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Special Edition
devoted to Infant
Observation

Observation and Reflection: Infant Mental Health Training Experiences Overview

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What follows is a detailed discussion of the Infant and Family Observation experience that is a significant part of the clinical training component of the Graduate Certificate Program in Infant Mental Health at the Merrill-Palmer Institute/Wayne State University in Detroit, Michigan (Weatherston & Baltman, 1992; Baltman, 1993). Infant Mental Health staff designed the infant and family observation experience to complement home visiting work with higher risk infants and their families. The observation experience offers graduate trainees from multiple disciplines (e.g. social work, psychology, child development,

nursing, and education) opportunities to learn from infants and families who are at no identified risk, beginning in the last month of pregnancy or in the first months of life and continuing for approximately one year.

Observation, twice monthly, helps trainees to watch how a new parent adjusts to the care of a baby and acquires the confidence to nurture and protect. They watch infants accomplish major tasks, which lead to attachment over the course of the first year. They watch parents struggle to understand and respond to a baby's wants and needs. They listen as parents ask questions about feeding, sleeping, returning to work, and choosing childcare. The opportunity to learn from an infant and family, under the guidance of a clinical supervisor, prepares trainees to observe and listen carefully, to notice the details of development, interaction and relationship, and to reflect on what they see and hear. These skills are basic to competent infant mental health practice.

Preparing for the Observer Role

How does a clinical trainee or practitioner new to the field of early intervention or infant mental health prepare to observe new parents caring for their baby? Course work, readings and discussions specific to pregnancy, infant development, parent-infant relationship development, the adjustment to early parenthood and techniques of

relationship-based assessment help to prepare trainees for the intellectual challenge. A supervisory relationship supports each trainee to observe, hold, and contain the emotional experiences of observation and reflection throughout the training year.

Guidelines

The following guidelines help trainees to organize what they see during each visit to the family's home. The topics are not all-inclusive, but meant to stimulate their thinking about the hour and to record in some detail what they observed.

Infant: physical description (unique characteristics); emerging developmental capabilities in multiple domains; interest in people and playthings; developing abilities to engage, interact and respond.

Parent: developing interest in, attention, investment and responsiveness to the baby; changing ability to organize around the baby's wants or needs; adjustment to infant's care; new roles and relationships.

Interactions: infant's and parent's abilities to attend, listen, smile, vocalize/talk, engage, reach, hold, follow; exchange during a feeding or at playtime, diapering or bathing; mutuality of interests, pleasures and capacities for affectionate response

Quality of the developing relationship: attentive, responsive; expres-

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sive, adaptive; comfortable and comforting; mutually satisfying, rewarding and appropriate; baby's use of parent(s) as source of comfort and security; response to separations and reunions; baby's use of parent(s) as a safe haven or secure base; parent's capacity to keep safe and secure; set limits.

Caregiving environment: parent(s), grandparent(s), sibling(s), day care provider(s) important to the baby's daily care; level of activity and stimulation in the home (or child care setting); description of home setting; degree of organization; toys available for the baby to play with; caregiving routines.

Infant history: pregnancy, preparations for birth, labor and delivery, hospital stay, father's presence, the homecoming, experience of early care, special circumstances, illnesses or hospitalizations, concerns as expressed by parent(s), significant separations, arrangements for child care.

Networks of support: family relationships significant to the parent's ability to care for the baby; quality and availability of family's support, network of friends surrounding parent(s) and infant, parent's ability to use the support.

There are other observations to make in the course of the year's observation of a non-clinical family. Each is important to the trainee's clinical growth and personal development:

Emotional response: the infant's response to each parent; each parent's response to the infant; the emotions contained and expressed within their relationships; the meaning of each relationship to the baby and to each parent.

Personal responses: feelings that the trainee is aware of as she/he meets with the infant and parent(s); identification with either the baby or the parent(s); memories or events recalled; the developing relationship between trainee and each member of the family and feelings surrounding that relationship.

Learning About the Complexities of Development

A family's willingness to enter into a relationship with a trainee at a time when they are beginning their own relationship with a baby offers the trainee an exquisite opportunity to observe the complexities of early relationship development. The trainee may meet with a parent, or both parents, before the baby is born. This gives the trainee a marvelous opportunity to learn how parents anticipate the baby's birth, what their hopes and dreams are for their baby, and what fears they may have about labor or delivery or care in the first months of life. Once the baby is born, the trainee has regular opportunities to look closely at the infant, noting weight, size, degree of activity, responsiveness to face and voice. What kind of a baby is s/he? Quiet, easy to comfort, feed and hold, or very active, difficult to handle, difficult to soothe? As the baby grows older, the trainee observes what the baby contributes to the interaction and relationship, how the baby initiates and engages his or her parent(s), and the baby's emotional response.

A trainee notes the ways that a parent attends to the baby when cradling, picking up or setting down. The observer watches and eagerly notes how curious a mother or father appears to be about the baby. Are they able to follow the baby's lead? Can they read the baby's cues? Do they take pleasure in what the baby can do? The trainee may also recognize the parent's fatigue, ambivalence about the early stages of parenthood and uncertainty about what the baby needs or how to respond. The trainee is encouraged to be fully present to hold and contain the emotion surrounding the interaction observed, without distraction, an agenda or a task to complete. It is a skill that is invaluable to successful engagement and responsive clinical work.

Arrangements

Each trainee is assigned one family for the clinical year and visits them in their home for one hour, every other week. The trainee schedules appointments when it is most convenient for the family and when the baby is most likely to be awake. The trainee videotapes the family for 5-10 minutes once a

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month, capturing an early feeding sequence, playtime, the introduction of a new toy, diapering, bathing, or "being with the baby" as the parent chooses to be. Each videotaped sequence provides a powerful record of the baby's development within the context of the family. Each sequence is reviewed and discussed by the trainee in supervision. The parents receive the original tape at the end of the observation year.

Written Summaries

No notes are taken during the observation. The trainee records what is recalled following each home visit, e.g. details about the baby's development, shifts in the early relationship and parental response over the course of a year. These details are shared in supervision or, on occasion, within the clinical training group. This offers the trainee opportunities to focus on development in multiple domains and assures attention to individual differences in relationship development, varieties in the security of attachment, and to wonder about the subjective experience of infant and parent. It also encourages reflection that is more personal, e.g. thoughts about another baby, longings for relationship, early attachments.

The Learning Experience

Within the course of the year, each trainee concentrates on the baby's numerous, emerging adaptive capacities, milestones reached and relationship domains. Each trainee observes the baby's ability to engage and a parent's capability to respond, watching carefully for signs of an early developing relationship, negotiation of crises and individual resolutions within that first year. They learn about the many different ways that relationships are forged and are often in awe of the capacities families exhibit to self-regulate when there are unexpected stresses or risks. Growing more skilled at observing and listening, the trainee learns to hold the uncertainties, the wonder, questions and concerns about a multitude of things, e.g. feeding and sleep routines, comforting, colic, early separations, mastery of developmental milestones, the father's role and relationship, the mother's return to work. The trainee works hard to contain what s/he encounters: the

stresses, frustrations, and delights. In the process of recording observations and bringing them to supervision, the trainee finds his/her "voice." S/he begins to clarify what has been observed and to speak about the infant and parent's behavior and development within the context of their emerging relationship.

Self-reflection

When discussing the observation family, the trainee has the opportunity to reflect on his/her own values about infancy and early parenthood. There is also time to consider more personal experiences, as a parent or child within a family recently or many years ago. In the presence of an infant or new parent, many thoughts and feelings are aroused. A trainee may bring these to supervision for further reflection where they may be shared and safely explored. For many trainees, this is the first and only opportunity they have had to consider their more personal responses to infants, families, relationship development, and early infant care.

Excerpts from an Observer's Notes

What follows are several excerpts from one trainee's notes to illustrate the usefulness of an observation experience in studying infancy and early relationship development and to reflect on responses, both professional and personal.

David is 5 weeks old today. I arrived to find the door open, but had to knock a number of times before Darlena let me in. She brought the baby into the living room, asleep, in an infant seat. He looked quite content as he lay there. Darlena told me, "he sleeps all the time, I hope he's O.K. I never thought I'd have such a quiet baby, after Desiree!" He stirred slightly, stretching his arms, making cute, little creaking noises. Darlena commented on how he was getting so nice and big, but he wasn't smiling at all or alert much. He let out a cry without opening his eyes. Darlena looked longingly, and touched him gently on the face...I wanted her to pick him up, to rock him gently, so maybe as he awoke he would be in his mother's arms and find someone to look back at him and smile...Maybe he

needs more of a pull from his world to be fully alert to his mother...I wonder what life was like for me as a baby and what it would be like to hold my own baby.

David is 7 weeks old today. My visit introduced me to a different baby and mother. I arrived to find David awake and Darlena much more relaxed than in earlier visits... "Look who's awake!" Darlena told me immediately. She held David in an en face position. He seemed so relaxed in her arms, loose in the way he just lies comfortably wherever he is. He made little squawking noises and Darlena looked up. She told me that he had smiled for the first time over the weekend! She described a game she had played with him that had made him smile. He had responded with quite a reward... I wonder if she will grow more confident in her new role, knowing that it is her available and playful presence that he responds to...I have less worry about how they will continue to discover one another, but I also have a sense of anxious anticipation, wanting to look ahead to see what will happen. As I write, I begin to wonder how my mother managed to care for so many of us, to play and respond.

David is 8 1/2 months old today. After he woke up from his nap, Darlena put him on the floor with a toy in front of him. He got frustrated that he couldn't reach the toy. He then figured out that he could roll to get what he wanted! It was exciting to see him go so deliberately for something. Darlena commented that she had tried to get him to crawl to her, but he wouldn't. He waves his arms and legs like an airplane, but can't quite figure out how to get up on his hands and knees. He smiled at her and clearly wanted to get to her, but he became easily frustrated. Darlena picked him up but soon decided to put him in his jumping chair. He sat passively in it, more interested in looking around than in jumping...It feels to me like everything is on hold...I wonder when he is going to crawl...

David is 9 months old today. He was in full bloom! It was such a joyful visit. "He's crawling!" Darlena said with excitement. As we sat watching him, David explored the toys around

him, crawled to a speck of food on the floor, crawled to look at Darlena's necklace. Darlena said that he had not crawled this much before! He began to babble and Darlena squealed, "OOOH, you talk so much!"...She talked about how big David was getting, that she still tries to feed him lying in her arms, but that she knows he is ready to be upright. She said that she felt sad that he was growing up so fast...I felt myself adoring David in a way that I hadn't before as I watched him drawn into his mother's conversation. She talked about how wonderful he was and he babbled back in delight...what a relief to see their relationship right itself...I myself am filled with anticipation about my own child.

David is 11 months old today. As we all (dad, too) sat in the living room, I watched with excitement as David pulled himself up on the edge of the sofa and tried to stand without supporting himself at all. He looked so proud and excited to be standing! In fact, he was so excited that he began to try to jump up and down, but fell in the process. Darlena said, "oops!" He began to cry and she opened her arms to him and he crawled up on her lap briefly. He then tried to stand again and successfully pulled himself up, babbling with excitement...toward the end of the hour, David had reached his limit. He broke down into tears and was not easily comforted. Darlena asked if he wanted a bottle. He began to cry more while looking up at her. She returned, sat down on the floor, and he quickly crawled up onto her lap, drinking eagerly. He remained there for the rest of the visit. Darlena is a great source of comfort, a safe, warm haven. His use of her as his secure base is reassuring to me, as is her capacity to respond. I leave feeling warm and contented, safe myself.

David is 13 months old. It is our last visit. I wondered whether my leaving would be acknowledged at all. I arrived to find that Darlena had thought of how to say goodbye to me. There was a cake, card, and balloon waiting for me...Celebration was in the air...Darlena helped David down from his high chair where he had been enthusiastically eating his cake...She

had a glimmer in her eye as she picked him up and put him back onto the floor. David stood up steadily and Darlena said, "Show Karen how you can walk!" David toddled right up to me, buried his head in my lap, turned around and went back to his mother who held out her arms and gave him a big hug. She said he had just started walking during the past week and that she was getting such a kick out of his enjoyment of this new skill...Darlena and I sat on the floor with David who played contentedly with his own book and then began cruising around. Darlena took out some pictures from David's birthday party and began to talk about what a wonderful baby he has been...In this reflective mode, she offered feelings that she had not spoken about before. She spoke about her rather difficult adjustment in the first months and her worry about his development...her early anxiety about him. She was amazed at how sturdy and contented he had grown to be. In the process of going regularly and remaining quietly available, I had learned to "hold" a mother and her infant son. Along the way, we had each discovered our own capacity to enter into new relationships. I wondered now what it would be like to care for my own baby, due in just a few months...I am in awe of the experience that lies ahead of me.

