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Perspectives in Infant Mental Health

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Presidential Address: Reflections on WAIMH's Responsibilities

By Miri Keren, WAIMH President, Israel

Contents

While reading Antoine Guedeney's description of the changes that he and Nicole witnessed since their last trip to Uruguay in professionals' stance regarding babies' competencies and vulnerabilities, I find that the theme of our coming conference in Edinburgh - «Our responsibilities, Babies' Contributions» - comes «just in time». Indeed, the more we know about an infant's abilities to perceive interpersonal affects and events and, consequently, to develop symptoms while facing adverse environments, the more we are called to act and protect his or her development.

As I travel around the world and meet infant mental health professionals from different countries, I realize how complex the meaning is of the phrase, «our responsibilities." Indeed, we must take into consideration the huge variation in our cultural, geo-physical and economical contexts and health policies. For example, while Palvi Kaukonen, Kaija Puura, Campbell Paul and myself, gave a pre-European Society for Child and Adolescent Psychiatry (ESCAP) Conference WAIMH Training day in Dublin, I had a talk with the chairman of the Irish Psychiatry Association. As the only adult psychiatrist at the Dublin Women and Infants Hospital, he was wondering about the relevancy of what we like to call «emotional prenatal care» to the Irish Catholic society where abortion is totally forbidden, even in medical cases, and Irish women who do not have financial resources to get an abortion in England, are simply left alone to go on carrying their unwanted and/or malformed fetus. …Obviously, many of those women and their infants are then referred to him with postpartum depression, attachment and/or relational problems. We wondered together about his responsibility as a psychiatrist and a member of the Irish community while I wondered about WAIMH's responsibility at the international level. The definition of WAIMH's responsibilities is a topic that has been discussed many times by previous as well the present WAIMH Board of Directos. What is our mission and what is our responsibility?

WAIMH's mission is to promote education, research, and study of the effects of mental, emotional and social development during infancy on later normal and psychopathological development through international and interdisciplinary cooperation, publications, affiliate associations, and through regional and biennial congresses devoted to scientific, educational, and clinical work with infants and their caregivers.

One clear responsibility is to disseminate the knowledge we have about infants' competencies, in countries where infant mental health does not exist as a field/profession. For instance, at the end of this month, Palvi, Kai von Klitzing, Astrid Berg and I, will present a symposium at the Asian Association of Child and Adolescent Psychiatry Conference in New Delhi under the title, «Early Identification of Psychopathology». We know that in India there are very few child psychiatrists and mental health professionals and that children's needs are great. We also know that infant mental health is not yet a priority in India's health system policies. In our last Executive Committee skype meeting, we decided to consider this our responsibility, to go there in person, (partly at our own expenses, partly with WAIMH financial support), to meet and talk with local professionals about what could be done to support the awareness and integration of infant mental health into local and national health policies.

The Edinburgh conference title - Our Responsibilities and Babies' Contributions - is also in line with a major issue we have been busy with, the writing of a

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WAIMH Declaration for Infant's Rights. As I announced in my previous Presidential address, we are about to send you a survey about the draft we have finalized over the last months.

A few lines of introduction to this draft:

The creation of WAIMH was, in itself, a declaration of the infant's rights for mental health, as reflected in its 5 purposes described in the bylaws:

«The ASSOCIATION has been organized to operate exclusively for scientific, charitable and educational purposes as follows:

1. To operate exclusively for charitable, scientific and educational purposes, and more specifically to research and study throughout the world, the mental development and mental disorder in children from conception through three years of age;
2. To facilitate international cooperation among individuals concerned with promoting conditions that will bring about the optimal development of infants and infant-caregiver relationships;
3. To encourage the realization that infancy is a sensitive period in the psychosocial development of individuals;
4. To promote education, research, and study of the effects of mental development during infancy on later normal and psychopathological development; and to promote research and study of the mental health of the parents, families and other caregivers of infants;
5. To promote the development of scientifically based programs of care, intervention, and prevention of mental impairment in infancy."

The infant (from birth to age of 3 years) by reason of his physical and mental immaturity and absolute dependence needs special safeguards and care, including appropriate legal protection, before as well as after birth.

As professionals who work with infants and parents within different cultures and societies, we feel there is a need for specifying the infant's rights, beyond what has been already included in the Declaration of Children's Rights». As detailed in the Declaration of Children's Rights, the first three principles deal with non-discrimination, protection by law and the right to an identity. Principle 4 states an entitlement to growth and development in health, with adequate pre-natal care, nutrition and medical services. Principle 5 states provisions for children with special needs. Principal 6 asserts the child's needs for love and understanding from parents and caregivers as well as the obligations of society to provide

support «in an atmosphere of affection and moral and material security». Principle 7 asserts the right to education, play and recreation. Principles 8 and 9 deal with priorities for the child for obtaining protection in the midst of adversity, neglect, cruelty and exploitation. Principle 10 asserts the right of the child to be brought in an atmosphere of tolerance as opposed to exposure to racial or religious discrimination.

This Declaration of the Rights of the Infant is drafted in order to bring to public awareness world-wide the foundational importance of the first three years of life as a period of unique sensitivity to environmental influences that may have enduring effects on later development.

The young child's capacity to experience, regulate, and express emotions, form close and secure relationships, and explore the environment and learn are fundamental to mental as well as physical and developmental health throughout the life span.

You will soon receive this draft to reflect on and send any comment/suggestion you may have to the WAIMH Central Office. We invite your feedback before we finalize the proposal and present it at our next conference in Edinburgh (15-18 June, 2014).

A second task in which we are very much involved is the revision of the DC 0-3R, as a joint effort of the WAIMH and ZERO TO THREE organizations. Again, you will receive in the near future a survey about how much you use the DC 0-3R in your current practice, clinical as well as research. The revision will use the results of the survey, as well as updated literature reviews about each diagnosis. The whole process is supposed to take three years, starting from May 2013, and is sponsored by the ZERO TO THREE organization. A special slot time in the Edinburgh conference program will be dedicated to this topic, so we'll have a chance to give your feedback also in live!

Last but not least, another responsibility of ours is to make our organization fit into our globalized world. Our coming Board and Honorary Presidents electronic meeting is dedicated to the development of WAIMH Social Media, with the help of a Finnish company, named Dicole.

For those who do not know yet, our two well-known WAIMH members, Astrid Berg from South Africa and Campbell Paul from Australia, have been elected as Board members. Campbell will therefore continue to fill the treasurer position. By the way, the voting rate was high, and the five candidates were quite close in their odds!

See you «soon» in Edinburgh, 15-18 June 2014….!

Very warmly to all of you,

Miri Keren

Draft proposal for the Infant Rights Declaration

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

Introduction

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Basic Principles of Infant Rights

1. To become a full member of his/her family, and be registered as a citizen straight after birth.

2. To be given the same value to life, regardless of gender or any individual character.

3. To be given nurturing caregiving, including safety, adequate nutrition, and a loving relationship.

4. To have his/her most important attachment relationships and their continuity valued and protected.

Public social and health policy areas that should be informed by these principles:

The provision of preventive physical and mental health hygiene, starting from pregnancy, through medically well-informed prenatal care, emotional support for parents, and early detection of physical and emotional threats to well-being. The provision of access to evaluation and treatment by trained professionals who are culturally sensitive and knowledgeable about early development and emotional health.

The provision of adequate time for parents to get to know their infants and become skilled in providing for their infant's care and comfort, through adequate social policies such as parental leave.

As needed, the provision of access to early educational programs that promote cognitive and socio-emotional development

As needed, the provision of access to effective mental health treatment that alleviates infant's suffering.

References

The Declaration of the Rights of the Child, adopted by the General Assembly of the United Nations, 1959; taken verbatim from the internet Office of the High Commissioner for Human Rights in Geneva – 6pp.

