The Signal

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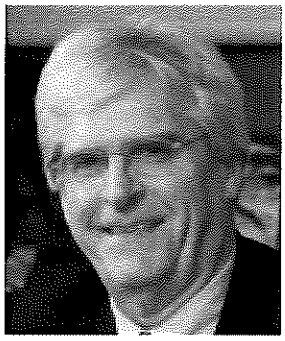

2006 DOLLEY MADISON AWARD

News Release
Friday, March 16, 2007

WAIMH's Executive Director joins honored group of early childhood leaders

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Dec. 7, 2006

EAST LANSING, Mich.— Hiram "Hi" Fitzgerald, associate provost for University Outreach and Engagement and University Distinguished Professor of psychology at Michigan State University, has been awarded one of the most prestigious honors in the multidisciplinary field of infancy and early childhood.

Fitzgerald recently accepted the 2006 Dolley Madison Award for Outstanding Lifelong Contribution to the Development and Well-being of Very Young Children and Their Families on Dec 2. He received the award at the annual meeting of ZERO TO THREE: National Center for Infants, Toddlers and Families, in Albuquerque, N.M.

The award is named in honor of former first lady Dolley Madison, who established the first federally- funded child welfare program, a home for orphans of the War of 1812.

Previous recipients of the Madison award include Anna Freud, psychoanalyst and daughter of Sigmund Freud; Benjamin Spock, M.D., pediatrician and author of "Baby and Child Care"; Urie Bronfenbrenner, Ph.D., world-renowned theorist of developmental psychology; and Edward Zigler, Ph.D., architect of the federal Head Start program.
Fitzgerald was appointed assistant provost for University Outreach and Engagement in 2001 and associate provost in 2005. He is the steering committee leader for the Higher Education Network for Community Engagement, is actively involved in the national evaluation of the Early Head Start and its substudy on fathers, and for 20 years was co-director of the Michigan Longitudinal Study of children at-risk for alcoholism and other psychopathologies. In addition, he served as president and executive director for both the Michigan Association for Infant Mental Health and the International Association for Infant Mental Health. Since 1992, he has been the executive director of the World Association for Infant Mental Health.

ZERO TO THREE is a United States, nonprofit organization dedicated to advancing the healthy development and well-being of infants, toddlers and their families. Founded in 1977 by top developmental experts, the organization disseminates key developmental information, trains providers, promotes model approaches and standards of practice, and works to increase public awareness about the significance of the first three years of life.

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Comments in Response to Presentation of the Award: Albuquerque, NM December 2006

Hiram E. Fitzgerald

I deeply regret that the ice and snow of winter prevented me from being present to receive this extraordinary honor. I first experienced infancy with the birth of our son during my second year in graduate school. This was a transformational event for Dee and me, but one that we managed to survive as very young parents. The transformational event in my academic life occurred when I enrolled in Yvonne Brackbill's graduate course in infancy at the University of Denver. After four years of undergraduate work and two years of graduate study, I finally found my niche in the form of small bundles of joy! Imagine the fascination of discovery about early human life that opened in the 1960s, as investigators adopted new theoretical models of biobehavioral organization and systemic development to counter the residual of Watsonian behaviorism and the positivist philosophy that dominated psychology during the first half of the 20th century.

The route I have traveled continues to fascinate me because it leads me to places and projects that I never imagined were possible during my teen and college years. Starting my academic life as a developmental psychobiologist using psychophysiological methods to study the early differentiation of somatically and autonomically mediated behavior during the first three months of postnatal life, I slowly transitioned to what I now consider to be much more difficult and alluring questions than those I was asking during the early years of my career. Questions that are directed to the ecological and systemic forces that give rise to psychopathology and addictive behaviors, the quality of early child rearing and child development environments, the role of fathers in early child development, and the creation of sustainable university-community partnerships focused on resolution of critical social problems. My pathway has been lighted by bright, energetic undergraduate students like Richard Aslin and Tom Powers; inquisitive and provocative graduate students, like Steve Porges, Barry Lester, Tammy Mann, and Nancy Hill; and an amazing number of scientific colleagues and friends, like Robert Emde, Joy Osofsky, Peter de Chateau and Robert Zucker. I have learned from each of these individuals and from a great many other as well.

Each participant at this conference is engaged in the most important work in American society; work that has as its starting point the enhancement and sustainment of American democratic values. I do not say this lightly. The extent to which infants and toddlers are not able to participate fully in our democracy because they are encased in negative developmental pathways that will prevent their participation, will determine the extent to which America will remain a civil democracy. One that allows every citizen to have full and equal participation. Your work is precious in this regard because your hands can help to shape new pathways for so many of our youngest citizens. I wish you well in all of your efforts. I am deeply moved by this extraordinary recognition for life-time achievements, but I want to assure you that there is still much work to be done. Collectively, we can help to set the research, practice, and policy agendas that will enable all of America's youngest children, to

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From the Red Cedar:
Hiram E. Fitzgerald

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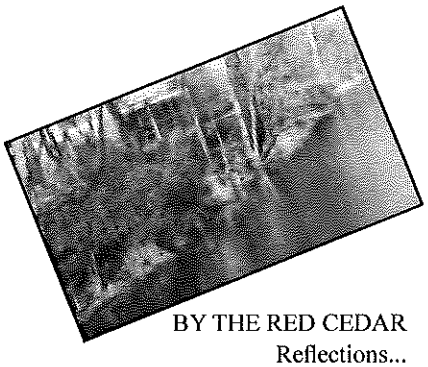
develop in loving, supportive rearing environments and to have their fair and equal opportunities to participate in and shape the benefits of a democratic society.
Thank you all for this honor.

My thanks to Bob Emde for reading an unedited version of these comments to the ZERO TO THREE conference participants. All of the airports in the midwestern part of the United States were closed down due to weather and I was unable to attend. It was a special pleasure to have Bob read these comments. We first met during the 1960s when Bob was a resident at the University of Colorado Medical Center and I was a graduate student at the University of Denver. Our friendship and collaborative work in infant mental health has only deepened over the years.



BY THE RED CEDAR
Reflections...
Hiram E. Fitzgerald

When Joy Osofsky called me in the fall of 2006 to inform me that I was to receive ZERO TO THREE'S Dolley Madison Award I was astounded. The list of past recipients included some of the most distinguished names in the broad interdisciplinary fields that have influenced theory, research, practice, and policy involving families with very young children. Nearly simultaneous to Joy's phone message, I received an email from a former doctoral student, Lisa Crandell, that caused me to reflect on one aspect of my scholarly career that I have always valued above all others. Specifically, the students who have worked in my lab (when I was a lab scientist), those who earned their master and doctoral degrees with me, and those who spent post-doctoral years on various projects. Undergraduate students like Richard Aslin, John Dowd, Roger Jansen, Darya Bonds and others who went on to complete their doctoral or professional degrees. Sixty-four doctoral students for whom I served as dissertation chair or co-chair, all of whom have made their marks as teachers, scholars, practitioners or policy makers. From students early in my career (Stephen Porges, Barry Lester, Mark Roosa, Katherine Hildebrandt Karraker, Catherine Best) to those who came later (Tammy Mann, Alexandra Loukas, Lorraine McKelvey), all have succeeded as they shaped their individual career paths.
In fact, it was a graduate student who connected me with infant mental health. In the late 1970s, Tom Taflan-Barrett (Ph.D., 1977), asked me to consider being a candidate for the board of directors of the Michigan Association for Infant Mental Health. Frankly, I had no knowledge of that organization at the time, but it seemed a natural organization to link with one of my research interests at the time: the impact of day care on infant and toddler development. So, I agreed to be a candidate, was elected, and the rest is, I suppose, captured within the context of life-time achievements.

Lisa's email also provoked me to think about how disconnected our professional lives can be from our personal lives. She described a personal life experience for which her intense training in infant mental health, child clinical psychology, and developmental psychology failed to prepare her. She graciously agreed to share her story in this special issue of The Signal. Her story drew me immediately to Barry Lester's work with crying and colic and an excerpt from his book provides a nice followup article (and a gift copy of the book from Barry to Lisa). Finally, an article from Laurie Van Egeren, reprinted from a prior edition of *The Signal*, that reminds us that for many families, parenting is not just a mother-child activity, but is one that involves dynamic co-parenting processes and systemic relationships.

My graduate students and post-doctoral colleagues introduced me to between-cultural diversity (China, Korea, Serbia, Malawi, Hong Kong, Singapore, Mexico, Canada) as well as within-culture diversity (African American and Hispanic/Latino) and they completed their doctoral degrees in diverse fields of study (experimental psychology, developmental psychology, clinical psychology, community-ecological psychology, school psychology, marriage and family therapy, nursing, family & child ecology, audiology and speech sciences, and criminal justice). I learned much from this rich diversity and from the extraordinary diversity represented by all of the colleagues, friends, and associates involved with my work with the World Association for Infant Mental Health.

So, to represent this diversity, we close this special issue with an update from Debbie Weatherson, Executive Director of MI-AIMH (WAIMH's Michigan Affiliate) on developments with the MI-AIMH endorsement program that embraces competencies and professional development activities for infant mental health specialists. In addition, we include the post-graduate and continuing education training programs developed by GAIMH (WAIMH's German-Speaking Affiliate). Each of these approaches deepens the professional stature of infant mental health, encourages development of cross-disciplinary competencies, and cross-cultural dialogue about the field of infant mental health.

THE LABYRINTH: FROM SCIENTIFIC PAPERS TO BIODEGRADABLE PAMPERS

By
Lisa E. Crandell, Ph.D.

