

# The Signal



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## *Using the Lausanne Family Model in Training:* AN ISRAELI EXPERIENCE

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### **The Israeli Well-Baby Care System**

The Israeli Well-Baby Care system is a nation-wide public health system. It supplies medical care, developmental follow-up, and childcare guidance from pregnancy through to the sixth year of life to nearly all Israeli infants. It can be used effectively as a main referral source for prevention and early detection of emotional disturbances to a community-based infant mental health clinic. Families are referred, assessed, and treated by a specialized mental health team. This referral process has been validated by Keren et al (2001) who found significant differences in the quality

of mother-infant interaction when comparing referred infants with socio-emotional symptoms to non-referred normally developing infants.

Based on a previously implemented pilot community-based infant mental health clinic, a nation-wide Early Childhood Psychiatry Program was launched in 1999, under the sponsorship of the Israeli Ministry of Health and the Sacta-Rashi Foundation. This program includes clinical training of child psychiatrists and allied professions from all over the country. Two units were inaugurated in 2000 and three more will be implemented in the next three years.

### **Clinical Training**

The field of infant mental health is a domain where the dynamic dialogue between clinical and research perspectives are a dominant feature. We have looked for a way to integrate these aspects in the training for the teams who will be involved in working in these units. There are certain important clinical skills professionals need when working with infants. The following main clinical skills were targeted for the first phase of the training:

- To be able to systematically observe the mostly non-verbal interactions between infant and family, including both parents; thereby learning to use standardized situations of observation for assessment.
- To be able to view the family as a unit and not only as a collection of individuals and dyads. Indeed, this can be a major difficulty for professionals trained in diagnosing problems of individuals.
- To be able to assess the strengths as well as the weaknesses of the family's interactions. This involves learning how to convey to the family their own sense of competence by emphasizing their resources, rather than pointing out their problems, in order to consolidate the therapeutic alliance.
- To be able to recognize the importance of the alliance not only with the family, but also within the team and with the entire network of the professionals involved with the family.

All these aspects are combined in the Lausanne family model (Fivaz-Depeursinge & Corboz-Warnery, 1999). The observational procedure, the Lausanne Trilogue Play (LTP), can be used for clinical as well as research assessment. It focuses on the

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strengths and weaknesses of the family alliance and of the family's working alliance with professionals. Indeed, the procedure's integration within a live systems consultation with the family, the therapists and the professional network can be used for training.

The reader will recognize many analogies between this model and the principles of Interaction Guidance (McDonough, 1993) and of systems consultation (Wynne, McDaniel & Weber, 1986).

## Case Example

*In this paper, we illustrate the application of the model by a case history. This intervention was conducted in three steps:*

1. Emergency intervention concerning an acute feeding problem, involving the joint involvement of father and mother, the intensive support of a dietitian and successful negotiation with the community pediatrician. In this first step, the alliance between the parents and the wider support network was a very crucial aspect of the intervention.
2. Assessment of the family communication by means of the LTP procedure in the context of a didactic systems consultation. This second step allowed for a review of the intervention, and an opportunity to plan for the future;
3. Feedback and follow up session following the end of the first stage of intervention, but leaving open the possibility of later therapeutic work.

### First Session

The parents of a 4-1/2 month-old baby boy (B) were referred to MK's and ST's Infant Mental Health Unit following the baby's refusal to eat while awake. The parents related that their baby was born after an uneventful pregnancy and delivery. Similar to

his older brother D, the mother had decided not to breast-feed him (she had had plastic surgery on her breasts and did not want to damage them). During the first month of his life, B ate quite well and slept through the night. However, the mother felt anxious about B not eating during the whole night and she started to wake him up in the middle of the night for a feed. This was the beginning of a vicious circle, since B started to refuse food during the day. The family pediatrician encouraged "sleep feedings" both at day and nighttime. The mother described how she "pushed" the baby to sleep in the middle of the day, and would try and bottle-feed him. Multiple changes in milk formulas did not help, and the mother even asked a friend who was breast-feeding her own child, to give her some of her milk.

B's father worked long hours and perceived feeding as his wife's role. However, after some time, the pediatrician advised them to use a specially devised bottle for minimizing colic gases. The father tried to suck from the bottle and discovered that it required a lot of effort. As a result, he lost confidence in the "doctor's advice" and became more involved. In spite of all these efforts, B continued to refuse food, slept less and less during the days and nights, and became significantly underweight.

The child psychiatrists advised the parents to reverse this course and feed the baby during his waking hours. The parents were put in touch with a dietitian in their city who would work with them day and night through the crisis. At the same time, the psychiatrists negotiated with the pediatrician to give up sleep feeding. The psychiatrists also noted several alarming manifestations of the family communication. For example, during free play, both parents chose to sit on chairs and place B on the carpet close to mother. The mother was the only one to interact with B, though from a distance. The father acted as if absent.

