarchal culture, the woman's plea to me is: "Help me to explain to my husband that I am not well, so that he has more understanding for me."

Mrs. R, a 23-year-old Yugoslavian, contacts me because she has been depressed since the birth of her 5-month-old son. Mrs. R did not take me up on my initial invitation for a meeting together with her husband and son. She wanted to come alone, she had a lot to say that she would rather do initially without her husband. She would not give me her telephone number because she lived with her parents-in-law, who were not to know anything about this.

At our first meeting, she described severe anxiety states which had been recurring since her second pregnancy. Sometimes, she worked herself into a panic and had heart and stomach complaints. She had been admitted to hospital several times, but somatic causes for her complaints were never established. Mrs. R described her difficult situation in a lively and differentiated manner. She had an extremely protected childhood and grew up with her family abroad. At the age of 18, she met and married her husband on a summer visit to her home village and followed him and his family to Switzerland. The very authoritarian father-in-law immediately cut off all contact to her original family.

Her despair and sorrow were interpreted in the new family as a sacrifice to growing up, and this, she initially tried to accept. She cared for her first child according to her in-laws' advice and instructions. With the second child, she found it harder and harder to tolerate her father-in-law's instructions and constant control. He refused to acknowledge that she was more experienced as a mother. In utter despair, she had telephoned her brother, who lived abroad, for advice. This had made her father–in-law furious.

My task was to make it clear to her husband that she is entitled to more independence and that he must stand up for her. I offered her a continuation of our conversation with her husband. Before our second meeting, attended by both parents and the two children, I received some telephone calls which made clear the severity of the situation. Mrs. R again had anxiety states, and the children were ill. The family doctor and the pediatrician contacted

me. They were considering prescribing a cure for mother and children.

During our conversation, Mrs. R mentioned that the previous day she had telephoned her father-in-law, who is in Yugoslavia. She told him that she would like to go and stay with her parents to recuperate. Her father-in-law was against this, but Mrs. R, had insisted despite experiencing palpitations and trembling. The following night she had such a severe panic attack that she thought she was going mad.

Mr. R had declared solidarity with his wife. He acknowledged that life with his father is very hard and explains how he himself had suffered as a child. He did not, however, dare to distance himself too much as he was afraid that his father might harm himself if he disappointed him. The rest-cure seemed urgent. Mrs. R made up her mind to get in touch with her original family, dangerous though this might be, because she was even more afraid of the cure suggested by her pediatrician. She never had been away from home before without a family member.

On her planned visit, she would have to be accompanied by her husband. This vignette shows that Mrs. R previously had enjoyed the positive side of her dependent status, namely the protection within the patriarchal family. Here, her personal (intrapsychic) autonomy-conflict manifested itself. Subsequently, Mr. R received support from his own grandfather to enable him to take up a more egocentric stance towards his father. In this way, he was better able to accept responsibility for his wife and nuclear family.
In this example, the patient came to the understanding that factors which until now she had accepted as part of her culture were no longer adequate for her new phase of life, and moreover, not generally valid in her wider surroundings. This caused a deep insecurity with anxieties and conflicts which were partially lived out within the patient's own cultural environment and partially accepted as an inner challenge. Here, psychotherapeutic work was able to pick up the thread. In this way, the husband's conflicted situation also was recognized, torn as he was between his duty to the older generation and to his own family. Subsequently, he could contribute to the easing of tension of the family crisis.

Conclusion

Work with immigrants is challenging as it forces us to look on the edge of our therapeutic capabilities. It is very enriching when we succeed in fostering the mutual understanding with foreign conversation partners. It is certainly important to estimate realistically the possible targets of therapeutic intervention. We are dealing with developmental processes — whether it is a question of coping with more or less traumatic migration history or the acculturation in the foreign social environment – which represent lifelong tasks. We can be glad if we can help the patients and their families out of the deadlock in which they find themselves and enable them to resume the thread of their development in a progressive manner.

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Editor's note:
This paper was translated from German by Tricia Schmid Tomlinson.