Lisa completed her doctoral degree in child-family clinical psychology and the Interdisciplinary Graduate Specialization in Infant Studies with me in 1994. Her dissertation, published in the Infant Mental Health Journal, investigated maternal representations of attachment relationships, using a modified version of the adult attachment interview. Following her graduate work, Lisa went off to the Tavistock Centre, supported by an International Research Science Award from the National Institute of Child Health and Human Development. As a research fellow at the Developmental Psychopathology Research Unit and University College, London, Lisa's project focused on the impact of maternal psychopathology on infant social, emotional, and cognitive development. In addition, she was a co-investigator on two other research projects at the Tavistock and received additional training from Lynne Murray, Alan Sroufe, Marinus van Ijzendoorn, Mary Main, and Eric Hesse. Then Lisa fell in love, was married, and with her husband went off to Italy, where they added a daughter to their family life. You will come to know Lisa, her family, and a random event in Paris that provoked the article you are about to read. The article is a digest of a longer story she is writing about one aspect of maternal and family life. HEF

My life used to be aligned with the center of my soul. After four years at university to obtain my Bachelor's degree, two years to obtain my Master's degree and another five years to obtain my Ph.D. in clinical child psychology, I was awarded a grant from the NIMH to conduct a longitudinal study of mother-infant relations at the Tavistock Centre in London, England. It was a grand occasion. With my specialty being attachment, I couldn't have been positioned in a better academic environment than the Tavistock Centre where John Bowlby had challenged the psychoanalytic circle of his day and wrote his vintage books on attachment. The library was filled with international journals as well as published lecture series, discussion groups, and thought papers from some of the most penetrating minds in the field. There were regular clinical and research presentations to attend all over London. I was invited to make presentations to the University College London Medical School, the International Attachment Network, the British Psychoanalytical Society and the Institute of Group Analysis. The study we were conducting was vibrant and novel. I was alive. I was alive with excitement, with growth and learning, with affection for the people I was working with and concern for the people I was studying, with the ideas and creativity that were percolating all around me, and most importantly, with the sense that I was a part of something that was important and meaningful.

So how did I get here -- here being a place of uncertainty, doubt and hopelessly locked into the mind-numbing drudgery of domestic life? Oh yes, I remember now. It all started the moment I decided to temporarily step away from my professional life in order to have a baby. Having entered the academic field relatively late, at 39, I didn't have the luxury of working a few more years before making the choice. The plan was to take three years out in order to have a baby and stay at home to raise him/her for those first two crucial years of personality development. It was a clear decision – a clear and single step - only a stone's throw away from where I was. It should have been easy to retrace my path back to the academic world. But then, I hadn't a clue what lay ahead of me.

My husband and I moved to Italy to advance his career while we set about trying to have a baby. Ah, those lovely hot summer evenings watching the moon rise over the mountains and basking in the scent of jasmine. Or was it those weekend trips to Venice, Florence and Rome where art, music, and history gathered together like old friends enjoying a cup of tea? Either way, I felt content and centered in my life. I could move back and forth between giving guest lectures in London and chopping tomatoes in Italy with equal ease. But then, the clear straight path began to bend.

First, came the mystical wings of pregnancy carrying me into watercolor daydreams about the spark of life inside of me that was somehow miraculously developing into a human being. I felt as beautiful and privileged as Michelangelo's Adam in the Sistine Chapel. How could I possibly review a paper for publication and focus my attention on the trivia of the external world? Then my precious little daughter was born. This was followed by several weeks of intoxicating new life scents, stroking silky

black hair nestled to my breast, hypoallergenic lotions, pink booties and dancing butterfly mobiles. It was surreal. In the meantime, I kept looking back over my shoulder to keep track of the multiple turns now required to take me back from whence I came, but I was falling head-over-heels down a very different path.

Then, I was ambushed by colic. Of course, I knew about colic, what mother-baby 'expert' didn't? But I had never encountered the sheer force of a baby screaming relentlessly in the grip of it. There were days and days when my six-week-old baby would cry continuously for six hours. Continuously. For six hours. She would then fall asleep from exhaustion, wake up three hours later and scream continuously for the next four hours. Continuously. For four hours. It felt like a bullet ripping through my brain. One day, in between these crying episodes, I wrote my desperation:

Colic is ruining our lives. I have held you in the colic posture. Still you cry. I have rocked you, sung to you, jiggled you, walked the floor with you, and drove you in the car. Still you cry. I have put you in your bouncy chair with the vibrating motor. Still you cry. I have given you the anti-acid medication, the enemas and the pain killer drops that the pediatrician prescribed. Still you cry. I have played the piano (once you slept), turned on your mobile and bought you a musical stuffed puppy. Still you cry. I have held you in my arms rocking you back and forth on my lap, looking out the window at the raindrops forming and falling off the balcony railing. Still you cry. There is no face-to-face play, no smiling and no cooing. You cry. I can't bear to see you in such distress. I wish I could take your pain onto myself. When I hold you close, I can feel the vibrations from your cries on my heart and the waves of sound piercing my ears. I imagine that this helps alleviate your discomfort. But still you cry. And yet, this is all that I can do -- to hold you and comfort you while you twist in pain. This is how we spend our days and nights.

I was exhausted, worried, frustrated, depressed and a million miles away from where I had started. I was sinking. I was alone in a foreign country where I could barely speak the language. There was no family. There were no neighbours. My husband was under pressure and working thirteen hours a day. There was no one to help. Any training, insight or clinical expertise I might have had was crushed under the weight of all this pain. I felt like a failure, both as a psychologist and as a mother.

After six unbearable weeks, the colic finally resolved. Help did not arrive from the hands of a paediatrician, a paediatric gastrointestinal specialist, nor a psychologist. It came from a friend who sent me a book she had read about a mother who discovered her baby had an allergy to dairy products. As it turns out, so did mine and when I stopped eating all dairy products, she stopped crying and began to smile once again. I could feel some semblance of myself returning. But it was a changed self. It was a self that had become intimate with hopelessness, with feeling inadequate, with doubting my clinical expertise, with questioning what it means to do research and study people's lives without really living them. If someone had been studying my transition to parenthood during those colic days, they would have seen a train wreck. If help had been available to me, I would not have wanted to talk about my past, to refute negative thoughts with positive ideas, nor learn effective coping strategies. I simply wanted someone to help me end my baby's pain and suffering. Failing that, I wanted someone to take her for three hours so I could sleep.

In the Buddhist philosophy, there is a belief that every event, even those deep dark tragic moments, is purposeful. Each day of our lives offers us an opportunity to learn. From those colic days, I learned about pain and how different types of pain manifest themselves. Colic howls. It is acute, intense and identifiable. It howls with such ferocity that it makes your ears throb and your hair stand on end. Depression is more oblique. It slithers and slinks in the shadows slowly infusing your entire being with a dark, sticky haze that distorts all of your senses. I learned about how desperate new babies and mothers can feel. I thought back to all of the mothers I had interviewed during my research and wondered how they had really felt during those early months. I wish I had asked them about the simple things like, 'how do you feel, are you getting enough sleep, are there people around to help'? I wish I had taken them for a walk in the park and offered them a cup of hot tea.

Days melted into weeks, which melted into months, which melted into years. Suddenly I was at the three-year-point where I had originally planned to resume my professional life. But then, my mother died after a two-year struggle against cancer. We returned to the States to be with her in those final days and then we said good-bye at her funeral. When we returned home, my daughter and I were both distraught. She was struggling to understand the concept of death and the impermanence of life. In my effort to explain it to her, I recalled a trip I had taken to Zermatt with my mother when I was pregnant. We had gone for a beautiful walk and rested together on a bench overlooking the Matterhorn. We watched the sun and clouds dance

in patterns of shadow and light across its face. The mountains appeared to link earth and heaven as they stood anchored to the ground and towering beyond the clouds. I remembered feeling like a link in humanity as I was seated there with my mother next to me and my daughter growing inside of me. I knew then that one day my mother would pass from this world, as would I. And still those mountains would stand as time moves over them like a wave, leaving only the most subtle impression of its passing. I told my mother then that the impression from my life that I would leave behind would be my child. I told my child now that the mark her grandmother left in this world was the life she gave to me and the life that I in turn have given to her. That as we celebrate our lives, we will keep her grandmother's spirit alive forever. And so, another year passed at home painting stones, taking walks in the mountains, buying fruit and vegetables from the local farmer's market, making fairy dollies, playing the piano and celebrating our lives.

The next time thoughts of my career resurfaced my daughter was entering kindergarten. With piercing clarity, I suddenly realized that not only was I a further distance from my point of departure than I ever could have imagined, but also, the path had become so convoluted that I could no longer see the way back. This filled me with great sadness and fear. I was now 45 years old and with no professional reference point. Motherhood had consumed my energy, my ambition and my old sense of self. Time had eaten away the crumbs of confidence I had left as a trail marker to find my way back. I felt completely lost.

And so, it was amidst this anxiety and insecurity that I made arrangements to attend the WAIMH conference in Paris, my first professional contact since leaving the field six years prior. The fact that it was in Paris was painfully symbolic for me. A decade ago, it was a conference in Paris that had launched my career. I had presented my dissertation research and met the people from England that I was eventually to work with. At that point in my life, everything was open, filled with promise and potential. It was an exhilarating way to culminate all those years of preparation and studying. Now, however, Paris represented everything I had once been and had lost. I dreaded walking into the room filled with all those confident, intelligent, successful people. I couldn't imagine how I used to be one of them and could not see how I would ever be able to retrace my steps.

First, there was the physical challenge of stretching my pre-baby trousers over my post-baby tummy. This was no small feat. The top button was under so much pressure it would have gone careening around the room like a maniacal champagne cork, had it given way. Then I had to face the awkward question of, "Where are you from?" (with the implication being that a university or clinical practice would be the forthcoming answer) as I walked into the main entrance of the conference hall. To which I meekly answered, "Well, actually I'm just a stay-at-home mom at the moment." Having only met this man moments earlier as we both searched for the entrance, I was surprised to have him question my response. "Pardon me" he offered, "if I'm being too forward, but why is it that all of the professional women I know who have chosen to stay at home to raise their children reply with, 'I'm just at stay-at-home mom', as if its something to be ashamed of?" I was speechless. It was only later alone in my hotel room that I reflected on this question. Why do we denigrate ourselves this way? It's as if once the professional identity is stripped away, we become the scrub women instead of the person we have always been simply doing the scrubbing. Somehow we automatically tap into the unspoken cultural belief system that mothers are somehow less important, less wise, and certainly less interesting than our dynamic, energetic, working, professional counterparts. I hadn't realized just how deeply I had fallen into this mind-set. Here I was embarrassed and ashamed of admitting that I was only a mother. Only a mother. Nothing else. Nothing special. Nobody really worth talking to. How had I been indoctrinated into this thinking?

Well, for one, the constant drumming of tired cries, temper tantrums, dirty diapers, wailing teething pain, spilled juice tragedies, and spin dry cycles on the washing machine does tend to blunt your mental alertness. Of course, it doesn't mean that you actually are a monosyllabic idiot; it's just that you feel that way sometimes after continuous nights of disrupted sleep, clinging sick toddlers and lack of social contact. But there is definitely a cultural side to it as well. For example, I've not yet had a single person at a dinner party ask me, "So, what made you decide to become a mother?" Or, "Tell me about your work." It isn't that there is any kind of overt disrespect when you say you are a stay-at-home mother, it's more that you are politely and silently dismissed from intellectual conversations. The bottom line is there is a deep-seated cultural stereotype of mothers that conjures up images of simple, plump dumplings. And the more people respond to you in this way, the more you start to see yourself this way.