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Hiram E. Fitzgerald

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Both parents sat apart from each other and did not interact at all. B was alert, calm and interested in his environment, but did not engage with his parents and conveyed a sense of self-sufficiency. He exhibited surprisingly good motor development despite his low weight. Accordingly, MK and ST invited the family to meet with an expert in helping families with infants (EFD). She was scheduled to visit the Child Mental Health Center to teach a group of professionals about families with infants. The goal of the consultation was to have EFD's professional impression of the parents' communicative patterns both with their baby and between themselves. The parents agreed to play with their baby in front of the group, to be video-recorded and to receive EFD's feedback after it.

## Second Session

The parents arrived with B, and the mother immediately began to show how she fed her baby with a bottle while awake. The parents described the hard days they had gone through and acknowledged the help of the dietitian. MK explained to EFD in front of the family and the group that she wanted help in assessing the family's communication.

## Trilogue Play

EFD (translated by MK) explained the LTP procedure. They were instructed to play as a family in four different ways. During the first part, one of the parents would play with B while the other would simply remain present. During the second part, the parents would reverse their roles. During the third part, both parents would play together with B and finally, during the last part, the parents would talk together leaving B to be on his own. At the age of four to five months, the play session generally lasts about 10-12 minutes. They would be free to decide who would start and when to proceed to the next play situation. Additionally, the parents would begin as soon as they felt ready and tell

EFD when they were finished.

Since the father insisted that B would not play in the infant seat that had been prepared, EFD, sensing his tension, asked for a rug to be put on the floor and thanked the father for his help at trying to find the optimal conditions for his baby. Accordingly, they all sat on the floor.

### *"2+1" configuration with mother and B, father as third party*

Play began instantly between mother and B, but without previous discussion with father about who was to begin. B was lying on the floor and mother turned his body to be in face-to-face position. The father sat at the side, attentive and moderately resonant in the interaction.

B was animated and tense throughout this first play situation, but was quite excitable and on the verge of crying. The Mother kept initiating different physical games, such as peek-a-boo, or shaking a bracelet to distract him. As a result the form of the play was fragmented, with no game fully developed. In addition, during the play and "out of the blue", the mother asked Baby "where is D?" (B's brother).

### *"2+1" configuration with father and B, mother as third party*

About three and a half minutes into the play, B shifted his attention from mother to father and back again. While he continued this back and forth gazing, the mother turned to father, talked to him and they switched to father-baby play with mother as third party. Mother sat cross-legged close to the dyad and kept readjusting her posture for over a minute, at the risk of distracting B.

As the father moved to play with B, he oriented B's body to face him and immediately set out to play a physical game; he lifted B to a standing

position and then lowered him down. As B grew more excitable and fussy the father tried other games, such as tickling him or looming in of his face. They finally reached a brief moment of shared pleasure, taking turns in vocalizing and smiling at each other, with mother resonating.

### *"3 together" configuration*

Two minutes into father-B game, the mother abruptly re-introduced herself by calling to B and tickling him. This was the signal to proceed to the 'three-together' play. This part lasted more than five minutes. During this time each parent kept trying to attract B's attention. For example, the father whistled while the mother shook her bracelet; the father made noises with his fingers while the mother talked, asking B again "where is D?" or the father held out a toy while the mother leaned close to B, obscuring his view of the father. It seemed that B was used to this climate of utter competition, and attended alternatively to either parent.

### *"2+1" configuration with mother and father, B as third party*

Finally, the mother sat up, talked to the father and announced that they would prefer to omit the fourth part of the play; but the father declared that he had something to say. He started a rather long monologue about politics, while the mother listened politely. B looked several times back and forth between them, then crawled towards his father, who attended to him while continuing his speech.

### *Immediate feedback*

As they finished, EFD congratulated them for obtaining their baby's collaboration and for accepting to work in front of the audience for the sake of their child. She asked whether they felt that B as well as themselves had been behaving as usual. They commented that this was a valid



observation, even though they had been more shy in the clinic than at home. When specifically asked whether they had the feeling of having played as a 'three-together' or rather as two separate parent-baby dyads in the third situation, they said three-together, but without elaborating. It was obvious that they did not wish to take up this issue. It was precisely at that point that B started crying. While the mother began to feed him, the parents again told about the struggle to feed him while he was awake. They continued to say that they had decided together in the car, after the first psychiatric consultation, to change this feeding pattern and call the dietitian.

It was decided together with the family and MK, that EFD would give them her first conclusions now and would examine the tape later with MK and the group. MK would review it in detail with the family during their next session and communicate EFD's and the group's conclusions.

