

ADVISORY COUNCIL FOR CLINICAL INFANT PROGRAMS

November 14 and 15, 1975

November 14, 1975 - 2:00 p.m.

Opening Remarks: Welcome to the Study Center, Stanley I. Greenspan, M.D.

I would like to welcome everyone to the Mental Health Study Center;
for those ^{of you here} who are new ~~I would like to welcome you~~ for the first time, ~~for and~~
those of you who have been here before with us as part of our group who
have been meeting on clinical infant programs, ^{I think our meetings} ~~I would like to welcome you~~
^{become increasingly} ~~back again and say it gets more invigorating~~ I think, each time we have
~~this meeting~~. It is a ^{privilege for} ~~rare opportunity and an honor~~ at the Study Center
to be able to bring together ^{so} ~~such an~~ outstanding ^a group of scientists, ^{and}
clinicians from around the country, ^{who are} ~~focusing on~~ different aspects of involve-
ment with infants and their families. And, ~~its~~ ^{is} just to see the effort
continue and grow and differentiate, ^{and} get more substantive each time,
is a comment about the original group ^{who} ~~that met~~ ^{for} the first time last year and
began evolving this idea, ^{It is also} ~~and, also, is~~ a comment about the National Institute
of Mental Health and its ~~focussed~~ ^{focused} interest in this area.

^{I like} ~~I~~ wanted to say just a few words about ^{the position} ~~where~~ the National Institute of
Mental Health is ^{taxing on infancy} ~~is~~ and what this group -- the original group that began

planning these conferences and those who worked with us along the way --

^{has just} ~~is that~~ Steve Hersh ^{that, from} ~~informed me at the last minute in terms of the~~ meetings

with Bert Brown and others ~~who were~~ involved in the policy and directions
of our national effort in mental health, ^{it appears that} ~~that~~ the focus on infancy and
^{presently receiving} ~~involvement in infancy is really taking an~~ extraordinarily high priority

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right now. One of the signs of ^{this} that is that Steve Hersh was just ^{has} ~~made~~ ^{been appointed} and I think we should all congratulate him, Assistant Director of the National Institute of Mental Health for Children's Activities, and I think that is not only an honor for Steve, but ^{it} also says something about where the focus is going. ^{from} In recent discussions we have strong reasons ^{strong emphasis} to believe ~~that~~ there will be ~~a very high priority~~ on approaches in the earliest years of life. ^{This, of course, is what has brought us, so that we may share} ~~the focus, really, that brings us all together, in terms of bringing~~ together the useful and potential ^{useful} knowledge in this area that can be applied and, ^{explore} ~~also, that points us in further directions for research and~~ clinical intervention programs.

~~It looks extraordinarily promising. I'll go into more detail when we~~ have our discussions on the national center concept and the national center functions. ^{it appears highly} ~~It looks extraordinarily promising that we will have the~~ ^{needed} ~~funding available to carry out a number of those important functions that~~ ^{some of the} we have all been waiting to do. Many of you have been waiting longer than I--I've come in on the tail end of this, ^{step} but I am pleased to report that ~~it looks like there will be funding available to carry out a number of the~~ important national center functions. ~~Also, it looks very promising in terms~~ ^{and} ~~of the ability to get our own research effort going in this area to comple-~~ ^{here} ment ^{the} research efforts ~~that are already going on around the country and that~~ ^{already} ~~have been started by many of you~~ ^{in other parts of the country} So ^{the outlook for} both of those areas ^{is} look very ^{bright.} promising and we'll ^{go} ~~get into it in more detail at different parts in the program when~~ ^{greater} ~~we discuss the national center function and when we discuss our own research~~ ^{later} program.

~~Now, I'd like to shift over and make one more comment before~~ ^{we} ~~I shift~~ over to the major emphasis ⁱⁿ on the first part of today's program, ^{which}

^{/s}
~~will be~~ our knowledge-generating ¹ and ^a series of presentations, but, before turning it over to Bob Nover to make some introductory comments, I would like to apologize for two mistakes and omissions. Dr. Solnit's name was inadvertently omitted from the list of consultants in our proposal and, as I told Al, it could not have been an unconscious mistake of mine because I had nothing to do with typing it up. But, it was an error and I apologize for it. And, also, Selma Fraiberg ^{showed me that there was an error} on her name tag.

(Comments -- Dr. Neubauer: May I say, also, that in the meantime, I have not changed my name the way it was this last time in all of the prints. Mine, too, has been misspelled.) (Misc. Comments)

For all errors, I would like to apologize now and, also, apologize for all errors that will occur over the next two days.

Now, I would like to turn it ^{our meeting} over to Bob ^{Nover} for his introductory comments.

DR. NOVER:

^{too}
 Yes, I ^{too} would also like to welcome you all to the Study Center. And, just to paint a picture, briefly, of the context of this conference, ^{that} ^{during} ~~and that is, about~~ the summer of this past year ~~when we~~ ^{received} at the Study Center, a contract from NIMH to run a series of three conferences, ^{that follow both} Really extending from the first one ^{that} ~~that~~ we sponsored here, ^{another} and the second ^{that, as} one, which many of you know was funded by the grant foundation, ^{conferences} and the next three ^{are being} including this one, ^{and two more} ~~and two more~~ will be funded by the Institute on a contract. In a few minutes I would like to introduce you to the person we have been working with, Mrs. Inez Kaiser, whose firm is in charge

Wayne's

~~of running these conferences.~~ I thought that, since there were a lot of new people here this time, it might be helpful again if we go ~~around~~ and introduce ourselves and say where we are currently working so that everyone in the room will know ~~in addition to~~ who is around the table ^{and} who some of our observers are, ~~in the audience.~~

ATTENDANCE:

(#575 on tape)

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Thank you. I'd like, at this time, to introduce Mrs. Kaiser, who is the head of Inez Kaiser Associates of Kansas City, and who is running the conferences for us here at the Mental Health Study Center. She has some things she would like to talk about.

MRS. KAISER:

Thank you very much Dr. Nover and Dr. Greenspan, and Good Morning to all of you. I think, really, my day started off right this morning. I happened to awaken at 5:30 to get organized for this morning.

I looked at this Morning's program called, "Knowledge and Stress" and it was real interesting to me to note that they were discussing infants and what happens in early childhood. Did any of you see it this morning? Well, it really gave me some idea and concept about what I might hear today, listening to all of you speak.

I would like to say to the persons at the Study Center that we are certainly grateful for having the opportunity to work with the team here and to put together this, our first conference in this area. I guess all well-laid plans go astray and I am very familiar with many of the names. If there are any misspelled names, may I reassure you that when we send out a list following the conference that your name will be spelled properly, if you wrote it so we can read it on the sheet outside the door. (Laughter) -- and I will send it to you.

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I, also, would like to say that the conference -- I think in the letters that went out following it, that the hour was changed to 9:30 instead of 9:00. But tomorrow morning we will begin at 9:00 o'clock.

You know, I am a former school teacher and home economist and a mother, so I have learned to hear everything and to see behind me. This morning I heard one of the gentlemen say, "I wonder who put all those ladies together?" May I assure that Dr. Nover was the gentleman who did it. Not Inez Kaiser, because I believe in mixing the women and the men up together.

I certainly hope that those of you who arrived last night found your lodging comfortable, and if you did not, will you kindly see me or one of the persons outside at the table. There are some of you who are going to, if you have not already registered in the hotel, we have made reservations for you to register late this evening. And, when we have just a few moments break at some point, would you kindly let me know so that we can re-check, because we do want you to be very comfortable. We have made arrangements at the Holiday Inn in Silver Spring, and they are registered there in your name.

I believe each of you received, prior to coming here, a little slip to fill out so that we would know when you were arriving -- what date, and what have you. And, for the forthcoming conferences, if you can get ^{information} this back to us early we would certainly appreciate it.

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I would like to, also, say that we will - do have coffee and doughnuts that are available and will ask you to quietly tip back and get the coffee. And we also have tea.* If you did not sign one of the slips or would like to contribute a dollar, we would certainly welcome it in the little cup that we have.

I want to go over the contents in your folders to be sure that you have everything. We have included the agenda, as outlined and given to us by the Study Center, and I certainly hope that on that agenda that all names and everything is spelled properly. If not, we will be happy to make any corrections. We have also listed the names of all the attendees and the observers who we had as of yesterday. I am sure there may be some persons here whose names we did not have, but, I will reiterate that when we have a follow-up mailing your names will be included on that list.

If you will look inside -- those persons who are serving as a corps group, you will find a little slip of paper like this. Will you pull it out. This is a very important piece of paper to you as well as to me. I would like each of you to please put your names on it now. This is the little school teacher in me coming out. And, would you be sure to put your Social Security number on there. At the end of the conference, would you kindly turn this in, with all receipts for expenses, so that we can see that you are reimbursed.

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On the back of here -- it's a small sheet but very important.

To those persons who are serving as a corps group, I do want to point out that the per diem is \$33.00 per day, which is to include the lodgings and the food.

You received, when you came in, some slips and if you did not sign one, please do so because we are going to order sandwiches today for those of you who would like, and coffee, and we will have the same available for you tomorrow.

We have arranged, and will pay for your transportation to and your home destination from Washington, D. C. Also allowed is \$7.50 for local transportation per day. And, of course, you will get your consultant's fee.

Inside we have placed an evaluation sheet. Now, it may not be the kind you are used to but we like to evaluate what we do and we have some "yes" and "no" for you to check. And, at the bottom I want you to feel free to put any additional comments that you might feel that will be helpful to us in planning the next conference that we have.

I would like to suggest, as I sat here and listened, you were talking very, very softly, and, I am certain that each of you can speak up just a wee bit louder because we are taping everything that you say. Now, you will not hear this again, please don't -- some people have a thing about tapes. But we are recording, shall I say, what happens here today and it is vitally important to speak up loudly enough for the microphones to pick up what you have to say.

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Outside, at the registration desk, we do have a message board. we have asked the receptionist to place any messages outside. If any of you receive any emergency calls, I will come and just tip you lightly. I hope that I will be able to identify all of you and find you so that you can step outside to use the phone.

If you need any confirmation for housing, please see me on that. If there is anything that you can think of that you need while you are here, please feel free to contact me because we are here to serve you and it is certainly my pleasure and I am sure that in the two days that I will learn much about what you are going to talk about.

Thanks a million!

DR. LOURIE:

Well, ^{and} just as a lead-in to the scientific part of our program, ^{to} add to the background information that Stan has provided, ^{of the thinking} these meetings are an outgrowth of a group of people working in clinical infant programs who, ^{on} felt the need for an exchange of information, ^{on the} to deal with training aspects and, ^{because} in general, ~~to have a communication system~~ there were many challenging new dimensions emerging in ^{the} this whole area of working with infants. ^{Fortunately} And even though some of the early attempts to work out ~~a way of carrying out~~ a communication system were frustrated, we were ^{build} fortunately able to utilize the background developed around the Mental Health Study Center's infant program as a basis on which to ^{bring} such a system.

felt

this group that ~~the need~~ and in the first two meetings
 there ^{was} ~~has been~~ the exciting kind of exchange of information
~~of the kind of stimulation~~ that a group of champions can
 generate. And, ~~on top of all that~~, the reason we call it ~~them~~
 "champions" ^{that} is because they take very difficult areas of
 functioning and programming ^{and} and make them look very easy,
 as well as stimulating.

Now, ^{it} is really excellent news that we start with,
 that the earlier two meetings have been so successful in
 generating the kind of information that needs to be shared,
^{from here on,} We'll have an opportunity to actually put it together, ^{from}
^{and that we will have} here on. And, ~~as well as having a picture of support that~~
 will keep this concept going and help it to become better
 organized.

Now, ^{to} get to the meat of the conference, we'll ^{now} turn
 it over ^{now} to Sally Provence, who will give us an overview
 of the evaluation of infants and young children.

INSERT PAGES ¹¹ ~~10a~~ through ^{22*} ~~10-L~~ here -- (omitted on this tape, picked up on another)

DR. PROVENCE:

Well, ^{review} now I would like to ~~describe~~ the process of
 evaluation for you again, ~~using specific~~ describing the
 way in which we do our work, in bringing in some of these
 concepts that I've mentioned, ~~and that is~~ children come
 into our ^{child} development ^{unit} referred from many
 different sources. We have no rule about how they may get
 there. So, they may be referred by parents, by schools,
 by physicians, by any child ^{or} child ^{agency} for
 children, and so on.

*Incorrect.
 See pp. 11 & 22

to p. 23

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~~Something missing here?~~ See p. 22 for lead-in to this

11-10a

DR. PROVENCE:

~~I~~

~~I will try (to speak a little louder) - I may not be~~
~~able to.~~ ^{I want} To talk a little about its relationship to
intervention, which, I guess, is part of why we're here.
Now, in doing this, what I'm going to do is to try to
abstract and summarize the last 25 years in an hour; And
I hope that I can do it. What I am going to present is a
particular way of working clinically with infants and
their parents ^{that} which we have found absorbing and fascinating
and, I think, valid for the kind of work we are doing in
the Child Study Center, so that it is presented as a
clinical method, and I hope you will hear it as such.

Now, in order to do this, I have to speak to you as
^{I were addressing} though ~~I'm talking to~~ beginning trainees, Because what I
want to try to do is to make a whole piece of this, so you
are going to hear some things that are far beneath your
sophistication, and I hope you won't feel offended or
patronized. But, I think a certain way of putting all of
this together is really the point of doing that, so that I
want to start by talking about what I see as the task and
talking about what I believe to be the most clinically
useful concepts in trying to do achieve this task that
is outlined.

~~And, some of this I am simply going to read because~~
~~it's more efficient and can be done more quickly.~~ So, ⁴ the
⁵ task in assessing the development of the infant or very
young child requires a comprehensive approach -- nothing
new to you -- that involves an awareness, a real commitment,

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to the complexity of development even in the earlier years, and an appreciation of its multiple determinants. To do this clinical job well requires knowledge from many sources, including medical^{ine,} pediatrics, genetics, neurology, psychology, and psychiatry, to name a few.

704 Increasingly, ^{too,} ~~just to mention~~ another direction, increasingly some of us have found we are having to learn more about the law if we are going to be child development specialists, clinically. So that there is hardly anything that affects childhood and parenthood that is inappropriate to be combined and synthesized in clinical work with the very young children. ^{Therefore,} So, ~~of course,~~ while the individual child development specialist ^{need} may not have in depth knowledge of all these fields in order to make an accurate diagnoses and ^{evolve} a sound treatment plan, he must be able to evaluate the relative importance of multiple factors known to influence the child's development. He also needs the conceptual framework ^{that} which not only guides the study, but permits the organization of information from a specific case and leads to an individualized, rather than a global kind of prescription for intervention or treatment.

There are many stimulating and useful ideas about early development; from these I will mention, briefly, several ^{that} which I believe to be of particular usefulness in clinical work. First, ^{I have} as suggested above, the

concept basic to the entire framework is that the development of the child is complex and is determined by multiple factors, even during infancy.

The clinically-recognized disorders of development that make up an increasingly large proportion of the health problems of childhood may stem from difficulties involving any one ^{of} or several factors that influence development. Developmental disorders of infancy usually cannot be defined as either entirely organic, or entirely psychogenic. The closeness of the ^o somatic and the psychic systems in the earlier years usually results in a picture being presented ^{in which} where there are bodily manifestations of psychogenic disorders ^{and} psychological results of organic or physical disorders, and it's terribly important that one keep this reality in mind.

Either-or questions, although they come naturally to us, often limit ^{our} perception and understanding. Rather, questions such as the following can fruitfully be posed:

^{functions}
One could ask what aspects of the child's development ~~are~~ what functions are impaired; what data are available on the functioning of the child's somatic and mental systems; does the child have a biological problem, and, if so, how has this influenced the adequacy and effect of the care he has received; what are the interrelationships between his defect and the influences of his psychosocial environment; is this a child, not with an inherent defect, but with certain

Either-or

?

Suggest
list here

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congenital individual tendencies of reactivity, activity, or temperament ^{that} which influence the attitude and behavior of his parents toward him in ways that have great impact in his development toward health or illness; ^{Is this a child} ^{who} that, for reasons due mainly to the behavior ^{toward him} of adults, ^{that} toward him develops signs and symptoms of illness which are somatic or mental, ^{or} both.

A second important concept is that innate and experiential factors are co-determinants of development, again ^a perfectly familiar notion. And, I guess the point ~~that~~ I want to make here is that we had better believe that, not just say it, because it is enormously important.

The child's progress in many dimensions of development, including symptomatic behavior, always reflects an interactional process. The diagnostician seeks to determine the relationship between the intrinsic and extrinsic factors in producing the child's developmental difficulty. Or, of course, ^{To put that} ^{he seeks} in another ^{in the child} another way of putting that is also to determine what ^{what his} is healthy or ^{are} what are the assets that he brings.

The vulnerability of the child to developmental disorders is increased by almost every biologic defect or dysfunction. Similarly, if the adults responsible for him are poor nurturers, or if his psychosocial environment for any reason contains noxious influences, his normal endowment is at great risk, even if he is biologically well-endowed, ^{his} his normal development is at great risk.

Inevitably, the combination of a vulnerable child and ^{an un} ~~a non~~ stable or noxious environment, results in significant developmental disorders. ^{that are} Sometimes transitory, sometimes permanent.

~~The~~ Third important concept is the central role of human relationships, which, I believe, can hardly be over~~em~~phasized in the early years. Much of what we include when we speak of experiential or environmental factors for the young child is based on or mediated by relationships with people. The ^{is,} younger the child/the more central these are to his total well-being. Neither normal nor deviant ^a development can be explained without an understanding of the nature, frequency, and intensity of the child's experiences with people.

We are all familiar with the effect of gross deficits in nurturing, ^{that} which many young children experience, due to indifferent care-givers; confused, disorganized, and negligent care-givers; angry, hostile, or highly ambivalent we are also familiar with the effect of certain care-givers ^{or} ~~to~~ events, such as traumatic separations from people important to him; discontinuity and deprivation; physical abuse.

Good nurturing means care, concern, and training of the child. Development takes place most favorably in an atmosphere in which comfort, loving care, and supportive and gratifying experiences predominate over experiences ^{that} which are painful, attention-producing, or psychologically frustrating. The balance of gratifying and frustrating

experiences, for example, is quite important to the child's healthy development.

No 41 One of the ways of defining "good-enough" nurturing is that this balance is in harmony with the child's developmental needs at various ages.

In addition to the gross deficits, such as those I've mentioned above, in many young children there are adverse experiences ^{that} which are harder to identify. For example, a lonely and depressed young mother often may not appear so in the company of adults; she may come to life when we are seeing her. Yet, she may be psychologically and physically unavailable to her child when they are alone.

There are, moreover, articulate and intelligent parents whose difficulties in nurturing their children may be well masked. In these instances, and this is one of my favorite things, I have to warn you -- ~~in these instances~~, the clues usually come, not from what the parents present at first glance, but from the child's development or symptomatic behavior.

The findings of the study of the child often suggest the areas to be explored in working with the parents. Accepting the concept of the central importance of human relationships in the child's development and his adaptation to his world means that the diagnostician must evaluate in each specific case the way in which significant persons, especially the parent, have supported or impeded the

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child's development, and have alleviated, heightened, or created his problems.

(?) The fourth concept of importance, began overlapping what has already been mentioned, is the notion of the maturation process, defined here as the progressive unfolding growth and differentiation of intrinsic characteristics according to a biological timetable. Again, both the psychic and somatic systems are involved. Elaboration(?) and differentiation proceed from a relatively undifferentiated state.

Maturation, in combination with experience, results in the manifestations or emergence of findings ? that are organized and integrated into the whole ~~(role) that~~ (at) successively higher and more complex levels.

no 91 The integrity of the maturational process is assumed to be an essential co-determinant of development; this is another way of talking about innate factors.

(?) Sequences of development assumed to be based on orderly maturation have been defined. A long view of the maturational process includes the concept that biologic maturation is influenced by the environment. In accepting what we now define as the patterns of normal maturation, we assume that adaptation over generations to a fairly stable and predictable environment in the immediate diagnostic situation, however, we rely on the best current knowledge about the sequence and timing of maturational

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processes and take these as norms against which we consider the development of the child under study.

In general, the sequence of maturation is more regular and predictable than the ^{that} timetable of the functions which reflect the maturational process. We expect, for instance, that the evolution of the grasping patterns, ~~the procedure~~ the progress from prone progression to upright locomotion, the concept of object permanence(?); the progression from single to polysyllabic vowel sounds, ^{all} have a high degree of regularity as a sequence of maturational events ^{that} which are reflected in observable development. However, we accept considerable variability in the time of emergence of these functions within what we consider the range of normal development.

Maturation, then, ~~is~~ an invisible process ~~is~~ represented by observable behaviors; ~~delay~~ or deviation in the process is inferred from characteristics of the child's functional development.

The fifth important concept is that of the ^{phase} concept, borrowed, as you know, from developmental embryology(?) in particular, and applied also to psychological development. Whether one speaks of the ages-and-stages concept of behavior, as presented by Gesell, the sequences of phases in psychosocial development outlined by Erickson, or psychosocial development as part of the psychoanalytic theory, the notion of developmental phases ^{has} considerable inheristic(?) value in understanding the child's development.

heuristic?

The phase concept encompasses the idea that each developmental phase is characterized by specific developmental tasks which must be performed in that phase. Certain capabilities as well as certain vulnerabilities are to be expected as a part of normal development. ^{The concept} It includes the idea of a critical period for the optimal development of each function; that is, that each capability has an optimal time for emergence and integration, and each developmental task has an optimal time for its mastery(?).

Permanent or transitory difficulties arise when something disrupts the normal time^{table}. It has been suggested, and in many instances ^{it} appears to be valid, that if the critical period passes without the organization and development of a particular function, the optimal level or integration of performance of ^{that} function may never be achieved.

Again, I think those of us ^{who} that have examined this question time(?), ^{and} have been impressed with the enormous flexibility in resourcefulness of the human child. At the same time, I think this does not negate this notion as a very important and influential one. We tend to think in terms of, ^{if it} "well, / doesn't happen now, all is lost." That isn't really the way to put it. One should ask, "Well, if it doesn't happen now, what effect does it have on subsequent development, how can we examine that, how can we think about the child's ability to withstand deprivation or trauma, or interferences with the ^{of} orderly development

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according to the best knowledge we have about developmental phases.⁷"

There is clinical and research evidence to suggest that when a function is newly emerging, such as walking or talking, it is at the height of its vulnerability to noxious influences. Acutely stressful experiences may be accompanied by loss of previously acquired skills, by regression in psychosocial development, while chronic stress or strain often delays their appearance and creates a picture of retardation or deviance. For example, a severe conflict between mother and child over eating, ^{that} which occurs at the time the child is beginning to speak, ^{may} can result in a loss of words or ^{delays} the acquisition of language for months or years.

Parental behavior that communicates excessive anxiety about the child's move toward greater independence may inhibit him to the point of slowing down his acquiring locomotor skills, or interfere with the development of his curiosity and eagerness to learn.

More subtle, but no less important, the characteristics of cognitive structures like sexual development, the depth and nature of human relationships, and symptom formation can often be more clearly understood through the application of the phase concept. The phase concept has relevance, ^{also,} to the validity of the developmental tests. When a younger ^{is} is being evaluated, for example, his physical or psychological discomfort may interfere with his being able to

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demonstrate his optimal functioning.

Developmental diagnoses and predictions made under conditions stressful for the child are hazardous at best. What is stressful for the child is determined by his phase of development, as well as by his early experiences and his immediate state of physical or psychological discomfort.

While ^{the} this following item is not exactly in the same category as the others, I did want to bring up the notion of the importance of learning as an essential process. Sometimes too much emphasis is placed on biologic maturation in the understanding of development. However, there are now relatively few clinicians who would deny the importance of learning as an essential part of the process of development and adaptation.

The emphasis on the importance of the learning process is not to suggest that every developmental problem is caused by experiential deficits, nor that problems can be cured simply by providing more experiences geared to developmental needs. As Hartmanⁿ pointed out, the human child acquires much of his adaptive capacities through learning. In this learning process, the infant is profoundly influenced for better or worse by the nature of his relationships with others, especially his parents.

Through countless interchanges, the child acquires, among other things, his style; his character; his way with people; his curiosity and eagerness; the tendency to trust

or mistrust; self-esteem or self-doubt; the capacity to solve problems through physical, intellectual, or social activity; his personal and group identities; sources of his satisfactions or distrust; the ability to cope with stress and defend against danger; the capacity for self-direction and self-control; and the ability to give and accept love. While adults are aware of teaching some of these attitudes, perceptions, and skills, most of these seem, as it were, to be caught ^{taught to} (?) or absorbed by the child in the daily experience of living.

The importance of such learning as a determinant of the development we assess requires recognition (lots of background whispering and talk re speaking louder, and ?)

FOLLOWING PICKED UP ON SONY:

~~The process of evaluation again using specific describing the way in which we do our work in bringing in some of the concepts that I've mentioned, and that is that children come into our child development unit referred from many different sources we have no real about how they get there. So, they may be referred by parents, by schools by physicians, any child or child agency for children, etc.~~

cont'd on work already typed from former tape--

in complete

This continues at the top of p. 11.

appears on

The first contact is almost always by telephone.

We have one person ~~who~~ does almost all of our intake,
And, in that telephone contact, she describes for them
what is involved in the evaluation, Listens to their
reason for wanting to come, or for not wanting to come,
Helps them decide whether they would like to have an
application form, and if so, ~~then she~~ sends it to them.

DR. BRAZELTON: ~~Excuse me, Sally;~~ you said they were self-referred?

DR. PROVENCE: Yes, many of them are, ~~Many of them~~ or they may
come from their physicians ~~or from~~ but ~~many~~ many of them
call us directly, because we have been there for a long
time, and they know we are there.

It becomes a case when they return the introductory
report form. If they have not returned it after a
reasonable length of time, we may give them a call ~~or~~ we
may call the physician who referred them, ~~or~~ the person
who referred them, if it is that kind of a referral, and
say, ~~that~~ "we would just like you to know that this person
has not responded yet; shall we leave ~~that~~ ^{it} as is, or do
you want to talk with ~~them~~ ^{her} further?"

As you can well imagine, the people who are sent by
others tend to be those who decide not to come. If their
physician or the nurse, or the referring person has really
referred them out of some agreement on their part that

they need to come, ~~then~~ they do tend to get there. But we think that the time that our intake worker spends talking to them on the phone is enormously important and accounts, largely, I think, for the fact that once they have accepted an introductory report form they are likely to return it, ~~and then are likely to follow through on the~~ first appointment.

The first face-to-face appointment is with the parents only, without the child. Now, there are rare exceptions to that. We try to be flexible, but we try to get them to come first without the child. Once in a while we encounter a parent who simply can't do that, whom you sense must bring the child ^{with him;} ~~there's~~ such anxiety that they have to come with the child. Or, some of them, having agreed to come without the child, forget and bring him along. So, we try to understand what that communication is, ~~where~~ ^{where} that fits into our diagnosis, and so on.

OK 1. One of the differences that is true of what I feel ^{is} ~~a~~ sound ^{way of?} ~~way~~ doing a developmental assessment and that that one encounters in working on a pediatric ward or often in an out-patient clinic is ^{that} ~~there has to be~~ ^{is} quite a difference in tempo. ~~It's a process~~ if you could bring the child in, ~~and parent~~ ^{the child} and have ^{he} ~~him~~ seen in ² ~~two~~ or ³ ~~three~~ days, as is done in some developmental centers, by all of the experts that you expect to have see him, you ~~still~~ ^{you would} would not have as much data about that child and parent as ^{had} ~~if you do~~ the

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same number of contacts over a period of a few weeks. So,
~~that I think one has to~~, although we do have to respond to
emergency situations, we ^{However} do often have to fit into the tempo
of a busy pediatric ward. ^{But} I think ^{this} it should be done with
the awareness that ^{it's} ~~that's~~ less than ideal, and if you can
start on the pediatric ward ^{and} but continue your evaluation
later, ~~again~~ you are ^{more} likely to have something that you feel
is valid and accurate ^{than} if you compress it all into a
couple of days.

~~Now, again~~, I am quite aware that in some medical
centers serving large areas, where people come from
afar and they ~~come into town~~ and stay a few days and hope
to get it all done, there is a temptation to fall into that
^{Also,} and one has to be realistic. But, I do think in those
situations, ^{however} one could do a lot more ^{by} to start the contact
with the parent's before they bring the child in, ⁱⁿ to follow^{ing}
it up later, and not limit^{ing} the service to those ² two or
³ three days when they are in the medical center.

~~Now, because~~ our children come ~~from~~ ^{had to} only from the
State of Connecticut now; we ~~have~~ limited our area of work
to the State because we began to get overwhelmed. There
is no place in Connecticut that you can't get to in a
couple of hours, so ~~that~~ we do not have the problem of
the long distances and the need for over^{night} stays that
do exist in a lot of other places. But ~~time~~ ^{what I want}
~~to say is that~~ the passage of time, if it doesn't go on

interminably, ~~that the passage of a few weeks~~ is an ally
in the accuracy of diagnosis in

DR. LALLY: Sally, ~~excuse me~~, does the same person stay with the
child throughout this time period?

DR. PROVENCE: Yes, I'll get to that. ~~Let~~

The next thing, ~~too, that~~ we are committed to, is
enormously important, and being committed to it means that we
really work on it when it isn't happening right -- and that
is our conviction of the need for ~~the~~ parent participation.
We take the view that the service is to the parents and to
the child. We take the view that parenthood is a develop-
mental process, ~~and~~ ^{that} part of our job is to try to support
that development in parents; and that the parents are more
expert about their child than we are -- at least about what
the daily problems are, what the transactions are, what
they feel about the child, and so on. So ~~that~~ we try to
make a partnership with parents in helping them, in treating
them with the respect that we feel is due them; ~~as~~ not
only as the parents of the child, but as people capable of
providing and sharing crucial information if one wants to
understand the child and recommend some kind of ~~it~~ [?] We work
very hard to get fathers in, too, and in two-parent families
we have an almost 99% ^{percent} participation of fathers. And, what
that says to me is that usually it can be done if you really
think it is terribly important. Once in a while there is

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a refusal, but it is extremely rare. ^{Occasionally we} ~~Once in a while you~~
get a mother who does not want the child's father to come
in, and ^{we} you have to learn to understand that and ~~to~~ figure
out how ~~you may have to deal with that~~ ^{it} as a part of her
problem before ^{we} you can ^{resolve?} achieve it, but ~~we have very active~~
~~participation of fathers, too.~~

The initial interview, then, is usually with both
parents. We try to accommodate to the realities of their
schedules.

