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Infants Born of Rape

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INTRODUCTION - FRANCES THOMSON SALO

These papers begin to explore a painful subject that at times may feel almost unthinkable, that of infants who are born as the result of a rape. These papers were part of a symposium on 'Infants and rape' presented at the World Association of Infant Mental Health 2006 Congress in Paris. Campbell Paul in the context of work with sick babies discusses questions about self representation and identity when there has been rape, and the defences used. Amanda Jones describes how a young, deeply traumatized asylum-seeking mother used a psychodynamic, systemically sensitive, parent-infant intervention, to find a way to accept, and gradually love, her seventeen month old first-born son born as a consequence of her suffering multiple rapes. Juliet Hopkins concludes with a discussion of the two papers.

The papers explore the ways that a baby conceived as a result of rape might be affected by the psychic work the mother needs to do to enable the baby to come alive in her mind as a person in his or her own right. With these babies, we need to consider the autonomy of the fragile self. It is crucial to be aware of the effects on infants and their families, and to refine and extend therapeutic approaches. Such work is increasing relevant given the conditions in which some infants and their families currently live. It is, for example, estimated that in Rwanda 10,000 babies were born as a result of genocidal rape. Perhaps it is only when clinicians can allow themselves to hear the pain in such shocking cases that these babies and their mothers can fully get the help they need.

When babies are born of rape their mothers frequently wish that they and their babies would die. Some mothers are not able to mother their babies and some give them away or try to kill them. The whole subject of these infants may be under a taboo of silence in their communities. Some resilient babies, however, help ease their mothers' pain and suffering. How a mother tells her child about his or her conception depends on how she has been able to find a place for an internal representation of a good father alongside the representation of the rapist biological father. The context is always important (Emde, R, personal communication, 18.5.06). One Rwandan mother was reported as saying that she would tell her son about his conception and add that God is not angry with either of them, that it happened because of war, and that God loves them (Wax, 2004).

WORKING WITH A SICK BABY BORN OF A RAPE - CAMPBELL PAUL

While no expert on the tragedy of rape I offer some of my thoughts from a clinical perspective. As it is 150 years since Sigmund Freud was born, it is timely to reflect on the question of where we have come to in our understanding of human sexuality and related issues since then.

Sexual violence is an issue both overwhelming in its enormity and yet in many ways hidden. The World Health Organisation (Krug, 2002) special publication on violence details that women in a range of countries, from 10% in Brazil to 46% in Peru[1], report incidents (often repeated) of attempted or completed forced sex by intimate partners during their lifetime. Up to fifty percent of women have therefore experienced something like rape or a similar assault within their own intimate relationships. As infant mental health workers, I suspect it is an issue we rarely ask about. What does it mean that so many women, presumably so many mothers of the infants referred to us, have been so violated? Do they make a complete disjunction between these assaults and the acts of sexual union that led to the conception of their babies? Or maybe they make a range of accommodations.

1. Other examples are 23% in UK, 15% in Canada.

Contents

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Rape occurs in a range of settings – what meaning does it have for the woman? What effect does it have upon the human integrity of the man? I shall, however, leave aside this question, one that is riven with controversy, to concentrate on mothers and infants. The consequences for women are many: gynaecological trauma, infections, STDs, HV/AIDS, as well as a range of psychiatric and psychological disturbances (depression, PTSD, suicidal ideation) - and of course the likelihood of an unwanted pregnancy. Other social consequences can be profound: women may be blamed, shamed and excluded from their own families, indeed in some communities expelled from the entire community. (In Kenya, women raped by soldiers were, on joining the settlement, rejected by their husbands, and set up their own community with their children.) Women may be blamed for bringing shame upon their families or partners, and justice seems so often a totally remote concept. Rape is at least to some extent a product of social mores, rules and behaviour, whether these are acknowledged or not. In some communities the woman and the baby are seen as the evil, guilty partners and are sometimes killed. Rape has for centuries been used as a weapon of war as part of a more conscious, systematic process but can also occur in the midst of severe social chaos or poverty where law has broken down – for example currently in Liberia at least 40% of women have been raped and fear this would happen to their daughters. The president, Ellen Johnson Sirleaf, is leading a fightback and courageously declared her experience of attempted rape when in prison earlier on.

Even in the 20th and 21st centuries, in the former Yugoslavia and Rwanda, women were held captive for the purpose of demoralising and destroying a community – a form of genocide - through alienating and shaming women, their husbands, their sons, their fathers as well as the children themselves. The trauma of the capture and sexual assault itself is then perpetuated on a daily basis as the family is *faced* with the offspring of their tormentors in their midst. How these infants themselves have fared in this context is not clear – we can only imagine how disruptive it must be.

In statements that victims of rape made to the Medical Foundation for the Care of Victims of Torture in the UK, many women said that they did not blame the child, whom they saw as 'an 'innocent victim of war (Papineni, 2003, p 362)'. While it is not known how many infants have been abandoned, clearly many still live with their mothers, who may identify with the child and also fear the infant being described as 'filth' by the whole community. In Rwanda, such children are often known as 'les enfants de mauvais souvenir', that is, children of bad memories or '*children of hate*' (Papineni, 2003).

How difficult it must be to seek help in such circumstances: the mother is doubly aware of her shame in that she knows that she was forced to gratify her oppressor's desire and she knows that everyone in her community knows this as well. What does she believe her infant will know? What does she glean from his eyes to her?

Correspondents Report (Australian Broadcasting Corporation 10.2.06) addressed some of these questions in a program in which two Bosnian women discussed their dilemmas. Safeda wondered when to tell her adopted son that his Muslim mother was raped by a Serbian soldier. Safeda was ill and about to die and was in great conflict about whether to tell her son about his conception. His biological mother had abandoned him so that he had not been breastfed; he was adopted by a Muslim couple. One question was whether he should try to find his mother - 'Not really, he has parents, there's love from the adoptive parents, his mother especially'. Another question was whether to tell him that he was Muslim - 'He is more Muslim than Christian…We will see this happen again. …Their children live with us.' The second woman, who was single, was raped by soldiers and became pregnant. She poignantly said of her son, 'He's my whole life. When I go, he'll be all on his own. But my son

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will be a good man.' Even though her son had a very divergent parenthood and traumatic conception, his mother was able to detach him from wrongdoing done to her by his father. Can she talk of his father? Can she even think of his father? As clinicians we see some mothers whose babies present with problems, who say, 'His father is not around' or 'I don't know who her father is'. Should we explore this with mothers or leave things unsaid?

Also of interest was the process of making the television documentary, of daring to talk about a topic of which so many were ashamed. For these mothers, despite the inevitable traumatic memories experienced by the mother or adoptive mother, the child was *a person in his own right* – detached, as it were, from the '*father*', if I can use that term,. Somehow they made this *dissociation* possible.

For families whom I see at the Royal Children's Hospital, Melbourne, this disjunction is not always possible, as with Helen[2], 28 years old, and her 5-month-old daughter, Sarah. Helen had been sexually assaulted and anally penetrated by a stranger when she was alone in the street one night. She has suffered considerable anxiety symptoms and severe gynaecological and bowel symptoms with intermittent pain and rectal bleeding. She subsequently became pregnant to her husband, unrelated to the sexual assault. She found the whole process of intercourse, pregnancy and childbirth very traumatising, but managed it in a private, self-contained way. Her daughter, Sarah, had become embroiled in Helen's sexual trauma as she reminded her of the assailant of some years before. The baby presented with distress and feeding difficulties, refusing bottles and Helen had 'lost all confidence in her'. For Helen, as it unfolded in therapy, it was hard to provide any sense of containing limits for her. She felt guilty for connecting her daughter to the violence done to her. But as she became aware of this unconscious connection: men – violence – rape – her memory – sexuality – her daughter, there seemed to be some degree of freeing that enabled her to provide more appropriate limits and containment and to help her regain better self-regulation and homeostasis.

Helen and Sarah are doing well at present but there remain tensions and lacunae in the relationship between Sarah's father and mother – many things had never been said between them. They have recently commenced marital counselling which Helen seems to find confronting and helpful, but there has been some freeing of Sarah from this sexual trauma.

What of those babies conceived in communities which are not in the grip of war or equivalent chaos? There are many babies conceived in rape in our communities whom we do not know about. In a 3-year longitudinal telephone survey in USA about trauma and health, 4,000 women were followed up three times a year and 6% reported rape-related pregnancies (Holmes et al, 1996). The context is that in USA an estimated 680,000 of women more than 18 years old are assaulted each year but 60% of all rape cases are females less than 18 years old, so that the figure may be much higher. Only 15% report the crime to the police. The researchers asked about non-consensual assault, with force or threat of force (with some sexual penetration of vagina/rectum/mouth). 80% agreed to interview. The results suggested a 13.6% *lifetime* prevalence rate of rape. In USA there are estimated to be about 32,000 rape-related pregnancies per year. For many this means having to experience the difficulties of being a very young teen mother. These figures are in the context of an estimated 3 million unintended pregnancies in USA per year. Often the offender was known – even well known - to the baby's mother, which suggests links to ongoing family violence. There is a high prevalence (more than 45%) of multiple assaults. Many were never disclosed to law enforcement or health workers. (There are different contexts: date rape, marital rape, incest and random sexual assault.) Or were they disclosed to the child? It is a complex problem: 30% for example did not discover they were pregnant until the second trimester, so that termination of the pregnancy becomes problematic. 30% opted to keep their baby, 50% had an abortion, 6% placed the child for adoption and 12% had a spontaneous termination.

