

THE SIGNAL

Newsletter of the World Association for Infant Mental Health



The Creative Embodied Experience: The role of the body and the arts in infant mental health

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By Suzi Tortora

"The body has to instruct the brain."

"Behavior does not live in disembodied form."

Thelen (1996, p. 31)

In recent years the interest in the role of the body and embodied experience as it informs selfhood and forms of attachment has increasingly gained more attention. Many theories of psychological inquiry have addressed the body and the psyche: Freud, Reich, Winnicott, Darwin, Bowlby, Trevarthen, Stern, Boston Change Study Group. The advent of the mirror neuron system has brought the neurological underpinnings of this into sharper focus.

As defined by Gallese and his colleagues (Gallese, Fadiga, Fogassi, & Rizzolatti, 1996; Gallese, 2005; Gallese, Eagle & Migone, 2007), through neural mapping in the brain multisensory sensations, actions intentions and emotions of others are experienced and understood by the dyadic partner. Through this experience a "shared body state" is experienced supporting the development of intersubjectivity (Gallese, 2009, p.523). Malloch and Trevarthen add a creative focus to this discuss emphasizing the role of creativity in this process using the term "musicality" to described the shared consciousness that develops in the emerging mother- infant relationship through moment-to- moment loving joyful rhythmic nonverbal movement and vocal exchanges (Malloch & Trevarthen, 2009, p.1; Trevarthen, 1980, p. 319; 2009, p. 508).

This emphasis on the creative process from an embodied state of knowingness and communication is a core component in the field of dance movement psychotherapy (DMT). Given the prevalent nonverbal

nature of infancy and early childhood experience DMT methodology is an important addition to the field of infant mental health, providing activities along the spectrum of wellness to therapeutic treatment.

Specific movement, multisensory, creatively-based dyadic and group activities, which enhance the young child's growing sense of self, physically, emotionally, expressively, and cognitively are a core emphasis of the DMT-based program I have developed called Ways of Seeing (Tortora, 2004, 2006, 2010 a, 2010b, 2011). These activities are designed to support the parent-child attachment relationship and are used in preventative and intervention programs. Tools to teach parents how to read and understand their child's nonverbal cues while providing playful ways to improve the parent- child relationship are central elements of this program. Assessment and intervention components are also included in Ways of Seeing to support young children and families with a variety of difficulties including trauma, post partum depression, developmental and sensory processing disorders, medical illness, attention deficit and hyperactivity and Autism Spectrum Disorders.

Ways of Seeing utilizes nonverbal movement observation, dance, movement, motor development and body awareness activities, music, and play for the assessment, intervention and educational programming of children and their families. These programs are based on the observational analysis principles of Laban Movement Analysis (LMA) (Bartenieff & Lewis, 1980; Laban, 1975, 1976; Laban & Lawrence, 1974; Stern, 2010); infancy and early childhood developmental theory; and dance movement therapy practice.



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Introduction to the Ways of Seeing program

As I shared during my presentation in Leipzig (June 2010) the focus of this work, with babies, toddlers, children and parents is to understand the role of movement, multisensory experience, and the nonverbal exchange in the expression of self, self and other, and the developing attachment relationship. Ways of Seeing is relationship-based. The word seeing in the title is used to emphasize that there are many ways to look, to assess, and to receive information about self and other (Tortora, 2006). In this program the practitioner learns how to observe and understand the communicative elements of each person's nonverbal personal movement style.

A key concept of this work is the understanding that qualitative aspects of an individual's movement style reveal information about one's emotional, social, physical, communicative and cognitive development. The nonverbal observational tool called, Dyadic Attachment-based Nonverbal Communication Expressions (D.A.N.C.E) (Tortora, 2010a, 2010b, 2011) enables the practitioner to observe the nonverbal qualitative components of each person's style in the context of the dyad. This tool provides specific information regarding the nonverbal dynamics that support or compromise self-regulatory and co-regulatory aspects of the relationship. Specific questions are provided to guide the infant specialist or psychotherapist to observe how the baby cycles through states of engagement and disengagement and how the adult caregiver supports or misses the baby's nonverbal cues. Contingent and non-contingent behaviors are delineated and can be approached by bringing the nonverbal elements that drive these behaviors into conscious awareness.

This tool highlights the embodied experience for both the caregiver and the baby. The nonverbal aspects of behavior can be quite overt or subtle. The key here is to consider how the nonverbal qualities that comprise these behaviors affect the developing relationship. The following [composite] case vignette of a typical way Ellie approaches her 6-month old baby Aaron elucidates these points.

Ellie and I are sitting on the floor talking. Aaron is lying on his back on a blanket on the floor about three feet away from Ellie. Aaron begins to become fussy,

kicking his legs in a random stop and start rhythm as he shifts his head and looks directly toward Ellie. Ellie looks over at Aaron for a moment, her facial muscles tense. She pauses, stops speaking and holds her whole body still for about three seconds. The strength and speed of Aaron's kicking increases as Ellie looks toward him. Ellie responds by increasing the tension in her whole body. Her eyes have a direct stare as she adverts her gaze to the left, away from Aaron. Her facial muscles heighten in intensity as her jaw tightens. Suddenly she abruptly moves sliding in her seated position toward Aaron and then abruptly stops when she is very close to Aaron, pausing for another approximately three seconds. She holds her body tall and rigid not arching over to bring her face closer to Aaron. She adverts her gaze from Aaron as she states, "What do you want?" The quality of her voice amplifies this tension and Aaron responds by accelerating and increasing the tone of his vocalizations. She bends over and picks him up. She places him in her lap facing away from her. Aaron's torso is concave against the front of her body and his head is hanging forward as he continues his accelerated cry. He again creates a stop and start phrasing quality to his actions as he tries to turn his whole body to face Ellie. Ellie continues to hold her body tall, not embracing Aaron by shaping her torso around him. She redirects his twisting actions by increasing the tension in her hands to hold him more firmly facing forward. She and Aaron are both in a heightened agitated state. Aaron becomes very difficult to sooth at this point, squinting his eyes tightly as he kicks and arches his body backward. Ellie states, "See

he doesn't like me."

During treatment these observations are addressed with Ellie in several ways. Jointly watching a videotape of this interaction opens a discussion with Ellie regarding her immediate feelings in response to watching the video, as well as the underlying meaning and feelings she had during the interaction. Together we look at the more overt and subtle nonverbal dynamics of their interaction. As will be exemplified later in this paper, we explore these qualities both through our conversation, specific body awareness, movement, and dance activities with Ellie and through interactive dance activities with Aaron. The term dance is used here both metaphorically and quite literally. Through discussion and exploration Ellie learns about her own nonverbal expressions. With this knowledge she explores playful ways to interact with Aaron expanding the qualitative range of her action repertoire. Together she and I observe Aaron's nonverbal responds. This enhances Ellie's ability to attune to Aaron's more subtle cues. Music that compliments or matches the style of the spatial approach and contact is used to explore playful ways to approach and engage with Aaron. Spontaneous improvisational dances between Ellie and Aaron develop. These dances become part of their playful repertoire, expanding their relational rapport. New ways to engage evolve.

Sense of Body (Tortora, 2006)

This approach emphasizes the importance of keeping the baby's embodied experience in mind. The most salient principle of Ways of Seeing is the concept of a sense of body. This sense of body concept relates to the infant's experience of her own body, interpersonal relationships, and the emergence of individuality. It emphasizes the role somatic, multisensory, and nonverbally-based early childhood experiences have in the young child's development. It is the sense of body that informs the young child's developing sense of self. The key points of this concept state:

- An infant's earliest experiences occur through the body.
- They are initially registered on a somatic, kinesthetic, sensorial level.
- These body-oriented experiences shape:
 - How the infant begins to make sense of the world.

- How the infant begins to develop a sense of self as a feeling, acting, moving, communicating, cognizant being in the world.
- This body sensing includes sensing one's own body as well as the body of another.
- Through this body sensing an infant first begins the dance of relating.
- The body and the (interactional) dance are continually intertwined, informing and developing one another.

This sense of body principle underlies how the baby processes his surroundings and develops relationships. It informs all of the practitioner's observations of the child and the adult-child interaction, and influences how the wellness and intervention programs are developed.

Role of the body and the nonverbal multisensory experience in building relationships (Tortora, 2006)

We know that the earliest learning occurs in the context of interpersonal relationships. Babies discover themselves and understand their world as their caregivers and the environment respond to their self-directed actions. The Ways of Seeing approach places emphasis on attending to the specific qualities of the primary caregiver's responses. This nonverbal aspect directly influences the baby's developing curious nature. The nonverbal quality of the caregiver's touch and holding style are especially noted as they may influence the baby's experiences.

In this method the nonverbal element is accentuated in all areas of the baby's development. Playful spontaneous movement-based interactions involving a mutual give and take between baby and significant adult support the development of a healthy bond. Communication, skills in relating, emotional, cognitive and motor development are effected by the young child's movement and multisensory-based experiences with her surroundings. Simply stated:

- Babies first learn through movement-based natural experiences.
- Babies need to explore their bodies moving and they need to feel their bodies being moved to support their development.
- Babies use their bodies and body actions

to explore, communicate, and learn in their environment.

- Babies don't need "instruction" to learn. They need the freedom to explore safely, through active playful engagements with people and things.
- Optimal learning requires the freedom of self-exploration through active physical engagement with people and objects.
- Early experiences form memories that are registered and organized through somatic, sensory, kinesthetic and nonverbal modalities creating perceptual images. (Gaensbauer, 2004)
- Babies translate their early perceptions and sensory-based experiences into actions.

The example of Aaron and Ellie above can be used to portray how this perspective influences my thoughts and approach to their treatment. As I observed their salient interactional style I am immediately drawn to the sequence starting with Ellie pausing and disengaging before she continues her contact with Aaron. What may Aaron be experiencing during the moments Ellie delays her contact? What does his heightened kicking during this time say about his experience and how may it influence Ellie's subsequent response? How may the heightened tension in Ellie's body when she lifts him, coupled with her averted gaze be influencing the overall quality of their engagement? Keeping in mind the co-regulatory nature of repetitive dyadic interactions, how may this dynamic sequence of actions be affecting Aaron's presymbolic representations of self and other (Beebe & Lachmann, 2002)? Ultimately if this becomes their predictable interactional style how will it affect Aaron's growing sense of self-efficacy? Playfully trying on other ways to approach and contact Aaron through discussion, dance and music is a creative way to explore these questions. It provides a window into how flexible they can be with each other while creating opportunities for change and repair.

Understanding the role our own nonverbal personal movement style plays in interactions with infant and infant-parent interactions

In order to understand how nonverbal and multisensory experiences influence

relationships it is also imperative to understand how the qualities of your own nonverbal experiences influence your interactions. In *Ways of Seeing* the practitioner monitors her/his own experience to be aware of how it may be influencing the therapeutic interventions with the child and other family members. This self-monitoring is similar to the psychological concept of countertransference. In *Ways of Seeing* the self-observation process has three components that enable the practitioner to analyze her/his experiential reactions in detail. Briefly outlined below these components involve both an objective description of each individual as well as the dyadic interactions, while paying close attention to your own reactions (Tortora, 2006, 2011).

- **Witnessing** – Two parts: (a) objective mapping of actions; (b) self-reflective comments, describing your immediate general thoughts, personal reactions, and sensations, which may come up when engaged with or observing the child/parent/parent- child dyad.
- **Kinesthetic seeing** – describes your sensorial experience. For example, did you hold your breath, change your breath rhythm, or increase your muscular tension level? Becoming aware of bodily reactions provides information about how the practitioner is experiencing the individual/dyad, and possible ways the individual/dyad may be experiencing the situation. This knowledge informs subsequent interventions and interactions.
- **Kinesthetic empathy** - describes your emotional reaction derived from experiencing, observing and “trying on” the movements of the participants. Through awareness of your own emotional/bodily reactions you reflect on how the individual/dyad may be emotionally experiencing the situation.

Learning about and understanding your personal multisensory style, greatly supports the ability to observe, relate and be empathic. Insight about the role multisensory experience plays in the lives of families you are working with is heightened. The initial vignette above provides an example of the witnessing part (a) objective mapping of actions. The description enables the reader to clearly visualize the nonverbal components of the interaction. Evaluative commentary does not color the observation. The questions I pose that follow the description reflect witnessing part (b)- these are

the immediate thoughts and personal reactions I have as I observe the dyad. This questioning directly influences how I approach Ellie and Aaron, and how I develop the movement explorations and choose the music.

As I approach Ellie I am aware of her tendency to suddenly disengage. As I observe this behavior with her son, I feel a jolt inside of me and I inadvertently hold my breath. This is my personal kinesthetic seeing response. Keeping this in mind, I momentarily check my own breath pattern making sure it is soft and flowing before I speak. I am conscious to keep my voice calm and clear, and my eye gaze directly toward her but gentle. Keeping in mind how she momentarily froze when Aaron’s behaviors toward her increased, I want to make sure my engagement with her is unimposing. The general posture of my body exudes a sense of flexibility. I keep my gestures small, light and fluid, and am careful to not hold any part of my body rigid.

As I watched her nonverbal exchange while simultaneously attuning to my emotional responses feelings of defensiveness and being overwhelmed with demands from others arise. This is my kinesthetic empathic response. This amplifies my awareness that the content of our work together has the potential to make her feel defensive. Is this how she is feeling and if so what are the specific verbal and nonverbal behaviors that trigger this response in her? I make a mental note to pay attention to the relationship between the verbal and nonverbal elements of the dialogue that precedes her momentary frozen postures.

Components of nonverbal observation

Utilizing nonverbal observation as a key to understanding an individual’s personal expression and interpersonal interactions involves looking at not only what the mover is doing but how the mover is executing the actions. It is the quality of the specific action the will reveal the meaning behind the behavior. The qualitative elements refer to the specific descriptive components of physical actions.

