

Perspectives in Infant Mental Health

Professional Publication of the World Association for Infant Mental Health

President's letter from Prague: Tel Aviv (Israel)

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By Miri Keren, M.D., WAIMH President, Israel, ofkeren@zahav.net.il, Sam Tyano, M.D. and Ghassan Abdallah, Ph.D.

Tel Aviv, 7/10/14

Dear WAIMH members, dear Colleagues,

As many of you know, our 2016 conference was planned to take place in Tel Aviv, and organized by a joint Israeli-Palestinian Local Committee, as an active step of WAIMH to provide a template for dialogue between professionals in areas of conflict and turmoil around the world.

Two weeks after the Edinburgh conference, the political situation in Israel and Palestine has quite unexpectedly deteriorated, the long-lasting well-known existing conflict escalated, and a full-blown war broke, with all its disastrous consequences. On July 20th, a letter from the Board of Directors of WAIMH was sent to our members, explaining the rationale of the decision to hold its 15th World Congress in Tel Aviv, a city in the Middle East which is currently afflicted by the hostilities. The intent was then and is now to work together with both local Israeli and Palestinian colleagues on behalf of babies, their rights to a safe and peaceful existence, and their families. Infant mental health specialists from both sides, Israel

and Palestine, restated this commitment at the 2014 World Congress in Edinburgh. In their view, coming to Tel Aviv means supporting our Palestinian and Israeli WAIMH members who are jointly standing up for the infants' rights and essential needs in the middle of political conflict.

As we wrote then, we promised to carefully monitor the safety needs of all conference participants. Following the violent phase of the conflict, we are now in a phase of high uncertainty.

This uncertainty has already engendered feelings of uneasiness and ambivalence among many, including among those who understand the complexity of this deep-rooted conflict. Moreover, on the practical level, we may face a very unpleasant financial situation with last-minute cancellations of flight tickets, accommodation reservations, social events etc...

Therefore, with a strong concern for your sense of safety, together with our strong will to keep the idea of science as a bridge for dialogue and mutual recognition, the Board of WAIMH has unanimously decided to keep the joint Palestinian Israeli Local and Scientific committees but to move the conference from Tel Aviv to Prague.



Ghassan Abdallah and Miri Keren at the WAIMH 14th World Congress Opening Ceremony.

Photo by Simon Williams.



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Prague has been chosen because it is an easy-to-access city for our Palestinian colleagues in terms of visas, and is relatively inexpensive and affordable to our local Israeli and Arab Infant Mental Health professionals.

Last, but not least, the announced theme of the conference was originally «Supporting Babies and Families in a Rapidly Changing World». We feel that in the light of the events that led to the relocation of the conference, the theme needs to be changed into

Infant Mental Health in a rapidly changing world: Conflict, adversity, and resilience.

With the strong personal conviction that we, as mental health professionals, have a special role in times of turmoil and conflicts, as we are facing today in various areas in the world, we invite each of you to come to Prague and to share with us your clinical and research work about Infant Mental Health in various contexts of challenges and opportunities. The overwhelming pace of high-tech developments, that characterizes the 21st century, has added a new dimension to our work that needs to be addressed.

This will indeed be an unusual WAIMH conference, where the Local Committee gathers professionals from two societies in conflict, and has the challenging task of organizing the conference in a country outside of their own. We all share the strong conviction that this is the adequate answer to WAIMH ultimate aim to provide a «transitional space» for spreading scientific knowledge in the field of IMH and promoting clinical reflective skills...

With this deep conviction in our hearts, we personally invite each of you to attend this unusual 15th WAIMH conference in Prague (May 29th - June 2nd, 2016).

Reflections About Coparenting

By France Frascarolo and Nicolas Favez,
Switzerland

Introduction

The aim of this paper is to share some reflections about coparenting, defined as the relationship that exists “when at least two individuals are expected by mutual agreement or societal norms to have conjoint responsibility for a particular child’s well-being” (Van Egeren & Hawkins, 2004, p.166). Distinct from marital relations, coparenting has a specific influence on child development (McHale, 2007). High level of conflict and competition between the parents coupled with low level of warmth and cooperation predicts child’s difficulties in terms of internalized and externalized troubles (Belsky, Putman & Crnic, 1996; Favez, et al., 2006, Frosch, Mangelsdorf & McHale, 2000; Stright & Neitzel, 2003). High discrepancy in parental investment during the first year is linked with high levels of anxiety at three years (McHale & Rasmussen, 1998). Inversely, cooperative and warm coparenting predicts an optimal socio-emotional adaptation (Favez, 2009; McHale, 2007). As it has been shown in the meta-analysis by Teubert & Pinquart (2010), balanced and cooperative coparenting is the most favorable coparenting for the child’s development.

The reflections we share here came from observations realized in play situations in a laboratory setting during the first two years of life.

Coparenting Observations

We observed primiparous volunteer parents interacting with their infant or toddler in the Lausanne PicNic Game (LPNG; Frascarolo, Tissot & Favez, 2011). A task is set in which families are invited to pretend having a picnic together for about a quarter of an hour. We are always amazed by the multiple ways in which parents get organized to realize the game. Some of them make a full game with pretend eating and moments of play with some toys, and they succeed in having fun and sharing affects together. The game of others is less structured and, in spite of moments of parent-infant dyadic interaction, the three of them do not succeed in sharing pleasure together and sometimes the atmosphere is rather cold or even mildly hostile. One can imagine that what the infants experience during these LPNG is very different from one family to the other. Following these initial observations, we were able to classify families on the basis of a typology inspired by Minuchin (1974) and McHale (2007) according to four categories:

1. Families belonging to the first category, so-called “balanced and cooperative”, are characterized by collaboration and mutual support between parents, dyadic and triadic interactions and family warmth. Parents take into account what their child is doing and adjust their behavior to his but they neglect neither their partner nor the couple relationship.
2. In those belonging to the second category, called “child at center” the parents are only focused on their child: the dyadic parent-infant interactions

are more or less adapted, there is no conflict observed between the parents, but no real triadic interactions occur. The parents are totally focused on their infant and they have no exchanges with one another, but the general atmosphere is rather pleasant. Somehow the hierarchy, as defined by Minuchin, is inverted, implying that the authority is in the parents’ hand; the parents are following more the initiatives of the child than framing the pretend play. As long as the two parents implicitly agree to put their infant at the center of their attention and put aside their couple relationship, they are not in conflict.

3. In families categorized “competitive coparenting” the parents not only lack mutual support and cooperation but they are in competition for their child’s interest. The child is in the middle, pulled between his parents. Competition can result in conflicts, or reciprocally, conflicts may lead to competition. In that case, the infant has the choice between withdrawing in order to avoid being in the center of conflicts or, on the contrary, he may get involved on the inside and play the intermediary or go-between.
4. In the “excluding coparenting”, one can observe that only one parent is invested in the infant and the other parent just withdraws from the play. There is no warmth and no cooperation between the parents. In case of conflict the non-invested parent could be excluded by a coalition between the invested parent and the infant.

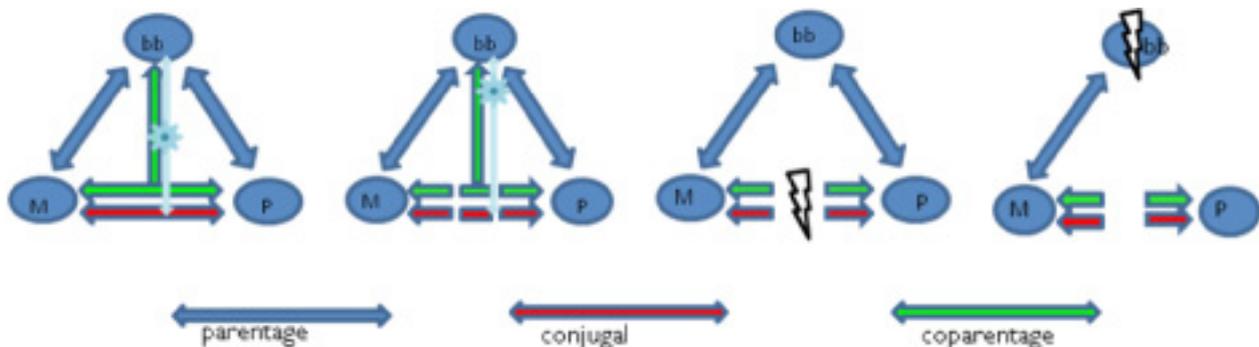


Figure 1: Blueprint of the four categories of coparenting (from the right) “balanced and cooperative”, “child at center”, “competitive” and “excluding”.