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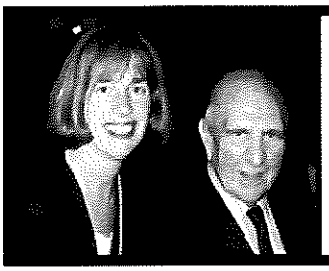
Retraction:

An error was made on Page 10 of The Signal, Vol 8, No. 3 (July - September 2000). The picture decribed as Peter Fonagy, was actually Jean Francois Saucier.

Also on Page 11 of the same issue "A group of friends gathers around xxxx a workshop presenter from Senegal" The caption should have identified O.D. Ly Kane.

We apoligize for any inconvenience these errors may of caused.



Serge Lebovici (1915-2000)

In Memory

By Bernard Golse

Serge Lebovici died on the 12th of August 2000. On behalf of WAIMH, we want to share how sad we are and to join with his family in their sadness.

In thinking about Serge Lebovici and his life, it is important to describe the broad lines of his work, the extraordinary importance of which has strongly contributed to the advent of a very modern child psychiatry and psychoanalysis. Instead of recalling the main steps of his professional life, which is now a well known story, I prefer to emphasize some of his major concepts which have deeply influenced the clinical practice of several generations of colleagues. His impact is still decisive today.

In France, during a memorial recently devoted to Serge Lebovici, Philippe Jeammet described him as truly a "twenty-first-century man", and Bertrand Cramer underlined the important transdisciplinary aspects of all of his work. Both of them emphasized that Serge Lebovici was, in France, a real pioneer in the field of child and baby psychiatry. While his professional career has been punctuated with difficulties at different times, these allowed him, thanks to his marvelous ability to face the obstacles, to found, for instance, the Alfred Binet Center in Paris (with René Diatkine) and also the University Department of Bobigny. These two institutions are very well known all over the world and are now fine examples of his perspective on child psychiatry as a central component in the collective and social field. They also are illustrative of his multidimensional approach, and his ideas about teaching and the transmission of knowledge.

For him, no institutional action was possible without deep and alive clinical, technical, and theoretical goals; and everyone knows of his persistence, and even stubbornness, in restoring and highlighting the issue of psychopathology in the field of modern child psychiatry. President of the International Association of Psychoanalysis from 1973 to 1977 (of which he was the first French president), his intellectual curiosity and his enthusiastic way of working at the borders of different epistemological fields (pediatrics, neuroscience, genetics, cognition, and so on) led him to take risks in order not to let psychoanalysis decline under the weight of dogmatic positions.

His interest in infant observation and in the new data of neuroscience, his strong and brave defense of the etiologic multifactorial model (actual heir of the Freudian concept named "complementary serial") did not stop him from insisting on working in a very pure metapsychological direction, even with babies and young children. He proposed a very useful distinction between infantile and clinical neurosis and clarified the way early interactions lay the foundations of infantile neurosis. He also described how the transference neurosis, in the context of a treatment, reactivates the infantile one.

So, he succeeded in showing how the human subject is the fruit of his own history, without which there is absolutely no possible filiation and affiliation. Through the concept of "unconscious transgenerational mandate", he also explored the problem of the roots of the psyche. Serge Lebovici said that history is - always and everywhere - the first target of all dictatorships.

Consequently, the need to take into account both the individual and the collective levels of psychic functioning lay at the center of his personal investment in the area of various institutions such as INSERM (National Institute for Health and Medical Research), AFM (French Association for Myopathies) and CEDRATE (Center for Studies, Research and Action in the field of Traumas in Childhood). This part of his work underlines the sociological dimension which was also at the heart of his work.

Lastly, everyone knows the place he gave to emotional sharing and that is the reason why his references to the concepts of enaction, enactment, and metaphorizing empathy have deeply modified our models of joint parent-baby therapies, and even perhaps our models of standard analytic treatment. Very interested as he was by all the debates between psychoanalysis and neuroscience on the one hand, and also between psychoanalysis and attachment theory on the other, Serge Lebovici pleaded for a revision of several psychoanalytic tenets, but it was probably a less drastic revision than has been suggested. It was a revision which did not lead to any renunciation of the very basis of psychoanalysis (Drive Theory and Deferred Action Theory, for instance).