These qualitative elements derived from the Laban Movement Analysis (LMA) system (Bartenieff & Lewis, 1980; Laban, 1975, 1976; Laban & Lawrence, 1974; Tortora, 2004, 2006, 2010a, 2010b, 2011) provide information about:

- **How (Effort)** an action is performed from the perspective of time, flow, weight and attitudes toward space;
- **What (Body)** body parts execute the action and how areas of the body move as a whole unit or individually;
- **Where (Space)** it occurs in reference to others and the surrounding spatial environment.

These qualities are exemplified in the vignette. The specific LMA elements of Ellie’s nonverbal style are italicized here. Her Effort qualities include abrupt actions that suddenly stop. She holds her body with increasing bound tension, accentuated in the quality of her face, jaw, words and hands as she holds Aaron. These descriptions highlight the Effort qualities of time and flow. Her body attitude is noted specifically in the heightened tension of her face, jaw and hands and the tall stance of her torso. This description emphasizes where in her body the tension is expressed. The space category is noted when she slides on the floor directly toward Aaron, stopping when she gets close to him. She maintains an erect body position that does not soften or shape around him as she picks him up and holds him against her body. This description enables the reader to visualize her movement through space as she approaches and then physically engages her son.

Stern has brought attention specifically to the four elements of Laban’s Effort category - flow, time, weight, space - referring to them as the dynamic “four daughters of movement” that create the experience of vitality (2009, 2010, p. 4). As discussed by Laban, these Effort details provide the feeling tone to actions coloring an individual’s experiences and impact nonverbal expressions. Effort, body and space dynamics construct a nonverbal language of movement. Observation and analysis of this qualitative non-verbal language provides a window into a fuller understanding of an individual’s personal expressions and interactional style.

Derived from LMA, the key points of the *Ways of Seeing* observation process state:

- **Movement is expressive of self.**
 - Each individual creates his or her own movement repertoire, movement signature, & movement metaphor:
 - Movement repertoire - the range of movement qualities and elements that a mover uses to express him/herself.
 - Movement signature - the specific qualitative actions used most

frequently in the mover's repertoire that most characterize or define the individual's style of moving.

- Movement metaphor - specific, personally stylized nonverbal segments or sequences of movement that recur consistently within the mover's movement repertoire and have symbolic meaning. Developed from a specific experience or set of experiences, this movement becomes distilled into an idiosyncratic gesture or group of actions.

The qualities of a mover's movement repertoire connect physical action to emotional and social experience. The movement signature provides a link between the mover's actions the mover's perceptions and understandings of his/her surroundings. A movement metaphor often becomes the core nonverbal expression depicting a significant psychic theme on an embodied level.

D.A.N.C.E. parent – child interaction questions

All interactions involve a nonverbal exchange between the participants. The Ways of Seeing program has developed a five-question protocol in D.A.N.C.E. to observe the quality of the parent-child interaction, based on the qualitative nonverbal elements discussed above in tandem with infant mental health principles. These components look at how the movers navigate their actions through the following elements: use of space, body, shaping of body actions, Efforts and phrasing of the movement actions (for brevity the definitions of these words are not explained here but can be found in my other published material, Tortora, 2006, p. 217). It is important to note that D.A.N.C.E. was designed to look at the parent-child dyad because that is the most typical clinical situation in which it is used. However, it can easily be adapted to observe multiple people simultaneously engaged [with the baby].

1. How do the movements of the adult establish a holding environment supporting the waxing and waning of attention?
2. How are turn-taking interactions opened and closed through each participant's movements, specifically looking at how they initiate, withdraw and resume contact?
3. How do mirroring, attuning and mismatch and repair cycles occur through body movement dialogue?

4. Does the adult attune to the child's style as reflected in the child's cues, giving room for the child's expression before intervening, or does she respond without attending to the child's style first? How is this expressed through the nonverbal movement exchange?

5. Describe the type of base of support that is established between the adult and the child, from which the child receives pleasure, understanding and comfort when exploring the surroundings and when returning to the adult in times of perceived danger or discomfort. Describe how these behaviors are portrayed in both the adult and the child through their movement qualities and movement exchange.

Reviewing the vignette with these questions in mind, it becomes clear that the easy turn-taking rhythmic exchange typically observed between mother and baby is not present between Ellie and Aaron. The timing of their unspoken dialogue is filled with pauses, and sudden and accelerated actions that are not contingent or attuned to each other. As the scene develops, their emotional connection becomes more strained, observable in Ellie's increasing body tension, Aaron's erratic stop and start movement phrasing, and their lack of joint eye contact. When Ellie places Aaron on her lap this disconnection is accentuated in the lack of molding in their body-to-body contact. Ellie's body actions do not appear to provide a safe base of support for Aaron. Instead he is left balancing on her lap squinting his eyes and arching his back as she holds him firmly.

Key principles and related questions for parent-child interactions

Based on these questions dyadic movement activities are created to support the parent-child relationship. Through this practice the parents are taught to learn about their children's movement styles and rhythms as well as their own tendencies. The dance therapist helps the parent discover similarities and differences in the qualities of their personal movement signatures, not expecting to find exact matches of style but rather compatibility between their unique styles. Finding compatibility alleviates blame and helps parents examine and understand the underlying meanings behind their reactions to their child's behaviors. Parents learn which

aspects of their nonverbal exchange best support their relationship and which aspects of their nonverbal style they may need to modify. An understanding of compatibility encourages parents to respect their children's behaviors as a form of communication and not to perceive these behaviors automatically as deviant actions. Through this process parents recognize that most often a child's behavior is a communication—even if it is a difficult one. Ways of Seeing has created several worksheets to help parents examine their nonverbal exchange with their child. A sample of the types of questions asked include:

Questions for parents: (Tortora, 2006 p 340 - 350)

1. What meaning do you "read" in your child's body expressions and what message is your child "reading" in your nonverbal behaviors?
2. Spend some time watching your child. How does your child show his or her emotions—whether happy, sad, angry, tired, or frustrated? What body signals are used?
3. What are your physical and emotional reactions to these body expressions and signals?
4. What might a child be saying by how he or she is moving? Mirror the movement by trying it on. What does it feel like to you? What is your reaction?
5. Most crucially, do you attune to your child's style as reflected in the child's cues, giving room for his or her expression before intervening? Or, do you respond from an internal impulse to help without attending to your child's style first?

As Ellie and I view the video and discuss these questions, she reveals that she is worried that if she softens her body her baby will consume her. Her strong tall posturing belies a deeper fear of victimization. On a very basic embodied level Ellie does not have the experience of being responded to in an attuned manner. She experiences Aaron's nonverbal actions as demands on her. She does not mold her body into him to sooth him for she is concerned this will make him weak and unable to sooth himself.

Movement activities that support parent-infant attachment and communication

The parent's responses to these questions are used to design nonverbal, dance and movement activities to support the development of the relationship. Activities are created for each dyad based on their own interactive movement styles. The themes of these activities include the following concepts:

- **Establishing eye contact:** The focus here is to help the parents understand the qualities of the dyadic nonverbal dialogue emphasizing the ebb and flow that naturally occurs during engagement. The parents learn how to attune to the waxing and waning of the baby's attention. These activities include playing with visual contact as well as spatial distances, dancing/ moving toward and away from each other in the surrounding space while staying emotionally engaged. I have created the term *embraced space* (Tortora, 2010a) to describe the emotional connection created between the intimate dyad that is maintained through the changing spatial distances of meaningful interactive exchange.
- **Trust:** This principal focuses on establishing trust through body contact with an awareness that physical contact is a form of communication. Parents become aware of the quality of their and their child's touch and holding style. Activities emphasize how body-to-body contact is established through yielding and molding or holding one's body separate from other. Activities include qualities of hugging, swaying, and swinging to melodic and rhythmic music as a baby feels her body weight being moved and supported through a dancing exchange. Activities also include waiting for the baby to initiate engagement by closely watching her movement actions. In these activities the parent provides room for the baby to move on her own observing the baby's motor curiosity.
- **Internal regulation of body & moods:** Feeling internally regulated on a body-felt level supports interaction. Relaxation methods are taught to help the parent with self-regulation, how to sooth her baby, as well as what multisensory conditions help her baby

self-sooth. Parents become aware of the quality of their voice, the use of touch including different massage strokes, where they hold body tension, how the tension in their body reflects their mood, and how they express their reactions to their baby's mood and nonverbal actions through their personal movement responses. Parents learn how to identify their own and their baby's regulatory capacity as they dance to music along the spectrum from slow, medium, fast to super- fast. These different tempos are related to feelings and sensations of being calm and centered at one end to extreme distress and dysregulation at the extreme end. Parents also explore their own regulatory and deregulatory styles. Focus is placed on the circular connection between the mind, body and emotions. By playing with these concepts through creative dance, body awareness, methods of touch and holding, breath and relaxation activities parents learn to better monitor and gain control over their own regulatory behaviors while exploring the connection between their thoughts, feelings and nonverbal behaviors.

- **Self-discovery:** The focus of these activities is to help the parents support the baby's experience of how her movement actions have agency in the surroundings. These discoveries include increasing the baby's awareness of her physical body- self by exploring simple actions such as reaching, grasping, pulling, pushing and climbing. How the child's nonverbal behaviors affect a parent's nonverbal reactions is also addressed. Parents are encouraged to follow their child's lead through dance, movement, music and play-based games that support the baby to explore using props such as musical rhythms, musical instruments, scarves and streamers. Toddlers participate in creating pathways across the room using cushioned climbing equipment, circles pads and rug squares to climb, swing on, crawl through, rock on, and balance.
- **Object permanence:** Games such as peek-a-boo, hide-n-seek, follow-the-leader and stop-n-go are explored through movement and dance activities that travel through the room. Parents and babies find ways to stay connected, maintaining their embraced space from all different places in the room. Creative dance props including scarves, musical

instruments and a variety of musical rhythms are used to facilitate these explorations that establish the parent – child relationship.

- **Relating:** Following along the lines of the object permanence and self-discovery themes these dance activities include follow-the-leader by mirroring the leader's exact actions and the feeling tone of the actions as well and responding with complimentary actions. Finger play musical games performed in synchrony or in response to the partner; and attuning, mismatched attunement, and re-attuning through movement explorations are created as the dyad dances and plays together. During these activities the parents pay attention to their child's unique qualitative movement style incorporating these nonverbal qualities into their movement responses.
- **Independence:** During these movement and dance activities parents learn to identify specific cues of their child that reveal self- exploration and initiation. Games of coming and going, crawling/ running toward and away from the parent, when the child is seeking connection verses exploration; and different ways to connect through eye contact, vocal cuing, body proximity, and gestural actions are explored.
- **Support movement and motor development:** A great emphasis is placed on learning how touch is a form of communication. Touch is emotionally expressive. It can communicate love and kindness or aggression and disturbance. It can calm and co-regulate or excite and agitate the recipient of the touch. Parents learn how to use touch to guide their baby's movement explorations rather than doing the action for the child by simply placing the baby in new positions. This enables the baby to experience how her own physical initiations and exertions influence her actions and her surroundings supporting her sense of agency, further developing an embodied sense of self.

The Ways of Seeing program offers these activities in a variety of contexts to best meet the needs of the families. These include parent-child groups, parenting groups, private parent –child dyadic sessions and sessions with the parent individually.

In Ellie's private sessions we discover that

during her extended moments of stillness she takes a quick shallow inhale and then holds her breath for extended periods of time. We realize that this physical behavior occurs even as we speak about the stresses in her life. Its prevalence in her movement repertoire is significant. We designate it as a movement metaphor and stay open to learning more about its origins. Exploring her breath holding pattern leads to an early memory of her hiding in a corner holding her breath and whole body in an extremely tense manner in an effort to not be heard or seen when her alcoholic abusive father entered the house. In this position she witnessed such a cacophony of chaos that during her retelling she unintentionally embodies this posture.

Two complimentary therapeutic activities are developed to repair this embodied pattern. First Ellie must be able to establish a sense of bodily safety so she can feel a sense of control rather than being flooded by these memories. We do this by teaching her how to maintain an equal length in her inhale and exhale particularly giving time to completely release her breath at the end of her exhale. We practice doing this as we continue to speak about her fearful history and her current stresses. She begins to make connections between feeling emotionally overwhelmed, her increased body tension, and fearful thoughts that often suddenly invade her.

This discovery delineates the specific mind – body- emotional continuum that drives her embodied behaviors. Ellie makes the association that the sporadic flinging leg and arm actions and increased vocalizations of Aaron act as a trigger setting off her negative response toward him. She becomes skilled at redirecting her attention away from this fearful reaction and body freeze. Instead, Ellie attends to the immediate moment, by taking full breaths until she feels quiet and calmer. She learns how to identify this calm sensation both emotionally and on a body level. I instruct her to take a “sensory photograph” (Tortora, 2006, p. 78) of this sensation, so she can bring it into her bodily conscious awareness whenever she is feeling overwhelmed.

Along with this breath activity personal expressive dances that further support body awareness and provide an additional way to explore these memories are created. Together we develop a body warm- up coordinating the flow of her breath with full body stretches lifting her arms up, to her sides and down. This evolves into large arm swings in all directions. As Ellie swings her arms around her lower torso she starts to extend the palms of her hands out into space at the end of the swing.

In my kinesthetic seeing reaction it feels as if Ellie is pressing something away. We begin to enlarge this action and take it into space. A rhythmic dance is composed as she steps forward, sweeping her arms around and away, culminating with this pressing action. We move together at times in synchrony side-by-side, at times in nonverbal dialogue silently passing the imaginary object between us. Without speaking a word we share this experience. In my role as witness I am struck by an image of mobilizing forward while pushing away imaginary obstacles. During the verbal processing period after our embodied dyadic experience, Ellie confirms my kinesthetic images. She discussed how empowering it was to realize she did not have to remain frozen in time and space when she was overwhelmed. She could mobilize, pushing past this stuck sensation and reach for help when she was fearful.