The conference went well in the sense

that I felt the professional side of me that had been dormant these past few years come rushing back to life. It was like a hot spark dropped on brush crackling dry from years of drought. But an emergency back home meant that I had to leave the conference early. It wasn't anything drastic like a broken arm. It was only that my husband's work required him urgently to travel (to Paris, ironically) and so I had to return in order to look after our daughter. And there was a perfect encapsulation of my life. On the plane on the way home, I thought about the choice I made six years ago to exit my professional life and what it has meant to be a stay-at-home mother. In comparison, conducting academic research and writing scientific papers is far more glamorous than cleaning up vomit or changing a dirty diaper in the middle of the night, but it is the latter that is more enduring. Every loving stroke that passes between a parent and a young child is registered on their unconscious and they carry this core of love forward into every relationship they will ever develop. While contributing to world knowledge is captivating, it is every bit as important and meaningful to be contributing to world love.

But, where do I go from here? I certainly can't retrace my steps and pick up where I left off. Time chisels its passing onto your soul and you change with every strike. Time and experience have delivered us to this moment and we can only move forward, tugging our possessions, obsessions and lessons in tow. But where is the path forward? Each time I look at the six-year gap in my c.v., I feel inadequate and insecure about presenting myself professionally. The field has evolved considerably since I left and professional ladders being what they are, I don't know whether there are provisions for closing such gaps.

And yet, I can honestly say that I do not regret taking the path that has led me here. The magic and the beauty of watching a human being take form and develop into a sparkling, radiant, loving person is simply the most breathtaking spectacle I could ever imagine experiencing. I know it isn't a novel idea – ontogeny recapitulates progeny and all that – but to actually witness a seed develop into a thinking, walking, talking, living human being is like peering into the eyes of the divine -- into eternity backward and forward. I wouldn't trade that for all the accolades in the academic world.

I do, however, sometimes wonder if there might not have been a middle road that I could have taken. Was there a juncture that I missed that would have allowed me to travel in both directions? I don't believe so. At least not up to this point. Every paper that I might have written or every conference that I might have attended would have meant a smile, or a cry, or a discovery, or an accomplishment, or a cuddle that I would have missed. And conversely, being there for every lull-a-bye, every scraped knee, and every bowl of rice that has been hurled at the cat has been at the expense of personal and professional achievement. Choices require commitment and commitment necessitates sacrifice. For every left turn we take, there is a right turn that we don't. While it may be difficult to accept the loss of everything that might have been, it is this loss that gives us everything we do have. This is the burden and the gift of choice.

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I would like to express my gratitude to Robert Clyman, M.D. from the Kempe Children's Center, Denver Colorado for having the insight and courage to pose the question about motherhood which inspired this article.

After Yokohama 2008, then where?

It is time to make bids for World Congresses 2010 and 2012. If your affiliate is interested in hosting one of the these upcoming congresses, form a local conference committee and make a bid.

Bids should include the following:

- Chairpersons of the local conference committee
- List of members of the committee
- Hotel site
- Preliminary budget

Send your bid to:

Hiram E. Fitzgerald
Michigan State University
Kellogg Ctr, Garden Level
East Lansing, MI 48824-1022 or email
fitzger9@msu.edu

So what is colic?

By
Barry M. Lester

Barry earned his doctoral degree with me in 1973. Two years prior to that he packed up and went off to Guatemala to work at the Institute for Nutrition for Central America and Panama, and of course, I just had to go there to observe his research lab and his dissertation work on habituation to auditory signals in very young infants. His interest in infant crying had its origins in this work and it launched what has become an extraordinary career in infancy, developmental psychology, psychophysiology, and developmental and behavioral pediatrics. Barry is Director of the Infant Development Center at Women and Infants' Hospital in Providence, Rhode Island, and is Professor of Psychiatry and Human Behavior and Professor of Pediatrics at Brown Medical School. We have published 9 books together over the years and I am delighted that he agreed to provide this very appropriate response to Lisa's essay. HEF

"So What is Colic?" and "How many different cries does a baby have?" are the two questions I am most frequently asked. What parents really want to know is: What causes colic, and how is colic defined and diagnosed. How can I make it go away? Underlying all the questions is the biggie: Is it my fault? The answers are more complicated than you might think.

We still don't know what causes colic. There is no simple cure, no magic bullet, to make the baby stop crying. And despite many heroic attempts by pediatricians and researchers to downplay the condition, the suffering of colicky babies and their parents goes on daily. Colic makes professionals feel incompetent because they can't treat something that upsets families so much.

Despite what many well-meaning pediatricians tell their patients, colic is not a harmless condition. Our research–as well as plenty of others'–has shown that these babies are more likely to have difficult temperaments and to experience feeding and sleeping problems. Their cries and their heart rates are different. How the family functions can be impaired. Their parents perceive them as more vulnerable. They can go on to have behavior issues in preschool and problems later on in school with attention/hyperactivity, sensory integration, and emotional reactivity.

You don't have to know what causes colic to be able to recognize, define, or diagnose it. There is a traditional definition of colic called the Rule of Three that is probably the one pediatricians use most. Developed in 1954 by pediatrician Morris Wessel, it was based on the patients that he was seeing in his practice in New Haven, Connecticut. I don't like it much, but in all fairness, it has been around for a long time. Here it is: The Rule of Three says that colic exists when an otherwise normal, healthy baby cries for at least 3 hours a day for at least 3 days a week and has been doing this for at least 3 weeks.

One problem with this definition is that it equates colic with excessive crying, and it explains why the literature often uses phrases such as "colic or excessive crying." Normally developing babies increase the amount they cry over the first 6 weeks. About 20 percent of babies cry for 3 hours a day or more–and that has been fairly well established. Babies who cry 3 hours a day may not have colic but may simply be normal babies with difficult temperaments.

There may indeed be babies who cry excessively because of colic–but there is more to colic than excessive crying.

For many colicky babies there is a distinct colic episode. The baby has normal periods of crying during the day, but when he reaches a colicky phase, there is something different going on. Mothers say all the time: "This is not his normal crying, this is colic."...

Many babies with colic have additional symptoms that occur especially during this distinct colic episode. At the Colic Clinic, we group these symptoms into four areas....

The main source for the symptoms, behaviors, and characteristics on the checklist come from the parents I've seen at the clinic and from countless interviews, magazine articles, and desperate calls and e-mails to friends and family. The second source was the scientific literature. What I learned from the research studies was that not all babies show all characteristics and not all babies show the same characteristics. But most show some. The four characteristics are sudden onset, cry quality, physical signs, and inconsolability.

Let's take a closer look at the four characteristics: Sudden onset means that the colic episode seems to come out of the blue. One mother described it by saying, "It's as if my baby is possessed." Another term for this is paroxysmal onset, which suggests the sudden and episodic quality that sets it apart form regular crying. It is as if the baby is separated or insulated from the outside world. The episode takes on a life of its own. You get the feeling that this is something that is going to have to run its course. While you may be able to dampen it or ease it somewhat, you can't really stop it. What you have to do is ride it out and make the baby–and yourself–as comfortable as possible.
The second characteristic is the cry quality. The cry changes–not in the

same way for all babies, but for most babies there is a qualitative change in the cry during an episode. For many babies, the cry takes on the characteristics of pain cry. Mothers say that their babies sound as if they're in pain.

What mothers mean by this, and what acoustic analysis confirms, is that the cry comes on suddenly and reaches its peak intensity very quickly. We hear that intensity as loudness, a higher pitch, and more noise. In fact, some mothers say it is more like a scream than a cry. One mother said, "He is screaming at the top of his lungs."...

So what happens when your baby is screaming out of control? You want to help her. She is saying, "Mommy, Daddy, make it stop!" But you can't. And that can make you feel helpless and inadequate as a parent.

The third attribute, physical signs, is actually a group of characteristics that describe changes in the baby's body during a colic episode. The baby pulls his legs up into his chest. He gets doubled over, which is why mothers often say his stomach hurts and he looks and sounds as if he is in pain. His stomach gets hard and his leg and arm muscles get tight. (The technical term for this is hypertonia, which means increased tone, or tension, in the muscles.) His face gets red; there may be episodes of breath-holding. His fists clench–sometimes squeezed so tight that you can't open them. It is almost as if the baby is holding on for dear life. The color in the wrists and fingers can get red or white. Sometimes the arms and legs stiffen and stick out straight.

The fourth characteristic is inconsolability. It may sound silly after all this to say that a baby in a colic episode is inconsolable. But the reason we included it is to underline what I said before: You really can't stop this. You may be able to ease it somewhat, reduce some of the crying, perhaps reduce some of the intensity, and make the baby more comfortable. But you won't really be able to stop it. Inconsolability happens when a baby is in an insulated cry state. This means there's a wall between him and you so that you can't really reach him the way you can when his cry state is normal. You need to know, though, that this thing is going to run its course. If you accept that, it will be easier and less frustrating for you–and for the baby.

You can see that by equating colic with excessive crying we run the risk of calling colic "normal" and missing a lot of other cry characteristics that colicky babies have. If it's just about excessive crying, it's easy to conclude that there's nothing wrong with colicky babies. Babies can be excessive criers but be in a normal, not insulated, cry state. These babies do not show any of the true colic characteristics....

When does crying become a clinical concern? When is it a true syndrome? When is it colic? It has to do with how much the baby is crying, along with the additional symptoms–special episodes with sudden onset, changes in the cry, physical signs, and outright inconsolability. But there is still one critical ingredient missing, and it's this: The crying has resulted in some problem either in the infant or in the family. In other words, colic is not just the crying. It's the fact that the crying has caused a problem....

The way I define colic means thinking about it as a behavioral disorder. So if we regard colic as a behavior disorder, infants with excessive crying that causes clinically significant distress in the family or impairment in the infant would be said to have colic. On the other hand, a baby with excessive crying that causes no significant distress in the family or impairment in the infant would not be said to have colic.

Two criteria need to be met in order to diagnose colic: First, there is a significant complaint of a persistent pattern of crying that is more frequent and more severe than is typical for babies at this age. This can be a disturbance in the amount, frequency, or quality of crying. There may be excessive crying (Rule of Three) as well as symptoms such as sudden onset, high pitch, physical signs, and inconsolability. Second, there is clear evidence of impairment in other areas of function. This could mean that the behavior is affecting the baby's development or other behaviors, the two most common being sleeping or feeding. Or the behavior could be causing stress in the parents, affecting family function and the marital relationship. It could be affecting the parent-infant relationship. There may be attachment or bonding problems. The parents may feel inadequate, suffer loss of self-esteem, and feel ineffective as parents. They may feel angry and disappointed that their baby is acting this way....