Summary

Trainees discover many unexpected rewards as they sit quietly and follow the parent and infant's lead. They learn to listen more carefully and begin to really hear what a parent has to say. They learn to watch the details of infant and relationship development that may have been overlooked before. They learn about the baby's contribution to a relationship and the importance of a parent's emotional response. They experience the regulation of each unique relationship in the course of the training year. They also grow aware of their own thoughts and feelings as they quietly observe. At the same time, trainees discover the wisdom of "sitting on one's hands" in the presence of infant and parent(s) (Baltman, 1993), with time to wonder about early development and relationship change.

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Editorial

At the Montreal Congress, there was a great deal of interest shown in the role of Infant Observation in the training of Infant Mental Health Workers. This double edition of *The Signal* brings together a number of papers on this theme, which will, hopefully, stimulate further thinking about this topic at the Amsterdam Conference. The first two papers describe the process of infant observation and its central place in some trainings. They are followed by an account of one student's experience of receiving this kind of training and the fundamental impact it has had on the way in which they practice.

In addition to being an invaluable training tool, this method also has considerable therapeutic potential, as demonstrated in the paper by Houzel, originally given at a psychoanalytic congress in Rio de Janeiro in August, 2000. Finally, Watillon's paper gives rare follow-up interviews looking at the parents' experience of being observed.

I would welcome any other contributions from readers on this theme for future editions of *The Signal*.

Paul Barrows
Editor

INFANT OBSERVATION: WHAT IS IT? WHAT IS IT FOR?

By: *Lisa Miller, The Tavistock Clinic, London, U.K.*

Introduction:

Infant Observation was developed by Esther Bick at the Tavistock Clinic as a unique way of getting to know about babies. As its name tells us, it is a process of going to see a baby from the time it is born and watching it grow up in the context of its family. The observer goes to visit the family once a week, at a settled time, and these visits continue for up to two years at regular weekly intervals.

Setting up an observation:

There is usually a preliminary visit to the family before the baby is born, so that the parent(s) can talk things over carefully and decide whether this is something that they want to be involved in. Perhaps it seems surprising that people should agree to a stranger coming into their family at an intimate time of change and development. However, they are often pleased to find a person who is just as interested in the baby as they are themselves.

The observed families:

These families are approached in a variety of different ways. What the observer is looking for is an ordinary family of one kind or another. The shape of the family is not important although troubled or dysfunctional families are not sought out. It is essential, though, that the observer does not have a link with the family, either social or professional, as this would make the observational stance impossible to achieve and maintain.

The observational stance:

Observers often explain to their

families that they would like family life to carry on as usual around them as far as that is feasible. They have to find a place in the family from which they can watch the baby's life and relationships developing. It is a delicate job to adjust in a friendly way to a particular family's culture while maintaining the slight distance necessary to be a receptive and alert observer. It is essential not to be standoffish, but not to be over intimate either. Observers are there to learn, and they always say so. The last thing they are is experts; they are there to watch by courtesy of the families, and they are generally very grateful indeed for this unique chance to learn about a child growing up in a family setting. As time goes on, each family makes its own individual sort of relationship with their observer.

The seminar group:

Infant Observation is not something to undertake on one's own. It is usually part of a course (for example, a post-graduate diploma/MA in Infant Mental Health, a post-graduate diploma/MA in Psychoanalytic Observational Studies, a post-qualification course in Social Work, a pre-clinical training for Child Psychotherapists, etc.). This is because the seminar group in which the baby is discussed is vital not only for learning but also for support. Each weekly observation takes an hour. Afterwards, the observer leaves to write up an account of that hour as soon as possible while all the details are fresh in his/her memory. Then these accounts are discussed in a small seminar group where the anonymity of the family is strictly preserved. The rules of confidentiality must also be impeccably kept, so that no family is ever discussed outside the

group. Each seminar group consists of about five people who, with their seminar leader, will have the chance to get to know all five babies. These observers learn about one baby in depth and the rest to a lesser degree.

The effect upon the observer:

For the observer, the experience is often a formative as well as a fascinating one. People who have had their own children or who are very experienced professionally in the world of infancy and toddlerhood are almost always struck by what a different world they are entering. They are there to look, listen, and remember, not to act or to take responsibility. The latter frees them to be receptive to all the tiny details of interaction, the shifting emotional states of individuals, and of the family as a whole. No detail is without meaning or interest.

Families with babies or little children are at a natural time of change and turbulence in the life cycle. Each new baby brings the opportunity for a family to alter, develop, and grow. The baby, of course, is growing as never again and adapting to a new world. The observer is a different sort of newcomer to the family system, adapting to the world of that family. Whether it is a baby or a young child that is being observed, the observer has to be receptive to all the strong and complex emotions, which are at work, either out in the open or just beneath the surface.

Observers are there to notice everything and to register it in their minds. They gradually develop stronger powers of memory and

retention as their interest deepens and they become increasingly able to think about the meaning of what they see. In addition, they start to reflect upon the meaning of the emotional impact that the observed events have upon them. The impact of entering the intimate world of the baby or small child is considerable. Family life turns out to have even more intensity than most people expect. Being in close touch with primitive infantile states of mind is a taxing and powerful experience; eventually this is the very experience which expands the observer's capacity to stay in touch with a variety of strong feelings and uncomfortable thoughts.

Dealing with possible problems:

There are various difficulties, which can arise, and it is here that the work of the seminar and the seminar leader is vital. For instance, it is essential to keep an eye open for disturbances in the discussion, which in general needs to be open-minded, non-judgmental and alive to the many ways in which our interest and thirst for knowledge can be gratified if our thinking is not hindered. Sometimes a group can get stuck in taking sides - for the baby and against the parent, or vice-versa. Sometimes idealization creeps in and a rounded picture has to be regained. Sometimes an observer finds himself or herself in difficulties and needs to talk about it. The discussion in the group, the support of the other group members, and the contribution of the seminar leader are all necessary to the working over of puzzling or even painful observational experiences.

Adaptations of the observational method:

A method which began as an observation of a baby, from birth to two years, has been successfully developed and used in other ways. The earliest was the use of it, which is now widespread, to deepen knowledge of young children by observing them in the same way. Shorter observations have been found to be useful for

training purposes and observational techniques have also been used in the care of the elderly, in neo-natal wards and special care baby units, in the assessment of babies and small children for court work, to name a few.

The gains from experience of infant observation:

The gains from doing an observation go far beyond learning about child development, although the process works on this level very well. But beyond that, the experience provides a stimulating mental, emotional and intellectual exercise, which strengthens the observer's power to see what is going on at depth and the capacity to keep thinking despite feeling doubtful, puzzled, disturbed or anxious. The aim of it is to broaden and deepen the observer's professional work, whether that work is in the field of health care, child care, teaching, social work, health visiting, pediatrics, or any other relevant profession.

The professional experience of doing an observation is often felt to be an eye-opening and influential one. It is training in refraining from action. Questions, discomfort, and doubt must all be contained and worked upon through thought and discussion. It is not possible to escape thought through action, because the observer is not there to act. Thus, the potential for containing anxiety is developed, and this is a true aid to a professional who must rely on his or her power to think carefully over different matters before deciding on the right course of action.

Observation observed: closely observed infants on film:

A pioneering piece of work. In November 1999, the BBC screened a series on the work of the Tavistock Clinic called "Talking Cure." One of the programs was devoted to infant and young child observation. In order to make this program an observation seminar was specially convened and led by Margaret Rustin, Head of Child Psychotherapy at the Tavistock. The

seminar was filmed, and so were all the weekly visits to two of the observed children, a baby and a young child.

This resulted in a great quantity of high quality film being produced, far more than could be directly used for a half-hour program. Margaret Rustin and Beth Miller worked to produce two video films about infant and young child observation, which are now available and on sale for people who would like to find out more about the practice of observation. The first video is a four-part presentation on the fundamental aspects of the observational approach, and the second is composed of brief extracts on significant themes; the booklet, which accompanies them, offers an outline, by Lisa Miller, of the nature of infant observation and some commentary on the extracts.

The work done on the booklet has been the foundation for this article; and now I should like to discuss the filmed observations and use them, I hope, to show how useful and interesting observation can be to those who are working with small children. The families who were filmed have given their full consent to the films being seen, and this is an important reason for using this material here as a basis for this article, since problems of confidentiality are avoided.

The filmed families:

(1) Damien - the early weeks:

In the videos we see a baby, Damien, from a black family. We watch him being born, and we follow him through the first year of his life. We see him with his mother and father, as well as other family members. In the first video, we hear extracts from the seminar discussion of him and we watch the observer in his home.

In the second video, we do not have a spoken commentary, but we have powerful moments of observed experience. The first of these is when

Damien is half an hour old. He is with his mother; she has been trying to offer him the breast, but he hasn't taken it yet. Damien's mother is quietly enraptured with him, and it is a very moving extract. But our wish to idealize these moments is challenged. While there is no doubt but that the mother is seeing Damien as absolutely beautiful, we are, even this early in a baby's life, reminded that this is, in itself, not quite enough. Damien can't connect; he can't fix on the nipple. He knows something is wrong; he makes little tiny querulous complaining noises; he isn't comfortable. As yet, his search for something hasn't been rewarded. He did not latch on straight away when the breast was offered, as if he did not quite recognize it for what it was. There is a strong sense that even when you are half an hour old you are born to the human condition, and life, no matter how much you are adored, is a struggle too.

Damien's mother kisses him tenderly, and we are reminded that it is a real psychological necessity for a baby to be regarded from time to time as simply lovely. However, it turns out that despite her soft, adoring tones and despite the obvious authenticity of her immediate affection for Damien, his mother is worrying just a bit about the fact that he didn't start feeding immediately. Some family members arrive and a conversation starts up. There is a hint of abruptness in her response when asked if he has started feeding yet. At the same time, when his mother starts to speak to her family visitors in a clear, lively tone (different from the soft soothing one she used to Damien when they were by themselves) Damien quiets completely. There are no more little complaining noises. Mother attributes this to the sound of her voice, and she may well be right, for it is a voice that must be familiar to him from his days inside her. Also, Damien might feel better because his mother feels better. The company and the conversation focus her, cheer her and restore her to the ordinary

world. We see how physical intimacy between mother and baby is matched by mental intimacy. The baby is totally dependent physically on his mother; indeed he has only just ceased to be part of her bodily system. Equally, the emotional division between them will only gradually widen.

We see in another filmed extract how desperate Damien becomes when he feels too far separated from his mother. Still only a few months old, he has had a bath and now has to wait for his feed while he is dried, creamed and dressed. It is a horribly distressing little piece of film to view and it gives an idea of how painful it can be sometimes to be an observer in the presence of such powerfully transmitted infantile distress. Nothing really bad has happened to him. But Damien feels abandoned; he feels that he has lost his good, helpful, kind mother and the wait for his food is endless to him; he has no hope of things getting better. We too, as audience, feel that the wait is endless, that the drying and dressing are positively cruel. It is painful to identify with him and accompany him through the procedure. The force and desperation of primitive anxiety is transmitted through his cries.

His mother goes to the kitchen to get his bottle, leaving him in his little chair. Whereas earlier, Damien was crying hard, pushing with his arms as though he could expel and shove away his anxiety, he now sits in his chair shrieking, juddering and almost convulsing. One can't resist the idea that he is in total despair, and that his world has disintegrated. We know his mother won't be a minute, but he doesn't.

But when he is picked up, hope is restored. (It is interesting to notice that although Damien is now bottle-fed, he is still seeking the breast.) As he takes the bottle and begins to suck strongly, his disintegration is resolved.

His whole being is focused on the experience. Regular, energetic sucking quite soon leads to him returning his mother's gaze. What we see here is the kind of episode that is many times repeated in all babies' lives. We see it, however, under the microscope: we watch a process of disintegration to reintegration, of distress being alleviated, of hope being fulfilled. At the same time as fulfilling Damien's bodily needs – for food, warmth, holding – his mother fulfils his equally essential psychological needs. We observe him taking in more than just milk; he takes in the focusing power of the feeding bottle and he goes beyond that to taking in his mother's gaze. Here is the early form of mental contact. Damien looks back into his mother's eyes, and communication, after its breakdown, is restored.