As Ellie explores these new ways of being in her own body, she is able to experience Aaron’s nonverbal behaviors differently as well. The evolving dance games focus on rhythm, timing, space and touch. These qualities are explored through verbal play and full body dances. A vocal pas de deux emerges as Ellie and Aaron create a rhythmic dialogue by playing with the length of their pauses between each of their utterances. They take turns initiating the game as Ellie learns to stay emotionally present and physically engaged by approaching Aaron with eye contact and a softer body attitude. Smiles and giggles spontaneously arise lengthening their engagement and adding to the fun.

Aaron’s stop and start kicking rhythm is developed into playful contact. When Aaron kicks his leg into the air Ellie follows his path and taps each foot with a lighthearted expression. An alternating rhythmic game is created as Aaron excitedly varies the timing of his kick. This naturally evolves into a peek-a-boo game, when Ellie leans over and catches his feet using them to momentarily cover and then uncover her eyes and exclaims “peek-a-boo!” as their eyes meet.

Ellie learns how to hold Aaron by shaping her arms and body around him as they dance to the beautiful undulating flow of waltz music. She releases her tension and breathes fully into her torso creating a secure firm container for Aaron. The waltz turns into a dance of dips and turns, as Ellie responds to Aaron’s enthusiastic reactions to the music by swaying his body to and fro. Ellie starts to enjoy Aaron and understands that the motivation behind his actions is to be with her rather than displaying signs of weakness. Aaron begins to thrive through these playful dance play

interactions, becoming more animated and regulated. Ellie frozen pauses disappear as her nonverbal behaviors become more contingently related to the ebb and flow of Aaron’s behaviors.

Conclusions

The creative explorations in the Ways of Seeing program emphasize the communicative nature of each person’s unique nonverbal expressions. Dance, movement and play activities enable the parent and child to attune to the specific qualitative aspect of their nonverbal movement style. Through the personal therapeutic discussion and dance movement psychotherapeutically- based activities the parent learns how to better read her baby’s nonverbal cues. The baby’s embodied experience during these more positively co-regulated interactions supports his/her developing self-concepts. Dialoguing through movement expression creates a resonance between self and other. A sense of self-efficacy and knowingness of other is experienced through these nonverbal exchanges. These activities encourage and strength the attachment relationship. The musicality of the emerging parent – infant relationship is realized on a felt-sense level through the dancing dialogue and emotionally through the improved relationship.

Individual and group sessions enable parents to explore their nonverbal movement repertoire to learn about their personal mind- body- emotional connections. This is very powerful for parents often discover that they did not experience attuned nonverbal interactions in their own childhood. Through body awareness, movement and dance explorations they embody attuned interaction. They also learn how to better regulate their own emotional responses through both calming and activating activities. They explore relaxation activities that focus on breath and body awareness and participate in group and individual expressive dance sequences created through their responses to music and emerging imagery that personally related to their life experiences.

In the composite case vignette, the quality of Aaron’s nonverbal actions initially triggered Ellie’s own difficult history. By exploring her associations to these actions along a mind- body- emotion continuum Ellie was able to disconnect these reactions from her baby’s behaviors. Aaron’s sense of body and self-agency develop as his repertoire of nonverbal experiences with his mother repair and expand through

their dancing dialogue. Their embodied shared experiences during these explorations enhance the intersubjective experience.

In our current era of increasing media and electronic stimulation, group day care, and sedentary activities, babies and toddlers need to explore their moving selves as a communicating source of connection within the context of meaningful relationships now more than ever.

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Applying clinically-relevant developmental neuroscience towards interventions that better target intergenerational transmission of violent trauma

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Within the context of infant-parent attachment, primary caregivers provide multiple, complex, and often “hidden” regulatory functions. These functions are akin to individual colored threads, that when woven together, compose a brilliant, unique, and clearly recognizable pattern, itself the focus of the artful tapestry that is the individual infant’s relationship to his primary caregivers (Hofer, 1984). One form of “hidden” regulation of critical importance to the child’s capacity to form healthy relationships with others and to learn, is emotion regulation (Cassidy, 1994). The term “mutual regulation,” as first used by (Tronick & Gianino, 1986), refers to a bidirectional, albeit asymmetric, process of emotion regulation between the adult caregiver and the infant.

Description of our study

Our studies, conducted both in New York and in Geneva, are aimed at understanding the interplay of factors that disrupt and facilitate mutual emotion regulation. It is well known that maternal psychopathology, such as depression (Tronick & Gianino, 1986), or anxiety (Moore, Whaley, & Sigman, 2004) disrupts mutual regulation. It has clearly been established that maternal history of attachment security and its robust marker, reflective functioning (Fonagy, Steele, & Steele, 1991; Slade, Grienenberger, Bernbach, Levy, & Locker, 2005), both embedded in the concept of maternal caregiving sensitivity, are the main tools for repair of mismatched parent-infant communication, and thus for mutual emotion regulation.

Central to our program of research is the

hypothesis that mothers with violence-related post-traumatic stress disorder (PTSD) may experience their very young child’s routine distress as a trigger of pre-existing post-traumatic stress (Schechter, 2003). We have noted, via our clinical observations, the particular phenomenon in which intense displays of helplessness, frustration, rage, and terror by very young children with limited developmental capacity to regulate their emotion remind many mothers who have been victims of violence of 1) their violent perpetrators’ behavioral dyscontrol, 2) the victim-mother’s own fear and helplessness. As such, the young child can trigger his or her mother’s PTSD symptoms.

Clearly, such a perceived interpersonal threat by the very young child in distress can shift a mother’s primary preoccupation with that young child’s needs to that of her own individual survival. Fraiberg and colleagues spoke of this shift among traumatized mothers in psychological terms by describing the notion that infant-parent intervention must involve the therapist’s hearing the traumatized “mother’s cry so that she can hear her baby’s...” (Fraiberg, Adelson, & Shapiro, 1975). More recently, developmental neuroscientists have been attempting to understand under what conditions, parents are more likely to be able to be emotionally available to or “affiliative with” their babies, and when they must turn their attention to planning “fight, flight, or freeze” in the presence of danger (Porges, 2007). This redirection of attention to self-preservation, which implies activation of the sympathetic overriding the parasympathetic (i.e. vagal) arm of the autonomic nervous system in Porges’ “poly-vagal theory” removes the parent from being attentive to her child’s cues, with a focus on self-rather than mutual-regulation of arousal and emotion, and thus greatly increases the risk for gross misinterpretation of her child’s cues.

When we started our research in this area—following from Fraiberg’s pioneering work, interest in parental trauma and attachment was burgeoning (Main & Hesse, 1999, Silverman & Lieberman, 1999; Fonagy, 2000; Scheeringa & Zeanah, 2001; Laor, Wolmer, & Cohen, 2001). Despite this

general interest, we and our colleagues noticed that only a single published study had systematically measured parental posttraumatic stress in relation to maternal caregiving behavior (Lyons-Ruth & Block, 1996). This study found a moderate correlation between severity of self-reported maternal PTSD symptoms that were associated with histories of maternal histories of maltreatment and hostile-intrusive caregiving behavior, the latter particularly associated with history of physical abuse (Lyons-Ruth & Block, 1996). In cases of maternal violence-related PTSD, these repeated acts of attentional redirection to mother’s self preservation amplify the sense of helplessness and distress in the child. Helplessness and distress in the child, in turn, often lead the mother to further defend herself from her own feelings of helplessness and to distance herself emotionally and/or physically from the child, rather than providing contingent comfort, emotional containment, and protection.

PTSD and negative maternal attributions

Maternal attributions open to the clinician a window into the mother’s mental representations of her child and her relationship with him or her. The running record of these maternal representations —“working model” in terms of attachment theory— are largely based on a mother’s own relational experience and strongly predict how a mother will behave with her child (C. H. Zeanah, et al., 1993). A mother’s perception of her child may be negatively skewed by the experience of interpersonal violence and subsequent triggers posttraumatic stress disorder (Lieberman, Van Horn, & Ippen, 2005; Schechter, 2003). Maternal self-reports themselves support the hypothesis that the child particularly in vulnerable and helpless states of mind poses a threat to the traumatized mother; the majority of PTSD-afflicted mothers reported that their very young child were one of the three greatest stressors in their lives rather than as sources of joy and have distorted, negative, and poorly integrated maternal mental representations of the

child (Schechter, et al., 2006).

In a previous paper (Schechter et al., 2005), we also described the association between mentalization, otherwise operationalized for measurement in research as “maternal reflective functioning (RF)” and balanced, integrated positive and negative maternal mental representations of the child. Often, caregivers with PTSD very specifically misperceived their child’s separation anxiety and sense of helplessness as anger, coerciveness, or otherwise a threat. As a result, many traumatized mothers stated that they often try to avoid their child’s distress by “tuning out,” “blocking out the crying,” or “leaving the room” so as to maintain their own emotional regulation (Schechter, Kammer, Grienerberger, & Amat, 2003). Mental representations that were excessively angry or otherwise distorted by being excessively negative or by attributing to the child characteristics that would clearly be beyond his power or inappropriate for his age, were associated with symptoms of violence-associated PTSD (Schechter, et al., 2005).

The child as a trigger of maternal preexisting PTSD

The idea that the child himself/ herself could be a trigger of preexisting post traumatic stress for a parent emphasizes the co-constructed parent-child interaction with primacy on the child’s impact on the parent in moments of distress and the parent’s reaction to the distressed child in return. This is in contrast to the more frequently described and no less important effects of the parent with her history and how she affects her child (Scheeringa, Peebles, Cook, & Zeanah, 2001). While Sameroff (1975) first described a bidirectional model of parent-child interaction in which the infant impacts the parent’s response, the notion that the child could represent a posttraumatic trigger for a traumatized parent emerged clearly for the first time to our knowledge in our work with interpersonal violence exposed mothers and in our work with children whose separation anxiety broke through parental defenses against the sudden loss of loved ones during the terrorist attacks on the World Trade Center on September 11, 2001 (Schechter, Coates, & First, 2002; Schechter, 2003).

One of the most well-studied paradigms in our field that is used to study child-caregiver attachment, the Strange Situation (Ainsworth, Blehar, Waters, & Wall, 1978) as well as the Crowell Procedure as modified by Zeanah and colleagues (2000) involves parent-child separation and

reunion that offer us a normative stressor that is observable in the laboratory and that, particularly within the second year of life, tends to elicit distress in both child and parent. While much attention has been paid to what happens during reunion, including the impact of the mother’s state on the child, relatively little attention had been paid to what happens in mother’s and child’s mind during separation and the subsequent effect of the child’s distress on the mother.

Joint Attention—as many of you will be more familiar with in the context of research specifically on language development and autistic spectrum disorders, is also a crucial focus of evaluation when considering emotion regulation and the development of secondary intersubjectivity beginning at age 8 to 10 months. Joint Attention is the process by which two individuals alert one another, often non-verbally such as by gaze and-or pointing, to a common focus of attention and reference each other so as to acknowledge their shared focus. It is thus a “triadic skill,” in that it involves two people plus a point of reference, which may either be an external object or event or an internal state or event (Schechter, et al., 2010). With regards to internal state awareness, we have argued that this capacity is an important prerequisite to a mother’s assisting her child with emotion regulation: jointly attending to the child’s emotional state and being aware of the child’s efforts to read mother’s emotional state.

Our research questions

We wanted to study the following questions; 1. Is there any difference in the way violently traumatized and non-traumatized mothers are affected by their child’s distress at separation, and in the level of the children’s distress? 2. What happens at the moment of reunion, when traumatized mothers open the door,? How do they perceive or read their child’s cues and distress? 3. How do traumatized mothers, compared to healthy mothers, tolerate and contain their own and their child’s fear and anxiety, and respond to their child’s bids for attention? Are the mothers able to settle down, and become emotionally available for joint attention with their child given their child’s distress?

We addressed these questions with a new cohort in The New York Parent-Child Interaction Project.

THE NEW YORK PARENT-CHILD INTERACTION PROJECT (NY-PCIP)

The NY-PCIP was a National Institute of Mental Health funded study, that replicated and expanded an earlier original study of a referred sample, but this time, within a community pediatrics clinic sample. The study ran from February, 2004 until February, 2007. Analyses of the wealth of data from this study are ongoing with publications still in preparation and under review. The sample consisted of 77 mothers ages 18 to 48 (mean 29 years, SD 6.8) with children ages 12 to 48 months old (mean 28 months, SD 10.7), out of which 58% of boys. The majority of mothers and children were Hispanic (81%). The average length of maternal education was 12-13 years. Roughly 60% were single mothers. Fathers’ histories were collected but the fathers themselves were not included in this study.

Procedure

After informed consent and screening (exclusion criteria included active psychosis, intoxication, developmental or physical disabilities that would preclude performance on experimental tasks), mothers underwent three videotaped interviews and observations.

Visit 1 was focused on mother’s mental state and psychopathology. Mothers were also interviewed about their mental representations of their child and relationship with their child (Working Model of the Child Interview (WMCI), (C. H. Zeanah & Benoit, 1995)). A detailed maternal life events history was obtained followed by clinician assessment of trauma-associated psychopathology (i.e. PTSD, dissociative, and depressive symptoms).

Visit 2 was focused on observation of interactions with the child and on the mother-child relationship assessment that included free-play and challenging structured play tasks that triggered maternal scaffolding, and most importantly, various stressors that remind daily sources of child distress, such as a separation-reunion, an obligatory clean-up and a novel surprising stimuli (i.e. being cared for by a stranger, meeting a furry spider toy that jumps).