Colic is not just in the eye of the beholder. It is not just a mother having a problem with normal crying. Colic is an identifiable cry problem in the infant that is causing some impairment either in the infant or in relationships in the family. Something in the baby is causing a problem for the baby or outside the baby. That's it. End of diagnosis. Beginning of treatment.

1. Excerpted with permission from: Lester, B. M. & O'Neill G., C. (2005). *Why is my baby crying?* New York, NY: HarperCollins Publishers.

The Development of the Parenting Alliance Over the Transition to Parenthood

By
Laurie Van Egeren

Laurie completed her doctoral degree in developmental psychology in 1999 with me, after having earned the master's degree in clinical psychology, also at Michigan State University. Her dissertation studied the development of the parenting partnership during the transition to parenthood. She continues to study issues related to co-parenting and both publishes as well as presents findings at World Congress meetings of the WAIMH. Currently, Laurie is Director of the Community Evaluation Research Center, located in the offices of Outreach and Engagement at Michigan State University. She is or has been principal investigator of teams evaluating state-wide programs involving 0-3 prevention efforts as well as after school community programs. In addition, she is working with Richard Solomon, a Zero to Three Fellow when he was a resident in pediatrics at Michigan State, on a statewide pilot study involving families with autistic children. Marshall Klaus and I served as mentors for Richard's fellowship years. HEF

Introduction

The transition to parenthood is a major milestone experienced by the majority of married couples. Conceptualized as a developmental stage, it encompasses a multiplicity of changes resulting from the entrance of a third individual into an established dyad. Spousal relationships must be renegotiated, familiar roles must be revised, and new roles must be taken on. The husband-wife dyad is characterized by the marital relationship; yet the new triad is characterized not only by the marital relationship, but also by each parent's individual relationship with the child and the new parenting partnership between the parents. Cohen and Weissman (1984) have termed this unique coparenting relationship as the parenting alliance. From their perspective, derived from family systems and psychoanalytic theory, the parenting alliance is a relationship between the parenting partners, different from but a component of the marital relationship. Four factors comprise the parenting alliance: (a) Investment in the child; (b) Esteem for the other parent's involvement with the child; (c) Respect for the judgments of the other parent; and (d) The desire to communicate regarding parenting issues. The primary purpose of the parenting alliance is to provide support and affirmation in the intensely stressful situation of parenthood.

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

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

Four questions will be addressed:

1) Is there evidence for the construct validity of the parenting partnership separate from the marital relationship?

2) How does the parenting alliance change over the initial months of parenthood?

3) What pre-birth characteristics predict the initial quality of the parenting alliance as well as individual patterns of change over time?

4) What is the interrelationship between the parenting alliance and other variables that may change over time, such as the marital relationship, parenting efficacy, and perception of the child's temperament?

Review of the Literature

This review of the literature first presents studies focusing on the parenting partnership, then identifies variables likely to predict the development of a new parenting alliance, factors that may affect change in the parenting alliance, and research on change in marital adjustment over the transition to parenthood that may be affected by the parenting alliance.

The Construct Validity of the Parenting Partnership

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

Measures of the parenting alliance have been shown to exhibit theoretically predicted associations with other parenting variables. For example, in a sample of parents with 4- to 6-year-old children, mothers and fathers who reported a positive parenting alliance were less likely to report high levels of parenting stress (Abidin & Brunner, 1995). They were also more likely to endorse a warm, authoritative parenting style; in contrast, marital satisfaction and parenting style were unrelated. Floyd and Zmich (1991) reported that a positive parenting alliance was related to greater parenting confidence and more positive parent-child interactions in parents of mentally retarded children and of typically developing children (ages 6-8).

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

A number of studies have demonstrated a relationship between an indirect measure of the parenting partnership (congruence between mothers and fathers beliefs, values, and attitudes) and marital quality. Parental disagreements about discipline have been shown to be related to lower marital satisfaction for parents of girls, but not boys (Stoneman et al., 1989), while congruent child-rearing philosophies when children were 3 ½ significantly discriminated between couples who were still married versus those who were divorced 10 years later (Block, Block, & Morrison, 1981). In addition, when mothers reported more frequent disagreements related to childrearing issues, they also reported more behavior problems in their three-year-old boys; in fact, the frequency of childrearing disagreements was a better predictor of behavior problems than marital adjustment (Jouriles et al., 1991). These studies suggest that factors such as child gender and compatible personality styles appear to play an important role in parents' ability to parent together effectively.

The parenting partnership appears to be particularly salient for fathers' relationships with their children. Abidin and Brunner (1995) found that for fathers, the parenting alliance was related to self-reported attachment to the child, while mothers' degree of attachment was independent of the parenting relationship. Furthermore, fathers', but not mothers', experiences of the parenting alliance were related to their child's adjustment across multiple raters (mothers, fathers, and teachers). Frank et al. (1991) demonstrated that fathers reporting a strong parenting alliance experienced greater stress when their child had frequently been ill, while fathers reporting a weaker alliance reported no relationship between stress and child illness, possibly due to less involvement and

investment in the child's well-being. The parenting alliance did not relate to mothers' experiences of stress and child illness. In a home observation study, the frequency with which husbands initiated discussion about their infants was not significantly related to mothering behaviors; however, the frequency with which wives talked about their infants was related to husbands' verbal and physical interactions and affection, both in the presence of their spouses and when alone with the child (Belsky, 1979). These findings also support the greater interrelationship for men than for women between parenting and spousal behaviors.

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

It appears that for men, more so than for women, a well-functioning parenting partnership is likely to be accompanied by a more positive parent-child and marital relationships. Furthermore, one study indicated that mothers', but not fathers', reports of a weaker parenting alliance were related to reports of fairly severe behavior problems in typically developing children, but not mentally retarded children (Floyd & Zmich, 1991). Therefore, while the parenting alliance appears especially important for fathers, it is by no means incidental for mothers.

The above review highlights a gap in the existing parenting partnership literature, in that no published research has addressed the relationship between the subjective experience of the parenting relationship and coparenting interactions. However, Laub (1990), in an unpublished master's thesis, found an association for mothers, but not for fathers, between self-reports of the parenting partnership and observations of the couple's problem-solving behaviors. Although the problem-solving discussion centered around a specific child discipline problem, problem-solving and conflict resolution are also an integral component of marital interactions. The researcher did not control for marital quality, so that the parenting relationship and marital relationship may have been confounded. One goal of this study is to examine the construct validity of the parenting alliance by assessing the subjective experience of the parenting alliance and global ratings of coparenting interactions, and looking at the distinction between the coparenting and the marital relationship. Confirmatory factor analysis using a multitrait-multimethod framework (Campbell & Fiske, 1969), with the parenting partnership and the marital relationship as traits and the mother report, father report, and observers ratings as methods, provides one way to assess the concurrent and discriminant validity of the parenting alliance. The transition to parenthood is a particularly fruitful period to study this interrelationship, as the new component of the couple's relationship is in the initial stages of negotiation.

Change in the Parenting Alliance. On average, the parenting alliance is likely to be fairly stable within each developmental stage that the child experiences, but may need renegotiation as the child moves between developmental stages (e.g., from infancy to toddlerhood, from school-age to adolescence) due to the different demands each stage places on parents. Certain factors, however, may contribute to the weakening of the parenting alliance in some families and the strengthening in others within a stage. Instability in the experience of the parenting alliance might be expected to be particularly apparent over the first few months after the infant's birth as the new mother and father engage in the process of negotiating their parenting partnership. Indirect support comes from the marital literature in a comparison of marital satisfaction assessed during pregnancy and at 1 and 6 months post-birth (Wallace & Gotlib, 1990). Results revealed that marital adjustment peaked at 1 month, followed by a steep decline by 6 months. This study suggests that an initial "honeymoon period" may occur immediately following the birth of the child, which may or may not be reflected in the parenting alliance. Growth curve modeling (Bryk & Raudenbush, 1992; Duncan, Duncan, & Hops, 1996; McArdle & Epstein, 1987; Raudenbush, Brennan, & Barnett, 1995; Rovine & Molenaar, 1996, in press; Willett & Sayer, 1994) provides a method of examining the trajectory of change in the parenting alliance over time. A within-person, or Level 1, model is comprised of two to three components: (a) an intercept, indicating the initial status of the parenting alliance at 1 month after the child's birth; (b) a slope, indicating the linear rate of change in the parenting alliance over time; and, if necessary, (c) a quadratic function that incorporates the rate of acceleration or deceleration in the change in parenting alliance. The parameters for the Level 1 model are estimated for each person separately and then used to derive an overall average growth curve. Since parenting may be a qualitatively different experience for men and women, it seems reasonable to estimate these parameters separately by gender, thus allowing the average growth trajectory to be plotted for each sex.

Although the Level 1 model will capture the average parenting alliance, it is likely that individual differences will contribute to substantial variation in the initial status, rate, and perhaps direction of change over the first 6 months. The growth curve approach allows individual differences to be

evaluated in two ways: (a) Level 1 predictors are within-person variables that may also change over time and interact with the parenting alliance (e.g., the marital relationship); and (b) Level 2 predictors are between-person variables that do not change meaningfully over the study time (e.g., age, SES). In the Level 2 model, the intercept, slope, and quadratic parameters estimated in the Level 1 model each become the outcomes in separate equations, and the Level 2 predictors are used to estimate new parameters that might predict these outcomes. This enables us to investigate individual differences in the initial status of the parenting alliance, as well as individual differences in the rate and speed of change. The following section reviews variables that are hypothesized to be meaningful predictors of the development of the parenting alliance.

Potential Predictors of the Parenting Alliance

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

Individual parent characteristics. One determinant of parenting suggested through this model is the psychological resources of the individual parent. For example, mothers' adaptation, competence, and capacity for positive relationships reported before the birth of their child related to their perception of general family adjustment and to their responsiveness to the infant (Heinicke, Diskin, Ramsey-Klee, & Given, 1983; Heinicke & Guthrie, 1992), and their capacity for impulse control related to less decline in marital adjustment as they became parents (Levy-Shiff, 1994). These studies suggest that ego development, a construct discussed by Loevinger (1976; & Wessler, 1970) that encompasses the individual's perspective of the self and world and includes cognitive complexity, impulse control, and interpersonal differentiation, may contribute to the development of a successful parenting alliance. Couples functioning at higher levels of ego development presumably have a greater likelihood of tolerating and working through differences in each spouse's individual parenting decisions. In the growth curve context, ego development is considered a Level 2, or between-person, variable.