Consequently, EFD concluded by telling them how impressed she was with their love for their baby and their hard work to overcome the problem together as a parental team. She recounted the story of their trilogy play, emphasizing mother's and father's competence in playing with B, as well as B's striving to engage, despite his fussiness. EFD commented on the fact that she didn't get a sense of the parents' working together in the three-together and suggested this theme for later review with MK. Finally, she stressed that in spite of the rapid improvement of the feeding problem, much remained to be done, so that B would now be in a position to catch up with developmental issues that he had not been able to attend to beforehand. She insisted on the importance of continuing work in the therapy.

### **Third Session**

It took the parents two months to schedule a new appointment at the

clinic with MK. The parents told MK on the phone that B's improvement in feeding himself was stable and that they were very busy at work. Nevertheless they set an appointment to review the tape together with MK. B looked well and a notable positive change was apparent in his engaging stance. While reviewing the LTP with MK, mother emphasized her pleasure in seeing the father's affection and competence in playing with B. It reminded her of the times when they had only one child, D, and had more opportunities for threesome situations. She expressed feelings of regret that this time had vanished, and this was the basis for her asking Baby "where is D?" However, the issue of their difficulty in playing together as a threesome was again avoided by the parents. They expressed their gratitude for all the effort they felt was put into trying to help them: "We needed to hear again and again, from different consultants, that we had to make the change". They felt they did not need any more help for the time being. An open door was offered to them to come back whenever they had any concerns about B.

### **Elaboration with the group**

The work with the professional group, which took place at the end of the second session consisted of assessing the family alliance and emphasizing several key issues. In this case, the priority was in focusing on the father-mother-baby alliance, namely the partners' coordination in working together. The assessment was conducted in four stages:

1. Were the three partners ready to engage in the play? The answer was positive in all configurations, pointing to a crucial resource, namely a motivation for change;
2. Was everyone in their roles? The answer was mostly positive in the first two "2+1" situations, indicating the ability of the parent-baby dyads to work together under the
- eye of the third party parent. The answer was negative in the "3 together" and the last "2+1" situation, namely the configurations where the parents had to work more closely together. It seems that irrepressible competition emerged between them, engendering confusion for the baby;
3. Was everyone attending to the same focus? The answer was mostly negative; in each part, and especially in the three-together play, the family had difficulty in co-constructing games;
4. Were they all continuously in touch with each other's feelings? The answer was mostly negative, in that there were hardly any moments of threesome affective communion, indicating a problem in establishing intersubjective communion as a family.

In summary, the family alliance was assessed as "collusive", because the relentless competition between the parents had the effect of deviating the tension between themselves onto the child (Fivaz-Depeursinge & Corboz-Warnery, 1999). The therapeutic implication of this assessment was that the treatment had to further focus on the co-parenting alliance. It seems that in addition to the mother's anxiety, a non-negotiable conflict between the parents was at the source of the child's feeding problems. The parents had been able to join forces under the pressure of the child's acute loss of weight and the consultants' authority. Yet the competition and lack of communication between them was still prevalent in the family patterns of face-to-face interaction, preventing the emergence of threesome intersubjective communion. It was to be expected that the family would need further help at later key developmental stages. Yet, in view of their defensive stance, it was critical to accept their concluding the intervention at this





stage, in order to protect a positive alliance and leave the door open for further work. Time was devoted to how to convey to the family the results of the assessment during the reviewing of the video-recording, by systematically focusing on their positive resources and only acknowledging the problems raised by the parents.

Finally, the importance of the cooperation between the professionals involved in the network was emphasized. In the case presented, for instance, when B lost weight, all the professional network was concerned that the baby needed to eat. The coordinating work between the psychiatrist, the dietitian and the pediatrician had a crucial therapeutic impact because it made the network more coherent. At that stage, it was probably more effective than adopting from the outset a psychodynamic approach that was disconnected from the pressing reality of a baby who was 'fading away.'

From this perspective, the Lausanne family model was applied not only to the family, but also to the team. The four main questions addressed by the model were: "Is everyone included?"; "Is everyone in his/her role?"; "Is there a joint focus?" and "Is there a positive emotional sharing atmosphere?". These questions are not only relevant to assessing family alliances, but also to assessing the working alliances of professional teams. Healthy working alliances in clinical teams have a definite impact on their work with families and young children. It is important for all professionals that are involved with a family to define and maintain roles, to define a common goal for their intervention and to remain in contact with each other. This is often a difficult task with newly formed teams, even though everyone is very much committed to the success of a new unit.