Visit 3 was actually an intervention session, based on the paradigm described below, the “Clinician Assisted Videofeedback Exposure Session (CAVES; (Schechter, et al., 2006).

Imaging Sub-Study

What happens in the brains of mothers who have been traumatized by violence and maltreatment when they parent young children? With Brad Peterson and his MRI Lab at the New York State Psychiatric Institute, and support from the Sackler Institute for Developmental Psychobiology and the NIH, we conducted a small neuroimaging study that tried to get at what underlies parental perception of child emotion and parental behavioral response in the face of common stresses in parenting a young child, among the traumatized, as compared with healthy controls. The goal of this sub-study was specifically to understand how mothers' stress during separation might affect their processing of child emotional communication while watching video clips of their own and unfamiliar children both in a positive affect-eliciting or free-play condition and a negative-affect eliciting or separation condition from Visit 2. Those mothers interested and eligible to participate were offered an additional consent form and participated in a neuroimaging sub-study which took place between Visit 2 and Visit 3.

Results of the NY-PCIP

Psychological findings

Mothers response to separation and other forms of stress.

We found that mothers with IPV-PTSD reported more parenting stress in general on the Parenting Stress Index (t-test [df 1,44]: -2.35; $p < 0.05$; also see (Schechter, et al., 2010). More importantly, during our post-MRI interview revealed that mothers with IPV-PTSD were significantly more stressed by seeing videos of their own and unfamiliar children during separation than controls (Schechter et al., submitted).

Mothers' reading of child emotional communication on reunion.

Mothers with IPV-related PTSD describe their children much more negatively and in terms that are age-inappropriate than healthy controls in quantitative analyses (Reliford & Schechter, 2009; Schechter, et al., 2006). We have also been analyzing qualitatively maternal interpretation of child affect upon reunion and find most often confusion between child anger, controllingness with child fear, helplessness (Schechter, 2003; Schechter,

et al., 2006). This requires further quantitative study that is under way.

Behavioral findings

Mothers' response to their reading upon reunion.

In this area, we have the most findings. We have noted that IPV-PTSD diagnosis and symptom severity as mentioned above is significantly associated with parenting stress and that both measures of stress are associated with more disrupted communication on the Atypical Maternal Behavior Instrument (AMBIANCE, (Lyons-Ruth, Bronfman, & Parsons, 1999)) which in arriving at a final overall score that involves coding of the entire interactive sequence (i.e. free-play, separation, and reunion), weights more heavily the maternal behavior with her child upon reunion to determine the score. We also found that greater disrupted communication on the AMBIANCE is associated with less time spent in joint attention during play generally. Specifically, during play following separation-reunion, greater maternal PTSD severity is associated with less maternal availability to respond to child bids for joint attention (Schechter, et al., 2010).

Disturbances of child-parent attachment.

We furthermore noted that greater maternal PTSD severity, is associated with disturbances of child-parent attachment when we analyzed data from the Disturbances of Attachment Interview (DAI) (Schechter & Willheim, 2009; Smyke, Zeanah, Fox, & Nelson, 2009). We found that four behaviors in particular: reckless self-endangering behavior, separation anxiety, hypervigilance, and role-reversal were interestingly and significantly related to one another (Cronbach's $\alpha = .75$) to form a construct labeled in the literature as "Secure Base Distortion". This cluster of behaviors were significantly related to the severity of maternal PTSD symptoms (Schechter & Willheim, 2009).

Neuroimaging findings

What do we think is going on in the brain of traumatized mothers during separation that would account for this disruption of mutual emotion and arousal regulation? We already have found that when mothers watch videos of their own child and unfamiliar children during separation—a stimulus-condition that shows the child

in a helpless, and frightening context, as compared with quiet play with mother—a stimulus-condition that shows the child in a safe and empowered context, the higher cortical areas (medial prefrontal cortex, superior frontal gyrus) that are activated in non-traumatized mothers' brains (controls) are not activated in the traumatized mothers. Traumatized mothers rather showed greater activation in limbic areas associated with hypervigilance and response to contradictory emotional input (i.e. entorhinal and anterior cingulate cortex) (Schechter, et al., submitted). These neural activation findings may well help us understand what underlies the disruption of maternal availability for joint attention after separation corresponding to maternal severity of PTSD (Schechter, et al., 2010). They also suggest that the "internal mutual regulation" that under normal circumstances takes place within the brain between higher cortical areas and limbic regions as observed through the microscope of functional brain imaging may be disrupted among traumatized mothers. So, this disruption among traumatized mothers at the level of neural activity in the brain may well be parallel to the behavioral disruption in the "external mutual regulation" of emotion and arousal with their young children that we observe with the naked eye. This is further supported by a post MRI-scan interview that we gave mothers from which we found that traumatized mothers as compared to healthy controls, rate that watching their own and unfamiliar children during separation is significantly more stressful.

These findings that suggest convergence between the psychological, biological, and neuroimaging parameters of post traumatic stress disorder, are indeed very exciting

GENEVA STUDY

Our aim is to replicate and expand the New York Study Parent-Child Interaction Project in Geneva. We are recruiting a larger sample (N=120) with 1 clinical group (Interpersonal Violence + PTSD) that is more strictly constrained to mothers who have been victims of domestic violence as well as to have multiple control groups including non-violence exposed and depressed mothers. We also lowered the upper age limit to increase the likelihood of dependence on mother for regulation of distress during separation (18-42 months). Finally, we wish to follow the different paths their children take over 3 years of follow up, more specifically the avoidant and the aggressive ones.

Clinical application: The Clinician Assisted Videofeedback Exposure Session

Given the clear disturbances in many traumatized mothers' caregiving behavior and the associated disturbances in young children's self-regulation of emotion and arousal, we must ask what we can do as clinician's to help these families.

Forms of parent-child psychotherapy that use videofeedback as a way of engaging the parent to focus with the clinician on interactive behavior have been documented to result in dramatic change in parent-child behavior in a relatively brief time-period (Robert-Tissot, et al., 1996; Rusconi-Serpa, Sancho Rossignol, & McDonough, 2009; Van den Boom, 1994; Zelenko & Benham, 2000).

An intrinsic part of evidence-based efficacious treatments for PTSD (Foa, et al., 1999) is a clinician-guided exposure to traumatic reminders, particularly avoided negative affect and arousal. Interventions for these traumatized mothers and children need to focus on helping them tolerate trauma-associated mental states in their children and supporting them read and respond to their children's emotional cues.

The Clinician Assisted Videofeedback Exposure Session (CAVES), (Schechter, et al., 2006), was designed as an experimental paradigm both (a) to test our hypothesis that traumatized mothers often misread child distress and defensively avoid helpless states of mind and normative aggression that remind them of their experience of violence; (b) to support the ability of mothers with violence-related PTSD to tolerate and integrate the negative, trauma-associate emotions stirred up by routine stresses such as separation and tantrums in stimulating and modelling mother's reflecting functioning.

This intervention combines specifically a joint attention to video feedback of mother-child interaction that involves mother and supportive clinician; the exposure of the mother to child distress during separation and possibly during reunion and novel stimuli; clinician's modelling of maternal reflective functioning (RF) during the intervention. This intervention involves also the integration of principles of Interaction Guidance (McDonough, 1995), mentalization-based parent-infant treatments (Slade, et al., 2005) and infant-parent psychotherapy that focuses on mental representations and affects (Beebe,

2003; Lieberman, et al., 2005).

This intervention was applied in NY to 32 interpersonal violence-exposed mothers of very young children (8 to 50 months) and the authors observed a significant reduction in the degree of negativity of maternal attributions towards the child. The variable "Maternal reflective functioning" the mother's capacity to think about mental states in herself and her child, accounted for 11% of the variance in reduction of maternal negativity.

Setting and technique

The video clips are drawn from the second visit during which we film the mother-child interaction paradigm. Four selected short excerpts (30-40") from videotaped mother-child interactions are viewed jointly by parent and clinician. The four excerpts alternate likely positively regarded moments (i.e. free-play and reunion) with likely stressful moments (i.e. separation and novel or otherwise distressing moments) in the following order: .

- a) an optimal moment in order to establish a positive, supportive frame by showing the most joyful, contingent, and mutually responsive moment during mother-child play;
- b) a moment of separation (when mother is not in the playroom) to focus the mother and therapist's attention on a situation that exposes traumatized mothers to avoided mental states of helplessness, distress, and perceived loss of protection.
- c) a moment of reunion (when mother returns)
- d) novel stimuli (clown and scary toys).

Following each excerpt, in order to stimulate maternal reflective functioning and evaluate changes therein, the mother is asked to think about what she and her child might be thinking or feeling in these four different moments.

We will now present a clinical vignette both to illustrate how the CAVES works and also the kind of mental representations that are elicited through the WMCI before and after the intervention.

MRS O AND HER SON SAM

Ms. O, a 25-year-old West African mother recruited from a domestic violence program participated in our study with her 15 month-

old son, Sam. With only an elementary school education, and no vocational training, she worked as a cleaning lady in her native country until moving to Switzerland, where she is unemployed. She describes a long list of traumatic life-events dating back as far as she can recall, including intrafamilial sexual abuse and witnessing domestic violence. Her exposure to violence continued chronically through adolescence, into the present. She most recently reported involvement with a violent, cocaine-abusing partner, who is Sam's father. He beat Ms O countless times since they met less than a year prior to Sam's conception. Ms. O and Sam live in an anonymous domestic violence shelter to this day.

Maternal representations pre CAVES

During the interview that explored Ms. O's mental representations of Sam and her relationship with him via the Working Model of the Child Interview (WMCI), Ms. O described Sam first in negative terms, saying, "he doesn't like it when I scream, he hits me and I have no other choice than to hit him back—and then he continues to hit me!". For Ms. O, Sam's behavior is clearly difficult to manage. Why? Ms. O stated that when Sam hits, he frightens her because he reminds her of his father. She said, "He makes me think of his dad. When I see him do certain things, I am afraid of how he'll be when he grows up." She observed Sam's "violence" when he was only 10 months-old and she tried to set limits with his mischief. "You know what he did? she remarked angrily, "He butted me with his head." On further questioning, it is not clear in Ms.O's mind if he did this deliberately or if he flailed while distressed and, arching his back, hit her with his head accidentally.

Ms. O further described that when Sam acts "difficult" like that, she picks him up and throws him on the bed. "It's the only way I can get him to understand that I don't like his behavior!" she added. And when Sam cries at that point, Ms O, who says that she does not like it when babies cry, picks him up and hugs him. Ms. O

above all stressed that Sam, as far as she can see, understands nothing and will not until he acquires more language.

Apart from that, Ms. O described Sam as « nice » like her maternal grandmother and « lively » like her. These positive aspects in her mental representation, which we think are precious indicators of hope, turn to unrealistic expectations when Ms. O states that « Sam wasn't born for nothing, he was born to guide me on my journey in life, the journey that led me here to Geneva ! »

Maternal mentalization

Here we see that Ms. O attributes power and control to Sam and how much she avoids his dependent and vulnerable side (i.e. his need for attachment, his need for connection, his separation anxiety). Relationally, we observe the incoherent nature of her narrative, the many contradictions—at once, her child is to « guide her on her journey », clearly a role-reversal and a loss of intergenerational boundaries. And at the same time, she describes her child as domineering and abusive like his violent father. We evaluate this maternal response to contrasting behaviors of this child in terms of mentalization and can easily see that Ms. O tends to describe everything in terms of action and virtually never in terms of mental states that might motivate the action. This language-delayed toddler who “understands nothing” because he cannot yet speak, seems by mother’s description to lack a mind of his own.

Intervention (CAVES)

Before showing video clips, when the clinician asked Ms. O what she remembered was most difficult about the interaction during Visit 2 with her child, she responded: “When he banged on the door.” In fact, Sam, during this separation, did cry audibly while Ms. O was just behind the door; but never actually became so agitated that he banged on it. Hence, there is a disparity between what Ms. O remembers and what is recorded on the video. Here the clinician will explore Ms. O’s experience while waiting behind the door and listening and will then confront this disparity of what Ms. O remembers of these experiences without a prompt vs. what she perceives with the prompting of the videofeedback. This part of the CAVES addresses the question of how does the child’s distress during separation affect this traumatized mother. For the purposes of this article, we will jump immediately

to this disparity by describing the videofeedback of the separation moment. However, readers should keep in mind that by that time, the clinician had already consolidated an alliance with the subject through the joint viewing of the optimal moment which in this case involved a mutual exchange of positive affect even though Ms. O stated that she could not imagine what Sam was really feeling.

Clip 1: moment of separation

Mother and child are playing. After a cuing knock at the door, mother gets up and goes towards the door to step out. On her way, she says softly, “I’ll be right back.” Sam runs towards the door. He displays extreme distress (i.e. sobbing, coughing, gasping). He never leaves the door during the entire period of separation (3’) and cries incessantly..

C: What happened in the excerpt we just saw ?

M: I see that a child always needs his mother. One always needs that with which one is familiar. Parents cannot leave their children without telling them. Perhaps if one...if I had explained to him before leaving, he would have waited. I don't know... if he understood.

C: Did you say something to him ?

M: No !

C: But you did say something to him just before you left...

M: It's the closed door that scared him... it's that I abandoned him.

C: You think that he thinks at that moment that you abandoned him ?

M: Yes

C: From what you said, I am not sure if it is that you think that it is only he who thinks that, or that you also believe that you abandoned him?

M: Both.