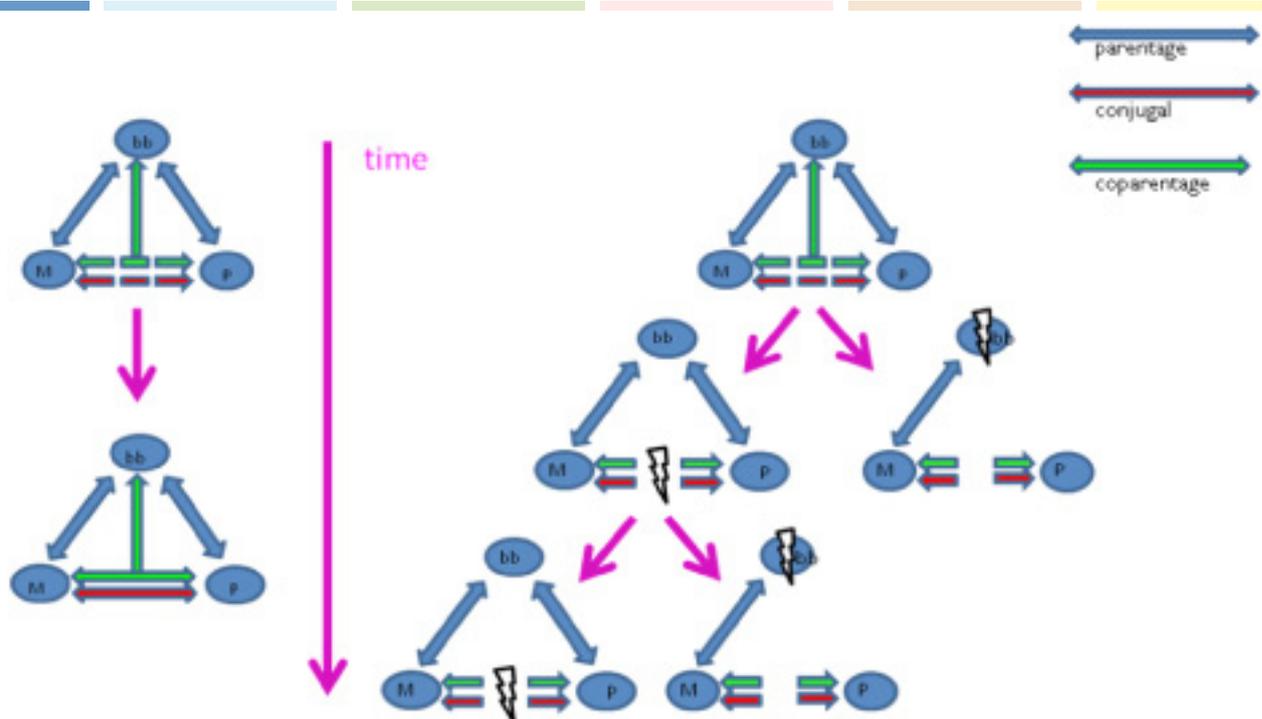


Figure 2: Possible evolutions of “child at center coparenting” (for the better on the left side and for the worse on the right side).

For example, at the very beginning of the game, parents of “balanced and cooperative” families would first discuss if they will eat on the floor or on the bench and then explain to the infant what they are going to do and ask him or her if he or she is as happy as they are. Parents of “child at center” families would ask their child where he or she wants to seat, even if he or she is too young to answer, without consulting each other. In families with “competitive coparenting”, each parent would propose to the child a different place, for example, one on the bench and the other on the floor. And each would stand by his or her position by settling down where he or she proposed. Finally, in a family with “excluding coparenting”, one parent will organize everything while the other parent will come and participate with more or less delay.

Among volunteer families, belonging to middle to high socio-education levels, observed in the Lausanne PicNIC Game, the coparenting interactions of the majority of families belongs to balanced and cooperative category. But there are also a not insignificant percentage of “child at center” families.

As one can see on the Figure 1, the first main difference between these two categories concerns the apparent lack of interaction between father and mother. We say “apparent lack” because there is sufficient cooperation in the second category despite the lack of direct interaction for not being competitive;

for example, parents interact one after the other with the baby. The second difference concerns the focus of attention of the partners. For the families with a “balanced cooperative” coparenting the focus (represented by means of the little star) is in the middle of the family but, in fact, it moves flexibly from the infant to the couple ideally according to the needs expressed by each of them. In the “child centered” families, the focus is rather rigidly fixed on the infant.

One can hypothesize that not only the “balanced and cooperative coparenting”, but also the “child centered coparenting”, is adequate as long as the latter is temporary and linked to the dependency of the infant or to the task. When the infant is very young some parents want so much to meet his needs that they, more or less deliberately, give precedence to him irrespective of the effect on their couple relationship. Also, comparing to what they would probably do in real daily life, in the specific context of the LPNG (presented as a family task), some parents may pay more attention to the child and reduce their couple interactions, especially if they believe that the researchers’ interest is the child’s behaviors. Given that the instructions are the same for all families, we do not think that the parents’ considering the infant or the toddler as the target of our studies is sufficient to explain the absence of interaction between the parents, but observations in naturalistic contexts are definitively needed.

As time goes by, with the empowerment of the child, the focus of the parents should ideally go to the center of the family. Moreover the couple relation should take up more space and coparenting should become “balanced and cooperative” (left side of the blueprint in Figure 1). But some parents may encounter difficulties in staying connected or becoming connected again and, in that case, they would keep a “child centered coparenting”. But can “child at center” coparenting stay stable? One can imagine that not being coordinated as parents would create a gap between them. This gap has to be filled otherwise there is a risk that it becomes deeper and wider. And couple relationships would get worse.

Indeed the lack of cooperation and connection between the parents could generate some tension and conflicts. When conflicts are observed one does not know if the attention given to the infant is the cause or the result of these conflicts. Is it because each parent gives “too much” to the child and not enough to their partner, that resentment and conflicts appear? Or, do the parents turn to the child in order to avoid the loneliness generated by their couple conflicts? Nevertheless it would lead either to a “competitive coparenting” characterized by conflicts or to “excluding coparenting” with the eviction of one parent (second line of the right side of the blueprint of Figure 2). As time goes on, the “competitive coparenting” itself may remain unchanged or it could lead to the (self-) exclusion of one parent (third line of the right side of the blueprint of

Figure 2). The latter “choice” might be done according to an observation made by McHale (1995) concerning coparenting and child gender, namely that in conflicting coparenting families with boys fathers tend to stay involved while in families with girls, fathers tend to be (self-) excluded.

In the families with a stable “balanced and cooperative” coparenting, right from the beginning, the parents adjust not only to their baby but also to their coparent. Moreover, they may think that interacting with the other parent in front of their infant, or with him, is an advantage not only for him, but also for their couple and for their family. As said above, the focus of the parents (represented by a little star) is rather flexible and adjusted not only to the infant needs but also to each parent’s needs and to the family’s. Over time, with the empowerment of the child, the parent’s focus goes more in the center but remains flexibly adjusted not only to the child’s but also to each partner’s and to the family needs.

Conclusions

As well documented by Fivaz-Depeursinge and Philipp (2014), the type of coparenting will determine the daily experiences lived by the infant which will in turn impact on his development. Being the observer or being included in a warm interaction with his two parents is definitively not the same real-life experience than being split when receiving simultaneous stimulations from two different partners. When the child is cut off from one parent in order to preserve his relation with the other one or when he has to renounce to his own agenda for being a go-between trying to repair his parents’ conflicts it is another different real-life experience.

According to some authors (Fivaz-Depeursinge, Favez, Lavanchy et al. 2005), infants are able to communicate with two people already at three months of age. One can assume that communicative abilities are given at birth; that infants are born with the potential to communicate with several people. According to the type of coparenting, the infant will either develop or fail to develop his triadic capacity and his “triadic communication skills”. Observing some parents’ difficulties to include two partners (their spouse/ significant other and their infant) one can doubt whether their ability to communicate with several people has been preserved and developed.

These theoretical models of coparenting evolution definitively need to be

confirmed on samples including clinical families and by means of longitudinal research. Nevertheless, we hope that these reflections will give ideas to researchers and help clinicians to see what is at stake in the consideration of the family and not only of the parent-infant dyad. We also hope that it will encourage them to promote cooperative coparenting.

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Winnicott Lecture AAIMHI Conference, 2014

By Beulah Warren, New South Wales,
Australia, lookes@ozemail.com

Before commencing my lecture I wish to share with you an email received from a friend, 94 years of age, in response to telling him I was to present the Winnicott lecture. -Beulah's Winnicott lecture promptly brought to mind this maxim,

"There are no perfect mothers, only at best good enough mothers." How that helped my lovely wife battling to be a saint and mother of four irrepressibles all under seven. Incredibly they insist their childhood was a happy one. I cannot speak for my wife. But Winnicott was on to something, not perfect but good enough.