CHANTELLE

Here I shall describe Chantelle, who was born early – too early in many ways. Her mother, Kerry had a complicated pregnancy, with high blood pressure and pre-eclampsia leading to a semi-urgent Caesarean section at 34 weeks. Chantelle had severe respiratory distress syndrome and needed five days of ventilation; she also had a mass in her abdomen and possible pre-birth brain damage, so that her start was very problematic. Kerry, aged 35 years, had also had a very traumatic life, with many presentations to mental health facilities and multiple diagnoses, mainly of Borderline Personality Disorder but including bipolar disorder. She had certainly been very sad and anxious about Chantelle's birth, fearful that she might not be able to bond with her or able to care for her. She feared losing her baby, but was nonetheless very honest about this experience and her feelings. She talked of her concerns that she had poor control of her own anger. 'I sometimes think of hitting her – but I would never do it.' She had found herself losing most of her relationships over the course of her early adulthood, including those of her long term foster parents who felt they could no longer bear the hurtful disappointments that resulted from their attempts to keep in touch with Kerry. She was unpredictable – one minute she was sad and needing their love, at other times angry, distancing and rejecting, and on rare occasions violently threatening.

Kerry revealed that she had been a child born of rape. She never knew her father – her birth mother found it impossible to talk about it, only that Kerry was conceived by force, by a man she had never known. Kerry found this out in her

2 Names have been changed to protect confidentiality.

early teens. There remained big gaps in her memory which seemed to make things worse for her – she was a person who could never know herself. She had begun self harming at 14 years but was, however, able to sustain her studies and get a job.

Her partner relationships had been many, complicated and disrupted, but in recent years she had settled with Sam, her current partner; there had been consistency, albeit with dependency. She hated him - he had raped her. She had refused sexual relations with him, but he insisted and forced her – she felt violated and dirty. Chantelle was a result of this intra-marital rape. It was as if Kerry existed without any sense of *self and boundary*, just as she fantasised it had happened to her mother – a repetition. Chantelle had medical problems: she had small brain haemorrhages and she looked 'odd' but no specific diagnosis was made. Kerry said how hard it was to care for her baby – she wanted so desperately to do this but felt incompetent and unable; she felt she needed help with basic aspects of child care. Indeed the ward nursing staff were very concerned at the way Kerry bathed Chantelle, whom she let slip into the water. Chantelle was very stiff and mechanical and it was a joyless and unsmiling procedure. Kerry seemed very detached from Chantelle who herself had persistent avoidance of direct gaze with her mother as well as others. It was as if Kerry, although a bright woman, had *no idea about her baby's body*, no idea how to hold, mould, contain it.

She said that Chantelle being sick made her very confused and she wondered whether Chantelle's illness was a *punishment* for Kerry's problems or whether Chantelle was being punished. For what? For being her daughter? Kerry said that when she looked into her daughter's face she saw herself - but as a shell of a person, as somehow '*bad, damaged goods*'. Her past was projected into her daughter – or was it *her daughter herself, she found it difficult to distinguish*. She thought that maybe Chantelle was really just her husband's daughter and there was none of herself in her daughter at all. Somehow there was a mockery of herself. Projections seemed to fly about like missiles and in the midst of this Kerry saw herself reflected in her daughter's face as bad, unwanted, abandoned and somehow evil. With the huge gaps in her personal narrative she fitted the fantasy of her own father violating her mother and herself into her self concept, that she must be bad and unlovable, like him. She also fitted this into her view of her daughter.

Donald Winnicott, (1971) paediatrician and psychoanalyst, wrote about the importance of the mirror role of the mother (and it could be the father), whose task is to enliven the baby through face-to-face engagement (and holding of the baby). In this context, 'the baby, looking at the mother … sees herself reflected in the mother's face' For Kerry, as she looks into her baby's face, she sees a shameful, damaged image of herself reflected and this is the image of emptiness that Chantelle may then see reflected back to her through what she sees in her mother's face; she then avoids the gaze of her mother and others.

Kerry was admitted to a mother-baby psychiatric unit with Chantelle for a couple of weeks, but still felt unsafe to look after Chantelle, despite improved self regulation, feeding, sleeping and containment of her medical problems. Chantelle went home with her parents, but Kerry was not allowed to be alone with her on a Protective Services' order, as she was unable to say that she felt completely safe caring for her daughter. Chantelle remains an infant of concern, although developing a relationship with the family support worker who visits regularly and has a vital role with Chantelle and her mother.

Chantelle *was* able to play, but usually began an interaction with a tense, hypervigilant gaze, her eyes reaching to the back of the eyes of whoever met her, so that there was a shift in the way she related to people. Her penetrating gaze seemed to be one of self defence. As Chantelle and her parents have moved out of the Children's Hospital geographical area we are not directly involved in her ongoing treatment. Her parents are her primary carers, she is now one year old and her physical and social development seem satisfactory. We remain concerned about her emotional development. Will she be able to be helped out of this chain of intergenerational traumatic projections? Kerry has been honest about her baby, in a protective way, even though the risk is high that she may harm her. The workers have strong feelings about Chantelle and have been able to work with them. Kerry was welcoming of our interventions (the mental health service), as well as those of her own therapist, the infant-focused family worker and Protective Services. So there is some cautious optimism.

To summarise, when pregnancy results from rape the family, the community, everyone has views about the woman – if they know - and about the potential baby. But what does the mother feel about herself and her baby, who is often seen as a 'bastard' infant, as evil and a punishment? Can she love her baby? I think that a critical role for health professionals is to gently engage with parents and the baby in an attempt to identify the powerful projections that lodge on the baby, and hopefully attempt to detach some of these. In the two cases here, the mothers volunteered their history of sexual assault. What of the many women whose babies have symptoms of a range of common infant mental health paediatric problems but who are unable to tell us about their assault? How can we establish trust in such women in a way that is facilitating? So much depends on the context. These two women presented their babies through a non-stigmatising child health system, which may have made it easier for them to trust. For others it may be that a longer term relationship-based home visiting early intervention program (Zeanah, 2006; Lyons-Ruth, 2006) can provide the necessary sense of safe containment to share feelings of shame and anger. Agencies such as sexual assault units can play a vital role in supporting

communities if they provide a safe, supportive setting in which terrible events can be disclosed to someone who will sensitively listen. Perhaps through these means we can help the mother see that her baby's own story must develop, separate from the narrative of the rape that resulted in the conception – that her baby becomes an independent person.

For clinicians seeing mothers before they have made disclosure of sexual abuse, when we ask a mother if her pregnancy was 'planned', we are asking a lot. It is not an easy question. For a woman who has been sexually assaulted, especially within her partner relationship, it can be a crucial question. She would be wise to assess us well before answering this question – if she does divulge the fact of rape leading to conception and the baby she is consulting us about. She needs to know that we – and the system we work in – can support her in a containing, non-judgemental way. But if she feels safe to tell us, I believe that there is a remarkable opportunity to help enliven the baby. By speaking of it, the mother may be able to begin to consciously disconnect any poisonous projections there may be onto her baby. She may feel better able to see her son, her daughter - as a separate person.

The baby whose very existence means violence can be seen by his mother as always a reminder of the violence – he is the embodiment, literally, of the perpetrator and at the same time the embodiment of herself as a victim. To look at him can be painfully distressing. But WE can look – we can meet and greet him as a *new* person, we can engage him, and help his mother more by possibly seeing him NOT as a representative of hate but *one of hope*. It seems a unique opportunity since it may prove impossible for a mother to talk of this again until in the midst of the intensity of her baby's *adolescence*, it having been a dark secret for so many years. If the mother can talk of it, this can prevent some of the build up of sadness, self loathing, hatred and detachment that can occur. At other times a shallow defence of denial of the rape and its impact can lead to parents avoiding an intimate relationship with their child. So I believe it is important to be receptive to such stories and secrets – the time of the new baby's life is one of great change, flux and of promise.

In summing up communication between infant and mother, Winnicott wrote, speaking for the baby:

I find you

You survive what I do to you as I recognize you as not-me;

I use you;

I forget you;

But you remember me;

I keep forgetting you;

I lose you;

I am sad.

So I hope that we are all able in our different contexts to help babies and their parents find – lose – and find again – each other, be sad – and then happy all over again. The baby can become a person.

RAPED IN UTERO - AMANDA JONES[3]

I met Fatima and Daniel when Daniel was seventeen months old. The memory of my first sight of them is vivid. As I was walking towards the clinic early in the morning I noticed a young African mother sitting on a wall with a screaming toddler positioned across her lap whilst she changed his nappy. It was a cold morning. The mother's face was very still; she was also painfully thin. I did not realise this couple was the new referral I was due to meet an hour later. A support worker had made the referral and had described a depressed mother who was finding her son's behaviour hard to manage. The support worker asked if she and an interpreter who knew the mother could accompany Fatima to the first appointment. I agreed.

When I went to the waiting room there was the couple I had seen on the wall. The room was a tip. Daniel was throwing toys around in a mindless way. When I greeted them Fatima did not look up at me, nor did Daniel. I started to lead them towards the room. Daniel ran ahead, unsteadily, as if he knew where he was going. On this brief journey down the corridor, he fell over three times. Not once did he look backwards to his mother for help. He literally fell into the room. Although I did not know it at the time, in those few moments, Daniel revealed his internal object relationship with his mother: she was not there in his mind as a mother he sought help from; he split off and denied any awareness of wanting a response from her or indeed of wanting contact or help from any adult. Yet, in the tripping, he demonstrated how he was continually *falling to pieces* and then having to gather himself together.

Fatima sat down. She did not remove her coat, or Daniel's. As the family support worker tried to take Daniel's coat off, he hit her face. Within minutes the room was trashed. Daniel tipped over all the boxes, pushed everything off the table, and threw a box of crayons at me. I felt as if something unstoppable was going on. I felt besieged. My emotional response suggested that powerful projective identificatory processes were in play between this mother and son.