A second individual characteristic that may predict the development of the parenting alliance is the degree to which the parent has internally incorporated the idea of being a parent. Mebert (1991) conceptualizes the transition to parenthood as a process that, for some couples, begins not upon the delivery of the child, but much earlier, perhaps even prior to the child's conception. Parents who have planned their pregnancy or have strong cultural codes about childrearing roles may have an "internal working model," or a set of expectations that provides a framework for parenting. Parents in this mode (which Mebert terms "assimilation") are likely to have discussed and problem-solved about many of the potentially conflictual issues that parents who are less cognitively prepared (the "accommodation" mode) may find surprising and stressful. Operationalizing the assimilation mode as a high degree of motivation for parenthood, Mebert (1991) found support for her hypothesis as more highly assimilated women had fairly stable perceptions of their marital quality over the period before and after the baby's birth, and that their pre-birth expectations of their infant's temperament were highly correlated with their post-birth perceptions. In contrast, women who were less assimilated had much less stable perceptions of the marriage and the child's difficulty. It appears that women who have assimilated the parental role may have an "internal working model" or set of preconceived notions that contribute to an experience of continuity over the transition to parenthood. Interestingly, the pattern of correlations was not particularly different for more assimilated versus less assimilated husbands and were generally lower than for mothers, suggesting that the process of becoming a parent may have less of a psychological impact on fathers than mothers. Thus, a Level 2 individual variable that may influence the development of the parenting partnership is the degree of assimilation of the parental role by the partners.

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

degree of negative change in their own marriages. Similarly, men and women who described the family of origin as more healthy reported better marital adjustment than those who rated the family of origin in a negative manner (Lane, Wilcoxon, & Cecil, 1988). These findings about the effect of the perceived family of origin on the marital relationship can be extended to the development of the parenting partnership. Individuals who have had the opportunity to observe a competent parenting partnership may have a more functional framework with which to foster their own parenting alliance.

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

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

Contextual characteristics. A second determinant of parenting proposed is contextual characteristics, which I suggest may be divided into demographic factors (e.g., age, sex, educational level) and relational factors (i.e., variables related to the couple's systemic relationship into which the child enters). Demographic contextual variables that have been shown to relate to marital satisfaction and/or more positive parenting are older parental age, longer duration of marriage, and higher socioeconomic status (Maccoby, 1984; Moss, Bolland, Foxman, & Owen, 1986; Wright et al., 1986). Since these Level 2 variables are likely to relate to more conceptually interesting variables in the study, they will be included in order to control for their effects.

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

The transition to parenthood appears to be a landmark in the development of the couple's spousal relationship. Both self-reports and observations of marital adjustment reveal consistent small but significant declines over the transition to parenthood, particularly for wives (e.g., Belsky, Lang, & Rovine, 1985; Belsky & Rovine, 1990; Belsky, Spanier, & Rovine, 1983; Levy-Shiff, 1994; Miller & Sollie, 1980; Waldron & Routh, 1981). However, investigations of patterns of marital relationships over time reveal that while some marriages do indeed grow worse after the child's birth, many maintain the status quo and

others actually improve in systematic ways (Lewis, 1988; Belsky & Rovine, 1990). The parenting alliance may, therefore, function as a buffer to minimize or even reverse the post-birth decline in marital adjustment.

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

Actual involvement in tasks appears to be a less salient predictor of declining marital quality than either satisfaction with or violated expectations about involvement. For example, individuals (especially wives) whose post-birth experiences in a variety of domains were more negative than expected reported a greater decline in marital quality and poorer adjustment to parenthood (Belsky, 1985; Kach & McGhee, 1982). Furthermore, different relations are revealed depending on whether the division of labor pertains to childcare or household chores. Cowan and Cowan (1988) found that men who are satisfied with the household division of labor report higher levels of marital satisfaction, while men who are more satisfied with the childcare division of labor experience less parenting stress. Similarly, among women, violated expectations around the division of housework were associated with feeling less close to their husbands, but violated expectations around the division of childcare did not affect their perceptions of their spousal relationship (Ruble, Fleming, Hackel, & Stangor, 1988). These authors suggest that childcare may be more intrinsically rewarding than household tasks; thus, despite the fact that more time was spent in childcare than expected, it did not elicit the resentment that assuming an unexpected proportion of housework might. Since the division of labor changes over at least the first 2 years after the child's birth (Cowan & Cowan, 1988), assessment of violated expectations at a single timepoint would be misleading. Therefore, violated expectations around childcare and housework are designated Level 1 (time-varying) variables. These variables are especially likely to relate to the association between the parenting alliance and change in the marital relationship.
Child characteristics. A third determinant of parenting, according to Belsky (1984), is attributes related to the child. First, the literature is inconclusive regarding the effect of the child's gender on the parenting partnership. In the few studies of coparenting, most have either not addressed child gender or have examined only one sex. However, in a study of the subjective experience of the parenting alliance, Floyd & Zmich (1991) found no association with the sex of the child. Alternatively, McHale (1995) discovered differential patterns of coparenting relationships according to child gender and marital distress. Child gender will, therefore, comprise a Level 2 variable.

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

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WAIMH *Affiliate News*

League of Affiliates: An Update from the USA

By
Deborah J. Weatherston, Ph. D.

What follows is a summary of some of the activity that has taken place in recent months in the USA through WAIMH affiliates and in partnership with state agencies and organizations. The activity is centered on the use of a standard set of infant mental health competencies and a systematic plan for endorsement at 4-levels in the infant and family field. The competencies and endorsement were developed over 10 years time by members of the Michigan Association for Infant Mental Health (MI-AIMH). MI-AIMH is eager to share its work with others within the infant and family community. The purchase of a license to use the competencies and the endorsement materials by a state enables each state to build their own system for professional development, using the MI-AIMH competencies and process as cornerstones. The work is complex, but as Sally Provence and Emily Fenichel reminded us, we need to "embrace complexity." As Sonya Bemporad reminded us, too, "Babies can't wait." Those of us in WAIMH affiliates seem to be taking these wise words seriously.

Michigan AIMH

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MIAIMH is enormously proud of its 10-year effort to develop competencies and a systematic endorsement promoting infant mental health. We are equally proud of our partnerships with other infant and family professionals across many states. As our relationships with other affiliates have increased, we have grown more confident that the shared work on the core competencies and also the 4-level plan for endorsement is "on target."

Updates include a policy directive for early childhood mental health consultants working for the Michigan Department of Community Health with funding from the Department of Human Services. Each consultant is expected to earn the MIAIMH Endorsement, minimum level 2, by September, 2007. Of significance, the department has included reflective supervision for all consultants as a critical cornerstone to assure quality services across all participating sites. A second policy directive from a large community mental health agency links IMH training, reflective supervision, training in reflective practice for supervisors and endorsement to contract awards for provision of IMH services in Wayne County. Our annual conference (May 6-8, 2007) reflects the core competencies throughout each plenary and workshop session. An 8 day training in reflective practice, initiated in January and continuing every 3-4 weeks through June, was also designed with the core competencies in mind. The MI-AIMH Board made a financial commitment to establish opportunities for reflective supervision/consultation in each chapter across the state in the coming year. We are slowly re-shaping the way we work with infants, toddlers and families through competency-based training and endorsement.

MIAIMH submitted a letter of intent to the Harris Fund on behalf of many state partners interested in a National Institute in Reflective Supervision and Consultation. There is an immediate need in all of our states for training and continuing support as we expand our capacity to provide reflective supervision to the infant and family work force. We will also submit a letter to the Mailman Family Foundation.

ZERO TO THREE staff are aware of and supportive of our state wide efforts regarding use of the competencies and the endorsement plan and an institute in reflective supervision.

Texas AIMH

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After completing the application process, preparing portfolio materials and successfully passing the endorsement exam, 10 members have earned endorsement in Texas. Several of these

will form the test review committee for TAIMH and oversee the endorsement for the next cohort of applicants.

A core group of 25 members continue reflective group meetings under the leadership of Bill Schafer, clinical psychologist from Michigan. The group is meeting for its 4th year.
TAIMH received a significant donation in February, 2007 of $300,000.00 from generous donors/board members. This donation will enable TAIMH to establish a significant presence in the infant and family community, to support the executive office and to market the endorsement. A celebration honoring the donors will take place in March. Their successful campaign slogan "Babies can't wait..." coupled with their succinct PR materials: "TAIMH educates and advocates for those too young to have a voice" and three words: educate, advocate and endorse.

Barbara Moss has very successfully initiated and encouraged the development of IMH trainings and reflective supervision groups that are directly related to the competencies and endorsement. She and her colleagues are seeking university/hospital partners to establish a training center and to apply for funding to sustain the center.

New Mexico AIMH

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New Mexico has made very significant strides toward systems change using the competencies as the centerpiece. Leaders across systems and disciplines agreed that training was a crucial component of their beautifully produced strategic plan. Deb Harris and colleagues sought and successfully received funding for a competency-based, two-year infant mental health training and reflective supervision plan for a core group of 25 professionals in New Mexico. The training got under way late in 2006 and involves participants from regions all over the state and emphasizes cultural diversity as integral to successful infant mental health. The training format varies, including one and two day training meetings, week-end meetings, summer institutes, weekly reflective supervision and monthly reflective group supervision groups. Some of the supervision is provided face to face; some is provided over the phone or "at a distance." The faculty and clinical supervisors are committed to high quality experiences, over time, developing a group of infant and family professionals who will qualify for endorsement at levels 3 or 4 and promote infant mental health. It is a very strong training model for other states to use as a model for competency-based professional development. Commitment to reflective supervision is a hallmark for the leadership who have worked with Mary Claire Heffron (California) as their clinical consultant for many years.

The NMAIMH Board voted in December, 2006 to purchase the full endorsement from MIAIMH, moving in one year from a license to use the competencies to a license using the whole MIAIMH plan to build capacity in their state. Four (4) NMAIMH Board members will apply for endorsement through MIAIMH in March, 2007. They will submit portfolio materials and take the MIAIMH exam and are identified as the leadership core for the endorsement in New Mexico. They will in turn help others in their state through the application process, learn the procedure for test review and become the Endorsement Review team for NMAIMH. This process makes sense and is one that will be replicated in other states.