(2) Damien developing:

I shall select a couple of themes, which are interesting to follow through in the excerpts from the film of Damien's observation. The first of these is Damien's relationship with his father. By the time that Damien is four or five months old, it is clear he has a quite specific relationship with his father, whom he seems to admire greatly already. We watch for example as Damien's father dries him as he lies on the bed. His father is very practiced and good at it. As he talks to the baby and blows throaty raspberries into his tummy (something which mother does too) father is rewarded by Damien making a tremendous effort and emitting the sound "Da!" His vocalizing is energetic: more than that, out of his mouth come deep, growling, Daddy-like sounds. Clearly Damien wants to be able to talk like Daddy. He is a well-focused, determined baby, ambitious to do what his father is leading him on to do, even at the end of the extract gathering himself for a renewed effort and producing "Ma!" to go with "Da". Later on in the first year of his life, we see Damien sitting up on the floor with his mother, grappling with what is

quite an intellectual challenge as he discovers the meaning of representation, the fact that a photographed image of his father conjures up the idea of his father. It is impressive to see the intensity he brings to the task of seeing daddy in the photo and recognizing him there. Again and again his mother repeats, "There's Daddy," and again and again Damien joins in finding him. When they have apparently finished, Damien wants his mother to do it again. "I don't want to," she says with definiteness, which is characteristic of this family. Damien, too, is definite; when offered a drink instead of the game he crashes it down on the photograph in rejection. There is a good deal to discuss and to think about here in terms of the family style, in terms of relationships, and of the development of thought and mind.

Briefly, the second theme, which I should like to discuss, relates to an aspect of Damien's relation to his mother. There were those earliest kisses, which I noted, and the raspberry blowing by daddy. Passionate kisses characterize the link between parent and child in this family. When Damien is only ten weeks, there is a long, strenuous interchange of play and talk between him and his mother during which he shows no sign of tiring or turning away. Communication and concentration are coming on apace.

His mother blows robust, noisy raspberries into his tummy. Damien is wide-eyed, not sure if this is alarming or not, but eventually catches her mood and, wreathed in smiles, very nearly laughs out loud. There is no doubt but that they take huge and sensuous pleasure in each other. A kind of gobbling game is in motion. What are the different ways in which we can think about this? Damien, at just under three months, is still entirely under the sway of what Freud would call the "oral" stage of development. That is to say, all his energy and

interest is fixed upon the top end of his mother, her face, eyes and voice (and of course the mind behind them): her breasts and arms and hands. He himself is focused on his mouth, with his eyes and ears and hands a good second, concentrating on what he can take in and devour. Mother is playing out a game of eating Damien up as though he were a delectable meal. It's common to hear mothers say "Doesn't he look edible?" or, "I could eat you up," and here we have a graphic enactment of this delight. Where does it stem from? This uninhibited wish to gobble the other person up, "Num, num, num!" is essentially an infantile one, and mother has great fun with it. But there is, we are reminded, another side to the wish to eat each other up. The raspberries mother blows are sometimes quite fierce, reminiscent of Little Red Riding Hood's wolf. There are some fantasies here of overwhelming and ruthless greed, the sort of greed that emanates from a baby's primitive emotional system. Mother is somehow quite aware there are some hostile feelings around - Damien's or even her own. She says to Damien, who can't really be said to be making much noise, "Who're you shouting at?" and "Don't you beat mummy up!" The implication is that there are some rough, fierce thoughts and feelings here as well as delight.

On the other hand, the passion between them is palpable, both here and elsewhere in the observations. When Damien kisses his mother's mouth it seems clear that the breast and her face are conflated in his mind as something to devour with kisses. Maybe this process gains extra intensity from the fact that by now Damien is bottle-fed; has he transferred not only his adoring gaze but also his hungry lips to his mother's face?

We see the same eating games emerging much later, at the end of Damien's first year. Still exciting, uninhibited, and realistic, they

foreshadow the fascination, which fairy tales hold for the slightly older child. Hansel and Gretel, Jack the Giant Killer, the Three Bears are all tales that play around with the small child's unconscious fear that it will be eaten up. Hungry, greedy, and ruthless wishes are projected by the child into their picture of a frightening father or mother, who turns in imagination and nightmare into a witch, a giant or a bear.

The other issue is the fine line we see drawn in Damien's game with his mother between ardent attachment, devoted possession, and a savage wish to possess entirely, to incorporate by eating up. These fantasies lie in everyone's unconscious imagination, at the infantile depth of us all; here we see them as they visibly emerge in infancy before they recede to the very back of the mind.

The filmed families: (3) Ben - aged four:

Ben is the other child whose life is partially captured on film. He has reached a very different stage from Damien, and we see that observing a young child is in many ways different from observing a baby. The person who is observing Ben has to follow him all over the place; it is interesting to see that he and his family are quite able to accommodate an observer, a person who is not family, not a friend, but a special kind of visitor. We see Ben with his parents but also Ben with his friends, and Ben moving outside the close family circle. He is an active, lively little boy, and it is plain that looking into his actions, observing the details, responding to the emotional content and seeking out meaning will repay the observer as it does in the case of a baby.

I want to select just one brief episode for comment. The observer has followed Ben into his bedroom where she sits quietly watching. Ben is lost in play. The heading of the extract is

“A Favorite Toy” and Ben is kneeling on his bed with his toy, a penguin. He is making the stuffed toy penguin jump rhythmically up and down. “Boing! Boing!” he chants, then thrashes the poor penguin and crashes at its tummy. Does he love the penguin or not? He is clearly much attached to it, but is he being kind or cruel to it? Is he sure?

We wonder what the meaning is of this game. Ben is playing it with intensity, with excitement and in the end with what seems to be some guilt. After all the excitement is over, he cuddles the penguin and looks as though he is falling asleep. His mother enters and says with surprise, “You tired?” It is as though reality steps in through the door. Ben has been lost in his imagination, treating the penguin as an object on which he could work out violently contradictory feelings. Perhaps these are feelings he has in relation to the mother of his internal world, the world of his dreams, thoughts and imagination both conscious and unconscious. When his real mother comes in she offers him either fish fingers or chicken nuggets, and he is a little boy in the real world again. No longer is he doing just what he feels like in an all-powerful way with this submissive, though beloved, penguin. Indeed, he seems worried, perhaps about the more ruthless aspect of the fantasies he has been indulging. “Ouch” he says: he hurts his finger, and although it isn’t very bad Ben seems worried as though he feels he might have been playing a dangerous game and hurt himself quite seriously.

What is the practical use of such observations?

The use of infant and young child observation is as an aid to training or to continuing professional development. It develops sensitivity to the detail of what is going on during a clinical interaction, and the emotional resilience needed to stay with that detail. This can be equally useful

whether the feelings evoked in a clinician are positive or negative. Too great a positive involvement can cloud the thinking process as effectively as a negative reaction of discomfort or dislike. It is helpful to be able to wait, to observe what is going on both outside oneself, and inside before forming a judgment or voicing a comment.

For example, here is a case seen in a counseling service for parents and their babies or young children.

Frances, aged 15 months, will neither separate from her mother nor be weaned from the breast. Her parents are said to be on the verge of violent quarrels with each other. The clinician involved watches as Frances whines, holds on to her mother and requests the breast every ten minutes. Frances does not play with the proffered toys. Her parents are at odds, since her mother is convinced that Frances should be allowed to wean herself, while her father says quite explicitly, “I’d like my wife back.”

Successful management of this case depended on several factors all related to observation of the sort outlined earlier.

- The clinician did her best to focus upon the unique factors of this particular situation, where all three of the family members were unhappy. Amongst other things, this helped her not to jump in with advice.
- The experience of watching and waiting was useful, as it became clear from the conversation that the couple had received a great deal of advice already, excellent advice, which they had not been able to put into practice. Their conviction that no advice worked was very irritating. The clinician felt deskilled, as though she were joining the ranks of the useless.
- Not only was she feeling cross and deskilled, she was also feeling anxious

for the baby, who had no space to maneuver.

- Sessions took place regularly, as with observations. Tiny changes occurred, with hopes for the better, and many disappointments.

- In the fourth session, a surprising development happened. The father lost his temper with the clinician saying that they had attended the sessions, listened, tried to think and nothing was better. What now? Despite her inward response (astonishment, hurt and anger) the worker held firm, did not deny the parents’ disappointment and upset, and offered a further appointment.

- During the following fortnight matters changed significantly. The family drew unconscious strength from their experience of a person who could tolerate a variety of difficult projections. They managed to put into practice some of the sensible advice that they previously found useless. Frances presented as a more relaxed, cheerful baby. She played with the toys and started to talk.

This is merely an indication of how one aspect of a clinician’s work can be strengthened by practice in tolerating projections. Space does not allow a further description of how helpful it is to be able to notice all the detail of interaction.

Infant observation is a discipline, which enriches clinical practice. It militates against burnout in workers because of the increased interest it generates. It is of relevance to a wide variety of professionals.

To obtain copies of the Infant Observation Video mentioned in this article please contact the Tavistock Clinic Foundation on 011-44-(0)207 447-3749 or e-mail: jbadger@taviport.nhs.uk for an order form. Credit cards are accepted. £50 per copy, £25 per copy for students.

The Impact of an Infant Observation Course on My Work With Parents and Infants:

Its Value as Part of Infant Mental Health Training.

By: *Rosalind Bennet*
Health Visitor, Bristol, UK

In this article I wish to explore why at least some infant observation experience is a vital training tool for those who are working with parents and their infants.

Esther Bick introduced the discipline of infant observation some 50 years ago as part of the child psychotherapy training at the Tavistock Clinic (Bick 1964). It remains an integral part of the training for child psychotherapists and has also been adopted by most adult psychoanalytic psychotherapy trainings. So what has this got to do with the training of a health visitor or of anyone else working with infants such as midwives, social workers, childminders, nursery nurses, pediatric nurses, neo-natal intensive care personnel and pediatricians? I would suggest that all these groups would benefit from training in infant observation even in an abbreviated form.

Is there any evidence to support that this is a worthwhile activity? What might it tell us? How might this be useful? How do babies make us feel?

Personal experience of the effect of Observational Studies on my work as a Health Visitor.

Before I signed up for an infant observation course, I had worked as a health visitor for some twelve years. (Health visitors are peculiar to the UK. They are trained nurses who work in the community in order to try to prevent physical and emotional ill

health and to promote good health, both physical and mental, across the full age range of the population. In reality, they work mostly with families with young children and sometimes with the elderly population.) In addition to my experience of working as a health visitor, I had four children of my own and also have two grandchildren. I had doubts about what more I could learn about infants but decided in the light of recommendations of friends whose opinions I respected that I would sign up for one year and see if there was anything more to be learnt! Three years later, I found myself writing a dissertation entitled 'Can Psychoanalytic Observational Studies Help the Work of a Health Visitor?' The answer was an unequivocal 'yes'.

In my role as a health visitor, I have always tried to be sensitive to the emotional needs of my clients at the same time as carrying out my professional obligations. By this I mean that I tried to listen carefully to what they told me and to respond with both respect and professional judgment. But my training had not included anything about the emotional development of children or anything about infant mental health. (It has to be said that when I trained in 1984, the term 'Infant Mental Health' was unknown to us or our course tutors).

The Infant Observation Course is comprised of the following modules: infant/young child observation; child development research; work discussion and theoretical overview. Lisa Miller describes the process of infant observation in this edition of the

Signal. As an observation student, I found the long process of watching a baby for two years and a young child for one year gave me some insight into the inner world of a small child. Observing the interaction between a parent and a child enabled me to focus on what is happening in that exchange. Body language and vocal sounds can show us so much. The observer's journey through these minute-to-minute exchanges between the parent and the child can show him or her some of the building blocks of infant mental health. The prolonged observation of a child is central to the observation course.

Prior to doing the Infant Observation Course, I carried out my everyday work with parents and their young children. The parents would ask me about problems such as a child who would not sleep or who was difficult to feed. As often as not, I would respond with practical suggestions. Sometimes these worked but many times they did not. The parents and I would search for more and more inventive ideas as to how to persuade the baby or child to sleep all night but often without any regard to the underlying issues that might be causing the problem. I did not take time to watch the child and to see what they had shown me about their relationship with their parents, their sense of themselves or their parents' ability to tune in to their child's needs.

The observation course has changed my practice in several ways. The most obvious change is in my ability to observe my clients, their interactions, and their reactions to one another and,

in particular, what is happening between parents and their infant. I am able to use what I see with the parents and they, in turn, begin to observe what their baby is doing/feeling and how they are feeling themselves. I also try to observe myself and to use my thoughts and feelings in a professional way to explore the difficulties with the family. The other important change in my clinical work is that I try to enable parents to come up with their own ideas of what their child may be feeling or thinking and what might help. My experience is that, given the space and time to think, parents of infants frequently provide their own solutions to their difficulties.