DR. BRAZELTON: Do you set up this expectation for the fathers in that
initial phone ~~contact?~~ ^{contact?}

DR. PROVENCE: We don't refuse to let people come, if they all agree
to this, but we let them know our way of working, ^{and} our
expectation, ^{that's} that's the way we think it goes best.

DR. NEUBAUER: Are you interested ⁱⁿ ~~there to~~ study ^{ing} both the father's
relationship to the infant ^{and} ~~as well as~~ the father's support
of the maternal function?

DR. PROVENCE: Yes, ~~you see right.~~ Again, we are committed to the
importance of the relationship to the father from early on, ^{but}
~~but~~, also, one of the things ~~that has been~~ apparent to us
over the years is that a very high percentage of the disturbed
young children ~~that~~ we see have parents ^{with} ~~who have~~ very severe
marital conflicts. It is a very frequent finding in our
, for instance. And some of those indicators, of

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course, appear very early. The parents are then seen at least once before the child is brought.

I don't think I have to ^{I think} /anymore than say ~~that~~ mention the importance of sensitive clinical interviewing. There is an added focus on gathering developmental data, and yet that is not the main goal of the intake interview. Most of our intake interviews are done by our social work staff. Most of our parent work is done by our social work staff, although not all of it, so that other members of our staff--pediatricians, psychologists, child psychiatrists--may do some parent work.

After that initial interview, or sometimes more than one ^{it} if that seems to be needed, we ~~do~~ ask that the intake interview be done in a clinically sound way, ^{but} we also have a form for recording it, ^{that} organized under categories which we are quite insistent upon. ^{So} it does not appear as a process recording in the record. And, while I think we lose something in doing it that way, the advantages of having it organized into categories that are comparable from one child to another ^{us to} and for quick reference, ~~I think~~ seem to outweigh the disadvantages of

DR. BRAZELTON: Do you have a copy of that with you, ^{or} can we get some copies?

DR. PROVENCE: Well, ^{but} I can provide them. ~~I'd be glad to give you~~ ^{one} whatever I didn't bring ~~it~~ with me. Anything that anyone

is interested in, that we have copies of, I'd be glad to send.

So ~~then~~ the child comes in for his evaluation. The average number of times that children are seen is six to eight. If the diagnosis is very simple and easy, it may only take a couple of times; ~~Some~~ of them take longer. Again, we try to be flexible about that.

His parents will be seen several more times as well. But the first time they come with him, and sometimes more than once, he is seen in their presence. The evaluation begins in the parents' presence.

And the work with the child consists of two major things. The formal developmental testing, which I will ^{talk} ~~mention~~ a little more about later, and the more informal play interviews. Observations of parent-child interaction are an important part of this ^{the play interviews for} ~~as well~~. With ~~an~~ infant, that may be set up as a special kind of session ~~either~~ in our setting, ~~or~~ at home, ~~or~~ in the hospital, or elsewhere.

But ~~to get back~~ the developmental test ~~that~~ we use is the composite scale that goes under the name of the Revised Yale Developmental Schedules. ~~It's a composite scale that~~ includes many items from the Gesell Scales, ~~from~~ the Merrill-Palmer, and the Binet, ^{and} a few, more recently, ~~from~~ the Bayley. It's organized in such a way that you can compute a score, ~~but~~ ^{How} when I am training people, I do not allow them to compute scores for at least the first ⁶ ~~six~~ months they are working,

because, ~~again~~, I found ~~through sad experience~~ that if you allow that, ^{early on}, they check their grades and they rely on the numbers, ^{They} ~~and they~~ don't really look at the child, ^u or think about the relevance of their data, but are bent on getting this figure. ~~So that there would be, by the same person, in other words--~~ the people who are doing the work with the children have to become quite versatile as child development specialists. They must learn how to administer the test, they must learn how to conduct a play interview, they must learn how to work with their colleague who is seeing the parents in an exchange of information through the process, they must learn how to synthesize the data. They must learn when to ask for consultants, ^{and} how to use consultation, ^{and} that has advantages and disadvantages.

Our commitment to the parents, when they bring the child to us, is that we will organize the study. We may need to use our colleagues in the medical center for various kinds of consultations, ^{neurology, genetics, hearing, and speech,} etc., but we insist on having the results of those consultations brought back to us before we are through with the case, so that we are responsible for the final synthesis and formulation.

^{During} ~~People doing~~ the developmental testing, ^{at least} ~~there is~~ nearly always ^{at least} one other observer ~~at least~~ the person who is working with the parents almost always sees the ^{child,}

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at least ^{for} the first session ~~of the child~~. And, again, we find that ~~it gives them~~ it makes their work with the parents easier and more sensitive ^{if} if the child is a reality for them too, And they see things that will enrich and facilitate their further interviews with the parents.

After the first couple of testing sessions, ~~then there~~ after if we feel that the child is ready to separate from the parent, ~~then~~ the person seeing the child will ^{hereafter} go on with that, and, simultaneously, the parents' person will be seeing them in this interview.

(9) The ~~enormous advantage~~ again, I am not sure that I have to defend this, but ^{I do want} just to explain it: ~~we~~ think it is terribly important for the parent to be with the child in those early sessions. Sometimes one can never separate them and we have to ^{set} have other times to see the parents outside ^{also} of the child's visits. Again, partly there are very few children of pre-school age who ^{one} one would expect to be entirely comfortable with a stranger without their parent. Occasionally it happens, but I would say that it is the exception rather than the rule, ^{by separating them early on.} So that we think you add a stress to their task. The other thing is ~~the children~~ the parents are ^{that} we kind of rehearse with ^{the parents} them what they are going to tell the child ^{about} about why he is coming. We try to get them to give him a simple and honest statement about that. Some can; some cannot.

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DR. ~~1. Berry~~ ? With you-

DR. PROVENCE: No, before they come. At least we would say, "well, ~~how would you - how do you think you'll tell him about this,~~
"what do you plan to tell him about this; could we help you
to figure out how to do it?" And then you ^{can} do it in your
own words. ^{But} Many of them do that very well.

DR. BRAZELTON: If they haven't, do you make any ----

DR. PROVENCE: If they haven't, then we may say, perhaps even in the
first session, "what does he understand about why he is here?"
Now, if we think ~~then~~ ^{the child} that he is perplexed or excessively
anxious, ~~then~~ we may give a simple explanation there. ^{provided} If we
~~feel it's~~ think ~~that's~~ not going to embarrass or ^{offend (?)} (enough) the parents.
But, ^{the child} at some point during the course of the thing, he needs
to know why he is there.

A lot of parents like to present this as fun and games;
~~you know~~, "you're going to go and play with a nice man or a
nice lady." You can't ~~even~~ ^{always} get by with that, even with
infants, because they ^{They} know something is up. ~~Always know~~
~~something is up~~. We see a lot of babies, for instance, being
placed in adoption, ^{tension?} and parental attention is such that you
~~get~~ you often ~~can~~ get a crying and irritable baby. And
~~there's not~~ ^{aren't} many ways you can tell that baby that you mean
~~him~~ them no harm. But, ^{the babies} they always know it's a very special
situation, very serious. There may be a lot of pleasant

things about it, but we present it as work, really. And, again, it has always fascinated me ^{to see} how early the child can accept ~~that~~ ^{the} ~~that~~ ^{that} notion we have work to do, That some of it will be fun, and that some ^{he} you won't like so well, but that's our work, and so ~~so~~

Well, ^{that} the observations of parent-child interaction ^{so fruitful}
I just want to mention ~~that~~ they may be more crucial for infants than for slightly older children, though I think they can be very revealing for older ^{children} as well.

But, very often with the disorders of infancy, the mother or father, particularly the mother with a child of that age, may have withheld information deliberately, ~~but~~ ^{however,} it's more probable that she has failed to tell you something important about what goes on between them, because she cannot tell you that. She is not aware of it. She hasn't observed it ^{of} herself. It's not available to her conscious ^{even} awareness to report, as a problem or/as a characteristic of what goes on.

DR. Are these observations done in the clinic, or in the home, or both?

DR. ^{DR.} ~~all of them are done in both?~~

DR. PROVENCE: Well, ^{DR.} both. / ~~Again~~ ^{we} try to do them in whatever way seems to be indicated for a particular case.

DR. ~~Is it structured in the clinic, I mean, what is the situation in which you do the observation in the clinic?~~

DR. PROVENCE: Of the mother-child interaction? Well, we would try to have them in a comfortable room. We'd try to have some toys, we might ask the mother to feed the baby, ~~we might play with the baby~~ play with the baby and the mother all together, to try to get some notion of what goes on between them.

DR. BRAZELTON: But you don't make it a part of your paradigm that you go out to the home in every case?

DR. PROVENCE: No, ^{we don't} that's selective. If we suspect that ~~they are going to be~~ if there are gaps in the data that might be filled ^{a home visit or that there might} by ~~that~~ if there is going to be substantial difference in the way either the mother or the child behaves, and usually you can, at least, have the best guess about that by the time you've seen them two or three times, ^{we do go to the home} I saw a child these past couple of weeks, ^{and} where I made a home visit this week, because he is a ³ three-year-old who is so inhibited in the clinic situation that he can hardly do anything. His mother ^{said,} says, "Oh, he is very different at home." So we said, well, that we'd like to come. Well, that suited her fine. Well, he is somewhat different at home, but not very different, ^{It} at home. What was awfully important to know that his inhibitions are not entirely explained by the danger of ^{the} that clinic situation. So, we try to individualize that.

I want to talk about the synthesis in formulations, because, I think this is probably, in my experience at least,

the ^{what} thing that is the least well done, in general, in child development work. Now, again, you will recall that the contact with the child and the parent has been mainly conducted by two ^{persons.} people. They are jointly responsible for the case, for the formulation, for the presentation to the parents. If consultants have been used along the way, ~~there's~~ very often the person evaluating the child may go along with the child and be with them during the consultation, but not always. ~~But,~~ in every instance we ask our consultants ~~to,~~ you-know, to tell the parents what they feel they must and want to, ~~But, but we want to let them know that we want to~~ have their data to put back into this ^{and} larger context of the total study, ~~Because what we found,~~ ^{is} I am sure everyone else has found, is what ^{the} social worker who worked with Al and me for years in the pediatric clinic used to call "comprehensive fragmentation," ^{this} characterized our OPD, ^{and} ~~and~~ ^{in other} many places where all of this expert help is brought to bear on the child and parent, ~~and they have, you-know, six interviews, six experts telling them something,~~ and they end up not knowing what they've been told.)

Even though there may be no dispute-- each one has told them a little bit of it, ~~No one has really said, "Well, now let's sit down and think about what all of this means, and what are your questions," and so on.~~

DR. BRAZELTON:

^{Could} Did you say who ~~what~~ the training of the two people ^{is}
~~are~~ ^{who} ~~that~~ relate to this child, to give us some idea of range
 ?
 1-

DR. PROVENCE:

~~Right~~ -- the people who do the work with the children
 are mainly ~~pediatric~~ pediatricians being trained ~~as~~ in
 developmental diagnosis, child psychiatrists, ^{and} developmental
 and clinical psychologists. They are the major disciplines
 involved. Once in a while we encounter a talented and
 attractive maverick who doesn't represent any of these
 disciplines but seems to have a talent for this kind of work,
 and we may take such a person from another field, ~~But, again,~~
 that's rare. They are mainly from child psychiatry, psychology,
 and pediatrics. They bring different things to the training,
 as you can well imagine, so ~~that~~ what they have learned before
 has to be supplemented in various ways.

Some

The ^{persons} people who do the work with the parents, as I said,
 are mostly social workers but, ^{they} ~~again~~ it might be ^{from one} anyone of
 these other three/ ^{disciplines} ~~or~~ sometimes ^{we may call on} an early childhood educator.

// We have an intervention program, so that we have also
 on our staff people from early childhood education, and special
 education, and depending on their individual interests
 and talents, we would see no objection to their having the
 training in developmental diagnosis if they are willing and
 eager to go through it. ~~But, again, that is getting off the~~
 track a little --

DR.

Sally

~~Sally, can I ask you one more question? You were speaking,~~
and I think it is commendable ^{for} that you have a way that all
of this ^{to be} ~~is~~ orchestrated so that the ^{parent} person gets a single
message. Who gives that message to the parent?

DR. PROVENCE:

There are two ^{persons,} ~~people~~ the person seeing the child and
the person seeing them. ^{the parents} Now, most of that would be carried
by the person who saw the child.

DR. *Sally*:

That would be one of these evaluators? --

DR. PROVENCE:

That would be right, -- the child psychiatrist, the pediatrician, or the psychologist. The parent-person is there to supplement to help them ask their questions. "Did you understand what Dr. So-and-so meant by that?" or "I know from talking to you that you wondered especially about such-and-such." So ^{while} ~~the social workers role is not as active or~~
the parent-person's role is not as active in that conference, ^{it's} ~~it's~~ ^{it's} ~~not as active, but~~ terribly important to the communication, we feel, and to the comfort of the parent.

DR. BRAZELTON:

Are ^{over seen again} ~~Do they see~~ them afterward, ever, or is all this together? ^{all of it?}

DR. PROVENCE:

Yes, we always invite them to come back after they have thought about what's been said or recommended, ^{there} ~~or it~~ may be only a telephone contact. ^{Our invitation} And, again, that is accepted in a high percentage of cases, because, again, as we all know, what we think we've said and what we have tried to say, and what they have understood can vary enormously.

There are sometimes, you know, in the middle of an interview ~~a final conference~~ ^{when} ~~that~~ the parents are so anxious or upset ~~that~~ they can't hear you, and you know they must come back ~~in a week, or whatever.~~

DR.

What is the rationale for, you know, using two people, ~~—~~

Schonfeld? one for the parents and one for the children, instead of ^{using} having one person?

DR. PROVENCE:

Well, sometimes it's done by one person, but it's a very hard job ~~and it's partly that the~~ ⁼ the comprehensiveness of the skills required is such that there are few people ^{who} that, I think, are prepared to ^{do it} ~~do~~ it all well. So, ^{it's} a sharing of the work. Also, ~~you see,~~ people are being trained all the time. And, if you have ~~a beginning~~ a person who is beginning his training with the child, you need an experienced person working with the parent, or vice versa, if the beginner is going to work with the parents, ^{then} we feel we need an experienced person working with the child ~~so that we~~ try to bring as much experience and expertise as we can ^{to} on the individual cases.

MS.

Is the focus of the interview, usually, to share with the parents more information about themselves, the situation of the child, or is it more ^{of} ~~to be~~ a springboard for some kind of intervention?

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DR. PROVENCE: Well, it can be both. What ~~we~~, we say is that we will try to the best of our ability to help them understand what the problem is. And, ~~you know~~ again that can vary enormously, depending on whether we've been able to ^{define the problem} find out, for instance, ~~We~~ may have a descriptive diagnosis without knowing causation. And that's not necessarily ^a disaster, because very often you can recommend intervention on the basis of what you can describe as functioning, as deficits, as assets, and so on, without necessarily understanding what it's all about.

DR. NEUBAUER: Do these two ^{persons} ~~people~~ see the parents together, simultaneously?

DR. PROVENCE: Yes, ~~it~~ ^{is} in the final conference, you mean? Yes.

DR. SOLNIT: I'd like to add ^{what} just one thing ~~which~~ may not be entirely clear. With rare, if any, exceptions, ^{whether} there is an offer of service, ~~it's~~ it's called intervention or not, ~~there is an offer of service being available~~ so that when you are trying to find out or understand that the implicit and explicit understanding is that we can be helpful to you and if you want the help. Intervention is a highly charged term because you have to say whether it's

DR. PROVENCE: Intrusion or assistance

DR. SOLNIT: And on whose terms

DR. BRAZELTON: Would that be within the setting that they have already become comfortable with, or is it ⁱⁿ another setting that you are

offering intervention work?

DR. SOLNIT:

No, it's the same setting, ^{the} whole way ~~in~~ which that setting and that environment is set up is that this is a ^{caring - term?} long-^{term?} ~~long-~~, available service --(background comments) ^{That's why Sally put} so much emphasis on the fact that increasingly there are self-referrals. Even when there has been a referral by a ^{physicians or teachers} ~~of something~~, very often the process through which the referral takes place becomes a self-referral. They think it over ^{and} call up when they feel like it.

DR. PROVENCE:

~~The other thing~~ and thank you, ~~for that~~, Al; I think that wasn't clear. But it also reminds me to say that for those people ^{who} ~~that~~ come from out of town, sufficiently far away that it isn't realistic for them to have the services from us, ~~then again~~, a part of our initial commitment to them is ^{that} ~~if we find that there is some need for some kind of service beyond the diagnostic period, we make a commitment to help them find it~~ ^{we} ~~help them look for it at least~~; ~~so we have a lot of contacts with agencies and physicians all over the State. So they may go back to their physicians, they may go to a family agency, they may go to a nursery school, they may go to a children's rehabilitation center, depending on what the problem is, and MR facility depends on what the problem is. But one of the greatest fears, again, that we've found that they don't always spell out that one of the greatest fears is that you are going to tell them what is~~

wrong and then leave them high and dry.

Sony: - *are the efforts to integrate what has happened to the child available*
 Female question - unclear -- answer "Yes" *to the parents*

DR. NEUBAUER:

I wondered what your general approach is here. You may already have a pretty good hunch about the child's difficulty *participation* *from* and the parental/contribution to it and response to it. *them*

How open are you *in* to tell *in* the parents what you have observed *about* -- maybe their own difficulties, *which have* which has contributed to it *according to*

Do you decide beforehand how far you may go and what is the capacity of the parent to understand it *more open* or do you have a general way of approaching *this is a more open way* (unclear)

DR. PROVENCE:

OK?
 I would say *we* are fairly direct, in general. Again, we - *one for*
~~I think one of the things we are likely to do when we are~~
~~recommending what is needed, -- I think there are times when~~
 we set up a program for the child in addition to *the parents*
~~that~~ *that* might not always be done, *when* ~~where~~, theoretically, one
 could work only with the parents to bring about improvement.
 Well, if we have a bias, it is in the direction of having the
 child seen, too, ~~Again~~, partly because we believe that
 something can be done in the direct work with the child,
 But, also, ~~again~~ because we think it helps ~~it~~ facilitates
 the work with the parents.

Now, it can be used as a way of avoiding getting them
 to work. ~~And~~, I guess if we have any kind of hazard among
 the staff, ~~it~~ *it* is seeing a very needy child whose parents
 are not ready to accept treatment *our* and trying to get the

?
parents?
who is
avoiding?

people to feel that they really must not say, "Well, bring your child and we'll fix him up." Because that's often the fantasy, particularly of parents like that, And, it's hard to resist if you feel, ^{the} ~~well~~ our staff could do something with that child. So, ^{parents'} ~~that~~ we do insist on their involvement.

MS.

Handwritten:
Thinking
OK

~~Sally, could I ask a question? If it is the wrong time to ask questions, just tell me.~~ You said that the greatest fear of your parent's, ^s ours too, by the way, ^h is the discovery ~~that~~ or the fear that ~~something~~ ^h will be discovered that is wrong and there will be no one to help them. In the event that the family cannot continue with you -- supposing they're just a little bit further away from your ^{center}, for example, -- are there facilities in the State of Connecticut that can serve these families after you have identified the need for continued service?

DR. PROVENCE:

~~Well, I would say --~~ I can't remember that we've not been able to organize some type of help. ~~Now,~~ ^{it} might not be what one would consider one's wish, And, ^{we} sometimes ~~our~~ assistance has been ~~they~~ ^{we} come up against the fact that there simply is no service available. Sometimes our assistance has been mainly to help the parents complain about this in such a way that somebody does something, so that it gets one into ~~as Al and I were talking about on the way down this morning --~~ helping parents to become advocates for their children with their school systems, with their towns. Also,

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MS: *Freiberg* ---advocacy bring help in time for this child --

DR. PROVENCE: Right. But I can't remember an instance in which someone who, at least, can be a source of some kind of tangible service, ~~which~~ *te* has not been available. It might be the visiting nurses, it might be ~~physician~~ *pe*, it might be --

DR. SOLNIT My comment was very much background to that kind of questions, Selma, because ^{I think that} as you listen to this method, ~~it's~~ it would be ~~slightly incomplete~~ significantly incomplete if you didn't realize some background factors. First of all, Sally and her group have been functioning continuously for more than 25 years in one place, in a small State that can be reached from any part of it within ² ~~two~~ hours. Sally, herself, and her nuclear group have trained a fair number of people who have worked in the State Dept. of Health and who run screening and evaluating clinics ^{They have} established a network of clinics, and so, when the child development unit reaches out to, let's say, the northwestern or northeastern part of Connecticut, there's usually someone there they've worked with and who can offer a helping hand. Even if it is short of ideal, it is a person with whom an alliance can be formed, if the parents want it, and who will take supervised advice, or take advice and counsel from the Child Development Unit periodically, but who ^{has the} have a sophistication of knowing how to translate and ^{is} ~~be~~ available. Now I don't want to overdraw this, but I want to say that when you are dealing with infants,

sp.

it seems to me that for all the tedium and lack of excitement that goes into staying in one place for a long time -- and, I am sure here that ^{and Peter} Barry can cite the same kind of thing for ^{their} his own work, ~~and Peter can cite it for his work~~ -- that those who have stayed in one place for a long time, you have such things as a person come to you and ^{ask} say, "May I look at my record," ^{now} now married, ^{with} having children of their own, who ^{was} were evaluated by Sally and her group 23 years ago, for example. That kind of continuity, which has its own burdens and tedium, also has an enormous way of reducing two problems. One is the pitfall of over-simplification, that is, thinking you know what you are doing ^{and} when you have things come back to you and you find out you either did or you didn't. And the other is the establishing of a network of relationships with colleagues throughout the region, -- some of whom you've trained and some of whom you've worked with in other ways on committees in various ways which ^{that} allow an effective communication -- at least enable an effective communication ^{that} which leads to the kind of summary statement.

I can't think of an instance recently, or in the past, ^{when} where I haven't been able to figure out some way of providing better than nothing, ^{or} far better than nothing, in following ^{on} up/what was an evaluative -- and -- an evaluative determination and an effort to reach a plan ^{that} which might be useful to the child and the family. Now ^{only a} there aren't many small states, ^{that} very few in which they are both small in populations and geography. =

There are a lot of small states in the West, but there are huge geographic problems. There are not many states that don't have a city larger than 150,000 in which these problems exist. So, I think that context in both the longitudinal and the horizontal are cross-sectional contexts in which this takes place sharpens the presentation that Sally has given you in terms of a method and an approach to this whole process.

DR. BRAZELTON: How many do you have to follow yourself? How many would you say you have taken into treatment yourself?

DR. PROVENCE: In our place? Oh, around 75 to 80 a year, which is about a fifth of the total.

DR. *Sally u*
Salmet But, Sally, how many have you carried over from the previous year? This is one in any/given year *←* you take on between 75 to 80 new ones. What about those that come back periodically from previous years?

DR. PROVENCE: Well, those that are kind of follow up *cases* things, well, there would probably be ~~Oh~~ *be between 30 and 40* 30 or 40 a year of those. It depends upon how hospitable *you* feel like being sometimes, *or* how overworked you are, but, ~~no~~ *it's very* it's also, very humbling experience to see people over time, because you are confronted with the question of whether you were correct or incorrect, ~~even in kind of larger, or more drastic, more~~ definite outcomes. ~~I guess~~ *by* I'm fond of something that I heard quoted as a statement of Ernst Kris recently *that* which said that if you want to feel successful, you should see

people only once and not let them tell you very much. I would add to that, ~~and~~ ⁵ and move every ⁵ five years. Then you can feel very good.

MS. ——— — what is the average age span - of population?

DR. PROVENCE: Well, this is concerned with the children under 5, and their parents.

MS. ——— How many are under a year?

DR. PROVENCE: Well, it varies, ⁹ somewhat from year to year, but I guess ~~there would be~~ out of 400 or so, perhaps 60 or 70 would be under a year. I guess the peak is between 3 and 4, or 3 and 4 1/2 ^{if one splits it a little} and then some 4 to 5. We see children who are older than that if we've started with them when they were in the age group with which we were concerned.

we also see some 4 to 5.

~~The other thing and then we see, and, in a way I suppose one would say perhaps we are megalomaniac, but what we try to do is to say that we will take any kind of problem development, whatever its cause, in the age group with which we are concerned. We will try to see if we can answer the question: What is the problem? What's its genesis? and, What could one do about it? And, sometimes we do it well, and sometimes we don't do it so well.~~

MS. (Woman)
DR.

families
Sally, what do you do to convince ¹⁵ /where the parents don't see the roles as part of the whole developmental process so easily? How common are families like that where

that is still a problem after the whole evaluation and
 -- input
 therapeutic/as well? and what kinds of thoughts do you
 have on how to manage that?

DR. PROVENCE:

Well, I would say that if we offer a service, if we
 decide that ~~its~~ that this is something that has some
 chance to be successful ~~case~~ and the parents won't join us,
 again we take them where they are, recognizing that for
 certain ^{cases} ~~ones~~ they may ^{be unable to} involve themselves or they may be
 able to use only a kind of educational child care advice
 -- and I must say I have to give them a lot of credit for to
 the patience and forbearance and expertise of ^{our social work} staff
 to do most of our parent work, because sometimes they have to
 work a long time with parents before they ^{can} convert it into
 something one would feel is a real casework ---. So that
 again they're willing to tackle it, ^{but} although, of course, the
 parent ^{have} has to be willing to come, ^{of course} And, if they don't, again
 that ^{too} is a communication. But, ² the people who work with the
 children tend to come to the person working with the parent
 and say, ^{ask} "How ^{how would you get her to} what would you get that mother to stop doing
 so-and-so, ^{or} do so-and-so?" So, again, ^{I would say that} the importance of
 the close sharing and working together and having some
 common goals I would say cannot be over-emphasized, because
 the staff can be really split apart if there isn't some
 agreement about how to do the work.)

If there is basis agreement and respect for the other
 person's job, then these human kinds of irritations and

difficulties can be surmounted.

But, ~~it is~~ ^{but} people who work with children who have never worked with parents in general, ^{by} tend to think that you can just tell ^{ing} parents what to do, ^{you can} and make them do it. Then, again, this is one of the reasons why we like ~~to have~~ everyone involved ^{to} have some experience in working with parents. The parents ~~do not~~ ^{out of} the parents, I would say, perhaps in one case in a hundred a parent brings a child to us as a ticket of admission to get help for himself or herself. The other 99 do not bring themselves as patients, although they may say "You know, I have something ^{I know} to do ^{with} this, but what I really want you to do is ^{to pick up} accept my child and help me ^{with} to do that," but they are very different from adult patients seeking mental health services on their own out of a felt need in terms of their own personal ^{problems} ~~so~~ it's very difficult, ~~a~~ lot of it is and one sometimes has to have limited goals for what kind of change ^{the} ~~can~~ ^{that} take place, ~~and you have to learn~~ ^{and} to accept those limited goals without becoming pessimistic about the possibilities of doing something worthwhile.

DR. NEUBAUER:

Sally, may I ask you about the developmental testing ~~to~~ ^{to} what degree, or in what form, do you outline where the infant or the young child may be at a given moment in his development compared with, or in addition to, ~~what is~~ the special individual process ~~of this child~~ developmental process of this child -- the speed, the ^(rush?) of it, the ^{belatedness,} ~~delayedness,~~ or whatever it is? Do you combine it

at a certain given time, particularly at intake, because you take weeks, or is this something that you later add as you know more about the child? My feeling is, ^{that} the term "developmental test" may include both aspects, ^{it is really} more of the second one than the first one.

DR. PROVENCE:

Well, yes, there are several aspects of ^{testing} ~~the~~ One ^{step} is the scoring on the test protocols of items passed and failed, ~~that's~~ ^{one} step. And we have organized those items that I mentioned using the old Gesell labels--gross motor, fine motor, adaptive language, and personal .)

We ask people to look at the development in all of those five sectors -- to look at the scatter, ^{the} age at which everything is passed, ^{the} peak, and put that on a profile in each sector of development, ^{you can} ~~to draw a profile.~~

^{we} But ~~then~~ to go beyond that and try to look at the possible meaning of those items, ~~and I have -- perhaps it would be better to do this later.~~ I brought a couple of protocols of ⁶ six-month-old infants that can be used.

Now ^{is that they} the other thing we ask them ~~to do is to~~ record them ~~not only -- to condense it not only what the child does, but~~ ^{the child} how ^{he} does what he does. Because, very ^{often} the ego aspects of the measurement, let's say, or something about, let's say, ^{of} about the child's relationships to important people can be inferred, not directly measured, ~~but can be inferred from~~ some of these observations. So it's used to score ^{quantitatively}. It's used as what I have referred to as a kind of structured

?

observational situation. So that either the examiner or the person behind the mirror will record some of these, particularly the qualitative aspects of the child's performance.

no ~~it~~ ^{They} And, maybe ask^{ed}, for instance, to characterize such things as activity, tempo, affective expression, ways of interacting with adults, self-stimulation; ~~there again,~~ one can be as extensive as one thinks is indicated. ~~That~~ those dimensions are not necessarily a part of every write^{up} on the clinical cases, but they may be invoked if we are perplexed about a particular child.

DR. NEUBAUER: I found it a matter of concern that less than 20% ^{percent} of the patients come to you ~~earlier than~~ younger than ¹one year, and most of them ^{come at the age} of three or four. I think that even if one does not accept ^{this is defined as} that the critical period, I think that most people would agree that ^{first} year that is patterned can be seen ^{last} ² and best dealt with, but at ³three or ⁴four some of them are really quite fixed and hard to dislodge, and I wonder whether there is any way of maximizing the earlier ^{approach}, which I think was most effective.

DR. PROVENCE: Well, Yeah, you know we try to get them as early as we can. We've picked up a number of the earlier ones from the consultations in the hospital. ~~Some of the physicians~~ ^{who} those that are referred in the first year are ^{not} more likely to be ~~not to be~~ self-referred, by the way, but to be referred by someone who has observed that there is something

going wrong.