Winnicott was reassuring to many ordinary families.

Introduction

At the WAIMH Conference in Edinburgh this year, in conversation with Professor Louise Newman about the plight of children in Australian detention centres, I asked Louise what we could do about the situation. Louise said the first thing to do was to write to our politicians. I came home with the intention to do so.

The presentation of this lecture was my preoccupying thought but I couldn't get started. I had to write my letter to the Minister first which finally got written early August.

My message today is that we have to be the voice for infants; we are the ones who read the infants, who hear the baby's talk.

Of course last century there were many who began to speak for infants; Winnicott was one of the first to focus on the early relationship between "the ordinary devoted mother" and her baby, to be a voice for mothers and babies and to listen to the baby.

I feel a special affinity with Donald Winnicott and I will tell you why. Winnicott trained as a paediatrician and gradually changed over into being a psychoanalyst and a child psychiatrist. He spoke of how his physical training influenced his work and the accumulation of a big volume of experience due to active practice for 45 years. My own original training was as an

Occupational Therapist and after working with adolescents trying to break their drug taking habits in London, I turned to psychology.

Like Winnicott I have acquired a volume of experience, not quite 45 years but many years of practice, and like him I wish to convey to you the 'strength of feeling' I have acquired over those years of working with parents and their infants and with colleagues who share the enthusiasm.

Something else I learnt of Winnicott which I will share. I quote from Sir Peter Tizard's foreword in 'Babies and their Mothers' (Winnicott, 1988):

Dr Winnicott was a good writer, sometimes very good, occasionally rather poor, but he was a far better lecturer and conversationalist ...to express his views most clearly and vividly he needed the immediacy of an audience. (p. viii-ix)

For myself too, it is easier to speak to a receptive audience than to apply the discipline of writing a chapter or paper. I prefer to speak of my work rather than write about it. Thank you for being here today.

Two realisations came to me from working with the adolescents in London. The first was that adolescence was too late to try and bridge the gap between parents and children, early intervention was crucial.

The second was that I didn't have enough knowledge of internal and interpersonal processes to adequately meet the needs of these young people.

TODAY I want to share with you my passion for infants and their families and what we can learn from observing babies and small children, what they are telling us. Also, I want to honour the place of the 'ordinary devoted mother', the importance of that role. Together let us think about how we can share that information with families. Our responsibility is to share the knowledge with families and the wider community.

A Voice for Babies

Selma Fraiberg who is credited with coining the phrase 'infant mental health' (and her colleagues), had an awareness of how important the newly acquired knowledge of infant emotional development and the role of parents in healthy development of their children was, especially to parents. To quote:

Today, we are in possession of a vast scientific treasure acquired through the study of normal and deviant infants, a treasure that should be returned to babies and their families as a gift from science. (Fraiberg, 1980, p. 3)



Beulah Warren at the WAIMH 14th World Congress Opening Ceremony. Photo by Simon Williams.

Arietta Slade (2002) said that Fraiberg demonstrated the power of a mother's discovery of her own and her baby's internal states and the link between their experiences. Fraiberg and her coworkers used straight forward techniques to bring the baby's experience into the mother's consciousness; to help mothers accurately read their babies' signals and underlying intentions.

It was in 1978 following the birth of our third child and meeting with new parents who felt ill prepared for the task of parenting when I had my epiphany moment and changed course to work with infants and their parents. It was the year I met Dr. T Berry Brazelton on his first visit to Australia. On that occasion he trained a small number of people on the Neonatal Behavioural Assessment Scale (NBAS) who undertook to train others. I gained reliability on the scale in 1979.

Berry Brazelton awakened us to what the baby brings to the relationship with his parents. From the beginning Berry contended that "new born infants were unique, with their own individual style of responding" (Brazelton & Nugent, 2011, p. 2).

What was Berry trying to teach us?

The newborn is a social organism, predisposed to interact with her caregiver from the beginning and able to elicit the kind of caregiving necessary for her species specific survival and adaptation. (Brazelton & Nugent, 2011, p. 3)

The Brazelton Scale, as it is commonly called, is an interactive assessment where the examiner plays a role in facilitating the performance and organizational skills of the infant. Specifically we learn about the baby's autonomic stability, the competence of the reflexes, the musculature and sociability of the baby. We learn about the baby's tolerance for distress, what comforts the baby and how quickly he can be comforted. We also learn what stimulation is appealing to the infant and how much can he tolerate. What a wealth of information can be gleaned by observing the full term healthy newborn.

(I now show a film of full term healthy infant)

Baby James and Baby Patrick

Baby James

So then, what do we learn of three day old James and what did we share with his parents? James is a well rounded full term infant. He has a beautiful relaxed body with gently flexed arms and legs, a balance

of flexion and extension. He has a good healthy cry when uncomfortable but he settles easily when his hands are held and he is spoken to in a quiet persistent tone. With a little help, he can self sooth. James can snuggle in when held by an adult, which of course is rewarding to the parent. When he is well fed and content he can focus on a face and a face and voice for 60 plus degrees to both sides and he can turn to the side to find a voice. We can assume his birth was not traumatic for him. James is virtually a "prototype" of the healthy newborn.

Baby Patrick

Now let me tell you of Patrick, also a healthy newborn but one who spent a lot of time crying in the first three days of his life. Patrick was born in a Maternity Hospital in Perth. Nurses who were doing training on the NBAS identified Patrick as very distressed and wondered if by doing an NBAS assessment with Patrick we might be able to give the mother some information about Patrick's needs. Mother brought Patrick into the quiet, softly lit room where the assessment was to take place. Patrick was asleep.

Patrick looked to be of average size for a healthy full term. I can't remember anything the mother said about the birth but I do remember the mother saying she had two older daughters. We began the assessment by assessing Patrick's habituation to a light across the eyes, a rattle and a bell. Patrick was able to shut out each of these stimuli and return to a deep sleep. I then rolled him onto his back and began to uncover him. The scale starts with testing gentle reflexes, glabella, rooting and sucking. The baby is then undressed to test further motor items. Once undressed Patrick had begun to fuss and very quickly went from fussing to a loud State 6 cry, I am sure you are very familiar with such a cry which demands immediate attention. On the NBAS consoling the baby is a measured incremental response. You initially show your face, then speak quietly to the baby, follow with restraining the arms(as shown with James). If that doesn't work, restrain the arms and pick up and hold, next introduce rocking and finally wrap and then give the dummy.

Patrick required the lot. Once settled, after a couple of minutes I tried to return to the reflexes; an attempt was made to lie Patrick down and un-wrap him. He remained quiet until I tried to grasp his hands or feet or move his arms and legs. He quickly began to cry again with full intensity. I went through the console procedure once more but realized we were not going to be able to continue with reflexes. Once

wrapped and held firmly Patrick returned to a quiet state.

It wasn't a quiet state of sleep, but a quiet alert state so I suggested to his mother that we would try and engage with him socially. Held out in front, well supported, Patrick followed a face, face and voice, the little red ball and the rattle from side to side and around in a circle. He also turned to each side to find the enticing voice, and the rattle. It was a joy to share the experience with his mother who was delighted with his performance.

Patrick's mother and I wondered together what Patrick's behaviour might mean? She thought it was what boys did. Her girls had been quiet babies, not crying in the way Patrick was. We agreed that being unwrapped with arms flailing distressed Patrick so keeping him wrapped until he felt comfortable unwrapped was going to be important. I suggested she wrap him for sleep and also for quiet alert times in his rocker or chair for at least the first few weeks or until he had a little more control of his arms. I left my card with Patrick's mother and said she could phone me if she wanted to discuss the assessment further.

Some six months later Patrick's mother phoned me. She identified herself as Patrick's mother and said she wanted to tell me of Patrick's progress. She said she had continued to wrap Patrick for sleep and initially when he was awake. Gradually Patrick gained control of the movement of arms and legs and then it ceased to be necessary around four months. He was now a happy little fellow enjoying being on the floor unwrapped and playing with his sisters.

The physical characteristics of James and Patrick were somewhat similar. However, Patrick did not have the same regulation of motor that James had. With Patrick it was evident it was where he needed help to enable him to engage in face to face interaction with his mother.

Let me now turn to premature babies.

What do we Learn from Premature Babies?