We see here how this mother has trouble putting her toddler’s distress into the context of the present time and space. She is unable to differentiate between what an adult and a toddler are able to understand and thus to regulate her own and her child’s emotional state. When Ms. O is confronted with the avoided helplessness associated with this observation, she becomes disorganized in her narrative. She

uses impersonal pronouns for child and self. She says, “A child always needs his mother...” which shows a confusion of self and son and other children. More specifically, when she says “One always needs those whom one knows.”, we note that she doesn’t differentiate her own sense of helplessness and her son’s.

The two following excerpts focus on the mother’s reading of Sam’s communication and her understanding of the response she offered versus the response she would have liked to have offered.

Clip 2: moment of reunion

Mother enters the room and heads toward a chair saying, « Come along ! » As soon as he sees his mother, Sam turns his back towards her and stays immobile in front of the toys. Seated in the chair, mother spreads her arms to invite Sam to come to her. He first watches from a distance, then approaches her, and starts to cry. Once he has gotten up on her lap, she wipes his nose and face roughly with a tissue before she hugs him. His sobs stop for a moment and then she again wipes his face brusquely while watching him. However, Sam stares out into space, towards the toys, away from mother. His sobbing starts again, less intensively. This time, his mother plugs his mouth with a pacifier. She rocks him and presses him close in a tight embrace. His tears stop.

C: What happened there ?

M: I was eager to come back into the room and pick him up. And when I came in, I saw that he was angry when I was calling him to come over. And then I felt that when he came to me, the way he was crying was like he was asking me a question : « Why did you leave me like that ? » and even that he was scolding me.

C: What made you think he was scolding you ?

M: The way he was crying....

C: How did you find his crying?

M: He was getting back at me

[..]

C: You wanted to reassure him. You were feeling how then?

M: Me, I felt bad.

T: Explain that a bit.

M: Because he does not understand anything of what we were doing there. I can't explain to him so that he understands and so he could calm down. Me, I don't like it when children cry.

[..]

C: Why do you think I chose this excerpt?

M: To show a child who... I don't know...

C: Go ahead, I can see that you have something on your mind.

M: Children, they always need to be reassured. There always has to be someone who is close enough to accompany him.

In the videotaped interactions, we put mothers into situations in which they must respond to the toddler's distress. And it is this, the heart of the question: What effect do negatively valenced, highly aroused emotions communicated by infants and young children have on traumatized mothers? And what effect does mother's response to child distress, in turn have on the child?

In response to the first question, numerous points of incoherence and confusion are revealed by mother's narrative. Sam's distress makes Ms. O feel « bad », uncomfortable physically. The perspectives of self and other become indiscernible from one another. As such, maternal reflective functioning cannot serve to help regulate Ms. O's distress nor help her help regulate Sam's. Moreover, Ms. O as many similarly traumatized mothers that participated in the New York studies, interprets Sam's distress as angry and hostile and puts Sam in a position of menacing authority (« he was scolding me ») with herself in a helpless role. In response, Sam first avoids his mother and then submits to her efforts to comfort him—not without some intrusive nosewiping, and all the time while avoiding looking at each other directly. Sam stops crying but remains sullen and tense. Maternal regulation of his negative state is not apparent..

Clip 3: novel stimuli

The clinician enters with various scary toys : a dinosaur robot, a rubber snake, and a furry spider. Mother is sitting on the floor with her son sitting up on her lap. With a playful tone to his voice, the clinician speaks of the toys as her “friends” who do odd things but are nonetheless friendly and harmless. She then shows the dinosaur robot that moves towards the child while making roaring sounds and opening its mouth by remote-control. The child frozen with fear, carefully watches the robot advance toward him. He remains visibly tense but does not cry. His mother chuckles and then displays a big smile. The child moves closer to his mother, nervously pulling in his feet so as to avoid any possible contact with the robot. The clinician stops the robot and pets it on the head gently, inviting the child to do the same. The child watches vigilantly but keeps his hands close to his body. His mother tries to take his hand and move it toward the dinosaur robot but Sam startles, then tenses up further. Mother does not insist. She continues to smile uninterrupted while watching the robot.

C: What just happened in what you saw? What did you see?

M: I saw that what was shown to him, he did not like...

C: And you, do you remember what you were feeling when you had Sam on your lap then as the dinosaur was coming towards him?

M: I was happy that he sees all those toys... and I was disappointed because they did not interest him.

C: And about Sam, what do you think he was feeling when he saw the dinosaur approaching?

M: He was afraid.

C: What do you think frightened him then?

M: I saw that he pulled in his feet... towards me... and the thing kept coming...

We see that Ms. O identifies for the first time that Sam was afraid based on his avoidant behavior. This signifies a heightened level—perhaps progress within the session given the three clips preceding, of her reading of Sam's affective communication as well as of his likely feelings of helplessness and vulnerability.

Maternal representations post CAVES

These small changes are of fleeting nature as illustrate her responses during the WMCI interview, immediately after the CAVES.

C: You said you think that Sam is not afraid of anything?

M: Sam is not afraid of anything at all!

C: But in the clip that we just saw, you said that Sam was afraid of the dinosaur robot and that you were a bit disappointed...

M: Yes... yes, he was afraid of the dinosaur in that moment, he was... or maybe... he just found it strange?

We thus see how Ms. O made rather fragile progress that is not sustained within this single session. It would take more work over multiple sessions of clinician-assisted exposure to avoid affects to understand what blocks Ms. O's capacity to continue to view her child with this level of sensitivity.

When we investigate which aspects of Sam are the most difficult for the Ms O, it is clearly Sam's dependence on his mother and his continuous bids for her attention that she finds difficult to manage. She states, “I tell him: Live your life and let me live mine!” Clearly, this is something one would say to a parent, partner, or peer, but not to one's 1 1/2 year-old child. But with his needs, his demands, and the emotions and arousal that he cannot yet himself regulate, Sam, much as for the 60% of mothers in the New York clinical sample, represents a major life-stress and a menace to his mother as shown further by the following exchange:

C: [When he cries like that]... what do you feel like doing in those moments... when he interrupts you in the middle of doing something you need to get done?

M: I want to smack him!! (Mother laughs)

C: Does he know that you don't like it when he acts that way that you described?

M: Sure he knows because he always does the same thing over and over.

C: Why do you think he does it over and over?

M: "Cause he couldn't care less about me!
(Mother smiles)

C: What do you think is going on in his mind then?

M: He's like: "You can't do anything... you are small and weak. I'll do what I want!" (Mother smiles)

There is clearly a reversal of parent-child roles that creates confusion—some would call a projective psychological defense, in the above exchange when Ms. O states reports in response to being asked what is going on in her child's mind, that he speaks of her as "small and weak"! At the point, Sam who was playing in another room during the interview comes back and we see before us a little boy of 20 months who walks clumsily and approaches his mother looking for comfort and his pacifier. With this stark contrast between our point of view and that of Ms. O already crystal clear, she adds just then: « When he grows up, I think I am going to end up taking a few slaps in the face."

Conclusions

The goals of the program of research discussed in this article are (a) to understand how normative child distress with its component negative emotions, hyperarousal, and helpless state of mind affects the minds and bodies of traumatized caregivers; (b) how then these caregivers read child affective communication and respond to their children; (c) how these responses affect their child during this formative period of social and emotional development (below age 5).

Our results from prior research in New York and preliminary findings from our current study in Geneva support the need for the development of specific interventions to help traumatized caregivers confront safely that which they try so hard to avoid: the affects and memories that are associated with the caregiver's experience of interpersonal violence. We are working on the development of such interventions also to support, to elicit and to model the caregiver's capacity to jointly attend to child interactive behavior and the mental states that motivate such behavior (i.e. parental reflective functioning), with the aim of repairing ruptures in mutual emotion regulation.

Towards this end, we want to carry forward what we observe to be the connection of a very specific error in the reading of child distress: the mistaking of helplessness and fear for rage and willfulness. We think that this specific alexithymic error is particularly

salient to IPV-PTSD as opposed to other forms of parental psychopathology that impact the parent-child relationship.

Finally, we are currently manualizing a CAVES-based intervention consisting of at least six to ten sessions. Subsequent research will examine whether observed effects on maternal representations as signaled by her attributions towards her child are sustained and what dosage of frequency as well as whether such changes correspond to measurable changes in caregiver's reflective functioning, her behavioral response to child distress and the child's behavioral outcome.

We do not assume that such an intervention specifically for high risk and for intergeneration violent trauma parenting replace a deeper, more comprehensive long term child-parent psychotherapy that relies mainly on in vivo use of words and behavioral observation. Therefore we consider the CAVES to be a potential catalyst or jumpstart to further and deeper psychotherapeutic treatment. We do think that, based on our experience with highly traumatized often dissociative caregivers and their young children, such caregivers must first be able to attend jointly with the therapist to avoided affects and child behaviors that elicit those affects before they can enter into a deeper psychotherapeutic process that will result in meaningful change in interactive behavior at a pace that can match the child's developmental needs.

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News from the WAIMH Affiliates Council

Affiliates Corner August 2011

As we write this, it is Rugby World Cup time. New Zealand, Australia, South Africa, England, Ireland, Wales, France, Argentina, Canada, USA, Russia, Romania, Italy, Namibia, Scotland, Japan, to name a few, are in New Zealand to play Rugby. We wish all the best to those of you who have a team playing in this competition. Rugby aside, a competition such as this reminds us about the power of joining together for a shared cause. However, observing the ease of sharing the cause when it's about sport, in contrast to getting governments to commit to policies and initiatives around infant and family mental health, is somewhat painful. Collectively, as part of WAIMH, our shared commitment is to infant and family mental health; an arena of play that lasts generations longer than a game of rugby. As such, as an international group of affiliates with WAIMH, we greet you and remind you, that you are part of an international team.

The task of the Affiliates Council is to grow in our understanding and in our actions regarding the very practical ways that we can work as a team: to be there for each-other in terms of sharing our resources; our quests; and questions. As part of this emerging understanding during the past few months the Council with the WAIMH Board have been conducting a survey where each Affiliate via their president has been invited to provide details around: a) their training needs, and b) any resources they have as an affiliate that could be shared with other affiliates. The survey is still in process and when completed the shared findings will be made available.

Second, the area "infant mental health social policy" has arisen as an area of interest and concern among some affiliates. However, communicating our expertise from the field of infant mental health with policy development experts is uncharted territory for many of us. If this is an area of development that you would like to share with others across the affiliates, please let us know.

Third, we remind you of the pending 13th WAIMH Congress to be held in Capetown, South Africa, April 17-21, 2012. We understand the many challenges in finding ways to attend an international congress and encourage you to creatively seek possible avenues of support in your area. As many of the Affiliates have a form of legal status in their respective country, it is possible that there may be funding available for you, upon application. Approaching a resource person who supports charities and or not for profit organisations access funding, may result in a potentially helpful funding source.

Finally, as a council we want to extend our ongoing thanks to WAIMH head office and especially to Minna Sorsa who works tirelessly to keep us in connection with each other. Further, we are always keen to hear from any of you about your activities/projects as well as any ideas for new projects that you may have. Any news/requests can be shared through the mailing list that is actively managed by the central office at office@waimh.org.

Wishing you all the very best over the next few months,

Maree Foley, MPhil (Dist)

Affiliate Council Representative

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Martin St-André, MDCM

Chair of Affiliate Council

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Celebrate babies! and a meeting at ZERO TO THREE's National Training Institute

The Consortium of US WAIMH Affiliates

The US World Association for Infant Mental Health (WAIMH) Affiliates announced the formation of the Consortium of US WAIMH Affiliates in 2009. The Consortium was designed to create a united and coordinated voice across US Affiliates to encourage a more active and healthy infant mental health community in the US, as well as a stronger relationship with WAIMH. Joy Browne (Colorado), Jacqui Van Horn (New Mexico), Angela Tomlin (Indiana) and Deb Weatherston (Michigan)

initiated the effort. 25 representatives from many US Affiliates met at ZERO TO THREE's National Training Institute in December, 2009 to network and officially establish the Consortium (see www.mi-aimh.org for additional information about U.S. WAIMH Affiliates).

TAKE THE LEAD AND CELEBRATE BABIES
AROUND THE USA - October 24-28,2011

For the past three years, MI-AIMH and a few other WAIMH associations have set the last week of October (October 24 - 28, 2011) as a time for affiliates and chapters to celebrate babies. This year the U.S. Consortium of WAIMH Affiliates and other infant mental health associations are invited to plan an event — in groups large or small — during the same week. Set your calendars now and join in the US wide celebration of babies and the promotion of infant mental health. What can you do?

Sponsor a training for parents about early development, plan a cross-disciplinary lecture about the needs of children birth to 3 for nurturing relationships, collaborate with your Baby Court team or CASA organizations, host an evening meeting to discuss reflective practice, review a recent Infant Mental Health Journal article, share a WAIMH Signal article, and/or view the inspiring movie, "Babies," with colleagues and friends. There are so many ways to celebrate babies!

JOIN US WAIMH COLLEAGUES AT THIS YEAR'S
ZERO TO THREE NATIONAL TRAINING
INSTITUTE

Save the date: Friday, December 9, 2011 6:00 -
7:30 pm more information TBA!

For additional information about the Consortium, please contact Joy Browne (Joy.Browne@childrenscolorado.org), Jacqui VanHorn (jacquivanhorn@comcast.com) or Deborah Weatherston (dweatherston@mi-aimh.org).