Over the years, we have succeeded in communicating to some of the pediatricians that ~~there is a~~ early referral makes some sense. There are others who ~~really feel that~~ ~~they~~ adopt a kind of wait-and-see attitude. Sometimes we get complaints from parents that they were not referred earlier, because they wanted to come, but they feel that were *from some sort of course,* prevented. Well, again, sometimes that's a rationalization or retrospective criticism.

One very common thing that ~~we~~ ^{we} hear over and over again -- let's say, about delayed speech, is that ~~there is some kind of~~ ⁴ ~~cliche~~ that says that age ⁴ four, and sometimes age ³ three, is the magic number, and you wait until then before you do anything about a speech problem. Well, that's ridiculous, of course, But it is a kind of recipe that people tend to look for and love.

DR. ~~Haynes~~ :

observation
I think your ^{the} question is absolutely critical to this group of people's ^{entire} efforts here. And, I have been intrigued with something that Kathy Barnard and Luna (?) Haynes (?) at United Cerebral Palsy ^{told me about} put me on to, and that is some statistics which show that ^{when} children with ^{of course,} that infants with minimal brain damage, and this, is a more fixed lesion and perhaps it's easier for parents to refer themselves for, but when they were referred by pediatricians, they got to a therapeutic intervention by ¹⁶ sixteen months; When they were referred by parents, they got there by ⁴ four months. And I have a feeling that if [?] you

*Don't
worry
from your*

are setting up an advocacy ~~or~~ your term is not advocacy,
mine is, of teamwork approach to parents, That ~~this~~ ought
~~to be our goal~~ ^{the should be} to get in a good deal earlier and to set up a
something that is more available for this, whether they are
self-referred ~~or~~ otherwise, and maybe we could discuss this
more as we go along.

DR. PROVENCE:

You know, Leon, you are worried about the percentage.
I would rather say that there are 80 to 100 infants ^{who} that do
get there. You know you are putting it in terms of the
total

DR. :
Discrepancy?

Out of 400, you said - ^{about 60 or 70 are under one year of age} your services --

DR. PROVENCE:

^{yes, but} You're right, But, but, you know, there tend to be more
who get there as time passes.

DR. *Yost*

I think there is a kind of Pollyanna ~~attitude~~ attitude on the
part of the pediatrician. I saw it in my work with mentally
retarded children who end up with an I.Q. of 30(?), and the
first year you ^{join} ~~lie~~ with the pediatrician ^{intellect} and tell the
mother, "Well, he's a late talker, and late walker ~~or~~ he
will out-grow it." And, ^{as a rule,} the diagnosis of mental retardation
in most children who don't have any physical stigmata is not
done before the age of 3 or 2 1/2 ~~and one-half~~.

DR. PROVENCE:

You know, there are some things - some physicians who
are terribly late in their referring, and no one believes
^{strongly} more firmly than I that every pediatrician, or every person

who takes care of young children, ought to know a good deal about child development, ~~But, I would also say that when~~ they say to us that if ~~we~~^{they} referred every child who is a little delayed and whose ~~then we~~^{they} would be referring two-thirds of ~~our~~^{their} practices. If ~~one~~, so that their rationale for waiting isn't entirely unfounded, because somethings are, indeed, quite transient. And they may, then, overprefer, to the detriment of the parent and the child. So, I think that ~~it~~^{this} is a real dilemma for many practitioners ~~to~~

DR.

Sally

Sally, I would like to get back to the statements you made ^{earlier} about the critical periods, ~~earlier in your talk~~ because, I think ~~one of~~^{one of} ~~the~~^{that is} things going on in the child development community that needs to be known by this group is the way that issue is being battered around, particularly in Boston, between two ~~people~~^{persons} ~~one who~~^{one} says people — you can bounce back after ~~three~~², and what happens to you before then doesn't really make too much difference. ^{if comment:} The other who says that the second year of life is the most important year of life. And some of the statements that ~~you~~^{can be} made about when a skill is being learned, ~~that then~~ it is at the height of vulnerability, makes a good deal of sense with relation to how you might look at critical periods in infancy.

But, I think we have to re~~define~~, particularly for the people who use our information, what we mean by a critical period when we are talking about humans ^{As I've pointed out,} ~~because this one~~

* It is beginning to retreat. This. Proven. Once the harm is done

at one ^{who says you have to} physician ^(get in there) during the second year of life, almost seems ^{totally} then that you can forget about the child after that, ^{while} ^{an} ^{says what happens before age 3 isn't} And the other is ~~well, those things obviously aren't~~ that important. And, even the physician that Leon ^{tell us about} taught is one ^{who is} ^{he believes} that's so fatalistic that by the time the child is ^{3 1/2} ⁴ ¹ three and one-half or four years of old ~~that he is doomed~~ ^{This} ~~it just means that there's going to be a Hell of a lot~~ of work ~~that needs to be done after three and one-half~~ ^{3 1/2} ⁰. It isn't that fatalistic, I don't think.

My feeling is ^{that need} ^{Somewhat} we ~~are going to have to be a little bit~~ clearer, particularly if ^{you} ~~we~~ are going to make recommendations from how the Study Center works, as to what ~~this~~ infant intervention means. It seems like it is a richness at appropriate times ⁰ ~~it~~ doesn't say anything about what the child is going to be like at 18 if traumatic things happened to him at 9, 10, and 11, also.

And, I am a little bit unclear ^{about} ~~as to where~~ the child development community even stands on this. It seems ^{that} like we have been battling one side against the other, rather than really paying attention to this as an important issue that needs to ^{addressed} be ~~spoken to~~.

DR. PROVENCE: Yes, I ^{agree} ~~think~~ that the question of long-range outcome certainly ^{is} ~~is~~ very important. I ~~don't know, ever~~ in clinical work, I don't feel any need for ~~that~~ ^{ance} to guide ^{about} what I ~~would~~ recommend, because I think it's important to

do as much as one can at a particular moment. And so

Stat
DR. ~~Lally~~ Absolutely

DR. BRAZELTON: We found, that in trying to retrain pediatricians, and I think that a lot of this lack of referral on the pediatricians' part, is a reflection of their own need to deny a pathological model -- the pathological model of seeing things as inevitable, as hopeless, as helpless, and all the rest, and the pathological model of identifying what's wrong with people is really interfering with people's eyes -- their capacity to see themselves as working with parents rather than against them, or identifying with them, or doing something destructive, rather than constructive.

OK?
I have a feeling, that, particularly in infancy, a more positive model of development and a more positive model of identification in working with people is really critical to our whole concept.

MS:
Eccalone
I wanted to get back to what you said, because I think it's true, especially in trying to use what researchers find in practical programming, that there is much confusion. And, one source which you didn't mention, I think, is the difference between when something, indeed, has its genesis and when an appropriate intervention is most effective. This is something that is still wide open, and this group probably knows about as much about it as any group/put together in this region.

we 41 But, because something starts in the first year of life, I think we know now ^{from} enough in Sally's work, and Peter's, and everybody else's ^{it} that doesn't mean necessarily that the optimal moment to move in is during the first year of life.

7 | This is, in the case of an intervention, where there is some deviation, really nobody can, ^{in my opinion} with the exception ¹¹⁷ of very severe disorders and where there are neurological or other physical components that can be very certain -- Most of us have seen children who seem simply dreadful at ⁴ four months and by ⁹ nine months don't seem this way. With the exception of certain very clearly identifiable entities, there is uncertainty, but, ^{it} it is nonetheless true, so far as we know, that very many things that may lead to vulnerability or to maladaptation later, ^{do} indeed have their origin in their first year. But, if I may use a very far-fetched analogy, it's like a cataract operation. If a person ~~will~~ ^{has} have trouble with their vision, and you can diagnose it early on, ^{but} you can't operate until a little ~~bit~~ later. It's not the best analogy, but it is something like that, ^{and} it seems to me that we have been at fault in ^{our} the use of ^{the} our term "critical period," ^{the idea that} the biologists have used this strictly to refer to a certain developmental event must take place during a particular period of time or it cannot normally later on be established.

0157 In working with humans in psychological clinical areas, it has been confounded with the point of origin, the point of optimal intervention there's been some mix-up between

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preventive efforts in the face of recognized vulnerability
and therapeutic efforts in the face of recognized pathology.

And, I think when it comes around this notion, when do
you move in and ~~what level~~ these may be
important distinctions.

MS. ~~16~~
DR. FRAIBERG:

I think this is true, too, Sybil, except that in one
area we have two sets of clinical findings. In human
attachments, for example, ~~now speaking from clinical~~ ^{experience}
experience in both analysis and psychotherapy, ~~aged~~
3, 5, 7 and up, if one attempts to build in the appropriate
condition for the development of human attachments when the
child already is "non-attached" or disturbed ⁱⁿ with human
attachments at age 3 or 5, we can knock ourselves out in the
clinic ^{in trying to achieve that} and may not achieve it in several years. Whereas
our experience ^{now} in dealing with children in the first two
years of life is that if we can work toward the facilitation
of human attachments, the amount of time and the investment
on the part of both the parents and ourselves is considerably
^{lighter} ~~lighter~~ ^{and} with much better results. So, really, in taking
apart the whole story of development and seeing ^{really} when effective
intervention — when the intervention is most effective

DR.

Sally

The problem, ~~Selma~~, ^{see} is that people look at that last
statement you made as a fatalistic one. When you are talking
about economy, ^{and} certainly the way that ^{is} Sally presented it,
~~before~~, we do what ~~it~~ is appropriate for us to do at the

time ~~that~~ we are with the child ~~and~~ and certainly we have learned that it is appropriate to deal with those attachment things early.

And, also, you could have said ~~and~~ and you ^{have} work a great deal with some of those families and ^{have} had some success, but it took you a lot of effort to do that. You ~~did~~ (even?) say that last part. And, so, what I am dealing with here is ~~that~~ ^{that} yes, economically and logically and naturally, in dealing with the development of the child, you might work earlier, but it doesn't mean, as some people have the impression-- I hope not the people here -- that, you know, you just give up ~~that~~ if you have to deal with things at 7 or 8.

DR. PROVENCE:

I think ~~what the mistake has been~~ ^{that} one mistake ^{that} has been made in using the critical period concept is, it's an ^{all or nothing} in relation to the human ----

MS

Much more complicated than that -

DR. NEUBAUER?

I'd like to add here, when we look ⁱⁿ at our experience with our infant care unit, you either have the developmental model and ~~then~~ you stand by over a period of years in the development of the child -- the question of the critical period -- not interference with new emergent functions becoming problems. But, very often, clinically there is an additional task. You do already see and observe either ~~that~~ intrinsic factors which are pathological or with development

59
47.
has been

already interfered with to quite a certain degree with

or second or third year of life

and you already see those impacts ~~and then~~ you have

all evidence to assume that further development will be

interfered with. So, I think we have a number of dimensions

when we speak about critical periods. Do we mean the

process of preventive participation in avoidance-- ~~not~~ ^{non-}

interference, as we see it? Or do we see and assess existing

~~pathological state~~ authority which is not just developmental pathology but

interferes with development. Unless one differentiates this,

the question of intervention becomes a question of inter-

vention as if you deal with normality unfolding, and now we

have the three wonderful faculty of saying how can we facili-

tate the processes of progression. ^{while very often the, all} (Unintelligible sentence)

^{coming already to} And then how to combine it ^{into} ~~Natural~~

-- which is a

very complicated affair.

DR.

~~Well, if I can say a word here. Just as one observation.~~

Do we have to think back to Sally's point about individual

differences? ^{because} I think there are children who close off

the channels earlier, ^{y while} than others who leave them wide open

and are available to interventions later

MS. Selma

What children would those be? Could you give us an example?

DR.

Well, there are, I think, children who can't integrate

--who were born with less capacity in their synthetic

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functions or whose synthetic functions ^{were} are interfered with.
 When we were asked to start ^{the} a program for four and ⁴ five-year-olds that ended up as Head Start, ⁵ there was part of our group that ^{said,} ~~was saying,~~ "For many of those children, it is already too late." And that's ^{how it} ~~what~~ turned out to be, in Head Start. But, there were probably more children who could be reached and could ^{not} ~~rework~~ or develop capacities that had been neglected earlier. Spitz's concept and (sounds like Orlisses) is that if you pass the critical period for the development of a new function, or what Peter Wolfe ^{OK?} would rather call the optimal period for development of a function, ~~that~~ you can still ~~develop it~~, help an individual develop it under most circumstances, but not to the level that ~~it~~ could have reached ^{had} ~~if~~ the appropriate experience had been available in the appropriate time for the development of that function.
~~But I.~~

DR. PROVENCE:

Well, I was just going to add to that, I suppose that ^{would be} ~~that~~ ^{important} one ~~appropriate~~ area for research, and I am not sure that we know how to research it. Although we have, from some research and ^{from} clinical experience, some impressions of ~~of~~ that ~~go like this~~ that there are certain useful functions, adaptive and otherwise, that are minimally impaired by ^{and} ~~and~~ noxious influences ^{in these cases}, and others that are severely impaired by noxious influences of a certain kind, at a certain time, so that ^{very} ~~it~~ gets ~~so~~ complicated, because we tend to speak in global terms of damage vs. [?] ~~recovery~~ and what

do we mean by that and, you know, part of what many of you are doing, of course, is attempting to tease(?) out things that have to do with individual capacities or vulnerabilities or certain combinations of things which, ^{that} combined with a certain kind of environment, lead to ^a certain kind of developmental picture. It's mind-boggling ^{to} me.

DR.

Richmond?

I think, of course, that we accept v ery readily that there's a wide range in the development of any given capacity ^{we're only beginning} but ~~that~~ when we begin to talk about damage we don't differentiate in our thinking to such an extent that there's a wide range of ~~of~~ damage, and that, therefore, possibly, a good ~~a~~ range of ~~of~~ reversibility

DR. GREENSPAN:

When we think about ~~when we think about~~ reversibility and the value(?) of critical period, I am reminded of your earlier comment in terms of talking about a general model of development ^{development in a Piagetian} to what degree, and I thought you were talking about the ^{when} ~~level~~ you were talking about structure developing at ever higher levels of integration and synthesis as differentiations occur, So that the model of development is, ^{well} you know, innate(?) given experiences interacting through a process and a sequence of maturation, all feeding in at higher and higher levels of differentiation ^{when} when we talk about critical periods, it may be hard to observe the effects of what happens in infancy, for example, in some children

with
something

to/late adolescence. In other words, it may not show up as
"what we can measure" ^{or} ~~even~~ observe ~~until~~ a/kind of
stress or strain which adds even more complexity to the issue.

I've seen adolescents who ^{with} have severe disturbances ^{whose} ~~where~~ close
history, even with seemingly reliable parents, doesn't
indicate ^{the} any really obvious course of schizophrenic illness
that one comes to expect. You don't see the schizophrenic

in a family, you don't hear about the soft neurologic signs ~~you'd expect~~ -- ^{the} "superschizophrenic" ^{has been}
~~there's a term that was given, called super-~~
~~phrenics--the ones who have done extraordinarily well, as~~

president of the class, his social behavior is excellent,
~~Close friendships are reported in the childhood~~ and yet,
all of a sudden, ~~you know, if we do not accept~~ ^{ing} the idea that
this is a biological trigger, ~~That this, in fact, was an~~
existing vulnerability ^{that} but did not become ^{appear} about until a certain

kind of stress, ^{occurred} such as the separation of late adolescent
life, ^{the} takes us back to look at what-kind-of pattern of early
development in the first year, not necessarily ^{9/11} would be

predictive, but if we want to differentiate or discriminate ^{between}
those who should be assessed ^{and} ~~vs.~~ those ^{who shouldn't be} ~~that don't~~ not have

every child that a pediatrician ^s ~~what~~ pattern/should be
suggested if further kinds of assessment, ^{are indicated} and how must we

further differentiate our assessment tools, our assessment
observations, in order to more effectively ^{look at} ~~look at~~ precursors?

And it's probably not "critical period," in the sense of biologists
talking about ^{non?} attachment that is irreversible, but ^{at} certain
stages in life, ~~no doubt~~ with new stresses and strains, it's

②

②

11/15

harder to capture certain of the tasks of attachment -- let's say, when a child is 5 or 6 and hasn't accomplished it. Well, he's faced with all sorts of issues at that time, too. Maybe it's a lot more difficult, but not impossible. (

the path ?) that you were suggesting earlier and elaborate ~~/~~ of structural development and structure building in a piagetian sense, also, relating to affective development, where the relative reversibility or irreversibility has to do with the complexity of the various structures as they exist in relationship to one another.

DR.

Brayton I haven't thought this through too carefully, but I'll just sort of label(?) it and do some more thinking about it. It seems to me *that* there, in all of the comments, there's an underlying, unspoken assumption about what *is* the role of the mother, ^s in dealing with children who have variations *that* ~~which are~~ fit into the category which Sybil described. In other words, we rule out gross neurological or central nervous system defects, We talk about the more subtle, the more difficult-to-localize kinds of things, and there are assumptions built into the way ~~in which~~ we weight these in regard ^{to such children} when ~~they~~ should be seen, to what extent we should become active or invited to be active, by according to how we value, or assess, the mother or the parents. Mothering (cough) - to serve as auxiliary egos, to provide nurturance, and to be able to wait for lags or ^{de?} dissynchronize to become more synchronized. And I suspect

there's a very vital issue in this, ^{first,} Having to do, (1) with
^{poss. ability of care} ~~in the most gross sense~~ ^{with} our need to be rescuers, ^{the} and ^{to}
^{becoming} become, really, too pretentious about what we think we can
do or know ^{what} we can do, but Sally did say that we ought
to remember the ~~mother~~, [?] ~~in a certain sense~~, is the expert
~~the~~ ^{the} mothering figures are the experts. And, then, secondly,
^{we must consider how} ~~somehow the way in which we~~ assistance is provided; so that,
for example, maybe the pediatrician or the medical service
model really is not one ^{the most acceptable} that is accepted for that kind of
problem. Maybe there ~~is to be~~ ^{should} some other model that we have
to look at and see, ^{is} is it the neighbor? is it the grand-
parent, ^{is} is it somebody else ^{that} that helps a parent decide ~~that~~
^{you know,} "Well, I think this is something we can wait ^{that} with, or this
^{they} is something ^{about} we ought to ask the question ^{of} of, and maybe we
don't get the questions; Maybe somebody else does. I'm
simply saying ^{that} ~~someplace~~ in this the mother-child pair in
that first year of life ^{is} are extraordinarily important and
complex. And, as we try to focus down, as we must, on the
child, there is a tendency, I think, to become less aware
of the differential role and the relative role of the
parenting figure in assessing the problem and in dealing with
the problem and in ~~being able to determine~~ ⁱⁿ which route to
take ⁱⁿ about dealing with the problem.

DR.

Quirre

Well, there was a I thought about Walrich(?) over the
last weekend, and he had discovered, in his father's notes,

the description of a syndrome, or a pattern, that he called
the "executive infant," and I think that's worthwhile
keeping in mind as we go about our discussion. But, I think
what Sally has done is assessed our developmental stage after
our first two meetings and she's decided that we didn't have
foundations, and she's given them to us. And we fit in our
previous thinking and contributions on top of those foundation.

DR. PROVENCE:

I was only trying to tell you what my foundation was,
Not what yours should be. I'd like to add two things, quickly?
~~I'm not~~ in my compulsion to neaten this all up, and that is,
the other thing that is demanded of the evaluation is that
there be a written summary, which everyone all of us groaned
about which,
—and I want to mention that, because I think report writing
is terribly important. And, it has to be geared to, you know,
where it's going to be used, whether it's an internal report for your record that's never
going to go anywhere else, or whether with whom you are going
to share this other than with the parents. And, most of the
reports that are written, by at least by physicians who are
child development specialists, and I suspect by others, are
in general useless for the people who are going to carry out
the work with the child. Now, if it's in your own place,
you can manage that. So one of the things we've struggled
with is -- what kind of reports and for whom, what information
do they need, how can over time, how can you
present things that you want -- in order to help
-- and then again -- the recommendations about what one is

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^{should}
going to do and should follow logically the materials --
and put it together. And I just mentioned one other --
that we all have, and that is pretty good, or we know the a
facility ~~that is~~ that is pretty good and we tend to recommend
what is available. So ~~that~~ we have another step in our report
writing, and that is, ^{that it contains} you know, the recommendation is required
to be ~~that~~ ^{what} which you would recommend if you ^{were} could organize ^{ing} an
ideal service for these parents and child. Then, your second
one is realistic and practical in relation to what
actually can be done. But, I think we've often left out the
middle step. So, we ~~get to~~ ^{that} thinking what is available is what
is good, ~~and now, you know,~~ maybe not everybody needs this
kind of thinking through, but we send people through certain
doors because we attach certain labels to them, instead of
~~looking at~~ ^{asking} well now what service does that agency ^{has} have that
might benefit this child and parent, ~~and~~ and then you write
up the report to fit who is going to get it. Where ~~you think~~
the child -- well, you know. I've developed a good deal of
guiltless expertise at helping agencies to accept the child
if they have a service ~~that~~ I think the child needs, and
saying, "well, I'll call him anything you want me to ~~if~~ if you'll
take him." Well, ^{But} that's ^{another} a whole ~~other~~ story, ~~it's~~ it's a
history of how services are developed and how fragmented and
specialized they are, too. But, ~~you know,~~ there are formula-
tions and formulations, and there are labels and labels, and
ought to
we all know that, I think.

75 step

DR. BRAZELTON:

Sally, there's one more aspect that I couldn't agree more with or complete(?) in descriptive write-up, and it goes back to John Benjamin's beautiful model of longitudinal study which, I think, is we can get that we're only looking at children at a certain stage in their development, and our failures may be just as important to their future development as our successes, if we look at them in a longitudinal framework. And, the sort of things that you write down may be critical for reassessment later on to see why you failed, what you missed early on, and what may be underlying the ~~underlying~~ reason for failure, which may make a big difference in an interventive point later on.

DR. LOURIE:

Well, to put this in a historical perspective, and maybe in a longitudinal point of view, I remember talking to Arnold Gesell (?) about some of the dynamics of the things he was describing, and he said to me, "What my mission ~~is~~ is to describe what happens; I'm going to leave it to others to find out why ^{it happens} and what ^{to} you do about it." And that's where Sally picked up, because that's what she has been doing, ~~if~~ carrying on from there. But, we've asked Kathy Barnard ~~to~~ would discuss this. Let's turn this over to you.

DR. BARNARD:

Well, I've revised my discussion a thousand times while sitting here, and it's a privilege to be with your group, and I'm not sure that coming in cold is a disadvantage or an advantage, but I'd like to just provide you with some of my

free associations during the presentation discussion, and
one is that I think the kind of work that Sally so carefully
described probably represents the kind of involvement that
a very small minority of children in our society would benefit
from and would ^{need?} ^{percent} 20% or so. And my concern today, coming
from a history of working with a select group of handicapped ^{and?}
mentally retarded children and their families, and now working
with normal children and their families and also premature
infants and their families, is a concern for the larger
population of children. And, I have ^{the} a feeling, ^{perhaps} that we
maybe need to re-think our human health care services in
terms of the kind of structure and the kind of support we
provide. And, ^{I'd like to alert} if I may, if I can just (clue) you out to
another frontier, ^{that} I feel ^{lies in} for the future, and that is the whole
business of a syndrome that I call "It's all right to feel
nervous about giving birth, but it's not all right to be
nervous about parenting."

And, I think we have now made some landmark kind of
progress in terms of mothers and fathers ^{and} with the whole
issue of pregnancy, ^{and} we realize that maybe there are some
alternatives to obstetrical and maternity -- childbirth --
preparations, ^{rather} ^{other} than going in to see the obstetrician
¹¹ eleven times during pregnancy, gain weight, have your blood
pressure taken, ^{and} your urine checked, ^{get} and patted on the butt.

And, I think we need to think more carefully and
maybe
examine, and then do some new studies on ^{whether it is} ~~in fact, is it~~

possible to do more preparation for parenting during the pre-natal period of pregnancy. I don't mean talking in Red Cross classes about diapers, what kind^{of} formula^s, ~~or whether you~~ should breast-feed^{in 9/5} ~~or~~ bottle-feed^{in 9/5}, or whether Gerber's adds salt to their baby food so you should mix your own. But, I mean establishing the kind of confidence^{mothers need} ~~that~~ you talked about the fact that the mother is the expert. Let me tell you, mothers don't feel that they are the expert. If we truly feel that they are the experts at taking care of their children, I think^{that} ~~then, that~~ we have to learn how to communicate. It's much more effective than ^{who} are doing today.

Most mothers feel unsure, unconfident, and ~~are quite~~ depressed about the whole business of parenting and confused about what father's role should be. So, I think we need to give some serious^{come up with} consideration^{and} and some fresh approaches to the whole business of preparation for parenting.

I'd like to pick up ~~on~~ one of Sally's points^{about} that the whole business of infant assessment^{and} and I was terribly pleased to hear ^{for} her emphasis on the fact that the first visit, they encourage the parents to come along ^{(alone without)?} the child^{because} because I've seen in so much of my work, particularly now as I have been working with a number of centers across the country who are giving services to ^{atypical(?)} ~~a typical~~ infants, ^{the} the fact that the parents do feel that they are bringing their child in for treatment^{also, it is} and, ~~its in fact,~~ the tendency of the staff people -- the therapist, the nurse, the pediatrician,

^{the} early childhood educator -- to work with the child, ^{and} the parents don't want to be worked with over a period of time, ^{and so} even though we talk about the fact that parents are important ^{and} they are, maybe, the primary programmer^s of the child, ~~in fact~~ because they bring their child for treatment, ^{it} takes awhile for them to accept that ~~that~~ they, in fact, also can get help for their situation, and need help in coping with the child. It takes an equally ^{long}, or maybe a longer time for staff to realize this.

~~Therefore~~ I think
So, then, ^{on} if possible, setting the focus ~~to~~ helping the parent^s realize the importance of their parenting is extremely important. ~~I think that~~ it is a complex issue in terms of infant assessment. ~~I think~~ it must be comprehensive. ~~I think it~~ gets all very confusing sometimes, ^{in the} assessment process, but I found, ~~that at least for me~~ in some of the work ~~that~~ we've been doing, that everything fits together if you look at and ^{you} focus on the interactive process, ^{how} the parent behaves, how he puts it all together, how the infant behaves. This does not negate the importance of looking at ^{the} ~~the capacity of~~ infant behavior or parenting behavior individually, But, I think where it all makes sense, in terms of the process of child development, is in the interactive situation; ^{therefor}, I think any infant assessment must include ^{the} component of looking at interaction between ~~the (character) of~~ parent and infant.

I was interested in your comment about clues in the

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as maybe being the clue to some of the problem^s in the parent;
or, I would also like to ^{phrase} that, as maybe the clue to
the problem the parent is having. And I would like to give
you two specific examples of things that I have been thinking
about recently. One ^{arose from} is working with premature infants ^{and} then
going back to some literature ^{which} and happened to be Brazelton and
~~Ken Cade's (?) Ken Hayes (?)~~ ^{on} "suck-pause"
Kincaid's ~~(?) Ken Cay's (?)~~ work looking at ^{"suck-pause"} "sucked-paws" (?) cycles,
and the idea that maybe the ^{of} "sucked-paws" is the framework for
the establishment and the communication network between the
mother and infant. In other words, the infant sucks and then
pauses, and it's the tendency of the mother to do something
during that pause. When she does it will often help you to
predict how the baby is going to respond, and I think their
work suggest^s ^{that} when she interferes, or when she does something
right after the suck, ^{it} ~~it~~ doesn't let the child pause for any
length of time ^{and} that tends to ^{pro} ~~pro~~ long the pause, whereas if she
gives the child some opportunity to pause and then strokes
or talks to the child, he sucks sooner.

Well, I was thinking about that, and we have been doing
a lot of work with premature infants, and I was particularly
interested in the organization of behavior. And, as I looked
at the kind of stimulus they provide for their mother^s or
their father^s, in terms of ^{the} this human communication and inter-
^{it occurred to me that we need} action ~~(?)~~ system, ~~if have to just~~ look at their suck-
pause cycle to see all the irregularities that that mother^s
^{are} is faced with in establishing a communication system. So I

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So think, here's an example of a biological, if you will, rhythm that sets a pattern and makes an interaction more vulnerable. It takes a pretty sensitive, astute mother to get in there and develop a communication system ^{that} has a flow, ^{and} a rhythm.

O.K. The second example ~~that~~ I have been looking at recently ^{that of} is the case of infants ^{we've been} ~~we've gotten into~~ looking at infants in the nursery with ^{Brazelton's} the New-born Behavior ^{Neonatal} Scale.

Neonatal?

~~that Dr. Brazelton~~ infants who are very alert, ^{they} just look around all the time, survey ^{ing} their environment ^{and} and I've had the opportunity to follow a couple of those infants. It seems ^{and} to me ~~that we need to, for instance,~~ I ^{tell} would like to give you ^{about one} a specific example of a case.

This is a family ^{with} very well-educated parents ^{who have} everything going for them. ^{They} ~~he~~ wanted this baby very, very much. ^{He's a} ~~of~~ and super-alert baby, ~~you know, just~~ looking around ^{with} an awake period every time the father comes home, ^{some time between} ~~at~~ 5 to 8 o'clock ^{all of} just taking in ^{the parents} his environment. But ^{kind} they were beginning to have tremendous problems with the child's sleeping. And, so I made a home visit, ^{while I} and was watching the baby, and they said, you know, they told me before ^{the fact} that he was going to ~~that~~ ^{start} that he was going to have his first cry period ^{had been holding} about 6:30, it starts ^{ed} so they were holding him, and ^{ed} had providing him with a lot of stimulation, and he was super alert and looking all around, and he started to 'fuss-cry' and they were holding him. And, I ^{asked} said, 'do you mind if I ^{could hold} took him for a minute.' ^{As I did,} And, it became obvious to me as ~~I held him~~

^{this} that baby and I happen to be interested in sleep-- that ~~he~~ he had so much energy stored up in his body that he ~~became~~ he couldn't do anything ~~else~~ but be irritable. Until (?) ⁹¹ we need to think about the special vulnerabilities of the infants who take in too much stimulation early. There are some ways that maybe we can help parents learn some safeguards, [≡] you know, of how to provide consolability, how to limit maybe the infant from being overtaxed in terms of the stimulus input.