Early Child Development: A Powerful Equalizer. Final Report for the WHO's commissission on the Social Determinants of Health, composed by Lori G.Irwin, Arjumand Siddiqi, & Dr Clyde Hertzman, June 2007.

Early Childhood Matters, Bernard van Leer Foundation, 2009

The UN Committee on the Rights of the Child. www2.ohchr.org/English/bodies/crc/index.htm

Council of Europe: Commissioner for Human Rights www.coe.int/t/commissioner

NGO Group for the Convention on the Rights of the Child www.childrightsnet.org

Young children's rights and public policy: Practices and possibilities for citizenship in the early years. Glenda MacNaugthon, Patrick Hugues, Kylie Smith, Children & Society, vol. 21(6), 2007

All current WAIMH members (2013) will receive a link to an online website, where they can comment the draft proposal for the Infants Rights Declaration and make their own suggestions.

Timeline:

Survey e-mailed October 15,

deadline November 30.

The Ububele Baby Mat Project: A Brief and Cost-Effective Community-Based Parent-Infant Intervention

By

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Abstract

This paper articulates our ongoing thinking about the Ububele Baby Mat Project – a community parent-infant mental health intervention currently offered at four primary health care clinics in and around Johannesburg, South Africa. We present the project as it exists currently and discuss three themes of mothering pertinent to our context. Other in situ factors, such as our therapeutic stance and two person treating team are introduced and briefly discussed. Our use of concepts such as holding, containment and the infant as subject are described in reference to a case vignette that illustrates the themes of mothering and the form of our Baby Mat intervention.

Introduction

The Baby Mat Project is a brief (mostly once off) community-based parent-infant intervention offered by Ububele, a non-profit mental health training institute in Johannesburg, South Africa. It forms part of a larger project called the Ububele Umdlezane Parent-Infant Programme (UUPIP). Umdlezane is an Nguni term that refers to the time, post-partum, when a mother's relationship with her baby is prioritized by other women in the family. These women manage the practical concerns in the home so that the mother can be most available to her newborn child.

The history, conceptualisation and initiation of the Baby Mat is outlined in Frost (2012). .It is a project that was developed in response to the need for brief and cost-effective interventions in South Africa. Central to the successful implementation of the Baby Mat intervention were many socio-cultural contextual factors specific to South African community settings. These factors were important in gaining access to mother-infant dyads in the communities in which the project functions. For a discussion of these factors, see Berg (2003, 2007).

This paper continues to explore the development of the Baby Mat intervention. The authors begin by describing the Baby Mat Project and communities in which the project functions. They then build look carefully at how Daniel Stern's (1998) motherhood constellation is applicable in our context (Berg, 2007). Following this, they articulate what the Baby Mat Project offers directly to infants and their mothers. Finally, the authors present a case vignette to illustrate the intervention in action. This paper serves to outline the authors' current thinking about the Baby Mat Project – 'thinking in process'.

Description of the Baby Mat

The Baby Mat intervention is facilitated by two practitioners, a psychologist (or intern psychologist) and a co-facilitator from the community. A Baby Mat session begins with an interactive announcement to parents in vernacular. This is an explanation and description about the brief intervention being offered. The introduction outlines the value and importance of an infant's early experiences, the significance of mother-infant bonding and the ways in which infants communicate. Difficulties in managing these aspects of parenting, given the ordinary demands of life, are also mentioned. The introductory talk includes an invitation to parents to approach the practitioners and voice any concerns that they may have about their infant or about parenting.

The mat (2 fairly large blankets) is set up on the floor in the primary health care clinics in full view of the parents, infants (awaiting their regular weigh-ins, immunisations and innoculations) and nurses at the busy clinics. Caregiver-infant dyads will either approach the mat or be sourced by the co-facilitator through further discussion. Since its beginnings in July 2007, over 1,900 caregiver-infant dyads have accessed the Baby Mat, with between two and six caregiver-infant dyads using the service in each 90-minute session. During the 2012/2013 financial year alone, 390 dyads made use of the Baby Mat.

Community Context

The Baby Mat Project, as a primary health adjunct service, is currently available at three primary health care clinics in Alexandra, and one primary health clinic in Mohlakeng township, Johannesburg. Many of the social difficulties that typified South African Townships prior to 1994, and now in a democratic South Africa, continue without significant change. Alexandra and Mohlakeng remain characterised by poverty, overcrowding, crime and a growing migrant population (Alexandra

Clinic Annual Report, 2009; Alexandra Renewal Project, 2006). Alexandra has recently been a flashpoint for the emergence of widespread xenophobic violence and service delivery protests. The majority of the dwellings are informal "shacks" and Alexandra is reportedly one of the continent's most densely populated human settlements. There are an estimated 328,579 people living in about 20,000 shacks in an area of 7,6km2 (Alexandra Renewal Project, 2006). The population density is 43,234 people/km2. Alexandra is 54 times more densely populated than Sandton, an affluent adjacent area. Mohlakeng is a township situated 38 kilometres west of Johannesburg. In 2012 the total monthly income per household was R3200 (USD330) or less for over 60% of the households in the area (Randfontein Municipality Annual Report, 2012). As in Alexandra, child headed households, poverty, violent crime, substance use, unemployment, reliance on government grants and municipality created jobs are aspects of life in the area.

The Motherhood Constellation in Context

The baby mat was envisioned as an intervention that relates directly to the needs of mothers and infants being mothered. It is important to note that our reference to mothers and to mothering is intended to refer to the role, rather than the gender, of the parent or caregiver. The Baby Mat Project originated out of the training in parent-infant psychotherapy offered by Tessa Barradon of the Anna Freud Centre and several of the iterations of such therapy into diverse contexts (James,2010), as well as the pioneering parent-infant work of Astrid Berg (2007) and colleagues in Cape Town. The interplay of these psychologies (of mother and infant) has been represented in the parent-infant literature through reference to 'the relationship between infant and caregiver'. Like parent-infant work, the baby mat was designed to support, nurture and encourage this relationship (Baradon, 2002). Our work on the mat and thoughts about our intervention have lead us towards searching for ways of understanding and representing the nature of the parent-infant relationship within our context. We have found Daniel Stern's (1998) motherhood constellation to provide us with a framework in this regard. Our use of Stern's (1998) ideas in understanding our work on the mat is expanded below.

Of central importance to us was Stern's (1998) idea that the motherhood constellation "becomes the dominant organizing axis for the mother's psychic life" (p.171). This captures a fundamental aspect of the dyads that access the Baby Mat: they are mothers primarily concerned with mothering, or their inability to mother in some way. Simultaneously we remain focused on the experience of the infant as a subject in his or her own right (Salo, 2001). In addition, we are cognisant of the recent research and practice that demonstrates that change in Parent-infant work occurs as a result of direct work with and through the infant (Barrows, 2003).

We have found Stern's (1998) notion of the motherhood trilogy, mother's mother-mother-baby, to be relevant to our context. Stern uses the motherhood trilogy to represent the mother's task in settling into her role as mother (for example, mother to a boy, mother for a second time, single mother), in relation to her own (often ongoing) experiences of being mothered by her mother and in relation to her (real and fantasised) infant. In the dyads that present to us on the mat, mother's mother may be deceased, absent, abusive, far away or a significant caregiver to the infant. Mother's grandmother, father's mother or father's grandmother at times hold the role of mother's mother. We have found these idiosyncracies to have significant meaning to the dyad and with the significance of the motherhood trilogy in mind, we almost routinely enquire about mother's mother on the mat.

Stern (1998) delineates the motherhood constellation in four themes. We have found three of his themes to relate to our work on the mat: life-growth theme, primary relatedness theme and the supporting matrix theme. After introducing these three themes and describing the forms in which they often occur in our context, we present a vignette to illustrate.