It was hard to know how to start. I did not know how to talk about parent-infant therapy to a woman who had clearly come from a situation where therapy would be an alien concept. I fumbled and said that the support worker had told me that Fatima seemed very low, and that I knew it was hard to care for a small child when a mother was unhappy and lacked support. Fatima still did not look at me, but I could see tears rolling down her cheeks. Daniel registered his mother's tears. A few seconds later he picked up a wooden object. Quick as a flash he went over to his mother and, with a blank expression, hit her across the head. Her bodily response was

3. A modified version of this paper was subsequently published in the Journal of Child Psychotherapy as Levels of change in parent-infant psychotherapy, 2006 Vol 32 pp 295-311, publishers: Taylor and Francis, http://www.tandf.co.uk.

startling: she brought both arms up to shield her face, and turned away from Daniel. He froze, hand in the air, as if poised to hit again, and she remained frozen. She made no attempt to limit Daniel, nor did she make any sound throughout the interaction.

This brief sequence captured a repeating behavioural pattern, a pattern which enacted in actions a mix of memories and feelings that could not be 'remembered' and put into words. Contact between them seemed catastrophic. Somewhat disorientated, I said to Fatima that I imagined she had gone through quite a journey to get to the UK: what would it be important for me to know? It was incredibly hard to follow her story. I realized there had been a civil war in her African country of origin and she had been imprisoned for seven months. Fatima managed to convey how during this time she was interrogated, beaten and gang raped, sometimes on a daily basis. I could see scars on her neck. Like many of the other women, she expected to die from her injuries, or be killed. This was not a fantasy: many of her fellow captives did not survive. Fatima's affect was flat, as if she had felt forced to recount details of her rape ordeals on many occasions.

As Fatima spoke of being raped, I started to realise that Daniel's father was likely to have been one of the military men. As I conceived this terrible thought, Daniel was banging an object noisily on the table. The sound frightened his mother; she covered her ears. Daniel came up to me and screamed, lashing at my face. Fatima made no move to touch him, but she managed to push a bottle of milk towards him. Daniel tried to hit her head with it, creating yet another startle response. He then ran and sat in a corner and sucked on the bottle. As his mother continued to talk, Daniel slowly came nearer to me. I hung my hand down from the chair and, to my surprise, felt his head start to push rhythmically against my hand, as if stroking himself. He stayed there, facing the wall, but he had made contact. I talked to him; his mother seemed surprised. Through the interpreter, I put into words what it might feel like to feel so full of terrifying feelings.

Fatima continued and described in a monotone voice how she escaped from the prison and after her arrival in the UK, having had no antenatal care, gave birth to Daniel. She had tried to leave the hospital without him. Somehow – and it is not clear how – she ended up taking him back to her bed and breakfast accommodation. She said she had wanted him aborted or removed from her.

For the first nine months of Daniel's life he spent most of his time in a room with a deeply depressed and traumatized mother who described feeling terrorized by his cries. She felt unable to touch Daniel, let alone hold him, when he showed distress. Then a woman took pity on them and offered to let them sleep on her floor in our service area. This woman encouraged Fatima to go to the local health clinic with Daniel where the family support worker had noticed signs of attachment disturbance and referred to our service.

Towards the end of this first two hour session I asked Fatima about life before her imprisonment. She looked at me in a confused way. She did not know what I meant. Again I felt disorientated, but persisted, saying I wondered about her parents, her early life. She said she had no memories. Then she mumbled that her parents had died when she was a child, in an accident. I asked how old she had been; she could not remember. I said that the horrifying circumstances she had recently been through might have also opened up the wound of that loss which, for a child, would have felt incomprehensible and cruel. She nodded. I describe this because of how, amidst the violence and trauma, tiny seeds of information were being offered that gave me reason to think this young woman might be able to use therapy, and make an attachment to me.

As I was so alarmed by Daniel's behaviour and his mother's state of mind, I offered to see them twice a week. I described this to Fatima, and how I would be available over a sustained period of time. I suggested that the family support worker join us for the first few sessions, as she was clearly important to Fatima. The interpreter said she would be able to work with us on a regular basis. As far as was possible, we made a regular therapy space. Fatima agreed. I could not get them out of my mind.

The next few sessions were suffused with Fatima's prison experiences, horrifying material that affected us all profoundly. I could see how it was impossible for her to think of Daniel as a small child in need of help. I learnt quickly the ways Daniel managed distress, mostly by banging his head on the floor. It was not easy, but whenever this happened, I would interrupt his mother and find ways to ensure we attended to Daniel's state. Fatima could feel angered by this.

Daniel was hyperactive and a poor sleeper and eater. I can only describe him as *pushing himself into or onto objects* in a mindless way. He was incredibly clumsy, always falling down and hurting himself, and then hitting his head hard on the floor to soothe his hurt, whilst his mother remained still. Fatima could admit that she did not want to help Daniel, or touch him. Again and again she spoke of how she would have given him up for adoption at birth had she been given the choice. It was hard to hear such hostility but I think it paved the way for other feelings to emerge. Fatima knew she could tell me if she no longer felt able to parent Daniel. In the context of her hatred being taken seriously, more benign feelings started to grow.

As the full horror of Fatima's imprisonment emerged, as well as her neglect of Daniel's emotional needs, I became more and more preoccupied with how Daniel too had been imprisoned in two situations. Firstly, when in utero during his mother's assaults and secondly, in the first months of his life, Daniel had been trapped with his mother's state of mind. In the present, we had to endure repeated experiences of feeling trapped in an enclosed

space which quickly became filled with terrifying anger and pain. I was continually worried as to how the therapy room could be felt as imprisoning for him. Daniel's stress response system was primed to perceive all of us as potential attackers to be fought off. His early neglect rendered him vulnerable to feeling assailed by any intense feeling coming from within or without. He coped with this by trying, particularly through his hitting, to get rid of such feelings. Over and over again I witnessed him mindlessly approaching his mother's head and hitting it. But his mother contributed to the pattern and it was my task to help her consider this dimension: to add new perspectives to her experience of being a helpless victim.

During this early period of the work, Fatima remembered my question about her parents. She often spoke of how she wished her father could have protected her from what happened to her. We moved in and out of talking about the imprisonment and how, as a child, she had also felt imprisoned by feelings she did not understand. The wish for her father's protection was, I think, critical in terms of some affection slowly starting to come alive for Daniel. It implied that there was, as Serge Lebovici described, a *fantasmatic baby* in her unconscious: the *want* to give her father a baby. Thus her want for maternity was already present as a small child. In her core internal world there was a creative parental couple. The fact that she had managed to care for Daniel's basic needs implies a strong, previously unconscious, commitment to care for a baby, predicated probably on the fact that she had been loved as a baby.

In the transference with me, I occupied many positions, but often I felt Fatima experienced me as if I was a father-figure, a paternal presence. I offered hope and protection and yet also, continually, the reality of absence and what felt like harsh limitations. I was aware of the depth of Fatima and Daniel's growing attachments to me.

In the first phase of the work with Fatima and Daniel I did not mention the use of video. It was hard to imagine using it with an interpreter, and with Daniel who could become so hard to handle. I also thought Fatima might feel intruded upon, raped again, if I filmed her. But I felt I was observing a behavioural pattern that it might help Fatima to see for herself: namely, her profound startle response when Daniel hit or approached her face, and then – swiftly – I observed her move into become taunting or aggressive with him. The movement between aggressed and aggressor flipped incredibly quickly between them.

When I explained to Fatima that it could help sometimes to watch together what happened between parent and child she cried, saying she would not know how to play with Daniel. I said I realized that finding ways to reach one another was painful, and that the video might give clues as to what works and what goes askew. Fatima agreed, but I think she did so out of a sense of obligation to me, not because she wanted to see herself.

So in the sixth session I filmed a three-minute interaction. In it, Daniel picked up a plastic phone and spoke into it. His mother responded, as if answering him. I think Daniel was thrilled at the potential play between them. His body was tense with anticipation. Then Fatima broke contact, she looked to the floor. Daniel froze. Then he lunged at his mother's head, hitting her with the telephone. She pulled back, as if she had been beaten by a grown man. Within a few moments, Fatima recovered and – under the duress of the film – attempted to continue some form of play with Daniel. But her play was impregnated with anger. She taunted and humiliated him by holding a small toy just out of his reach. Daniel tried to grasp it as she brought it nearer to him, then just as he was about to grab it, she lifted it high again. After several thwarted attempts, Daniel cried out in frustration. At this point Fatima smiled, as if unconsciously triumphing at having the power to cause him to cry out. She was relieved, I think, no longer in the position of terrorized victim. Fatima then proceeded to pile up bricks in Daniel's lap, which covered his genitals.

SOME THOUGHTS ABOUT THE INTERACTION

At first, there was contact in the play and the play was about telephone communication. When Fatima broke it, cutting the line so to speak, perhaps she needed Daniel to be in touch with the theme of something unwanted. She had not wanted to be filmed. I think Daniel felt a primitive experience of catastrophic loss: in this instance initiated by me, enacted by his mother, and experienced by him. He felt the disconnection and mood, he felt unwanted - his deepest trauma - and threatened, and he hit out at her. He induced in her, fleetingly, a feeling of pain and terror which she seemed to experience as an assault by a grown up, not a small child. Then Fatima adopted the aggressive position, creating in Daniel a diluted version of the humiliation and helplessness, the kind of feelings she possibly felt when raped or tortured. Daniel then ended up in the vulnerable position with his penis under bricks.

At a deeper level still, Fatima seemed to repeat the experience of loss: loss of a potentially responsive, loving figure. Her feelings about the traumatic loss of her parents were, at this stage, heavily defended against. Daniel too experienced loss of a responsive parent in these moments of daily abandonment. I helped Fatima talk about her feelings towards me filming her, and how my power and the power of the military men became confused. I think she felt she lost me as a helpful figure during the filming and this contributed to the enacted rupture of contact.