So, I think that -- at least my experience suggests -- ⁹¹ I don't know always the right answer of what to do, and I don't know always the right answer about later outcome, but I feel kind of committed at this point, as Sally said, you need to respond sometimes, clinically, to the distress that people are having now, in addition to being concerned about some of the other factors that maybe are more predictive of later problems.

~~I feel very definitely~~ -- I don't know why our country can have ^{the} a system that we ~~do~~ have ^{to provide} in terms of the support of agriculture, which is an important commodity, that is very sensitive to the needs of growing crops, ^{and} very sensitive to the needs of farmers, ^{and} farm wives, ^{yet} and we fail to have an equal system to provide support to families, ~~to provide~~ support to parents. I think we need to steer away from the, you know, either the pathological model of child development. I think most families need help, and we've got to

get down to the level of knowing how to use the nurse in the maternity ward, the nurse in the labor room, the obstetrician, the parent[✓]educator, to provide the concept of supportive services that are going to help not only the 20% of ^{percent} ~~the~~ population but ~~to reach~~ ^{the} far more general population. And, really, if we are interested in optimizing development, I think we must address that. So, ~~I think those are primarily my~~ reactions.

DR. LOURIE:

Well, thank you. Just in time for the arrival of the sandwiches, particularly --

DR. BARNARD:

I always speak just before food.

DR. LOURIE:

Particularly as you were talking about the rhythmic patterns related to (too much background noise)

BREAK FOR LUNCH -- END OF TAPE. (EG)

* Replace?

ID CODE: DR. (Unidentified male voice)

MS. (Unidentified female voice)

Left blank when not completely sure of speaker's identification.

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I said when I introduced
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e crux of the preventing model

*Penailed Amendments
listened to 2nd Tape*

Ethel

~~in pediatrics~~ I think, as Kathy Barnard
identified, that we also feel that at least 90, ^{perhaps even} maybe 99% of the young parents in
this country are at risk and need help, ~~and to not~~ change our model at the time
when we are conscious of this and conscious of the breakdown of the American family
and the stress ^{on} young parents, ^{would be an} ~~really, somewhere~~ ^{on} ~~abdicating~~ our role.

We're also conscious of another thing, ^{ing} and I picked up the hostility in some-
body's voice ⁱⁿ as ~~they~~ ^{ing} talked about pediatricians. Bea Whiting ^{who} is an anthropologist,
~~and she said,~~ ^{that} "you know, one of the troubles with pediatricians playing in an
interventive role or teamwork role with people is that they've been trying for too
long to fill ^{up} the gaps around the lonely and nuclear family that can not be
filled up as easily as that. And they get so angry and so frustrated in not
being able to fill ^{the gaps} ~~them up~~ that they become ineffective and hostile, and I think
this is a tremendous danger. We see our model in pediatrics, ⁱⁿ and I think I see it,
having been trained in child psychiatry, ^{as} somewhat the same, ^{was} as having been
destructive, in as much as it's a pathological model. And as long as we go on
identifying people and looking at people for their pathologies, we are going to
have less than success in reaching a target population, because the Rosenthal
effect is too strong, ^{People?} ~~and they~~ can feel it and they don't want to have to deal
with it. When we came down to the NIMH consultation the other day, ^{to} bring down
our tools for identifying parents and children at risk in the mental health area,
~~I came down with all my tools ready, Al came down with his ready, Peter,~~ there
~~were several of us~~ we were met by black Puerto Rican advocates who said,

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"Don't identify us one more time. You don't know what it's like to be poor, and you don't know what it's like to be black or Puerto Rican. To go on identifying us with no intention of doing anything about it ~~once you've done it~~, is ~~so~~ ^{doing for} destructive." I really heard them. I think this is what we've been ~~up to~~ ^{doing for} too long in pediatrics and, I suspect, in psychiatry too, And it's time we changed it, ~~so~~ ^{so} this is our challenge in Childrens' Hospital in Boston today, and we're trying to meet it in several different ways, and the outcome of part of it, we'll present to you today. We're mostly stuck with the old models, ~~and the old models that~~ we're stuck with, at Childrens' at least, have first become tertiary models of intervention. We've been asked ~~to see consultations~~ ^{called in as consultants to see} on the ward of children ~~and parents who are failing and we've already failed and identified enough to be~~ ^{or have} brought into ~~the~~ ^{They} childrens' hospital as failures, ~~to represent clinical syndromes~~ ^{been} such as failure to thrive, ~~such as~~ ^{we see as} child abuse, multiple poisoning, multiple accidents, all of which ~~as~~ ^{as} failures in mother-childhood interactions. ~~All of which we see as failures of mother-child interaction.~~ And all of which, taking Kathy's model, if you go back with ~~mothers~~ ^{the} historically, ~~into her earliest~~ ^{for} association with ~~this~~ ^{the} baby, every single patient we've admitted in the past ~~two~~ ² years, the mother has said, "That baby never turned me on." And if you go on beyond that, "That baby never looked at me," ~~as a person, never mobilized~~ ^{as} what strengths I had. ~~And we see these as not only~~ ^{as} a challenge to us at the identification point and the therapeutic point, ~~but~~ ^{as} a challenge to look back beyond that, to see what it was that never turned her on. ~~What we might have done~~ ^{we might have provided} ~~the~~ ^{that would} was supportive discipline ~~to have helped turned these two~~ ^{persons} people on to each other.

Now we have another model, the secondary model, ~~which we see people in what we call~~ ⁱⁿ the Early Childhood Program, ~~and the Three I's sends us all children under three.~~ ³

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Unless ^{the parents} they identify themselves ~~on the phone~~ as having psychiatric problems or ~~are~~ ^{so peculiar that} being ~~so kooky that~~ they can't answer the ^{our telephone interviewers'} questions, ~~on the phone, with the phone~~

interviewers, ^{most} we get pretty much of the not-so-terribly-ill problems in the under-3 ^{group} the age of three in our Early Children Programs ^{hood} on Monday mornings ^{come to} in the clinic.

^{R.} ^{already} We do have a multi-disciplinary team ^{there} ^{with} we have a social worker, and we have nurses, and we have psychologists, and we have a play therapist who plays with ^{to?} the children in a group and see how the mothers and ~~the~~ children are interacting, ^{they're} they're interacting in the waiting room, so we can cast that against their interaction with us in the pediatric examining room ^{and} to this extent, we have teamwork evaluation around this secondary care model. ⁹¹ Now we are trying to extend our third-year program into looking at how we could have an effect on primary care ^{the} and what kind of tools ~~that~~ we can offer primary care, ^{for} for identification, for assessment, and for advocacy--how we ^{can} ~~get in~~ as advocates ^{get} into the mother and father interaction as early as prenatally ^{and} we're starting prenatally because we think that's where most of the action may be ^{and} ~~and~~ certainly around the perinatal period, ^{we've} we've become extremely aware about ^{powerful} ~~powerful~~ the power of our model for interaction if we take it on as an advocacy program. And ^{we} happen to believe that most parents know what they need and what they want if they're given the opportunity, as Sally said, to identify it. So this is the ~~sort of~~ context ^{in which} that we're developing ways of looking at people and ways of looking at ourselves, ^{and} and it's probably ~~a heck of~~ a lot more important than anything else. And we are doing it in a research paradigm ^{the} the research paradigms mostly come from child development rather than from psychiatry, although, as most of us know, all of the conceptual thinking behind research paradigms ^{come} from the dynamics of child psychiatry. Within that context, we've been trying to develop something that I hope will begin to solidify some of the ^{mother-infant} interactional things we ^{told} ~~we~~ showed you ^{about} ~~in~~

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we were here

the last time ~~between the mother/infant interaction~~. We'll ~~come to~~ looking at the baby ^{to see} for what he can show us. There are three different contexts ^{in which} that we ^{make our observations,} have to ~~see~~ ^{be} thrown in then, whether we like it or not. One is in a hospital without anybody else available, and another is in a clinic or our offices with and without the mother and or a lab, and the third ^{is in the} is at home with or without the mother, and we're trying to identify the differences in what we can tell about the baby and about his behavior with those three layers in mind, We're trying to create a test with the baby within the context of an interactional setting, whether the mother is present, or not present, ^{we} are still looking at the baby's behavior and what does it ^{can} tell us about his interaction and about his past experience about interaction. As many of you remember who were here last time, I showed you how, clinically, we pick up the same thing that we see on our videotape [#] that cyclical reciprocity model of interaction, about getting a baby jazzed up slowly and on his own rhythm until we either begin to get it or not get it, and we can gray this in a baby ^{who is} that's isolated on the wards. There ^{is} no question in my mind that it's there to be captured if we use the right maneuvers to get it, and even ^{when} if we have a baby ^{who is} and it's isolating, destructive, and overwhelming ^{on the} as a pediatric ward without the parents present.

Well, our second goal was to create a test of temperament or style beyond the presently available and accepted tests, ^{that} which would provide all of Sybil Chess and Thomas's ideas Escalona's beautiful ideas about individual differences, about temperament, ^{Chess and Thomas's ideas} that Chess & Thomas brought out, ^{and} the Bayley and ^{Gesell} ~~Gazelle~~ items ^{Gesell} and I've fortunately, I had the experience of watching Sally give a ^{Gesell} ~~Gazelle~~ test early in my career and I got some idea of what ^{Gesell} ~~Gazelle~~ was talking about. We want ^{ed} the cognitive, the motor, ^{ic} and the neurological items assessed there-- concepts of what we can get out of

these layered approaches to a baby. The other thing that is vital is that we must think of the test as ~~an observation~~ ^{no to} as a coping paradigm and think of it as just looking through the looking glass without thinking of it as a coping situation for a baby, whether at home or in the office or in the hospital, is somewhere ~~some~~ kind of wishful thinking ^{it} and certainly for the mother ^{being} is a coping paradigm ^{she is} looked at, herself and her baby, ^{being} examined with professional eyes and rather than say, ah well then, that limits us, we can use that as the basis for our look and see what the child's equivalent of coping is ^{as} as Winnie points out, coping is really a measure of the defense systems. To thing of coping as something we should ignore or shut out ^{to} is missing the strength of the situation. And so we look at this as a coping paradigm on the part of the baby, on the part of the mother, and ^{primarily} on the part of the interaction. Although our main concentration is on the baby, we are also looking ^{to see} at ~~the~~ or how this can be adapted to pediatricians, the nurses, the people who have an opportunity to play a preventive role in the developing situation. We're obviously hamstrung by that in certain ways. We're ~~trying to make a test and we~~ ^{have a test} now set up that will only last ¹⁰ 10 to 20 minutes. The strengths of anything beyond that becomes so overwhelming, and everybody's defenses begin to get up ^{pediatricians say that} you can't spend more time with people, ^{because} you can't spend, it costs too much money; "you can't afford it, we can't afford it, ^{Also, they say that (?)} and our target population seems to be not a middle-class population, ^{and} ^{that they} Particularly, they ought to be looking at a cross-population. This is one of our goals, to find things that we set off automatically in a pediatric situation and then conceptualize them and document them and scale them and so we'll begin to take credence from the ^{pediatrics} standpoint, this is where a lot of the action is. It isn't ^{that} the pediatricians and nurses who are in

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homes and in the office don't pay attention to these things. They do. They store it away somewhere in something they call intuitive responses. To me, that is no longer acceptable for us if we're really going to begin to document and pay attention to what we're seeing, calling it intuitive no longer is not enough. We can document it, and we can put it down and look at it and ^{see} say what ~~did~~ we pick up ^{ed} when ~~he~~ ^{the child} was ⁴ four months old, ^{or} what didn't we pick up when he was ⁴ four months old. And again, ^{HS} what Benjamin said, maybe what we didn't pick up ^{was due to} is because of our own set of mind, our own limitations, or more important, maybe ^{they were} it's, unconscious mechanisms that ^{were} are going on between the mother and the baby, and these are the things ^{that} documenting it, having it inscribed and ready to go for a reassessment later on would provide us with. Within this kind of thinking, we set up a six-frame ^{matrix?} Dave Elkind's meaning of a frame, ^{what} is expected within a set of an interval of time, because of the expectation of the situation and the participant. Within this, we set up five frames: the baby alone, the baby with the mother, the baby and the mother and the examiner, the baby and the examiner, and then the mother and the baby. We are aiming at presenting a limited number of stimuli, which includes some concepts of how a baby will respond to an object versus a person, and ~~object and a person~~ and also the whole concept of what it means to have an object and a person proximal, ^{both at a short distance} out here somewhere and closer up. And we know from our work that ^{thrive} failure-to-cry babies are stress babies, and this is a very critical sort of reach spacing ^{at a short distance} here, and when you get closer ^{to the certain place,} the overloading the hypersensitivity, all the things we talked about way-back in 1951, becomes critical in how ^{a baby} ~~they~~ can deal with an object or a person, and so we don't think of this as ⁱⁿ any way affixative at this point. We've just been working on this ^{only ever} in the past ⁴ four to six months, and all the (continue on next page)

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group effort went in. The three fellows that here have been working very hard on it, and what we really would like to do is see if we could get your suggestions and then we'll go back to the drawing board. And with that as an introduction, maybe Winnie Parker would take over.

Parker

~~XXXXXXXXXXXX~~
I thought that I'd start by telling you the kinds of children that we're ⁱⁿ in the hospital. ~~XXXXXXXXXXXX~~ We get very very few infants referred to our outpatient clinic. ~~XXX~~ Maybe it has to do with the fact that we haven't been there that long, so we haven't really had many infant referrals. Most of our children in the outpatient clinic are 2 year olds. I thought that since we're going to concentrate on infants today, ~~XXXX~~ I'd talk ~~XXXX~~ about infants and how we perceive them there. The first thing is that we used to be ~~XXXX~~ and I think that we've been moving up a little bit ~~XXXX~~ Sometimes the ~~XXXX~~ So they asked us, usually these are children that have come in and it is really not - they don't come in to us, we really are coming in as consultant basis. For example, ~~XXX~~ the kind of child that we'd be apt to see would be the ~~XXXX~~. And they've had ~~XXXX~~ they've really been worked over examined and all findings have been ~~XXXX~~ by the X-ray department. They've been worked over ~~XXXX~~ by the chemistry they've been worked over in every possible way. They don't come up with anything and your clinical history reminds me of one of the cases I thought I might briefly present ~~XXXX~~ cause it's very similar to the child we saw. With this child, every time this child became excited, ~~XXXX~~ one of these really very wide-eyed, alert children, and at 4 months, every time this child became excited the child regurgitated and the whole nervous system got involved in the response, and the child would regurgitate and that would be a kind of case that we would be apt to see. And when we're really through looking at the child's behavior,

82 6971
visit on 81

PARKER:

I thought ~~that~~ I'd start by telling you the kinds of ^{infants} children ^{that's where} that we're asked to see in the hospital because we're really ^{mostly} asked to see ^{them} infants ~~mostly in the hospital~~. We get very, very few infants referred to our out/patient clinic, which was why I asked you how many infants --

~~We get very few, which partly has to do with maybe we haven't been there that long.~~ ^{because we} We've only been running the out/patient child clinic ^{for only 2} about ² two years. Most of our children in our outpatient setting are ² two-year-olds.

~~I thought I'd~~ since we're going to concentrate on infants, ^{you a} looking at infants and how we look at infants, I thought I'd give ~~some of the~~ spectrum of the kinds of infants that we're asked to see in the hospital setting and how we proceed from there.

~~It used to be~~ we used to be really the last consultant, asked to see and I think we have been moving up a little.

11/95

we got some feeling for what in fact, was ~~it~~ ^{the} at the basis for this regurgitation
~~When we came to work~~
we met with the family and with the mother. In this case, it was not a very
sophisticated mother and it was a very disorganized family, in terms of how
to work with the family to work ~~XXXXXXXXXXXX~~ for the child. And another
kind of case I thought I'd bring up was ~~XX~~ when you're feeling something
is wrong with the child-- an intuitive response/a pediatrician may have ^{that} ~~is~~
there's something wrong with this child! But how do we get beyond that
sort of intuitive feeling that there's something wrong with this child
and what can we do about it. And that's the kind of case I was asked to
see yesterday. ^{the pediatrician reported that the child, now over 4 months old,} It's a child that has had a great deal of ~~XXXXXXXXXX~~ "diarrhea"
since birth ^{and the child was over 4 months old.} This is a child who has had diarrhea
since birth and the mother came up from Mexico City, so the only way of having
continual contact - ~~XX~~ In fact, she was already discharged and she was ^{the mother}
just waiting for us to see her at the last minute. This was a child who had ^{been}
had absolutely all of the organic ~~XXXX~~ ^{work up} and there's was no
reason as to why this child ~~has~~ had diarrhea since birth. The child did not
have poor weight gain and when we went in and looked at the child, what we saw
was some ~~XXXXXX~~ of the kinds of things that you were talking about. We saw ^{communication}
a disorganization of the child's behavior! And this is what people were
picking up ^{she had it} ^{had observed} ^{unusual} thinking and the nurse picked up on the ward that there was something weird
about this child. And when we were actually able to look at it, we saw for
example, in the visual system the child just looked at you and never had
any ^{cycling}. And then by history, the child also didn't have any cycling
in his sleep cycle. ^{she} ^{he} didn't have any cycling in his sucking, so we see a
whole disorganization where the child not only had a ~~forcep~~ ~~XXXX~~ ^{abnormal}
didn't have any ^{great} cause pattern to herself. ^{She} had some mildly/neurologic
~~XXXXXXXXXX~~ findings

can't read

Regard

?

pause?

girl

11/75

of persistent chronic neck reflex.
defects?
5

findings. Then the other thing we noticed about her was that she went from deep sleep to vigorous crying, ~~With nothing in between~~ just back-and-forth. She would bounce back-and-forth - deep sleep, vigorous crying, ~~and when the mother held her and rocked her and gave her a little noise~~ that she used to carry - kind of a - ~~thing~~ - ~~became~~ ^{that} thing, we did see the baby was able to come through this disorganized state, ^{cyclical} have some interaction, even though it wasn't a normal typical rhythm interactions, she ~~XXXXXX~~ was able to smile, she was able to have some interaction. This is the kind of way we look at sort of the total picture, and what we found was that this baby had been doing this - these terrible crying spells and then falling in deep sleep and when the baby would have terrible crying spells, the mother would feed the baby and the baby was taking in about 1500 cc's of milk a day, so it's not surprising ~~XXXXXX~~ that the baby ate maybe as much as 6 ^{six} ^{weight} 8 ^{oz} ounce ~~XXXX~~ bottles a day, So it wasn't really surprising that the baby was having diarrhea. But instead of looking at the one pathological symptom of the ~~XXXXXXXXXX~~ diarrhea, and say what are the causes of the diarrhea, you had to look at the whole picture. ~~XXXXXXXXXXXX~~

You have to put the whole case together and to make sense, make the case make sense for the mother, too. Give her some suggestions of ways of handling this kind of child. Then a third case we are asked to see very often, and these we're usually called a little earlier, on would be

And here again, what we try to concentrate on was the baby's contribution to the interaction. We also look at the mother's contribution and the interactive patterns, but again it's hard to understand what the baby's ^{bringing with the interaction} ~~bringing with~~ to the interaction. Again I will bring an example in of a baby I saw who was

6 months old and weighed only one pound more than his birth weight of 7 lbs. 2 ozs. At the time we saw the baby, the baby had very abnormal interactional patterns and turned away when we were standing close and we used the scale

Dan Rosen has developed to look at the babies to try to differentiate between a good area and a bad area

and the house

And the ~~offices~~ offices were pretty tuned in to the fact that this was probably

'an interactional problem. They said they just ~~can't~~ ^{couldn't} find anything wrong

with the mother. She seems ^{ed} really ~~XXXX~~ at ease ^{we're talking about some of these} she seems really well

put together, and ^{she} we just ~~don't~~ ^{couldn't} see how it could be the mother's fault,

that the baby is this way. So obviously, they ^{were} communicating records

to the mother, ^{who was at fault} ~~and the mother was~~ ^{messages} ~~defensive~~ which she ^{persisted to be so}

~~She was really very defensive, which she~~ ^{for} ~~persisted to be so~~

to be over 6 months, and we really ^{only} got two clues. and one was that

she said well I was concerned about this baby/because she ^{she} didn't follow ^{from the time she was about 2 months old}

objects. The baby wasn't a person to her. The baby wasn't following her,

the baby wasn't looking at her. It wasn't that the baby wasn't following

objects. And the second clue we got is absolutely ^{asking what we often ask} one thing in

that - What is your baby like in a certain situation? ^{to} See how much

the ~~XXXXXXXXXXXX~~ baby seems to be a person to that mother? And XXX

this baby wasn't a person to that mother. She said well, ^{he was} he's a good baby,

That was pretty much all she could say about him. And ~~what that meant~~

~~XXX~~ when we got down ^{asked} and ~~said~~ what happens at the end of the day, we learned

was that the baby was in the crib 20 hours a day and not complaining about

it. So ^{he} it was a good baby to this mother, who had ^{six} other children, ^{who} That

was a good baby and the other 6 children seemed to be thriving fine. This

baby as we got to know the baby and the mother better, ^{we found that the baby} could not take ^{very} much in

the way of stimulation at all, and ^{autonomic responses} ~~didn't have any sort of~~ but just

absolutely turned it off completely ~~just tuned out 100%~~. You just couldn't

reach that baby even if you came with a bright red object. The baby completely

tuned out. ^{But} If you came with a tiny little red thing, then you could get the baby

^{attention} to function, you could reach the baby. So we learned a lot about the baby.

^{any interactions} The ~~XXXX~~ baby never initiated anything with the mother or with us and still

and a non-complainer?

persists as a non-initiator. Then we know when the mother brought the baby in to see us, if she had an hour wait, the baby would just be lying on her coat out on the bench. It seemed very unusual that mother was not holding the baby. So we worked with them for a couple of months and now they are doing pretty well.

QUESTION

What was the format you used for working with the mother ?

ANSWER

The baby was in a very precarious state, and she was always on the verge of feeling she might have to admit the baby to a hospital, so I had real organic concerns that I had to follow the baby very carefully for. Plus as I was following the baby, what I was doing with the mother is trying to increase her perception of the child as a person, trying to help her to see this child as a person and I did that through looking at the child and saying to her what I'm seeing about the child and increasing her perception.

QUESTION

Was that set up merely to balance the task you were involved in

ANSWER

Did I set it up between her and me? I set it up in my head; I did not set it up between us; as I said, this lady was very hostile, and she really remained extremely remote and defensive, although she became less hostile cause the baby did better.

question

She was bringing her baby in and you took advantage of that occasion for you to know what the baby was like.

ANSWER

Exactly, in the beginning she wouldn't even look. She would stand and look out the window during the time, but she was hearing me, something was getting through. And then I would interpret the baby for her, help her to see the baby as a person and see the baby as an individual, and what he could and couldn't do, and also communicate my real concern and interest in the child.

and be somewhat of a model for her about ^{how} she could act.

E.B.

I think your question raises something that we run into a great deal, and that is that ~~we do not~~ we get people who do not self-prepare themselves and are mostly sent in and pushed in, even ^{if it's} because of somebody's concern about the baby or because of their own concern about the baby ~~and~~ that may push them in, too. ^{they don't come in looking for} But ~~not for help~~ the kind ^{of help} we're ready to offer, and so their defenses often increase around an intervention ^{this} and it raises fascinating questions.

Over the years, we've been seeing patients on the wards and we've been coming up with formulations about ~~them~~ and I've been sitting ^{there} jotting down what we've been saying about the babies -- what goes into making those formulations and writing down descriptions ^{and} what we wanted to do was somehow ^{to} systematize our observations and try to dissect and look more closely at what we are basing our impressions on, in terms of looking at the baby's behavior, ~~and that~~ at the same time, we didn't want to lose the whole Gestalt of what the baby is like ^{and} ^{this is} ^{are} this was really where we're at now, ^{of} trying to dissect out ways of getting a conceptual framework, something you can actually score, ^{then} and they have a valid instrument ^{with which} to look at ^{5-month-old} a baby, showing you a little ^{bit} ^{of} how we go about looking at the baby and when the _____

Diff. Speaker:

~~One other thing~~, ^{is} one reason it's so important for us to dissect the baby's behavior, I think, ^{is that} since these people don't present themselves for help or for intervention and get more defensive around their own great reactions -- and I think of the syndrome as feeling guilty, of being helpless, ^{we really} have no way of reaching ^{up to} ~~thru~~ to the mother as anywhere near as effective as understanding the baby and the way she sees it. ~~And it becomes a very~~

Corrected → (9)

88 17

Dissecting the baby's behavior
powerful tool for communication and for laying the basis for a transparent
~~that enables us~~
situation to understand the baby's behavior and seeing the facets of it, and
then be ready to use that as a communicative tool to reach through the baby to
the mother.

PARKER:

Going down the left hand side of the paper, ^{see?} (they handed out) ^{you will see} a list of
behaviors that you can observe in infants. You can look at and _____.
You also have a list of qualitative aspects that you can use as signs for
each of these observable behaviors. For example, you can decide the inten-
sity of the body movement. I hope we have some sort of reliable scoring
for that parameter of body movement and the range of movement. These are
the kinds of behaviors that we look at, and these are the kinds of obser-
vations that go into our saying this is a baby who is extremely low
calorically (?) organized, ^{this is} or a baby who is visually organized, is hyper
alert in a visual sense. These are the kinds of observations really that
go into that kind of Gestalt picture of the baby, ^{that} we've all been ^{making} doing
clinically without having done the evaluation and the way the baby functions
that we've been using on the board. This is really what the _____
today will be based on, and then we're going to look at these behaviors in
a variety of diagnostic situations that we call frames. Our goal is to
try to _____, which is what we've all been doing clinically with-
out having a valid _____ of which to do it, To extrapolate from these
observations in a valid and reliable way, to some of the temperamental
characteristics for a 4th to 6-month-old infant in our test situation. And
the ^{six} 6 that we've picked out and have been working ^{with} there, although this is
certainly _____ where activity level the child's intensity both are
reactions in an interactive situation. Attentional characteristics of

11/15

the child and the child's coping styles and this is something we really do
put a lot of scores on. We do ~~really~~ look at the ^{stress} intense situation as a
situation in which we have different task situations may be different stress
_____. And then the other one or two reliabilities which is

^{showing you}
~~For the film that we're doing,~~ today we have a film on a 5-month-old baby.
The baby was a full-term product of uncomplicated gestation, labor, and
delivery.

Pick up
just out of 92

100
90-Sup. 93
Parker:

I guess I'd like everybody to have this paradigm in mind.

Brazelton: (corresponds to original p. 13) - BEGIN SIDE 6

I think this is what we're obviously getting at, and this limits one's thinking if you look at this. One of the things constructive in doing these scales was trying to find a way of, a process, and rather than looking at cross-sectional--a baby -- a mother-baby or a....we've been trying to look at the process dealing with process that tell you about 100 times as much as a cross-sectional cut, And the neonatal scales as we talk about them. The last time we went after best behavior. Well, as we thought about the kind of behavior you draw out of a 4-month-old in a situation like this, you draw out the process most indicative of what the process had been and what it might be in the future obviously, too. We felt that the coping paradigm seems to have come out of Rene _____ (?) work, although that's pretty drastic. Some of the questions that her coping paradigm had raised which are how....not having the mother in the room cuts in half ^{the kind of play behavior the baby has available to him and cuts in half} ~~cuts in half~~ his cognitive style, and what have you, ^{that} ~~was~~ really something which was worth our understanding, because it might give us some clue as to the richness of his affective and cognitive personality, and as such might bring us back into a postdiction as well as a prediction. And this baby, I thought ^{this baby} ~~the kind of way~~ she responded to frustration versus to ---- I love the way she gripped the mother's arm with her feet, as well as her fingers. She just got hold of her all around. And this kind of richness, for instance, around this paradigm being expected to be picked up and not getting it was really something that you scored very highly on in terms of coping capacity. And the other things that we

11/95

thought ^{was} ~~were~~ really nice was that ^{something} ~~which~~ Winnie just became aware of, and that is that the richest ^{vocal} ~~full~~ behavior that we get out of a 4-month-old baby is when they ^{are} ~~re~~ trying to maintain communication around the corner. And if you get ^{vocal} ~~both~~ the behavior and the mother ^{with} ~~there~~, you get one kind of responsive vocal behavior, but if the mother ^{is} ~~s~~ around the corner, ^{the baby begins} ~~he seems~~ to cast ^a ~~this~~ ^{rich} ~~sort of~~ complex, vocal activity in an attempt obviously to get the mother back. And if indeed, we can begin to sort of document some of these things, it would be ^s ~~fascinating~~ to put into effect. ^{a kind of assessment}

ESCALONA: corresponds to original P. 14 (?)

as there
on p. 93
described before

stress

really look at the intense situation as a situation in which we have different task situations may be different stress

And then the other one or two reability which is _____

For the film that we're doing today we have a film on a 5-month-old baby Have maternal history
This baby was a full term uncomplicated gestation _____

The baby was a full term product of uncomplicated pregnancy, labor, and delivery. Not on tape - skipped to p. 99

The labor only lasted 5 hours and the delivery was spontaneous; no medications were used ^{was} and the baby being completely normal at birth and persisted to have a normal no problems in the nursery. ^{had} and it wasn't ^{When} until the baby was 9 days ^{old and at} of age she was home with her mother, she was

being breast-fed, and there were no problems she was found by her mother to be quite _____ and not breathing. The mother was able to

revive her ^{Two} at that time by shaking her and hitting her. and then 2 days

later ^{was done} they did a breathing study on the baby over a ~~maximum~~ 13-hour

period ^{It was} and found that ^{she} in fact that baby had _____ in ^{int} maturity in

the nervous system and had a breathing pattern similar to what you see

in hypoglycemic children where ^{in that} she had prolonged periods ^{when} where she just

didn't trigger herself to breathe. ^{There were} and had long periods of waiting ^{for} in between

breathing, and you could easily see ^{for} she'd just go along and then she'd stop.