On completion of the course, I was still practicing as a health visitor with a caseload of over 200 families. When I met with a new family presenting with difficulties, I would listen carefully to the family's story of what was worrying them. I would then ask about the story of the child who is presented as having difficulties. At the same time, I tried to observe what was happening for all the members of the family who were present. As this process progressed, the family often began to make links themselves with both the story of the child's history and how it might contribute to the presenting behavior.

I do not underestimate the value of sitting quietly with a mother and her baby or young child while she tells me the story of her child's life. It frequently results in the mother and father reflecting on their own experiences as children. Often the family begins to join in with the observation and begins to notice what their baby is telling them and what he or she is contributing to the process. Sometimes it helps to do an observation with a mother who is having difficulty responding to her baby's cues. Many isolated mothers find it too lonely to look at their baby on their own; some are too depressed to look, while others feel too

threatened by what they might see. When I look at a baby whose mother is depressed, ambivalent or despairing, I often notice the same feelings mirrored in the face of the baby. It is a painful sight. How much more painful for a lonely mother to see her feelings reflected back at her by her distressed baby. Most of these sad mothers can 'read' their baby if they feel contained enough to do so (Bion, 1967).

I no longer feel that I ought only to do something or suggest something. Knowledge of practical suggestions and child development are an important part of the health visitor's repertoire of skills, but I also now have more faith in the idea that a client may experience my presence in a containing and healing way. Even during a relatively short encounter with a client, I feel less rushed and more able to tune in to how things are without the need to ask a lot of questions. It seems that the sense of space enables clients to tune in to themselves more easily.

I find some of the clients are able to tell me how they are feeling about things in a way that still surprises me. It is as if, because I have begun to learn something about observational skills and making links, they are able to do the same. Parents are sometimes then able to see themselves and their children in a different light. The containing quietness of observation can give clients the space and safety to explore some of the terrifying feelings they may be having, such as a fear of destroying their child or the child destroying them. This in itself can begin a healing process for the parents.

Other aspects of the course have enhanced my understanding of not only where the child is coming from but also the parents. It was important to have an opportunity to study the work of Freud and Klein and see their historical contribution to psychoanalytic thinking. In addition to this work, discussion seminars were crucial

in enabling me to alter my approach to my day-to-day work. Finally, but by no means least, the theory of child development and exciting research papers highlighted by the course tutors now influence my approach to parents who come to see me with difficulties about the behavior of their child. Fraiberg says in her book 'The Magic Years':

Do we need to know these fine points in infant development in order to be good parents? Well strictly speaking, no. Good parents will manage without the knowledge of child development. But with such knowledge I believe that the job of rearing a child can be made easier. The unease, the uncertainty and the anxiety, which is experienced by even the best of parents when presented with a child's incomprehensible behaviour can be alleviated at least in part by such knowledge (Fraiberg, 1996 p68).

It is my experience that the same applies to the unease, the uncertainty and the anxiety often felt by health visitors and other professionals who work with young children. It could be said that the course exposes too much pain, but it could also be argued that it could help professionals not to be so stressed and exhausted in their attempts to avoid the pain and have better ways of doing something about it.

I found myself wondering about what might have been written about the experience of other professionals who have been able to undertake the observation course. The literature available on the impact of Observational Studies for those professionals working with children is very limited. The exception to this is for child psychotherapists but this is not surprising because it is an 'established component' of many psychoanalytic child and adult psychotherapy trainings. (Bick, 1986)

While there has been some discussion about infant observation by other professions, they have written very little about the use of infant observation in training. Notable exceptions to this are as follows. Briggs (1992) explores the role of child observation in social work training courses. He also gives two case histories. He begins his paper with a quote from Freud. 'I can only advise my readers . . . not to try to understand everything at once but to give a kind of unbiased attention to every point that arises and to await further developments' (Freud, 1909). Briggs concluded his paper by saying that what is most useful for training is the actual experience of observation itself, 'it can have a crucial impact on developing social workers' sensitivity to the needs of children and clients in general, to the impact of emotion in clients, their relationships and in the workers themselves' (p 60). He also discusses the possibilities of a shortened course for students. Another paper relating to social work training called 'On the Outside Looking In' (Bridge and Miles, 1996), gives a vivid account of the impact that observing a baby or a young child made on experienced social workers while they were doing an observational studies course. This is the first material to be published by and for the social work profession on the subject of observational studies. It is 'designed to acquaint social work tutors, practice teachers and their students with the experience of observing young children'. It explains how the course was run as well as the theoretical background and the experiences of the students. Truckle (1998) rightly views this book as a considerable achievement. But he questions whether there is any hope of transferring the experience to often very young students on Diploma Courses. It has to be said that despite these excellent papers I have met very few social workers that have undertaken the observation course or have even heard of it.

McFadyen (1991) has written about child psychiatrists. She points out how they are expected to know about the physical, cognitive, and emotional development of children. She goes on to say that most of their learning will have been acquired from lectures and reading. Some of her colleagues will have worked in general practice or in casualty departments but she acknowledges that observing children was not their main aim in those settings. She concludes her paper by saying that "[the course has] relevance to every area of our work. The 'learning' of 'the capacity to be in doubts and uncertainties' is crucial to our training, an essential part of preparation to become a consultant child psychiatrist."

Barrows and Bennet (2000) have written about the use of the course for health visitors. Prolonged observation is something most nurses find extremely difficult to do. Their training and their work in a hospital environment is about getting on and doing, not reflecting and waiting to understand. It is understandable since in many hospital situations the staff has to act swiftly in order to save a life.

It surprises me that Infant Observation and Observational Studies have taken so long to find a place in the many professions that work with children. Maybe there is a perceived lack of time or funding. Maybe it is a defense as we see so many sad children and parents in community work; it is, at times, hard to live with the pain. Although the course makes one more aware of the pain it does give professionals a better way of doing something about it. The only disadvantage of doing an infant observation course is that there is no going back afterwards and, in my own experience, the parents welcome the new approach that follows from undertaking such a course. They frequently find it effective in terms of support for themselves and their understanding of their children.

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Preventive Applications of Esther Bick's Method of Infant Observation

By: *Didier Houzel - Caen, France*

Esther Bick wrote very few papers – just four in all, in fact, one of which was published posthumously. Everything she actually did write, therefore, is all the more significant. The very fact that her written legacy is so succinct is proof enough that well aware of her aversion as regards putting her thoughts on paper, she wanted to condense into the space of a few pages the whole of what she had to pass on – and, in truth, we have not yet finished exploiting the rich vein of her teaching. I shall begin by quoting two extracts from her writings in which – though she makes no specific mention of preventive or therapeutic applications of her method – she quite clearly states that a well-conducted observation cannot but be helpful for the mother and, consequently, for the baby too.

The first extract is taken from her seminal paper on infant observation: "Notes on Infant Observation in Psycho-Analytic Training," published in 1964 in the *International Journal of Psycho-Analysis*. After noting that "[c]ontrary to our expectations, there was no difficulty in finding mothers willing to have an observer," she continues thus:

"Mothers have frequently indicated explicitly or implicitly how much they welcomed the fact of having someone come regularly into their home with whom they could talk about their baby and its development and their feelings about it." [Bick, 1964: 558]

The second extract is even more explicit. It comes from the paper on psychic skin published in 1986 – after

Mrs. Bick's death – in the *British Journal of Psychotherapy*:

"In many cases, an observer can help when he can stay in his role of sympathetic listener because all that mother wants is to unburden herself." [Bick, 1986 :295]

These two extracts lead me to believe that Esther Bick had clearly perceived how her method could be used to help mothers, even though she may not have drawn any practical conclusions from this idea. This belief encouraged me to devise applications of her method, concerned as I was to offer parents of babies who run the risk of becoming autistic support and help at as early a stage as possible. From 1993 on, I have systematically developed these applications thanks to the setting up of a team of therapists trained in infant observation who practice therapy on a full-time basis, their objectives being either curative or preventive.

With prevention in mind, other practitioners have modified Mrs. Bick's technique of infant observation. I am thinking in particular of Catherine Druon, of the neonatal department of the Port-Royal hospital in Paris, who devised a technique for observing premature babies that she describes as a "psychic incubator" [Druon, 1996]. Jocelyne Siksou and Yolène Quiniou Pizzoglio make use of baby observation techniques in a neonatal intensive care unit. Geneviève Haag [1985], Cléopâtre Athanassiou, and Anne Jouvét [1987] have adapted the method in order to observe infants in a nursery or kindergarten environment. Anik Maufras du Chatellier [1982] employs it in her work in mother and infant welfare centers.

These various adaptations were devised to take account of the institutional environment of the child. My own, on the other hand, have more to do with the infant's family situation, which is one in which the child's mental development would appear to be at serious risk. Most of the observations are conducted in the home environment, though some begin in the maternity unit and others may be carried out in an environmental setting other than the family home.

Indications

In order to discuss the preventive applications of Esther Bick's method, the term "prevention" must first be defined. The World Health Organization draws a distinction between primary, secondary, and tertiary prevention. Michel Soulé and Janine Noël [1995: 3013] define them as:

"Primary prevention refers to all actions aimed at diminishing the occurrence of a disease in a given population, and therefore at reducing the risk of having new cases appear..."

Secondary prevention refers to all actions aimed at diminishing the prevalence of a disease in a given population, and therefore at reducing the length of time during which the disease can develop. It includes early screening and treatment of initial symptoms.

Tertiary prevention refers to all actions aimed at diminishing the prevalence of chronic disability or further outbreaks in a given population, and therefore at reducing as far as possible the functional disabilities caused by the disease..."

These definitions are perhaps more suited to physical ailments than to psychopathology. They are however useful in the latter field as well, in that they help us to differentiate between three phases: primary health care as regards factors that may give rise to mental illness, early screening and treatment, and interventions aimed at reducing and alleviating the degree of disability associated with a given mental disorder.

The preventive applications of Esther Bick's method that I have devised deal with primary and secondary prevention. This kind of intervention is offered to parents whenever we feel that they are engaged in a dysfunctional relationship with their child (who should be less than three years of age at the time of the initial referral). Therefore, this is a preventive and curative treatment method particularly well adapted to infant psychiatry. At the time of writing, we have treated 87 children in all, 28 of who meet criteria for primary prevention, which will be the main topic of the rest of this paper. In such cases, the impression is that, from birth onwards - perhaps even before birth - or in the first months of extra-uterine life, the link between mother and baby is not functioning as well as it should be. In some cases, it may be necessary to set up other treatment procedures that go beyond home-based interventions: the mother may need a home help, for example, or the baby may have to be taken into full-time or part-time foster care. However, most of the time, maintaining the relationship between mother and infant is highly desirable for both of them - at least for as long as the mother evidences a desire to maintain some kind of link with her child. The risk of unfavorable outcome in children who have been permanently separated from a parent deemed unfit or ill is now well known. Often, years of effort and careful upbringing are wiped out at a stroke when the child, whom we thought would thereby be sheltered from some paternal or maternal pathology or

other, has a severe breakdown - literally engulfed by what we hoped to protect him or her from. The reason no doubt is that we ourselves had been contaminated by powerful projective mechanisms against which we had reacted by setting up counter-projective ones. The development of those children for whom we are able to maintain (wholly or in part) their relationship with the parents is quite different. Infant observation has a particularly useful contribution to make in situations such as these, since the method enables projections to be contained and processed, thereby significantly reducing any risk of counter-projection.

As regards to secondary prevention, I have already mentioned the fact that my main objective in adapting Esther Bick's method to this kind of work was the early treatment of babies who were at risk of becoming autistic. This is still one of my principal aims. A significant number of babies in our sample (21) are, or were, at risk of

becoming autistic. Most other referrals also have to do with secondary prevention, quite simply because when this form of treatment is reserved for infants under a certain age (three years in our case), psychopathological problems are

usually not yet entrenched; the situation is therefore much more mobile and disorders may often disappear completely in a relatively short time. With our three-year age limit (at time of referral), we are also

Table 1: primary prevention

Mentally-ill parents	7
Dysfunctional or inadequate parenting	7
Perinatal problems	11
Multi-problem families	3
Total	28

Table 2: secondary prevention

Risk of developing autism	21
Other childhood psychoses	8
Functional disorders	14 (4 sleeping disorders, 10 feeding problems)
Problem behavior	9
Other (physical problems, infantile depression, difficulty in communicating, etc.)	7
Total	59

able to offer this intervention to children suffering from functional disorders (anorexia, psychogenic vomiting, sleep disorders, laryngospasm, etc) that are sometimes associated with organic (physical) factors; it is also offered to families with major problems that often lead to emotional deprivation, inadequate

parenting, or even abuse (in this case, abuse must first be acknowledged, and all necessary measures to safeguard the child have to be in place).