### **Conclusion**

One of the first steps in our national training was to show how a structured assessment paradigm, such as the LTP, was useful both in evaluating the infant's interpersonal context and in conceptualizing alliances, including team alliances. Since then, one member of the team (MK) has been involved in supervising one of the two new units, working in parallel on clinical cases and on the team alliance formation. Indeed, during this work, it was revealed that one of the professionals found herself excluded from the team. However, the conceptualization of her situation in terms of alliances moderated these feelings and enabled the identification of the factors at work. The teaching of infant development and observation, the assessment of early parent-infant relationships and of the infant's environment through direct observation of free and structured play, home visiting, developmental testing and questionnaires to parents have become "taken-for-granted" components of any infant mental health (IMH) training program (Pawl et al, 2000). The assessment of triangular relationships in infancy, on the other hand, has only recently been introduced into the IMH literature (Fivaz et al, 2000). As far as we know, the application of the "family alliances" concept to the supervision of newly formed teams in the field of IMH is new. Wieder et al (1987) have shown in their book "Working with Infants in Multi-risk Families" the extent to which team cohesion is needed in working with very disordered families. Knowing that parallel processes take place at various transacting levels, brought us to the idea of using the LTP procedure to teach the basic concept of alliances in infants' families as well as in IHM teams. From our own standpoint, we found this training experience useful, and we would be glad to share it with those who are involved in the process of implementing new Infant Mental Health clinics.

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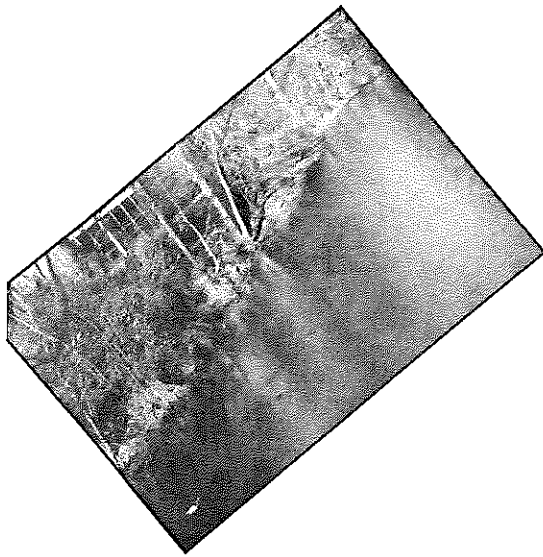
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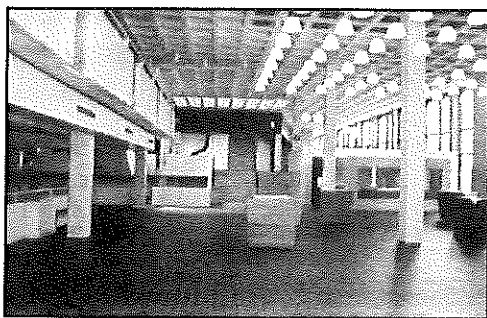




By the Red Cedar  
Hiram Fitzgerald

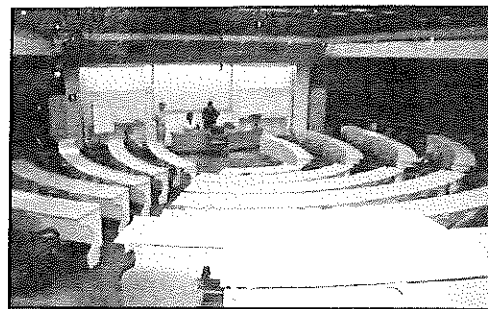
## AMSTERDAM 2002!

This summer, Jean Francois Saucier and I visited Amsterdam, site of WAIMH's 8<sup>th</sup> World Congress. The Congress will be held in the Congress Hall of the Vrije Universiteit. The Vrije Universiteit is located near the railway station Zuid/WTC in the south-western part of Amsterdam, close to Schiphol International Airport and the Congress hotels. There are good railway, tram and bus connections between the Vrije Universiteit, the hotels and the airport.



Vrije Universiteit Congress  
Hall Reception

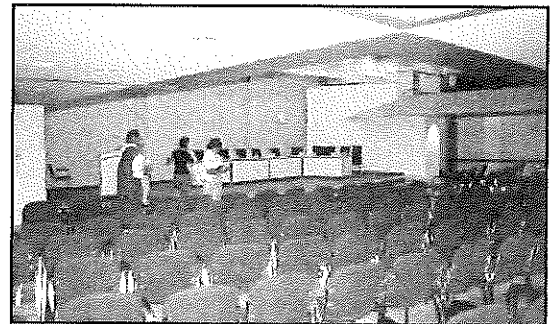
Dining area within the  
Congress Hall



Fully  
equipped  
meeting  
rooms

The opportunity to visit the Vrije Universiteit (Free University), walk through the hallways of its Congress Hall, see the rooms to be used for plenary sessions, workshops, symposia, teach-ins, and visualize settings for posters, receptions, and other events related to the congress was invaluable. When the program committee meets in December to make final decisions about program content, their work will be just a bit easier because of our first-hand knowledge about room layouts and the functional space available for various congress activities.