^{Sometimes} I didn't know whether she was going to start again. And these episodes seemed

to be much more frequent in ^{During} her sleep study in the 13-hour ^{breathing} study in the time

she was asleep just before she woke up. There have been findings on hypoglycemia

^{that} to go along with this, or any organic cause ~~for this~~ would probably be

on the basis of the immaturity of the central nervous system. The mother

kept the baby on the ^{advice} of other pediatricians for ² two months, and after

a monitor on

girl

to p. 94

~~insert for p. 93~~

11/75

DR. BRAZELTON; She would not present herself as such. She would never, even
^{Even} if you pushed her, admit that she had a problem. And ~~so we,~~
 by inference, because of this ^{her} ghastly ^{we} past history, ^{we} assumed
 that she was going to have certain problems in certain areas; ~~the~~
~~the~~ separation, ~~the~~ autonomy would be an issue, ~~and by inference~~
 we were stuck with this kind of soft antennae, ~~that we go into~~
 but ~~it doesn't~~ ^{she don't} even have to be soft any longer. We've got ~~have~~
 behavioral back^{up} now that we can use to either answer our
 questions or to raise other concerns.

a friend of Winnie's?
~~And this lady, who is /is not~~ ~~xxxxx~~ a person who would
 ever identify herself as having a problem, and in reality,
 she doesn't have a serious problem.

^{on 8.90}
~~But~~ these are the kinds of developmental issues that
^{exploring} we are ~~into~~ all the time and we would like to ^{explore even further} be more into.

opportunity for intervention

MS: —

I guess I would like everybody to have this ~~in mind~~ ^{paradigm in mind}

DR: ^{Berry B.} ^{14 hints}

what obviously we are getting at and this limits
 one's thinking as you look -- One of the things we discovered
 were
 from doing the neonatal scale was that we trying to find a
 way - a process and rather than looking - a baby - or
 a mother-baby. we've been trying to find some way of
 looking at a process- feeling that process tells you
 a cut.
 as much as/cross-section/ Into the neonatal scale as we
 talked about last time we went after best? behavior. Where
 if we thought about the kind of behavior that you can draw
 out of a 4-month old ^{or} in a situation like this - what could

Pick up
 Brazelton from
 89/6 - (Begin Side 6)

_____ they kept the baby on _____ big sound off every now

and then during the time the baby was _____. It makes quite a

large noise and the mother never found the baby not to be breathing,

and may be there was a monitor probably with a loud noise that _____

They're small, portable, these uses
There little monitors like they have in the premature nursery unit, with

leads that are put
They're really small, portable monitors and you put leads on the baby

and there's been a lot of question about the effect of having a baby on

the monitor, on the mother and on the mother-child interaction.

And there's been a lot of caution recently in pediatric _____ about

not tacking out these monitors

I think it's a very good thing for the baby to go home in a monitor _____

There is enough substantive work now to show that a lot of these

"sieve" babies can be prevented and can be *identified* even in the

neonatal period, because of their lack of *state* control and lack of CNS

AND autonomic monitoring their breathing patterns and just like this they

miss _____ in a "sieve" baby and the mother's a nurse and the

father's a doctor and they knew it. They were loaded with this from the

time the child was _____.

There's no question that *the* this monitor helped this mother in the period of

2 days period between the time
the two days she found the baby not breathing until she got the monitor it

was really a critical two days in which she called in all her extended

family, and they took turns watching this baby and and it wasn't really

until she *gained* got somewhat confident in the monitor that she could get any

rest at all. It was very helpful. *9/* The mother doesn't really have any

developmental concerns about the baby at this time. Her milestones are

all very normal. She describes ^{her} him as a very cuddly, alert, and responsive baby who eats a great deal. She says the baby likes to suck a lot and uses the pacifier frequently. She also says that ~~this~~ ^{the} child's needs are very urgent. That's how she describes her child. She knows what ~~the~~ ^{the child's} needs are and she knows she can satisfy them. When ~~the child wants~~ ^{the urgency} something, ~~the need is very urgent~~. I think that ~~that~~ ^{may} relate to the kind of disorganization state behavior & autonomic reactivity that you behavioral correlate ^{of the baby} with this kind of disorganization in the autonomic nervous system and the mother's not concerned about the baby so at this time we're really looking at the baby. So ^{we're} where going to show the first part of the film -

END SIDE 5

Already on
pp. 90-91

BEGIN SIDE 6

One of the things is that we're trying to find a _____ process and rather than looking at a cross-sectional cut of a baby or a mother-baby or _____, we've been trying to find some way of looking at process feeling that process is _____.

Or we thought about the kind of behavior that you draw out of a 4 month old in a situation like this ^{has been} or what the process is in or what it might be in the future obviously, too but we thought the _____ paradigm seemed to have come out of _____ *drastically*

And some of the questions that her / _____ coping paradigm has raised which are how not having the mother in the room cuts in half the kind of play behavior the baby has available to him and cuts in half his cognitive style. There's really something that's really worth our understanding and looking at because it might *the baby* affective and cognitive personality and such might bring us back into a post-accusation *system as prediction* and this baby I thought the kind of way she responded to frustration - I love the way she gripped the mother's arm with her feet as well as her fingers - she ~~XX~~ just got hold of her all around and yet this kind of richness - for instance around that paradigm of being expected to be picked up and not getting it was really something she scored very highly on in terms of coping capacity. The other things I thought were really nice was something that the richest focal behavior that we get out of a 4-months old baby is ^{they're} when their trying to maintain communication around the corner. and ^{with} if you get vocal behavior/~~XXXX~~ the mother there you get one kind of sort of responsive vocal behavior but if the mother 's around the corner

bulled?

this on p. 91

the baby begins to cast this rich complex vocal activity - when XXXX he can't obviously get the mother back and if indeed we can begin to document these sort of things it would be fascinating to put into field of assessment.

QUESTION

I was just wondering whether you had under the intuition ^{ive} pattern looked at the same thing because ^{it would appear to me that} the mother's appearance under the projectile field? organized for fertility(?) most differently from an unfused bond.

As soon as the mother's voice changed, before ^{she appeared and even} the mother herself came, but more so ^{after she appeared,} when the mother came, all of a sudden there was a well-

organized harmonious postures and basic movements in which _____ and then it broke down very noticeably when that mother ^{she} just wouldn't pick her up, but not right away. There was quite a bit XX of interaction

XX than _____ and then it deteriorated and it struck me that in a way _____ than by the vocalization which - have

that simply the mother's appearance alters the integration of postural and ^{gross} movement patterns.

XXXX

ANSWER

The sort of mid/range behavior dropped out around the mother ^{brain} that organized the report and came back when she was _____.

QUESTION

I would have liked to see baby's response changed a little bit but you could still see it.

QUESTION

One of XXX the things that struck me, I was just looking at cross after in ^{was somewhat} the parents in a role that ambivalent? One was the usual model to be a good parent and the other is to follow directions in a situation where I'm supposed to be doing a good job for these people and I'm wondering if you have a look at XXX that - that must get across to the baby. The mother's not paying

11/75

attention to me as much as paying attention to something else .

The direction

DIFF.
SPEAKER

IN terms of this mother's requests, we had about how locked in to the baby she was and how much autonomy she could allow the baby, you could go to that one observation of frustration and ^{make} get a very optimistic prediction about how ~~XXXX~~ much she could allow the baby to find her own ways of coping, which I wouldn't have predicted ^{that} from the history, and you could feel a little bit more comfortable about that .

QUESTION

One of the things that struck me was the way that she set up the frustration. She held that ring just at the right spot ^{so} that the child thought that she might possibly be able to reach it, but couldn't. It wasn't so far away that the child was discouraged ^{enough not to try,} and didn't go into it, where she didn't give in and just put it down, but she seemed to know what her frustrated situation was .

DIFF.
SPEAKER

what the mother
If anything, I thought ^{what the mother} she did was to get in rhythm with it, though she didn't really ^{frustrate the baby} ~~frustrate~~ She got in rhythm with ~~XXX~~ that ring and kept it going ^{the} for the baby in a way that kept that baby's head going with her. *So she had her hands as controllable*

QUESTION

I have a question in terms of personal ^{to a} because I think the baby's mother in sight ^{activating} is usually an interesting spectacle ^{on game} acclamating in relation to that unless it also becomes a certain threshold That baby doesn't think, ^{to hold} "I want that ring," does it? It happens all the time as long as it

DIFF.
SPEAKER

I think that that's a very good point and that takes me back TO REALLY looking at your behavioral parameters instead of saying the baby's frustrated, you say the baby has an increased organization or

disorganization of motor movements or that the baby's frowning or you go back to actual observations instead of sitting there.

DIFF. SPEAKER That is very interesting because what we were looking at is specific? is persistent and very often we were trying to see how long the baby would attend to this by ~~fixing~~ doing all of these energizing kinds of strengths.

DIFF. SPEAKER

to do that + the mother and then we compare the two different levels of activation and motor organization and all these other things with that in mind.

diff. speaker

to really focus on the child because the organizing ^{in time} affect of the mother or the synchronizing interplay which we will see at the beginning with Voice + act to Voice and then the answer of the baby and sometimes screening it out as the organization between speech you did not want intrusions cross-talk laughter

DIFF. SPEAKER

In an interactional setup? I don't think we excluded situation where the mother's only using herself. There seems to be high arousal in terms of the baby's motor activity and then the mother wants the baby to experience that ^{and to want to be predictable} and then the baby settled down a little, ^{did} ~~and then~~ the mother went to what most mothers do when they pick up babies is she She gave ~~the~~ the baby that kind of a message ^{what says} You know, I'm really not giving you up, but it was then after that ~~XXXXXX~~ that the baby's legs grabbed the mother's arm.

diff. speaker

There's another dimension. I'm wondering if you find it very much

looking at it as an interactional coping paradigm both through the mother and infant in terms of the mother's relationship to you in terms of how ~~XXXX~~ she chooses to carry out the instruction has input into the

DIFF.
SPEAKER

We've just started using this ring above-paradigm ^{with} but another mother, ^{whose} where the baby's reach was a little less developed ^{ed} and she was really encouraging the baby to reach, and then she knew she had to take the ring out of reach. And then she took the ring out of reach _____ and didn't encourage the baby at all. The mother just stopped encouraging the baby so they're completely different sets. I think those are things to look at and really learn a lot from, rather than try to _____ situation.

DIFF.
SPEAKER

_____ is an outcome of this and that means _____ and which is getting to some very interesting observation material in just this area in an area in which the mother is turning over her baby at 6 weeks _____ ^{to a} secondary caretaker, the mother says she doesn't see herself as the one who makes individuation in this baby and indeed ^{directly teaches + the baby to individuate, but rather} whatever teaching of the baby to individuate she sees herself as going through this 6-^{to} 8-year-old child, so we decided ^{it} to way to find out what she says is true is as she really sees or whether she's really doing something else ^{set up} within the bay leave that we're doing and the ^{ecological} that we're ^{incorporating} with them. Teaching her, like Kathy's ^{done} with her mother, in which you give the child a ^{Tracy} item one step above his capacity and then tell the mother to teach it and we set it up so she teaches the child directly and then she teaches the onerary to teach the child and it's been very interesting indeed. The mother does see herself as teaching the onerary to teach the child, and the kind of teaching she does with the baby directly is all shoving, whereas through the onerary she teaches the onerary to teach the baby to ^{shape & shove} and she's very sensitive to the baby through the intermediary, and this is the sort of thing you can get at. We haven't yet, but we hope this is ^a precursor.

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DIFF. *four* What is the age at which you can really teach parent education?
SPEAKER

ANSWER at this age (~~Several people talking at once~~)

That's when the first learning takes place by the parent. *Dr. Hauer*

DIFF. _____ culture of ours _____

SPEAKER *every* talk about paradigm of the feeding situation

DIFF. D. Two situations that are repeating happened so often and then _____
SPEAKER _____ and babies

of
We have a sample now that approx. 200 mothers/that we've been following *all through?*
altered their first year of life and they're now into their second year.

And we're just really into *getting some of the* data analysis *about* of the consistency of the mother's behavior and the infant's behavior at the various time points. *Overtime*

and how they correlate with other factors. You might be interested in

one of the things that we did in terms of our sample selection, we took a group of mothers *half of* who have had high school or less of education and half of *whom* ~~them~~ *group*

had one or more years of college and then half of the population had

conflict of perinatal in and/looking at the differences between the *education?*
collection factors in terms of the parents already, one observation *is based on their education* that there are

educational differences in the way the mothers interact in both feeding

and teaching *This* ~~based on their education~~ and it means ~~that that~~ then *that* there are

some *then with no ones who* education that don't act like those with higher education

but overall there are some the differences.

DIFF. Some of it has to do with/sensitivity that the mother has ~~inxx~~ ~~xx~~ terms
SPEAKER of _____

DIFF. *Barry* Certainly it's a good way to bring the child
SPEAKER the kid up, better than _____

DIFF. ~~XXXXXXXXXXXXXXXX~~ I guess I view the teaching situation is as a behavioral function *analysis*

Key a glucose tolerance test. You kind of bring it up in a short period of time, particularly with a difficult task, of some interesting performances with the baby and the mother.

DIFF. Are you talking about each of the _____?
SPEAKER

DIFF. Would you rather _____? *Barry*
SPEAKER

DIFF. I don't know what it would be. Since _____ but that's just
SPEAKER a suggestion.

Diff. ~~xxx~~ _____ been saying kind of message in terms of the mother alerting
speaker the child to _____ or in giving him reinforcement _____.

Diff. Barry - Side #2, Tape #1
DIFF. Back to your question and _____ looking at the _____ situation
1-2-3 Is it possible
because he's being puzzled a little a bit now. ~~XXXXXXXXXXXXXXXX~~ for us to
get an actual ~~xxxxxxx~~ situation from the mother and the child are doing
outsider.
what they usually do in their natural ~~xxxxxxx~~. It seems like
has all sorts of
the presence of an outsider here / _____ ramifications and might tend to
make it _____ statements about parenting practices _____
_____ and it seems to me that these types of things would be stumbled
over and you all would _____. But the way the parent
is limited by your direction might be _____ of the way the parent
has other directed _____.

DIFF. g It may for us mean a very powerful _____ for which mothers are going
to comply with _____ hoping ~~that~~ none of this _____ and to
an
that extent it becomes a/indication for us that ~~which~~ which ones may need more
than we're giving them. One of the things that we've spoken about that I
don't ~~xxxxxx~~ think we've handled in observation is really identified with
the parent and child when they are alone. They may live in a household with
people in My Mayan Mexico and _____ Africa as well as here for 24 hours or
48 hours at a time are enough, but it's got to be through this period and
they resort to after I leave, I just stuck my head back in. The best
you can do is to assume that they are under stress and measure them under

11/15

DR.

Was that what you suggest?

MS.

^{yes. it}
Um, hum. ^{involves} the kind of methods? in terms of ^{altering the child's} the mother of ^{or in him} giving reinforcement --

DR.

I want to get back to ^{Stan's} that question that Stan had before about looking at the parent's coping situation, because it is beginning to puzzle me a little bit that -- when is it possible for us to get at a ^{actual} natural situation when the mother and the child are doing what they would usually do ^{in their natural setting} and they are not trying to impress an outsider? ^{that the presence of} It seems like impressing an outsider here has all kinds of ramifications which might then allow us to make statements about parenting practices, going all the way up the line ^{for example, you} -- when we visit someone else's house, ^{is} your child ^{not} allowed to touch anything ^{and it} seems to me that these are the kinds of things that we stumble over ^{you} -- some may be more important ^{but the} way a parent is limited by your direction might be a powerful prediction of the way that parent is other-directed in many of the ways

DR.

For us it may be a very powerful predictor ^{of} of which mothers are going to comply with ^{coping} system -- ghastly?/medical system, and ^{to that extent}, it becomes an indication for us ^{of} for which ones may need more than we are giving them ^{One of the things that we've} stumbled on about that, because I don't think we can make

an observation that ^{accurately} really identifies what a parent and child do when they are alone. Having lived ^{for} in a household with people ^{there} in Mexico and now in Africa as well as here, 24 hours and 48 hours at a time -- I know what a stress it is for them during those periods and what they resort to after I leave, having stuck my head back in, (laughter)

Perhaps The best we can do, ^{is} may be to assume that they are under stress and then measure ^{that to} under the stress that we are setting up

And, then what we've done here, if you've noticed it, the mother frustrates the child, then she picks up the baby and plays with her without /and I would bet you that the most--

the best sample of interactive behavior that's closer to the natural is after a stress period. ^{The ~~to~~ the mother. Damn} And when she's so/mad at what we've been ^{and} us or so sick of/telling her to do and all the things that go

into it that she now says, "now, this is my time, and this is your turn with the baby." ^{time?} And, within that context, we will take the ~~data~~ ^{the films we took} that we've got and analyze it for the rhythmic interaction and all the ^{other} things that we've been looking at.

I think what we see there ^{are} is different things. /When Rich sings songs she picks up the baby. What we see on this tape is the baby gives the mother ^{ing} brief grin? and then she turns away and "now it's my turn to be with you." (Laughter)

You may see all of that ^{can} (Cross-talk) These others, I don't know how many ^{of these films} you want to go through and talk about.

MS.

DR.

See p. 104

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But each one is designed to bring out something else as a
~~sort of evolutionary or a way of looking at different levels~~
of interaction, and what we think we'll do, and this is where
we'd like some help -- is to get each of these levels on some
matrix like this and then go back and figure out a way to
put them together and ^{sort} store them for richness, for levels of
change, for what the change means, and ^{We can} in some way, then come
to a summary assessment of activity level, of intensity?, of
equality?
additi- characteristics, coping styles, theory of a quality
of mood, ~~all these are~~ -- we haven't done enough pre-testing
to know whether that includes all the things we want to get at,
but it seems to me that if we could set up a 20-minute evalua-
tion, it would give us enough data on videotape, and ^{we could} then go
back and analyze ^{it} in detail to get the dimensions of this, we
would have a fairly rich matrix, at least, of a baby and a
mother to look at.

OK?

attentional?

pp 104 & 105

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the _____ that we're starting out and then what we've done here is the mother frustrates the child then she picks up the baby and plays with him and I would bet you that the best samples of ~~interacting~~ interacting behavior ~~would~~ that's closer to the natural may be after ~~a~~ a stress period and when she _____ what we've been ~~telling~~ telling her to do or any of the things that go into it that she has the "this is my time and this is your time with the baby." And within that ~~context~~ ^{context} we will take the films that we've got and analyze it for the rhythmic interaction and for all the things that we've been looking ~~for~~ at.

DIFF. I think what we see there is just a sing song when she picks up the baby. What we see on this tape is the baby gives the mother brief _____ and _____ to you. You can see all of that. It may be a good invention but we've been seeing more not the baby _____

DIFF. But these others, I don't know how many of you want to go through and talk about, but each of them is designed to bring out something else so evolutionary are a way of looking at different ~~levels~~ levels of interaction and what we think we'll do, and this is where we would like some help, is to get each of these ~~levels~~ levels down to some basics like this and then go back and figure out a way to put them together and sort them for ~~richness~~ richness, for levels of change, for what the change means and in some way then come to a _____ assessment of activity levels as intensity, of attention characteristics of the child _____ & quality of mood. ~~Then~~ ~~are~~ We haven't done enough pretesting to know whether that even includes all of the things we want to get at but it ~~seems~~ seems to me that if we could set up a 20 minute evaluation which would give us enough data on ~~the~~ videotape ~~we~~ and then go back and ~~analyze~~ analyze it in detail you'd get these dimensions of this we would have a fairly rich nature _____ of the baby and the mother to look at.

DIFF.

11/95

keep not

DIFF. I think my understanding ~~that~~ where the mother is in this.

DIFF. We haven't got to her; Just as an opera participant, not ~~as~~ in any way as

I don't think we see this as ^{except that within} interaction as a measure of mother, ^{conflict?}

her. And I think we'd like to get on to that, but first we want to identify what we think we can see and document ^{it maybe} and we're going to stay within

the three contexts: in hospital, without any caretaker, maybe caretaker within the office or in a strange ~~xxxx~~ setting like that, ^{and at} in the home.

Once we got the baby, ^{that} I guess my own prejudice ~~is~~ it's going to be more complicated, for me at least, to get on to the interaction framework that

the mothering capacities or range of mothering capacities that the mother can show you. I really ~~xxxx~~ haven't ~~xxxx~~ started thinking, ^{about what} except in the

little ways that I mentioned, ^{contacts} to that, but we want to identify this first.

DIFF. This program _____ a three ~~dim~~ dimensional process _____

DIFF. Are you asking the question, let's see, in this one whether or not all of those behaviors are possible to _____ discuss the _____

DIFF. We don't know how much we'll get out of it, but _____

DIFF. I think they're talking really about what Dr. ^{sculova} was talking about when she said that the baby's movements were much more organized than ^{Amnith} modulation would go into an organizational pattern, something like coordination.

DIFF. Well, we can ^{newborn} movement, ^{fac} facial expression ^{also}

DIFF. What we see is with ^{the neonate} ~~the neonate~~. It's easier for me to have that ^{neonate} ~~neonate~~ than it is to form _____.

What we see with an ^{the neonate} ~~neonate~~ on a bed by himself ~~that~~ is ^{this} disorganized ^{part of} sub^{ject} ^{behave} behavior,

(Right). And we measure how much it takes from the interactive to bring him into a smooth, ideal performance, and that's the sort of thing that ^{I think} we have here; how disorganized ^{or mind brain does he get} when the mother is either not there

or is just ^{giving} getting him her voice or just ^{giving} getting him her face or

DIFF.

Tape 6
at 348

Start Co 8:20

DR. NEUBAUER: It would be very difficult to fill it out for each item - meaning. For instance, what would organizational visual measure of/behavior compared to motor

MS: -- gross motor very easily

DR. NEUBAUER: Also, what I'd like to know is how ^{he sees as being?} would the rater? here determine with what we see is beyond normal expected behavior, - would you put down intensity high, or would you put down "I don't know - high or low. inside or? outside the normal expected behavior. This is not included in your rating

DR: *Berry* → Well, we'll have a manual which will describe, each, *types* I suspect -

new speaker? ~~cross-talk~~ -- to be stated as such-- you don't have the manual --

Dr. Brazelton: No, we haven't. we haven't done enough work-- we've been writing? for the last several years ? (laughter) Lot more fun!

Cross-talk -- Progress -- It will be a complex , but I don't see that that's any reason - but it will, I hope, identify *the*

MS: *Escalator* Well, there is one problem with that that I think is less and I think you alluded to it. Since, as you earlier mentioned, there are these it is going to be difficult thing that always might be deviant from ordinary because there are really on some of these such as intensity and ^{urgency?} emergency? things, we know already well within the normal range

what you end up with several parallel? sheets

If your aim is _____ to do ^{it} something in principle

Really don't believe _____ that on some of
- decide it goes like that , but really that there are
syndromes that are equally adapted?, ^{ive?} equally
and within each, undoubtedly you have all kinds of combinations - in these things of something not functioning
But, I doubt very much there's going to be very much

DR. BRAZELTON: I couldn't agree more ^{about} Sybil, and one of the things
~~that~~ I would say to that, as I say ^{about} to the neonatal scale, is that
we're not looking for an I.Q. measure or a sign of what is
normal or what isn't. I don't feel that about the neonatal
scale and I've resisted in making it into the sort of scale
in which that can even be interpreted. I would see that
~~well,~~ one way we are trying to limit ourselves is ^{by} ~~set~~ up
a very rigid sort of presentation framework within which
we'll see a range of behavior and then if we
got pejorative about it, I think we'd deserve the ax, Because
I don't think that would, in any way, be constructive.
I think we'll get some clinical diagnostic information
back from that, but it ought to be ^{a clinical} then put into matrix for
assessment but not for measures.

MS. definite
Not for just separating out the median ? from the non-

11/75

DR. GREENSPAN:

The issue ^{is} ~~it~~ to sort of choosing ^{parameters} of behaviors to observe ^{and} we might want to ^{fair} tell/ a little bit about the rationale or thinking about choosing these particular areas to observe

and also the ways then to observe them in terms of intensity

etc., In choosing these parameters, we'll ^{distriminitive?} then see how well they serve as discriminative instruments

and the test, the assumption is ^{that} the microcosm sometimes serves as ^{macrocosm} for total behavior, looking at little slices of

certain pieces, even though we know that behavior is multiply

determined and ^{has} many facets? ^{which} you can pick up ~~and~~ things that

the ~~we~~ we will discriminate among individual differences

as you here earlier scale. And, ^{so}, in elaborating ^{basically?}

of what went behind it? and also to hear the group's

^{seeing whether} thought about ^{should} ^{might} other things be looked at that would

also possibly have discriminative properties, ^{because}

the end goal would be how well it does discriminate.

DR. ^{Solnit?}

I wonder if you would try? once more - I still don't ^{what the aim is?} understand why we came here? ~~what the real goal is~~

for this kind of grid. I read that you are, ~~you know~~, trying

to put neurological integrity and temperament, But, I wonder

if you could say it in other words, ^{but} that doesn't somehow

ring a bell for me in terms of particular things that are

selected for the

What is the goal for this kind

of standard procedure?

If you make too much of an

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attempt to neaten it up, you are losing the benefit of what
might be unique or unique to visual behavior
or facial expression, or any one of these.

DR. BRAZELTON: I think that's a good point. You mean where one child's
individual strengths might stand out in one area -

MS. Well, not only that, but I ^{don't} think you can't fit facial
expression in the same characterizations that you fit bodily
movements so why try to do that? You get more out of
your observations if you don't try to do that

cross-talk

DR. NEUBAUER: to classify a of items
to what degree does movement or
organization? under a set of circumstances the way things are
outlined, particularly behavior when you take autonomous?
responses and you put autonomous responses similar to, let's
say, ^{visual?} initial? or facial / ^{expression} and then you speak about
?disorganization - you have a very different way of attempting
you get in a different way of curving? ---

DR. BRAZELTON: That is that concept. I think that one of
the things ~~in answer to Al, is that~~ we want ^{is} a systematized way
of looking at a baby and a mother ^{eventually?} that pediatricians and
nurses and people who are at the fore-front of intervention
would use. It has to be simple, etc., and I like your idea
of then picking up on the major things --

DR. SOLNIT? What it reminded me of was the old ?Stay-9's? --The
old Stay-9's? that helped to select clients? for personnel

DR. *Gregory?*

I can give ^{only} kind of a ^{rather} simplistic answer, because we're just ~~really~~ in the process of evaluating, and ~~this~~ just ~~really~~ represents a way of ~~thinking~~ of trying to decide what ^{which} behavior we'd like to look at and then, you know, how do we ^{assess qualitatively} ~~you know, what are the qualities of certain behaviors.~~

OK?
The grid is not meant to be anything more than, I think a schematic representation of maybe a ^{possible} way of starting to approach ^{to} ~~you know,~~ looking at behavior. I think we use a lot of these things clinically, but ^{now} we are ~~really~~ just trying to systematize ^{these} ~~it at this point.~~ And, you know, maybe that is an answer to your question. I think that ~~what~~ one of our goals is that ~~we would like~~ to hear what other behaviors people would like, or think are good

DR.

So you are looking for correlations or for things that tend to help you make more sense of the baby, But right now you ^{have} ~~ve got~~ a very wide net? and you may narrow the net? down

DR. *Gregory?*

Jos
Sure, we would like to, very much.

MS:

Suppose you ^{try} took for each of these six items-- facial expressions, etc., ^{and} of them suppose you undertook to characterize each /and, to the extent that you can use a similar characterization for each ^{at} ~~OK.~~ What would be wrong in deciding for each of them what is really observable and ~~are~~ measurable, and not try to ~~make it~~ try to use the same labels, ^{or} dimensions, ^{or} parameters for each of them? It seems to me, that ~~in the~~

which ~~is~~ we need the following competences. Now, we
~~any~~ test we can think of that will touch on competences --
 and then we'll look at them statistically and see which ones
 actually survive in terms of predictive value
 But here you don't really have a ~~yet~~, a clear-cut definition
 and you may not be able ~~to in a miniature organism?~~ to say
 what are the competencies that make a competent baby? Because,
 it seems to me that the method prevailing? is really not
 applicable to this immature organism. You have to get much more
 than Peter, and Sybil, and Sally are saying --
 This way assumes some place you get a competent
 baby.

DR. BRAZELTON: Well, Al, I won't go completely along with that, because.
 these are things that we can ^{see} observe and do observe in an
 observation like this, and ^{we} can systematize it. And so, what
 the question becomes whether we over-interpret it, or put ^{the items?} a
 perjorative value on them. And, I think that is where I would
 surely agree with you that if we go to that extent, we are
 doing a more -- you know, we are not getting where we are going.
 I don't think that we at this point, have any idea about
 what the normal range, or expected range, or anything else might
 be, but we know we can make these observations

DR. I don't deny that

MS. How do you observe consolability? --

DR. BRAZELTON: Consolability in terms of the baby --relaxed when the mother began -- how does she not relax - for one thing when she got frustrated

MS. Inconsistencies? Cross-talk
 Laughter -- You'd better answer that -- Laughter

DR. BRAZELTON: Watching the baby and how she used it -
 There's some benefit -
 I wouldn't want to be put into a consolability measure -

DR. BRAZELTON: There's no doubt that you can observe the gross body movements, facial expression, position, etc.,
 verticle ?tones -- But the abs is
 not - can't be that we can have - take each one of those
 if you are going to use the stay ^{empirical?} imperial way of
 doing things. And so what this gross body movement - let's
 not be consistent - let's just say, what are the items in
 the gross body movements that we can rake? [✓] or that we can
 follow to try to understand as being evidence of competent
 or adequate development, and what are the things under gross
 body movements that indicate troubles. And then take the
 facial expressions, ^{but} and not necessarily stick to the same
 list, because I don't think we can do that.

DR. Let me make a suggestion. I think that the initial
 plan was to a second time, really
 you know not so much but to go through
 carefully, frame by frame, ~~the first two frames~~, at least
 the first two frames, [✓] to try to see what we can pull out -
 from the observations of the child anyway - about the

competence of the infant.

MS.

~~Cross-talk~~ -- Look at the data, you know, whether that
quests?
is what you are doing -- which is one of our questions
~~whether it's suitable~~ ^{is} ~~that's~~ another question

MS:

~~cross-talk~~ --

behind the neonatal scale.