Technical matters

(a) The setting

What modifications to the setting does the application I am describing entail? First, the way the target group is recruited is entirely different: the initial interview is conducted by a child psychiatrist, who thereupon suggests a therapeutic observation. Second, our objectives are quite different: we aim to help parents who find themselves in a difficult relationship with their infant or whose concerns about the child's development seem perfectly justified.

If we examine closely what Esther Bick said about the observer's role, we see that she insisted above all on paying attention, listening carefully, and being responsive. To my mind, these three elements are especially typical of the state of mind that therapists should try to adopt. I have elsewhere described attention as being both conscious and unconscious. Conscious attention enables the observer to note the slightest of changes in the child's behavior, and helps him or her to listen carefully to what other family members may need to communicate. But this in itself is not sufficient: the therapist has to be able to receive implicit communications that are expressed, not through objective channels, but via a kind of induction that draws the therapist into a particular state of mind without his or her being aware of it. In order to take on board these implicit communications, the therapist/observer has to tolerate these induced states of mind that are sometimes extremely distressing and almost unbearable. The therapist must also agree temporarily to defer understanding of what is being communicated via these messages - they are not only implicit but also enigmatic. This corresponds to what Bion, following Keats, called negative

capability - the ability to tolerate the psychic tension that meaninglessness creates deep inside us. The mind's ability to respond involves many more communication channels than our five senses can provide. Therapists can call not only on their five senses and their ability to listen carefully, but also on their emotionality, their capacity for fantasy representation, and their drive-related dynamics - in other words, on an entire multidimensional mental experience. I call this ability to receive communications through other than the ordinary sense channels (and without being directly aware of the fact) unconscious attention.

There is no doubt that - as compared to observers - the objectives of this home-based treatment, and the knowledge that therapists thereby obtain about the difficulties experienced by both child and parents do have an influence on the mind-set with which they approach the material - not in the sense that interventions tend to manifest themselves more concretely, but in the sense that empathy is heightened and manifested more explicitly. I shall discuss at more length *infra*, the way in which this empathic attitude can be evidenced. The therapist may also try to make the child's behavior meaningful, whenever it appears necessary to help the parents in their attempts to process the situation. However, no transference interpretations are made; if there are attempts at linking, these are part of the therapist's containing function - not only to take in but also to make sense of whatever is taken in.

(b) What the therapist says

The question then becomes: what exactly may the therapist say or not say? It might appear unnecessary to underline the fact that politeness is de rigueur when we are invited into someone else's home. Esther Bick herself insisted on this point, and I wholeheartedly agree with her: the therapist should be polite, amiable, and friendly (though in a restrained way).

It is of course vital to inform the family verbally of any useful information as regards to establishing and maintaining the therapeutic setting: days and times of the visits, interruptions for holidays or for any other reason, etc. On the other hand, the therapist must not be drawn into becoming a messenger between the parents and the referring consultant whom they will continue to meet from time to time. It has to be made quite clear that the home-based treatment has its own specific framework, distinct from that of the consultations or of any other therapy that may be suggested.

Third, I feel that in this situation as in others, language should be employed in what the linguist Jakobson calls its phatic function - to give some indication of one's responsiveness, for example, rather than simply to convey information. The little "yes...", "well...", "hmm..." and so forth that we all use during phone conversations (and that psychoanalysts use in working with their patients) are examples of this phatic function, the importance of which ought not to be underestimated. Experience teaches us that if these little comments are not interjected from time to time, the person with whom we are talking on the phone can suddenly begin to feel uneasy.

I would suggest also that the therapist put into words anything new that is observed, though I admit that not all specialists in infant observation would agree with me here. Some would argue that observers should never comment on what they observe, others that it is a good idea to say something about some behavior sequence, etc, that is observed for the first time. In my view, this encourages the parents to go on being attentive towards their infant and helps them to take an interest in the child's mental growth. Of course, observers must take care to describe what they observe in as neutral a manner as possible, without being judgmental or saying something such as "Oh, that's good! It's the first time

I've seen him walk!" I would suggest that highlighting newly observed events is close to what Bion meant by his "K" (Knowledge) link. Bion (1962) hypothesized three kinds of mental link: "K", "H" (hate) and "L" (love), all three of which are emotional in nature. "K" corresponds to the tension that the mind has to bear when faced with meaninglessness or with having to wait for meaning to emerge. According to Bion, "K" represents the psychoanalytic link par excellence; this is indeed the case, in my opinion, because it possesses a certain kind of stability that applies neither to "H" nor to "L". I make this association between "K" and some newly observed event because both have to do with novelty. Whenever we characterize an aspect of the child's development in the sense of "good" or "not good", we are involved in "L" or "H" considerations; the risk then is falling prey to instability or even turbulence, both of which I think it preferable to avoid.

When an emotional state is about to invade and overwhelm one or other of the child's parents, my advice to the therapist is to try to delineate and to describe what is going on in as neutral a manner as possible - this is what I call "putting words to the affect". An example would be to say to the mother we experience as over-distressed when her baby cries and seems inconsolable - "it's so difficult to take care of someone so little!" - without attempting to indicate any solution. In this way, it seems to me, the therapist makes it clear that mother's distress is being acknowledged, that she is not being criticized, and that no one is claiming to have a better solution than the one she herself is trying to implement. Often, surprisingly enough, the mother, her mind eased by these simple words, may then get back in touch with her capacity for reverie and find by herself a new approach to the problem.

Finally, as I have stated, the therapist may create links in an attempt to make

sense of the infant's behavior. This can be helpful in cases where the parents' ability to process and integrate is particularly weak. However, I do not recommend interpreting in the traditional meaning of that term - pointing out instances of repetition either from the patient's past (as Fraiberg [1975] proposes) or in the transference. Also, as in infant observation for training purposes, no advice is given, no professional counseling - and, of course, no judgments are made.

The processes involved

(There are four elements that I would like briefly to outline.)

1. Containment of parental distress

My use of the word "containment" corresponds exactly to that of Bion; a state of mind in which projections from another self can be taken in and modified in such a way as to make them less toxic for the mind in which they originate. Practically speaking, it is as though the simple fact of listening to the parents' confusion, doubts, anxiety or aggressiveness - without being in any way judgmental or counter-projective - helps to make the parent-child relationship just that little bit smoother. We could hypothesize that, in situations which respond to this kind of treatment, the birth of that particular child reawakened in one or other of the parents unresolved infantile conflicts that interfere with the work of parenting to such an extent that the infant becomes the target of disorganizing parental projections. The possibility they are now offered to communicate, consciously and unconsciously, what it is that prevents them from having a better relationship with their baby seems to remove the obstacle that was making the relationship so stressful.

2. Reinforcing parental competency

I have observed that the fact of reinforcing the qualities the parents do

possess is particularly helpful for mothers of autistic children, but it plays a role, though perhaps to a lesser extent, in many dysfunctional interactions between mother and baby. It is as though somewhere in the mother's mind there exists an invalidating element that makes her doubt her own intuitions and undermines her self-esteem as a mother. This invalidating/judgmental aspect is projected onto other persons in the environment - with the risk that they may well end up behaving in an invalidating manner towards her. As a result, the vicious circle becomes even more difficult to break into, with a more and more negative overall effect on the mother-child relationship. However, if these projections can be contained in the mind - in other words, if the person who is projectively identified with the invalidating aspect can step back a little from the projections and endeavor to process them mentally (instead of responding in the way an invalidating object would) - the mother may gradually become able to break free of the vicious circle into which she felt locked. Little by little, she will be able to have more faith in her own intuitions, find her own solutions, and develop a true capacity for containing her infant's projections.

3. Sorting out inter-generational confusions

In order for adults to communicate with an infant, they have to be able to get in touch with their own internal infantile aspects - those that can identify with the child with whom communication is sought. Adults must, therefore, be able to regress towards their own baby aspects - yet at the same time remain in contact with their adult part, for otherwise there would be a complete identification with the infantile aspects, creating a relationship of rivalry with the external (real) infant. This sometimes happens in parent-child relationships, where the parent, in regressing to an internal infantile aspect, loses contact with the

adult part: the relationship, instead of being between parent (adult) and child, then becomes one of rivalry with the infant.

I have elsewhere called this situation inter-generational confusion: the distinction between the parents' generation and that of the infant is blurred. Home-based treatment can help to alleviate this by containing parental distress (which is usually infantile in origin) and enhancing the parents' own sense of competency.

4. Encouraging identification with the observing function

The observer's responsiveness, attentiveness towards the child's progress, however small, and capacity to put into words any freshly-observed events all help the parents to become more attentive towards their infant and to maintain their interest in his or her mental life and development. In the course of home-based treatment sessions, some parents discover just how rich the mental life of their child can be. A benign kind of circle may then be set up, in which the more the parents cathect their infant's mental development, the more this development is encouraged.

A clinical illustration

I would like to illustrate the applications of Esther Bick's method that we have implemented with a case that corresponds to my definition of primary prevention: the infant concerned has no psychopathological symptoms, but the very disturbed family environment in which she lives gives rise to considerable concern for her future development.

"Colleen" was born under conditions of strict surveillance because both her parents have a history of psychotic disorder. Mother ["Maude"], who is still in her 20s, was diagnosed schizophrenic as an adolescent. Father ["François"] also has a schizophrenic-type condition. In the

sixth month of her pregnancy, mother had to be hospitalized for a psychotic breakdown. It was during this hospitalization that my department was asked to set up a treatment program for the mother-baby couple.

There were a few meetings with the mother before delivery took place, and in the course of these her transference with respect to the consultant was intense. After the birth, Maude's mental condition worsened, and three weeks later she had to be transferred to an adult psychiatric ward, while baby Colleen was taken into foster care.

Therapeutic observation sessions, twice weekly, were offered to the mother while she was still in the maternity unit. These were continued afterwards in an outreach social services center, where the parents were authorized to visit Colleen twice weekly. At the time of writing, these sessions are still ongoing - now on a once-a-week basis - and take place in the same outreach center. There have been ups and downs - some of them quite dramatic, such as when, both parents arrived in such a state of psychotic excitement that the father began to assault his wife: we really thought then that the worst was about to happen.

We have managed all the same to cope with such incidents thanks to the care network that includes my own department, the social workers dealing with the foster-care arrangements, and the adult psychiatry teams that are helping Colleen's parents. For a time, each of the parents visited Colleen separately, until it became once again possible to reunite them - both of them are genuinely attached to their daughter, and Colleen is very affectionate towards them. Her development for the moment is quite normal. The foster mother has complained that, after her parents' visits, Colleen is a bit faddy about her food and tends to sleep less well - but she does acknowledge that these visits are important for

the girl's future development.

Here are the notes the therapist made immediately after the first session².

The first session: Colleen is five days old

As I make my way towards Colleen's mother, I hold my hand out to her; we say hello. I introduce myself; she seems slightly surprised. We go into her room.

Mother: "Oh, excuse me. I'd forgotten you were coming so early. I haven't tidied the room yet." She opens the window, pulls a chair towards me and sits down in the armchair. She looks at me as though trying to interpret what is going on in my mind.

I tell her of my aims in coming to visit her: to observe, together with her, baby Colleen's behavior, to pay close attention to her, and to see how she is developing.

Mother: "Yes... yes, well, as it happens, I've some baby clothes here and I wanted to ask you about them... I don't know how to dress her."

She fetches a bag apparently full of baby things, sits back down and rummages inside it. She takes out a thick sheet, a blanket, then another one, says "that looks fine" and adds that she'll wrap baby up in this. Next, she takes out a woolen wrap-over top that her grandmother had knitted, then a woolen vest that her mother had given her. She rummages again inside the bag, saying she will open everything up. She takes out a little pair of white woolen trousers, but says that they'll make the baby too warm, and holds out a pair of white pants.

Mother: "Yes, I could put these on her." Then she rummages even deeper in the bag. "Yes, I have other things." She takes out a cotton vest, a pair of pink pants and a pink romper suit - "It's too big!" she says.

Maude picks up the blankets again and asks me if they are clean. To tell the truth, none of the things she has shown me seem particularly clean. She hasn't said a word about the baby yet. Leaning back in her chair, she says: "Well, I don't work, but I do a lot of painting".

Me: "Do you like painting?"

Mother: "Yes, I do a lot of painting, everything I see - I look outside, I paint. I really like that, I'd like to show you my paintings."

Me: "Yes, of course, you can show them to me."

Mother: "I'd like them to stop the medication I've been prescribed, the one the psychiatrist gave me, because it stops me thinking and looking after my daughter properly. Will you be able to let her know I don't want to take that medication any more?"

Me: "So you want to take good care of your daughter?"