It is many years now since Dr Robyn Dolby, two physiotherapists, Dr Vickie Mead and Ms Jan Osborne, and I, carried out a research project that involved intervention with premature infants over the first year of life. We learned so much from the observation of the infants over the year. Two important pieces of learning were acquired from the project which involved meeting with the families in the hospital and in their homes four to five times over the first year.

Lesson one: Listen

Before intervening we had to listen carefully as the parents gave us their observations of their baby's behaviour and their reflections on the meaning of that behaviour.

Lesson two: We need a framework

The second lesson was the complexity of human development in the first year of life and the underpinning of the motor system and how it influenced the baby's capacity for social engagement. As psychologists we learnt from the physiotherapists the baby's motor communication. We had to be trained to know what we were looking for. *It is crucial to have a framework for what we are looking for.*

Professor Heidelise Als, who initially worked with Berry Brazelton went on to focus on the development of premature babies, especially very low birthweight babies. Dr. Als has changed the environment and ambience of Special Care Nurseries in many countries with the introduction of the Newborn individualized Developmental Care and Assessment Program, (NIDCAP) and the Scale, the Assessment of Premature Infants' Behaviour (APIB) specifically adapted from the NBAS.

Heidi Als introduced us to the "Synactive Theory of Development" in an article in the *Infant Mental Health Journal* (IMHJ) in 1982. Her conceptualization of infant development appear below and I quote:

Focuses on how the infant handles the experience of the world around him. The baby's functioning is perceived as continuous intra-organism, subsystem interaction and the organism in turn is seen in continuous interaction with the environment. (Als, 1982, p. 230)

Furthermore:

We have termed this view of development synactive, since at each stage in development and each moment of functioning, the various subsystems of functioning are existing side by side, often truly interactive, but often in a relative holding pattern, as if providing a steady substratum for one of the system's differentiation processes. (Als, 1982, p. 230)

The systems referred to are the:

1. Autonomic system;
2. Motor system;
3. State-organizational system;
4. The attention and interactive system and;
5. A self regulatory, balancing system.

Dr. Als maintained that the functioning of all these systems was observable; *we needed to know what we were looking for.* Thus, she identified what to look for in each system to explain the functioning:

The autonomic system

- observed via the pattern of respiration, colour changes, tremulousness, and visceral signals such as bowel movements, gagging, hiccoughing, etc.

The motor system

- was observable in the posture, tone and movements of the baby.

The state organizational system

- observable in the kind and range of states of consciousness available to the baby, from sleep to aroused states; also in how the infant transitions between states.

The attention and interactive system

- typified in the baby's ability to come to an alert, attentive state and to utilize this state to take in cognitive and social-emotional information from the environment and in turn elicit and modify the inputs from the environment.

The regulatory system

- exemplified in the observable strategies the baby utilized to maintain a balanced, relatively stable and relaxed state of

subsystem integration or to return to such a state of balance and relaxation.

If the infant is unable to maintain or return to an integrated balanced subsystem state another aspect of functioning is identified. What does this baby need to return to a balanced state? What amount and what kind of facilitation is required from the environment to aid the infant's return to balance?

Let me show you some video of an assessment of a premature baby using the NBAS.

Baby Elli

At the time of filming Elli is 5 weeks corrected age, or 17 weeks chronological age. It is obvious how important it is to correct for prematurity. Where is the imbalance for Elli? In fact all of her systems are being stressed. The coughing and painful cry indicated her autonomic system was challenged in the testing of reflexes; her inability to sit without going into extension, her increased muscle tone and jerky movements demonstrated the imbalance in her motor system; while her persistent fussiness bespoke poor state control, and her inclination to hyper-alertness was an expression of her difficulty in regulating attention.

What did Elli need to return to a balanced state? Elli required loving gentle handling; to be held curled in to help her flex and reduce the increased muscle tone when being held. Also to be firmly wrapped when preparing for sleep. Her strengths were that she was responsive when cuddled and held curled, relaxing and looking into the face of the person holding her, and when lying on her side, she quietened when spoken to and stabilized. It was very apparent that to engage with her motor system required assistance and her arousal needed to be regulated.

At Elli's age of 5 weeks the parents were longing for face to face engagement with her. How patient the parents would have to be to prepare Elli for interaction and we wonder how many engaging moments she could manage in her awake times?

Parent-Infant Interactions

Parent infant dyads are the focus of many methods of intervention in the first year of life. Some are working on the mother's representations (see Beebe, 2003) while other interactional approaches attempt to intervene into specific behavioral transactions.

With an understanding of a synactive theory of the developing infant, we appreciate that at any moment of functioning the infant's various subsystems may or may not be interactive. We are better equipped, when observing parent infant interactions to understand what might be influencing the infant's contribution.

In observations of parent-infant interactions, optimally, self and interactive regulation are in dynamic balance.

Beatrice Beebe (2003) states in her outline of brief Parent Infant treatment using video feedback:

The approach of her team is based on a theory of face to face interactions developed over a number of years. Self and interactive regulation are concurrent and reciprocal processes, each affecting the success of the other. Interactive regulation is defined by bidirectional contingencies in the partnership of parent and infant, a continuous process in which each partner makes moment-to-moment adjustments to the behaviours of the other. The infant's capacity to detect and to be affected by contingent stimulation underlies all current theories of how the infant develops predictable patterns of the relatedness and their representations. (p. 27)

Beebe (2003) comments that many intervention efforts actually focus on the parent, to the point where it has been asked: "Where is the infant in infant intervention?" A unique study by Weinberg and Tronick (1998) (cited in Beebe, 2003) evaluated the outcomes of an early intervention in which only the mother was treated. They documented by microanalysis that the infants were still in distress even though the mothers reported improvement. Suggesting that the dyad should be a focus of intervention, they noted that the infant is often the "forgotten patient".

Hofacker and Papousek (1998) argue that the infant's contribution to the mother-infant interaction is still poorly understood. They wonder if this is due to our greater ease with verbal than non verbal forms of communication.

My experience is that this is so.

Introducing psychotherapy trained psychiatrists to mother-infant interactions at St. Benedict's mother- baby unit I ask the trainees to observe the interaction between mothers and their infants on video. They are asked to think what it might be like for the baby in this interaction, this situation; what is the baby's experience, how do they think the baby is feeling; are the baby's needs being met?

The participants may give one or two comments about the baby but invariably there is lively discussion about the possible diagnosis of the mother based on her facial expression, her posture, her interactions with the baby, her vocalizations, until they are directed again to the experience of the baby.

Is it that in the clinical setting we are confronted and feel helpless when we observe the pain of the baby? Often the baby is experiencing intrusion, or being ignored; sometimes the baby actively avoids the parent or is vigilant of the parent. On other occasions the baby may give furtive glances in the direction of his mother.

Beebe (2003) summarized studies of early face to face interactions which analysed second-by-second contingency behaviour of gaze, face, orientation, touch and vocalization. Some studies have linked early interaction patterns to outcome variables but the work is still in progress and reliable norms are not available. Beebe describes behaviours for each of the items but stresses they are not prescriptive nor do they assume an optimal mode of interaction: "Ranges of 'normal' interaction are more ambiguous than extremes of difficulty" (p. 28). Some of the problematic patterns observed are used by all dyads at various times and are potentially adaptive solutions to the challenges of specific interactions.

To emphasize once again it is useful for us as clinicians, when observing a baby and her mother in a clinical setting to have a framework in which to observe the infant's response in the moments of interaction. The items of gaze, face, orientation, touch and vocalization provide the immediate picture while the synactive model gives a whole of organism framework.

I recommend the article by Beebe in the *Infant Mental Health Journal* for an understanding of the more optimal and less favourable behaviours for gaze, face, vocalization, management of infant distress and self-comfort on the part of the infant and the parent and how each adapts his behaviour to the other.

The baby and infant are constantly looking for emotional expression on the face of his mother or carer which creates a resonant emotional state in the infant. The responsiveness of the adult is the food of brain development, the laying down of pathways in particular areas of the brain (Schore, 1994).

Let me illustrate with another short film of interaction between mother and infant around a breast feed.

Video of mother and 5 week old infant

When observing an infant the task is to describe as completely as possible what is seen and then to allow one's thinking to develop. It is often our capacity to observe, reflect on and try and understand the baby's behaviour which will assist the parent to understand her own and her baby's feelings as they exist both internally and externally. As a thoughtful observer I model for the mother her own reflective observation of her baby.