Life-Growth Theme

The life-growth theme relates to the mother's ability to, and fears of not being able to, keep her baby alive, developing and thriving. The presence of this theme on the mat is very often evident. A common presentation relates to dyads in which the mother is HIV-positive and the infant is HIV-negative (though usually only tested at 6 weeks). In many of these presentations, the mother, despite the relief of finding out that her infant is HIV negative, remains anxious in a generalised sort of way about a number of aspects of her infant's physical wellbeing and development. With mother's mind filled with this anxiety, we often imagine that the infants in these dyads are overflowing with their own anxieties. These infants tend to present with very concrete difficulties – difficulties with sleeping, feeding, eating or their emotional regulation. Other presentations of this theme take the form of culturally-based beliefs such as ibhala – a red birthmark behind the baby's neck that, if it moves to the fontanel, is believed to cause a baby's death.

Primary Relatedness Theme

Stern's (1998) primary relatedness theme refers to the mother's ability or inability to know, understand and relate to her infant. This theme is often presented indirectly by the dyads we have seen on the mat and identified by us through observing the interactions of mother and infant We pay attention to the manner in which the infant is presented to the Baby Mat practitioners by his mother, as well as whether baby is introduced to us and how this is done. We often observe mothers who struggle to think about their infant, who struggle to comfort him or to think about him as a subject in his own right. Occasionally concerns relating to this theme are presented directly, when a mother states that she is concerned about her ability to bond with her baby or when a mother states that she takes out her anger towards the infant's father on the infant directly.

Supporting Matrix Theme

Stern's (1998) supporting matrix theme relates to the mother's need for a supportive structure in which she feels safe and secure enough to do her mothering. In addition to presentations relating to the motherhood trilogy, as discussed above, our dyads often present with themes related to the infant's father. Conflict in the parental relationship, conflict between mother and the father's family and absent fathers (through work or otherwise) are examples these presentations. Difficulties related to this theme are described by the mother or elicited through the exploration of the infant's presented difficulties or interactions with the practitioners on the mat..

A Baby Mat Session: Anele and Kagiso

The following vignette is an example of a baby mat session in which Anele appears to represent difficulties that she and Kagiso are experiencing in the symbolism of the life-growth theme. Difficulties with the primary relatedness and supporting matrix themes are also evident but elicited

through Anele and Kagiso's interaction with the mat practitioners and with each other. The names of the mother and infant have been altered in order to protect their identities. The session is presented from the perspective of the therapist, Nicola Dawson. We would like to thank her for allowing us to use her case as our vignette.

Anele, a well- dressed woman sat on the mat and placed her 9 month old baby, Kagiso, to face me and my baby mat co-facilitator, Brenda. The mom began immediately to explain to Brenda in vernacular, "My son does not sleep at night or during the day. I am exhausted!" Brenda then introduced herself and I introduced myself. Anele gave us her name, but she did not offer her baby's name. I then asked her for her baby's name and she said that his name was Kagiso. I greeted him by name and he held my gaze though did not smile. Brenda took out the string of toys and handed it to Kagiso. He immediately took it and played happily with it. Brenda acknowledged to Anele that she looked very tired and then translated the presenting problem to me. I touched Kagiso's leg and asked him why he wasn't sleeping and letting his mom sleep. I noticed he put one hand on his mom's leg and looked at me when I spoke. Mom responded by saying, "He needs to sleep so that I can sleep". I commented on how Kagiso touched her as if to comfort himself in meeting somebody new.

Brenda asked Anele if we could ask her a few personal questions about herself and Kagiso. Mom agreed and Brenda asked if her pregnancy with Kagiso had been planned. Anele answered flatly, "He was a surprise." While they talked about the pregnancy I asked Kagiso if we could play a game. I had wondered about separation and decided to play peek-a-boo with him. At the time, he was playing with a string toy. I held my scarf up over my face to play peek a boo. He watched closely, but didn't laugh. Brenda then joined us and took a white elephant and tried to interact with Kagiso. He lunged towards me and continued to play with me. Brenda commented to Kagiso, "You like him." She noted that "even with other toys you won'tt play with me."

I asked Anele why she thinks Kagiso doesn't sleep well. She replied, "I really didn't know." I suggested that perhaps we could think about it together. I asked Anele if Kagiso's father was still around. She said, "He is not always around as he often works in Limpopo". Brenda then asked, " What does dad think about the baby not sleeping?" Anele responded, " He was the one who suggested that I speak to someone at the clinic." I then asked about her parents and she explained, "My dad died in February this year and my mom died in December last year." We expressed our condolences to her for losing them both so recently and so close together. We all sat in silence for a time. Brenda then asked where her family had lived and Anele answered, They were from Zimbabwe. I went home to bury them both; Kagiso's father joined me." We affirmed that this was very important for her. She reitereated the importance of Kagiso's father's support.

Anele discussed the death of her parents with Brenda and she began to cry quietly; Brenda handed her some tissues. While they were talking, I turned my attention to Kagiso who kept playing with the string toy seemingly unphased (I was surprised by this). I said to him, " This was all a hard business." Anele shook her head and agreed that it had been very hard. We offered our sympathy. When Brenda asked Anele about the rest of the family, she explained that she only has one sibling (a brother) who lives in Cape Town. "My mom was an only child and so I have no aunts."

I pointed out that Kagiso (who was still sitting playing with the strong toy) was 2 months when Anele's mother died. I asked how Kagiso had coped when Anele had found out about her mother's death. I rubbed Kagiso's back, looked at his face and said to him,

xxx. Photo by xxxx.

"You were very little when your granny had died. You are still little now, but you were very little then… it must have been hard to have your mom be so sad". Anele explained that Kagiso had never met her mother and was too young to remember her. I tried to explain that I had wondered more if he had noticed her sadness. This seemed to resonate with her.

I asked Anele if Kagiso had struggled to sleep around the time Anele's mom died. When Anele explained that Kagiso had difficulty sleeping from 3 months, I commented, "That was very close to the time of your mom's death and all the funeral travel." At this point, Kagiso pulled himself up, using his mother's body and planted what looked like an open mouth kiss on Anele's cheek. She moved him away, wiped the spit off her cheek and said to Brenda in vernacular, " He was biting me!" Brenda translated this to me and I asked Kagiso, "Are you biting mommy or kissing mommy? Sometimes when we're so little it's hard to make our kisses come out just right". Anele laughed and when Kagiso lost his balance, he began to cry. His posture was very awkward and mom did not respond. I decided to draw her attention to this. I asked her what she thought had upset him. She explained that he was hungry, and flipped him onto his side, and took out her breast. Kagiso latched and began feeding. He immediately calmed down. He then went on and off the breast, looking around for a moment or so and then returning to feed. At one point, while off the breast, Anele zipped up her top and Kagiso became very upset and started kicking me. Brenda pointed to him. Mom took out her breast again and Kagiso latched and immediately settled again. I turned to Kagiso and said, "It is hard to get you mom's attention when her mind is far from you." Brenda agreed and touched Kagiso's chubby leg and asked Anele if this was "all milk". Mom explained that she also fed him solids. Brenda spoke in "motherese" to Kagiso about all the "milk deposits" on his body, while gently tugging his skin. Brenda said that even though things were difficult that Kagiso was growing well.

The loss of Anele's parents within months of each other shortly after Kagiso's birth appears to have impacted the dyad in numerous ways, but it seemed as though Anele was not able to acknowledge the impact of the loss on her baby's experience. We also noted that Kagiso was not introduced to either of the baby mat practitioners and wondered why not. The sections to follow discuss how we have begun to think about our intervention on the mat. Where relevant, we will refer back to the intervention with Anele and Kagiso as presented.