The visit also provided many opportunities for members of the program committee to converse with members of the local arrangements committee about budget issues and activities that may be available for accompanying persons or for family vacations after the congress.



Ton van Strein (Local Arrangement Committee Chairperson), Jean Francois Saucier (Program Committee Chairperson), and Dolores Fitzgerald (past Administrative Assistant for WAIMH), discuss activities for accompanying persons.



Amsterdam, capital of The Netherlands, is one of Europe's famous historic cities. Wandering through the picturesque narrow streets of Amsterdam's centre, the oldest part of the city, criss-crossed by its



dreamy canals, you will find many neighborhood stores, bakery shops, and bistros. Accompanying them are nearly 7,000 historic buildings, many dating from the Dutch Golden Age. Amsterdam also has 42 museums (the Rijksmuseum, the Van Gogh Museum and the Municipal Museum). It is home to the world famous Concertgebouw Orchestra, the Dutch National Ballet, the Dutch Dance Theater and the Dutch Opera. Also, numerous theaters and cinemas, cozy bars and pubs and a wide variety of good restaurants provide ample

opportunities for entertainment and recreation..

We have selected the Novotel Amsterdam as the main congress hotel. Within easy walking distance of the Vrije Universiteit, the Novotel is a 600 room, air-conditioned hotel, with spacious rooms. Rooms have modem connection access, minibars, double beds, coffee and tea facilities, an English Pub, coffee shop, and a charming restaurant Côté Jardin.

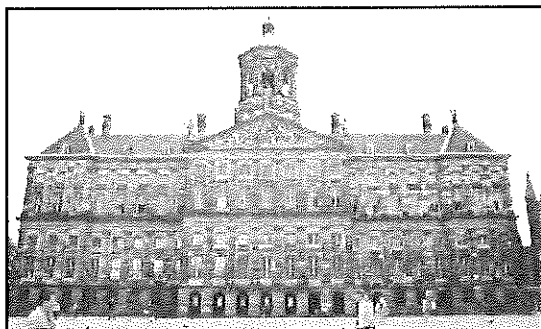
Adjacent to the hotel is Amstelpark.

In future issues of The Signal, we will keep you up to date about congress activities. When you are reading this, members of the various review

panels will also be reading the proposals submitted for presentation. This peer review

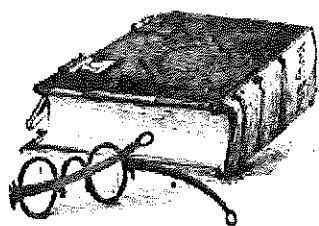


picture of the canal



picture of the Royal Palace

process helps us to assure proper balance among disciplines, nationalities, and clinical and scientific perspectives. I look forward to greeting each of you in Amsterdam, when we meet to discuss cutting edge theory, research, and practice that has as its common goal, the enhancement of the quality of life for infants, toddlers and their families throughout the world.



## LITERATURE MONITOR

This section aims to bring to the attention of the readership of The Signal books, Journal articles, and similar resources likely to be of interest to the Infant Mental Health practitioner. It makes no claims at all to being exhaustive or indeed critical - but all the items appear relevant and interesting. Please send any suggestions of recent items that you might have to: paul@pbarrows.freereserve.co.uk

### Journals:

'Effects of maternal depression on cognitive development of children over the first 7 years of life'.  
Kurstjens, S. & Wolke, D.  
Journal of Child Psychology and Psychiatry, 42 (5): 623-636 (2001).

*'It is concluded that maternal depression per se has negligible effects on children's cognitive development. Long-term effects may be found when maternal depression is chronic, the child is a boy and neonatal risk-born, or the family suffers other social risks.'*

'Rethinking maternal sensitivity: mothers' comments on infants' mental processes predict security of attachment at 12 months'.  
Meins, E., Fernyhough, E.F. & Tuckey, M. Journal of Child Psychology and Psychiatry, 42 (5): 637-648 (2001).