Arietta Slade (2002) acknowledged the reflective process of Fraiberg's approach. As Fraiberg or one of her team listened to a young mother talk about her own experience of being mothered, they wondered together about mothering her own baby, present with them in the room. Fraiberg's therapeutic successes evolved with the mother's capacity to link her baby's experience with her own, that is, reflecting on her baby needing her and her mothering, just as she had needed to be mothered as a baby; her baby was separate to her. Fraiberg's framework was psychoanalytic, dynamic psychology. It linked the present with the past, and was reflective. Slade's (2002, p.13) perspective of developing maternal reflective capacities says it is the link between mental states, and between mental states and behaviour that is at the heart of healthy mother-child relatedness. Sometimes these connections develop through an examination of past-present links; at other times they may more simply arise through the process of reflection as it pertains to daily, relational experience, the mother reflecting on how her baby might be feeling in a particular situation.

Slade quotes Sally Provence's directive to parents: "Don't just do something. Stand there and pay attention. Your child is trying to tell you something". Slade believes helping parents to observe their child and learn to "read" their actions and words are at the heart of the reflective model and essential for healthy mother child relationship.

Is this part of modern new mothers' repertoire, to observe, and learn to read the actions of their baby? Can we still talk of the ordinary devoted mother?

The Ordinary Devoted Mother

Reading again the lectures and talks that Winnicott gave I was warmed by his simple principles of good parenting. He believed strongly in the "ordinary devoted good enough" mother who, if supported through pregnancy will have the capacity to hold her baby. The ordinary devoted good enough mother will have an intuitive knowledge that what her baby needs "is the simplest of all experiences, that based on contact without activity, ... the feeling of oneness between two people where in fact there are two" (1988, p. 7). To just be with the baby, to endorse Sally Provence's words.

So what are the essential characteristics of the mothering of the "ordinary devoted good enough mother"?

- A supportive partner or supportive community environment through pregnancy and over the early months and years.
- "Holding" of the baby, and
- "Primary maternal preoccupation" which begins in the late stages of pregnancy and continues through the early days and weeks of the baby's life.

Winnicott (1988) said that these things give the baby the opportunity "to be" from which the infant becomes the self experiencing infant. The personality develops from the simple to the complex:

"At the beginning, however, it is the physical holding of the physical frame that provides the psychology that can be good or bad. Good holding and handling facilitates the maturational process and bad holding means repeatedly interrupting those processes because of the baby's reactions to failures of adaptation" (p. 62).

That is, if the new mother is struggling to adapt to the demands of her baby to be held and responded to in a consistent way, then the baby is unable to form a pattern of response.

Is it the primary preoccupation which allows the woman to intuitively mother, to be able to "hold" her baby? Winnicott stressed that the mother has to allow

herself to experience this state of oneness with the baby.

In *The Magic Years* (1959) Selma Fraiberg gives a beautiful description of what is happening in the early days and weeks of the infant-mother relationship. I quote:

These first weeks are not entirely a time of darkness and primeval chaos. An invisible web is spun around the child and his mother that emanates from the mother and through which the most subtle impressions are transmitted to the child. And while the infant doesn't know his mother, can't recognise her on sight, he is receiving an infinite number of impressions through physical contact with her that gradually lead to the formation of his image of her. (Fraiberg, 1959, p.37)

Mahler like Winnicott, sees the intense involvement of the mother in these first few weeks as crucial to the psychological birth of the infant. I quote:

"...we believe the mothering partner's 'holding behaviour', her 'primary maternal preoccupation' in Winnicott's sense (1958a) is the symbiotic organiser - the midwife of individuation, of psychological birth (Mahler, Pine & Bergman, 1975, p. 47).

Winnicott (1988) identified that many women are afraid of being absorbed in the baby:

Many women fear this state and think it will turn them into vegetables, with the consequence that they hold on to the vestiges of a career like dear life, and never give themselves over even temporarily to a total involvement. (p. 94)

The new mother has to trust that her total preoccupation with her baby will pass.

If not supported, either by a partner or by community the mother is left holding the baby literally and the task of being at one with her baby is virtually impossible. As a community are we supporting the new mother in her preoccupation with her baby, in holding of her baby?

If the ordinary devoted mother is consistently available to her baby, the baby begins to assume that someone is there when needed and this is foundational for the baby's ego. However, there are situations where the baby does not experience enough physical holding to allow for the development of the personality. That is, some children are let down before damage to the personality can be avoided (1988, p. 9).

Winnicott (1988) also stressed that in time the baby needs the mother to fail to adapt to the infant's needs: "there is much satisfaction to be got from anger that does

not go over to despair" (p.8). The baby needs to know he can express his anger and still be accepted. And mother needs to know that the time of utter dependence will pass.

Surely our policies of encouraging new mothers to get back into the work force as quickly as possible are not supporting the early formation of the relationship. Should we be advocating for at least six months of maternity leave for all new mothers?

Winnicott was the advocate of the ordinary devoted mother supported by her partner, being the crucial factor in the healthy physical and psychological development of infants. He felt this needed to be owned and spoken about, that some of the failure in development was because of absence or 'failure of the ordinary devoted mother factor' at a certain point or over a certain period. He felt we had to be able to acknowledge causal significance but not blame.

Winnicott (1988) argued, if we don't acknowledge where the deficiency is, then we can't recognize "the positive value of the ordinary devoted mother factor" (p.9). That is, it is of vital necessity, for every baby, that there is someone, some other, for the healthy development of the infant, neurologically, physically, cognitively, emotionally and psychologically.

This is a very important principle for Winnicott (1964):

I am trying to draw attention to the immense contribution to the individual and to society which the ordinary good mother with her husband in support makes at the beginning, and which she does simply through being devoted to her infant. (p.10)

Winnicott wondered if the contribution of mothers was not acknowledged, because it was so immense? If we acknowledge it, "it follows that we all feel a debt to our mothers – everyone who is sane, everyone who feels himself to be a person in the world and for whom the world means something, every happy person is in infinite debt to a woman...in our infancy we were absolutely dependent (p. 10). Winnicott (1964) argued that with an acknowledgement of this dependence within ourselves will come a lessening of a fear which allows ease and complete health to flourish: "If there is no true recognition of the mother's part then there must remain a vague fear of dependence" (p.10). He explained that the fear may take

the form of fear of women in general, or a particular woman or other less recognized forms but always a fear of domination (p.10).

Let us focus on the new generation of young mothers; the young women who have been educated and expect to share the parenting role with their partners as many of them have been together for some years and have shared domestic responsibilities and work load before having a baby. When the baby comes, suddenly they are the one at home with the baby, cut off from their friends and network. They are also the ones to have the broken nights and feel exhausted. Without income there is a sense of dependence on their partner and the partner's potential domination. Do these new generation young mothers feel honoured by society in their role as ordinary devoted mothers? I think not. Society pressures them to return to work as quickly as possible and their fear of not keeping up with their peers, added to the fear of being lost in preoccupation with the baby, is a strong impetus to return to the workforce and to hand the baby over to others.

As advocates and a voice for the infants we need to speak up in support of the important work a woman is doing in being the ordinary devoted mother to her new baby.

Winnicott (1964, p. 86) spoke of the ordinary mother taking care of her baby, being thoughtful of her handling of her baby because of her love; because of maternal feelings which have developed in her, and a deep understanding of baby's needs. Most women who become mothers, want to be mothers, they want to be good mothers but just what does that mean to the new mother in 2014.

Here are my suggestions to "an ordinary devoted mother":

- Be sure of a supportive partner or community support through the pregnancy and early days and weeks of the baby's life.
- Tune in to your body as it prepares for the birth; the physical and hormonal changes which are happening.
- Allow yourself to be preoccupied with the potential new person in the last weeks of pregnancy and early days and weeks of baby's life, assured that this time of

preoccupation will pass.

- Own the overwhelming sense of love for this new little person unashamedly whether it hits like a wave of emotion at the time of birth or creeps up slowly.

- Delight in the miracle of the birth of a human being.

As professionals let us acknowledge above all the importance of love as the emotion which makes good enough parenting possible.

We have to be more outspoken about love so women will allow themselves to be "irrationally in love" and at home with their babies, supported by their partners for the early months. Two recent quotes on the importance of love in psychological understanding come to mind.

A listener (21.7.2014) phoned in after listening to an ABC program which acknowledged emotions as crucial in cognitive learning, said;

"We hear about people who are good with their hands, or good with the heads, but don't hear about people who are good with their hearts."

Again, (5.5.2014) in an interview on the ABC Radio National program, 'All in the Mind,' Professor Dadds of the University of New South Wales, said, "In Psychology we talk about teaching, rewarding, praising children, but we do not talk about Love".

Finally, as advocates for babies and mothers, we have to become more politically active.