The Therapeutic Alliance and Therapeutic Stance

In addition to that presented above, we have found Stern's (1998) discussion of the therapeutic alliance to have similarities with our experiences. He describes an alliance based upon the therapist's acceptance of the "good grandmother transference" (p. 186). The therapist within this alliance is more concretely maternal and takes on a more actively nurturing role. Although the 'therapist' on the baby mat is two people, our interventions are often more concretely maternal than in a more formal psychotherapy. We view the specific provision of knowledge as an appropriate part of our relationship to the dyad and an indication of our attunement. Examples of this include brief discussions about a feeding and sleeping routine, the task of mother and infant learning to know one another, the importance of play and the infant as a person who is able to perceive and feel. As Stern (1998) also describes, we work to draw attention to, highlight and encourage the positive aspects of the relationship between mother and infant that we observe during our intervention. Brenda's affirmation of Anele's breastfeeding and Kagiso's healthy appearance provide examples of this in the vignette. We view this therapeutic stance as an integral part of how we meet the needs of our dyads sensitively and responsively. We also understand it in relation to us working in primary health care clinics and to our positioning within the clinic – amidst the community with whom we are working.

The therapeutic dyad or couple is a key aspect of our intervention. As with our therapeutic stance, the use of a therapeutic dyad rather than a single therapist relates to the needs of our communities. In a society where differences (in race, culture and language) were, and continue to be, divisive it can be difficult for the individual to access something that is new, different or unusual. With the above in mind and the differences between our therapists and co-therapists clearly evident, we have been thinking about the symbolism of the therapeutic couple. Our co-therapists are mostly middle aged, black women (we have recently had a black male in his twenties) while our therapists are white and black, mid-twenties to middle aged, men and women. As our baby mat practitioners work together closely (as a team), we wonder about this representing an overcoming of difference; a coming together across dividers to help with mothering and with the infant and the mother becoming. This is something to consider, as our therapeutic couples, whatever the combination of demographics[1], have been equally successful in attracting dyads to the mat. With a male as therapist/co-therapist we have begun to consider the symbolism in a 'couple' working together in order to meet mother and infant. We believe that this symbolism is also present in all-female therapeutic dyads. Thus in the therapeutic dyad, there is perhaps something symbolically beyond the grandmaternal. These thoughts are leading us towards further considering the meaning present in the role of the father, as it is presented to us by the dyad. It has also resulted in us considering whether there is a paternal element or function in the intervention that we provide.

Holding, containing/ wondering and infant subjectivity

We understand our intervention with our dyads to support the presenting concerns (whether spoken/acted or unspoken/ unacted) specific to our context. We have discussed these concerns in terms of the motherhood constellation. This section attempts to articulate how we work with and begin to address the anxieties,

1 We have not had two men sit on the mat

fantasies and processes underlying the motherhood constellation themes. Our direct intervention takes three forms: a provisional form of holding, a provisional form of containment and engaging with the infant as subject. These ideas are briefly explained below.

Holding

We have made use of Winnicott's (1960) idea of maternal holding in describing our intervention on the baby mat. He uses the concept in his description of the infant's gradual individuation in relation to his mother. As a result, it is a concept that describes a mother's care for her infant at different stages of the infant's development and over an extended period of time. Through the mother holding her infant both physically and mentally, she is able to soothe his anxieties. Central to Winnicott's (1960) holding is the idea of consistency over time in relation to mothering, a psychoanalysis or psychotherapy (as something occurring over an extended period). We believe that our dyads are held by the therapeutic dyad on the baby mat, but as our intervention may be once off and is very short in terms of time, we have decided to refer to this phenomenon as provisional holding to denote that it is a taste rather than a full experience of being held. We will say for now that the therapeutic dyad holds what is presented as difficult, what is not said or implicitly presented, and through this some of the pieces of the mother and the infant's experience. It is the themes of the motherhood constellation (stated and unstated) that are partially held by the therapeutic dyad in our therapeutic stance on the mat. We also understand our more concretely maternal interventions to relate directly to our partial holding of the presenting dyad. Although direct interactions with our dyads are short, there may be something significant in the baby mat's symbolism and consistent presence at clinic (there is a place to think about mothering and being mothered).

Containing

We have similarly made use of Wilfred Bion's (1962) model of containment in articulating our intervention. His model relates to a mother's capacity for soothing her infant's fears by using her own mind to process his experiences. In this way, a mother is able to articulate and respond to what had been inarticulate, unvoiced and unknown. As Bion (1962) also presents this model as a process occurring over an extended period of time, we have decided to refer to this phenomenon as provisional containment to denote that it is a taste rather than a full experience of being held. On the baby mat, the therapeutic dyad's containment of the presenting dyad occurs through wondering ('mhlawumbe) and tentatively exploring possible symbolic meanings. It is ideas relating to the motherhood constellation themes that are contained. We have found that seeing and naming the infant's fear or pain is difficult, and that it is often easier to see, name and affirm the infant's enjoyment. We have found that tentatively stating a symbolic meaning to a dyad to elicit startling changes in non-verbal markers. We understand this form of the intervention to provide the possibility of new meanings.

Infant Subjectivity

By engaging directly with the infant – talking to and through the baby (Slade 2007; Salo, 2001) – and attributing possible states of mind, the Baby Mat practitioners begin to promote the baby's coherent sense of self as well as model a way of being with the infant to the parent. We understand this intervention to act as a form of provisional holding, wherein the infant's subjectivity is held by the therapeutic dyad. As in the vignette, this holding can at times be very physical in its form. We view this as an aspect of our therapeutic stance on the mat and as a way of meeting the infant in his world; his experiences of and need for physically-based caring (Winnicott,). We are often left wondering whether we are at times also holding the infant's subjectivity for his mother, who may desire to relate to him more wholistically but struggle to do so as a result of the many possible factors discussed. Our engagement with the infant may also be viewed as a form of provisional containment, wherein we are wondering and symbolizing possible aspects of his emotional world. We are dreaming aloud and together with his mother about the infant as a subject. We also wonder whether this at times meets an unspoken process within the mother which she very often is struggling to sustain.

Tensions Held in intervening

This section describes something of the process of intervention. The time frame, number of people on the mat, explicit and implicit nature of the presenting difficulties and multiple forms of intervention mean that there are complex decisions to be made in intervening. We have found it helpful to think about these decisions as tensions held by the therapeutic dyad. The first is a tension between an intervention that relates more to partially holding or one that relates more to partially containing. We recognise that these forms of intervention are not mutually exclusive, in line with Ogden (2004) who describes holding and containment as "two vantage points from which to view an emotional experience" (p. 1349), yet within our time frame, a relative focus can result in an intervention that is very different in form. A second tension (always present and perhaps evident in our presentation of this paper) lies between it feeling like there is not enough time to the point of there being no time and therefore no work done, and the idea that the experience we provide is on some level enough. This is also felt as a tension between relying on our referral to interventions of longer duration and working in the time available to us on the mat. This tension interacts with the first in ways that can feel quite confusing to the therapeutic dyad. A third tension is implicit in our intervention with the infant as subject. It lies between giving enough time to the mother and enough time to the infant. This tension feels ever-present in our thinking about the mat, cases seen on the mat and in supervision. It is aided by there being two treating minds on the mat – two people in the therapeutic dyad.

Conclusion

After 6 years of Baby Mat Service and steadily increasing numbers of mothers with their infants using and then revisiting the mat, we are assured of the value of such a service. The introduction of the mat in another township clinic is a first step toward replication. There remain challenges, namely working toward more rigorous evaluation of the intervention and replication in other contexts. There is a need for a continued thinking, questioning and remaining open to the mothers and infants who sit with us and those who share their stories.

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From the Editors

By Deborah Weatherston, Hiram E. Fitzgerald, Editors, Michigan, USA and Maree Foley, New Zealand

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The editors of Perspectives in Infant Mental Health are delighted to announce the birth of The World in WAIMH, an occasional column intended to generate reflection and dialogue on the roles of context, culture, and community in infant mental health around the world. Our shared hope is that this will offer a space for questioning, challenge, dialogue and interdisciplinary discussion.