When Fatima watched this interaction in the following session, she physically flinched again when she saw Daniel hit her. Fatima asked to watch it twice. She said how she

seemed so scared. She asked: how could such a little child frighten her so much? Then she was able to notice how she became angry. This was a critical moment. Fatima's noticed how she retaliated. I am not sure this could have been thought about, with the same speed, and in the same way, without the visual aid.

Throughout the rest of the session, after Fatima had seen and felt the visual interaction, she was able to put into words more clearly how Daniel terrified her, how she felt him to be a huge military man, and how his needs felt like the soldiers' needs: she hated having to attend to them, she felt she was submitting. It was hard to listen to yet somehow she managed to hold Daniel on her lap both whilst she watched the tape, and whilst she free associated to it. Although what she was saying was distressing, Daniel rested against her. He was calm.

The next week, after these connections, something surprising happened. In the midst of all of the previous, very entrenched, fight-flight-freeze responses, a new intimacy was allowed to develop. I filmed, without knowing it, the first time Daniel was ever allowed to kiss his mother's face and mouth. During the interaction Daniel was on her lap.

THE KISS

At one point their eyes met. Fatima pulled back but Daniel persisted in reaching with his hand to touch her cheek. She could let him. Then, with both hands, he pulled their faces closer and opened his mouth wide. Fatima closed her eyes. Daniel's mouth touched her jaw line. Fatima flinched but somehow managed to stay still. A small smile started to emerge; her face softened. Daniel registered this non-verbal invitation and grabbed her shirt. He kissed the side of her face clumsily, beautifully, and she moved her mouth towards him. He then, very gently, made lip-to-lip contact with his mother. Her face broke into a full smile; so did his. Then, as if the intensity needed diluting, he slipped off her lap and started to play on the floor.

A moment of intimacy happened and the video was able to capture a new movement. The next week, when we watched it, Fatima told me how it was the first kiss, and she wept as she felt sorrow for Daniel. This was the first expression of feeling *for* him. She also noticed how bewildered Daniel was when she had pulled back from him. She saw how his eyes looked painfully bewildered when she had stilled in response to his hesitant, and yet determined, attempt to make contact. She could *see* his confusion and distress. She was in a different, observer position and could see Daniel's experience from a different perspective (Britton, 1989).

This helped Fatima to describe how her head and face had been traumatized during the beatings when in prison. She could see how Daniel reaching for her triggered a startle reaction, and then how this confused him. At this point I said how it was as if she was starting to feel that they had both been brutalized and raped. This contributed a new narrative: Fatima and Daniel as a mother and baby who had both suffered.

The kiss, held on film and in our minds, provided a transforming moment. Thereafter, Daniel was not automatically equated with a raping penis; he started to become a little baby, traumatized too. In a way, this was a new moment of conception for Daniel. It helped Fatima build up a sense that she was his mother, who had chosen to try and help him, and she could be effective in protecting him.

From my perspective, Fatima's tendency to use automatic defensive processes – especially projective identification – started to change. By owning her own wish to retaliate and hurt, and putting such feelings into words, how she behaved changed. It would take longer for Daniel.

In the next phase Fatima and I worked together like a parental couple to help Daniel with his tendency to violently eject distressing states of mind. Fatima began to understand Daniel's bodily violence as a way of getting us, and particularly his mother, to experience his as-yet unrepresented feelings of terror and rage in the context of feeling abandoned. As Daniel started to find his mother, he became more vulnerable. He started to use me, as a relatively robust third figure, to help him express a particularly desolate experience. In one session, when his mother was unwell, he hid under the desk for some minutes, as if trying to find a safe space. Her physical fragility frightened him. As I was speaking to Fatima, Daniel suddenly came up beside me and grabbed my hair. He hung off it; it was painful. When I managed to look in his eyes, they were blank. I did not have a sense of Daniel trying to hurt me. I felt he had disappeared into a dissociated space in which he felt nothing but I felt, and experienced, his need to cling, as if for his life. This pattern manifested again and again over the ensuing weeks. I lost handfuls of hair because Daniel *could not* let go. The interactions were hard to handle. But over the months we worked on understanding Daniel's need to cling and Fatima and I spoke of it as his *capacity to cling*. The trigger his mother and I realized was always when he felt dropped or abandoned.

This case has left me wondering about the transmission of unconscious forces between the generations. Out of such circumstances, how can we explain Daniel's determined capacity to cling, shown both when in utero, and then vividly through the scenes with my hair? Perhaps the unconscious force of his maternal grandparents was, at some level, *always* being transmitted. That force has now found a way into consciousness and words, and it shows now in the close physical and emotional contact he and his mother can now enjoy.

I think Daniel's first kiss was a transformative moment. Fatima and I became the new parental couple who could love him and want him as he was. The men who brutalized Fatima were propelled by complex and tragic unconscious forces. In the present therapy something of Fatima's parents came alive again and allowed the two of us, although both female,

to have a deep enough therapeutic relationship such that Daniel could in a way be conceived and born again.

DISCUSSION - JULIET HOPKINS

What these papers convey is truly shocking. The therapists have protected us from the full impact of their patients' horrifying experiences by the containment of their understanding and the hopeful outcome of their cases but horror must remain with us at the sadistic act of rape and its most tragic and lasting consequences.

Campbell Paul has referred to the condemning attitude to rape in many different countries but as therapists we are caught up in our own emotions and cultural values in this subject, too. What challenging issues therapists deal with and what decisions would we have made? Campbell Paul reminded us of the significance of the mother in the child's mind. In view of the shock and horror surrounding rape, it is not surprising that there is a dearth of research on any outcomes for babies of rape. The anecdotal evidence shows that many are aborted or abandoned at birth by mothers who refuse to look at them, and among those who are kept by their mothers, girls vastly outnumber boys.

Amanda Jones has shown how Daniel's approach was a trauma trigger for Fatima but the evidence, particularly from Bosnia, suggests that girls cannot escape being trauma triggers either – she has described a refugee mother who kept her daughter of a war rape but remained obsessed by her child's vulnerability and the continuous challenge of protecting her. Babies of rape inevitably grow up unable to understand the fear that they arouse in their mothers; a disorganised attachment must develop with its underlying expectation of catastrophe. In order to achieve coherence the infant may develop irrational fears or become aggressive as Daniel did, projecting his own fear while trying to make sense of his mother's fear of him. And as these children grow up the representations of their fathers in their mothers' minds will create enormous difficulties in forming an identity, as Campbell Paul has described. Amanda Jones has brought us the detail of her therapy work, a deeply psychoanalytic approach. She did not offer this depressed mother a prescription or tackle her symptoms of PTSD, or give her a behavioral program for her tyrannical toddler as might have been done but by most sensitively working with the couple's unconscious projections she was able to help them to begin a positive relationship.

I think the two points that Amanda Jones illustrates particularly well are

1. The value of enabling the patient to reach back behind the recent trauma and to reopen emotional contact with loving figures in the patient's past, in this case Fatima's parents, tragically lost in her childhood. Jones could do this because she recognised from Fatima's developing positive transference to herself that she must have had a good enough beginning.

2. The value of thinking in terms of the third position, the position that Jones took as the third party, able to accept both mother's and son's projections and to mediate in the space that she had created between them, a position that enabled Fatima to see Daniel increasingly from a new and much less threatening perspective.

I would like to end by paying tribute to the magnitude of the therapists' work. The emotional burden that has to be carried in cases like these is enormous. I think it is crucial to have colleagues to help to bear the pain and anxiety – and in addition to the support of colleagues, the necessity to balance each therapist's caseload to protect us from insensitivity and burnout. It can also help to have had a psychoanalytic training which supports the therapist in the value of containing intolerable emotions, so that they can be thought about as possible communications and so can be used to further the therapy.

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Child of Hope: Sexual Trauma in Infancy

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Sexual abuse of infants has become increasingly manifest in South Africa. Statistics from the Red Cross War Memorial Children's Hospital show a steady increase in presenting cases: 200 records traced from 1991 – 1999 (van As et al, 2001) to 294 cases seen from 2003 – 2005. Fifty four percent of children in this latter group were less than 5 years old (Cox et al, 2007).

The reasons for this horrific act of sexually abusing very young children and even infants are multiple and complex (Pritchard et al, 2002; Meier, 2002). Notions of patriarchy, male dominance, alcoholism, overcrowding, and cycles of abuse come into play in an extreme form. Added to this is the HIV pandemic in South Africa.

Babies and toddlers are less likely to suffer from this disease and hence are regarded as safe sexual objects. Added to this is the belief in virgin cleansing: this is an old universal myth which was even present in Scotland in the early 1900's. It is a myth that has been much debated and spoken about in South Africa, but no robust evidence exists that it is an entrenched and acted-upon belief today (Jewkes, 2004).

In the case that will be described, the issue of male dominance and revenge is pertinent – revenge from the man towards the woman. How best to punish a woman than by hurting her baby?

This brief paper is a synopsis of a high profile case of infant rape. Justice cannot be done to the infant or her family in this brief narrative, but it is important that their story be told. I feel privileged to have been so closely involved in this case and thank the mother and foster family for their permission to talk about them and their child.

BABY TSHEPANG

The story of an infant who became known as "Baby Tshepang" burst into the open with horror reports on the television and newspapers in October 2001: three elderly men, one of whom was the grandfather to the 9 old month baby, were arrested following the claim that they had raped an infant. The community they come from is in a poor Northern Cape rural area, where the sheep farms are huge, the droughts severe and the deprivation of the farm workers great – they have not tasted the milk and honey of the new South Africa. Alcohol abuse is rife, education and social services exist only at the most basic level. As it turned out a few weeks later, the 3 alleged perpetrators were not the guilty ones. The real one turned out to the mother's ex-boyfriend, who had been angry with her for having jilted him. He was apprehended and is currently serving a life long jail term. The 3 older men were released and paid compensation for the overly hasty police action.