Mother: "Yes, and I'd like to take a few hours off so I can go home and get her cot ready, put sheets on her bed. I'd like to do that with François [the baby's father]." As she pronounces her partner's name, a smile comes over her face. "You will be able to ask them, but for that they'll have to reduce my medication. I didn't ask for any pills, they insisted on giving me some, I didn't want any. Do you understand?" "Oh, I've got more clothes here!" She takes another bag and pulls out a pink winter suit; as she does so, she says: "My mum bought this, but I made a mistake - I told her the baby weighed 10½ lbs., but in fact she weighs only a bit over 6 lbs.!" She bundles it back into the bag. As far as I can see, none of these items of clothing are new.

Then she talks of her parents: her father had phoned, and her mother had visited her, seeing Colleen on the other side of the glass screen. Maude seems both moved and upset - because she

no longer wanted to have anything to do with her mother. "Something" had happened when she was 15 or 16. She says she doesn't want to be her parents' little girl anymore, she doesn't want them to bother with her, especially since they don't like her partner. She then talks again about the medication that's preventing her from thinking: things are more or less OK in the morning, but in the evening she feels tired and thinks that she won't be able to take care of her baby all the time, though she would really like to be with Colleen during the day.

The phone rings. Maude picks up the receiver, asks the caller to phone back after 1:30 p.m. because she's in the midst of a discussion, then hangs up. She says: "That was my brother. I'm glad he phoned. I didn't know how to get in touch with him. I left his phone number at home." Then once again she talks about her medication: she'd like the dose reduced in order to get her strength back; she adds that she feels a bit depressed right now - tears come into her eyes and she starts to cry.

Me: "Are you feeling depressed now?"

Mother: "Yes, and I'm crying. I haven't done that in a long time."

Me: "Sometimes it's good to have a cry."

Mother: "Yes. And I'm glad you're here to listen to me. It's doing me good."

She looks me straight in the eyes, and our eyes stay locked together like that for some time. My feeling is that she is trying to get me inside her eyes, to seize hold of me, to make me experience her distress from inside.

Mother: "Let's go and see the baby. I could bathe her while you're here."

Me: "If you like, I'll stay with you during bath-time, but you should do as

you usually do and bathe her with one of the auxiliaries."

Mother: "Well, I don't think she'd like being observed."

We go to the nursery. A midwife asks me: "Are you the therapist from the child psychiatry unit?" I say that I am. Maude asks if she can give Colleen a bath, but she is told that Colleen is asleep and that she took her bottle at 7:30. Mother asks if she can take Colleen with her; the midwife asks me: "Will you still be with her?"

Me: "Yes, until 10:30."

We head back towards the bedroom, with mother pushing the cot along the corridor. She opens the door and, as she pushes the cot inside, she bumps it against the door.

Mother: "Oh! I'm waking you up gently!"

She leaves the cot at the foot of her bed. I think to myself that if somebody comes into the room, the door will bump against the cot.

Mother sits down after shutting the window, so that Colleen won't catch cold. She looks at her daughter sleeping, then says: "Can you tell me what a four-day-old baby's like?"

Me: "Well, what do you think of your baby?"

Mother: "I feel she's sensitive and fragile at the same time. Yes, I think she's fragile, but she does tend to play on that, both with me and with her dad. The other day, he carried her around for quite a long time, but afterwards she cried. My daughter's shoulders are not very wide, but she'll have to be strong in order to carry me. Yes, I'm happy I have a daughter. I'll have to get better now that she's here."

I did not manage to write down what Maude said to me just after this sequence, but my impression was that

as far as she is concerned, it will be up to her daughter to look after her, Maude.

Mother: "Well, I think that will be enough for today. You can leave now, and I'd like to see you again once I'm back home."

I say to her once again that I'll come to see her and her baby while they are still in the maternity unit, as we had agreed.

Mother: "Yes, but for today, that's enough."

I remain silent, thoughtful. I'm thinking of the setting; I can understand her wish for this session to stop there, but I hesitate a little, thinking to myself that it's not quite good enough. Maude seems to want to have a cigarette - she offers me one. I thank her and say that if she wants to smoke a cigarette, I'll wait for her here. She immediately agrees.

I remain alone with Colleen, asleep in her cot. I move slightly in order to see her better. I'm glad I've managed to respect the setting we agreed upon, thanks to the compromise solution I suggested.

Mother comes back and sees me more or less in same position as when she left. "Ah yes, you can see her. Now I'll have to start thinking in practical terms."

Me: "You want to start thinking in practical terms?"

Mother: "Yes, you see, I left the room with my cigarette lighter and my cigarette, and I come back holding the lighter in my hand. This afternoon, I'll have to remember to take my bag with me so as to put the lighter away inside it."

Colleen whimpers a little and mother looks towards the cot. She seems to be listening carefully, then says to me: "Are you of Italian origin?"

I say no.

Mother: "Because I know an Italian woman who looks just like you."

Colleen's noises become louder. Mother goes to pick her up, but at first doesn't support her head properly; then she sits down, holding the baby in her arms. She puts her hand around her in such a way that Colleen's head is lying more or less on mother's forearm. She is a very delicate little girl, her face is slightly red and she has light brown hair. She looks at her mother, who turns her round to face me.

I say: "Hello, Colleen, I'm the lady who will be coming to see you and your mummy."

Mother stands the baby on her knees. "Look, she's standing!" she says. Then she takes her back into her arms. Colleen cries, opens her mouth wide, and waves both her arms about. "Oh! You mustn't get into the habit of demanding things like that, you don't demand something to eat, you have to wait, you know, a good girl wouldn't behave like that!" says Maude.

She leans towards her baby saying "darling, darling." Then she kisses Colleen, who immediately grabs at her mother's nose. She sucks silently on it for a moment or two and calms down. Then mother snuggles Colleen right up to her, with the baby's face against her neck. Colleen again starts to cry, Maude lies her down in her arms once again. Colleen turns her head towards her mother, opening her mouth wide like a starving bird.

Mother: "No, you mustn't be difficult, that kind of thing is not nice!"

Me: "Do you think she's being demanding?"

Mother: "Yes, she'll have to wait a little bit longer before she has something to drink." Mother fetches a little cloth doll and shows it to Colleen,

wanting her to take it. Colleen is screaming with hunger, I find it hard to do nothing; I really feel like ringing the bell for someone to bring a bottle.

Then Maude looks at the doll and says: "It's handmade, François and I bought it together. He wants her to hold a doll... but you'll have to open your little fingers." Colleen is too agitated. Mother takes a cloth nappy from the cot and puts it into Colleen's hand. But, of course, Colleen does not catch hold of it. Mother does not seem to be aware that she is with a newborn baby. She lies Colleen down on her (mother's) bed, lying on her back, and puts a hand on her stomach; Colleen gradually calms down. Then Maude puts Colleen down on the flower-patterned blanket, the one she showed me at the beginning of the session and which seems to be very important to her. She places the nappy close to Colleen's face, up against her nose, and the baby calms down completely. Mother again speaks about the bath she'll be able to give her baby at the nursery. I suggest that I accompany her there, just before leaving, because it's the end of the session.

Mother asks me to help her put Colleen back into her cot. She wants the cot to be in a completely horizontal position - it's slightly inclined - because she is afraid that Colleen might fall out. She asks me to hold the cot while she's doing this, because she is worried it might capsize. I have the impression that she feels some anxiety about falling. Perhaps her feeling is that I'm letting go of her when I leave.

I go with her to the nursery. Mother is holding the blanket close to Colleen's head, and I put a hand on the cot near the baby's feet. Mother puts the cot back where she had found it. Colleen looks as if she's fallen asleep. We say goodbye to each other.

Commentary

In this first session, the crucial question concerning this young mother and her relationship with her daughter is highlighted not so much by what Maude explicitly says, but by the manner in which she behaves and by the experience the therapist has of this. Every baby needs an appropriate maternal container - comfortable, clean, protective, and the correct size. When Maude shows the baby clothes to the therapist, this theme immediately comes to mind - and the clothes that the mother and grandmother have given the baby are old, worn-out, dirty and too big for her. Maude gave the wrong measurements to her mother... perhaps she herself needs a maternal container, as the clothes she keeps on pulling out would seem to indicate. She seems to be saying that her own mother had not provided her with an adequate container (I happen to know that Maude's mother had been incapable of protecting her from her father who, when Maude was an adolescent, had proved intrusive and perhaps even incestuous). The question would seem to be: in the treatment offered her, will she (Maude) be able to find a container for her deep distress? "I'm glad you're here to listen to me. It's doing me good." - this is a moment of intense communication when the therapist feels that Maude is trying to get inside her through her eyes in order to leave all her pain with the therapist, so as to be able - at last - to think about caring for her own baby.

However, almost as soon as she is in contact with Colleen, another dramatic moment ensues. In a kind of role-reversal, it becomes clear that Maude is expecting her daughter to adopt a therapeutic role with her and to be a container for her.... It is interesting to note that this theme appears just after Colleen's father is mentioned - in other words, just after setting up a triangular (Oedipal) situation that immediately made Maude feel intensely jealous: Colleen, so charming towards her

father, is trying to play up to him. In this state of mind, the therapist - cathected as representing the third-party object - is no longer acceptable: "Well, I think that will be enough for today." The therapist is quite justified in insisting that the setting initially agreed on be maintained - thereby signifying that she refuses to collude with the mother's psychotic defensive system that seeks to re-establish a mother-daughter relationship in which they fuse together, denying the father any kind of role.

Maude then has to evacuate the tension she is unable to process adequately in her mind - she leaves the room to smoke a cigarette. Nevertheless, when she returns, she is once again able to interact with her daughter - even if these interactions are not always appropriate, they do exist and they do acknowledge the therapist's function as a third vertex.

What is crucial in this kind of treatment is to hold things together for as long as possible in order to facilitate the development of what could be called "partial parenting." Though this may fall somewhat short of complete functioning as parents, it does imply the kind of genuine parent-child communication that is essential for giving the child a secure base: belonging to that particular family, being the child/grandchild of so-and-so, etc. When all is said and done, this is the very foundation of a healthy narcissistic state of mind.

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¹ Translated by David Alcorn, Caen, France.

² I would like to thank the therapist, Ms Laurence Grandin, for authorizing me to quote extensively from her material. I shall use the first person singular throughout in order not to make the text too unwieldy for the reader.

Observed Mothers' Interviewed

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In her article on baby-observation Bick (1964) expressed her astonishment at how easy it proved to find mothers who would agree to be observed with their newborn baby. She also wrote about the positive aspects of the presence of the observer in the family: 'Contrary to our expectations, there was no difficulty in finding mothers willing to have an observer – either through acquaintances or through other channels. Mothers have frequently indicated explicitly or implicitly how much they welcomed the fact of having someone come regularly into their home with whom they could talk about their baby and its development and their feelings about it.'

Some years ago (in 1981), I decided to visit mothers after the end of an observation. My intention was to try to understand why mothers accept this intrusion into the intimacy of their relationship with their baby and secondly, to try to find out if the observers' presence had been of any harm. I contacted the parents of observed babies, who had been discussed in my seminar. Since 1981, I have met sixty-two mothers and in half of the cases, the fathers also took part in this interview.

The first surprise was the extent to which parents were agreeable to meeting 'someone who is interested in baby-observation and wants to discuss with them their feelings concerning the observation'. All the contacted parents accepted and in only one case was the mother not present at the agreed appointment. It very soon became clear that the parents were glad to have the opportunity to discuss with someone

and understand more about the goals of the observation. In nearly all of the cases, I have been very kindly received and have met no significant resistances. The parents expressed different impressions: 'they understood better what they had participated in, they were able to accept the silent attitude of the observer more easily and they felt they finally received something back for all they had given.' Taking into account these results, I decided to continue making such follow-up visits and, from 1996, I have regularly met with the parents when the observation has finished. There are two main reasons for doing so: first, because the parents seem to be very much interested and helped by these contacts and secondly, because the observers appreciate the feed-back they receive as, after finishing the interviews, the group of observers and seminar leader meet one last time to discuss these conversations.

The observation technique I use is the classical one: the group consists of three or four observers with one seminar leader, every participant has a baby to observe for 18 months and has the opportunity to read his most recent observation in the weekly seminar. We try to have all the babies of nearly the same age.

My intention in this article, is to describe the most important facts I learned during these conversations with the mothers or the couples. Even when the fathers had not often been present during the observation, they were glad to give their point of view concerning the observation and to ask questions about its goals. I have written an article concerning the first interviews (1994) and wish to complete my suggestions taking into account the sixty-two interviews I have done since.