His thoughts about the mechanisms of intergenerational transmission processes led him to study the question of the transmission of knowledge and to create, during the last years of his life, together with myself and with the collaboration of Starfilm International (Alain Casanova and Monique Saladin), a new tool of transmission; that is to say, the multimedia collection named "A l'Aube de la vie" (At the dawn of life). President of WAIPAD from 1989 to 1992, his influence on the life of this association has been very strong and stimulating, and I believe we have much to thank him for in the models, perspectives, insights and caring for infants and families that he has left for us.

THOUGHTS ABOUT SERGE LEBOVICI

It has taken me some time to put pen to paper regarding my thoughts about Serge Lebovici. He played a very special role in my professional life and, in some ways, in my personal life as well. Serge, with his warm wife Ruth, was a very generous, nurturing person, one for whom age differences made little difference in terms of respect and confidence in abilities. I first met Serge during the WAIP meeting in Cannes, France where it was extremely impressive to see the respect and influence he had over French people who were interested in infant mental health. The meeting was huge and Serge played a very important role in creating this very successful event. At that time, I became active in what was then WAIP to become WAIPAD and subsequently WAIMH. Serge was always very active and generous ranging from sending me faxes almost every day regarding WAIMH activities he was proposing including outreach to infants in need in Rumania and South Africa, to supporting efforts that I was involved in related to new directions for WAIMH, to inviting me and my family for a warm dinner at his lovely home. He introduced me to some wonderful home cooked French food that I had never tasted before.

I vividly remember several occasions where his remarkable generosity of spirit and energy was WERE amazing. One related to our trip together from the regional meeting in Graz, through Vienna to Helsinki to plan the next world congress. Our flight was leaving Vienna late and we would have missed our connection to Helsinki. Serge flexibly took our luggage as we transferred to another airline and insisted on carrying my hand luggage and showing me around the airport on the stopover in Copenhagen. It was on that trip that he also shared with me some of his memories and difficult times earlier in his life, and I recognized in addition to his warmth and caring, his enormous resilience. On another trip to Riga, Latvia, we visited several orphanages together to learn more about the system and how the babies were cared for in an institutional setting. Every time Serge entered a new room, he smiled and the babies ran over to him to be picked up. I was so impressed with his warmth and caring for these babies and it served as a very important moment and model for me.

Serge Lebovici made WAIMH feel like a big family and our work for infants and families a "labor of love." I am very grateful to Serge for this experience and will miss him very much.

By Joy Osofsky

Editor's Farewell

On the occasion stepping down as editor of the Signal, I would like to avail myself of editorial prerogative in order to bid farewell to my many friends and colleagues in WAIMH. I appreciate your support and help with this publication during the past 8 years. Contributors will always be special to me, as the Signal depends upon the willingness of WAIMH members and friends to share their ideas for no obvious reward. For those of you who still owe me a contribution (you know who you are), I am certain that you will surprise my successor, Paul Barrows, by sending it to him.

Hi Fitzgerald deserves tremendous credit for his many organizational skills that have provided much needed solidity to our organization. He also faithfully got his columns written for the Signal despite his many other commitments. I had the pleasure of working closely with four presidents of WAIMH—Serge Lebovici, Joy Osofsky, Yvon Gauthier, and Peter de Chateau, and each of them deserves credit for their many tangible and intangible contributions. I also would like to remember Steven Bennett for his illuminating column that always felt "just right" to me. I miss him, and I don't think we were ever quite the same publication after he died.

Finally, I do want to wish Paul Barrows all the best in his new undertaking. We can all look forward to a new level of excellence under his leadership. I hope that he finds his experience to be at least half as rewarding as mine was.