The little girl was named "Tshepang" by the Northern Cape Member of the Executive Committee meaning 'have hope' in Tswana – so desperate and shocked was the whole community that something positive had to be found and, when all is dark, there is only hope.

Baby Tshepang was treated as an emergency and given anti-retroviral medication in a local hospital; but when the doctors saw the extent of her injuries they referred her to the only children's hospital in Sub-Saharan Africa, the Red Cross War Memorial Children's Hospital in Cape Town. There paediatric surgeons had to perform major reconstructive surgery to her genital area and she needed a colostomy for few months in order to ensure sepsis free healing of her wounds.

Child Psychiatry only became involved 3 weeks after her admission when I was asked to comment by a newspaper, and I then requested to see her. The surgeons had not thought of referring her, so preoccupied were they with her physical condition.

IMMEDIATE PSYCHOTHERAPEUTIC INTERVENTION

I met N (the abbreviation of her real name) in the corridor of the ward, in a walking ring, greeting me with a serious gaze and looking wistfully at the gate which closes the ward corridor off from the central area of the hospital floor. The nursing staff said that she was fine, to them she seemed happy. It was only the more discerning social worker of the ward who said that N was searching for her mother. I was informed that P, her young mother of 16 years, had been sent back to the Northern Cape as the local Social Workers had insisted that she go to school (though she had not been in school for the past 2 years).

The first therapeutic intervention was to insist that P be brought back to the Hospital to be with her child as a matter of urgency. This took a few days and required much persuasion and authority to ensure that the wish of the Social Agency did not prevail.

Upon her mother's return N visibly relaxed and became happy. A string of national and international newspaper and television crews visited them, and the case assumed huge proportions. The Media Monitoring Project was commissioned to analyse the media coverage of this rape case. Of the 155 newspaper articles, 80 covered "Baby Tshepang" (Bird et al, 2004). There was even a play "*Tshepang*"- described as an 'irredeemably grim piece'[1]- produced locally and also internationally.

1 http://www.britishtheatreguide.info/reviews/tshepang-rev.htm

A number of sessions with N and her mother followed. Time does not allow giving details of the assessment. The history is a painful one, but is probably an average one for the kind of community she comes from. Of note though is that the relationship P. had had with her little girl had been a positive one, very much supported by the maternal grandmother.

N was a delicately built toddler, with pale skin, beautifully dressed – she had been showered with gifts from all over the world! She engaged enthusiastically with the world around her. She was very confident in her mother's presence, and explored the room and the toys freely, making regular reference to her mother.

Almost immediately it felt that this child had been given the right name: despite the horror, she represented hope and until now, this intuition has proven correct.

The recommendations to Social Services were that N and her mother not be separated, but that they both

needed mothering. In view of the publicity storm that had been created around them, it was agreed that they should probably not return to their community of origin, but that they should both be placed in foster care elsewhere. A minister of the church and his wife volunteered to foster N and include her mother in this. They had a little boy of almost exactly the same age. This has been the most successful foster placement I have been privileged to witness. The transition for N was smooth and not traumatic, as she was in contact with her mother daily, but also got to know her foster family.

When P turned 18, she sadly fulfilled the pessimistic predictions of the Social Workers, and left school and the foster family and went home to her mother, back into this deprived community. By this time however N was well attached and did not miss her mother much, though she talked about her freely - the foster parents did all they could to keep regular contact with her biological mother.

I was able to follow N's symptom progression as the family visited Cape Town at 6 monthly intervals and always agreed to come for a session.

SUBSEQUENT PSYCHOTHERAPEUTIC CONTACT

To recapitulate: this little girl was brutally raped at the age of 9 months, resulting in third degree vaginal tears, extending into her anus, requiring major reconstructive surgery, which included a colostomy for the first 4 months post-trauma. The care she received subsequently was from a medical and emotional perspective optimal, with the one possible hiatus: that no regular psychotherapeutic intervention has been possible.

The evolution of N's presentation over the following 3 years will be sketched in a much abbreviated format.

One year post the rape, her foster mother reported that for past 2 – 3 months N had been waking up at night and screaming and saying "eina" (which means 'ouch' in Afrikaans) and then holding tightly onto mother. She had also been observed to climb onto children and even mother and make thrusting movements. At times she could be quite aggressive. She was scared of noises of machines – the cleaning machine, washing machine, the steam iron – she would then go to the other end of the room.

During this particular session she immediately played with the toys, particularly the doll that she held and rocked and wanted to put to sleep and also bath. When undressed she spontaneously pointed to the genital area and mother reflected that the doll was sore, like N, who apparently often pointed to the scar of the colostomy on her abdomen. This clearly preoccupied her and she spent much time thereafter taking care of the doll.

Eight months after this visit the foster parents and mother, whom I saw for the last time on this occasion, stated that she had continued to masturbate and show an increased awareness of the genital area. The nightmares had however decreased. Very strikingly in her play N, by now 2½ years old, made red chalk marks on the dolls in their lower body parts. She seemed more distant from her mother and her face brightened when she was reunited with her foster parents and brother. Mother at this stage had returned to her family of origin and the contact between them had been less frequent.

In December 2003, when N turned 3 years, she came with her foster family only; her mother had become increasingly unreliable and also exploitative of the publicity around her child. N was by now securely attached to her foster family and they treated her in the same manner as they did their biological son.

There were no major behaviour problems though some peculiarities remain: N remained very aware of the genital area of the dolls and was interested in sexual differences – this however could have been by now age appropriate. She was masturbating less than before. Foster-parents had noted that she at times would stand in front of their bed, pressing against where her abdominal scar is. When they entered, she seemed to get a fright, and would react defensively. They speculated whether she was having any associations of her trauma while standing next to the bed. Foster-mother had also noted that she sought out men when they had visitors.

She still had the occasional nightmare, but this too had lessened since last seen.

Foster-parents keep the communication about her biological family alive and open.

She had been fully toilet trained, and foster mother was planning of sending the two children to a play-school the following year.

At age 3½ she was again seen– the nightmares had now completely resolved, there was less crying. The sexual behaviour and interest had virtually disappeared, other than a normal curiosity which her foster-brother also had. She is aware of the scar on her stomach – and would say "die dokters het my seergemaak". (the doctors have hurt me)

When N was 4 years 4 months old she presented as a lively, interactive, bright little girl who was confident and a 'leader'. She played appropriately with her foster-brother and on family interview nothing untoward could be detected.

One year later, in April 2006, when she was 5 years 4 months, N again was bright, very observant and this time it was considered important to see her individually. She took this space with ease and it was evident that it would not take much to allow for repressed memories to emerge. She offered that she was scared of watching wrestling on TV; she was very clear on sexual differentiation and keeping boys and girls separate. She acknowledged that something scary had happened to her, but then became defensive, drew a black flower, and said it was closed. In view of the fact that a follow up session would be far into the future, the matter was not pursued further.

DISCUSSION

N initially showed symptoms of anxiety and fear – separation anxiety (though 'hidden') and fear towards men. As time passed and as her cognitive, language and motor abilities developed, she displayed the entire spectrum of Traumatic Stress Disorder. What was most distressing was that she had retained a somatic memory of what had happened to her and that she acted this out – her masturbation and sexual interest. I do contend that this was out of keeping of her family environment and age at the time and that it had everything to do with her trauma. This is in line with theories regarding memory and the finding that "even in the first year of life, infants experience evocative memories that are not dependent on an external stimulus." (Gaensbauer, 2002)

The symptoms have disappeared in time and what has remained is the repressed memory of the trauma, being manifested now in a displaced and symbolic manner.

This little girl has had no access to regular psychotherapy. She has done well up to now with the excellent care and the ordinary love she has received from her foster family. Had she lived nearer to Cape Town regular therapy would have been recommended– but given the circumstances, all we can do is observe her and keep a connection albeit at 6 monthly or yearly frequency. The publicity that continues to surround her, especially on her birthday, is something that needs attention.

The points which the case of Baby Tshepang illustrates are the following:

1. In the face trauma, supporting the attachment relationship is the first task of the health professional. Coping mechanisms can only be employed if the primary attachment relationship is secured (Shore, 2001); without this the Traumatic Stress Disorder would not have resolved spontaneously and N would not have become a Child of Hope.

2. Infants, even at the pre-verbal stage, remember trauma; it becomes enacted as a somatic memory. "The body keeps the score" (van der Kolk, 1994) was literally demonstrated in this case.

3. With the development of cognition and language this somatic memory can be made it accessible through symbolization. Psychotherapy, the conscious working through of the trauma, then becomes possible. Whether this working through can occur naturally with in-tune parents and a good environment remains to be seen. The challenge with this case is of course that the story about what had happened cannot so easily be told as in the case described by Gaensbauer (2000), where an illness during infancy necessitated medical procedures.

IN CONCLUSION

N does indeed do honour to her pseudonym as she is a 'child of hope'. Her easy temperament and robust physical constitution, as well as the secure beginning with her young mother, who despite the environmental deprivation has loved her, have been protective factors that made it possible for her to survive this catastrophic trauma to her body.

The subsequent respect shown for her needs for solid and ongoing attachments with her ordinarily loving foster family have enabled her to develop sound ego functions. There is hope that these will equip her to deal with the complexity of growing up and knowing her story and to incorporate this into her developing identity as a woman.

From a mental health perspective her suffering as well as her healing was caused by, and came directly from her human environment – the role of the professional was to help actualize and to support the good that was available in her community.