I don't really think you want to say that a certain cluster
of scores on the neonatal scale or on this scale equals the
competence ^{of an infant} -- I don't think the neonatal scale has ever
really been popularly used ⁱⁿ that way. And, our use of this
scale would not really mean to say this score equals compe-
tence and this score equals incompetence.

how speaker

DR. GREENSPAN:

a category?
~~cross-talk~~ - well, what did you really mean to say -
May I offer a clarification of what I think ^{are the} ~~of the issue~~
two issues. One ^{group of} ~~is~~ these items ^{is} in the vertical direction,
are they the most discriminative items -- how
you arrive at them. ^{as for} The horizontal direction, ^{is this} should you
use the same one to differentiate the fine points of each of
the vertical items = suggestion / each one be judged/differently
In selecting each particular one of these items, I think Al's
point is, ^{is} are you inadvertently, or without really caring
to, ^{as for} setting up certain implications for competence, even
though your scale doesn't imply competence because you're
picking certain items to measure. But ^{it} we only measure 10
items and one infant is way off ^{one} in/direction on those 10,
he looks like an extreme infant regardless of whether

imply any connotation to extreme. He may do right in the middle of the range on 10 entirely different items. But, I think that's the question of implied competence by selection of items, but how you choose to select the items does imply something because you are only measuring certain features and not every single item. I think that's the gray? great of debate.

DR: Thank you, Stan.

MS. And if your observations follow a course - other kinds of observations - If these then are used to assess? infants in some way, then, whether you wish it or not, you are going to find yourself noticing things, -- certain items of behavior tend to cluster together, and certain and certain kinds of biological difficulties and certain kinds of experiential factors /particular ages -

DR. BRAZELTON: I'm not against that, but I'd be hesitant to make an evaluation -- I mean -- to say that was good/or bad or something else until I'm -- I began to get clusters like that to see what the effect of the environment was - how much there was things like that which was implicit I guess what we need to do is what you were talking about -- are we, is this the best we can do about making observation around the Bayley, or around the pediatric exam or around any of the other assessments, that we're all into. And, in terms of doctors? -- and the way I would use this matrix ^{which be} ~~to~~ put down the behaviors of the baby, that we were making the

②
assessment on ~~not~~ in any way saying that ~~one~~ plus, or a
5 plus, or 9 plus, because that already gives a kind of
majority? - a measure - gives a weight. --

But what one is, is the raw data to go back to (and then give
us a range?) cross-talk

DR.

On one hand, you imply a gross/ observation of
observation of behavior - that
is of the patients/ assuming certain integration? already
of the nervous system - autonomic responses and it
is more or less like a mixed metaphor -- in other words
it would seem to me that we could

MS:

take for example- at other times on the
tape the baby regurgitates, the skin mobility

DR:

And so you are assuming that is the conduct
which very well may be, but how is ^{it} tied up to other inte-
grations of the nervous system which we - I admit my own
naivety ^{turns} of the other ~~turns of the other~~
in/ comes in, which we the other
correlates which and other organized behavior
within the brain. And this is something I find the most
fascinating - the most difficult: is how to organize it - correlate
the behavior to what happened within the brain, which is
something where I think maybe what you are talking
about in 20 years that happening in 200 years and that is
something - we ought to keep that flexibility in terms of our
observation.

Berry

You implied in your question that we are going to equate each of these in some way and, I suppose that that is important in attempt to any ~~and~~ ⁴ systematize it, but I certainly would resist that notion until we know a lot more about what the range of behavior we are going to get at each point in time --⁴four, ⁵five, ⁶six months, for -- any of those.

DR. ¹⁵herbener?

There ~~seems to be~~ ^{is} another gray area that bothers me, because you were frustrated by this also ^{as} as you move in age from birth to, say, 12 months, the setting becomes becomes very important in which you collect the data because for example, you say the child is forming some kind of a ratio of trust ^{to} vs. mis^{to}trust and then some of these reactions almost? you are getting in a particular setting would be on that validation on who the child is, or his ^{one} pre^{to}social repertory^{to} to respond to a-particular setting in a particular way and ^{to} another setting in another way. We have assumed an expansion of social-emotional behaviors, all of which could be appropriate and adequate in a particular setting ^{but} which may never show up other than in the setting you are using ^{to} ~~that~~ you collect this information in ~~in~~. You might not (enough) settings to get a better feel for what these things are because the child is run by them

DR. BRAZELTON:

And they get more complex as they get older? --(/?

Question:

Answer: This was aimed at 4 to 6 months and it was an attempt to give us something wherein? ^{try to validate it} to evaluate the

neonatal scale, and the tools that we have at present to
validate it are grossly inadequate. And in no way represent
the kind of organization and response to organization that
we see in the neonate, so ^{?? then,} what's the point of going on at
12 months with the Bayley and the neurological, and even throwing
in some of the temperamental measures the way they are set up?
because I don't think they are set up for the ^{kind} of organization
that represents the interaction, including physiological and
neurological and social organization, that we are identifying
with the neonate.

DR:

validation to predict

DR. BRAZELTON:

Well, just to see if it works out or not - if it doesn't
work out to make an assessment of the baby in the beginning
^{to see} is going to go -
~~to~~ which way it ^{but} we are just trying to struggle with that
idea and ~~trying to~~ struggle with a way of heightening our
eyes and our willingness to look and record the sort of things
that we see on the pediatric wards and the pediatric
all the time - ^{look at} so this is sort of what we started with.

MS:

-- trying to work with this and understand that

those are representative of the kind of
^{behaviors} ^{interactions} and kinds of responses the mother would
react to and when I think about it a

little bit I might want to change some of the element?
^{that we have identified as} -- but in fact it is the
^{organization} reduce? the property of the ^{what I saw}
that a mother captures in ^{terms?} giving that quality of the baby
^{happen right away} - is it ^{is it unorganized?} organized, that she uses to interpret what

that behavior means

DR.

This may be what we were really getting at. What is to the environment that the infant presenting/~~and~~ is ~~it~~ meaningful? Since it is an observational situation and we've become the observers ^{who} to make up these data sheets, then what is it ~~that~~ the infant is calling out to us that we can in any way use in a clinical assessment?

MS:

May I ask you where these came from, ^{I did that} these came from people taking notes of what ^{they} were saying, of what they were doing [?] when we were looking at wards? This is what people were saying -- these were the dimensions

~~cross-talk~~

DR. NEUBAUER:

-- sometimes - I am surprised, therefore, we find it so often in response?

you would get as much a response as you would get here

MS:

you can see, for example - coming in using a

-- from parting? --

DR. NEUBAUER:

Yes, or to auditory stimuli or to the touch stimuli.

?

Did you select other sensory modalities of the ?infant before

⁵5/6 months -- more visual than any other?

MS:

Only because of a response move that I

categorized. I can't - you see, not as what I'm doing to the baby. We do have a space where we ring a rattle or a bell for a response to that and the baby's response to the auditory response to the mother's voice or the ring of the bell, but the visual behavior ^{is} here is the response

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category, ^{where} which you can actually see whether the baby's eyes are left or right, moving around, --you know you can see where the baby is looking -- looking at the object, looking away or (response to I can't tell you - I can't (question) observe what is going on in the baby's except maybe through whether the baby is looking to the sound, you see using? so I'm usually --?

DR. NEUBAUER:

??? Or you ask the mother to speak or not to speak from a distance because then you do what is very often ^{done} you do in these tests -- you use these items which ^{that} are most testable and others which ^{she} most testable? we considered non-testable as a statement of where is the child/in development. Now, I can't tell you the second part, because I really don't ?fill? the first part but I think we touched on auditory responsiveness. I don't think as an inference of all of that. Also --the effect of tone? on the child - the ?facial Very often we have an observable response to as something we pick up

MS:

When I get down to quality of mood -- I think quality of mood has to be -----cross-talk -- what is it - when you say the child -- that child gives me a good feeling, that child is in a good mood, -- what is it

MS:

That's the interesting difficulty and one we all struggle with

For instance in the baby we saw, the most expressive thing about that baby was

setting?

Now if you wanted any kind of a statement where you can come in . If you sit down under a mood business for this

voice

baby, inflection and quality was expressive. I don't like the word "mood" even for babies. Another baby it would be movement? -- From a point of view

DR. BRAZELTON:

Well, this has been really helpful to us suggestions -- but if you have any more because I personally am not going to give up on developing some sort of instrument that more of the things than we've got so far in having watched you babies and you know, put it together in the way that you have in the past. I'm sure it's all there for us to observe whether we should use it for interpretation is another matter but at least we can begin to look systematically, and systematically and referring / it may be what we are aiming for

MS:

Inaudible

DR. BRAZELTON:

organizing, systematizing, and that might be the most valuable

MS:

we all choose our own framework - had an don't know exactly? example where this fits in -- inaudible

I think those of us who are responding to this

DR: Behavior— behavior of infants —behavior in these various social situations, also responses to different kinds of stimuli, as Peter and others said, the same, somehow break down the responses in relation to active stimulation or the auditory stimulation or mother's smile or the facial expression of the mother

DR: That's another important dimension, and I'm not sure -- I think you've probably thought of that, but I'm not sure how it fits in --cross-talk

MS: I'd like to see "potentiality" in here somewhere to see what we have (laughter) -- cross-talk -- the definition?

DR: *Greenberg* I'd like to make one announcement ² some of the work at the *Center* are going to be related to the style? of the people ?grading the operation - the work rather than what we talked about. I feel very good about what I am going to say, and I'm not saying ^{it} but ~~this~~ to compliment Barry/because I think it's important that I share this with you.

~~As I was listening to the opening remarks when Berry~~ ² *can* was telling us about what ~~can~~ the baby ^{going to} show us ~~the settings~~ and he was going to collect information in, the hospital with and without the mother ~~and~~ in the clinic with and without the mother, and in the home, with and without the mother. [?] He said that he was going to the places where the

data has to be collected and he is not ?shirking in setting
up any particular setting where he needs to have it nice and
easy to collect information.

And also he looks at -- these statements I am looking at
an observation as a coping paradigm, -- I think what he is
trying to do is to look clearly at what is actually happening.
My impression -- having known these things of the past, is
that he is very open to what turns up and that he doesn't
seem to come in having to prove that his way is right; or
that there doesn't even seem to be the need to be right.
there just seems to be this openness, somehow ?uncover
the truth.

Encompassing this is a tations to keep looking
honestly before jumping to conclusions, and, I think he's
been like a man who stands on the highway pointing in the
directing all the cars are going and thinking he's
in power and control of all of those cars, where actually
he's just seeing very clearly the way they are going and
he's pointing in that direction (laughter)

DR. BRAZELTON:

Or maybe get a ride

DR.

It takes a lot of self-lessness? to be able to look
without that investment -- without having the structure to
say, "I'm going to predict that this is what is going to happen
and I am going to prove to you that it does." And, I think
that what we've learned from your efforts is that if we can be
that way? -- If we can listen to conversations like this
and gain from it

The only way we can look and observe
what's really going on

I want to commend you on the honesty with which you handled
the task Sally?

DR. PROVENCE: Well, you know I --

you are not going to make it directly

DR. BRAZELTON: and so you also you know/we listen to what is driving

us to find ways that are interactive in a way that she
can identify with you as you look at and then
you can make it, you know at a time when could use it
and I guess this is what hopes for as

MS: inaudible second

to me it is a moment of great importance

You say that give you a good

clue something going wrong interacting

Would you be willing to -- other side of the fence, that -- -----

I find myself arguing

baby clearly ^{as a} appropriate relationship with the mother,

do we have the right to attempt intervention --

reasons on one hand - you know very well that some of the

same features in this situation

But I feel very strongly that if you if you say

this baby isn't functioning in the relation

as it should

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and therefore there is something wrong in the relation,
then I feel ?honor bound to
and say, all right, and at least

the baby giving evidence that up to this point nothing has
happened which required us to

in practice implementing very
unimportant questions - Where are the dilemmas? and what --

DR: There is an important additional perspective or referring
?

perspective that theoretically we knew then that we didn't
really and Sally really when she said
that we kept the mother into treatment. Actually,
now when we do our inventory we also say what's going right
as well as what's vulnerable and not going right. And, you
know with such a mother you've got to start approaching her
with what's going right -- like the ?grasp - like getting her
to do something with the baby or come into the center with the
baby and to give her something to do as an would
because, ^{if} once you approach this kind of mother through what's
wrong,
going on she can't tolerate it alone. You approach her through
what's going right and say ^{that} now the baby it needs more
practice or whatever it is-- whatever terms you use - depends
on the nature of your contact. You are more likely

through least conflict, rather than through most conflict,
broaden rather
to be able to draw ~~xxxx~~ the alliance/than to drive her away
from ^{the} what alliance you have with her, or take a risk of doing

that. And, if we are so oriented toward pathology, because
it is the place that you can see most sharply
that we ^{have} really only now, [?] and we haven't started teaching it
very well, I'd say -- found how to fit that whole package
together so that what isn't running right, - what's breaking down
~~down~~ -- we won't get so anxious about it and label it and
move on, toward saying "well, now, ^{the} baby is doing pretty well
here and not so well here, and let's see how we can work along
with it." I don't want to go on but seems to

MS:

Yes, I'm having trouble with that - they are not
responsive to

Material on this page doesn't mesh with that on preceding page 129. This refers to Fraiberg's presentation, which hasn't yet appeared.

This is 11/15/75 A.M. - Fraiberg ESCALONA

P. Neubauer - this correlation between limitation and the correct influence that lack of vigor or intense - - - - - to make a dynamic correlation between such items of the grandmothers a simple formation - I don't think . One would be either interested in to see^{ing} whether the further development of the mother would show lack of vigor with or without phobia, - would show lack of intentionality and intensity of effective performance. We see correlation in a single aspect of personality. It has shown the capacity of modified adaptive behavior or differential behavior under different[?] circumstances - differential behavior with different people relation or that you carry_____

Fraiberg?
Sally F. - Now post-assessment - we'll give you the complete picture up^{date} and this is what we're looking for.

Sy. Escalona -

So many of the points that you want to touch on have a close already. If we point out the way in which examples called admissions (?) differ from a situation where the baby - that often exists when there is not an elaborate research context. It is very important that this was the 6th contact that we had and a good deal about the baby - the situation with the mother - that is very different from what is collectively knowⁿ now, assessment and the occurring practice. On the basis of/this wonder whether we should take a stand against a one^{or} or two-shot efforts to get at this kind of problem and say it just can't be done. Even what we have may in the areas where thorough exploration, one would still want to know more about it with all the . Just in principle, I think, as one looks at the issue of officious (?) assessment, there tends to be some kind of balance between the / needs of one's formulation of what one would even be responsibly be able to think of, and the closest one would also challenge and experience a variety of that's

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11/15/75 - A.M - pg. 2

available to one and to me, what you are doing represents one of the experiences
whatever there are more of

itself on the other developmental tests is not a preferred/ situation(?) in which to go

after ^{what} the things you stress most, - which is interaction - it is a situation,

au contraire, in which the mothers of most of seeing what there is

something not attuned between mother and baby - where the mothers just can't

say no in a lousy family example to build up something, whether exclaiming or
helping or imposing or whatever - it is a situation where tact and common sense

requires - should be able to focus on this so that it's not the - not that you

don't get telling instances of whether the baby does respond

and its very constraining. Many of the ordinary things

One is much more tempted as to speculate on what happens the rest of

the time from what we've heard about

Now on that there are two questions raised only because ~~mx~~ take it one
different people

time this exercises to look at the same what do they see that is

merely complimentary to the major things that we pointed out. One of them has to

do with the difference in the child's behavior with pacifier and without pacifier.

I would feel that except for the intervals when the child can do without the pacifier,

and I don't think that was demonstrated very well, the facial mobility, the hand

^{movement} the orientation and it is still true at this age ^{for some children} that when you have that thing
seduce(?)

in your mouth it seems to induce the kind of lack of vigor, passive mobility

of some excitement and then letting it ^{wane} again so that in our standards

with the exception of children who are just who simply can't

do it and then you

11/15/75 - A.M. - Escalona - pg. 3.

I thought there were even in this brief episode, if you compare the one with the pacifier which I think is very significant - but on all of the dimensions that interest me - quality of behavior, this is something of interest. I just want to comment impressionistically of the child and then seeing her she would look so somber, so I think she is the kind of baby that if you just walk through the ward before you know anything you think there is something good - and to me on the tape she is a funny looking baby sometimes then, they turn out to be so charming and so alive, but the first look is odd. When she was a baby essentially not on the pacifier, on the tape we saw she was consistently more responsive to the human partner (?) than to any object, including that gal, which she liked - she was a baby who could oriented to its cases - and there were many, many times with mother and the family when she was ready to set something ^{going?} in an area where she showed initiative - she was the one who started something; she was all set to go a great deal further than she went. In other children who suffered from less than adequate life circumstances, the development correlation was just the opposite. They are somewhat or either tuning out of the social components and once you get them that's where ^{their} there orientation lies, and it should not be that way at all - there is another form of initiative that ^{is} diagnostically of some usefulness. When you started tying her ¹ stereo / it reminded with the baby at home and in just getting household compositions - general conversation about how things are ^{when she is asked} at home, who is the youngest person in the house, and she says ^{she is} I'm the youngest, - not seriously forgetting about the baby, but perceives ^{ing} the baby as the youngest member of the family but herself. Some of the things that are so useful to us, ^{when the} the mother is socially, economically, in most instances functioning as the mother, seem to me to be kind of relationship that emerge^s and the kind of attitude that

develop^s psychologically and realistically. Another systematic point is that when we look now at the quality and the caliber in the developmental perspective of what . There can be sometimes because of the genesis of the most important development in that age period. The focus on mother-child relationship in two ways; one, the importance of where this child is developmentally but also as part of an explanatory thing - the miracle that ^{she} child is doing that well ^{despite} with all these hinderances ~~or whatever~~. That aspect is going to be separated very shortly - in the case of this child in terms of up to the point where we first came in contact with her. It may be extremely important, but it in fact of a small proportion of what this child could cope with and the conditions in which she grew up. What we really want to know (something about the pacifier) Selma - yes I will tell you more - Karen was not to understand - the baby really didn't need the pacifier; there were other ways the mother could comfort the baby. Karen then gave up the pacifier in the nursery.

S. Escalona - I really think from a point of view it takes an enormous when she took a nap it probably dropped out & which tends to restrict when she wakes up and puts it back in/and it takes the kind of observing motor activation, sensory motor that in a good stage that no one is going to very much. The nature of the input on her which would seem to be anything but which would be inappropriate to a child of her age many adults and it is very hard to know what happened toys, you don't know whether she was in confining clothes or not . I am trying to mention some of the variables in children and they get a little bit big and if you have ever watched it, it is one garment and if the baby stretches the neck or raises the neck, there isn't room in them and they don't get to centration going for their feet, many of the other things that you can do to amuse yourself and learn something from I always have an impulse to reconstruct the picture

~~the picture~~ of the kinds of perceptual and motoric and perceptual and ~~active~~ ⁷asmtic states and activities that are at least possible today under the clinicians in which to see the emergence of - in the context of the that comes from particular deviation or quality in the mother/child relationship and the total and the kinds of things punctuate that day when - the kinds of things that tend to elicit affect of whatever . And ⁹¹lastly, ~~one of the things that~~ I'm curious about ^{what}in relation to this mother's ~~what her~~ range of possibilities ^{is}are in terms of the baby. First of all isolate the baby they really are very much ^{visually}imbedded in their peer group ^{look}at those girls who almost ^{visually}are confined at home ^{they}go to school, come home, help with the housework or whatever they are supposed to do, or they just sit there and watch TV. I have come to feel very critical variables that determine potential for the development of all the things we are talking about for the baby is and I am horrified ~~aby~~by the degree of high One wonders ~~ab~~out that and one wonders about how she feels about of overcomes the rejection, the loss/ the mother, the father, and the thing was originally it must make a difference in how she feeds the baby, punishing at some level, or transgression / ^{is the one result of} to spite your parents that the value no matter how guilty you feel - the wide range to begin what is going on unless I believe it was Reg who asked a question ⁶Selma - Six months ago we have a tape showing Nina six months after our last ^{taping}one ^{as well as}we followed her once again, and I will give you the additional information that came out ⁱⁿand also the problems that translating our assessment into a method of treatment, which ^{which}became especially difficult for us. Peter had raised a question, what ^{was it?}

Peter's question (something about adopted babies) Selma - we have often been of the theory asked for neonatal testing- what is the projectory, ^{this} is exactly the question that we ask ourselves, too, ⁱⁿ in the midst of all this chaos, and the morbidity of the mother's picture, the families picture, and the nurse --- what is working for both sets, and yet, qualitatively speaking, there is much that is needed . By the way, ^{how} it is worth mentioning when we ask ^{characteristically} how the one tape session might be for the total of six sessions, Evelyn thought that there was some ~~there was~~ qualitative interaction between mother and baby seen in every session, ^{as well as} and clusters of such behaviors ^{as} we saw in this session, which ^{tell} us again Sybille how important it is to have more than one session to be sure that we are getting ~~truly~~ a good repertoire and yet in talking to Evelyn she confirmed your impression that this was the real and ^{ethi (?)} Berry - Is Sibylle picking up on some of the genetic and ~~hereditary~~ genetic effects of this girl's anorexia

all the problems with it and, of course, under the influence of malnutrition in the uterus which has ^{horribly} and suspiciously permanent effect on this baby in terms of what I thought was the two people can face and maybe the amount of and again two things, not only the mother's ^{ability?} stability to overcome the influence of this kind of funny strength looking baby and the ~~XXXXXX~~ she can but also ignore that and would reproduce what went on here in pediatrics and .

Alot of it in terms of ⁱ lining up some of the . They are very offensive in predicting for us which people ~~XXXX~~ need the marbles. Also, predict which babies in livid failure-to-thrive need more than ³ ~~three~~ ^{of} days hospitalization change the baby as a solicting stimulus/ ^{to} dangerous ~~k~~ length of time. The fact that she went on ^{to} gain is certainly a testimony of the [?] year support, but not for pediatric wisdom/ that was invested in this baby. I just think that there are an awful lot of things from a pediatrician's stand point and from a nurse's stand point and a public health stand point that ~~they~~ we really ought to pay attention to there are alot of so then whatever

Question:

Answer: at one point and the impact and the "00000" was heard, ~~imitating~~ what we thought and there was a very large expressivness in a comical imitation of somebody . Something repertoire does not .

Question:

Answer: I don't know if we have the answer to that. A baby who was certainly receiving much more from her mother and her mother / in the process during this period, I can not really follow the lines very carefully then that's the kind of thing that Evelyn could ^{have} of reported to you, having done the ^{assessment} ~~assessment~~ , and I could not report, ~~being the one~~

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^{since I set}
~~getting~~ it second hand from Evelyn, but we will ask her.

I think so, now ^{but} I understand your question. ^{I'd like to} I should ~~also~~ mention some-
thing else that you should all know about. Let us not think that the
hard work because mechanically once it functions as
being primary /and the time that you ~~W~~ on tape here
and the ^hcaos that having started earlier, multiplies by
that much more, and the amount that may have banging each other
over the head, snatching things from each other and allowing
their children to ~~If~~ the best they can survival

. I can not understand how an adequate ~~_____~~. This mother,
who has her ~~own~~ own limitations we know ~~that~~ there is nobody else in
the picture, ^{have} could ~~of~~ provided this much for her baby.
You know in a ^{perverse} ~~perverse~~ way, it may be a relief to not have so much
supervision in that ^{nursery} ~~nursery~~ because the competition ^{you described} between the ^{nursery} ~~nursery~~
person and mother ~~you described as~~ might have been more
destructive than the support she is going to get

. Two places that I think relate to the same
development that you were getting at one of
them is whether she is beginning to have an idea of / where she
could point to which I think is the same change

next page is not continuation
of this

Where
beginning
this?
Green's part

plus that I think, in the three presentations we have had over the last two days, we ^{saw} served some differences in approach. I think Sally began with some of the conceptual foundations we ^{can} could use when we approach the whole class of evaluations, pointing out a number of assests to critical periods

their approach to assessment and evaluation, which was orderly and systematic, and attempted to take the ~~kind of~~ ^{as} many variables as possible to them. I think Barry then presented a slightly different way of doing things, though I think ^{he} basically following the same ^{velocity} ~~velocity~~ that Sally presented to us. But Barry focused our attention on very often debatable issues and ^{there was} some heat in the discussion I think we . Can we select two variables out of the multiplicity of those that we must deal with?

faced with a slightly different ^{velocity} ~~velocity~~, things the ^{velocity} ~~velocity~~ of that if we always try ^{to} and look at all the variables ^{described} so far that we are so confused, we ^{will} have to rely on our ^{inte} ~~integrating~~ ability, and perhaps it will let us down sometimes. Only a few people are capable of that kind of ^{inte} ~~integration~~ to take all of the variables in account and use that complex to reach a conclusion. In terms of you can not get some variables and be

. As I ^{have} already pointed out, ^{Barry has been} brave enough and to take its first beginning argument, through research effort, ^{and show} sharing two variables, showing us how he is attempting to focus on ^{them} him in a ^{delineated} ~~limited~~ way, by showing us the number of variables directions and ways to look at these at different angles in terms of the horizontal directions, and the questions is, how does this sort of approach to the broader

of approach that this has our way. There seems to be a number of questions that this always has a potential benefit, as Barry demonstrated . And the questions one has to ^{ASK} ~~ask~~ is it better than one's judgement, can it be that

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ADVISORY COUNCIL FOR CLINICAL INFANT PROGRAMS

November 14 and 15, 1975

November 15, 1975

TAPE BEGINS:

DR. GREENSPAN:

---through, and we are hoping and re^eestablishing our

--continued from previous tape -

DR. LALLY:

I wanted to be clear about the question- the recommenda-
tion that Al made, and also Selma's concerns with relation to
the ²/_{to} ⁴/_{four-week} idea and making a decision at that time
(previous tape ends here/
as to whether or not the child/should go to the center or not.

It seemed to me that you are not going to have many cases *in which*
where you are ^{so} completely sure that your home intervention
isn't going to work, ^{percent} that you are 100% confident that that child
should be in the center at that time. If we could, on Al's
recommendation, move out of making a firm decision about any-
one ^{'s} coming into the center at any particular time, but in each
have the child case, stay in the home ~~as long as we can~~ until there is ~~so~~ *certain*
much evidence that the child should be in another place, I
think we would be in a lot better shape than making a decision
at 6 weeks or 4 weeks.

DR. GREENSPAN:

Yes, I think we agree, basically. ^{intended} I think we wanted to
imply--~~maybe it's our unconscious doing something else~~ that
we weren't going to try ^{to} and reach decisions ^{has it?} ~~very quickly~~, but
^{our} the over^{is}riding principal, I think, ^{should} would be to ~~do~~ keep the

baby at home with the mother, ^{and} provide supports there ^{insofar as} where that's possible ^{is} and make that an over-riding philosophical

judgment because you can, I am aware that if you have a vested interest in getting a center program started, you don't try everything in the home, you don't expend your best efforts; you don't work as hard in establishing the kind of relationship that Selma described in her program where work can go on at home. And, ^{hope} we are ^{will} hoping that we are not, through unconscious collusion, going to run into conflicts among ourselves.

~~Our over-riding philosophy will be to keep it going at home,~~ ^{we feel it is important} and ~~the other over-riding philosophy,~~ ^{is} however, ^{is} to have a range and flexibility of back-up services so that we are not --- you don't ~~have to exclude people.~~ ^{that don't} And, those are the two over-riding principals.

We ^{we} had a chance to hear about a ^{very successful} program in ~~it was for~~ neglected children in ^{Nashville} a place where the country-western music capitol -- Nashville program -- was presenting -- they had a very successful program. Some of you may be familiar with it.

To be available, really - it was a kind of primary, ^a secondary prevention model - but ^{was set up to be} to be available in the first ^{to} to any calls for help, a neighbor, ^{from} family -- where there's any question ^{possible} of child neglect, ^{or} child abuse, and what distinguished their program was that ^{its} it had a variety of back-up services, so that they weren't pushed into doing just any one thing.

The first ^{step} thing was to have a worker available ~~to~~ spend from 12 o'clock to 8 o'clock the next morning in the home with the distressed family, ^{the} for whatever reason ^{for the initial call} -- if it was a case

delete?
a memo?

parents?

OK?

noon
midnight?
either?
depend on
when call
came in?

of a fight or a child being beaten; and to maintain the child
in the home to give time the next day for some kind of
organized thinking to go on about what would be best and in
most cases they are able to do remarkable work in maintaining
the children who otherwise were going to institutions, in many
of the cases, in the home doing intervention of a variety of
sorts--homemaker services, available, back-up services, but
they did also have short-term and long-term support services
for day involvement, and what used to be the institutional
involvement where no therapeutic efforts were going on but just
a maintenance institution for a lot of these children, Actually
became a therapeutic back-up, and the program wound up, and I
was very impressed when they presented it to us, costing the
Nashville much less money than they were spending on their
current program where they were they had to support these insti-
tutions, where a large variety of the children were actually,
you know, the corrective services the police would come in and
the child would be placed in some kind of institutional setting
for a time, and either foster care or back in the home, but it's
a similar kind of a deal. We want the over-riding philo-
sophy will be the involvement of the home, but to have flexibility
of the variety of other kinds of support services, so that we
neither have to exclude--and there is a danger, I think, that
are commenting on, that you don't fall into the trap of having
a center and finding that maybe some of the services you don't need
need and you say 'well, you've gotta send some there, anyhow.'
but use because they're there

where is
material
referred to?

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4.

I hope we don't get trapped into that sort of a --

DR. NOVER:

we Don't want to become the parents, *either*. That's the other side of it. Although we have talked to a local facility, *about the need,* that ~~there may be~~ *for* from time to time, *care* emergency needs for a baby for a day or two just in a regular day care center. You know, you can be there until 7 or 8 o'clock at night sometimes, waiting for a parent where something will come up. And, we are prepared, *in the event of* if there was a crisis in the home, or child abuse, or some *other* serious thing to provide back-up, but I think the philosophy has got to be that there is a parent there *and it's up to us* to maximize their capacity to take care of the infant, *parental care* and not try to replace it but to supplement it. I think that's where the center fits in and where the outreach fits in *at your* and all the comments, I think, are very helpful in terms of addressing those issues.