Best wishes,

Charley Zeanah

Visiting Baby Home 13

ST. PETERSBURG, RUSSIA

By Joy D. Osofsky

In early December 2000, I had the opportunity to visit our wonderful WAIMH colleagues in St. Petersburg, Russia and want to report on a unique intervention program that is underway in Baby Home 13 (an orphanage). This is being carried out collaboratively by a Russian team, Rifkat Muhamedrahimov, Oleg Palmov, and Natalia Nikoforova and an American Team, Chris Groark and Robert McCall from the University of Pittsburgh Office of Child Development, funded by grants from NICHD, and the Howard Heinz Endowment. I have the good fortune to be a consultant to the project and one of the people participating in the "training of trainers" (doctors, nurses, teachers) who will be training the caregivers for the babies to implement this program.

Rifkat Muhamedrahimov from St. Petersburg, Russia has been involved with WAIMH for some time. Before assuming his position as the Russian Scientific Director for this intervention program, he initiated important activities for young children at the Center for Inclusion (previously the Early Intervention Center) in St. Petersburg helping infants and children with special needs. In 1995, I visited the Early Intervention Center in St Petersburg with Tuula Tamminen from Finland, current President-Elect of WAIMH, then we were planning the 1996 World Congress in Tampere, Finland. At that time, Rifkat had begun an intervention "experiment" in one of the Baby Homes designed to provide more stimulation to the babies by placing three of them together in a crib. He followed these babies for over a year with periodic videotapes which showed clearly that they tended to be increasingly responsive to each other verbally, physically, and through touch as they grew and played together each day. This "mini-experiment" was carried out in Baby Home 13, the main site for the current intensive intervention efforts.

Rifkat and I became good colleagues and friends and in 1998-1999, through major efforts on both of our parts with visas and funding from the Harris Center for Infant Mental Health in New Orleans, he participated as a Fellow at our Center and he and his family spent 6 months in New Orleans. During that year, Rifkat not only learned much more about Infant Mental Health and American culture, including Mardi Gras in New Orleans, but even more he developed and incorporated creative evaluation and outcome measures to include as part of the evaluation component of the Baby Home Intervention Project. Among the measures that are unique to his work is an interesting observational measure, The Affect Manual, designed to observe changes in baby and caregiver affect over the course of the intervention project. He is also using the IFEEL Pictures measure with both caregivers in the Baby Home and with Russian mothers raising their children at home to evaluate their perceptions of baby emotions before and after the intervention. In comparing the responses of caregivers to these pictures with those of mothers with year old children at home, he is finding interesting differences, and I hope to include some results of this early work in a forthcoming issue of the Infant Mental Health Journal.

Rifkat, Oleg, Natasha and the rest of their team of interveners and researchers in Russia are unique. With the persistence and excellent work of the Pittsburgh group and the encouragement of members and leadership of WAIMH, we have reason to feel gratified that we have helped to nurture and encourage this groundbreaking work in the orphanages in St. Petersburg. The outstanding efforts of Chris Groark, Bob McCall, and their colleagues of the University of Pittsburgh Office of Child Development were rewarded with a 5 year NIH grant as well as other funding to carry out this unique project. The purpose of the project is to attempt to increase : 1) caregiver stability, and 2) the social responsiveness of caregiving behaviors of staff in an environment in which most other aspects (e.g., nutrition, medical care, toys, equipment, and adult staff hours) are all right. These aspects of early experience are widely thought to be crucial not only for early and later social and emotional development, but also mental and even physical development.

The most important outcome of this project is that the infants and children in Baby Homes in St. Petersburg are the real winners. These babies have an opportunity to receive very special care which will benefit their social, cognitive, and emotional development and the adoptive families where they find new homes.

To all involved, congratulations !

Editor's Note:

Dr. Federici is a Developmental Neuropsychologist who is a Diplomate of the American Board of Professional Neuropsychology (ABPN) and the American Board of Medical Psychotherapists (ABMP), and a Fellow in the Psychopharmacology-Prescribing Psychologist's Register (FPPR), the American Board of Disability Analysts (ABDA), and the American College of Professional Neuropsychology. Also, he is an Adjunct Professor of Child Development at the Virginia Polytechnical Institute and State University in Blacksburg.