The Editors are calling for

- commentary,
- field reports,
- case studies,
- concept or theory building papers,
- research articles,
- book reviews,
- literature reviews,
- and (when proper permission can be obtained) adaptations of previously published articles

(Articles of any length up to 20 pages (250 words per page/12 point font) will be considered for publication. See below for additional guidelines. Please email submissions to Deborah Weatherston at dweatherston@mi-aimh.org)

We welcome articles about individual, family, community and population level practice, policy, research and theory that address questions such as those that follow and that pose other pressing ones.

In our globalized world, every infant and family is affected by forces far beyond their reach, forces that may strengthen, hinder, or undo the work of infant mental health professionals. To be a truly global organization, WAIMH will increasingly need to understand and develop strategies to address these forces. To foster healthy early development around the world, WAIMH will need to extend its reach, and to learn from contexts, cultures and communities that are not or only minimally represented in its current membership. Among the many questions to answer are:

- What processes can contribute to a more inclusive and expansive knowledge base?
- What kinds of partnerships – with members of cultures not yet represented within WAIMH, with other organizations, with other disciplines such as cultural anthropology or community psychology – are needed to truly put the world in WAIMH?

Roughly 97% of academic research on developmental psychology has focused on less than 1% of the world's population and many of its findings have mistakenly been assumed to be universally applicable, leading us to ask:

- What do we know, and how can we learn, about infant mental health around the world?
- How do local contexts, cultures and communities understand, affect and optimize infants' development? What are the implications of contextual specificities – for example, how 'family' is defined - for infant mental health

intervention design?

For decades now, the field of infant mental health has conceptualized human development as transacted within dynamic systems made up not only of the infant's family, but also of the broader social, economic, political and physical spheres in which they are situated. Bronfenbrenner's ecological model and Sameroff's transactional model are often invoked, but their implications for infant mental health practices still hold much untapped potential, leaving many questions for us to explore:

- What do infant mental health professionals need to know about the institutions and environments and other constituents of the systems in which infants and families develop?
- What interactions can or should infant mental health professionals – and their professional organizations- engage in with the members of the dynamic systems beyond the family in which infants develop?
- Would such interactions dilute the work or overwhelm mental health professionals? Can their goals be achieved for all infants any other way?

In the United States, a shocking 20% of children are currently living in poverty. Despite expanded healthcare coverage, most of those who need infant mental health services do not have access to them. Yet in many developing countries, efforts to improve infants' survival rates still often take precedence over efforts to ensure their healthy development, inviting us to think more deeply:

- What is the role for infant mental health services in contexts like these?
- What would it take for infant survival and development to be integrated, and what would this look like in different contexts, cultures and communities?
- How can infant mental health services be scaled proportionally to the needs?
- What role can mental health prevention and promotion play in these settings?
- What role should infant mental health and WAIMH play in scaling prevention and promotion strategies?

Joshua Sparrow, Director of Planning, Strategy and Program Development at the Brazelton Touchpoints Center (Boston Children's Hospital/Harvard Medical School), conceived of this column and has enthusiastically agreed to coordinate it. The Editors are calling for concept papers, research articles, adaptations of articles, and literature reviews that address questions such as these and that pose other pressing ones. We look forward to your reflections and hope that vigorous dialogue in this reflective space will ensue.

The following are general guidelines for Perspectives:

- APA, sixth edition, for style
- 12 point font
- Double spaced
- 250 words per page
- Articles of varying length are welcome, however, length should not exceed 20 pages Word-format
- Send pictures and tables in separate files, with a resolution of at least 72 pixels/inch
- Manuscripts are accepted throughout the year.
- Articles much shorter than 20 pages are also welcome for submission.

The World in WAIMH: A Reflective Space on Context, Culture and Community

By Joshua Sparrow, USA

The first article to be published in The World in WAIMH was selected to complement the publication in this issue of WAIMH's Declaration of Infant Rights. As with the United Nations Declaration of the Rights of the Child, Infant Rights raise at least three dynamic tensions to be considered:

- First is the tension between child survival and child development first;
- Second is the balance between the promulgation of universal rights, and the right to self-determination of individual communities, cultures and families;
- Third is the balance between the rights of infants and children, and the rights of parents and other adult caregivers. The latter is complicated by the fact that although the wellbeing of infants and children clearly depends on that of their family, international bodies, national governments, and nongovernmental organizations often find it easier to garner support for infant and children needs when these are divorced from those of their parents.

Could it be that at the global level, policymakers experience tensions similar to the ones that we face as we endeavor to simultaneously keep both infant and parent in mind, and to shift our focus from each individual to the relationships through which they exist with and for each other?

This article is excerpted from a chapter entitled, "Child Justice, Caregiver Empowerment, and Community Self-Determination" in B. S. Fennimore, A. L. Goodwin (eds.), Promoting Social Justice for Young Children, Educating the Young Child 3, DOI 10.1007/978-94-007-0570-8_4 , © Springer Science+Business Media B.V. 2011. Child Justice, Caregiver Empowerment, and Community Self-Determination .

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Excerpted from

Child Justice, Caregiver Empowerment, and Community Self-Determination

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B. S. Fennimore, A. L. Goodwin (eds.), Promoting Social Justice for Young Children,

Educating the Young Child 3, DOI 10.1007/978-94-007-0570-8_4,

For several decades, international bodies have sought intercultural consensus on children's rights (U.N. General Assembly, Convention on the Rights of the Child 1989), many of which correspond to biological requirements for survival and health. The biological construct has served as a basis for appeals to "universality," while child development has often been conceptually separated from survival, narrowly construed as dependent on water, food, shelter, and basic healthcare. Yet children's survival also depends on the fulfillment of basic developmental needs, for example, undisrupted attachments to primary caregivers (Ainsworth 1962; Bowlby 1988a, b ; Bronfenbrenner 2004; Winnicott 1964/1987). When children lose critical attachment figures in the first years of life, they may stop eating and die from starvation and the associated stress can also suppress their immune systems, leading to life threatening infections (Spitz 1945; Soulé et al. 1995).

The continuity of children's early attachments depends on the health and wellbeing of their caregivers. In order to survive, grow, and thrive, children need caregivers whose own survival, development, and ability to nurture their young are not endangered. Development-promoting early interactions must be nested within strong communities where broader social relationships protect and reinforce these primary ones. Yet the inseparability of children's rights from those of their caregivers sometimes goes unrecognized, as does the critical role of the community context for child survival and development.

Despite the powerful effects of resilience, poverty can weaken communities, jeopardize caregiver functioning and survival, and impede child development. Anti-poverty programs can support caregiver functioning if initiated, designed, and implemented with full and continuous input from the families and communities that they are intended to serve. Otherwise, despite the best of intentions, they risk disempowering caregivers. Caregivers' active participation in development-promoting relationships with their children, in the fulfillment of their children's rights, depends in part on ongoing experiences of being able to positively influence their children's lives.

Children's survival, like their development, depends on relationships with parents and other caregivers. Caregivers engage most effectively in these development-promoting relationships when they feel competent about their caregiving abilities, connected to a community that supports them in this function, to a culture that provides guidance in childrearing practices, and to a future for themselves and their children that they feel empowered to influence (Guterman 2001). Future opportunities to uphold and widely disseminate justice for children will arise through the design and implementation of services and supports for children, families, and communities that are comprehensive enough to ensure survival and health yet are also developmental, relational, strengths-based, and culturally transformed. The challenge is to do so via processes driven by communities themselves and by the empowering principles of self-determination.

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Diary of an Uruguayan Trip

By Antoine Guedeney, Paris, France

May 3, 2012.