Oklahoma AIMH

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OKAIMH purchased a license to use the competencies and endorsement in September, 2006. Karen's leadership skills are evident in her ability to gather stakeholders into the process, Smart Start, Center for the Study of Social Policy, an early childhood consultation initiative, universities, Department of Human Services, to name a few. Office space will be provided for the association by the Sarkis Foundation for a year or so while the association seeks more permanent headquarters. The Commission on Youth is contributing a computer for the office. Smart Start will cover the funding for the purchase of endorsement material.

The Arizona affiliate generously shared its action plan which Karen used successfully as a template for work in Oklahoma. She has a strong, active endorsement committee that is committed to getting the endorsement rolling. A core group will earn endorsement in 2007, following the model established by Texas and New Mexico.

Reflective supervision/consultation remains a challenge in Oklahoma. As a consequence, the board invited 25 infant and family professionals, leaders in the community, to meet intensively several times a year for reflective supervision under the leadership of Bill Schafer, clinical psychologist. This group process should help to more firmly establish a core group of professionals who promote infant mental health to work with others in the community.

OKAIMH will emphasize "infant and early childhood mental health" in all presentations, believing that the phrase

ties them to the "roots" of the field and also the field of education. Early childhood mental health consultation is a new initiative that offers opportunity for training/consultation leading to endorsement in the infant mental health field.

Infant Toddler Mental Health Coalition Association - Arizona

Robert Weigand, President ITMHCA Arizona, Robert.weigand@asu.edu

ITMHCA Arizona Board voted in January, 2007 to purchase a license to use the MIAIMH (and affiliate) competencies and endorsement. MI-AIMH will provide a two-day training in the Spring and welcomes this strong southwest affiliate into the "league."

Bob Weigand just announced that a new child and family master's program was approved at Arizona State University, preparing infant and family professionals to promote infant mental health and, upon completing the program, meet many of the qualifications for endorsement in their state. The new program reflects the competencies that are core standards for infant mental health practice. Bob and board members are to be congratulated on birthing both the endorsement and the new program in the same month.

The Arizona affiliate has again invited state partners interested in the competencies and the endorsement to their annual conference which will be held September 27-28, 2007. Many of us involved in the endorsement met at the Arizona conference last year and valued the gathering so much that Bob thought we should gather again. This invitation will allow us to do that, to share what we are each doing, and to learn from one another as the competency-based system for professional development grows. We are quickly learning that there is strength in numbers and wisdom in greater collaboration.

The Arizona affiliate has nurtured the development of reflective practice for many years through Southwest Human Development and Healthy Families Arizona, to name two important partners. In addition, Bill Schafer has worked with a core group of professionals related to IMH and personal growth. As a result, there is a ready group who will qualify for endorsement at levels 2,3 & 4 once the system is under way there.

Arizona has been generous in making its Action Plan available to others who might welcome a template for organizing their plan to move competency-based professional development forward.

Minnesota Infant and Early Childhood Association

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The Minnesota Association is the most recent addition to the group. State leaders sought and secured funding from the Bush Foundation to establish an infant and early childhood mental health association under the umbrella of the Minnesota Association for Children's Mental Health, to convene a national roundtable discussion about competencies, and to institute a professional development plan for endorsement. The leaders convened a national roundtable discussion in St. Paul that took place February 13-14, 2007. It was an extraordinary opportunity to reflect on the competencies, their meaning in different states and barriers or challenges to the process. Participation was lively as we exchanged ideas and learned from one another the value of having standards around which to build training and capacity. The Minnesota stakeholders listened thoughtfully and concluded that the adoption of the MIAIMH competencies, now shared by other state entities, would promote best practice and the growth of infant mental health in their state. Contributions from states not currently embracing the Michigan system enriched the discussion, e.g. Florida's competencies developed for mental health practitioners in their state. We celebrated the work that had been done and left refueled by our exchanges with one another.

With the announcement of an infant and early childhood mental health association and agreement to pursue the MIAIMH competencies, Marti Erickson and Christopher Watson announced the "birth" of a new certificate program in infant mental health that will begin at the University of Minnesota through the Harris Programs in the fall of 2007. This certificate program is linked to the competencies and plan for endorsement of professionals at multiple levels.

In sum, we have made a lot of progress in 3 months and look forward to continuing to help one another in building capacity promoting infant mental health in each of our states.

With warm regards,

Debbie Weatherston, Executive Director, MI-AIMH

Postgraduate and Continuing Training Standards 2005
German-Speaking Association for Infant Mental Health (GAIMH)

Issued by
The German-Speaking Association for Infant Mental Health (GAIMH)

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Introductory remarks to "GAIMH-postgraduate and continuing training standards"

GAIMH, the German-speaking affiliate of the WAIMH, was founded in 1996 by a group of prominent figures working in the field of early childhood. At present it has approximately 600 from three countries—Germany, Austria and Switzerland. Each of these countries has different legal requirements for the professions, different approaches to care-giving and early childhood education, and each has developed various public and private institutions for early intervention. In addition to this, the GAIMH comprises various specialized fields at different hierarchic levels.

Initially, the GAIMH attracted interest primarily because of the prominence of some of its early members. Subsequent discussions of new understandings of early childhood, which all professions attempted to implement in their own field, triggered a process of clarification and a new phase of development within the organization. The first project groups to work on training standards were unsuccessful because of concerns that the individual fields of study would clash and that as a result the society would fall apart.

A breakthrough was achieved when a clear country-specific legal framework for psychotherapy was defined, distinguishing psychotherapy and counseling as separate professional fields. In the course of the initial discussions within the GAIMH it became clear that a third group exists, which does not fit into either of these two fields. This group includes specialists who work with infants and toddlers on an everyday basis away from problem-situations, or who are entrusted with preventive/salutogenetic approaches. We have defined this field as guidance of parents and small children.

This initial structure enabled us to form a project group made up of representatives from guidance, counseling, and psychotherapy. Over a 2-year process this group succeeded in formulating a self definition, minimal standards for postgraduate and continuing training in the respective fields, as well as points of intersection and points of common focus affecting all fields. These findings are laid out here in an English translation, for which we received financial support from the WAIMH.

The GAIMH postgraduate and continuing training standards have had a positive effect on the stability of and internal communication within our affiliate. Particularly significant was the decision not to apply the standards as a certification instrument for GAIMH members, but to recommend them as a point of reference for individual training monitoring, and for establishing appropriate curricula. Communication between specialized fields has become more intensive as a result of this greater transparency and through increased mutual recognition. Further projects have already benefited from this clarification.

Although we are aware that other WAIMH affiliates have a different membership structure from that of the GAIMH, we would be very interested in receiving feedback and comments, and to share experiences with societies that find themselves confronted with similar issues.

Fernanda Pedrina, PD Dr. med.
Child and adolescent psychiatrist, psychoanalyst
Swiss President of the GAIMH, project leader for the postgraduate and continuing training standards project

PREAMBLE:

"Postgraduate and continuing training standards for GUIDANCE, COUNSELING, and PSYCHOTHERAPY for children from 0-3 years with their parents and other caregivers"

1. Tasks and aims of the GAIMH

The GAIMH, founded in 1996, is an association of infant mental health professionals from Germany, Austria and Switzerland. It is an interdisciplinary affiliate of the World Association for Infant Mental Health (WAIMH). In accordance with its statutes its tasks include the following:
Promotion and development of postgraduate and continuing training programs for all professional groups concerned with pregnancy, infancy, and early childhood.
Enhancing awareness and understanding of the significance of pregnancy and early childhood for psychic development, the risks involved, and the needs of young parents, as well

as enhancing the appreciation of the maternal and paternal roles in early child child-rearing.
Support and coordination of all efforts to improve basic conditions for the mental health of parents, families, and other caregivers as a prerequisite for unimpaired emotional development during pregnancy and infancy.

2. Standards for postgraduate and continuing training programs

The following recommendations were drawn up between 2002 and 2005 by an interdisciplinary project committee of the GAIMH. They define standards for postgraduate training and training programs that qualify persons to work with children between the ages of 0 and 3, their mothers, fathers and other caregivers. As a contribution to quality assurance they provide guidelines for:

- the development of relevant curricula,
- the evaluation and recognition of existing postgraduate and continuing training programs,
- the postgraduate and continuing training of staff in related institutions,
- policy-makers from institutions involved with the health, education, and welfare system in order to monitor the array of programs offered in the field of early childhood.

These standards were developed consistent with the latest scientific findings and practical experience. They presume that these findings and experiences are of great significance for the appropriate professional conduct of anyone working in the field of early childhood. Their timely, goal-oriented, and consistent use in the course of guidance, counseling and psychotherapy helps to prevent later developmental and relational problems. Subsequent interventions in cases in which problems are already chronic are generally more time-consuming and costly.

3. Age-dependent features

The individual development of an infant or toddler takes place within the context of the mutual mother-child, father-child and/or caregiver-child relationships. For this reason it can only be understood and supported in the context of the development of these relationships.
The developmental processes of early childhood are characterized by the dynamic processes of maturation, adaptation, and learning as well as the resultant rapid change, great variability, and daily crisis. The related behavior patterns and ways of experiencing people and things are dependent on the respective developmental phase. The transitions from normative crises to subjective burdens to clinically relevant disorders are fluid.

4. Definition of postgraduate and continuing training

Postgraduate training is defined as a higher or additional qualification based on professional education and several years of work experience. Postgraduate training programs are intended to mesh with professional occupations, and to prepare the participants to take on special functions or positions by expanding and enhancing specific competencies.

Continuing training comprises teaching and learning processes based on a particular profession with its own theories and practical skills. The goal is to reflect upon, deepen, renew, and expand professional competencies (knowledge, abilities, skills, behavior patterns) in this specific profession.

5. Types of early intervention

Services for infants and toddlers between zero and three years of age, their mothers, fathers and other caregivers are available in the fields of guidance, counseling, and psychotherapy. They can also begin during pregnancy and around the time of birth. Depending on the family background and target group, they can have an educational, psychological, medical, or social emphasis.
Significant similarities emerge in the three areas out of the particularities of early childhood, and for this reason it is neither possible nor sensible to draw strict boundaries between them. The basic underlying principle of guidance, counseling, and psychotherapy is a respectful attitude toward the children, their mothers, fathers, and other caregivers in the context of their personal circumstances.

Guidance, counseling, and psychotherapy must consider in equal measure the dependence of the child's behavior and experiences on his/her stage of development and on the relationship and situation that pertains. The transitions from short-term stress and crisis to problems and manifest disorders must be considered within the respective concepts, as should the fluid transitions between prevention and intervention.