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References continued on Page 20

President's Perspective

Peter de Chateau

First of all I want to tell you about the problems we have met around the sponsorship of WAIMH of the congress "The promised childhood 2000", organized by the Israelian Child Psychiatric Association with the sponsorship of IACAP AP, ISAP en WAIMH. This congress was planned for early November 2000. Since mid-September 2000 we have been occupied with different developments around this congress. Many of our members and also members of the E.C. (Executive Committee) expressed their worries about holding a child psychiatric congress in that particular region. The main reason for this concern was the contrasts between what was happening to (young) children in the area on the one hand and what organizations like WAIMH stand for on the other. Safety of participants of the congress was also a major concern.

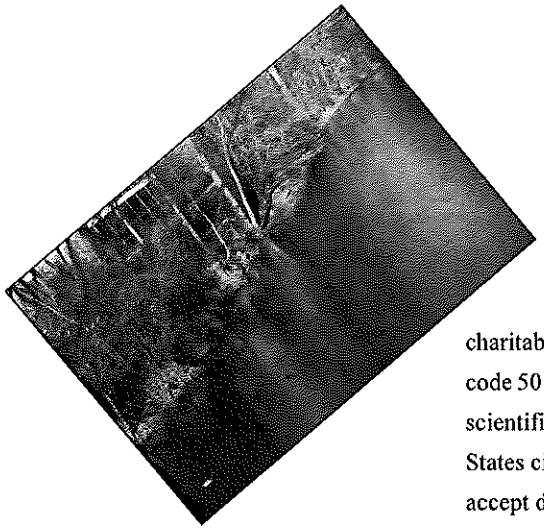
In the second half of September we decided to take the initiative together with IACAP AP and ISAP to discuss this serious matter, and to that end we had several telephone meetings with the boards of both organizations. A mutual request was made to the local organizing committee to postpone or cancel the congress. Some two weeks before the congress was to begin it was finally decided to postpone the congress until April 29 - May 3, 2001. The decision and conditions were made through the local organization mediated to the participants.

By now there should be a new program for the 2001 congress, adjusted to the circumstances of violence and fear, which children and their families in the area live under. Before, however, this step of adaptation of the program by the Local Organizing Committee is made, new developments must take place. Within the E.C. the question has been raised whether we should sponsor this new meeting at all. We heard from our Italian affiliates that they strongly doubt the possibilities of going to that meeting and that they look for guidance to make a fair and appropriate decision, taking all factors of importance into account.

Over the last month we also tried to work with IACAP AP and ISAP on a common statement regarding this issue, but have unfortunately failed to accomplish a statement. Now we struggle with the question whether we will continue our sponsorship or see us forced to abandon that standpoint. Such a decision will have to be made by the E.C. By the time this issue of The Signal is published, our time limit will have passed. Still we would very much appreciate comments, points of view, and suggestions on this topic by our membership either to the central office or to me directly.

The second item in my column this time is the upcoming VIIIth World Congress of WAIMH to be held in Amsterdam, The Netherlands, from July 15 – 20, 2002. I do hope that you have received the information package sent out by our central office last November, inviting you to renew your membership in WAIMH. This package also included the benefits you will receive as a member and a first announcement of the Amsterdam Congress. The congress will be held in the main building of the Free University, situated in the southern part of Amsterdam and easily accessible by plane, train, car, etc. Hotels are located in the central or southern part of the city. The scientific program is going to include the state-of-the-art from birth to three years on parenting, poverty, prevention, and policy. These items cover a great part of the field of Infant Mental Health, yet they give the opportunity for presenters and participants to interact scientifically, clinically, and/or socially. The Program Committee is working hard in preparing the scientific part of the congress and can be reached with ideas and suggestions through our central office.

By the time you will read this perspective we will be well into the year 2001. I sincerely do hope that all of you have had a good start of the New Year and extend my previous invitation to let us hear about matters that are of importance to our membership.



From the Red Cedar

Hiram Fitzgerald
Executive Director

TAX TIME!