After a 12-hour flight on a fully booked plane-but nowadays planes are always full-Nicole and I land in Montevideo. We are greeted by Nahir Bonifacino, psychologist and psychoanalyst, from the infant team at the Children's hospital Peirerra Rossel. This is my third time in Uruguay. It's Nicole's first visit to Uruguay and her first time in South America.

We are here because we've been invited to provide a three day course in the child psychiatric department of Pr Viola in the main public paediatric hospital Peirrera Rossel in Montevideo. This event has been organized by Dora Musetti, a child psychiatrist and psychoanalyst. The course is held under the auspices of APPIA, the Uruguayan branch of WAIMH, headed by Julia Ojeda de Prego.

Like the plane, the program is full. It includes: Four interventions each day at the hospital; interventions at the university and at the City Hall; and finally at the Uruguayan Psychoanalytic Association. The social program is also quite busy.

Nicole talks about adoption and attachment. She talks about the development of attachment, about the importance of developing a working relationship with families, and about the importance of the first session with a toddler and his or her family. I talk about: the familial and social influences on early development, on the paediatric consultation as an opportunity for screening both infants and parents' mental health, on ADBB and on early prevention.

While we talk, we listen and reflect; past and present dance. 'Twenty years after' as in the famous French novel by Alexandre Dumas, here I am, back in the great city of Montevideo. However, I am re-minded of my first visit. The ambiance in the eighties was much gloomier. The country was in economic marasmus and still in the aftermath of the dictatorship. Many people were still away, expelled by the dictators. The memory of the missing, people who died in prison or babies having been separated from their parents and sent into foster families was still very present. The city was quiet. It was sad, it was gray. My talk at the UPA was received coldly as it did not abide with the rules of psychoanalytic thinking.

Amidst this rather gloomy ambience, there was light. I had had the honour to be received by the founding member of the Uruguayan child psychiatry, the famous Professor Prego. It was a brief visit, at his home, as Prego was already retired and quite aged. He was an impressive man, quite warm in fact and we had an interesting exchange. He looked a bit like Gabriel Marquez, the author of "A Hundred Years of Solitude", a major book in South American literature. I had met with his Prego's son, also a child psychiatrist and with several psychoanalysts and researchers such as Ricardo Bernardi and Marina Altman de Litvan, a WAIMH member. They were a very active group, working on lullabies and on early mother infant relationships.

People were working incredibly hard, from 8 am to 10 pm. They worked between hospital practice where they received almost no salary; and they worked in private psychoanalytical practice. But students were numerous at the courses and several came to France to follow courses at the Institut de Psychosomatique, where I was working at the time. Child psychiatry was organized around and by Miguel Cherro, who teamed closely with Salvador Celia from Brazil and with Miguel Hoffmann from Argentina.

I am now brought back to the present; back to Uruguay nowadays. My impression of the ambiance is quite different now. The city is awake and lively, with 1.5 million people in the Montevideo area. It is considered one of the safest cities in South America and one with the highest quality of life, which may not be true for all, as the average income is 8400 UDS. Uruguay is also the only country in South America to have a temperate climate. Business seems to be active, with a growing alimentation industry. Uruguay is a little country with 3.5 million inhabitants. It sits between the two giants: Brazil on the north and Argentina on the south. There are still descendants from the Indians Guaranis and Charuas; and also a black minority mostly from Brazil, but most of the people are from European descent. The level of education is the highest in South America, and it also has the highest level of literacy.

Uruguay had a golden age around 1900 till 1920, and was called the Swiss of South America before being hit by the 1929 crisis. However, poverty is still high, around 40 % but this has decreased by 50% within the last 5 years. Growth rate is 6% and unemployment is 10%, but the birth rate is low, except with the poorest. Uruguay came out of a financial crisis in 2005. After a long period of military dictatorship and death squadrons, from 1971 to 1980, Uruguay came back to democracy. It recently elected a large left front, in 2009 with a president, José Mujica. This new government are former urban guerilla, the TUPAMAROS. They do not come from the traditional Colorado or Blanco party. The president is a medical doctor, who spent 13 years in jail and most of it in isolation. The ministry of culture is a high level neuroscientist, who was tortured then exiled in France. Their discourse is rather unusual for politicians in that they speak openly and freely.

Amidst this new ambiance, Nicole and I had a day teaching at the city hall. This was a rather impressive building, with a rather Stalinian-like architecture. We were in the main auditorium. It was very beautiful. Attendance was large and the conferences were open to the public. I gave a talk on early development. Nicole talked about the role of front-line workers in infant mental health and about the need for them to be trained in attachment issues and in making working alliance.

A professor of paediatrics; a colleague and a politician who is responsible for the nation early prevention politics gave the first opening talk. The inter-play between what he talked about with what I and Nicole talk about takes me by surprise. The talk he made was very close to mine and Nicole's.

I have never listened to such a talk from a high ranking health manager and politician. He spoke with such knowledge

of the importance of early development. He highlighted the importance of cognitive and emotional development in infants with the centrality of parent infant interaction, as the foundation for a solid and good enough mental development. The idea was clear: Infants are our future. Our investment in their development is an investment in the development of the country, particularly since the birth rate is so low in middle class people, and high in very poor people. Prevention and early intervention is taken very seriously. The goal of reduction of poverty and of bringing early attention to physical and emotional development has been labelled as a priority by the president.

Of course things are never too simple. This talk referred to psychoanalysis, which is the main culture in mental health in Uruguay. There is still a journey to make to bridge the use of psychoanalysis with the goal to invest now, in infants and their relationships. What Nicole and I brought to this conversation, through our parent-infant focused intervention with an emphasis on attachment issues, supported the move to bring psychoanalysis into the here and now: of real life relationships (Amidst history and politics) and of taking care of the parents with infants as way to build a safe present with good enough mental health.

To further illustrate the dance between bringing infants and their families into view with the day-to-day context of people's lives, in the afternoon, Nicole got herself stuck into a Uruguayan-Uruguayan debate, in which harsh critics were launched towards 'people in Montevideo getting all the money and nothing be spared for people working in the country'.

Further showing the exciting growth in the field of infant and family mental health, in Uruguay, and South America more generally, we also had a day of presentations by Uruguayan clinicians and researchers. The Infant team presented their experience with training the paediatricians with the ADBB and assessing changes in their clinical practice after training. The team, Nahir Bonifacino, Dora and Andrea Plevak, paediatrician had received a grant from IPA, and they had received financial help from my research association APRA. The Uruguayan team had trained with Dr Monica Oliver's Argentinian team at the Alleman Hospital in Buenos Aires in 2008. Andrea Plevak and Nahir Bonifacino have developed an expertise in scoring with the ADBB and in training, and this is to be used by the Spanish Valencia faculty to train some PhD students.

Moreover, the results of a recent study were presented, with ADBB assessments made in well baby clinics (beautifully and adequately named Centro de Attencion Infantil). The study showed a high rate of withdrawal behaviour and showed the rate was double in very poor districts of town. The next study will make use of the astute system of prevention in the Centros de Attention Infantil: in these public centers, families and infants are seen freely each month for the first year of life, with attention to the physical and emotional development of the child. But if the family fails to show up for two meetings, then the team schedule a home visit. A trial of effectiveness of using video for the examination of the child's development will be done shortly.

In addition, a presentation by the head of the Institute Pasteur in Montevideo gave a very nicely illustrated and very up to date account of the risk and resiliency factors in early development. An ambitious study on oxitocin in the post partum was also presented, so research in the perinatal field is quite active.

Salvador 's Celia brilliant idea of la 'Semana do bebe' in Porto Allegre (the week of the infant) has finally taken, up here, with a Day of the Infant beginning this year. Let us be reminded that there was a very successful regional WAIMH/ IACAPAP /ISAP joint meeting in Punta del Este, in 1980. Also Miri Keren and I were invited two years ago by ASMI Argentina in Buenos Aires, to talk about organizing a South American WAIMH affiliate group, to include among others: Brazil, Argentina, Uruguay and Chile, and possibly Mexico, since most of these countries have a fairly active WAIMH affiliate society. Miri was here in Montevideo last year, after the WAIMH Capetown congress. She was sponsored by the Israeli embassy; and my trip was sponsored by the French embassy.