The following formulation of curricular standards for the three fields takes into consideration the fact that it should be possible to distinguish the tasks and participants of guidance, counseling, and psychotherapy on the basis of their fundamental focus and training.

The respective social, educational, health, and family laws in Austria, Germany, and Switzerland, as well as the necessity of providing for individual services for families, can also result in country-specific differences in the three fields.

Postgraduate and continuing training standards for GUIDANCE for children from 0 to 3 years with their parents and other caregivers

1. Definition:
Guidance is available to all moth-

ers, fathers, and children in the form of services from pregnancy until the child is three years old. It is voluntary, easily accessible, and geared to coping with daily life.

Guidance helps to promote the successful development of child, mother, father, family, and other responsible caregivers, even if there is no predefined problem.
Guidance is carried out on the basis of an attentive relationship between guidance expert and mother, father, and child within a specific program, either in an individual or a group setting. Depending on the situation, guidance makes use of various resources and methods and incorporates different services.

It has a preventative function by providing useful information, activating existing resources, making use of existing networks, and creating new ones.

Initial remarks
Guidance is carried out in four fields of activity:
1. *Surrounding the birth*: A range of programs available before during, and after the birth, e.g., pregnancy guidance, birth preparation, birth guidance, puerperal care, breast feeding advice, pre- and postnatal gymnastics.

2. *Family Guidance*: Programs geared to handling everyday situations, the education of mother, father, and child; their personal development; and the development of the family as a relationship system. e.g., courses in parental education; group activities for mothers/fathers with infant/toddler, mother-father-child gymnastics.

3. *Family Support*: Childcare services where the primary caregiver is not present, e.g., playgroups, babysitters, foster families, day nurseries, day-care homes and centers, kindergarten, nurseries.

4. *Educationally relevant problem situations,* e.g., occupational therapy or remedial teaching for children with manifest developmental disorders, speech therapy.

The GAIMH welcomes the appropriate incorporation of the principles of the standards for postgraduate and continuing training programs described below into basic training for diverse professional groups working in these fields of activity.

2. Eligibility requirements
The eligibility requirements differ according to the target group:
- Age limit 21 and over
- Medical, psychological, educational, or basic social training
- Practical experience in working with children aged 0 to 3, or proof of internship or practicum
- Affiliation with a recognized institution
- Candidates coming from another field (with no specialized basic training) require specific psychological/ educational/social entrance modules accompanied by practicum.

3. Theoretical content of postgraduate and continuing training

Because various professional groups with different basic training and priorities come together in the four named fields of activity, it is important to adapt contents and methodology to their respective educational needs, and to develop the curriculum with the respective target group in mind. The following contents or parts thereof should be incorporated into the postgraduate or continuing training curriculum, depending on the prerequisites.

3.1. With reference to the child

- Knowledge of the child's development—physical, emotional, mental development—before, during, and after birth
- Knowledge of the learning prerequisites and factors in early childhood
- Knowledge of the child's competencies
- Ability to interact and communicate
- Interrelation between neurobiological developmental processes and experiences of early relationships
- Development of attachment and sense of self (experience of contingency)
- Attachment behavior
- Exploration, quest for autonomy, experience of self as an agent
- Initiating contact with others
- Process of self-development
- Sensory integration
- Eating, sleeping, self regulation

3.2. With reference to the caregivers

- Demands arising from the birth, transition to parenthood
- Mother/father competencies
- Sensitivity
- Interaction, communication, and handling of conflicts
- Attachment and relationship development
- Handling of the crises typical of early childhood
- Handling of rules and boundaries
- Creating an environment that permits self-determined development and education.
- Handling of "co-educators" (incl. the media)
- Support of social networks for families

3.3. With reference to basic theoretical principles

- Relationship systems from various points of view (from the child's, mother's, father's, "guidance expert's" perspective)
- Basic knowledge of family development
- Dealing with research/theoretical concepts such as attachment theory (e.g., Ainsworth, Ahnert, Bowlby, Grossmann, Main et al.), developmental theories and models (e.g., Dornes, Keller, Stern), adult education (e.g.,

theme-centered interaction, Cohn), concept of sensitivity (Ainsworth), fit concept (e.g., Chess & Thomas, Largo), intuitive parenting (Papoušek), dialogue management (e.g., Rogers), pre- and perinatal psychology (e.g., Janus), salutogenesis (Antonovsky), temperament (e.g., Chess & Thomas, Zentner)

- Dealing with user-oriented educational concepts such as those of Marte Meo, Montessori, Pikler, Reggio, and Waldorf education
- Dealing with educational concepts for group/course programs in early childhood; groups for mothers/fathers with their child (e.g., PEKiP) and group sessions/courses for mothers/fathers without the child
- Group leadership
- Basic knowledge of learning theory for adults
- Basic knowledge of programs relating to early childhood (guidance, counseling, psychotherapy).

4. Practical content of postgraduate and continuing training

In postgraduate and continuing training programs, theoretical content is combined with practical application and its consequences.

- Recognition of and appropriate response to a child's requirements and signals
- Recognition of and appropriate response to the mother's/father's requirements and signals.
- Learning methods for group sessions with infants, toddlers, mothers/fathers
- Familiarization with diverse fields of activity in early childhood.
- Regular supervision of practicum (if possible incorporating videotaping) in terms of self-experience and self-reflection.

5. Scope and duration

The scope and duration of postgraduate and continuing training programs depend on the educational needs of the target groups. Postgraduate and continuing training programs comprise multiple sections with an interval of time between each section for self-reflection, which give participants a chance to gain experience by using the acquired knowledge in practical situations.

6. Requirements for persons offering postgraduate and continuing training

Teaching must be organized using recognized, tried and tested methods of adult education. The instructor must have relevant practical experience with children, mothers, and fathers in the field of early childhood.

Members of GAIMH's project group postgraduate and continuing training standards for guidance

Sabine Hoeck, Munich
Pediatrician, psychotherapist, Castillo Morales teaching therapist; Early Intervention Center Bavaria and Children's Hospital Munich Harlaching

Thomas Mix, Würzburg
Dipl. psychologist, psychotherapist; Early Intervention Center Würzburg

Dores Beckord-Datterl, Salzburg
Clinical and health psychologist, psychotherapist, adult education instructor; Parent counseling for the province of Salzburg; supervision of toddler teachers in the day nursery, and of parent-child group leaders

Margrit Hungerbühler-Räber, Basel
Educational consultant, child therapist, practicum supervision, project work; at present co-director of F-NETZ, northwestern Switzerland; continuing education and public relations work in the field of early childhood

Kathrin Keller-Schuhmacher, Basel
Chemist, psychologist, adult education instructor; longstanding experience in group work with mother/father/infant/toddler; and in education in the field of early childhood; project leader prevention/health promotion in early childhood in Basel Land; at present co-director of F-NETZ, northwestern Switzerland

Christine Kügerl, Landskron
Dipl. marriage, family and life consultant DGKS, parent education, birth preparation, parent-child counseling for children from 0 to 6 years of age; parent education in early childhood at the Institute for Family Counseling and Psychotherapy of the Kärnten Caritas Association, teaching parent-child group leaders and marriage, family and life counselors

Yvonne Mellin, Sinsheim
Educator M.A., PEKiP-group leader, infant and toddler counseling; continuing training and practicum supervision in early childhood, project leader "Balanced Family"—a service for parents in transition from pregnancy to birth to the child's first years; psychological counseling services of the Evangelical church district of Kraichgau

Lena Neuburger, Berlin
Dipl. educator, parent education course instructor, training to be a child and adolescent psychotherapist, course instructor for starting a family in the Federal Association of the German Red Cross, Berlin

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Postgraduate training standards for COUNSELING for children from 0 to 3 years of age with their parents and other caregivers

1. Definition

Counseling is a process of mutual exploration of possible solutions to promote development and relationships when stress, problems and crises affect families with children aged 0-3 and their external systems of childcare. Counseling empowers the recipient to utilize existing resources within an acceptable time frame to support the child's subsequent stages of development. It is based on the latest scientific findings and is case-, solution-, and resource-oriented. Counseling offers a relationship opportunity without making this the focus of the counseling session.

Initial remarks

The GAIMH welcomes the appropriate incorporation of the principles of the postgraduate training standards described below into the basic training

for various professional groups working in these fields of activity.

Eligibility requirements
• Completion of professional training (technical college, college of higher education, or university education in a psychosocial or medical field)
• Access to infants and toddlers and their families in a counseling context
• Counseling competencies

3. Theoretical postgraduate training

Developmental psychology of early childhood

• Development tasks of early childhood
• Preverbal communication and early speech development
• Individual variability
• Development of attachments and relationships
• Pregnancy and transition to parenthood
• Parental relationship and child-rearing competencies
• Age-dependent conflicts and crises
• Biological and social parameters
• Transition to supplementary forms of childcare
•Risk and protective factors in child development
•The child's well-being and parental child-rearing capacities

Children in special situations:

• Children with adaptation disorders
• Children with regulation disorders (crying, sleeping and eating disorders, disorders of affective and behavioral regulation)
• Children who were born prematurely
• Handicapped children
• Children with chronic illnesses, during and after hospitalization and surgery
• Children at risk of or affected by neglect and abuse
•Children in foster care and adoptive families

Families in special situations

• Juvenile mothers and fathers
• Immigrant families
• Single parents
• Poor families
• Mentally ill mothers and fathers
• Substance-dependent mothers and fathers

Separation and transition to child care forms that replace the family

Legal and institutional principles of the counseling assignment

4. Practical postgraduate training

Diagnostic procedures

• Video-assisted behavioral observation
• Solution and resource oriented interpretation of behavioral observation
• Orientational developmental assessment
• Communication and relationship diagnostics
• Identification of age-dependent disorder patterns
• Identification of early warning signs of impending or current emotional and physical neglect and abuse
• Detection of mental health problems of family members
• Risk assessment of the child's well-being
• Assessment of child-rearing capacity
• Recognition of indications for multimodal interventions or psychotherapy and referral to other support services

Counseling competencies

• Self-perception and how one is perceived by others
• Development and relationship oriented parent counseling in individual and group settings, especially in the child's presence as well as in multigenerational settings
• Incorporation of video taping
• Counseling methods and materials
• Cooperation and communication with other support services

Methodology of practical postgraduate training

• Hands on teaching of theory
• Observation training
• Self-experience and self reflection
• Documentation of three completed and supervised counseling cases incorporating video taping and evaluation (one in the 1st, 2nd and 3rd year respectively)
• Case supervision
• Intervision