*'...mothers' Appropriate mind-related comments, assessed individual differences in mothers' proclivity to comment appropriately on their infants' mental states and processes. Higher scores in this...category related to a secure attachment relationship at 12 months. Maternal sensitivity and Appropriate mind-related comments were independent predictors of attachment security at 12 months, respectively accounting for 6.5% and 12.7% of its variance. We suggest that these findings are in line with current theorising on internal working models of attachment, and may help to explain the security-related differences in mentalising abilities.'*

'Promoting mental health after childbirth: a controlled trial of primary prevention of postnatal depression.' Elliott, S.A. Levertton, T.J., Sanjack, M., Turner, H., Cowmeadow, P., Hopkins, J. & Bushnell, D. British Journal of Clinical Psychology, 39: 223-241 (2000)  
*'...Questionnaire measures of mood in first-time mothers invited to the*

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## HARRY POTTER AND THE MAGIC CIRCLE: THE CONCEPT OF RESILIENCE

Angela M. Tomlin, Ph.D.  
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J. K. Rowling's series about orphan and unsuspecting wizard Harry Potter has enjoyed increasing success with each installment. Harry's worldwide appeal is illustrated by the translation of the novels into 28 languages. The novels took over the top slots of the New York Times Best Seller List for so long that editors finally requested separate fiction lists for works for children and adults (Gray, Gleick, & Sachs, 1999). This last achievement is stunning since it is unusual for books written primarily for children to be named to the list at all (Fialkoff, 1999). When the date of the fourth installment was announced, bookstores planned parties beginning at the stroke of midnight on the eve of the release (Gray & Sachs, 2000). A movie planned for later this year is so awaited that the announcement of the actors who will play Harry and his friends was a lead story itself.

Not all of the attention has been positive, however. Some critics have viewed the books' magical themes as endorsement of occult concepts and even Satanism. Rowling and others have strongly defended the series against this allegation, specifically denying any links to wiccan, for example. Rowling is aware of readers' tendency to interpret the books in many ways. "Every reader will bring his own agenda to the book.

People who send their children to boarding school think I'm on their side. I'm not. Practicing wiccans think I'm also a witch. I'm not." (Jensen, 2000).

What could account for the popularity of these books which have been described as perhaps "great escapism" but certainly not "great literature" (Fialkoff, 1999)? With thanks to Rowling for understanding that a good character can mean many things to many people, this article will discuss two possible sources of Harry's popularity, beginning with Rowling's use of typical childhood fantasies. In addition, relationship-based themes in the Harry Potter series will be identified and discussed, with special focus on how Harry's adventures illustrate the importance of early relationships and the concept of resilience in childhood.

It is readily apparent that the Harry Potter stories make liberal use of several common children's fantasies, "familiar to anyone who has ever read a decent fairytale" (Gleick, 1999). Just as young children's play reflects their preoccupation with "special powers", so do the many characters they love, from Superman to Pokemon. Harry Potter, along with his friends, teachers, and other important adults, are no exception to this rule, as they all have rather spectacular magical powers. The children in the series hone their powers in class, then use them to solve mysteries and rescue themselves without much adult help.

Another typical theme in children's fantasy is the suspicion that adults (or in this case, Muggles) fail to see what is really happening around them. (Adults, of course, are not immune to these wishes and beliefs. The

American television program X-Files is an example of the view that those in authority are blind.) Harry and his friends inhabit a world that exists unnoticed side by side with the human world. Further, within the magical world they manage to solve mysteries without alerting their parents or professors. Finally, Harry actually gets to live what may be the most compelling childhood fantasy: that one does not really belong to the world in which one finds oneself, but to a much better one. Freud called this fantasy "the family romance" and stated that in its most common form the child imagines the parents being replaced by grander or aristocratic people (1909/1959). Indeed, almost every child has imagined that she or he is really a prince or princess and that at any moment "my real family will come and take me away". Many classic children's stories, such as *The Prince and the Pauper* and *The Little Princess*, play on this theme. Frequently these stories feature children who, like Harry, have to rely on themselves and their friends because adults are not available or are uncaring.

"Harry has to make his own choices. He has limited access to caring adults" says the author (Gray, et al., 1999). This lack of availability of adult caregivers makes these fantasies of having special powers, the unawareness of adults, and belonging to another family, especially pivotal for Harry. On the one hand, Harry may be especially susceptible to this type of fantasy because of the poverty of his pre-Hogwarts life. On the other hand, his terrible life makes the moment the fantasy comes true that much more wonderful.

For Harry, a skinny orphan in too big





clothes and a broken pair of glasses, this moment of discovery could not come soon enough. Harry is worse than unloved, he is actively disliked by his caregivers, who keep him in a closet and make no secret of their wish that he had never come into their lives. He is given next to no information about his biological parents, thus providing him with no conscious basis for knowing himself as part of a family. Despite this rather awful situation, Harry does not himself become an awful person, and this may be another attractive theme to this series: the notion that one can overcome and even thrive despite terrible experiences. In recent years, both mental health professionals and the public have been intrigued by the stories of very young children who have been rescued from institutional care and adopted by caring families only to have the adoptions fail when the child cannot adapt to the new setting. Researchers and clinicians have not yet completely agreed on what these behaviors mean, and why some children cope well and bond with the new family while others never do (Zeanah, 2000). In general, it is thought that some combination of internal characteristics and external supports lead to successful outcomes. The terms "resilience" and "protective factors" are often used to describe these ideas (Rutter, 1979, 1985).