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BY THE RED CEDAR

By
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Reflections

For nearly a generation significant portions of my professional and personal life have involved leadership positions for organizations devoted to enhancing the quality of life for very young children and their families. Executive positions with the Michigan Association for Infant Mental Health, the International Association for Infant Mental Health, and the World Association for Infant Mental Health lifted me from a relatively sedentary academic life, to a robust, challenging, tension filled and enormously rewarding world featuring diverse cultures, passionate colleagues, and the challenge of mission. In August, 2008, this 28 year cruise finally arrives at the shore and I disembark.

Transformations

In my work with communities throughout Michigan, we talk extensively about transformational change as the gold standard for changes in the community and the university as a result of university-in-community partnerships. Transformation means change, not just in the resolution of a community problem, or a parent-infant relationship, but in the individuals who are attempting to effect change as well. If interactions with others do not lead to transformations in self, other, and self-other relationships, then the players have only been passive observers, automatons, who were disengaged from the joy-despair continuum that defines the life course.

My inaugural meeting of the Michigan Association for Infant Mental Health Board of Directors in 1979, was a transformational event. It awakened a dormant interest in social justice, community change, and policy that I had put aside in graduate school, especially when I transferred from a doctoral program in child clinical psychology to one focused on experimental studies of early human development. That board meeting enabled me to define my niche within the world of 12 Selma Fraiberg trained infant mental health specialists who had established the first professional association exclusively focused on infancy and very early childhood, more as an effort to conduct a statewide training program than to actually organize a professional society (Fitzgerald, 1985). That niche lead to executive positions with Mi-AIMH, the International Association for Infant Mental Health, and for the past 16 years, with WAIMH.

Memories

Since the formation of WAIMH in 1992, WAIMH has had three major ways to communicate with its members about the world of infant mental health: face-to-face via World and Regional Congresses, electronically via web pages and emails, and by print via the *Infant Mental Health Journal (IMHJ)* and *The Signal*. Previously, I published analyses of the content of the IMHJ focusing on the topical content of the articles, the authors, and the subject populations being studied or involved in treatment programs (Fitzgerald & Barton, 2000). Publication of these content analyses was followed by a surge of submissions to the IMHJ that vastly expanded the diversity of authorship, cultures, and subject populations represented in the articles (Fitzgerald, 2006).

Attempting to write history always places one on a slippery slope, because so much of history is the writer's social construction rather than hard fact. As I prepared to write this article it occurred to me that *The Signal* is the repository of many memories of my 16 exciting years as WAIMH's executive director. I worked with three editors (Charles Zeanah, 1993-1999; Paul Barrows, 2000-2006; Miri Keren, 2007-) from three cultures, and with four presidents (Joy Osofsky, 1992-1996; Yvon Gauthier, 1996-2000; Peter de Chateau, 2000-2004; Tuula Tamminen, 2004-2008) from four cultures. Each of these individuals had their own style and each left their footprint on WAIMH. Joy focused on organizational issues associated with the merger of the World Association of Infant Psychiatry and Allied Disciplines and the International Association for Infant Mental Health, building on the strengths of each organization to assure the merger's success. My recollection, probably exaggerated with time, is that Joy and I were almost in daily contact about WAIMH business issues during her four-year term as president. Yvon and Peter focused on issues related to the social context of infants throughout the world and WAIMH's responsibilities for advocacy and

attention to public policy. Tuula has focused on deepening WAIMH's attention to cultural diversity and to broadening the democratic structure and function of the association. Each has played a key role in guiding WAIMH from its organizational infancy to its adolescence.

Responsibility for moving WAIMH to its early adulthood falls on the shoulders' of President Elect Antoine Guedeney, and Executive Director Elect, Pälvi Kaukonen.

The Signal authors reflect WAIMH's diversity; authors of published articles reside in 18 countries (Austria, Argentina, Australia, Belgium, Brazil, Canada, Finland, France, Italy, Israel, Netherlands, Russia, South Africa, Switzerland, Sweden, Turkey, United States, United Kingdom) and represent all five of the Olympics-defined inhabited continents of the world.

Table 1: Selected authors: Published in The Signal, 1993-2008.

Stephan Bennett
Sonya Bemporad
Wendy Burnston
Salvadore Celia
Marguerite Dunitz-Scheer
Laurie van Egeren
Ilgi Ozturk Ertem
Ruth Feldman
Tiffany Field
Nicholas Favez
Elisabeth Fivaz-Depeursinge
France Frasarolo
Bernard Golse
Peter Gorski
Antoine Guedeney
Nicole Guedeney
Robin Balbernie
Marinus H. Ilzendoorn
Brigid Jordan
Jon Korfmacher
Penelope Leach
Barry M. Lester
Alicia Lieberman
David Lonie
Lisa Miller
Marie Rose Moro
Rifkat Muhamedrahimov
Joy D. Osofsky
Fernando Petrina
Linda Richter
Frances Thompson Salo
Ronny Scheer
Stephen Seligman
Marian Sigman
Daniel Stern
Frances Stott
Graziella Fava Vizzielo
Deborah Weatherston
Dieter Wolke
Barry Wright
Bonnie Young
Charles Zeanah

Authors of the 100 articles appearing in *The Signal* include some of the world's leading scholars in the interdisciplinary field of infant mental health (see Table 1). An admittedly arbitrary categorization of the contents indicate that most articles address issues related to parenting and infant care (see Table 2). In Memorium articles call to mind five colleagues who helped to craft the field through their national and international leadership, scholarly work, and clinical insights (Myriam David, Sonja Bemporad, Serge Lebovici, Jack Stack, Norma Ringler). At the other end of the emotional continnum, *The Signal* also publically celebrated the lifetime contributions of Robert N. Emde, the only individual to be awarded the title of Honorary President, WAIMH's highest honor.

The history of a movement can be captured in many ways, through personal recollections and reflections, and by monitoring the printed works of professional publications such as the Infant Mental Health Journal, or by societal newsletters, such as The Signal. My 16 years with WAIMH have been extraordinary, not only because I've met nearly all of the individuals mentioned in this article, but because I have had the opportunity to work with people throughout the world who are deeply committed to humankind's youngest children and their caregivers; who play as hard as they work; and who always find the way to bridge culture, discipline, and personal ambition for the good of infants, toddlers, and their families. One can only hope that one day politicians will also discover the importance of relationship-building for crafting peaceful solutions through compromise!

Farewells

So, 16 years draws to a close. These articles started as "From the Executive Office", transformed to "From the Red Cedar" (the river that flows past my office in East Lansing, Michigan), then somehow became "By the Red Cedar", and soon they will be written by Pälvi Kaukonen, perhaps while she sits "By the Tammerkoski" in Tampere. For me the river still runs through my campus and I will continue to ride its waves seeking ever more challenging destinations to engage in scholarly research for the public good. I hope to see many of you in Yokohama!!!

Hi

Table 2: Major Topical Categories of Articles Published in the Signal, 1993-2008.

General Topic Area	**Frequency**
Parenting and Child Care	26
IMH Issues, Definitions, Training	16
Attachment/Attachment Behaviors	16
Psychotherapeutic Issues	11
Preventive-Intervention Programs	7
Psychopathology	7
Cultural Context	7
Neurobiological Disorders	6
Prenatal/Perinatal Experiences	4

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The Tammerkoski
Photo by courtesy of Hiram Fitzgerald, 2004.

The 11th World Congress of World Association for Infant Mental Health
Date : Friday 1st - Tuesday 5th August, 2008 Venue : Congress Center, Pacifico Yokohama, Yokohama, Japan

Welcome to Yokohama!

Dear Colleagues:

It is a great pleasure for me to invite you to the 11th World Congress of the World Association for Infant Mental Health, to be held in my home city of Yokohama, Japan, August 1-5, 2008.

This is the first world congress of WAIMH to be held in Asia, and colleagues from all over the world, especially from neighboring Asian countries where people are in dire need of infant mental health services, are welcome.

The Local Organizing Committee of Yokohama is working hard to create an ambience for rich verbal and nonverbal communications during the congress. Inside Pacifico, the conference center, words are crucial in plenary sessions, symposia, workshops, poster sessions, and master class lectures, so we will make sure that translation in English and Japanese is of good quality. In the immediate surroundings of Pacifico, where words matter less, there will be a wide choice of entertainment jointly arranged by the City of Yokohama and grassroot groups. Just relax and forget about your tough reality at home. Enjoy concerts, art exhibitions, and funfair, or a portside spa with healing hot mineral waters brought in from nearby mountains. You will immediately find yourself basking in Japanese “amae”, a mutually gratifying companionship reminiscent of the sweet intimacy of infancy.

On August 1, a fireworks display will adorn the sky of Pacifico and Port Future (Minato Mirai) to celebrate the historical eve of the 150th Anniversary of the Opening of the Yokohama Port.

With your participation from the East and the West, this Yokohama Congress will set the stage for a new dawn of worldwide infant mental health.

I look forward to welcoming you all in Yokohama.

Hisako Watanabe, M.D.
Chair, Local Organizing Committee

THE SPARE ROOM

This wonderful monologue is about a man becoming a father, about the process of entering the "fatherhood constellation" with its gains and losses, its joy and sadness. This man is at the opposite end of the rapist...

Miri Keren

Editor of the Signal

By

Joanna Murray-Smith[1]

This monologue was first performed by Neil Pigot in Melba Hall, the University of Melbourne on Friday, January 16, 2004, as part of the program of the 9th World Congress of the World Association for Infant Mental Health. Joanna Murray-Smith is a Melbourne based playwright, screenwriter and novelist. Her plays, which include Honour, Rapture, Bombshells, Nightfall, Redemption, Love Child and Flame, have been produced around the world. Honour has been produced in over two dozen countries, including productions on Broadway and at the National Theatre in London. Her latest play, The Female of the Species, opens on the West End in July. Joanna is the author of three novels, Truce and Judgement Rock and Sunnyside, published by Penguin.