For those of us in the United States, we are closing in on our annual contribution to the federal government day, April 15. This is the date each year when out taxes are due, and the date has developed some rather delightful rituals such as waiting until midnight on the 15th to mail one's taxes. The United States Postal Service cooperates with such foolishness by staying open in order to date each letter so that no late fees are due (oh yes, our government charges a little fee if one's taxes are late). This is also a time of year when many American's begin to wonder why they did not make more charitable contributions during the prior year. Charitable contributions can be deducted from one's taxes via a rather complicated system, but they are deductible. Of course, there are perfectly wonderful altruistic reasons for also providing support to charitable organizations, organizations such as WAIMH. Oh, you didn't realize that we are a charitable organization. Well, WAIMH is what we know as a tax-exempt charitable organization under the tax code 501 (c) (3), for educational and scientific organizations. So, for United States citizens, WAIMH is able to accept donations, which in turn are tax deductible for the donor.

One of WAIMH's charitable activities is the Beacon Club, which provides memberships and issues of the Infant Mental Health Journal to colleagues throughout the world. Half of every dollar donated to the Beacon Club is spent in support of a membership/ journal and the other half is invested. Currently, the Beacon Club endowed fund has about $7000 (USD) in it. When it reaches a value of $10,000, we will begin to use 5% annually in support of more charitable activities. Over the past 5 years of its existence, the Beacon Club has provided WAIMH memberships and journal subscriptions to individuals residing in the following countries: Argentina, Armenia, Bangladesh, Boznia/ Herzegovina, Croatia, Czech Republic, Estonia, Hungary, Indonesia, Kazakhstan, Moldova, Romania, Russia, South Africa, Switzerland, Turkey, Ukraine, Venezuela, West Indies, and Yugoslavia. At least three Affiliates (Russia, Argentina, and South Africa) have emerged from these countries, with, hopefully, more to follow. Each Beacon Club membership is for 3 years initially, with the possibility of renewal. Donors can specify who they would like to receive the membership. When a recipient is not specified, WAIMH draws from a list of potential recipients to make the award.

So, if you are feeling a need to reduce the amount of money you donate to the United States Department of the Treasury, or if you are simply one of those altruistic folks, please consider a contribution to the Beacon Club. $100 provides the recipient with a copy of the Infant Mental Health Journal and a WAIMH membership. The Beacon Club Memberships are for three years. If the donor does not renew his or her gift annually, then WAIMH provides the two additional years of support from its own resources. This is an extraordinarily appropriate way to support WAIMH and the field of infant mental health. The more we support infant mental health at the local level and help to under-right training and knowledge dissemination, the more infants and families will benefit worldwide. So, please consider supporting the Beacon Club when assessing your charitable activities for 2001.

Hiram Fitzgerald

Middle-East Summer Workshop

Parenting and Parent-Child Relationships in Context

The University of Haifa and the International Society for the Study of Behavioral Development (ISSBD) will host a Middle-East summer workshop (June 16-20,2001) entitled "Parenting and Parent-Child Relationships in Context". The workshop is designed for promising junior scholars and for advanced graduate students, who are engaged in research and/or public policy commitments. We expect to have 30-40 junior scholars in attendance from different parts of the world.

The workshop will be held at the University of Haifa, Israel. It will begin Saturday evening, June 16, 2001, and will conclude Wednesday evening, June 20, 2001. English will be the official language of the workshop. The workshop will consist of four single-day sessions on research and social policy led by different senior investigators, including Muhammad Haj-Yahia, Cigdem Kagitcibasi, Willem Koops, Richard Lemer, Raija-Leena Punamaki, Miki Rosenthal, Kenneth Rubin, Avi Sagi, Rachel Seginer, Rainer Silbereisen, Charles Super, Ross Thompson, and Marinus van IJzendoorn. The workshop will also include poster presentations by junior participants, followed by a discussion-hour with other workshop participants and senior scholars. There will also be discussions on research issues and career development with senior scholars and workshop participants, and opportunities for collaborative activities and network building among workshop participants. The workshop, chaired by Prof. Avi Sagi, Prof. Rachel Seginer, and Dr. Samia Dawud Noursi, is modeled on prior events sponsored by ISSBD in Africa, Europe, North America, and South-East Asia, and it promises to be a stimulating and challenging developmental experience. One of the goals of the workshop is to promote successful career development among junior scholars and cohesive networks of junior scholars who can enlist one another in necessary career development support functions. We will set aside time for these networks to meet informally to discuss scientific and academic careers, and perhaps initiate collaborative research activities. Applications are now being accepted to attend the summer workshop. The workshop organizing committee will cover successful applicants' travel expenses and participants will also be provided with accommodation and meals for the duration of the workshop in Haifa. Applicants should submit a brief CY, a letter of intent to participate in the workshop, a statement of career and research goals, a one-page poster abstract if intended to present a poster, and a letter of recommendation from a senior scientist. Applications should be received in Haifa by **March 30, 2001**, and submission can be made via E-mail, fax, or regular airmail. Please submit material to:

University of Haifa-ISSBD
Summer Workshop
Center for the Study of Child Development
University of Haifa, Haifa, 31905, Israel

or Email to: sagi@research.haifa.ac.il, **or** fax to ++97248253896.

Please feel free to direct email inquiries to Prof. Avi Sagi at sagi@research.haifa.ac.il or Prof. **or** Rachel Seginer at rseginer@construct.haifa.ac.il.

Decisions will be made and sent by **April 10, 2001**. Additional information will be posted at the ISSBD website (www.issbd.org) as it becomes available.

Research Articles Needed:

The Child Psychotherapy Trust has begun a project to produce a booklet with back-up research targeted at policy makers in the U.K. The aim is to gather a synopsis of a wide range of available evidence - based practice that confirms the importance of early intervention, and thus begin the process of establishing Infant Mental Health services within the framework of current state provision. The booklet will also layout the financial benefits of preventative work with parents and babies, in comparison to the resources from multiple agencies that might get tied up in the future, as well as, considering the personal costs to the individual and the next generation. It may be a bit of a tall order to get everything in!

I would be grateful if anyone who has references or details of useful research covering evidence - based practice across the field of Infant Mental Health, or indeed anything that they feel might be helpful, could send me details. The final paper will available to all who are interested. My e-mail is balbernie@connectfree.co.uk and fax no. UK+01452 891304.

Thank you.
Robin Balbernie.

Infant mental health services Strategies for support

Infant mental health specialists use a range of strategies to strengthen infant and parent capabilities within the context of early developing parent-child relationships. These strategies include emotional support, concrete resources, developmental guidance, infant-parent psychotherapy, and advocacy (Weatherston & Tableman, 1989). With respect for strong and stable working relationships, infant mental health specialists offer some or all of these strategies, as appropriate, for each infant and family referred.

Emotional support
An infant mental health specialist may offer emotional support related to an immediate crisis, e.g. the birth of a premature infant, the hospitalization of a baby, the death of a child, the loneliness of a parent who is unprepared for the care of a baby. The specialist looks and listens carefully, acknowledges the family's strengths and needs, and shows compassion for their difficulties. The specialist invites the parent or caregiver to talk about experiences with the baby, careful to follow their lead. She/he offers empathy in response to the crisis, and to the family's need for care. In many instances, it is the specialist's behavior -for example, regular and consistent presence in the home -that communicates concern and support. The specialist's words also offer reassurance, helping to identify troublesome feelings, to define risks, and set limits that are firm, clear, and fair. Actions and words help parents to more successfully nurture their infants and establish relationships that reduce developmental risks.

Concrete resources
Many families referred for infant mental health services have basic needs for food, housing, clothing, and medical care. These needs must be met in order for parents to feed, nurture, and protect their young children. The specialist who sees that a family is hungry helps them to eat and, in turn, to feed their children. By meeting a family's needs for concrete resources, the infant mental health specialist helps parents to survive and care for their infants. Such concrete support serves as a powerful metaphor for ways that the specialist can be helpful to the infant and family, and facilitates the development of a working relationship.