DR.

Yes -- yes, I think, in light of what *has* *been* said, I think that one of the things I *is* struggled with and been a little confused about in particular comes to the issue of Selma's model vs. *the* you-know, day care model, and you-know -- what Ron's doing, or whatever -- this whole thing about being everything to all people. And, I'm just wondering about *I wonder* -- if really *effort* home-based, doing something similar to what Selma does or whatever it might be, is your main *is* (*germane*) model in talking about, you-know, contracting your day care, or whatever. I am a little confused about how you're going to run a day care center where you might have five infants one week and no infants the next.

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week. What is your staff going to be doing, and how do you ^{plan} to do that kind of thing. I'm, you-know, just raising this as a question. And, clearly, -- it seems to me in light of the things said here and, Stan, what you just said about other support systems that this -- I guess, maybe, I get confused in trying to think about what you are doing -- jumping from a more day care model ^{to a} or more home-based model, and if one focuses more on one and thinks about contracting out the other services or supplying them as a back-up, or whatever it might be, it seems to me that focuses things a little a little bit better.

DR. BRAZELTON: They're into Sally's -- They took Sally seriously there, talking about the idea of the reality is yet to come.

Minor comments (yes, I guess so, etc.)

DR. PROVENCE: But also, it seems to me there, Bob, that, for instance I guess what I would try to think about is how you could, -- within something that is realistic, -- plan all this for flexibility, which is what you say, of course -- in various ways, over and over again.

Presumably, the child ^{who} ~~that~~ is not in the day care center that particular week will be seen ^{in his own home} by ~~that~~ ^{the same} person who usually takes care of him in the day care center, ~~in his own home, or~~ wherever he is that week. At least that's the idea -- or as I understand the idea.

DR.

I think that's lovely, you know, I can remember, for example, an experience ^{as} on ^{an} adult psychiatric day care ward when I was a resident and we did not have 24-hour hospitalization available. Even though ^{it was} we were a university hospital, they didn't want always to be dumped on. We finally ended up ^{imposed on} doing ^{ed} was renting a motel room on the nights when our people ^{stayed} couldn't make it through the night, so, if it was my night, one of the nurses and I sat in this motel room all night keeping an eye on ^a this psychotic patient who ^{we} ^{had} ^{tried} ^{to} be able to keep in our day care center. It didn't happen very often, but we had that back-up.)

So that kind of flexibility I can ^{see} ^{though} say? —but it took a tremendous resource toll after a while — I guess that's partly ~~my~~ what I'm feeling here

DR. PROVENCE:

I think that ^{the} demand and the need for flexibility stresses the adaptive capacity ^{is} of the staff more than any other single requirement, too, because however talented, if they can't roll with the punches and change the plan, ^{or} and scrap one, ^{it} and do something different, they are going to be ^{under} in great stress.

DR. BRAZELTON:

But it reinforces the ^{talent}, because you learn very quickly how to get around some things. — Minor comments —

DR. LALLY:

One of the things that seems to be happening is that you are trying to deal in exactly the same way, but in a more ^{at}

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intense level, ^{as} is the child and family resources program
that ^{Jim} General Gage directs over at ~~OCD~~ they have just come
out with 200 pages ^{on} of how they plan to solve some of these
early problems. And ~~one is that~~ in the beginning they do
some needs assessment interviewing with the parents ^{on} what
their goals are and what their needs are, And they talk about
the goals of the program. And, what I would recommend is that
you at least get a copy of ~~the~~ ^{on} work that they have already
done on this. They have been operating since 1972.

DR. NOVER: Who is that, Ron?

DR. LALLY: Jim Gage at the Office of Child Development, and the
Program is called the Child and Family Resources Program.
And what they try to do is ^{job of their} the facilitators of services
within a particular area and their job is home visitation, ^{followed}
and then referral to all of the other places that might be
of help to that ^{a particular} family. Some of them do create their own
day care center when they think it is necessary. The others
do not, if there are appropriate services in the area that
the child can be referred to.

But, they go through an intricate evaluation plan at
the beginning, when the parents and the staff people get
together and talk about some of these things.

DR. NOVER:

One of the things I'd be interested in knowing ^{about} and
^{something} that you have had experience with, because it's such a ^{you come from} similarly
^{a number of} large area and although the population may have things in

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common, and the agencies may be cooperative, there is not the kind of community support that perhaps one finds within a more contained neighborhood or urban area, or wherever they -- if ^{we} you get the babies from a lot of different places, that one disadvantage would be that we ^{wouldn't} ~~won't~~ be able to rely on the kinds of neighborhood^s, except ^{perhaps for} a neighbor for a particular child ^{as} -- I think someone said, three blocks away. * I can imagine that ^{there} it might be ² two or ³ three miles between where one ^{where} infant lived and another infant lived, and that would be a challenge.

DR. SOLNIT:

?

You may have to get those mothers to know each other, even though they live far apart, and give them a morale ^{core} a corps experience in which their own morale is enhanced by being a member of a group that is doing something new and worthwhile. ^{They welcome a chance to see} the change ^{the} a little piece of the face of the world..

That's what I meant when I said that there's no big external enemy that's out there that we can unite behind, you see -- you've got to help them find that kind of enemy, which is the corrosiveness on their lives and on the ^{ir} babies' lives. But, ^{the} you give them a chance to rally around and have something to say about their fate.

DR. LOURIE:

Well, I think we have profited a great deal from this discussion.

* Statement appears on p. 151

DR. PROVENCE:

So much, ⁵⁰ that I think you may ~~that~~ you eventually may change the name of your project.

~~comments~~ that's good - thank you
to something that includes "parents."

DR. GREENSPAN:

Thank you. Thank you very, very much for your help with this part of it and for your, your

Interruption -- an excellent job

DR. BRAZELTON:

Amazing, and after your presentation last time how far you've come.

DR. PROVENCE:

It's fantastic how much has been condensed and synthesized and reviewed *in this brief time*

END OF TAPE -- #370

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The other question I have comes from some experience in a somewhat similar problem of a mother where it made a great deal of difference when one could rely on beginning there's a tremendous difference between feeding and between allowing the child to eat . It was really a turning point in the sanctions of because the mother would no longer provide. that I was just wondering if something like that can in XXXX area

Question: Do you have here?

Greenspan?

Answer: she could have gotten that wrong, I was thinking . It could be that this was a sign that we were looking for but that there were ways which needed the preparation for her mother and when . And we also have where again and again feared by her own observers, a running, , an embrace, and a radically , I mean not running . just some- thing I was thinking of today, that it would seem a great accomplishment that she doesn't be fed when she enters the and her time would be needed by / judging what she could and that could be good nutrition. The doctor, by the way, is entirely . and very healthy and in turn to a checkup of the things . The last time structurally from the fact that there is a history of speculations her actions, in the child's normal ability to be very much effort . It leads to a kind of a good question, which is, XXXX kind of vulnerability attend the hyperness or what kind of XXXX vulnerability in fact, intended to reduce the risk. This child, for example, has been able to avoid, what seemed like the child would not be called to your attention. And it is very interesting question about what kind of

would be with increasingly part of
the and what combination him to reduce the risk
because of combine all kinds of help that would be available.
I think that it's an interesting trying to see what type of

. I must say that the general atmosphere of a day care or
nursery school, I can see almost no advantage to, especially everyone is
trying to help the child achieve a kind of relationship the mother
the differentiation I am speaking about. I was reminded that the reason

I saw young . Do the ability to have a
as a real asset, as compared to people who ways
of compensating for psychic pain and lingerers, ,can
develop symptoms which along with tension, or subtle,
series of softer signs later in life. What I wanted to do
is, simply make us two summaries of comments. together

anyway a series of presentations and discussions on how
each one of their own stood by itself, . I was
hopeful that two summary comments will lead it into some thinking and
discussion of the planning for our next scientific agenda and also,

some talking and thinking in hopes that we will pick up a
little bit of planning the agenda for the national center functions
party at the next meeting as well, and do all that before lunch. After
lunch we will hopefully have a discussion about the Study Center.

It struck me that this is one kind of summary comment that doesn't
bring us back to the issue that is called clinical

national center concept. I thought clinical would also
simplify . I think we consider something clinical when
we try and consider all the variables that we can conceivably conceptualize

that relates to a given ^{phenomenon} phenomenon. at the center, at various stages of the life cycle. We would get all the conceivable ~~XXXXXXXX~~ variables or ~~the~~ those that brings into the world with them, those that were given to him , and those that how we begin to ~~XXXX~~ organize those

I think that clinical from other kinds of programs, that were very good, select ~~X~~ certain variables to ~~XX~~ look at in more detailed ways. As a clinician gives up in some ways, experimental data often for dealing with problems faced with them . I think that does the that we all have been struggling with over the series of presentations today, what we kind of ~~XXXXXXXX~~ decided I think with our first mission? on getting a clearer ~~XXX~~ ~~XX~~ picture ~~N~~ on how to evaluate infants or ^{child-rearing} in first year of life. It seems the issue, are, ~~XX~~ from the clinical approach, is what are ^{the} variables we need to look at. What are the relevant variables? from the side of the infant, ^{the} side of its mother, and the side of mother and her actions. The side of all those systems or the ^{impinge on?} that enhance the primary organization.

And the second question, I think it's ~~XX~~ aside with what suggested earlier, is always have the ^{idea} ~~idea~~ ~~XXXXXXXX~~ for relations first before you go and practice them. And she thinks from her evaluation point of view, which is also , what is the idea all those variables whether we ~~can observe~~ ^{CAN OBSERVE} them, measure them, or even with them, we need to know about to fully evaluate anything in the first year. And then move to the second level, what's ^{is} practical, what can we observe in what kinds of settings. And then ~~the~~ ^{is} the third point is, always be aware of what's missing in the and the idea so that ~~XXX~~ ^{our} formulation and evaluation always have this clear what we the life to know.

I think in achieving these goals, I think we have perhaps the arrangement ^{difficulties?} ~~defferiencies~~

actually put the average

up against the unique positions

but the average positions

. Or is it at least

as good? And the third question, is it

can others learn

more easily?

ADVISORY COUNCIL FOR CLINICAL INFANT PROGRAMS

November 14 and 15, 1975

November 15, 1975

MS. KAISER: Pardon me, please, before we begin, do you mind filling out your evaluation sheets so that we can collect them since some of you will be leaving at different times -- etc.

DR. LOURIE: Can we start the last lap for today?

(LOTS OF PRE-MEETING COMMENTS)

We are ready for the last phase of our meeting and we are going to turn this over to Stan.

DR. GREENSPAN: What I thought we would begin with is -- I hope, I think most of you ^{have} received a copy of our most recent ^{the} revised version of our own proposal to begin research in this area, and I would like to just make a few general comments. ^{about it}
But, ^{all of you} first, I would like to thank ^{you've} everyone, again, for the help that they've given us in past meetings. -- just to give one illustration -- really, I hope it is illustrative ^{I hope} throughout the proposal ^{reflected} -- our attempt to integrate and synthesize the suggestions and thinking of the group, because ^{greatly} it has enriched our own perspective and thinking ^{to a very} high degree.

^{To give you} One example, of it was -- you will recall ^{that at the} last meeting ^{you} the group was ^{argued} yelling at me to take into account the use of the word "control" vs. "comparison group" and ^{the} the thought ^{with} that it might tend to ^{the use of} pseudo-experimental design, and the

Of the many suggestions ^{that} were made, ^{2.} suggestion of the group, one of many, but that one comes to mind for a specific reason, ^{This was that we} the suggestion of the group was to use it as a real comparison group, not even ^{not} attempt to imply any control status, ^{but rather} and to look at how the actual delivery system ^{functions} exists in an actual community, such as Prince George's County, and, ^{it} then make comparisons with our own program, which would be a different type of involvement, ^{and} and to use the comparison group also to then see how our findings might translate and be useful to existing service delivery systems, vis-a-vis, consultation, etc. etc.

^{Apparently} The group, I was not listening very well, at the time ^{because the need for this approach had to be explained to me} the group had to make its point numerous times, and, indeed, out in the hall ^{But} The interesting thing was that I did finally integrate it and took ^{it} into account ⁱⁿ the proposal, and ^{is}

Early this fall, when I met with Bert Brown ^{about} around our own proposal and the national center concept, ^{I was} to my surprised ^{when he told me he had} he had read through, ³ spent as he told me three hours reading through the proposal, which I was happy ^{that it} had a lot of background information on infancy in general and ^{on} the other programs around the country, ^{Steve Hersh tells me that} so it gave him a broad perspective. To demonstrate and prove the fact that he had actually read it, ^{Bert} because he usually has someone else read ^{these} the things and then brief him ^{So} for a few minutes ^{to find} Steve Hersh was amazed because Steve was prepared to brief him five minutes before the meeting, and in fact Bert told Steve that he didn't need ^{Bert} it ^{any briefing} because he had covered ^{the proposal} it thoroughly. He had picked out a

few points to make, ^{about our having} One ~~relating to a committee that he had~~
~~been a member of where we misquoted something about the con-~~
~~clusions of that committee.~~ ^{he had been a member of}

But, more important, he was particularly impressed with
 the way we had decided to use comparison groups. And not only
 did he show a great deal of sophistication - ^{in his} ~~in our presentation,~~

but that was the one point that he selected about the
 thoughtfulness with which you can both try ^{to} and begin something
 new, ^{and} have some way of looking at existing services, ^{and} making
 some comparisons ~~and the way we described that particular~~
~~section.~~ ^{This} It highlighted to me, the usefulness of listening.

I was not only thankful to the ~~group~~, ^{you} but thankful that
 we were able, ^{it} to, although fighting ^{to} at the time, ⁱⁿ sit back to
 the promise(?) of the next few weeks and take it in--which is
 not ~~perfect~~ ^{This is a dramatic illustration of} of what happens in the heat of debate of such a
^{the benefits of heated debate, when there has been}
^{time afterwards to sit through and}
^{be integrated} afterwards. That's just one illustration, I think, of --
 in the dramatic sense -- of the usefulness.

As I mentioned earlier, it looks promising in terms of
 strong interest from NIMH, both for getting our own intra-
 mural research effort in this area to complement all the
 existing programs going on and also for, you know, support
^{for} of some of the national center functions ~~that we've been~~
^{we are} discussing. The impression I get is that you're going to be
 starting small but ^{that} there will be increasing support as we
 go along.

For a variety of reasons, Bert sees this as a very high priority now ^{HIS} and, I think, from some of the things that people have been saying? and you know it was recommended early? -- there are also other ways we, ^{group} as a group, can serve as an advocacy ^{group} but, with that aside, back to our own proposal.

What I would like to ~~do~~ ^{our meeting} is open up just for general discussion of any thoughts that people have had about ~~some~~ ^{you} some have been kind enough to write us, ^{we have been very appreciative} and we have gone over and studied their comments. ^{your} But, for general discussion, we do have some specific questions we'll throw to the group. But,

^{After the discussion,} we'll first open up for any thoughts that you people have had and then, ^{on} if we have time, I'll throw out some specific ^{ies} questions that relate to the difficult/ that we are having that we'd like to more focus ^{one} -- more attention to.

DR.

^{thought} Stan, I had one right at the beginning and that's why I'll speak first. My feeling was that some of the justifications in your review of the literature for this being a unique program were playing down a little bit some other programs that were being reviewed. And, ^{I think it was unwise to} also, building up a case almost like Head Start built up the case for what they were going to be able to do. ~~I think that is unwise to do it.~~

^{not} First of all, ^{more little} some of the programs that excited ~~I didn't~~ ^{I didn't} see the impact ^{anti} a couple of years after they stopped, that were reported in the review, and also, ^{have been} there were some other programs that were trying to do things in the home and in the center ^{have led} that it came across that ^{it was as though} you were completely unique, and I

feel
 didn't think that ~~you~~ you are going to raise the ire of some
 of the people out there who have done things in the past, and
 that's not necessary, and it might also make people expect
 too much from you, ~~which~~ ^{and this too} I think would also be a mistake.

DR. GREENSPAN: Yes, thank you, that's a good _____

DR. NEUBAUER: I ~~just want to throw out some questions.~~ It is very
 impressive ^{that you have done} that kind of outline, and I use it as a source
 material for all kinds of -- so thank you for making it
 available to us.

I ~~had~~ ^{have} a number of questions -- ^{stated} you did speak, at one ^{point} time,
 in the proposal, that a major aspect of the selection process
 involving ^{ed} assessing the mothers and families prior to the
 birth, and from there you will assess, I suppose, the ?notifi-
 ability, the availability for treatment, etc. At another time,
 you speak about the infants of families selected will be distri-
 buted between the two groups. One group is the ^{for those who} one where you
 do feel they do not need full assistance with the care of the
 child, because there is sufficient ?availability within them,
 to take care of ^{also stated that} at least minimally, for the child, -- where
^{for} the other ^{group} one you feel ^{availability} it is absent, and therefore you put him
 into the group for your own center.

This ~~is~~ doesn't sound too clear about selectivity, because
 obviously the selectivity does exist. And the random distri-
 bution is not random -- ^{not at all} -- these
 aspects ^{of which} may decide.

The other question which I have ^{is} that since you have ^{with} two groups which have major ~~at least in certain areas~~ differences from family resources -- the other one much less. To what degree, therefore, ~~how~~ ^{low} will you be able to assess the maternal or the parental availability for the child? ^{are} what is your criteria to do that? because you really base very early, your decision on that.

And, ^{also} secondly, what is the differential and the therapeutic intervention, ^{what it will be} or will you learn by doing it rather than assuming that since one is available and the other one isn't that you will proceed very differently? I don't only ^{where it will take place the centers} mean in the home or in your own place but the modality of intervention. And, how will it affect the outcome? statements, since you start really with - what I thought, at least at ^{two substantively} times, ^{essentially} different two groups. ~~One~~

DR. GREENSPAN: Yes, ^{to} Let me try and clarify. I think the major point and one of the actual issues is ~~I was hoping which~~ interest now is what ^{one that} Sally mentioned as a possible topic for the next time ^{which} fits in with our needs. Right now, ^{with} we are trying as in most proposals, we are constantly open to revision. We make it ^{may as if} sound like ^{as if} our thinking is more advanced than it really is, but, of course, it has served a double purpose. It has to provide a clear statement of what we are attempting to do, in terms of certain audiences and for other audiences such as this ^{but we know there is} obvious, ~~much~~ that we don't know. What we have

working on now is trying to figure out how to select potential mothers and families to establish an availability during the course of pregnancy so that we can be available before symptoms are actually manifesting themselves in the infant or developmental deviations or severe pathology in the mother.

And, we are really trying to work out a way of deciding which benchmarks to use, ^{with} taking advantage of the fact that we want to follow a large group of mothers during the course of pregnancy, and use a large time span in which to make a determination ^{if} some of which, ^{mothers will} presumably, who would give some signs that there may be difficulty with mothering, will turn out as we get to know them and establish availability, they seem to be doing fine and our impressions ^{will} change. Others we may have questions about and establish an availability and a channel for communication and they may seem to get more distress during the course of pregnancy, or we may see different aspects of their character that would lead one to assume greater chance of difficulty in the mothering situation.

But, ^{don't} we have not really - as far as I know, no one has - do we have a clear picture - I think this is what Sally has suggested that we spend some time, next time, ^{at the} what characteristics should one look for in even the first step of establishing availability -- certainly not saying that something is definitely going to happen. We certainly don't have predictive tools, But in establishing availability to a large enough group, we may, out of this, a retrospective analysis, you know,

be able to lead to a clearer picture of what kinds of behaviors ⁱⁿ is the family -- mothers in the early stages of pregnancy or middle stages -- do lead to later ^{are} Or associated with later difficulties.

So, ^{still} we are really working out this part, and this is one of the questions ^{problems for Louie? +} I was going to ask for some focussed help on ^{from} in the group. We are interviewing lots of ^{many} potential mothers now, and we are meeting and trying to work out some profiles ^{used we are getting} similar to the approach Barry has ^{used} and, also, some general clinical impressions. But, this is one of the things we are really going to try and learn about.

DR. BRAZELTON: I just have one word of warning. It came from our longitudinal study at the ^{Putman} Putman children's center and I think that ^{As} ^{in his work, along with} ebring's work certainly bore it out, and I guess anybody else who has been into trying to predict from pregnancy ^{his} interactions, that you may hit paydirt, but you may not.

I guess one of the things that would be -- I had the same question that Peter did -- How do you get -- how do you make your selections? You say you are going to make a selection, and I suppose I think the dangers of making it are about as great in terms of selecting the wrong people as there are ^{they in selecting} the right ^{people} ones. But, if you're clear about why you are making them and document why you make them, then the process -- it sounded to me as though you are going ^{are to} use like John Benjamin's ^{of, making a prediction, and then,} idea, at the next stage, seeing if what you predicted was ^{great deal of} right and what was wrong. You would teach us all a heck of a lot.

And I think that would be the main thing to do, to document exactly why.

DR. GREENSPAN: Yes, that is what we are working on now. We plan to do that, although the better our ^{initial} usual hunches are, the more likely we will be to establish availability with the right group of mothers as opposed to less predictive

DR. BRAZELTON: Less predictive to see how they might relate to medically secure outreach (outrage?)

DR. GREENSPAN: In what sense? --

DR. BRAZELTON: Just ^{who can hear what you're saying,} the ones ~~you know what you are saying in terms~~ of putting out your hand and then, ^{are the ones who} you know, will reach out for it too-- Maybe the ones who are going to do the best within the mothering situation.

DR. GREENSPAN: They would do the best, so the ones that we have the most difficulty in establishing any kind of alliance would be the first benchmark ^{in our selection procedure} ~~that's a useful~~ ^{criteria} (comments)

DR. BRAZELTON: Well, we use it in the transfer situation. I am not sure it would work in a predictive way, too.

MS. I haven't read the proposal, but asked my neighbor, ^{who said} ~~that~~ did you make reference to or think about what you are doing in relation to the experience of the pattern standards of ^{Sanders, etc., study} ~~that they can be pre-selected~~ ^{with this} that they can be pre-selected on fairly sophisticated psychiatric grounds. ^{name?} had a

great deal of difficulty in that a control group, by every-
thing they could tell, ^{was} were not, and you'll recall that they
gave up that way of looking at the material, because really
highly competent psychiatric appraisal at — during the
pregnancy did not establish a meaningful grouping of the
families as they then developed and, as you probably know, ^{they}
are doing an 18-year follow-up on the majority of those
children, ^{6-year} having done a follow-up that ^{earlier} — 6 years on them.
To me that has been a very illuminating thing in terms of
the difficulties of the kind that you are referring to —
and possibly some of what they are finding/really grouped
itself in could be useful, especially if you could have
access to some of the data, ^{the way it} most of which is in the
literature, and some of which I know is in their files,
to see, you know, retroactively, ^{it} to see that didn't work.
^{With} If ^{ch} hindsight could one now see some of the things that the
mothers showed in pregnancy that — during pregnancy that
might have been a clue if one had known how to read it, — — — ?

Or is it really impossible? I don't know.

MS.

Barnard:

I think that I've developed a lot of confidence in
the fact — how people see themselves, ^{which} Maybe the most
important thing to know in terms of prediction and, ah, I'd
be glad to share with you one thing that we have tried out
in terms — in terms of a maternal perception inventory, which
is kind of based on some of the philosophy that Bresard?
used in her ^{maternal} neo-natal perception inventory ^{that} is, really getting
at how the woman ^{sees?} sees herself as a woman and her pregnancy

in relation to what she thinks should happen. And, we have been using that, somewhat coupled with then how the woman sees her life in terms of how much change she is undergoing and what kind of support she feels she has in the environment, and, I think, getting back to, again, I think some of the people who are the most vulnerable for many reasons are those who see themselves as not having very much support.

DR. BRAZELTON: There is another piece of work in which mothers predicted how well they would be--become mothers, how well they would mother. And it was the most predictive to their outcome in making the adjustment was their own self-perception and their own concern.

DR. LALLY? ^{Salmon}
Salmon Stan, there is an instrument that I don't know has ever been used with pregnant mothers, but it's been interestingly been used in the Navy for predicting who will have trouble when there's ^{a stressor} distress. And I think it's called "change of life index," that Ransom? Arthur and people like that -- I think Ransome? ^{who} is the one, he is now at UCLA, helped develop that. And, it seems to me it would be a very interesting instrument to consider adapting for this, because what it does ^{it} is to select out those people who've had a lot of changes in their lives in the last ^{must} ~~well~~, recent two-year period, and then they followed ^{they} them without prejudice, and found out that it was a fairly useful instrument for predicting who would be able to take stress and challenge and master it, and who would be overwhelmed, or at least set back, by it. Kathy

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seems to know more about it than I do.

DR. BARNARD:

It has been used during pregnancy, and there are some studies ^{that} which suggest that it is correlated with complications of pregnancy and birth weight and things ^{of that kind} like that.

(Background comments)

DR. BRAZELTON:

page 27?
I have two suggestions about the scale that Barbara has probably picked up by now, ^{at your proposal, you say} on page 25 you are going to use extreme items on at least three of the main items on the neonatal scale. We have a ~~cluster~~ a new cluster analysis ^{that} now that's really a lot better for picking up on that than any single item or even any several such items, and Barbara knows about it so she'll --

~~Inconsequential conversation~~ ^{and} re coffee

The other thing is the scale as a way of facilitating the relationship with the mother. For instance, on page 27, ^{where} you discuss the treatment, I've forgotten it now but I thought you were a little pejorative, I don't know whether that is the right word-but anyway,

DR. GREENSPAN:

Sounds strong enough

DR. BRAZELTON:

^{proposed}
--in some of your interventions, and, unless you are very careful, ^{and} not make them, such as the home visits? I think there are ways to do it so that they aren't, but I am sure many of you are aware of that. But, I think, particularly where you are sorting out at-riskness, the vulnerability and the sensitivity of mothers who are at risk ^{are} is always out of

proportion with anything we are aware of, ~~or sensitive to.~~

And, I think that the kind of sorting out that you might be doing unconsciously, ^{un} will get through to them/ consciously very quickly. And I urge you to set yourself up as an advocate rather than an intervener or whatever else you might have in your mind. And one tool to do that is using the baby's behavior because every ^{body} can communicate through that in a way that is ^{? necessary} ----, so it's really a very powerful tool in relating in her neonatal period to the mother/and getting on her wave length and getting her to communicate back to you what her wave length is and where she ^{feels} she needs support, etc. , and Barbara is ready with ^(a lot?) that.

DR. GREENSPAN:

Well, it seems to me also that for another ^{time?} coming from myself and Bob predominantly, obviously Reg, psychoanalytic and coming from a psychodynamic background, I am always struck with of simply of pointing out the baby's individual differences as a starting point ^{is} to view the baby-mother as one at the beginning of life, and it's talked about that way in terms of a psychological unity, at least, particularly when you see a good rhythm where they actually do feel like one. It's very similar to the psychodynamic model in working with adults, where you never go beneath the defense and you first make observations and ^{then} give the individual, then, the freedom to react to those observations in the beginning when you establish an alliance. I agree with you on this --

DR. BRAZELTON: There's another way of looking at that unity, though, that came out of working with atypical or psychotic children, and that was that the symbiosis that may look great ~~(gray)~~ may also interfere with the job of maternal-infant interaction. And, one of the values of looking at the neonate as a person early on, is to begin the job of separation - differentiation, ^{which is} at high risk in some of this. And, I think this comes about through an artistic use of the baby's individuality with the mother, and letting her voice ^{not the same} her side of it, but you are establishing ^{that} you are seeing the baby as an individual for her as well as for yourself.

DR. GREENSPAN: Would you say a few more words about the use of the cluster analysis as a way - you have spoken on that before.

DR. BRAZELTON: Well, I don't know how many people are interested in the neonatal scale, but we haven't been very happy -- you know there are 26 behavioral items - interactive items in 20 reflex items, and we haven't been very happy about using it as -- with a correlation coefficient matrix, or any of the things that, because they're not equal items, it doesn't lend itself to that. We very carefully didn't want an I.Q score for babies or a personality score for babies, or anything like that so we made each item different. And one will go like that for optimal in the middle, and another one will go like that for optimal at the end, and it ^{has} is driven psychologists or statisticians up the wall, which I find is an asset, not -- (lots of laughter - someone completed sentence with 'deficit') ----- because

I think it's the kind of thing that we could so easily get into, and particularly as we show it to a mother. We can say this is an active baby and somewhere set her into a track that maybe wouldn't be her track, anyway, you can see all the obvious problems.

But, what we did come up --- what we found when ^(up) tried to do correlation coefficients or anything like that, with (folding?) (withholding?) holding those middle ones out, and all the things that you have to do to do that, ^{we found} was that we were getting clusters that were really relatively meaningless and that, ⁱⁿ from with a clinical sense, didn't tell us what we were looking for.

^{This} And, it first came out with a group of babies in Guatemala who had been undernourished in the uterus, and we knew from looking at them, ~~we could make a prediction~~ --- I guess I told you all this before, that we could make a .9 prediction in the neonatal period --- a year and a half later or ^{marasmus} ~~later~~ later on in the year from the neonatal behavior, but this wasn't showing up when we clustered the neonatal scale, and that ^{was disappointing?} drove me up the wall, because I wanted to be predictive.

^{when} But what we went back, ^{we} and found out was that the mothers who were eating 1500 calories a day were producing a kind of baby that acted like a (mid-brain?) preparation, ^{these babies} had good reflex behavior but very little attachment behavior, very little, I mean --- poor state controls, ^{and} poor cortical involvement after they made a reflex response or automatic response.

And, the 2000 calorie babies, showed a just perceptible but significant difference in all of these clusters of what we thought, as cortical behavior. So, we went back to try to see how to do it and we came just sort of ^{over} kind of clustering that came from clinical experience, which is where it ought to come from in the first place, I think. And, we made up four clusters: one of motor, ^{the second} one is sort of affective scale, ^{the third} another is the use of states, and the fourth is mid-brain or reflexive behavior. And, we cut off the top and the bottom, the worst and the best, and then in the middle fall about 80% of the (variance?). And, that first slice with those four clusters gives you a kind of profile that then you can -- that cuts off the deviance, which is what you're after, and then you can go on with the 80% of variance and make your next slice to fit next clinical question. And, this really does do the work, and it did it in these very subtle differences in interuterine nutrition, and we've done it with SGA babies, as I've said -- told you earlier, and some other clinical conditions that we knew ^{were} it was there but we weren't sure how we could get to it.