Infant Mental Health Association of Turkey (IMHAT)

Affiliates Corner August 2011

By Nese Erol

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As an affiliate of WAIMH, the Infant Mental Health Association of Turkey (IMHAT) was founded in 2005 by its present president Nese Erol (Ph.D.) and her colleagues. Currently the affiliate mainly comprises of 94 individual members from various disciplines such as child psychiatrists, clinical psychologists, developmental psychologists, pediatricians, social workers, nurses, child developmentalists, speech and language pathologists and psychological counselors. The administration of IMHAT is in Ankara. It has no branch offices but has representative members in various institutions around the country. IMHAT collaborates with universities and non-governmental organizations such as the Turkish Association of Child and Adolescent Psychiatry, the Turkish Psychological Association and the Foster Care and

Adoption Association of Turkey. Presently, the main activity of IMHAT is training. It is in the process of developing and therefore is striving to increase awareness regarding the field of infant mental health among professionals and the public in general. Training is provided in the form of lectures, workshops and courses, all of which has aroused great interest and enthusiasm among professionals in the area. Also professionals from various disciplines are trained in clinical assessment and treatment in Ankara University Department of Child and Adolescent Psychiatry - Infant Mental Health Unit, where the founders of IMHAT are presently affiliated with. Membership to IMHAT is mainly encouraged through training activities in national child psychiatry and psychology meetings. The members of the association are awarded for their researches and projects on infant mental health.

Affiliate web site: www.bebekruhsagligi.org.tr

The most important challenges we face as an affiliate are:

1. The paucity of professionals interested in the field;
2. Economic difficulties hindering especially international training opportunities;
3. Insufficient number of infant and toddler assessment tools developed for the Turkish culture;
4. Insufficient awareness, knowledge and experience of the public and policy makers who are critical in supporting the development of the field of infant mental health.

ANKARA ÜNİVERSİTESİ TIP FAKÜLTESİ
ÇOCUK VE ERGEN RUH SAĞLIĞI VE
HASTALIKLARI ANABİLİM DALI
BİLİMSEL ETKİNLİKLERİ



BEBEK RUH SAĞLIĞI
(0-3 yaş)

XXIV. Prof. Dr. Mualla Öztürk
Çocuk Ruh Sağlığı Sempozyumu

28 Şubat / 1-2 Mart 2011
Ankara Üniversitesi Tıp Fakültesi
50. Yılı Konferans Salonu, Cebeci Yerleşkesi
ANKARA



The above picture of a mother and a baby, and the two photos on the next page are from the lullaby documentary by Tülin Sertöz (read more on page 19).

Infant Mental Health Symposium in Ankara

Affiliates Corner

Infant Mental Health Symposium organized by Ankara University and Infant Mental Health Association of Turkey (IMHAT) was held in Ankara on the 28 February-2 March 2011, for the second time dedicated to the memory of Prof Dr. Mualla Ozturk founder of the Child Psychiatry Department in Ankara University.

In the 24th symposium the day care children from Ankara University greeted participants with narcissus flowers. Opening Ceremony started with the quotations from the documentary "Lullabies" by Tulin Sertoz, famous Turkish documentarist from Turkish Radio and Television Corporation. "For those who've once been a baby and cried..." "The intimate relationship between the mother and the baby"....

Following the lullabies, Prof. Dr. Ayla Aysev, Chair of the Ankara University School of Medicine Department of Child & Adolescent Psychiatry, Prof. Dr. Ilker Okten, Dean of the Ankara University School of Medicine and Prof. Dr. Cemal Talug, Rector of the Ankara University mentioned about the importance of Infant Mental Health in Turkey.

This year the symposium program was organized by Prof. Dr. Nese Erol founder and the president of Turkish Association for Infant Mental Health and Prof. of the Ankara University.

Prof Dr. Zeynep Biringen gave a two day pre-symposium training on "Emotional Availability" on the 26-27 February as well as a general presentation in the symposium on the topic of "Emotional Availability (EA): Conceptualization and research on its assessment and intervention for caregiver-child relationships."

Prof. Dr. Antoine Guedeney gave a presentation on the topic of "Developmental Psychopathology Comes of Ages: The (still) mysterious unfolding of development and psychopathology".

Turkish colleagues from different professions such as child psychiatrists, clinical psychologists, developmental psychologists, pediatricians, social workers, nurses, child developmentalists, speech and language pathologists, psychological

counselors and lawyers from different provinces of Turkey participated to the symposium and information in a lot of topics was shared. Documentary films on lullabies were presented.

About Lullaby Fest

At the end of her documentary "Ninni" (Lullaby), Tülin Sertöz made a lovely suggestion about a dream she had conjured. Here is her proposal enthusiastically supported and flamed by Neşe Erol:

"I am dreaming of a Lullaby Festival. We can send invitations to several countries asking them to make their own "Lullaby" documentaries so that each country can come up the next year with her own version of the "Ninni". Thereon, we can make an International Lullaby Fest where a documentary, the film's director, and possibly a mother and her baby can show up. What a lovely cultural sharing and what a colorful festivity it would have been..."

"This idea is not as far fetched as it seems. An announcement can be sent to Television Corporations of different countries and this can be made by the support and leadership of UNICEF.



Documentarists from different countries can make documentaries about lullabies and about mother-baby relationships in their own culture. They can film examples of different life styles from different levels of income specific to their country. They can document ways of cradling babies to sleep, authentic cribs, baby carrying styles, traditions and superstitious beliefs about protecting babies against evil eye, archaic ways of baby care especially about methods before modern diapers came out. These documentaries can also be a way of telling about how cultures lose their identity in the process of modernization."

Tülin Sertöz has been invited by the President of WAIMH Prof. Dr. Antoine Guedeney to the Infant Mental Health Congress which will held in Cape Town in April 2012. She will be there with a full screening of her "Lullaby" film.



Our experience holding a two-day training on “Attachment and psychodynamic theory and practice: A move to representation”

Training Corner

Istanbul, Turkey

May 29-30, 2011

By Elizabeth Tuters and Susan Yabsley

Following our clinical presentations at WAIMH Leipzig (June 2010), Elif Gocek, Assistant Professor of Psychology at Yeditepe University, Istanbul, and Member of the Turkish WAIMH Affiliate, invited us to offer a two-day training to mental health professionals interested in and struggling with infant-parent psychotherapy.

Elif Gocek had completed her doctoral dissertation at the University of Toronto, doing her internship at the Hincks-Dellcrest Children’s Centre, focusing on maternal mentalization skills and responsiveness on the Watch, Wait and Wonder research tapes. Elif was familiar with the work of our infant and preschool training teams, which practice several approaches to Infant-Parent Psychotherapy. In 2009 she had invited Dr. Nancy Cohen (Director of Research, The Hincks-Dellcrest Centre) to offer a training in Watch, Wait and Wonder (WWW), an infant-led approach to infant-parent psychotherapy. (For more details see: Cohen et al, 1999; Cohen et al, 2002; Cohen et al, 2006; Lojkasek et al, 1994; Muir et al, 1999). Briefly, WWW psychotherapy helps the parent and infant discover for themselves a new way of relating, and aims to prevent repetition of intergenerational transmission of insecure attachment patterns. Those who attended the training were encouraged to practice the WWW approach, but some were finding it difficult and not as effective as they had hoped, and needed to have further training.

Reflecting on Elif’s request, we thought those practicing were having the same difficulties we find our students have when they are first trained in either WWW or in Infant-Parent Psychotherapy (IPP). Although all the students are well trained in behavioural, physical, cognitive, social development and other theories, we find they are missing a key piece of understanding /knowledge that is essential to the work. Something happens and they see the infant and family through their theoretical lens rather than as an

experiential question to try and answer – what is happening and why now?

To achieve such understanding, however, involves – for most of us – learning to see, know and feel what we have previously avoided seeing, knowing and feeling about infants’ experiences in relationships (Bowlby, 1979; Tuters, 1989; Tuters et al, 1989). Our avoidance may stem from defenses of thought established in the course of our own efforts, as infants, to cope with failures in attachment relationships. Reflected in society at large, such avoidance may take the shape of training for mental health professionals that specifically excludes attention to emotional development, their own feelings /responses, or of social policies that dismiss the relationship needs of infants and young children.

We find the fulcrum of the learning experience for our students is observation – of infants and young children with their parents in a clinical setting during the process of assessment, formulation and treatment. Students experience the impact on themselves of observing the developing

infant /young child in the relationship with their parents, through understanding the feelings aroused in themselves. This means becoming able to see what they have been unable to recognize; that is, the pain and distress of an infant /young child with parents who are avoiding the emotional needs of the infant /young child.

With this in mind, as well holding in mind some thoughts from Daniel Stern’s article (Infant Mental Health Journal, 2008), where he mentions “good parent-infant psychotherapy has five things in common in all cultures: (a) You’ve got to listen; (b) You’ve got to take the time; (c) You’ve got to support them; (d) You’ve got to be open and welcoming; and (e) You have to have an attitude in which suffering is as important or more important than illness” (p 185).

Stern goes on to suggest that we have to look at our therapy from the perspective of, “How do we do this”? He reminds us we have a number of names for the relationship which seems to be the largest therapeutic factor to enable change to take place: the therapeutic alliance; a



Elizabeth Tuters and Susan Yabsley in the Istanbul Training (Photo: Elif Gocek).

holding environment; attachment or attachment transference; transference; and countertransference. These are key terms and concepts when talking about the therapeutic relationship. Stern tells us we need to be clearer about these notions and incorporate these five nonspecific attributes in some way (p 165).

And as well, holding in mind Patricia O'Rourke's article (Infant Mental Health Journal, 2011), where she reminds us "Parent-infant work is inherently relational and occurs in the intersubjective space between parent, infant and worker. The space can be charged with primitive, unmet needs of both parent and infant, and this in turn can trigger these same states in the worker". We could add these same states can be triggered in the students we train to do this parent-infant work.

O'Rourke offers us a thoughtful quote to ponder upon:

"She was a baby once and she has in her the memories of being a baby; she also has memories of being cared for, and these memories either help or hinder her in her own experience as a mother". (D. W. Winnicott, 1987)

To return to reflecting on our planning for our two-day training, of what and how we would teach in Istanbul, and taking into consideration the challenges

and difficulties inherent in doing infant clinical practice, we decided to focus our first day of training on Attachment theory and Intersubjectivity (Stern, 2004), in order to give a foundation to the students. The second day we would present two approaches to infant-parent psychotherapy (both models based in Attachment theory and Intersubjectivity) so the participants would have a common theoretical frame from which to deliberate.

We sent ahead for translation a PowerPoint presentation on Attachment theory, updated to include mentalization (Fonagy et al., 2002), and we decided, based on previous experience as trainers, it also would be crucial to include an experiential /observational component, including an interactive discussion with the group. We showed the classic films directed by Jim and Joyce Robertson (1956), "John" and "Jane".

"John" tells the story of a 17-month old boy, who experienced a nine day separation from his parents when he was placed in residential group care while mother had a baby. John had no consistent person to relate to, and he went through a process related to sudden loss – sadness, anger, protest and despair. In the reunion with his mother, John was avoidant and pulled away, a painful experience for both mother and for John.

"Jane", also 17 months, experienced a

separation for nine days while mother had a baby, and was placed in planned foster care. Jane had someone who was consistent and she did not experience the devastation of the sudden loss experience; she was able to relate to the consistent caregiver and able to keep the memory of her mother alive. In the reunion behavior with mother, Jane enacted her ambivalent feelings about the separation.

Our translated PowerPoint was projected onto the screen. However, as most participants did not speak English, all the interactive dialogue we had with the participants had to be translated. This process was challenging for both of us, but as we were already familiar and comfortable in a dual teaching relationship, the process went surprisingly well. (We received an E-mail from a grateful participant to tell us how containing our style was, which enabled the group to get to the earliest difficulties some of them had experienced as babies themselves.)

Day Two focused on the two approaches of infant-parent psychotherapy we utilize most. Again, we had a PowerPoint presentation describing the approaches translated ahead of time; however, as we were also showing clinical material which could not be sent ahead, and the subtitles were in English, the text had to be translated on the spot as it appeared on the DVD clips. The translators were



Trainees in group photo (Photo: Elif Gocek).

interested in the work and were excellent.

The first case was a Watch, Wait and Wonder (WWW) case presented by Susan Yabsley, consisting of excerpts from three sessions focusing on both observation and discussion of the first, seventh and tenth sessions. This mother had sought help because she felt her two year old daughter was too shy, and reminded her of her child's father who had a diagnosed mental illness. The parents were not together after the birth of the child, and father did not see the child. Following the assessment phase of five sessions, WWW was offered. In each session, instructions were given to mother to follow her child's lead, letting her take the initiative at all times, to respond to and be accessible to her child, to pay attention to her infant's self-initiated activity and, after about 20 minutes, to stop and discuss with the therapist what mother had observed, felt and experienced during the activity.

The role of the therapist during the infant-led segment parallels what we ask of the parent, that is, to watch, wait and wonder. The therapist quietly observes the unfolding interaction and functions much like Winnicott's good enough holding mother – that is, one who is present but non-intrusive. This may appear straightforward, however it is often very difficult. As O'Rourke (2011) states, the intersubjective space between parent, infant and therapist can be charged with primitive unmet needs of the parent and infant, and can trigger these same states in the therapist. The therapist needs to be open to 'seeing, knowing and feeling' what has previously been avoided about the infant's experience in the relationship, and to be able to tolerate and process these states.

The second case was an Infant-Parent Psychotherapy (IPP) case presented by Elizabeth Tuters. This approach of IPP is based on the same principles as WWW, but with an adaptation where the clinician is more active and forms a relationship with both the child and the mother, but holds the relationship between the mother and child as primary. This way of working is more visibly interactive and triadic in nature and composition.

This case was a 3.8 year old girl, who had temporarily lost her mother when she was 18 months old during the birth of her sister, and her mother had become seriously ill following and was hospitalized for seven weeks. When mother returned home she still was recovering and had to be careful, and could not physically hold her children. M became immediately upset, withdrew from mother, would not talk, and refused to take part in any activities.

She clung to her mother and seemed to be more secure with her father.