1 Not to be performed without permission from the author.

Stephen. Forty. Well dressed. Confident. Very intelligent.

'Let me just say this as a preface. There are a lot of things I like about my life, and the thing that gives me the most satisfaction, in an incidental way, is the spare room. A good man deserves a spare room. A mark of success is having a place where useless and obsolescent objects can be stored. The kinds of things you only think about when you're staring at them, you never miss. They are the transitory relics of a human being's inability to focus or commit. And that's fine. I'm man enough to know it. The spare room eliminates guilt and depression caused by awareness of money wasting and intellectual dilettantism. You chuck everything in the spare room and you close the door. It doesn't seem like much, but believe me, it is. It's everything.

[BEAT]

My wife is Fran. She has big eyes and long legs and she drives with one foot on the accelerator and the other foot on the brake. At the same time. She's proud of this. Until recent events overtook it, this one act of marital treason was the thing that brought me closest to the edge of insanity. Apart from this, the big difference between us is that she thinks things only exist if they're spoken. Whereas I'm suspicious of things that are spoken and trust the existence of something much more if it's silent. She bangs on about everything. We're watching the news and she starts on about the starving masses and that's fine. But I care about the starving masses without trivialising them with words that can never be adequate to the horror. Somehow, she thinks I am only my spoken self. I can't persuade her, or maybe I don't want to, that the better part of me doesn't have a voice.

And that's how it was from the start. I'm not kidding, she'd wake me up at 3am screaming: BERTIE or STEPHANIE or AURORA or SEBASTIAN. At one point she was considering Mandela. Mandela McPherson. Almost certainly the only one at kindergarten. At that point I think I did ask why stop there? Why not...Butrous Butrous McPherson... Some nights she'd take my hand and lay it on her belly and say: *Just think, we made it, it's in there, real. Isn't nature incredible, isn't a woman's body a brilliant mysterious thing, doesn't love deepen with the act of creation*, you know the stuff. All well good. All true. Just... what? Overstated. I had the distinct impression that there was only one appropriate response to fatherhood, and that was Misty Eyed. What she wanted was a misty eyed handy man. The sort of fellow who would cry tears of joy at the spiritual dimension of procreation whilst niftily assembling an Ikea change table, cot and nursery wall unit.

Okay, look, I've got tertiary qualifications. I've read every Thomas Hardy and all the Russians, I can even make pasta, I'm not an idiot. But I'm not a handyman. I have a visual/spatial problem which rules out all diagrams and if they'd only call it something, name it, Spatially Challenged Affliction or whatever, people would start feeling tender towards me instead of holding me in contempt.

I´m an intelligent, cultivated person, but Misty Eyed wasn´t my response to the news. I'm standing on the dock and my life is on the ocean liner and we're connected by one, blue crepe streamer and it's stretching, stretching and then comes the realisation that I'm never, ever, ever going to leave the dock. There is no leaving. There is no future point of embarkation on HMAS The Good Life. I've jettisoned my ticket for one very brief moment of ordinary hanky panky and there... Gosh... there on the upper deck is every single man I've ever known and disliked. Yes... Bradley Kershaw from the rowing team and Two Boots Maltravers from

first year law... whose head was so far up the Dean's arse, you could only see the soles of his boots... and every surly waiter I've ever endured, the various bureaucratic arseholes, customs officials, aggressive roof plumbers, the guy at the Thai takeaway who always leaves one dish out of the order necessitating a return to the shop, my cousin Ted the walking Cornflake and Harry who made a pass at Fran in our living room while I was in the study writing him a fucking reference... all of them... off they go... ready for the banquet of life, the strange and interesting sexual positions, the whimsical trips to the Seychelles or Tibet, the self-indulgent spending on, you know, phones that transform into irrigation systems, whatever... there they go, so blase... so expectant that of course life is just a pleasurable cruise. And here I am on the dock. Holding a Target bag full of nipple shields.

Okay, I'm selfish. I never asked to have a baby. It just came. I used to see Fran's body as this soft, firm, luxurious, sweet-smelling.... thing. This gorgeous, inviting, impractical refuge and I'd sink into her and smell her neck and taste her skin and feel hungry for her and the appetite was completely connected to the sense that she was not necessary, not something that worked for you, that had some kind of technological imperative, some orderly managerial role in your life, but something extra and highly impractical. And then... who would believe it... that luxurious human day-spa that was Fran's body, that invitation to indulge, turned out to be hiding an extraordinary Meccano set of functioning parts. And there it was. A few tiny pieces of not immediately tantalising machinery in Fran's body came together with perfect synchronicity and a human life started. Kaboom. There it is. And you can bang on as much as you like about pro-choice and God knows I'm all for it, but nobody's telling me human life doesn't start in an instantaneous breeze, a breath of air that eddies and flows and dips over you right about the time... you feel like a cigarette.

In moments, there's a heart-beat. And forty weeks later, your ship, the ship you've always believed had a very very nice cabin waiting for you, sets sail. And you're on the dock with a streamer blowing kisses to Two Boots Maltravers.

At the hospital... We'd taken in a full kit of stuff all the books had.. aromatherapy oils and photos of sunset in the Himalayas and a couple of camellias from the garden, because apparently women like this stuff when they're experiencing interminable diabolical pain. It's amazing how a few drops of lavender essence can make all the difference. And then... what?

Fourteen hours later, there she was. Pale blue and wrinkled like one of those weird puppies. I saw her and nothing happened. I mean, nothing is an overstatement. I felt confused. I felt... as if I had a small anonymous role in a major event. Like the guy who, say, who suggested a convertible for JFK's ride through Dallas... or the NASA scientist who designed moon-boots.

It couldn't have happened without me, but who was to know. Really. There was Fran and My God, she was beautiful. She always looked good exerted. Hiking at Kosciosko, when I proposed. Rushing down the city street towards me waiting outside the cinema, flushed, hair loose. I like her raw. And here she was, smooth, hot skin, unbelievably fantastic breasts and a smile that said: Hello, I've just been to Pluto and it was a blast and now I'm home and I've brought something back with me and she's ours, and she's moving in to the spare room, so you'll have to move the golf clubs and she's never, ever, ever, moving out.

And then.. how was it? We started visiting and being visited. You know, showing her off. And friends said those things, the right things and aren't you thrilled? Aren't you thrilled? Isn't she incredible? Isn't it the most incredible? And I'm thinking most of the time... how disappointed everyone would be to know that mostly I'm tired. I'm tired in a way I've never been tired before, so deep in my bones and what I want to do is crawl into bed, alone, and just stay there, nurse myself, be left there, with nothing calling for me, no Fran, no baby and then I'd think: *I'm the father!* I'm the strong one! She's breastfeeding, left at home with the baby all day, in shock, never sees the real world, depressed about her body, cracked nipples and I'm the one whose complaining. Me. Who still gets to go out for a café latte at eleven and talk to adults about political events or popular culture while she's at home nursing a human hand grenade in a bomb site. What a fucking selfish prick. No wonder women went berserk in the seventies with men like me walking around. No wonder they said all men were rapists! I'm a disgusting insensitive spoilt middle-class Yuppie male who is completely out of touch with what is important and real and true. I'm the reason Andrea Dworkin existed.

And I wanted to fall, to tumble, to tip headlong into love. Believe me, I wanted to. But I couldn't trip. I didn't fall. I felt... like a witness to somebody else's story. Like I was in a movie. And Fran and the baby were up there, in some beautifully rendered story of love and pain and transition, and I was in my seat, eating popcorn, simultaneously wanting to be in the story and relieved that I wasn't.

And then... when was it? Maybe around four months... I couldn't sleep. There was an electrical storm and the lightening kept flashing into our bedroom and the rain was pouring down and I got up. It was that Spring when there was wild flooding and some months before, there was a story in the newspaper about new parents who had woken up and went to check the baby and floodwaters were lapping the edge of the cot. A half hour longer and the baby would have drowned. This was in my head and I went to check the kid.

There were no flood waters. But she was awake. I looked into the cot and there she was, her huge eyes looking up at me. She didn't cry. She seemed perfectly happy just lying there, enjoying the lightning flashes. And our eyes locked. I had thought, foolishly, during those 40 weeks, that

the baby was... somehow just another bit of me. That suddenly, there was just this extra accessory made available, an extension of an already familiar apparatus that was myself. But when I looked at her, lying there half in shadow, this bundle of life, I had this sudden sense of... what? Her intactness and differentness. That, really, regardless of the process of getting here... she was weirdly unto herself and quite possibly would not love licorice and rugby. She had her own little momentum, an energy that was... distinct. Something... shifted. I can't say that I fell, nothing so perfect as that. But I had a sudden sense of... the impossibility of keeping her... safe. And the moment the idea of it hit me, I realised how huge it was and how much of me had been filled up with the thought.. That life stretched ahead, not so much a calendar of lost opportunities for me, but of hazards and obstacles to her well-being. Forks in toasters, Madeleine McCann intruders, cars in driveways, peanut allergies, sadistic teachers, pederastic priests, unexplained lumps, unsafe balconies, plane crashes, suicide bombers.... I mean the Twin Towers were full of somebodies' babies... babies grown into stockbrokers or janitors... and what could I do?

What could a thirty eight year old graphic designer from Templestowe do to stand in the way of her vulnerability? This little one looking up at me, as if to say: Well, well, *you're the caretaker, caretake*.