There is momentum here, and in the South America. The time may have come for a new surge of collaboration between these countries, on a sort of MERCOSUR for the baby, as these countries are sharing a lot of common experiences.

After a 12 hour flight, on another fully booked plane, Nicole and I land in Paris. The connections are strong. We remain mind-full of Uruguay and the tremendous efforts and work of our colleagues across South America.

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Obituary

Remembering Daniel Stern (1934–2012): A legacy for 21st century psychoanalytic thinking and practice

The editors of the Journal have invited me to highlight in this obituary the contributions of Dan Stern to psychoanalysis. As a longtime friend and colleague who worked with him in many settings, sharing interests in early development, clinical work and the wonders of art and life, I am pleased to do so. Dan wrote books that were widely read and translated into multiple languages. His easy-flowing writing, like his speaking style, almost poetic at times in his use of metaphor and intuition, as well as his gentle way of engaging his audience to join him in exploring a widening world, was wonderful. He was an integrator who took new findings and visions from science and added his own insights gleaned from observations, experiments, and clinical encounters as well as his creative imagination. As Robert Michels put it, in his moving memorial given at Rockefeller University in New York on 6 December:

> Dan built bridges, and was extraordinarily skillful at moving back and forth across them and leading others to follow him. Bridges between research and practice, between developmental psychology and dynamic psychotherapy, between infant observation and clinical reconstruction, between the interpersonal and the intrapsychic, between science and art, between explanation and understanding.

A bit of biography. Born and raised in New York, he attended Harvard University, Albert Einstein College of Medicine, received some training in internal medicine at Belleview Hospital, following which he spent two years at the National Heart Institute doing research, then completed his psychiatry residency and his psychoanalytic training at Columbia University. His academic career included faculty positions at the medical schools of Columbia, Cornell and Brown as well as at the faculty of psychology and sciences of education at the University of Geneva. During the last 25 years of his life, his primary residence was in Geneva but he commuted to New York where he also maintained a residence and adjunct appointment in psychiatry at Cornell. His international prominence was indicated by a myriad of invited lectureships in Europe and the United States, various prizes as well as five honorary degrees (Universities of Palermo and Padua in Italy, of Copenhagen and Ailborg in Denmark, and the University of Mons-Hainault in Belgium). I will add some more personal aspects of his biography as I reflect on some of his enduring psychoanalytic contributions.

Stern moved us to thinking about the dynamic aspects of experience, over time, both in the course of early development and within the therapeutic encounter. In his writings, a reader can typically link his working concepts to advancing scientific knowledge about the processes of experiencing. And this is so as we think about experiencing from the outside – where it can be

thought of as interpersonal as well as personal – and from the inside where it can be thought of as intersubjective as well as subjective. Many of his concepts are intuitively appealing to clinicians and developmental scientists and have been influential already in psychoanalytic literature and training. I reflect here on three areas of experiencing that continue to suggest new questions for theory and practice.

Experiencing the other in early development

Stern's writings about experiencing self-with-other and modes of intersubjectivity have helped to generate a transformational shift in psychoanalytic thinking, particularly with regards to early development. Before Stern's writings, the word 'intersubjectivity' was virtually absent within our psychoanalytic discourse; now it is commonplace. Now, even though psychoanalysis is being acknowledged more and more as a two-person rather than a one-person psychology, it is still difficult to think of a developing subjectivity shared between us as well as a self-with-other within us and Stern's writings have much to contribute. Not only did Stern usefully bring forward Colwyn Trevarthen's ideas of an intersubjectivity present in earliest infancy, but he also wrote about it compellingly from the mother's point of view as well as the infant's. The infant is born to be social and sharing at the beginning and, even though dynamic development follows, earlier psychoanalytic ideas of egocentrism followed by later socialization and ideas of fixed stage theories were shown to be inconsistent with emerging developmental observations and knowledge. In *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology*, Stern (1985) vividly portrayed the overlapping phases of the early development of self-with-other relating it to observations, experiments and his ideas of cognitive representations of interactions with significant others. In that book he bridges cognitive science with psychodynamic and attachment theory and, as importantly, with affective science. His formulation of 'vitality affects' and of 'affect attunement' and its significance in early parent–child interactions, later elaborated in *Forms of Vitality: Exploring Dynamic Experience in Psychology, Art, Psychotherapy and Development* (Stern, 2010), have been influential in early prevention programs as well as in elaborating psychoanalytic notions of 'emotional availability' as originally put forth by Margaret Mahler and later by our group. In *The Journal of a Baby*, Stern (1990) puts his ideas in a purely literary mode. He imagines, poetically and empathically, what the baby feels, experiences and would tell us in a diary about what is important in an ongong intersubjective world.

In *The First Relationship: Infant and Mother* (Stern, 1977), and later in *The Motherhood Constellation: A Unifying View of Parent–Infant Psychotherapies* (Stern, 1995) and in *The Birth of a Mother* (written with Nadia Bruschweiler-Stern, 1997), the experiencing of the mother is given emphasis, specifying and expanding Donald Winnicott's insights of 'primary maternal preoccupation' and updating it with additional interdisciplinary knowledge and thinking. Although Stern brings a main focus in these cited works to newer insights about normal development and adaptation, there is

discussion of 'misattunements', or what René Spitz referred to as 'derailments of dialogues' – with special attention to interventions with depressed mothers. His continuing interests in early preventive interventions for disruptions and what became known as infant psychiatry are contained in many of his published articles and chapters. When we formed a group to work on early developmental psychopathology at the Center for Advanced Study in the Behavioral Sciences at Stanford, Dan commuted intermittently from New York to join our group and contributed to the specification of 'relationship disturbances and relationship disorders', with a chapter in our edited book (Sameroff and Emde, 1989). His contributions to thinking about the significance of intersubjectivity in clinical work lead to my next reflections.

Experiencing what matters in therapy

Perhaps Stern's most influential contributions to psychoanalytic thinking – and those giving us a basis for research and practice yet-to-come – are presented to us in his writings on psychodynamic psychotherapy. In *The Present Moment in Psychotherapy and Everyday Life*, Stern (2004) points out that psychoanalytic therapy for nearly a century tended to neglect the interpersonal everyday world of the patient, and this motivates his directing our attention to the centrality of interpersonal exchanges and intersubjective moments in therapeutic action. As the book's title suggests, he focuses on small units of time that he refers to as 'present moments'. These have remarkable characteristics. They typically occur in an average of 3–4 seconds, with a range of 1–10 seconds, and are the length of phrases of speech, turns in dialogue, and music corresponding to what can be done in a breath cycle. He conceptualizes these as basic units of subjective experience in which 'schemas of being with' occur. He elaborates that present moments are complex aspects of experience that involve simultaneous parallel processing with implicit, intuitive and procedural non-conscious activity, often modeled according to 'time intensity affects' and with 'temporal feeling shapes' that organize them. Further, there is an intimate context for lived experience, referred to as an 'intersubjective matrix', that resides in the connectedness with others and that we breathe continuously without being aware of it, like oxygen. Thus, in psychotherapy, individual consciousness is extended to include 'intersubjective consciousness', and much of what happens occurs between two people who are closely connected and guided by 'implicit knowing'. Repeated intersubjective exchanges of two people give rise to an emergent experience, 'moments of intersubjective meeting'. In addition to joining, such moments result in frequent mismatches that present opportunities for negotiation and correction. They occur throughout a psychotherapeutic relationship, and are largely implicit not requiring verbalization in order to have their therapeutic effects. Verbal interpretations of the intersubjective field are complementary acts. Thus psychotherapy consists of a series of present moments, driven forward by a desire for intersubjective contact, and with important 'moments of meeting' between patient and therapist. For Stern, change takes place through a

rewriting of past experiences as lived, and as the temporal dynamics of the past are activated bringing an influence on present behavior. What is experienced is in the present, happening in real time so that a story can be re-written.