We formulated this case in terms of Attachment theory, the child's traumatic loss of her mother, and their inability to regain their emotional connection. The case became a most painful situation for the mother, the clinician and the team, as we observed the emotional withdrawal of both mother from the child, and child from the mother, and the pain of the mother, who was trying to be accepted by her child. M's little sister was full of vitality. She had not suffered the loss experience the same way as M, and seemed to be securely attached to her mother and her father. Throughout the 26-session treatment, we encouraged the mother and M to play together. M symbolized the loss of her emotional connection by initiating play with train tracks and the missing pieces. M was obsessed with getting the pieces of the train track together, and we encouraged mother to participate actively. Mother became totally emotionally involved with the play.

DVD clips of the process were shown and discussed with the group, who participated actively and appeared to be affectively involved with the mother and child's process of the recovery of the relationship. They identified with the pain of both the mother and the child. We thought about the intersubjective matrix involving therapist, mother and child, to enable them to find the connection, and then to have the therapist pull back and allow mother and child to be in the recovered relationship together. The observing team members were also involved in this intersubjective matrix and experienced the pain of the mother and child and therapist. This triad experienced the team as part of their holding environment, much the same way the group participants worked with the clinical material presented in both cases.

To end, together we articulated the key principles of clinical infant-parent practice: the importance of 1) observation, 2) attachment theory and intersubjectivity, 3) developmental theory, 4) affect and regulation, 5) mentalization – finding oneself in the mind of another.

Evaluating the effectiveness of the training, we asked the participants what had worked and had not worked in what we had offered. They felt the two days were important. They felt the first day on the theory and experience of attachment had laid the foundation for them to be able to locate themselves and their reactions in the two clinical approaches and case material presented. They felt themselves able to work at understanding the material

and to struggle with the pain of not seeing, knowing and feeling. This is the same struggle the therapist has in both approaches presented (WWW and IPP) – to struggle with the feeling of not really knowing what is going on and to stay with this uncertainty.

The group participants were interested, curious and affectively engaged. Some were new to the field while others had had many years of experience. Some had done training in Infant Observation and in Watch, Wait and Wonder. The group members all worked well together, with each other and with us. We were gratified by their focus, commitment and willingness to struggle to learn a new way of thinking.

We were delighted by the enthusiasm of the Turkish WAIMH Affiliate and the training group. Feedback from the participants indicated they were very impressed to hear how a "therapist felt, thought and lived when working with mother-infant dyads", noting "these kinds of sharings cannot be found in books". Dr. Gocek, who had initiated the invitation to Istanbul, commented, following the experience, "The workshop provided the participants such an important experience that in the future it will be possible for them to feel with the clients, to hold them, and to be able to stay with the uncertainty".

Postscript:

The following statement strikes me as the way we work, not only when we do therapy but also when we train others:

"Therapists are consumers of metaphors because metaphors are the links between implicit, nonverbal communication and explicit, verbal communication. They help to convey what we subconsciously perceive in a form that is communicable but that conserves some of the wealth of intuitive knowledge. Thus when we work in systems consultations we prepare ourselves to let metaphors emerge in our minds from the very beginning of the observation". (E. Fivaz-Depeursing, A. Corboz-Warney, 1999)

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“Potential Space” in therapy

-Helping a toddler come to terms with her mother’s death

By Teresa Ostler

University of Illinois at Urbana-Champaign

Stewart and Virginia came to the clinic in late February. Snow still lay on the grounds outside of the clinic. Exhausted and cold, Stewart hung up his winter jacket before sinking into a chair in the therapy room. I knew something from the intake notes about why Stewart had come. The notes mentioned that Stewart was anxious. He was seeing a therapist to help him, but needed help with Virginia, his 2½-year-old daughter. The intake worker wrote down the following words to describe the problems: temper tantrums, screaming fits, and fears of separation. Virginia also stared into space. She often did not want to hear what was being said.

Stewart, age 30, told me that he knew anxiety all too well. It paralyzed him. He felt it when he woke up, when he left for his part-time job, when he dropped Virginia off at preschool, when he tried to fall asleep at night. It rarely left, dwelling in his stomach, his bones, his very movements. Stewart revealed that he experienced his first symptoms of anxiety when he was a teenager, right after his father passed away. At that time, his symptoms were so severe that he developed panic attacks, attacks during which he felt he couldn’t breathe or move. At that time, his anxiety was paralyzing, so paralyzing that he struggled to finish high school. Stewart was helped by a psychiatrist, but continued to have anxiety in the ensuing years. Stewart also talked about his wife, Anna. He had met her 4 years prior in the library. They dated and married about a year later.

Parental mental illness

“Anna had bipolar mood disorder,” Stewart noted a bit later. This is a mental illness characterized by bouts of depression and mania. When she was depressed, Anna was despondent, indecisive, and slept for long periods of time. When manic, she talked incessantly, her thoughts raced and became grandiose. At times she showed rapid cycling, going from depression to mania in short periods of time. The mood swings worsened after Virginia was born.

ZERO TO THREE Corner

To fully grieve a parent’s death, a young child needs to come to terms internally with the loss. In this article (Zero to Three, Vol.31, No.6), the author describes this process in a toddler whose mother committed suicide. In therapy, the child formed a relationship with a stone statue and communicated her need to be found and protected. Drawing on the notion of “potential space,” an intermediate area of experiencing between reality and fantasy, the article underscores how creating potential space in therapy can help a young child tap into a wellspring of imagination and subjectivity where personal meanings about loss can be explored in ways that are uniquely helpful to the child.

The story continued in starts and stops. Stewart didn’t understand why Anna refused to hold Virginia after they returned home from the hospital. One day she said she “couldn’t stand all the fussing” but on other days Anna didn’t hear Virginia’s cries. Stewart became alarmed and contacted mental health professionals when Anna typed strange notes on the computer talking about how her baby was gone. Anna refused medication, he said, claiming that it was poison. Remembering those days, Stewart also recalled that he couldn’t reach Anna. Nothing was right.

Stewart took Anna to an inpatient psychiatric unit where she stayed for 2 weeks. There he learned that she had postpartum psychosis, a condition that begins abruptly, usually 3 to 14 days after giving birth (Attia, Downey, & Oberman, 1999). Women with postpartum psychosis evidence severe and often dramatic symptoms, including insomnia, hallucinations, delirium, and confusion (Attia, et al.). Postpartum psychosis is a rare condition that affects 0.1 to 0.2% of all women experiencing childbirth, and women with bipolar disorder are at higher risk than women without a psychiatric disorder for developing it (Altshuler & Kiriakos, 2006).

On the unit, Anna was treated with antipsychotic medication. In the meantime, Stewart became Virginia’s caretaker. He learned how to prepare bottles and to change Virginia’s diaper. He began to swaddle and rock Virginia when she cried. He cared for Anna too when she returned home from the hospital. Over time and with antipsychotic medication, Anna seemed to improve, but Stewart

remained anxious. “I took care of Virginia as much as I could,” he told me. “But I was working too so I couldn’t always be there.” One day Stewart found that Anna had tossed her medication away. In the next weeks, Stewart noted that often Virginia was hungry or her diapers had not been changed when he came home.

Stewart’s voice grew strained as he told me about a painful memory. One day, shortly after Virginia’s first birthday, he trusted Anna to take Virginia for a walk. Later that day, the police came to the house. He learned that Anna was holding Virginia in her arms as she tried to run in front of a passing car. A man grabbed Anna, holding her and the child and saving both. I asked Stewart where Anna was now. Stewart paused for awhile. He then said she was gone. I asked if he could tell me more. “Soon after,” Stewart said, “Anna committed suicide.”

Coping with loss

Stewart told me that he had been seeing a therapist to better cope both with his loss and his own anxiety. I learned too that Virginia knew very little about her mother’s death. Stewart didn’t think she could handle or even understand what had happened. “She’s too little, too fragile,” he insisted. Stewart shared other worries: he had met someone new. He wanted to start a new relationship with Janet. “I don’t think Virginia wants me to see her,” he added, “she says she has her own mom, even though I never talk about her.” Stewart did want help with Virginia and, for this reason, he had sought me out.

When I observed Stewart and Virginia together, strengths were also evident: Stewart had cared for Virginia since birth and the two could show genuine pleasure when they played with each other. Virginia herself was curious and articulate. A bundle of contradictions, she was also petulant, fragile, easily frustrated, and had a strong need to control. If Stewart didn't go along with her wishes, Virginia would tell him to "go away."

As I showed Stewart and Virginia the way to the bus stop, we walked through an inner courtyard in the back of the clinic, passing by a stone statue of a woman that stood half hidden by a copse of trees. With one arm, the woman fought off a dragon; in her other arm she held her baby up high to protect it from harm. Virginia stopped as we passed. I can still see her now—a dark-headed child looking with intent interest at the statue. It was only after Stewart called her name that Virginia came out of her daze.

Where to begin?

As I jotted down notes from my initial assessment, I began to synthesize in my mind what I knew about the family. This helped me to formulate steps that could be taken in therapy to promote healing. Throughout my account, I have modified details to protect confidentiality.

Two themes stood out in my notes: mental illness and suicide. Neither had been talked about or shared. Stewart and Anna both had a mental illness. Stewart was in treatment and therapy. Anna had received treatment, but had stopped. Her illness was also chronic and severe. These illnesses affected both Stewart and Virginia and their relationship. Stewart worried constantly that Virginia would develop bipolar disorder like her mother. His concerns about this made it hard for him to set healthy boundaries that might make Virginia feel safe. He caved in easily to her outbursts and let her make many decisions on her own. Anna's mental illness had also greatly affected how Virginia was cared for in her first year of life. Anna's illness had made it hard for her to recognize and meet Virginia's needs. On many occasions she had not responded to Virginia's cries. Virginia had likely experienced many lapses in caregiving. At one point, Anna had tried to kill both herself and Virginia.

Loss was another prominent theme. Anna was gone. She had taken her own life when she was severely depressed. Although Virginia was young when her mother died, Anna was still immensely important to her.

For instance, when Stewart mentioned Anna's name, Virginia became all eyes and ears, clinging to any words that her father might mention. Virginia was also terrified of separations, something that was likely linked to her mother's death. Stewart too had been devastated by Anna's suicide.

Approach to therapy

How did I approach therapy? I started by laying the foundations for a relationship of trust to develop: I listened, supported, and tried to give Stewart and Virginia the safety to marshal their energies to articulate, express, and actively make sense of what happened. The format was flexible. Stewart and Virginia saw me separately, but we also had joint sessions (Lieberman, Compton, Van Horn, & Ghosh Ippen, 2003). When the two were together, I helped to bolster their own relationship and to further a sense of security in each other's presence. A secure attachment relationship to a parent is a powerful and positive force in a child's development (Bowlby, 1988). In a secure relationship, a parent helps a child to tolerate and make sense of painful situations and to feel confident and safe in exploring the world. I reasoned that furthering a sense of security in the relationship between the two was Virginia's best hope for long-term mental health.

Bolstering security comes about in many ways: through reassurances to a parent that they can give a child the love and support they need, through a parent's reassurances to a child that the child is loved, by a parent providing open, honest communication about experiences, including death. I reasoned that Stewart was the person best able to reassure Virginia that he was there. He was also the person best able to help Virginia understand what had happened. He needed to tell her more about her mother and why she had left. He needed to tell her about her mother's mental illness. Virginia also needed the space and freedom to ask her own questions and she needed time to take in information in. Virginia was a toddler, however. How much could she understand loss or mental illness? How much did she even remember her mother?

To talk with Virginia about her mother, I reasoned that Stewart needed to feel comfortable himself about what he was going to tell Virginia. He also needed to tailor what he said so that she could understand. Stewart also needed help in how he told Virginia about Anna. Children listen both to the content of a message and to its emotional tone, how it is said. Stewart needed to talk with Virginia in a way that led to understanding, not to more

anxiety, avoidance, or fear.

We talked about mental illness and parenting. In this context, Stewart shared his fear that Virginia would develop bipolar mood disorder. Parenting is an important life role, including for individuals with mental illness (Apfel & Handel, 1993). Stewart came to learn that when mental illness is treated and monitored, it does not necessarily need to eclipse good enough parenting (Goepfert, Webster, & Seeman, 2004). We also talked about how parenting can be supported for an individual with mental illness who is struggling to raise young children (Henry & Nicholson, 2005). These discussions alleviated some of Stewart's worries.

There are many barometers of progress in therapy. Some indicators are unexpected and surprising as it was with Virginia. Her behavior with the statue, as described in the next section, became my barometer for change.

What was therapy like?

Whether Stewart and Virginia invested trust in me would depend on them, I knew, but also on me: whether I could be perceived as available and responsive; whether they felt that they could share with me through words or play what they were feeling inside; whether they felt that I could tolerate and understand what they shared.

Relief that the truth could be spoken

A first priority was to understand more about Anna, Virginia's mother. I knew little about why Stewart kept information about Anna and her abandonment from Virginia. In the next sessions I therefore worked alone with Stewart. Together, we explored together how Stewart met Anna, what he had felt about her, their decision to have Virginia, the times she was hospitalized, and when she left.

It soon became clear that Stewart had done much grieving work already in individual therapy. But he had never talked with Virginia about the loss so I asked him why. Stewart said he felt he should have kept Virginia safe. He also worried about how Virginia would take the information: what she didn't know wouldn't hurt her.

Talking with Stewart directly about Anna's death helped build trust. He felt relieved that the truth could be spoken and shared. I understood too why Stewart had not told Virginia about Anna: He wanted to protect her from devastating information. But in so

doing he had also cut off the possibility for Virginia to heal.

I had a dual message in mind when I spoke. I conveyed genuine understanding for his decision to remain silent. However, I also considered the potential damage that the silence was inflicting on her and on their relationship. She trusted him. She believed in what he told her. What if she heard from someone else?