- Let us be open in our belief that love is what makes parenting possible or, as my son says when he is trying to help teachers understand children's difficult behaviour, 'It is all about relationship'.
- Let us be outspoken for parental leave for all mothers for at least 6 if not 12 months, with a guarantee that their employment will be there for them on their return, as happens in some European countries.
- Let us speak for babies and

parents wherever we see the need and are prompted to respond.

I guess this is why, in 1988, it was so important to a little group of us to create our own Australian Association for Infant Mental Health. Thank you.

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From the Editors

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This is the last issue of *Perspectives* for the year 2014. The year is memorable for many things, among them, a spectacular WAIMH Conference held in Edinburgh in June. Those who attended felt connected and optimistic about their work with infants, toddlers and families. There were troubling events, too, as conflicts erupted around the world, leaving many children and families in war-torn communities or a continuing state of crisis. WAIMH is a global organization, challenged to support and sustain its members in many different ways. Highlights of this issue include contributions from many corners of the world. Miri Keren reminds us of the careful decision to move the 2016 Conference from Tel Aviv to Prague, ever mindful of the importance of working toward peaceful resolution of conflict in Israel and Palestine. Authors, France Frascarolo and Nicolas Favez, offer reflections about coparenting. Beulah Warren, WAIMH Awardee and member of the Australian Association for Infant Mental Health, contributes the Winicott Lecture that she gave at the AAIMHI Conference in October of this year in which she invites us to be a voice for infants. Maree Foley, WAIMH Affiliate Council Chair and Anna Huber, Affiliate Council Representative, share updates in the Affiliates Council Corner. Joshua Sparrow features excerpts from Astrid Berg's book, *Connecting with South Africa*, including portions of a case study inviting reflection and response.

Of additional importance, let us introduce three new WAIMH members who have volunteered to be part of the *Perspectives* editorial review board: Connie Lilas, Mary Marchel, and Robin Treptow. We offer a very big thanks to those who have contributed, reviewed and/or edited articles this year. *Perspectives* is one important way that WAIMH fulfills its mission to disseminate information and share knowledge about the field of infant mental health. Thank you and a very happy new year!

Author 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 15 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 15 pages are also welcome for submission
- Send the submission to:
Deborah Weatherston,
dweatherston@mi-aimh.org

Celebrating WAIMH members' contributions to infant mental health: News from Professor Tuula Tamminen

This column provides news from Professor Tuula Tamminen regarding some exciting infant mental health initiatives. Tuula Tamminen is from Finland and is a long standing WAIMH member. She was the President of WAIMH from 2004 to 2008 and was presented with the Honorary President Distinction in 2012. She is currently on the WAIMH ethics committee whose members are drafting the WAIMH Infant Rights Declaration.

Tuula is a newly elected member of the European Commission's Scientific Panel for Health

Within the past month, Tuula was nominated as a member of the European Commission's (EC) Scientific Panel for Health. The European Commission is the "government" of European Union (EU) and its Scientific Panel for Health is a most prestigious and rigorous scientific body in the European Union. It focuses on the health needs and aspirations of those in Europe, but as it is a collaborative international body, it also works with non-European partners. As such, funding grants for research, such as infant mental health research, may be considered from partners within, and outside of Europe. Tuula says that she is "looking forward to seeing excellent applications on infant mental health..."

On behalf of the WAIMH family, the Perspectives team would like to congratulate Tuula on this appointment.

Horizon 2020: Research funding possibilities for Infant Mental Health

Horizon 2020 (2014/2015 and 2016/2017) is a research

funding program. It is an initiative of the European Union, and as Tuula reminds us, it is their "biggest research funding program ever". Within this program, health science and research are under the scope of "Societal Challenge (SC1)" and named as "Health, Demographic Change and Wellbeing". There are 8 key focuses for 2016/2017, with one of these being early development and it's relation to mental health. For further information follow the link:

<http://ec.europa.eu/transparency/regexpert/index.cfm?do=groupDetail.groupDetailDoc&id=15073&no=1>

This Horizon 2020 program in conjunction with Tuula on the EC scientific panel for health, presents a marvelous opportunity to all of our WAIMH members to direct IMH research funding submissions to this program.



Tuula Tamminen, Professor in Child Psychiatry and Honorary President of WAIMH .

Infant Mental Health training in Arabic countries (www.emacapap.org)

Tuula shares with us the following:

Four years ago I was in a World Health Organization (WHO) Task Force together with Professor John Fayyad from Lebanon and we talked about infant mental health training in Arabic countries. John has worked hard and now there will be the First Arab and Eastern Mediterranean Infant Mental Health Meeting in Kuwait (www.emacapap.org). This is one step on our long road to global presence of infant mental health professionals.

Rutter's Child and Adolescent Psychiatry (6th Ed.) Wiley Press.

Rutter's Child and Adolescent Psychiatry (6th Edition) is now in press. Within this text, keep an eye out for a chapter on "Infant/early years mental health". This chapter has been written by Tuula and Kaija Puura, and it is the very first time that Rutter's textbook will have a chapter on infant mental health. Following many tight revisions (as is in keeping with the rigor of such high quality publications) Tuula and Kaija recently saw the final proofs. Amidst the delight in seeing the chapter in its final shape, Tuula said:

Gladly the figure presenting map of globe with WAIMH's affiliates and logo is still there! At least in the proofs the picture is a full page picture! This also helps us to get visibility around the world.

On behalf of the WAIMH family, the Perspectives team would like to congratulate Tuula and Kaija on this publication, and, for their generous work in keeping WAIMH in view. We look forward to reading the chapter, learning from it and citing it frequently in our writing.

By Maree Foley (Chair of the Affiliates Council), Wellington, New Zealand

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Greetings to all WAIMH Affiliates. This column includes updates about: The WAIMH 2016 Congress; the WAIMH social media initiative; and initiatives within the Affiliates Council (AC) to continue to build connections with emerging and established affiliates. It also provides a brief update concerning the voting process within the AC and the WAIMH by-laws regarding the requirement for each affiliate to be comprised of a minimum of 10 WAIMH members.

The WAIMH Congress 2016

Over the last couple of months you will have received news from our President Miri Keren about changes to the location and title/theme for the next WAIMH Congress in 2016. First, this Congress, which was planned to have been held in Tel Aviv, will now be held in Prague. It will be hosted by the Israeli and Palestinian Infant Mental Health Associations. Second, a new focusing title has emerged for the Congress: Infant Mental Health in a rapidly changing world: Conflict, adversity, and resilience.

The AC look forward to working closely with the Israeli and Palestinian 2016 Congress team as they navigate their way through this creative solution to a remarkably complex, challenging and frightening time.

Social Media

You will have received a recent email from the WAIMH office inviting you to participate in the WAIMH social media initiative. This initiative aims to develop of a social media voice between WAIMH members and a voice from which to communicate with our partner colleagues and associated organisations and groups. Please do consider sharing any time you might have spare to support this initiative.

Making Connections with each other

The AC aims to connect affiliates with each other. Over the past years this function is steadily growing and we invite you to continue to reach out to each other with your good news as well as sharing the challenges you may be facing. Furthermore, we have noticed that enquiries for help and support are typically both unique to the affiliate while also sharing much in common with other affiliates. For example issues such as: working effectively with teams of professionals in a volunteer context; wondering how to access resources/ training for affiliate members; and what to do when energy, motivation and membership numbers dwindle.

We are in the process of trialling a new way to respond to individual requests to the AC by inviting a small group of Affiliates to gather on-line to listen, reflect and respond. The goal of this approach is to use the technology available to us to create pathways for affiliates to talk with each other about shared issues using skype or go-to-meeting, for example.

If you have a special issue or a question regarding your affiliates needs, please direct these to Anna Huber, AC Representative (annahuber.marymead@gmail.com)

“WAIMH Study groups” for groups that are in the process of becoming a WAIMH Affiliate

A core task of the AC involves identifying and meeting the needs of affiliates at varying stages of their development. In response, the WAIMH Board suggested that new groups who as yet do not meet the criteria to become an affiliate, but who are in the process of developing their membership will be able to be part of WAIMH as a “WAIMH study group”. This initiative provides emergent groups, such as China, with an identity within WAIMH as they develop into an affiliate.

In developing this idea the AC has invited an emerging group to participate in a trial program which entails being helped to create and implement a plan for their group that:

1. Takes a structured step by step process over time to gradually meet the criteria for Affiliate status;
2. Outlines a time frame to create a sense of purpose and focus to the group's efforts; and
3. Provides opportunities for existing affiliates to provide pockets of specific support and encouragement to the emerging group.