5. Scope and duration

• Modular approach
• 1-2 years, comprising around 150 hours

6. Requirements of persons offering postgraduate training

• Several years of professional experience in fields of work relating to early childhood
• Counseling and/or psychotherapy qualifications
• Knowledge of recent specialist literature and research findings
• Experience in adult education

Members of the project group postgraduate training standards for counseling

Mauri Fries, Borsdorf/Leipzig (project group leader)
Dipl. psychologist, child and adolescent psychotherapist; postgraduate training for specialized staff in youth welfare services and early intervention, counseling for parents with babies and toddlers, case supervision in establishments for babies, toddlers and their parents

Mechthild Papoušek, Munich
Apl. Prof., psychiatrist, developmental psychobiologist; basic research, publications and teaching on integrative communication-centered parent-infant/toddler counseling (IESK-B) and psychotherapy (IESK-P), "Münich Clinic for Fussy Babies"; case supervision

Eva Vonderlein, Heidelberg
Dipl. psychologist, scientific collabora-

tor in the Department of Developmental Psychology, as well as in the counseling services for families and children at the University of Heidelberg. Main focus: premature birth, postgraduate training in parental counseling of specialized staff in neonatology

Maria Mögel, Zurich
Psychologist in child and adolescent FSP; psychoanalyst; child-rearing counseling at the Parent-Toddler
Counseling Center of the district of Horgen; teaching development and child-rearing counseling (professional school for counselors for mothers); supervisor

Claude Zangger, Zurich

Counselor in mothers HFD, adult education instructor KAEB; Director of the Parent-Toddler Counseling Center Zurich, director of the Parent-Toddler Counseling Social Center Dorflinde Zurich (city social services),
Postgraduate training in child protection in early childhood for social workers and for counselors for mothers working with parents with babies and toddlers

Peter Scheer, Graz
University Professor Dr. med., pediatrician, psychotherapist, teaching therapist at the Austrian Medical Association; Director of Psychosomatic Medicine and Psychotherapy at University Hospital for Children and Adolescents, Graz, Austria

Thomas Mosler, Graz

Dr. med., representative of the SHFI: University Course and Institute for Interdisciplinary Early Intervention, Graz

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Postgraduate training standards for PSYCHOTHERAPY for children aged 0-3 with their parents and other caregivers

1. Definition

Psychotherapy in early childhood is a scientifically founded method of treating children aged 0-3 and their parents and/or other primary caregivers.
Its goal is to cure or improve mental and/or functional somatic disorders in children. At the same time it aims to improve the relationships between the child and his/her caregivers, thereby helping to prevent subsequent disorders.

Psychotherapy in early childhood can begin with the treatment of parents during pregnancy.

Initial remarks
The GAIMH supports the incorporation of the content of these recommendations into the training of psychotherapists for children, adolescents, adults and families. Based on his/her training, each psychotherapist should be qualified to deal professionally with problems regarding parents and their infants and toddlers, and if necessary to refer them to a specialist.
The standards of postgraduate training described below are intended for psychotherapists whose focus is or will be in the field of early childhood (incl. pregnancy and birth), and who address themselves to complex disorder patterns or would like to acquire a special qualification for training activity in this field.

2. Eligibility requirements

In order to be eligible to train as a psychotherapist for children aged 0-3 with their parents/caregivers, candidates must have completed their psychotherapy education and be accredited psychotherapists in Germany, Austria, or Switzerland, according to the laws of those countries. At present the three countries have different regulations concerning educational requirements, and a number of therapeutic procedures are recognized. The following specifications take this situation into account and are supplementary to the respective state-approved procedures. Candidates who are in the advanced stages of psychotherapy training may begin the postgraduate course of training described here, but can only complete it once they have successfully finished their psychotherapy studies. Previous professional experience with infants and toddlers as well as with their relationship systems is recommended, as is a process of reflection as to the personal suitability for therapeutic work in this field.

3. Theoretical postgraduate training

The following will give a brief outline of topics, some of which refer to very extensive specialist fields. In conjunction with the postgraduate training outlined here, one must learn particular aspects that relate to early childhood and/or aspects the knowledge of which is essential to the differential diagnosis or to interdisciplinary cooperation.

3.1. Significance of the early parent-child relationship for the child's development
- Selected findings from infant research and interaction research
- Development of attachment, attachment be
- Variability of early developmental processes

3.2. Biological and social parameters
- Aspects of the biological foundations of development (genetic factors, neurological development, somatic processes of pregnancy and birth)
- Pediatric aspects (e.g., illness and functional disorders in early childhood, prematurity, congenital deformities, developmental disorders)
- Aspects of the sociology of the family, significance of psychosocial factors
- Legal aspects (e.g., legal guardianship, right of asylum)
- Cultural aspects (e.g., culture-dependent concepts of child development and upbringing, of child behavior and of the causes of illness)
- Possibilities of institutional support for families with small children (nursery, day-care, kindergarten, community services)

3.3. Concepts of physiological and pathological development
- Developmental psychology in early childhood: self development/individu-

ation, dyadic and triadic relationship dynamics, early sibling relationships
• Psychodynamics of the development of parenthood, couples and family dynamics in early parenthood, multigenerational perspective
• Psychopathology in early childhood Children with primary disorders (incl. somatic regulation disorders)
• Children with psychic disorders as a result of severe illness and/or after major operations
• Early interaction and relationship disorders (incl. disorders of a child's behavioral regulation in the context of interactional regulation between parent and child)
• Children of parents with a physical or mental illness
• Psychopathology of parents and their significance for the child's development
• Enhancing recognition of the respective contribution of the child and adult in the issue at hand.

3.4. Diagnostic procedure
The candidates should be empowered to make a comprehensive clinical diagnosis, which generally includes a multiaxial assessment (child's behavior and mental condition, parent-child interaction and relationship, development and somatic conditions, psychosocial circumstances). Special diagnostic procedures that are connected with the chosen method of treatment should be studied in depth.

A discussion of the diagnostic examination findings with the parents or the responsible caregivers must be handled with care. Particular caution must be taken when dealing with unproven findings and suspicions: It is important to weigh the necessity of drawing attention to behavioral difficulties or a disorder, particularly with regard to its potential progression, against the risk of unsettling the parents, which could potentially trigger a process of pathologization.

• Clinical diagnostics
• Context clarification (reason for referral, parent's request)
• Diagnostics of age-dependent disorder patterns in children
• Assessment of the quality of early relationships and relationship disorders
• Assessment of parental mental disorders which compromise the parent-child relationship
• Introduction to the multiaxial classification system ZTT:DC 0-3 ("Zero to Three") of the US "National Center for Clinical Infant Programs," in addition to a general international classification system of mental disorders (ICD-10 or DSM IV)
• Video-assisted diagnostics of early interaction
• Developmental diagnostics
• Family and couple diagnostics, psychosocial diagnostics

3.5. Concepts and methods of treatment
The candidates should familiarize themselves with various methods of treatment, but study one method in depth and acquire his particular therapeutic technique.

Whatever the method used, it is important for the candidates to learn to recognize and to reflect upon their personal involvement, which is an issue when working with infants and small children, as well as aspects of counter-transference.

• Parent-infant/toddler therapy: limited interventions, short-term therapy, long term treatment
• Transition to individual therapy, couples and family therapy, group therapy
• Intervention focused on parenthood processes
• Long-term parallel treatment of child and parents
• Comprehensive multimodal approach, interdisciplinary networking, child protection
• Treatment indications for parent-child therapy, for multimodal interventions, for partly inpatient and inpatient treatment and in addition
• Therapeutic technique for one method

4. Practical postgraduate training

In the course of the practicum, the candidates should use their knowledge of the potential of various methods, but focus on the method that best corresponds to their training and personal aptitude.

4.1. Supervised case treatment
• Candidates own case treatments
  • 4 cases
  • Of these, one in the 1st, 2nd and 3rd year of the child's life, respectively
  • Of these, one long-term case (> 10 sessions)
  • In total at least 40 sessions of treatment
• Supervision
  • In total at least 20 hours of supervision
  • Partly possible in a casuistic supervision group

4.2. Practicum

A practicum is recommended:
• Baby-toddler observation within the family with an accompanying seminar or
• Internship in an appropriate institution (neonatal unit, premature baby care unit, early intervention, nursery, psychosomatic ward) with psychotherapeutically oriented supervision.

5. Scope and duration
Approx. 120 hours of theory over a period of 2 years. (For scope of practical training see above)

6. Requirements of persons offering postgraduate training

After completion of studies (not yet formalized) at least 5 years professional work experience in the field of psychotherapy in early childhood.

Members of the Project group PSYCHO-THERAPY

Fernanda Pedrina, Zurich (project group leader)
Pediatrician, child and adolescent psychiatrist, longstanding experience in parent-infant psychotherapy; research on postpartum depression; teacher of and publications in psychoanalytic therapies in early childhood

Vera Brunner-Kalman, Zurich
Psychotherapist in Zurich and in the Child and Adolescent Psychiatric Services of St. Gallen, longstanding experience as supervisor; co-founder of the "baby clinic" at the Child and Adolescent Psychiatric Services of St. Gallen.

Wilfried Datler, Vienna
University professor at the Institute for Educational Science of the University of Vienna. Publications include papers on the significance of the father in early childhood

Marguerite Dunitz-Scheer, Graz
University professor, pediatrician, child psychotherapist, Psychosomatic Department for Early Childhood at Children's Hospital Graz; teacher of and publications on diagnostic procedure and inpatient treatment of severe eating disorders

Tamara Jacubeit, Elmshorn
Child and adolescent psychiatrist; director of Department of Adolescent Psychiatry and Psychotherapy, Elmshorn

Inken Seifert-Karb, Oberursel
Psychotherapist and analytic family therapist, director of parent counseling services Oberursel. Research on triadic interaction and subconscious family dynamics in the early parent-child dyad

Monika Strauss, St. Gallen
Child and adolescent psychiatrist and psychotherapist. Longstanding experience in training assistant doctors and psychologists. Co-founder of the "baby clinic" at the Child and Adolescent Psychiatric Services of St. Gallen

Consolata Thiel-Bonney, Heidelberg
General practitioner, psychotherapist (TP) and systemic family therapist. Director of the consultation hour for parents with infants and toddlers at the University Clinic in Heidelberg; teaching activity, publications

Christiane Wiesler, Freiburg i.B.
Analytic child and adolescent psychotherapist; supervisor and lecturer at the Institute for Psychoanalysis and Psychotherapy, Freiburg; postgraduate training in couples and family therapy; initiator and member of the Psychotherapeutic Baby Clinic, Freiburg.

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