In the beginning, Harry does not experience many of the external supports that are thought to help children in this situation. For example, in Book One we learn that he is as friendless at school as he is at home. Nevertheless, Harry can be seen to demonstrate many of the personal factors associated with the presence of resilience—such as social competence, an easygoing temperament, positive persistence, and a sense of autonomy.

Harry's world starts to get better once he is allowed to know he has a history

and especially that his history includes being the cherished child of two important people, James and Lily Potter. Unlike Sara Crewe, who had her father's words, "Every girl is a princess", to draw on, Harry does not remember feeling special when we first meet him. Near the beginning of the first book, however, Harry finds that his history is more than he has been given to believe. He discovers that although his parents are dead, they were not lost in a car accident, as he had been told. Rather, Harry's parents were killed by a very powerful and evil wizard and, most importantly, he learns that they died protecting him. Most astounding of all is the discovery that as a result of surviving this attack, Harry is considered a hero and a very special person, from whom great things can be expected. This is difficult information for a young boy to accept, but Harry, like most children, finds that learning a hard truth is better than not knowing at all. It is interesting that Rowling has Harry recalling more and more memories over time, as though the external supports given by new friends and helpful adults allow the memories to come forward.

It is possible to argue that Harry carried with him all along both the frightening moments of losing his parents and the positive memories of their early time together. The protection offered by the early period may explain how Harry is able to retain his sense of self and ability to relate despite his unfortunate circumstances. In the now classic article, Fraiberg and colleagues (1975) ask why some children are protected from the ghosts in the nursery, while others are left to re-enact the cruel behavior they experienced. It is generally agreed that for some children the experience of at least one positive relationship in the early period provides a framework for later

relations to develop. In our literary example, Harry did have the opportunity to bond with his biological parents, if only for the first year. His ability to overcome years of isolation and destructive caregiving may be attributed in part to the "magic protection" offered by his first few months of optimal caregiving.

The suggestion that Harry has many "good ghosts" in his life is reiterated throughout the books. The resilience and protective factors models suggest that Harry is able to build on the good start provided by his parents when he reaches a safe place and has a chance to experience normal relationships. In this more supportive and positive setting, Harry demonstrates behaviors associated with securely attached children. For example, he readily adapts to a completely new way of thinking and being, masters new skills, and is regarded by others and himself as a competent and resourceful person. He develops new friends (Ron and Hermione) and quickly bonds with adults who offer him appropriate parental figures, such as headmaster Dumbledore and Ron's mother, Mrs. Weasley. He does not allow unkind people (Malfoy) to poison his new-found happiness.

In the third book, Harry discovers that he has a godfather, Sirius Black. In a nice bit of foreshadowing, Black is introduced briefly in the first novel as the person who takes Harry to safety after he and his parents are attacked before taking a more central role in later episodes. The knowledge of his godfather is a gift almost as important as learning about his parents. For an orphaned child, a godfather, selected by his parents and holding important memories of them, has many meanings. Black serves for Harry as both a link to the past and a secure base to the future. For the first time in his memory, Harry has a living relative who can be trusted and counted on for help. After learning of his godfather and making a connection to him, Harry's ability to



establish and maintain relationships begins to mature. This maturation process develops across the four novels and Rowling has suggested there is more to come. For example, in book four, although being pressured to perform in an important competition, Harry shows compassion, concern for his competitors, and even a willingness to sacrifice for others.

This maturation process is most clearly shown at the end of the competition in book four when Harry finds himself again threatened by the wizard who took his parents and who has repeatedly tried to kill him. The evil wizard acknowledges and even defines for Harry the "old magic" his mother used to protect him so long ago as parental sacrifice of self for the child. Almost defeated, Harry magically brings forth the "ghosts" of his parents, who instruct him and in the process save his life again. This time Harry plays an active role in the defeat of the enemy; this substantive success signals that Harry has earned the praise that he received for surviving the initial attack. When the ghosts disappear, Harry relives the loss of his parents, but only after once again feeling their "magic protection".