If you are an emerging group and you would like to be part of this structured trial please contact: Maree Foley, AC Chair. (maree.foley@xtra.co.nz)

Update in the voting process: A recommendation for the 2018 election

Since 2010, the AC have been working together to refine the original voting system of members to the roles of Affiliate Council Chair and Affiliate Council Representative. To date an iterative process of reflection has included identifying the diversity of types of Affiliates, such as:

- a) Affiliates that represent a whole country, such as New Zealand;
- b) Affiliates that represent a number of countries, such as the Nordic Affiliate; and
- c) Countries that are represented by a number of state based affiliates, such as the USA.

The process has also involved an online survey with the AC members, discussions at the AC meetings, and WAIMH Board meetings.

As a result the following recommendation is proposed:

When voting for the election of AC officers: each affiliate will receive one vote except in cases where:

An affiliate is made up of more than 1 country. In this instance, each country within that affiliate (up to 5 countries) will hold one vote each; and

In countries where there are a more than 1 affiliate. In this instance, the country will receive 1 vote per affiliate, up to a maximum of 5 votes, irrespective of whether or not that country is comprised of more than 5 affiliates.

In early 2015, an online survey with AC Presidents will be conducted regarding the election process proposals so as to ascertain the voice of all the AC members.

Maintenance of WAIMH Affiliate Status

Our WAIMH bylaws state that each affiliate is required to sustain a minimum of 10 WAIMH members to maintain their affiliate status. Feedback from the previous AC survey highlighted the need to balance the 10 member requirement with scope for flexibility for individual affiliates on a case-by-case basis. The AC acknowledges that affiliates are dynamic social systems that function within dynamic social and political systems.

WAIMH is committed to supporting Affiliates who may be facing difficult times. As such, in the forthcoming AC Affiliate Survey that will be sent to Presidents at the end of November will include a question about current WAIMH members within each affiliate. Sharing this information provides a pathway to engage in discussion between WAIMH and the Affiliates with a view to furthering understanding about the unique circumstances and working together on a shared plan to try and re-build the number of WAIMH members within each affiliate.

Finally, the Affiliates Council functions for you and we do this by learning more about how we can actively support each other. We welcome any contact you make with us.

The World in WAIMH

The World in WAIMH is a column intended to generate reflection and dialogue about infancy and infant mental health within our global community. 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. Our shared hope is that this will offer space for challenge and interdisciplinary discussion. We are asking the WAIMH community for commentary, field reports, case studies, research articles, book reviews, new submissions and (when proper permission can be obtained) adaptations of previously published articles that may be of interest.

What follows is a contribution from Astrid Berg, a child psychiatrist and psychoanalyst who resides in South Africa. We selected excerpts from her book, *Connecting with South Africa: Cultural Communication & Understanding* (2012). We have received permission from the author and the publisher to reprint portions in Perspectives. The book may be ordered from Texas A & M University Press, College Station.

We include passages that invite consideration of differences and similarities in work with very young and families around the world. Of importance, Dr. Berg emphasizes that all infants and children have the status of whole human beings, with a right to be seen and heard and cared for.

Excerpts from *Connecting with South Africa: Cultural Communication & Understanding* (Berg, 2012) with brief commentary by Joshua Sparrow and Deborah Weatherston.

In chapter two, "And What About the Infant?" the author presents a moving clinical case study in which she illustrates how she works with deep respect for the personhood of the baby, while holding in mind the relationship between mother and child. The case study follows:

"Kwanga was five months old when he was referred to the clinic. His mother was twenty-one years old. His recent failure to thrive was of concern—two months before there had been a marked drop in his weight. Kwanga had had gastroenteritis but had not picked up his weight since then, although the symptoms had ceased.

On history taking, it emerged that he was mother's first child. His maternal grandmother was living in the Eastern Cape, while his young mother was 'drifting from aunt to aunt,' as she had no fixed abode in Khayelitsha. The father of the child was not really present, and she was entirely dependent on the aunts. She stopped breastfeeding when Kwanga was one month old, because the baby 'did not want to.' It seems that the bottle feeding and the gastroenteritis contributed to the drop in weight. The mother denied any other problems, saying she loved her baby and that she herself was eating and sleeping well. These few facts we elicited with some difficulty.

We observed that this young mother was well dressed, as was her baby. She would give him a pacifier when he cried (this is a rare habit; usually in Khayelitsha the breast is given for comfort.) Kwanga was quite a thin child. His mother was cut off from him and avoided eye contact with the interviewers and with her baby. I felt that her eyes were 'drifting,' like she was with her life. The team had a sense of hopelessness when they heard this story and when they saw the non-interaction and wondered what could be done. Because the mother denied any negative feelings, it seemed pointless to be empathetic.

After a while my co-worker Nosisana took Kwanga, put him on her lap, and talked to him. He needed to be coaxed to respond, but eventually he did so with a smile and physical movements. His mother did not take any delight in this and looked away. However, when her problems were addressed, she did look at Nosisana more steadily. I asked that Kwanga be turned to look at his mother, but he avoided her—he rather looked at us. He was returned to his mother, and now for the first time she held him facing her and smiled at him, and it appeared that he met her gaze. His mother was given a pamphlet explaining the importance of interacting with the baby.

The baby's failure to thrive was diagnosed as deriving from depression and deprivation in his mother. We hypothesized that the early weaning occurred because there was no older mothering figure to help this young woman. She was asked to return in two weeks. By the second visit Kwanga's weight had increased, and when Nosisana approached him, he cried, indicating that

he had now attached to his mother. He was more responsive to her and more alive. His mother had a 'lighter' feel about her and she was interacting with him face to face. She was still living with an aunt, but the relationship with the boyfriend seemed to have stabilized. She spontaneously said that Kwanga looked like his father. This was an important acknowledgement in that the feelings belonging to the father can so easily be displaced onto the baby. This young woman felt more positive toward her boyfriend, and this in turn may have enabled her to have the same feelings toward her infant son.

This case illustrates how even in dire circumstances where poverty and family disconnectedness are so prevalent, and where official social support is so limited, and where the mother seems unreachable and closed off, turning to the infant can result in bringing new life into the situation. The baby was spoken to, he responded to us, and the mother saw this. Something seemed to have changed for her, enabling her to take her baby and do the same for him. His weight gain and his attachment to her were evident during the subsequent visit.

The harder the struggle for physical existence is, the more basic and simpler everything seems to become. In psychotherapeutic interventions, a regular twice-weekly talking session is neither possible nor appropriate. However, the essence of the interaction remains the same whether in Stockholm or in a township in Cape Town: seeing the infant and her or his distress, taking this seriously, and communicating this to the infant. All infants need to be recognized as persons who are eager to communicate." p. 29-30.

Astrid Berg uses this single clinical case to invite readers to think more deeply about all infants and families and about themselves. She believes that the work with infants leads professionals on a journey in which they discover many things about their own humanity. She ends the chapter with the following comment:

"However, if we start to think about infants as full human beings from the very beginning, who have abilities that allow them to see, hear, and feel in their own right, then the projection and reversal reactions are challenged. If we regard the infant as subject, not as object, we enter another realm of relating and doing psychotherapy (Salo, 2007). We can no longer afford to hide behind defensive reactions such as 'they are too young to notice.' The denial has to give way to acknowledgment—and it is a painful, indeed an excruciating acknowledgment.

It confronts us with our own beginnings, and we have to imagine what it could be like to be that infant whose mother is not available, who fails time and again to respond appropriately to his needs. From an adult's perception such a breach may not be that dire; but from the baby's point of view this maternal failure is experienced as catastrophic (Baradon 2005). We have to use our imagination, as Jan Wiener so clearly invites us to do when working with countertransference (Weiner 2009). In the case of infant psychotherapy it is about finding the words for what we feel that could link to what we imagine the baby might feel.

Once we have understood and integrated the fact of infants as sentient beings, we cannot remain aloof and dispassionate: there is something compelling that draws us into their world, and into what they represent—indeed, it becomes an issue of human rights. Human dignity and justice are not the prerogatives strictly of verbal adults—they extend to the helpless and the wordless; in fact, these vulnerable people require human rights possibly more than anyone else. The feelings evoked in us with infants go beyond the personal. If there is a universal theme that connects us all, it is the way in which we all began this life." p. 31-32

We welcome letters of reflection and comment from the field in hopes of generating thoughtful discussion about clinical case approaches with infants and families across cultures and in different communities around the world.