The paper entitled *Non-interpretive mechanisms in psychoanalytic therapy: The something more than interpretation* (Stern *et al.*, 1998), published in this Journal, deserves special mention, as it has been listed in the Archival PEP-Web as the most cited of all its publications among users. This paper and others from what is referred to as 'the Boston Psychotherapy Group' will continue to provide contributions, in my view, to psychoanalytic thinking about training, practice and research. It begins with the well-known observation that patients, when asked about what made for a successful analytic treatment, tend to remember special moments of person-to-person connection as much as interpretations that made a difference. In this paper, exploring the 'something more than interpretation', the authors expand upon the concept of the 'shared implicit relationship' in psychoanalytic therapy and connect it with experiences of transference and countertransference. They elaborate how 'implicit relational knowing' is distinct from the symbolic domain and connect it meaningfully to its early manifestations in infant development as well as its manifestations in therapy within a shared intersubjective relational domain. Moments of meeting are described in general dynamic systems terms originally formulated by the developmental psychoanalyst Louis Sander (a member of the group who also died in November 2012); they are key to state shifts and regulatory reorganization and, in supplementing interpretations, they provide much of what is lasting in therapeutic effects. It would seem the paper is 'most cited' because it compellingly describes the sequences leading up to such moments of meeting and afterwards using terms that link to many of the clinical concepts of psychoanalysis that are in use today. It also introduces a landscape for what needs be pursued with clinical research and practice.

Experiencing ways of connecting

In reflecting on Stern's contributions to psychoanalysis, one also thinks of his style of communicating with us. Not only in his writings but also in his presentations and collaborations, he made use of a style of connectedness from which I believe we can learn. When presenting, rather than reading from notes or using PowerPoint, he would speak directly, moving from the immediacy of one posed question to another. He would develop a story, with his audience, with lots of eye-to-eye contact and playful expressions as he shared ongoing thinking with engaged listeners. If he used any prop it would typically be an extension of a gesture, drawing a directional chalk line on a blackboard. You might say he had a special sensitivity for engaging intersubjectivity in an audience of others.

The details of connecting with his interesting life and legacy can be left to future biographers, but two themes occur to me, related to these reflections. The first includes the fact of his having experienced a series of heart attacks beginning in his late 30s. Surviving these led to a sense of gratitude and to

a conscientious healthy life style. And it also gave him a continuing sense that he was 'living on borrowed time', valuing each moment as precious for himself and with others. The second is one I only learned of at his memorial, from his surviving older sister, Ronnie Chalif, who described to those gathered how, in early childhood, he compellingly appealed to their depressed and nonverbal mother who was in that condition for an extended period following the death of their father. His sensitivity to connecting via nonverbal behavior was seemingly early and lifelong.

Dan had a love of art, especially dance, which entered into many of his metaphors, and in adulthood he had a close friendship with Jerome Robbins to whom one of his books was dedicated. In the dance of his life with others, and in the midst of adversity, he was typically positive about possibilities. Especially for those of us who knew him, we continue to share in our memories his creative playfulness in the midst of urging us in psychoanalysis to be more critical in our thinking, participate more in science and be open with others.

He is survived by his wife, Dr. Nadia Bruschweiler-Stern; two sons, Michael and Adrien; three daughters, Maria, Kaia and Alice Stern; a sister, Ronnie Chalif; and 12 grandchildren. At his memorial his grandchildren tenderly lit candles as memories were addressed to them. The back of the printed program, in enlivening colors, quoted Dan: 'Just have fun'.

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Purposeful use of social media: Keeping infants and their relationships in mind and in view

Affiliates Corner

September 2013

By Maree Foley , New Zealand and Martin St-André , Canada

Social media is a relatively new resource for organisations to tap into. Social media has become popularised with endeavours to connect with others via self promotion, detailing daily life and sharing the mundane. Building on this popular use, social media is here for us utilise as a resource to support the development of our organisational infrastructures. However in contrast to self-promotion, or goals are aimed at supporting day-to-day professional connections with each-other within WAIMH, across our affiliates, and with all those who share similar goals. The challenge is to leverage this resource with wisdom and purpose: to help us increase our experience of connection with each-other, so as we can in turn increase our experiences of connection with the aims and goals of WAIMH.

To this end the WAIMH board are working on developing a protocol from which to optimise this medium to support of goals of WAIMH. The emerging outcome of this process will in turn actively benefit all affiliates and their members and will help us to refine our current use of FaceBook as a mode of shared communication. It will help also help to situate WAIMH in connection with other like minded colleagues, across countries and organizations.

We also want to thank all of those who were able to participate in the online 0-3 survey run by the ZERO TO THREE's DC: 0-3R Revision Task Force who have been collecting information to update and revise the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition known as DC:0-3R.

The WAIMH Congress in Edinburgh June 2014, is fast approaching. The organisation of the WAIMH affiliate pre-congress Reflective Supervision event is well underway with a lot of work going into this by the UK Congress team including Prof Jane Barlow and Dr Louise Emanuel to name but two members of the UK team. This pre-congress event will entail an opportunity to learn and develop through sharing ideas about clinical practice across international boundaries.

We cordially invite you to continue providing much needed feedback about the development of these various WAIMH initiatives and we wish you ongoing success and energy with your various Affiliate activities.

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2014 WAIMH World Congress in Edinburgh, Scotland

From the Kauppi Campus -News from WAIMH Central Office

By Pälvi Kaukonen, Kaija Puura and Minna Sorsa, Finland

Every two years WAIMH organizes a World Congress in collaboration with a WAIMH affiliate to promote interest and new ideas in infant mental health. This year's Congress will be held in Edinburgh, Scotland in partnership with the UK Affiliate, from June 14 to 18.

The abstract submission deadline for the 2014 WAIMH World Congress has been extended to October 20th! Be active, consider submitting an abstract for a workshop, symposium or poster and invite your colleagues to join in this fantastic event!

The 2014 WAIMH World Congress website contains all possible information about abstract submission and registration. See http://waimhcongress.org/ where you will also find all of the WAIMH World Congress newsletters that offer additional information about the Congress, the plenary speakers and special attractions in Edinburgh.

WAIMH Awards

The Congress is also a time to recognize and celebrate members from around the world who have made significant contributions to the infant mental health community. WAIMH has 5 special categories for awards: the WAIMH Award, the Sonya Bemporad Award, the Serge Lebovici Award, the Réne Spitz Award and the New Investigator Award. The deadline for nominations for the different awards is December 31, 2013. Look on the WAIMH website to find out how to nominate members for each award and what materials are required for each nomination.

WAIMH and Social Media

WAIMH is about to step into the 21st century as the Board, WAIMH members and Central office staff explore new initiatives and possibilities for utilizing the web and social media! WAIMH will launch new social media projects during the next months. Remember that each of you can also contact us (office@waimh.org) with your ideas for improving networking, connections and the visibility of our association via social media.

We are also continuously developing the WAIMH web-page (www.waimh.org). All important notifications are posted in the web-site. Take a look! The web-page is crucial for our members, because the membership applications, renewal forms, and subscriptions for the Infant Mental Health Journal may be completed online. Please consider joining WAIMH if you are not a member or remember to renew your WAIMH membership if you haven´t already done so! The Professional membership rate is $75.00 annually and Student membership $45.00.

Members (Professional and Student members) may purchase the Infant Mental Health Journal at a very reduced subscription rate: $50 (USA), $52.50 (Canada, including $2.50 tax), or $62.50 (International orders). The journal is a remarkable membership benefit.