OK? And, it may well do it for you in this ^{to utilize} at-risk-ness of mothers and what they need to be fed back to from the baby, so we could help you with the second clustering if you wanted. ^{in your determination} In the first cluster we sort the sheep from the goats baby.

DR. LALLY:

SK I want to switch topics back to the program. I was equally impressed with the usefulness of the information

that you gave us, and the specificity of the therapeutic side of things, and what concerns me about the program is the relative lack of information about the therapeutic---the day care center, ^{and} how it would run ^{from} day to day, and---there are other kinds of things that have to go on all day long, and Selma and Sally will tell you that there are few very good infant day care centers around the country. There are some that are good, ^{but} there are many that are horrible, and I think that what I would like somebody on your staff ~~to do~~ is to spend some time on really working to set ^{the} that infant day care environment up so that the day-to-day activities that the children are getting-- not the necessarily therapeutic ones, but normal development, ^{I would also want to be sure} are rich and appropriate, and that the teachers are well trained, ^{that} and they know where you are coming from, ^{what your goals are?} and there is some way to code them ^{on} as to how they are acting. And, ^{this} ~~it just~~ seems to be ^{an} one area that is shallow ^{and} that needs a good deal of work.

DR. PROVENCE: I have some questions there, too,

DR. GREENSPAN: Your suggestion is on the mark. We did have a more detailed description of ^{at least} our initial thinking of that component-- ^{and Reg have} and Bob has had a lot of personal experience, ^{with this} and Reg, and we had to make choices in preparing the material. I think you-- ^{of} the seriousness and your point is very well taken. We might be able, ^{to} to, at another time, perhaps, share in more detail the thinking that is not reflected in the ^{our proposals} written thing. ^{Originally} But there was, initially, a longer, section, very detailed.

on scheduling
We went over it -- what would happen between 9 to 9:30, 9:30 to 10:00, *etc.* and what-kind-of training, *but then we thought that* might distract a certain audience that we were preparing it for *it*

DR. LALLY: *Count?* -- I'd like to take a look at that, maybe -- I could probably criticise that more *probably* than some of these other things.

DR. LOURIE: Thank you. We are also suggesting that there be a plan *in there* for observation of what goes on in a center. *there* are lots of fine schedules that are *setup* for existing centers, and *but* they don't conform to what happens to the children. *we* You think that it is important, very important *as we found in* to look at as they talk about Head Start, for instance, *is going* to look at what goes on rather than what the program specifies *should be going on*

MS: I must say that the ones who really *for those rigidly* follow a 9 to 9:30, 9:30 to 10, schedule -- you've got a judgment right there.
(Laughter)

MS: As an observer, may I offer some help in that area in terms of providing some practical experiences in the area of *and I don't know the* *names* you are speaking to, but I might be of some service in the area - in Washington. -

MS: *some* I felt too, that -- I have two questions regarding day care. What is the -- ah, estimated number of children in your population of 20 *who* might need to use the day care center most of the time, *This* which would have some influence on staffing and objectives? -- then, too, it had not been too clear -- I guess

there were more questions than one had thought of originally, ^{who are} How/the cribmobile operators. ^{7 This so} It was given a rather short a statement ^{that} it led to such obvious questions ^{that} which I am sure you have thought about ^{the procedure} but, nevertheless, they need to be written down for everybody's -- for everybody who cares about the issue. Who picks up the baby at home? Will the baby have a primary day care person, or will that be the person who is, indeed, ^{to} related the stress between home and clinic and, even the rationale for the cribmobile, which, I must say, jarred me slightly, because I am not sure how this works as far as the baby is concerned. ^{questions} These needn't be answered now, but I felt ^{that} they were issues, not dealt with sufficiently to answer the questions for the reader.

DR. BRAZELTON: I think there is ^{enough} riskness? for the mother, too, in the cribmobile. What we'd like to do is keep her feeling involved and important in the day care situation. This may give her ^{so participate give her} more opportunity, as well as a signal that she is separate.

DR. NOVER: ^{our} The intention, of course, would be where we ^{think} thought the baby did need ^{is it} a day care experience, to use this as a transitional experience, and engage the mother and, where necessary, use it both teaching-wise -- a demonstration in the home but to facilitate bringing the mother in. It would not be a way of creating a hiatus, but rather ^{would be} serving as a way of facilitating and engaging the mother ^{engagement} where we felt the baby ought to come in for part of -- bringing the mother in, actually.

One of the things about this particular County and this program is that it is not an urban area, ^{it has} it's rural, it's suburban, and, just to give you an idea, ^{it's} the largest school bus fleet in the country ~~in terms of number of buses~~. That's how stretched-out the population is, and, we think our subjects, ^{stay within} although we'll try to keep it in a discreet area, may come from a much wider area than we can control in terms of being in a neighborhood. And, ^{this is} so we may have to -- one of ^{our} the other reasons was to have this out-reach component.

DR. PROVENCE: I remember that issue--

DR. NOVER: It's a real problem. And, we may also go beyond the County itself. A lot of the babies whose parents live in the county, ^{aren't} don't always deliver ^{at} in the County hospitals, and we've ^{had} also got some feelers from some other communities who might like to cooperate in terms of becoming involved ^{with} in their mothers and infants. It isn't necessarily restricted to the limits of the County but there is no urban ⁷ -- I don't know if that is a disadvantage, but that is one of the ideas about how the cribsmobile would serve. I think you're right, also, about the issues of ~~who would~~ -- we had a laugh about who ^{the cribsmobile, since} would drive this thing, that often the transportation of infants and young children is by the least skilled and we ^{we feel that it might be} were kidding about -- that it ^{be} the most skilled person going out there and we expect these parents to have so many problems, so it is going to take more than a knock on the door. "We're Here" -- it may take, for instance, we've talked about even

having some of the outreach members of the team go out and that would be the ones identified with that infant and parent.

MS: ?Who is known to the baby?

DR. GREENSPAN: We would hope to have constancy in terms of the team set-up, so that ^{the same} one person would be either in the home or at the center, able to make transition points with that depending on the needs of that family. The ^{family} ~~goal~~ will be to keep the mother working with the baby and ideally would be working in the home if that's possible, and to have the mother be able to ^{come with} bring the baby to the center ^{if necessary} component ~~to be expected to be with the mother there.~~ We wanted to have the capacity to reach out if, ~~for a variety of reasons,~~ ^{to come to the center} the mother was unable to or unwilling, and that's where the idea of a cribmobil was evolved. ^{how (what)}

MS: That's for the mother, ^{but} -- what about the baby? In giving continuity and stability in this transport, and in still another place -- you know, home, cribmobile, nursery -- cribmobile, home.

DR. GREENSPAN: Yes, I understand your point. Can we have the same person be available when ~~the baby~~ -- if the baby is to be separated from the mother; for example, if the mother is unable or unwilling to come in ~~for a variety of reasons~~. Can the same person ^{who is} be in the vehicle, ~~or whatever sort~~, with the infant and ~~then~~ be with the infant during the day, and ^{also} ~~then~~ again be the same person who has contact with the mother at another

transition point. I gather that -- is that

MS.

Maybe the framework has not been spelled out. I may be asking superfluous questions, really -- Are you assuming that most of the mothers will be coming with their babies to the center, ^{is that it?} ~~is that it?~~ Therefore, you do not need to build in a special person for them.

DR. NOVER:

I think we're assuming that some will, and, in that case, the mother herself might be the transitional person with the baby, and in those cases where the mother, for one reason or another, ^{is} ~~was~~ unavailable then where it seemed optimal to have the baby in the setting, we would try, I think, to have a continuity ^{and have} ~~between the caretaker who would be at the center~~ be the same one ^{person} ~~who might be involved in the transition back and forth with the baby.~~ I don't know ^{whether} ~~how possible~~ that ^{will} ~~would~~ be ^{possible} ~~all the time~~, but ^{we} ~~one would hope to maximize that~~ -- Isn't that your point that you wouldn't want several different people at the center, in the cribmobile, in the home -- working with the baby being all very different people

MS:

Maybe Sally, who has had a lot more experience, can point to this

DR. PROVENCE:

Well, my head was just spinning. You know, you have certain children assigned to certain caregivers. Suppose you have 10 in the center at a time. You are going to have a lot of changing of the guard and shifting to match all of these things up.

I'll bet you'd end up ~~by~~ having a cribmobile mother who is the same for all of the ^{children} kids and who would know how to talk with the parents,

DR. NOVER: ~~A caretaker - a particular person (cross-talk)~~

DR. PROVENCE: Well, someone who would be really skilled in making that contact with the exchange of information with the mother at home and transmitting that to the person who is going to be with the child most of the day. I'd just would bet you'd have -- it would be impossible to schedule people who are going to be the major caregivers of the children to also be the ones to be the ones who are on the cribmobile. You know, you could try it, Bob, I think it would be very, ^{but} and I'm not ^{difficult to do} sure it would be any great disadvantage if you ^{didn't} have constancy in that person who is the transitional person, -- I'm not sure that would be an enormous disadvantage since I suspect the children ^{are} going to inevitably in the day time -- some of that is going to happen anyway.

DR. LALLY:

on
Secret

I know that, ⁵ for a five-year period, the stickiest problems that we had with the families were related to transportation, and if you offer the cribmobile and expect some people to bring their children in and other people to use it, ^{it} becomes an issue of "why do we have to bring our children in and how come the other people can ride," "I have to go somewhere and the cribmobile isn't here." "So, and So, came home without his sweater."

we were hampered with

Thousands of these things

174
24.

DR. PROVENCE: "Where are my Carter's baby pants?" --(~~Gross-talk~~)

DR. LALLY: That's right, It's an unbelievable issue. I was overwhelmed by all these transportation problems that we had, and I really don't know how to solve them.

DR. PROVENCE: It's very hard.

DR. FRAIBERG: Are you confident that you really need a day care center ^{unit} with this, because with our fairly good-sized population already identified as being in need of special services for our program, I ^{remember} tried to tick-off in my head how many children really needed day care -- ~~really needed day care~~ -- there might not have been more than six or seven over the past four ⁴ years.

DR. LOURIE: But, Selma, what percentage of your referrals ^{were} ended up as the families that wouldn't let you in, -- that wouldn't maintain any communication with you?

DR. FRAIBERG; (~~Hesitation-ahs, etc.~~) There were a substantial number of cases where we felt another community agency could better serve -- I mean really better serve -- the family, than we could. So it is already a population that has been sorted out on the basis of a particular need for our ^{particular} kind of service, and that that is a good question which I cannot immediately answer. I was simply registering the fact that as an adjunct therapeutic service in our special population, we have (neutered?) rather

seldom. But I ^{have been} was trying very hard throughout ^{this discussion} to try to imagine your population, which is not yet known to you either, and nearly every question that I had in my own response to -- had to do with trying to get pictures in my ^{mind} head of your population, which is bound to be different from ours and the issue, which you are addressing yourself to are different, too. And there I will stop in trying to follow through the program with an imaginary population that is not like mine, for example.

DR. LOURIE:

Yes, well, Ruth Fisher, who was here this morning and yesterday, head of Protective Services of Prince George's County, ^{has} was raising questions about when ^{we} could we take on some of these depressed mothers that she's got who are just not available to their babies because of their depression. And, just thinking ahead about some ^{of} our earlier experience, ^{we found that} when you've got mothers who are so severely wrapped up in their own pathology, and while ^{we were} you're going through the process of trying to help them, ^{we} you'll still need access to their babies.

Unless you put someone into a home under those circumstances, ^{we} - we've been wondering about whether we'd need a central facility where we could have access to provide what that baby needed which the Protective Service people feel that baby didn't get. That's one of the types of --

MS: Maybe you could demonstrate, in the course of your work, that a large number of the depressed mothers could be helped

in their homes, excepting possibly ^{those with} the psychotic depressions, which ~~separations~~ ^{depressions} we have a very considerable number of depressed mothers, actually but we have not had success with the small number of mothers who have been in and out of hospitals ^{and who are} ~~gravely, gravely~~ ^{disturbed}, but we have presented some of our depressed mothers here, and there is ^{range} quite a region there, of course

DR. BRAZELTON:

I wonder if Selma's model isn't telling us something about whether, if you do less time -- you know, less time ^{2, 3, 4?} work, but do it with the mother and the child, ^{whether} isn't a more productive model ^{and} as well as a cheaper model than the day care model in which you take the child away, -- as you were talking about all the problems about panties, and the diapers, and all the rest, it sounds ^{with} like just the sort of thing we get ^{involved with at} into at the Children's Hospital in Boston when we get into competition with mothers for their babies, and the whole competitive aspect of separating mothers from their babies and our taking over as professionals, you know, is at the base of all this anger ^{about} at being separated at the mobile not being there, at "why am I getting it, she's not," or "why am I not getting ^{it}" -- all that sort of thing.

Maybe you ought to think about that model as an area ^{it may be} a cheaper and a more productive one.

DR.

Well, ^{one of} the problem here, Barry, is that there are people here who are not going to be available ~~if~~ they are not going

to be in the home and maybe you want to exclude those from your population or something. You know, the mothers who after you allow ^{those mothers} them to have day care or you contract them with day care, they'll do something else; -- they'll move out of the home, or take a job, or go into training, or go back to school -- do any number of things. Others will be doing that anyway, leaving the baby in the home or with a relative or someone down the street. And, all of these kinds of situations are ~~then~~ could occur within the population you select. You might want to think about Selma's point and maybe ^{including} some of these other situations or incorporating some of these other things as your reasons for having somebody in the day care center.

DR.
Schwartz

Dr. Brazelton was ^{talking} saying about separating the mothers from the child during the day, and the typical way ^{that we think of} would be day care. ^{I wonder} I'm wondering whether or not, as Dr. Lourie was saying, ~~is day care~~ it's always assumed that the child and mother are separated, isn't it possible for some of these day time facilities to really have the mother staying with the child and working with the mother in the day care facility? ~~2~~
Cross-talk -- "selection has been made" -- "so they're not available."

DR. PROVENCE:

I wanted to ask ^{about} something. I didn't know whether it was there or not; I tried to see it and couldn't find it, and that is, what kind of verbal agreement or contract ^{are you} you're going to make with the mother about -- or the family about -- what you provide and what you require of them in order to carry this out? ²

and the, you know, -- I think one cannot over-emphasize the importance of trying to create a partnership. I think that most of us who have been struggling with this at all feel that if you want to have any abiding influence, you really have to have the, you know, not immediately, but at some point -- not immediately necessarily but at some point, a real partnership with the parents. At whatever level you can begin, it's going to be difficult with a lot of these families, to the extent that they come in to the center themselves, and, I think that some of them can be persuaded to and will want to, ^{may out of} need ^{for} something for themselves ^{and} not simply to be helped with infant care. So that either free time or something provided that means something to them as adults and not simply as a parent, I think, ^{as} is terribly important for them as well as ^{given} the tangible services and the other kinds of assistance ^{as} to them, being parents.

The other thing that I wanted to say is, ^{that} again, I have no criticism of doing some or a good deal of the work ^{in the} at home, but also I feel that ~~here is~~ where you have to think about the durability? and morale of your staff ~~because if they are~~ they are going to have to be remarkably creative and resilient and durable to tolerate day after day of working in a home, even half a day, with a very needy mother and her child, unless they have ^a an awful lot of support from their colleagues.

And one of the things that one gets by being a part of a group in a day care center is that you do not have to be on stage

every minute yourself, there are other people who share,
not only the difficulties but some of the gratifications and
pleasures of it, too, so

DR.

Submit
(22)

I want to make a comment that is -- First of all, I
want to say how much I admire the draft of this proposal;
I found it extremely helpful and stimulating. And, of course,
it couldn't have everything ⁱⁿ it, but it certainly did have ^{a great deal} shows
an awful lot of careful thinking and showed a lot of sophisti-
cations about accepting complexity and not trying to ignore it.
But, what bothers me is trying to get a set on what's going
to give this thing the commitment from the personnel that it
needs. There's no war on, and I hope there isn't going to be
one. There's no external crisis that's going to say to people,
now, you can commit yourself to this because this is a battle
~~we are going to have~~ ^{we have} to win by helping these children and these
families." And, it's in a sense, ^{this is} what both Ron and Sally and others have
been saying -- you've got to get some kind of commitment, ^{for example} you
obviously want, for example, your child care workers, to
relate on a continuity basis to the same children, otherwise
the thing won't work, and that needs to be said, by the way,
more clearly ^{than} that the need for continuity with the same care-
takers will be protected. Then, if we, or you can figure out
how to get the commitment that will -- that something special
that makes that commitment, then that will have to be alluded
to, because that's what everyone's looking for, for example,
^{there's} that's a model ^{for children} that's working, in quite different circumstances,

for ~~adolescents up~~ in Springfield, in ~~western~~ Massachusetts, now where foster families are now asked to make a commitment ^{until} till the children are old enough to be adults and leave home on their own. And, they cannot have those foster children unless they accept that commitment. Now, ^{we have} we got to find some way of trying to approximate that kind of commitment, and, some of those last comments talk about whether you can get it better, ³ let's say if it is ⁱⁿ a small center, or if it is in the home.

And, I would wonder if ^{whether} you're not going to have to move ^{work} toward really more of a sort of small group home model in which some of the homes are the homes where the children are, but where you have ~~more than one person~~ -- more than one member of your staff, And bringing some of the children together that ^{who} perhaps tend to cluster together ^{this model} anyway, geographically, so that they are not on stage all the time, but it doesn't get into the problems of center and long-distance logistics. In other ^{you would have} words, a de-centralizing of the center, and with ^{the} commitment not only a matter of agreement ^{and acceptance that} but the fact is that's where they go because they take care of the same group of children in a small group on a continuous basis, and you still may need a small group home at the center for the most difficult ones -- or ^{cases} those the ones where you can't go in the home, but ^{I would} to try to reduce its size to an absolute minimum and to have a cluster of these homes so that you get the kind of implicit as well as explicit commitment to continuity of care of parents and children in

11/75

a sense, and I haven't thought out the details of that, but it seems to me that's what is one of the urgent needs. And, it would also, I think, tend to give very great strength to the idea that we're exploring how to deliver services in the home, rather than to take children away from the home, even if the home is a neighbor's home being borrowed, in a sense --that is, a neighbor ³ three blocks away who is another one of your families that now group.

Because, there will be a few mothers who not only need help for themselves but who need to work. And, many of those mothers should be paid to stay ^{at} home and take care ^{of their children} with the help of staff, ^{There are} and even ^{who} some where you can predict, with help, might become professional caretakers, child caretakers, so that they have an occupational pathway.

DR.

Sally

There's a model for that, Al. As a matter of fact, Ira Gordon(?) used that model, it's called the 'back center', model, in Florida about ⁴ four years ago, where he paid people who had been in the program a year before and who had ^{shown} some evidence that they had caregiving skills, to furnish their homes for five or six children from the neighborhood. *It's called the "Back Center."*

DR. SOLNIT:

Pacific Oaks has another facet of it, in their own way of trying to professionalize ^{+ give} elevated goals and assistance to getting to those goals, ^{to} for the mothers who want to become professionals. And, Sally's done that, also, with a cooperative day care program of mothers who got together, this is what we want, you give

After they've had some

training, and a few of them have gone on to school and got degrees, and now ^{they} are leaders and ^{are} giving us trouble in the whole matter of day care programs. But that's right, -- that's the way it ought to be. What I'm getting at, ^{is that} even in 20 or 30 families, you may find ² two or ³ three like that, so that way, although it sounds a little chaotic, it isn't, because it has a principle, an underlying principle, which is to decentralize, to recruit those who can do certain things, and to help those who can do certain other things, and in that way, ^{it} seems to me, also, that you get the kind of alliance that Sally's talking about, because they participate in the selection of who makes the commitment.

DR. Brazelton

It isn't a cheap model, though, I don't suppose.

DR. SOLNIT:

Oh, yes, it can be a very much less expensive model than ^{having} everything at a major center, much less expensive

DR. BRAZELTON?

It may, but if you're really giving them quality home care it's not ^{as} any less expensive --

DR. SOLNIT:

Oh, but you see, some of them will need quality day care, ^{and} but you can't ^{provide} do it without a mother there, and the mother, ^{the mother who} if she is the kind that can stay home and be helped to do some of it, by having extra help, -- a lot of the caretaking ^{is} will be done by the mother who is going to be paid to do caretaking.

For example, it means that you may want to pay certain of the ^{monies} monies for certain amount of the work that they do, ^{the mothers} for example.

GPO?

It's not ~~it~~ it could be expensive; it could be quite inexpensive.

DR: *Engelton*

You'll need a lot of supervision.

DR. SOLNIT:

Oh, yes; and you'll need in-service training, and so on. But, but that, in itself, when you've got a critical masses, they're going to have anyway, ^{and it} may not turn out to be much more expensive. Anyway, that would have to be looked at.

Finally, there were two details, ^{are} On page 26 where it says "return home for 2 weeks" ^{I'd like to ask about the proposal} -- I found that phrase a little bit difficult to understand. Return home from where? On the page where it says 'return home for 2 weeks'--

MS: ~~---~~ They've never been there, but they're returning to their home.

DR. SOLNIT: Oh, they've never been there. I see. You know, I thought they'd been home ^{at} ~~and~~ sent back to the hospital, and now returned home for two weeks.

MS: They had been there in utero before.

DR. SOLNIT: I see. In other words, they would be going from the hospital to the home for at least two weeks before any plan was made.

DR. NOVER: Before any plan would be made that would ask the mother and infant (cross-talk).

DR. SOLNIT: Yeah, you know it would be creating an artifact -- before they've stabilized at home for ² two weeks,

DR. NOVER: And ~~to give us a chance to see~~ -- we're assuming that there will be a certain number ^{whom} that we might predict ^{to} have problems that will require a day care program where, in the first ² two weeks, things may change dramatically, ~~so that~~ --

DR. Solnit? Bob, ² couldn't you make that "a span of time" ² because in some families ² two weeks is too short.

DR. NOVER: Yes, I think what you are saying ^{is that} it's too arbitrary.

DR. SOLNIT: Yes,

DR. GREENSPAN: Yes, ^{and need to clarify,} what I think we meant to imply, ^{that} would be a minimal time -- ^{It + 2 weeks} at least two weeks. ^{2 weeks} Certainly would be no shorter than that, but certainly could be much longer, and that's what we meant to imply.

MS. ---attempt to be specific, I found that my reaction was that the plan was intrusive and that you were being, in a way, intrusive and (smothering?), and I don't think it would turn out that way, but the way it sounded on paper that's the way it came across. And it came out that you expected everyone, or almost everyone, to be almost a little bit incompetent, and I don't think that's at all what you mean to convey, but that's what came out.

DR. *Laurie?*

There is a ?Rosenthal or Hawthorne? invective there

MS. *Trailing*

~~that~~ I was trying to say this, and I said it awkwardly, possibly out of fatigue, (Laughter) -- I think it's just about that now --- No, what I wanted to say is that we do have an experience, for whatever it's worth, and I couldn't answer your question, quickly, Rich?, ^{see} -- because I had to think about our own selection.

We don't select; they are selected for us, really, in that we are willing to take the most difficult cases in the community, except ^{that} if we think the child's life is in danger and we can't save him in time, in which case we would recommend, ^{as} and we have in a few cases, immediate referral to the local court agency, ^{we may take the same course} or in the case of a mother who is absolutely incompetent because of psychosis and we do not think, again, we can help the child ⁱⁿ in time; and the third limitation is simply staff. Mainly, we will take, and we are known in our community as the resource for the most difficult children in ^{Washington} ~~Washington~~ County, up to the limits of our staff capacity to take on additional cases. And, out of that population, ^{there have been} it is ^{few} surprisingly few who have needed/adjunct ---- I am only hoping that the demonstration, for your sake, will be in the home as much as possible. You may be pleasantly surprised at the capabilities of mothers who do not seem, on paper, ^{competent to take care of their children} -- when we look at our intake referral we just shudder, and ^{but after} then comes the first appointment, the second, third, and fourth, and the picture begins to shift in the largest number of cases.

DR. NOVER:

Maybe I ought to just add another dimension⁵ that we are not necessarily thinking of ⁵five-day, all-day, day care² that it would be therapeutic and part of a program that would ^{be}include mostly home-based and outreach, but that the center would be very flexible and at one time there may be more children, and at ^{another}one time less² and that a child could, I think we envision, quickly move from needing a center-based program into a home setting. This is not a, I think if we started getting ^{into}the business of ⁵five-day infant day care, -- 9 to 6, -- we would be for all the babies and we would be overwhelmed in no time, and would be cut off from the population if we tried to do that. That really is not the idea.

DR. SOLNIT:

I think what you want to do is make sure that it is clear that there is a continuity of personal concern and interest and professional care that then allows you to use any adaptation, geographically or physically, because of the psychological environment of the baby and the mother and the father of the children is the, really the special factor that's being introduced.

^{I'd like to}
~~Can I~~ add one other thing, too. I wonder if it would be possible, I don't want to add to your already extensive ^{burdens, but} burdens, to use some of the ^{same} ?_ess ?_ell stuff when the mothers are in the hospital with the babies, especially if the hospital has some tolerance for the mothers being close to babies, and the babies close to mothers, to see whether you can keep track of what happens and whether ^{that} -- they have some

instruments which I think might be useful to you, not only in terms of prediction, but also in terms of giving you clues as to -- early cues about how -- what's needed for that parent-child pair

DR. NOVER:

-Measuring the interaction. It's an interesting facility, at least taking that one hospital where we are beginning to work in we've only now, in an atypical kind of way, implemented rooming-in in the last four months, and to them, I think, for reasons historically -- which takes more work on their part and the kind of staff that is prepared to deal with it, and the baby isn't really rooming-in until almost 24 hours after they're there. And, the other side of it is ^{that} the baby is only in the hospital for 48 to 50 hours, in many cases. They are finding shorter and shorter ^{the} period of time to be in the hospital, ^{is becoming}

DR. SOLNIT:

At least if the babies ^{who} could be with the mothers as ^{were} compared to those who aren't, even in that short period of time.

DR. NOVER:

Right.

DR. BRAZELTON:

Well, now, there's a back lash to this, though, that I don't think Marshall takes into account in his zeal to put over the critical period of attachment, and that is, that there are a lot of mothers who are not ready to attach from the beginning. They need time for themselves, and particularly, I think, in a high-risk group like this where they have been stressed physically, and all the rest, at home. They need

time to organize before ~~then~~ they get on with the attachment.

And, I think often in our professional zeal to put this over we ignore and get angry at this kind of -- this part of the curve.

DR. SOLNIT?

Are they not ready to attach? Or are we not able to support them so that it doesn't demand too much of them?

DR. BRAZELTON:

Both. ~~I don't think~~ -- I think you ^{have} got to be open to both. I don't think it's just institutional -- I've seen mothers in my scene ^{who} that have said to me "wait, wait" --

DR. NOVER:

Of course, ~~48 hours~~, and I think that ^{the 48 hours} this is one of the things that is an economy move as well as for whatever therapeutic -- it forces the mother and infant for whatever other reasons ^{including} those who may not be ready to be sent out and back home with a very short period of adjustment to each other. It could be argued, that, I suppose, that ^{this} is best done in the home ^{or} in a more natural setting, but I think ^{that is} difficult for some of these mothers, ^{The hospitalization period} they're not even quite ready -- that ^{as} serve an in-and-out kind of an experience -- you're there, and you deliver, and you're home. I think it depends on the ^{stage?} ^{which?}

DR. BRAZELTON:

Well, I'm not against what Al is suggesting. I'm all for it, because I think it is one of the biggest problems in this group of people is that they can't face the system and we don't make any effort to help ^{them with} on it. And, sometime the baby can bridge that for them, too. So, but I just say that -- don't get too zealous about it, because you can overdo it.

MS.

One of the studies in Detroit, they found that one of the things that ~~was~~ most predicted was that the emotional health of the mother and the physical health of the baby during the first ~~six~~ ⁶ months of life ^{depended on} was whether the mother had physical help at home during the first ³ three weeks. And, I think if you look at our whole system of the way we take care of mothers, it has changed drastically in the last 40 years.

One of the things that I think is a big problem is the role of assumption that we expect ~~out~~ of the new mother 48 hours after she's had some tremendous psychological and physiological changes. And, I think, perhaps one of the most effective pieces of intervention might be that you could provide the kind of help to the mother that would relieve her and help her store up the energy and psychological readiness to interact with ^{her} the baby. It would take some of the pressure off for her responsibility of family life survival, you know, ^{that which should be} maybe a homemaker, ^{would be helpful} or -- I don't know what but --

DR. NOVER:

One of our thoughts was in those mothers where we were concerned, and I think it is in there somewhere although maybe not elaborated, that some of the infant caretakers, those who would be in the outreach aspect of the program, would be prepared in that transition phase to spend time helping the mother to deal with the problems that we picked up with the baby and also to help her because of her new role ^{in the home} as a mother, ^{in the home}. And, I think those might be some of the cases that we would even turn around, whereas at the point where we

might be concerned about them, ^{2- to 3} that two-three week period that you were talking about-- we could facilitate some of the things that we --

MS: *Provinces?* But, I don't mean ^{to} take care of the baby. ^{Somewhere to} scrubbing the ~~elbow~~

DR. NOVER: No, helping the mother as well.

DR. BRAZELTON: The extended family, ^{that} used to be, *done by members of*

DR. GREENSPAN: *This is on p. 138* We hope to have through -- we are hoping -- continuously establishing and re-working and re-establishing our relationship with partners in the community -- the Health Department, Social Services -- not only in terms of referrals, but also in terms of services ^{we can draw on to} which they have available where we can get homemakers ^{to} come to the home where that might be the primary help ^{needed} -- what we want to do is take the burdens off. And, we hope that it's not all just our own staff or funding, but that the other community agencies can interdigitate with us in terms of us kind of helping get things going sometimes. ^{Also, what} And, where that may be indicated is relief from some economic or practical burdens and more sophisticated help is not needed ---

DR. LALLY: *This appears on p. 138* I wanted to be clear about the question - the recommendation that Al made and also Selma's concerns with relation to the two- to four-week idea and making a decision at that time as to whether or not the child *continue next page*