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A personal experience of the WAIMH Edinburgh Congress: Presenting a poster and being part of the WAIMH Interview Project

By Angela McLaughlin (PhD Candidate, University of Edinburgh)

Angela has recently joined the WAIMH's editorial team of Perspectives with a specific focus on encouraging Masters and/or Doctoral students to share their work with the wider WAIMH family by contributing to the column on Perspectives. In addition, Angela has established the Butterfly Baby Clinic (www.ButterflyBabyClinic.com). If you would like to connect with Angela she would be delighted to hear from you. You can contact her via her website or email: angela@butterflybabyclinic.com

The WAIMH World Congress 2014 is an experience that will always remain close to my heart, not only because it was hosted in my academic hometown of Edinburgh. It was my first realisation that I was part of a wonderful and warm extended professional family with each member contributing something very special to the world of babies. My personal experience of the congress was made all the more memorable because I both presented a poster of my PhD research and was also part of the small team interviewing some of the most prominent members of WAIMH about their contributions to our field.

Many of the interviewees were not necessarily old in terms of chronological age, but the wisdom they had to share was beyond their years. Putting age aside, the experience felt akin to sitting at the fireside whilst a parent or grandparent told stories from the past about their lived experiences, dearest memories and departed guidance about how to navigate the path that may lay ahead for us. It reminded me of traditional storytelling where family history is passed from one generation to the next through the magical experience of connecting eye to eye, mind to mind and heart to heart.

The WAIMH Interview Project was a personally enriching experience and professionally inspiring one. I consider myself honoured to have heard many of those stories first-hand and will look forward to sharing those stories, and those created by my peers, with the next generation of infant mental health

professionals who will join our family in years to come. The experience has also left me with a sense that creating a mentorship programme, where early career infant mental health professionals can be nurtured by veteran members, would ensure that the next generation get the best possible start... just as we aspire to provide for the babies and families we work with.

I would like to take this opportunity to thank, once again, all of the interviewees who allowed me to listen to their very open and honest stories about their personal and professional life-journeys as I filmed the interviews. I would also like to say a special thank you to those who allowed me to interview them directly: Hiram Fitzgerald, Peter Fonagy, Joy Osofsky, Colwyn Trevarthen and Deborah Weatherston; many of whom are founding members of WAIMH. Tribute is also paid to Kevin Nugent who created the idea of conducting the WAIMH Interview Project during the congress in Edinburgh. I also want to acknowledge the hard work and commitment shown by my peers who collectively conducted the interviews and are preparing the footage and transcripts to allow this wonderful collection to be shared with the wider WAIMH family: Jessica Bartlett, Christine Bartram and Aditi Subramaniam. Gratitude is also extended to the School of Health in Social Science, University of Edinburgh, for offering hospitality for many of these interviews to be conducted.

Perspectives: From the Field

Medline Recognition for the *Infant Mental Health Journal*

The *Infant Mental Health Journal* has been selected for indexing by MEDLINE/PubMed. MEDLINE citations are indexed with the National Library of Medicine (NLM) Medical Subject Headings (MeSH®) and are directly searchable from NLM as a subset of the PubMed data base. Congratulations to Hiram E. Fitzgerald, Editor-in-Chief of the IMHJ for the past 5 years, to the Associate Editors, and to the Consulting Editors from around the world.

Scientific Award

WAIMH is pleased to announce that the following paper was awarded a Best Scientific Paper Prize by the French-Speaking Psychiatry Association (le Prix de la Meilleure Publication du Congrès Français de Psychiatrie):

Moser DA, Aue T, Wang Z, Rusconi-Serpa S, Favez N., Peterson BS, Schechter DS (2014). Comorbid dissociation dampens limbic activation in violence-exposed mothers with PTSD who are exposed to video-clips of their child during separation. *Stress*. 16(5):493-502.

Daniel Schechter is a long-time WAIMH member.

Infant Observation – A Collaboration

Several papers devoted to infant observation and its applications, originally published in WAIMH's *Signal* in 2002, Volume 10 (1 and 2), under Paul Barrows editorial direction, will appear, with permission from the WAIMH Central Office, in the December 2014 issue of *Infant Observation*, Volume 17 (3). The papers selected include: "Preventive Applications of Esther Bick's Method of Infant Observation" by Didier Houzel (France) and "Observed Mothers' Interviewed" by Annette Watillon (Belgium). All past issues of the *Signal* appear on the WAIMH website: www.waimh.org

Lullaby Circles

Rock with Me! Babies From Around the World Lead the Dance!

Suzi Tortora Ed.D., BC-DMT, CMA, LCAT, LMHC

New York

In honor of Infant Mental Health Week, I released Rock with Me! Babies From Around the World Lead the Dance! a dancing dialogue of attuned connection based on my Embodied Parenting Program. The clips were taken of students, parents and colleagues from around the world during various workshops and trainings I led as part of my Lullaby Project. Through the Embodied Parenting Program and Lullaby Project I teach parents [and caregivers] how to use play, songs, dance, movement and breathing activities to enhance their body-to-body connection, creating a dancing dialogue with their baby.

Building upon Papoušek's Angel's Circles concept I have created a seven-step process called Lullaby Circles ARC -- Attend to baby's nonverbal cues; Reflect on both what these cues are saying as well as what the parent's internal reaction is: Connect back with baby through playful dancing interactions.

You and your baby dance together right from the start! Your baby tells you how she feels through the way she looks at you, the faces she makes to you, and how she moves her whole body. The very first way she talks to you is through her body, for even her coos and cries are accompanied by actively moving. Your baby first learns about the world around her through how she explores her body moving when alone and with others.

Babies' actions are contagious! It is hard to resist those bright shining eyes and the bursting smile that spreads over your baby's face when she sees your loving gaze. As caregivers we automatically respond to babies by exaggerating our facial expressions and raising our voices into a playful tone called motherese. These playful connections are the core building blocks of how you and your baby create a lasting attachment [bond].

It is through feeling her body moving with you that your baby first begins to feel your love. Your loving embrace can both soothe her and get her up and going as you sway and bounce your baby in your arms. Singing, dancing, and playing with your

baby teaches her how to calm down when she is upset and become energized to play with you when she is alert and awake. Your body-to-body connection through movement is the first way you and your baby communicate. This vital connection between parent and baby is seen everyday, across the globe and in my latest YouTube video: <https://www.youtube.com/watch?v=XgKIUpFpyno>

Please do check it out and enjoy!

15th World Congress of the World Association for Infant Mental Health

May 29 – June 2, 2016
Prague براغ פראג
Czech Republic

Theme

**Infant
Mental Health
in a rapidly
changing world:
Conflict, adversity,
and resilience**

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WORLD ASSOCIATION FOR
INFANT MENTAL HEALTH

The Congress is organized by WAIMH in cooperation
with the Israeli Infant Mental Health Affiliate
and Palestinian Infant Mental Health specialists.

From the Kauppi Campus

-News from WAIMH Central Office

The Association is Growing

By Pälvi Kaukonen, Executive Director,
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Dear Friends,

The year 2014 is soon ending, and from the perspective of the World Association for Infant Mental Health it was really successful.

The 15th World Congress in Edinburgh brought together 1600 Infant Mental Health specialists. Also during the current year the number of WAIMH members grew to 1030 individuals. Additionally we have affiliates on all continents: 16 in Europe, 28 in Northern America, 2 in Southern

America, 2 in Africa and 5 in Asia and Oceania.

The Board has been preparing the Infant's Rights document all through the year. The Board of Directors also got new members, since Maree Foley started as the Chair of the Affiliate Council and Anna Huber as the Affiliate Representative.

Membership

As the year is ending, please renew the WAIMH membership for the year 2015. Go online to the website of the association: www.waimh.org.

There are two separate categories: the student (45 USD) and professional (75 USD) memberships. As a WAIMH member, you have the privilege of ordering the Infant Mental Health Journal at a special rate.

The rates differ according to your country: USA 50 USD, Canada 52.50 USD (including tax) and International orders 62.50 USD.

All journal subscriptions are also including access to the online IMHJ at the Wiley. A new popular form of getting access to the journal is the online only option, which is available for WAIMH and MI-AIMH members worldwide at the fee of 40 USD.

Please, contact the Central Office of the association, if you need guidelines or support for the membership renewal (office@waimh.org).

Social Media

The Social Media initiative is progressing, and Reija Latva started as the Social Media co-ordinator. We now have volunteers all over the world, who are helping us with the social media channels (yet not opened for the public).



15th World Congress in Prague

The 15th World Congress of WAIMH will be held in beautiful Prague in the Czech Republic. The date is May 29 – June 2, 2016. The Central Office and Programme Committee have started their work in order to produce a memorable and scientifically high quality congress.

Seasonal Greetings

We want to thank all our members and networks for your work on behalf of the infant perspective globally! Your work is especially important in the turmoil of the world events. We hope that the supportive network of Infant Mental Health specialists involved in WAIMH can give you new insights and joy also in the next year 2015!