First, I would note that the conclusions I shall suggest are the results of a semi-structured interview by which the parents express their conscious feelings and ideas. It is clear that the parents are reluctant to criticise the observer and also that in our western European civilisation, negative feelings are not so easily expressed. Nevertheless, some mothers could show their disappointment and aggression. I am also aware of the importance of denial and repression of some feelings. For example, parents nearly always denied the jealousy of the older children towards the newborn although its existence was so evident for us during the observation sessions.

When the observers meet the parents for the first time, generally before the birth, they are informed that the observation can always be stopped if they want. The rate of interrupted observations is very low. When I asked some mothers, who expressed rather negative feelings about the observation, why they did not put an end to it, the answer always concerned their loyalty to the agreement: 'We had accepted it, we did not want to be unfair'. Besides normal super-ego reactions, I wonder if this answer is not also a reflection of an unconscious link mothers make between their baby and the observer. If so, refusing to go on with the observation, would have the unconscious meaning of rejecting the baby.

I was attentive to this link already during the observations, noticing that there was a parallel between the way mothers treat the observer and the babies. When mothers are very ambivalent towards their newborn, they often behave in the same way towards the observer: being late for the observation hour or forgetting it;

not being very accommodating, making many changes in the time of the observation and so on.

Nevertheless, such confusion can also be positive. I remember an observation where mother brought a blanket to the observer while she was looking at the sleeping baby. But the most significant example was the following:

Alex is 7 months old and sits on mother's lap with his back leaning against her body. Mother holds his little feet. The observer sits at the other side of the table in front of them. Mother starts a hide and seeks game with Alex's feet, putting them on the table and under the table...but baby does not laugh, as for him his feet never appear or disappear. It is only for the observer that the game works but mother was totally unaware of it, confusing her baby and the observer.

During our interviews, I tried to find out if mothers could become conscious of this phenomenon. In some cases it was possible and mothers told me how, when their thoughts turned to the observer, their baby was immediately evoked in their mind. I noticed also that this confusion only existed in very positive transference situations towards the observer.

When the baby gets older, parents are very attentive to the real relationship existing between baby and observer; they speak of a real link and appreciate it very much. Once, parents told me that, if the baby had not been positively oriented towards the observer, they would have put an end to the observation. When finishing the observation, observers generally offer a little gift to the baby and when I visit the family, I am told that it is baby's preferred toy or book. It is impossible for me to tell if this preference comes from the child or is induced by the parents - or perhaps both?

It seems evident that a baby is fully aware of the attention given to him by the observer and we often notice that the child observes if the observer is really looking at him. In one of my last

interviews, I asked the mother if she had noticed if the baby was aware of the end of the observation. Mother could not answer but a few minutes later, while the little girl (22 months old) was looking at me with much interest, I told her I was a friend of the observer, calling her by her name. The child answered by telling me the name of an aunt. Mother explained that her sister-in-law, this aunt, had stayed with them for some weeks but had just left. It is interesting to note that the child associated the name of the observer with someone who had also gone away after some time of being present.

In the case of another baby-mother couple, I was told that during the weeks which followed the end of the observation, when the bell or the telephone rang, the toddler always asked 'Ann?' with questioning eyes. Mary, another observed child, gave the name of the observer to the doll she received from her at the end of the observation. When the children I visit are not yet speaking, it is more difficult to perceive if they have retained a memory of the observer but when I tell them that I know the observer, I have the impression they establish an easier contact with me.

People often wonder why parents agree to taking part in a baby-observation and to allowing a stranger into such an intimate relationship as the one that exists between a mother and her newborn. When putting this question to the mothers, two main answers emerge:

1. to please the person making the suggestion (70% of the cases) and/or
2. to help young people in their training (35%) or to help the progress of science concerning babies (35%).

In relation to the first answer, which is the more frequent, I would comment as follows. The person who asks the mother about participating is generally a gynaecologist, a social worker, or a physiotherapist. Their role is crucial. First of all, because it is much easier for a mother to say no to such an intermediary; but secondly, because the positive investment of that person

will be transferred to the observer and help the beginning of the relationship between mother and observer. We all know how mothers feel fragile, uneasy and uncertain just after the birth of a baby. One mother described it in terms of 'being like a zombie'. A very high number of mothers recognised that the start of the observation was a bit difficult, that they had to make the observer's acquaintance, to get to know him but that finally he became a friend. It is interesting to note that parents also have to make their baby's acquaintance and learn to know him too. The sustaining attitude of the observer and the development of the relationship between mother and observer can perhaps be helpful in building up the relationship with the baby.

Mothers often refer to the intermediary person in whom they are very confident and transfer this trust on to the observer. 'I knew he was someone truthful as he was recommended by Doctor X' or 'she could not have been a harmful person as she was recommended by my physiotherapist'. Another aspect of this recommendation is more narcissistic: the parents are proud because this person, who knows so many patients, has chosen them.

The transference of the positive investment of the intermediary to the observer favours the beginning of the observation and later on a direct relationship will grow between the family and the observer, if he is able to negotiate a role in which the family can accept him. I am convinced that one of the benefits of baby-observation for the observers is to learn to find this place in the family. Each family is different and some persons need to feel at ease and not disturbed by someone 'looking' at them without having some verbal exchange with him. Some observers cannot easily adapt to what is needed by the family (mother, baby and others) either because they do not feel it or because it does not fit with their personality or defences. This can be worked through in the seminar but is not always effective.

What mothers tell me about the attitude of the observer can be very interesting. In some rare cases, the observer was much too 'neutral' and mothers complain about it. One of the mothers I met called the male observer the 'green plant' because he was so silent and discreet. In most cases, mothers appreciated the discretion of the observer provided it was accompanied by an attitude of affective participation. Mothers only rarely complained of having had the impression of being subjected to a criticising look. It was very interesting, during these meetings with the parents, to see how important are the recommendations of Mrs. Bick. She writes: 'In other words, he (the observer) would be a privileged and therefore grateful participant observer.' It seems not always so easy for some observers to find the right attitude which allow one to be a discreet 'observer' but also a 'participant', to find what I call 'the exact place'.

It is only when the observer can find an equilibrium between discretion and giving signs of a real affective participation, a real concern and empathy for the mother's and the baby's experiences, that the intrusive aspects of the observation situation can be borne by the mothers. Mother's personality also plays a role, as does the atmosphere in the family. It is the task of the observer to feel what is needed and to adapt to it. When a direct and positive relationship is built up between mother and observer this feeling of intrusion diminishes and the reactions of mourning provoked by the end of the observation testify to this. For the mothers, the presence of the observer remains linked to the first months of their child.

I was also struck by the fact that in almost half of the situations, the answer to my question about the parents' general feeling concerning the observation, was put in a negative sentence: 'it did not annoy us, we were not disturbed by it'. If we interpret this analytically, it sounds like the negation of a real disturbance. I would hypothesise that an observer is an

intruder but mothers are able to defend themselves against this feeling by the narcissistic gain they find in the fact of having been chosen by the intermediary and thanks to the feeling that they are helping the progress of science or the training of a young person. Another defence used by the mothers is to switch the look of the observer on to the baby. They forget the observer's request to 'observe the mother-baby interaction'. Although the observation is in many cases felt as an intrusive experience, mothers are able to adapt to it and transform it into a positive experience, with the help of a good observer and probably also as a function of their unconscious motivations. I shall come back to this.

When I asked if they behaved in the same way when the observer was present as when not, the answers varied. Some mothers were aware that they were slightly inhibited, others recognised that they tried to be calmer and less quickly upset (generally with the older children). In some cases, it was father who answered the question and the mothers were sometimes very astonished by the father's response because they (the mothers) had not noticed their own modified attitude.

In about 90% of the cases, parents recognised that they looked more at their baby. 'We sat down for one hour, taking the time to admire our child', 'between the observations, we were attentive to his or her progresses, to tell the observer', 'I would surely have looked at my baby but not so often, not for such a long period.' This expresses one of the gains parents can find in baby-observation. Another one is the identification of mother with the observer. Let me tell you how one mother explained this phenomenon to me: 'When taking care of my baby, I looked at myself as I thought Mrs D. did. I wondered if Mrs D. saw the same things as I did; I looked at my baby in a different way, with Mrs D.'s eyes, and when I saw my baby in Mrs D.'s arms I saw myself with my baby in my arms.' For this mother, it was a positive experience. Another mother explained that, by having this other look, she could achieve some distance from the

painful feelings aroused by her interaction with the baby. I encountered this identification in about half of the cases and it made the observation a pleasant experience and gave an impression of support.

Besides this identification, mothers felt sustained by the containment a good observer can provide. As this is an unconscious phenomenon, mothers could not verbalise it but I had a sense of it when mothers spoke of 'good advice', reassurance and help. As I have no reason to suspect the honesty of the observers, I think mothers expressed a feeling of support and not real words of help. I think this kind of support has to be distinguished from the help provided by identification. Most mothers had the impression that the observation brought them help and support. More narcissistic mothers could not admit that someone else could have had an influence on their baby and their relationship with him. I noticed that the father was not present in the mind of these mothers as if they had to be self-sufficient and could not admit the third in their way of thinking and psychic functioning, in terms of what Green (1990) calls 'tiercéité'. Why do mothers accept a situation which, in many cases, is felt as intrusive? My opinion is that they have a secret wish to be helped but do not allow themselves to admit it - except for about twenty mothers who could verbalise it. They gave, as an explanation, their anxiety about a first baby and their ignorance. For them it was important to know that the observer was himself a parent. It is noteworthy that all the parents asked the observer if he or she had children. For some parents it was a comfort, 'they have experience and will intervene if something is going wrong', for others it meant a danger of criticism. If the observer had no children themselves, some mothers were proud to have something to teach them. Nearly all the parents were afraid that they had nothing interesting to show and wondered what could interest the observer. It is disappointing to have to state that so many parents are still unaware of the presence of a mental life in their young

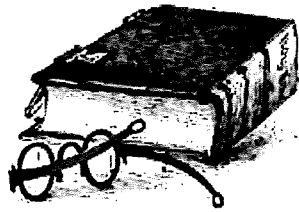
child and that they are unable to identify with his emotional life as they ignore its existence. I have the impression that an observer can, without words, help parents to become aware of it by sharing the babies' emotional life.

I also have the sense that the wish to be helped found expression in the fact that some mothers were very disappointed by the observation. They reproached this technique with being a 'one-way' relationship. 'I gave so much to the observer, he or she knows everything about me and I know nothing about him or her.' Once again, it is difficult to separate out the part played by mother's idealised expectations and the attitude of the observer. Some parents complained about the absence of feed-back and explanations. They were convinced the observers know a lot of things concerning their baby, about the 'ideal' way to behave with babies and they were disappointed not to receive information.

It seems evident that the parents perceive the observation in function of their own personality and history, and in function of their way of life. A striking example concerns the way they deal with the frame of the technique. For some parents, it was a real comfort to have the visit of the observer every week on the same day, at the same hour with as few possible interruptions; for some others, this regularity was a real burden and it was difficult for them to adapt to the agreed timetable even if the observer tried to accept the imposed modifications.

As in all aspects of human science, it is difficult to draw general conclusions. In baby observation, so many factors intervene on both sides that it would be dangerous reach conclusions with too much confidence. In any event, it seems important to me to be aware that this technique can be a burden for some mothers. It is, therefore, very important to be attentive to this phenomenon during the observation,

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LITERATURE MONITOR

In line with the present themed edition, this Literature Monitor is largely concerned with drawing readers' attention to some of the texts relating to infant observation rather than necessarily the most recent publications.

Books

Donald, M. *A Mind So Rare* Paperback edition published 2002. W.W.Norton. 0-393-32319-6. \$16.95 "The most significant contribution yet to the rapidly growing literature of minds, brains and consciousness"- Steven Rose; and highly recommended by Colwyn Trevarthen.

Forthcoming: Fonagy, P., Gergely, G., Jurist, E.L. & Target, M. *Affect Regulation, Mentalization, and the Development of the Self*. Publication scheduled for June 2002. Other Press, cloth, 1-892746-34-4. 600pp \$65 £45

Houzel, D. (2002) *L'Aube de la Vie Psychique*. ESF editor. 2-7101-1519-0. 305pp. 27.30 euros.

Miller, L. et al (eds.) (1991) *Closely Observed Infants*. London: Duckworth.

Reid, S. (ed.) (1997) *Developments in Infant Observation*. London: Routledge.

Papers

O'Connor, T.G., Heron, J., Golding, J., Beveridge, M. & Glover, V. (2002). "Maternal antenatal anxiety and children's behavioral/ emotional problems at 4 years".

British Journal of Psychiatry 180: 502-508. The authors conclude that 'There could be a direct effect of maternal mood on foetal brain development, which affects the behavioural development of the child' and that 'These findings raise the possibility of benefit from an intervention program targeted specifically at anxiety in pregnant women'.