And I thought well, it's just not possible. It's just not feasible. A year or two, perhaps, if I'm vigilant, I'll keep her safe. I'll watch the driveways, never leave her in a locked car, feed her organic everything and even try.. try to take an interest in the world at large, the rainforests and the ozone layer and women's health issues.. try to make it better for her. But to be honest... a few years would be it. And even then, even then, a glance in the wrong direction, a sudden distraction, a quirk of fate, engine trouble in the plane, a suicidal train driver, a gas leak... meteors... the chances of her actually making it were... slim. Slim. Baby. My baby.

Okay, Fran and I had shared most things. I had told her about my one homosexual experience as a nineteen year old. She had told me about the anorexia. I confessed my fetish about women applying lipstick. Once we talked about hiring a... a woman... so that she could watch me making love to someone else which was a fantasy of her's. I mean, there really wasn't much we couldn't say. But now.. now... the baby had walled us in... Not together, but into two separate spaces. There wasn't a way to share it. And now, it seemed as if I was inside my own, ghastly bubble. There was nothing I could say to her... that would not ruin us. She was keeping her end up.

She was battling... for all I knew, other demons, not letting on, somehow getting through the vast, impenetrable strangeness. And if I said these things (beginning to break:)... that the... mmm... the.... love was.... not absent but.... (breaking:) strangely not absent, but... too intense... too present... too huge... then, then... my sense was, that all three of us would collapse, would fold into the chasm and never get out. Sometimes the pretence at normalcy is actually what delivers it.

And for three days I wept. I left the house, as if I was going to work, but didn't go and wept in the car. The day went like this: happy, kisses, leaving, in the car, driving down the Peninsula, weeping, eating a chicken sandwich, weeping, walking on the pier, weeping, drinking a milkshake, weeping, driving home, happy, kisses. And this was what I thought. That no matter if we got through this, no matter if I did... fall... did collapse into the baby... did begin to feel like a... father... Even if I did and the weeping stopped and I didn't feel strange any more and my life felt like my own and suddenly the change-tables and baby clothes and play-gyms all began to resemble my life and everything went back to normal and we got takeaway and had dinner with friends and saw movies and changed jobs and planted gardenias, even if all that happened, it would still never be like it was.

It will never be Fran and me.

It will never be simple.

Love arrived in a new form and it was terrible in its size and it would never, ever go.

And you could leave your wife, you could change girl-friends, you could fly away from complicated relationships, but you couldn't do anything about this kind of love, because nothing... neutralised it.

And the sadness... the sadness was... The simple recognition that loving is an act of suffering...And the knowledge was eating me up from the inside, spreading throughout me, stretching into my corners, agitating at me, knocking at my heart, whining, wheedling, insisting its way into me and I was fighting and I was fighting but I couldn't win. I couldn't turn away and I couldn't win. Just like the spare room, she'd moved into me and she was never moving out.'

End

The new publication:

Courts, Child Welfare and Infant Mental Health:

Improving Outcomes for Abused/Neglected Infants and Toddlers (2008)

Tableman, B. & Paradis N. Southgate, MI:

MI-AIMH (www.mi-aimh.org) is out and should be of interest world wide.

EDITOR'S PERSPECTIVE

Infants born of rape, Raped infants… The need to have them in mind

By
Miri Keren, M.D.
Editor, The Signal

I remember being in Melbourne, attending the symposium on infants of rape at the Melbourne conference in 2004, reported in this Signal Issue, and thinking about how little I have ever thought of them in my clinical practice. I could not remember any conference about this specific topic, nor lectures, nor books…Still today, very little is written in the professional literature: Many articles can be found about rape, but from the woman's perspective only. In a literature search I've done very recently, I could not find any developmental nor clinical follow-up of these infants. Even Amanda Jones' beautiful case description has been published under the title "Levels of change in Parent-Infant psychotherapy", and not "Infant born of rape". Same for the painful topic of sexual trauma in infancy, which may be even rarer in the Western societies, than are infants born of rape? My next step after the Google search…was to look in…the Old Testament, the most ancient book about human psychology…and again, no mention of the infants born of rape nor victims of sexual abuse, though histories of incest and extramarital sexual relationships are there.

Rape is a very common "side effect" of wars: in the book named "A woman in Berlin", the anonymous young woman who had lived in Berlin during the first weeks of the Russians' invasion describes how she and all the other women around her had been raped and would get a bit of food in return. She was able to put in words the psychological processes she went through, starting with unsuccessful resistance and turning into dissociative states. The very idea of becoming pregnant did not really came to her mind, and anyway, abortion was the obvious solution. Furthermore, the very existence of the fetus goes against the raped woman's dissociative defense mechanism for "not being here",

Rape is indeed one of the weapons of war: in Bosnia for instance, it was a means to force women to bear the enemy's child. In Rwanda, it was an ethnic cleansing weapon, and according to a report published in Pubmed (with no authors listed) in 1997, some 2000-5000 infants were born. One may think that, nowadays, with the flow of refugees who fled civil wars to end up in western countries, clinicians would see and treat at least some of these cases of mothers and infants born of rape.

How many of these deeply traumatized mothers and infants are left hidden and untreated? What is the developmental and emotional fate of these infants? Is disruptive and violent behavior the common outcome, as a manifestation of the infant's projective identification with the aggressor? Or may we find the opposite reaction, meaning identification with the victim/the helpless mother, and if so, would we expect a depressed-like clinical condition?

To answer these bothering questions, we obviously need to detect these infants…but how many mothers will admit they have been raped? For so many, it is already quite difficult to admit the pregnancy was "just" unplanned and unwanted…

It becomes even more bothering when one realizes we may have these infants "under our nose" : how can we detect the "fruits" of rapes within the family, in contexts of domestic violence and incest?

Quite anecdotally, I have asked colleagues around me how often they have thought about finding these cases among their referrals, and the usual reaction I received was…a puzzled, somewhat embarrassed…as if feeling guilty…look and murmur "I don't know really, I never had a case, I did not really think about this problem"..

Maybe, we are faced with parallel processes of projective identification: these infants are not very much in most of the clinicians' mind either… like they were not in the mind of their progenitors at the time of the conception/the rape. Ultimately, they are in no one's mind….

The late French psychoanalyst Francoise Dolto had introduced the concept of the joint progenitors' Desire as being the origin of the infant's basic wish to live. Infants born of rape are born of aggression and violence, while their mothers lay down *as if dead*. The cases described in this issue of The Signal fit very well Dolto's conceptualization of the psychopathology that results from the total absence of Desire during the conception.

Still, these are just theoretical reflections. In order to know these infants, we need first to bear them in our minds. We may be surprised to find them much more easily than we think…Only then, we will be able to study their developmental pathways and responses to different therapeutic modalities.

Our first and modest step is to signal their existence in …The Signal.

PRESIDENT'S PERSPECTIVE

FAREWELL AND WELCOME

By
Professor Tuula Tamminen
President of WAIMH

This is the last President's Perspective that I write as the president of WAIMH. Although January 2004, when I started my presidency in Melbourne seems like yesterday, the four-year term will be fulfilled in Yokohama in August 2008. And of course, I am full of mixed feelings! On the one hand I am content and grateful, it has been wonderful to work together with so many friends and colleagues in infant mental health around the world – truly "the best days of my life". On the other hand I realize that only a part of the aims, ideas and dreams that I had in the beginning has proceeded into something concrete. One always learns something new about one's limitations and the borders of reality when one tries to do something new to oneself. So, I have had the best lessons of my life, too.

But it's not me, it's we, both horizontally and vertically. Many presidents before me have had similar ideas and those who come after may have the same aims, the chain of active, dedicated individuals is what matters. Also, it is never only one person that counts. We are many and only interactions and relationships change the world and promote development. So, the transgenerational attachment in the world-wide WAIMH family is the key issue, isn't it!

Two important steps have been taken during the past four years. The revision of our By-laws will start to function in Yokohama Business Meeting after a long process. The aim of the revision is of the utmost importance: to increase the role and power of WAIMH Affiliates without losing the true nature of WAIMH based on personal memberships. I want to thank the Executive Committee, the By-laws Committee – especially Hiram Fitzgerald and Robert Emde – and all voting members of WAIMH for their input in this task. But in order to complete the task it will be essential for as many WAIMH Affiliate Presidents as possible to participate in the Yokohama Congress, where we will have for the very first time the official Affiliate Council based on the new By-laws. So, welcome to Yokohama!

The second historical task is also in its final stage. The WAIMH Central Office's move from USA to Europe, from the Michigan State University to the University of Tampere, Finland, has been a much bigger task than at least I understood. During those 16 years that Hiram Fitzgerald worked as the Executive Director in the Central Office he accomplished more than a small army! I express my admiring thanks to Hiram and also to the Associate Executive Director, Pälvi Kaukonen in Tampere.

The one issue that I am pleased with – and perhaps proud of – is the collaboration between international and world associations in the mental health field. For about two years the presidents and past-presidents of International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP), International Society for Adolescent Psychiatry and Psychology (ISAPP) and WAIMH as world-wide scientific organizations and World Federation for Mental Health (WFMH), International Alliance for Child and Adolescent Mental Health and Schools (Intercamhs) – and from now on Zero-to-Three – have been meeting together. The group named itself the Consortium and its aim is to promote infant, child and adolescent mental health all around the world. This group will hold its first and very special symposium in the 11th WAIMH Congress in Yokohama. We wish to let the world know why infant, child and adolescent mental health is the first priority in building up the world's future. I hope all of you will join us and participate in the Consortium Symposium. So, again, welcome to Yokohama!

Ever since my first WAIMH Congress in Stockholm in 1986 when I was a young infant psychiatrist and researcher, I had a wild dream. With the support of many WAIMH people, through the wise guidance of WAIMH directors and based on the confidence shown by WAIMH members I have had this unique opportunity to grow and mature to fulfill my dream. WAIMH is, indeed, a skillful organization in promoting human development through interactions and relationships!

I thank all of you!

Tuula