Developmental guidance
The infant mental health specialist may also provide developmental guidance that is specific to each baby's pattern of growth and change, encouraging parental attention, interest, and appropriate response. The specialist offers information about the baby and basic child care routines, e.g. feeding, sleeping, crying, comforting. The specialist encourages parents to look for the baby's changing competencies, suggesting what developmental tasks lie ahead. She encourages activities and experiences that will enrich both the baby's and the parent's pleasures and capabilities. The specialist makes informal observations about the baby and invites a parent to do the same. It may also be appropriate for the specialist to speak for the baby, identifying the baby's immediate wants or needs.

On occasion, the infant mental health specialist may model a particular caregiving behavior, encouraging the baby to respond. However, the specialist is careful to support the parent's capacity to do the same with the baby, as it is the parent-infant relationship that is of importance here, not the relationship between the specialist and child. The specialist may also make playthings available to families, offering opportunities for pleasure where resources are scarce.

Infant-parent psychotherapy
Some families need only support and guidance to successfully strengthen their parenting capacities and support healthy relationships with their infants. Other families need more help in understanding their distress. Infant-parent psychotherapy helps parent(s) to explore thoughts and feelings about the baby, caregiving responsibilities, and relationships. Major clinical concerns may include early or unresolved loss, prolonged separation, maternal deprivation, or trauma leaving physical or emotional scars. Memories attached to difficult past experiences and relationships may be awakened with intensity in the presence of an infant, placing painful burdens on parents as they struggle to provide this infant with care. In protecting themselves from feelings that are aroused, they may shut down, withdraw, lash out, or run away. They place their infants at continuing risk because they cannot hold, comfort, or respond with sensitivity. This of course makes the care of a baby problematic and heightens the risk. The infant mental health specialist explores feelings and behaviors, as parents are able to do, in the presence of the infant, and within the context of the trusting working relationship.

Advocacy
Finally, the infant mental health specialist may act as an advocate as needed by parent or infant. The specialist speaks for the baby's need for stable and affectionate care, as well as for the parent's need to care well for the baby. She may go to court on behalf of their right to remain together. She may work within the child welfare system to secure a permanent plan for a baby whose parent cannot provide adequate care. The specialist has continuing responsibility to speak for those who cannot, in settings where decisions are important to healthy attachments. All of these strategies help infant mental health specialists to support early developing relationships in families. In practice, some or all strategies may be appropriate to the needs of individual infants and families referred for service. Some or all may be interwoven in the course of each home visit.

(Zero to Three, February/March 1995)

NEWS & VIEWS

United States

April 5-7, 2001 in Charlottesville, Virginia. The conference: *Frontiers of Practice: The New Dialogue Between Attachment Theory and British Object Relations* is sponsored by the Under Fives Study Center of the University of Virginia Health System. Using case material and research findings to inform their theoretical views, speakers from England, Canada, and the USA will present their perspectives on how to use these two traditions in working with children. For more information, see the website at http://faculty.virginia.edu/underfives-conferences; e-mail: uvaseminars@virginia.edu; or call (800) 346-3882.

Infancy Institute

Infancy Institute will be held on June 19-21, 2001 at Bank Street College in New York City. Registration for the three days is $225. Scholarship money is available.

The keynote speaker is the nationally known author **Janet Gonzalez-Mena**. Her talk is entitled "In the Spirit of Partnership: Culturally Sensitive Caregiving."

In addition, 35 small-group workshops will be offered on a variety of topics, such as brain development, supervision of staff, activities for toddlers, sensory integration, and caregiver-parent relations. Furthermore, there will be an opportunity to visit an exemplary infant/toddler program.

To request a program or for more information please contact us at Phone: 212-875-4728 or Fax 212-875-4753.

Head Start looking for reviewers

The National Head Start Bureau is expanding its pool of peer reviews and consultants who will assist with the review of current and future activities, policies, and research. Individuals who respond will also receive announcements concerning the availability of funds for grants, fellowships, and programs. Contact: Ellsworth Associates, Inc., Attn: Reviewers and Consultants, A-003, 1749 Old Meadow Road, Ste. 600, McLean, VA 22102; E-mail: biblio@cainet.com

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