Russell, R.C. et al (1995) 'Infant observation. A relevant educational method for psychiatrists and other mental health practitioners.' *Child & Adol. Psychiatric Clinics of N. America* 4(3): 529-538.

Journals

The International Journal of Infant Observation and its Applications. Subscriptions from Tavistock Centre, 120, Belsize Lane, London NW3 5BA. ltaussig@tavi-port.org

Tuters, E. (1988) 'The relevance of Infant Observation to Clinical training and practice: An interpretation.' *Infant Mental Health Journal* 9(1): 93-104

Hopkins, J. (1990) 'The observed infant of attachment theory.' *British Jnl. of Psychotherapy* 6(4): 460-470

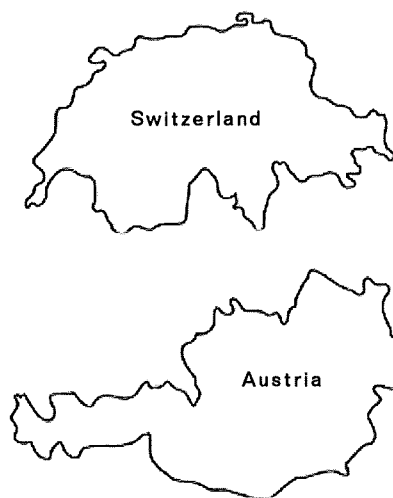
Magagna, J. (1987) 'Three years of infant observation with Mrs Bick.' *Jnl. of Child Psychotherapy*, 13(1): 19-39.

The German Speaking Association of Infant Mental Health GAIMH

The German Speaking Association of Infant Mental Health is called "Deutschsprachige Gesellschaft für Seelische Gesundheit in der Frühen Kindheit." It is an assembly of various professionals concerned with infancy from Austria, Germany, Switzerland and some other European countries and is based on the bylaws of WAIMH. After the WAIMH world conference in Tampere, GAIMH was founded in 1996 and has grown to 485 members. The president and two vice presidents represent the three German speaking countries and are chosen with the two other board members every two years by the whole assembly. Thus, GAIMH is one of the few affiliates to cross over political frontiers and even succeeds in coordinating the affairs of two countries within the European Union (Austria and Germany) with a non-

European Union country (Switzerland). In its structure it is basically organized like other WAIMH affiliates. One of the main challenges for GAIMH, apart from offering support for the needs of its members, institutions and families seeking help, has been the organization of annual meetings with a high standard at a scientific, clinical, teaching-training and social level. The successful annual meetings have been held with main topics in various fields of infancy.

The development of GAIMH has been an interesting, challenging, and rewarding project for most members involved with it. As in any professional organization the process of development and growth is a



continuous and dynamic project of defining topics, views, and positions between individuals with different interests, personalities, goals, and needs. In an organization like WAIMH or GAIMH, its interdisciplinary and multi-professional nature - which are fundamental to its qualities of mutual communication and joint identity - also cover and produce polarity and tension between the various theoretical backgrounds and different professional ethics and standards. This effect is normal, expected, and basically very positive. It makes up the diversity and quality of the whole group as a collective and dynamic movement and is mirrored in the interactions and development of each individual member involved in the challenging venture of the whole. After an initial period of growth and basic organization under the first presidency of Mechthild Papousek, wife of the late and cherished Hanus Papousek, GAIMH has now entered a phase of stabilization and is getting down to structuring its different subgroups, specifying standards, and defining new goals and means. To support this process the current president, Marguerite Dunitz-Scheer, has undertaken a postgraduate qualification in professional management of non-profit organizations. Additionally, the frequency of board meetings has been intensified to four meetings per year

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| 1. 1996 Munich, Germany, | Interaction centered analysis in diagnostic assessment of relationships, (Mechthild Papousek) (foundation meeting) |
| 2. 1997 Basel, Switzerland | Psychotherapy & Counseling during Pregnancy and Infancy, (Kai v.Klitzing) |
| 3. 1998 Graz, Austria | Interdisciplinary Communication (M. Dunitz-Scheer) |
| 4. 1999 Köln, Germany | Play & Infancy (Alexander v. Gontard) |
| 5. 2000 Zürich, Switzerland | Development and Relationship in Infancy (Fernanda Pedrina) |
| 6. 2001 Vienna, Austria | Fatherhood & Infancy (Sabine Fiala-Preinsperger) |
| 7. 2002 Berlin, Germany | The Baby as Subject (Andreas Wiefel) |
| 8. 2003 St. Gallen, Switzerland | The Baby & Society (E.Ruggle) |
| 9. 2004 Salzburg, Austria, | L.Thun-Hohenstein, in preparation |
| 10. 2005 Hamburg, Germany | In preparation |

and two additional days of intensive work in a task force group of 12 members have lately been added. GAIMH has its bylaws, an organizational diagram and a set of specified business rules, enabling it to define and describe the structure of the organization as it has developed. GAIMH is now organized into five work groups highlighting different important aspects of infancy:

1. Psychotherapy & Psychoanalysis
2. Infants in high-risk constellations
3. Infants of parents suffering from psychiatric disorders
4. Excessive screaming, sleep- and feeding disorders
5. The impact of healthy development for infants and their families.

These five groups are each headed by two members and report their activities to the board and assembly every year during the annual meeting. Additionally nine regional groups have developed in the three countries, which are less structured and work on various, mostly case-oriented, topics chosen by the visiting members. The frequency of their meetings varies between monthly and twice per year. Financial matters are taken care of in Munich. The administration center of GAIMH is attached to the institution of the current president and has been based in Graz since 2000. The duties and task of the president include writing the newsletter, which is edited 4-6 times per year and includes information about a number of activities and the abstracts of all manuscripts published in the IMHJ, translated into German by Peter Scheer. GAIMH also has a well visited website: www.gaimh.de with a special

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President's Perspective

Peter de Chateau

In my latest column, I had the opportunity to write about the goals and guidelines of our organization. Among them the methodological issues and the long-term outcomes of studies in infant mental healthcare are of special importance. The Amsterdam Congress will furnish ample opportunities to work towards these aims and perhaps help us in the development of further knowledge in our field. The need for larger and perhaps more international investigations from several countries is obvious in order to overcome some of the methodological problems we encounter today. Increased cooperation in clinical work and research between different countries and continents is absolutely necessary.

Another very important issue not only this year but also in the near future is the structure and organization of WAIMH. A true, international integration in a democratic fashion is desired here as well. Through our future efforts, we hope to increase the influence of the affiliates within WAIMH and also accomplish a better democratic development of the organization. The Executive Committee is more than willing to cooperate in such a direction. We do hope and expect that the national affiliates will play their part and take responsibility.

Among the purposes for which WAIMH has been organized, the research and study throughout the world on mental development and mental disorder in children from conception through the first three years of life is of special interest. Prenatal or prepartum influences are

included only in a small number of our publications and presentations at meetings. However, these influences are gaining in importance since more knowledge about this particular period of children's development is becoming available. In our daily clinical work, we also experience the influence of prenatal conditions more clearly. The use of modern reproductive techniques, for instance in the treatment of fertility problems, can have an impact on families seeking help. What precise impact these prenatal influences have on child and family development is still not fully understood. Since the arsenal of reproductive techniques and their use is increasing, it seems worthwhile to encourage and stimulate the study of their psychological consequences. An initiative could be taken within our association to facilitate such a development and at the same time look for appropriate partners in other organizations for cooperation. The Executive Committee could be helpful and supportive in this respect. To stimulate the membership in many different ways is most certainly one of the major tasks of our board. We, therefore, look forward to your reactions to this proposal or any other subjects you should like to bring to our attention.

ATTENTION:

WAIMH's website
has moved to:

www.waimh.org

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in particular during the work of the seminar. Mrs. Bick has given us precise and important ethical instructions but it seems not to be so easy, in some situations, to apply them. I would hypothesise that in all cases the situation of being observed is an intrusive experience, but that mothers and observers can reduce this to a minimum and transform it into a warm and pleasant experience. The gain for the observers is many sided and evident if he engages himself totally; it can also be a gain for the mothers and babies, if the mothers are not too narcissistic and borderline and are helped by an observer who can find his 'exact place' in that particular family.

As in the therapy of early mother-baby interactions, the relation between mother and observer should be on a positive basis, in order to favour the containment phenomenon and the process of identification. An intermediary seems necessary to start the observation with a positive pre-transference. This intermediary also plays a role in finding a 'normal' family. We all know the definition of normality is difficult but we must rely on this person's sense of reality. When the observer has to deal with a pathological family, it can be very difficult and painful to hold on without intervening. This raises an important ethical problem where the observer and the supervisor are caught between the ethics of the observation (no intervention) and the general ethics of assistance to a person in danger.

Conclusions.

It seems to me, after these interviews, that the presence of an observer is an intrusion in the relationship between mother and baby. Nevertheless, the extent of this intrusion can be diminished and in good cases transformed into a pleasant situation. This depends on a variety of factors and on the two parties engaged in this experience.

Mothers can use defence processes to deal with the burden of the observing presence. These will be a function of their personality, their history, their relations with baby, father and older children. I have given some examples which my interviews enabled me to identify: the fantasy of being a help to science; or a real help to a person in training; the narcissistic gain of having been chosen by the intermediary. They also find a help in the real relation they build up with the observer and feel supported by his participation in the emotional experience of rearing a baby. Unconsciously, they will benefit from his 'containing' attitude and the possibility of identifying with him or her.

On the observer's side, there is a lot of work to be done to find the 'exact place' in the family and be as little disturbing as possible. He must find an attitude that will suit both mother and child, participate without losing his calm, be able to contain the powerful emotions of mother and baby, identify with both of them and accept the aggressiveness of the family particularly that of the older children.

As regards the impact of baby-observation on the baby itself, mothers do not speak of it. Just one, very recently, asked me if her child would have been different if she had not been observed? This was a crucial and difficult question. I first enquired about her impressions. As the observation had been a good experience for her and as she had spoken of a feeling of containment by the observer, it was easy to explain that I thought the baby could benefit from this method. I think this question makes it clear that we must not neglect the importance and the influence we can have by being present, or intrusive, between a mother and her baby for so many months.

I think we also need to ask ourselves questions about the influence our 'look' can have on babies' development. Winnicott (1967) and

Meltzer (1988) drew our attention to the importance of looking at and being looked at. The importance both of mother's eyes as a mirror, and the presence of admiration in the mother's look, can be reinforced by the presence of the observer, as these interviews showed us. During some observations we are aware that, when the mother's reactions are not attuned to the baby's expectations, babies will turn to the observer and try to find in his eyes some support and understanding. The containment and supportive presence of the observer represents something positive, but what of how we look at the baby? How will he integrate the presence and interest of the observer in the building up of his internal world. We can observe how attentive the baby is to our looking at him, but how does he understand the sudden disappearance of this look?

I think we must remain very attentive, as Mrs. Bick was aware, to creating a positive climate during the observation without being too explicit or too intervening. The observer has to find his 'exact place', which demands significant psychic work based on empathy, affective participation and control of counter-transference reactions.

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chat section for parents, and helpful links and addresses of related institutions and private GAIMH consultants. On request the names of all GAIMH members and all affiliated institutions can be found there too. ZTT DC was translated into German in 1999; more information about general development in infancy, published by the DC parent program - the contents of the chart are titled "developmental milestones" - have also been translated into German. This was performed in the framework of a running governmental project about health promotion in early childhood in Canton Basel - Landschaft, Switzerland (fecit K. Keller-Schuhmacher). The goals for the next period are to encourage regional activities, to define specific guidelines for the annual meetings, and to enhance lively communication between GAIMH members in their own chat room.

GAIMH will be represented at the meeting of the European Affiliates at the World Conference in July in

Amsterdam by the Swiss (Fernanda Pedrina) and the German (Mauri Fries) vice presidents. The 7th Annual meeting is being held September 5-7, 2002 in Berlin, in the famous Charite Hospital. GAIMH would be happy to welcome any visitor from other WAIMH countries to the exciting city of Berlin and hopefully a great meeting! Don't be shy, since most GAIMH members are quite fluent in English and we even have lectures in English this time. You will find all the important information on the annual meeting in Berlin at: www.gaimh.de under "Jahrestagung." The following email addresses can be used if WAIMH members would like any specific information on the three countries:

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Frenanda Pedrina, Vice President,
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Mauri Fries, Vice President,
Germany: mauri.fries@t-online.de

We greet all WAIMH members abroad and would welcome anybody who wishes to develop contacts on a personal and/or professional level!

Marguerite Dunitz-Scheer



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