At the end of book four, as in all good stories, loose ends are tied up, good prevails, and evil is vanquished (at least until book five). Harry is surrounded once again by his surrogate family and his friendships with Ron and Hermione are shown to remain strong. There are hints that Harry will begin to develop a relationship with a young lady, Cho. This ability to develop a love relationship can be seen as further evidence of Harry's resilience and his ability to be fully human despite his difficult history. As we close this chapter in Harry's story, we feel hopeful for his future and look forward to his next adventures. Rowling's stories about Harry and his

world are successful because they attract us on a number of different levels. On the surface, the heroic friends, magical creatures, improbable escapes, and delightfully wicked villains are enjoyable escapism. If this were all Harry had to offer, however, he would soon be forgotten. Rowling's stories are likely to entertain future generations because they allow children and adults to share a secret thrill of recognition as Harry portrays many of our universal fantasies, including his transformation from lonely orphan to beloved hero. This dramatic change illustrates the most hopeful meaning of the concept of resilience in children. In the end, though, perhaps the deepest appeal of the Harry Potter tales is their celebration of the "magical protection" offered by a positive early relationship. Harry affirms our belief that nurturing early care is so valuable it literally changes a child's world.

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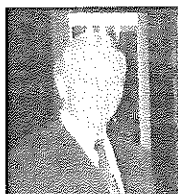
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## President's Perspective

*Peter de Chateau*

One of my tasks as president of WAIMH is to inform the membership from time to time about current developments and ideas occurring within WAIMH and especially the Executive Committee. I have received many reactions regarding the Montreal Congress and most of them were positive, a feeling that I do share with the majority of the participants. One major setback however has been the financial result of the meeting. Unfortunately, and due to many unforeseen factors, we suffered a substantial financial loss. Many of you might think that a loss organizing a congress is not such a large problem. That of course is true, if it is a one-time occurrence and when other income to the association, such as membership fees, manage to keep the organization functioning. However, we really do need to recover our expenses when conducting world meetings in order to keep a healthy financial situation. We have implemented some organizational changes in responsibility related to world congresses. For instance, we have clarified more clearly the division of duties and tasks between the Executive Committee, the central office and the local organizing committee for world congresses. No major changes in the content quality of the conference had to be taken, although minor changes were made as a result of feedback from the membership and the attendees in Montreal.

As you may remember during our last international meeting, the position of our Regional Vice-presidents was evaluated and discussed. In our efforts to expand the growing number of our affiliates and

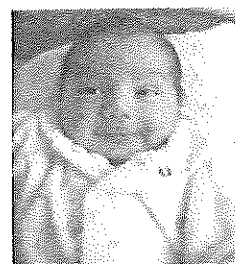
the search for a more democratic organization for WAIMH, the position of our affiliates has gained in importance and influence. Therefore the Board of Directors recommended and the membership approved a change in board composition, with one member of the board to be elected by the affiliate presidents or a representative. Moreover, we discussed ways to implement a bottom-up model more in line with modern thinking and management, as opposed to a top-down way of working. We are strongly advocating this last process and will spend much energy during the coming years to accomplish this important and necessary goal. Affiliates are therefore urged to either directly or through their representative on the Executive Committee, Brigid Jordan, bring forward their wishes, ideas and new initiatives that will help us to take the desirable new steps for the future of our organization. We do hope that this new initiative will prove to be a good and successful choice.

The cooperation with International Association for Child and Adolescent Psychiatry Allied Professionals (IACAPAP) and International Society of Adolescent Psychiatry (ISAP) has improved as you can judge from recent developments in this area. We need to stimulate and enhance the number of professionals exposed to the latest ideas and results from a larger population than is represented solely by professionals working with 0-3 children and their families. This growing cooperation is especially desirable in the area of diagnosis, classification of diseases, and scientific methodology. Continuing

to invite representatives of these two organizations to take a prominent position at our world congresses is just one possibility. Here again the role of our Affiliates is a very important one and presents a golden opportunity for new initiatives and for enlargement of our networks and of our clinical and professional knowledge.

At this moment, we have 35+ affiliates in our organization. The potential must be much greater. The number of countries without affiliates is over 150 and some very large and important countries are not included in our association. Their representatives are at best individual members of WAIMH. The question is how and when will we be able to welcome these countries as Affiliates? Do we have to change the conditions for joining WAIMH as an Affiliate and can we be more active in some other respects? One opportunity to both strengthen our bonds with IACAPAP and discuss the creation of a new affiliate is the IACAPAP meeting in New Delhi, India (Oct 29 to Nov 2 in 2002). It would be wonderful to be able to announce during that meeting the birth of yet another daughter of WAIMH. I am currently in contact with colleagues involved in this meeting and would like to urge any member of WAIMH planning to travel to India to contact our central office so we might be able to get excellent representation and good coordination of our active input there.

Any ideas or items you might wish to bring to my attention can be sent to me through the central office.





## Literature Monitor Continued:

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