"Can she remember?" was an early query of Stewart's. "Can she understand death, let alone suicide?" What he said was true. Virginia was very young when Anna died. She was still very young. Yet, Anna was Virginia's mother and even very young children can remember experiences long before they learn to speak (Lieberman et al., 2003). I spoke about the intense interest that Virginia had shown when Stewart mentioned Anna's name. I explained that if children are not given the facts about death, they may persist in believing that the parent will return. The best reason I understood for sharing had to do with trust. If their relationship was to be viable, it had to be built on being accountable. Virginia had to know that Stewart would tell her what happened. She needed to experience that he could tolerate the pain of loss and help Virginia tolerate it too.

Over time, Stewart came to see that talking made sense. We agreed that it was best to give Virginia a simple explanation of what had happened: He would say to Virginia that he had something to tell her that was sad. She had a mother. Her name was Anna. She wasn't with them any more. She had died. She died because she had an illness of the mind. He wanted Virginia to know that Anna had loved Virginia. Stewart also wanted to reassure Virginia that he loved her and was there for her. He did not go into the exact details of Anna's suicide or her attempt to kill them both. With time, he would fill in these gaps too.

The larger message was conveyed over many sessions, often in small bits and parts, allowing Virginia space to absorb what he said. When Stewart first broke the ice, the emotions in the room were intense. "Do you remember your mother, Virginia? You had a mommy once. Her name was Anna."

Virginia stared at Stewart with seriousness and intent beyond her age. "Anna's my Mommy," she said. Stewart told her more. He told her that Anna was gone and would never come back. She had died. Virginia looked at Stewart for a long time before saying "I know." He told her that he wanted to tell her other things too. Some of the things he wanted to say were sad. Virginia said "OK," but then abruptly turned to play.

In other sessions, Stewart shared more about Anna. He brought in photos of Anna and showed them to Virginia. He told Virginia that Anna was sick in her mind and that she had hurt herself. He told Virginia that she had not made her mother go. Later, he told Virginia that her mother was buried and that she would never return. In the sessions, Stewart gave Virginia space to process what he had said. He answered her questions and listened, giving Virginia time to take in what he said in her own way. He also assured her that he was there for her. He was her parent. He loved her, was accountable, and would stay with her. He would be available to answer questions that she might ask.

Close your eyes and count to ten

The stone statue stood in the clinic courtyard, half-hidden in the shadow of the clinic and surrounding trees. Sculpted in the 1930s by Edouard and Olga Chassaing, the statue was created to symbolize "the powerful figure of Medicine clutching the infant Humanity high on her right shoulder while calmly but strenuously warding off the Dragon of Disease with her taut left arm" (Scheinman, 1995, p. 155). Each week, Virginia asked to see the life-sized statue of the woman safely holding her baby to keep it from the dragon. We went outside and she stood there, lost in thought, mesmerized for a short period of time. Then she ran off and hid. I was the finder, but also the one left behind, the abandoned one.

This is what a typical session was like: Virginia asks me to stay near a bench and "not" to watch. She runs. I count to 10. I search for her near bushes, behind the statue, calling her name. She is delighted. She grows flustered and angry if I don't find her soon enough. She perceives my difficulties in finding her as painful misattunements. In describing the urgency of Virginia's hide and seek games, words from Tom Waits song, Georgia Lee, come to mind:

Close your eyes and count to ten, I will go and hide but then

Be sure to find me, I want you to find me

And we'll play all over, we'll play all over, we'll play all over again.

What Virginia might have been communicating dawned on me first slowly, then more forcibly: Would she be protected? Did someone care enough to find her? Was her mother gone? Could she be found?

With time, Virginia's hide-and-seek game

included the statue. She hid near the statue, as if seeking safety in its shadow. Sometimes the game of hide-and-seek stopped as she stood to look at the statue or to touch the woman's hand. At times she placed small piles of stones, acorns, or leaves near the statue, often humming as she did. Sometimes she ran up and touched the dragon's face. In her games, Virginia expressed longings for her mother. In her mind, the statue who was not her mother became her mother, a safe and protecting mother.

Later on, she began to share fragmented pieces of herself through questions that were laden with meaning. She asked questions about the woman, the child, the dragon. She asked whether mothers love children and why they go away. She also asked about graves. Fathers, at first almost absent in her stories, became more prominent in her storytelling.

One day Virginia found a purple coneflower. She plucked it and asked me to wait. I saw her slight figure running to the statue. She placed the flower at the woman's feet. She looked at the woman for a long time before skipping back to me.

Virginia and Stewart came to therapy for 9 months. We finished in November, when leaves were still changing colors. There were strong indications that both were moving on. Stewart was dating Janet. Virginia too was changing in subtle, but significant ways. She was less clingy, more able to laugh, less prone to go into dazes, more herself.

Lessons learned

A parent protects a child in many ways, by words, by holding the child, by thinking of the child, and by being attuned to a child's feeling states (Bowlby, 1988). I tried to hold Virginia in mind when we told stories about the statue. I held her hand too when we returned to the clinic. Stewart held her in his arms during some sessions and he learned to hold her with words. He told her the truth about her mother. He told her that Anna had loved her. He told her that Anna had a mental illness. He told her that Anna was now dead. He told her Anna would never return. He also told Virginia that he loved her and was there for her. The words became a powerful bond. They helped Virginia to grasp and tolerate what had happened with Anna. They helped her to trust that she could believe in what her father said, that he could tolerate pain and help her to tolerate it too. The words calmed her in ways that were at times almost imperceptible.

Young children think concretely. They take explanations literally. But they are also learning symbols, words, or thoughts that stand for things (Piaget, 1951). Toddlers also develop play and an imagination—sticks become horses, statues become mothers. With symbols, children move from acting on to contemplating. With symbols toddlers begin to create and make internal sense of their own feelings and experiences. Words are shared symbols. Through words, children can remember and can talk about people that are gone, things that are past, experiences that are too painful to understand without help.

Death is one of the most painful experiences we know. It is painful to grasp, painful to talk about, painful to come to terms with. Mental illness too is hard to grasp in its entirety. Facilitating open communication between Stewart and Virginia about Anna's death and mental illness was a first critical step in promoting healing. Virginia took in what Stewart told her, but she also needed to make internal sense of what this meant to her. She came to terms with the death in a transitional space where she played hide-and-peek and created a relationship with a statue.

Hide-and-peek, the perpetual game played by young children, helped repair Virginia's fears of being lost, fears that had been fueled the suicide and by early and painful gaps in mothering. In our games, Virginia enacted her fears of abandonment in play. I called Virginia's name and found her. In the space of the hidden courtyard, I let her know, again and again, that she could be found.

Potential Space

Potential space (Ogden, 1990; Winnicott, 1971) is an intermediate and protective area of experiencing, an experiencing that lies somewhere between outside and inside, between fantasy and reality. In potential space, a toddler develops the capacity for symbols and selfhood through a dialectical process of oneness and of separateness. In this space, a subjective internal world emerges as the toddler comes to distinguish between what is "me" and what is "not me" and between symbol and symbolized.

The hidden courtyard where our therapy sessions took place likely helped to spark Virginia's entry into potential space. In this transitional space, she could begin to make sense of fragmented, frightening, and painful events that she had experienced but had not understood. The concrete nature of the statue and its likeness to a mother, especially a mother who was

struggling to protect, may have also facilitated Virginia's entry into potential space in our sessions. In a safe place in the courtyard and in her mind, Virginia established a dialectical relationship with this stone mother who at the same time "was" and "was not" her mother. This dialectic afforded some safety for Virginia to explore and share feelings about a mother who had, at times, been dangerous. It also helped her to better grasp in mind what she had experienced.

Potential space can also be created in therapy, especially if meanings are played with, considered, shared, and understood (Ogden, 1990), but it is not inevitable. If a therapist intrudes "too much" on the child's imaginative play, potential space will not emerge. Similarly, steering away from imaginative play will reduce the likelihood of its emergence. The security of the relationship that Virginia established with me likely helped her to explore in her mind and to enter into her own potential space, a space she also shared with me. She trusted that she could play, imagine, and dream without getting lost. She could also ask me questions and share her meaning-making with me.

Coming to terms with loss is both arduous and painful. Being told promptly about what happened (Bowlby, 1980) and being able to share in the family grieving process and to ask questions in the aftermath are central to health grieving (Lieberman, et al., 2003; Ostler, 2010). Facilitating a young child's ability to enter into potential space in therapy sessions can help further the grieving process even more, as it allows a child to tap into a wellspring of imagination and subjectivity as the child makes internal sense of the loss. Entering into potential space appeared to facilitate a child's ability to "work through" the meaning of a parent's mother's death in a way that was uniquely helpful to the child.

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Editor's Perspective

By Miri Keren, M.D.



From research on maternal and infant PTSD to specific modalities of parent-infant treatment

In parallel with the preparation of this issue of the *Signal*, including the review and revision process, a research article appeared in the July issue of the *Journal of the American Academy of Child and Adolescent Psychiatry* (Feldman & Vengrober, 2011) on the high prevalence (37.8% , n=148) of PTSD (Post Traumatic Stress Disorder) among infants and toddlers (1.5 -5 years) exposed daily to war-related trauma. The major resilience factors that differentiated the Exposed-PTSD group from the Exposed-non PTSD group, were maternal PTSD, depression and anxiety levels and support networks (Note: Unfortunately, fathers were not included in this study, though, in our clinical experience, they always have a direct and indirect impact, via the quality of co-parenting, on the infant's adjustment to adverse life situations). An additional, interesting finding was that children diagnosed as having PTSD exhibited high levels of avoidant behavior towards their mothers during the evocation of traumatic memories by the mother. Maternal proximity to the traumatic event and the mother's PTSD symptoms correlated with the child's avoidance symptoms (gaze aversion, emotional withdrawal, increased preoccupation with objects, and physical distancing from the mother). Furthermore, maternal depression and PTSD predicted the child's avoidant behavior.

This study reinforces the well-known notion that PTSD in infancy is very much linked in its pathogenesis to parental PTSD and consequently to its treatment. We may even say, "There is no such a thing as PTSD alone in infancy..." The more specific finding around the high level of avoidance behavior obviously signifies an insecure attachment. Schechter and Rusconi's paper, in this issue of the *Signal*, may be viewed as a clinical application of this finding. Most interesting is the Clinician Assisted Videofeedback Exposure Session (CAVES) model the authors have developed for traumatized mothers and very young children (8-50 months), aimed at helping mothers give up their own avoidance behaviors while facing their child's daily distress. Again, we see that video reviewing is a powerful therapeutic tool, especially for the more "difficult-to-engage" parents, and that it has an impact on the neurobiological level and psychological level, too.

Similarly, the Dyadic Attachment-based Nonverbal Communication Expressions (D.A.N.C.E.) model, developed and presented in this issue of the *Signal* by Tortora, emphasizes the need to address the non-verbal aspects of the parent-infant interaction in general and, even more importantly, in our psychotherapeutic work with traumatized parents and infants where the trauma has left them without words.

More and more often, with the increasing frequency of large-scale disasters and terrorist attacks (while writing these lines, I read about the approaching huge hurricane in the east border of the United States...), clinicians are also at risk of being exposed to the same traumatic event that will bring parents and infants to their clinics. Large-scale traumatic events have a paralyzing impact on everyone. While reading about the CAVES and the DANCE models of treatment, I thought these tools may help not only the parents, but also the clinicians who have lost their power to describe traumatic experiences they have had with words.

Reference: Feldman, R. & Vengrober, A. (2011). *J Am. Acad. Child Adolesc. Psychiatry*, 50 (7):645-658.

Renew you WAIMH 2011 or 2012 membership online at www.waimh.org! There are two types of memberships:

1) Professional and 2) Student. The *Signal* is a WAIMH membership benefit, but the *Infant Mental Health Journal* is ordered at an additional cost. Go online www.waimh.org.

Book review

By Elisabeth Fivaz- Depeursinge, PhD

Handbook of Jealousy: Theory, Research, and Multidisciplinary Approaches. Edited by Sybil L. Hart and Maria Legerstee, Wiley-Blackwell, 2010.

The impressive Handbook of Jealousy edited by Sybil L. Hart and Maria Legerstee draws attention to an important and universal yet startlingly under-researched field of inquiry, namely the development of jealousy. Adopting a balanced approach, this volume treats jealousy not solely as a destructive force, as so often portrayed in the literature, but also, “as having a more pro-social function driving ardor as well as goal-directed behavior that helps protect relationships and ensure survival” (Hart, p. 1). Authored by an outstanding list of experts, chapters address jealousy’s evolutionary sources, its presentations in adult friendships and romantic love relationships, as well as during infancy, childhood, and adolescence. The work on

infants is especially provocative. Unknown to many infant clinicians and researchers, evidence of jealousy is apparent in early infancy. Since this is a point in development that is well in advance of a sibling’s arrival and well before the emergence of complex emotions, this evidence raises pressing questions about the kinds of experiences and cognitive capacities that underlie nascent jealousy. Commenting on the challenge of explaining the early emergence of jealousy’s affective nucleus, Campos, Walle & Dahl note, “The paradox is that jealousy should not exist in the first year of life, yet evidently it does” (p. 315).

Because it isn’t manifested by a single facial expression but rather by a varying blend of negative affects, jealousy is not easily defined. Importantly, however, a definition can rest on the fact that jealousy is elicited in a specific type of triadic context that includes: a subject, a beloved and a rival. Of special interest for

infancy clinicians and researchers is Sybil Hart’s jealousy evocation paradigm, where an infant is confronted by her mother who is directing affectionate attention exclusively toward a life-like baby doll. Typically, the infant’s response is a mix of negative affect (sadness, anger, fear) and mother-directed approach behavior, much like attachment behavior. Contrastingly, extremes of response, as in tantrums and intense aggression or blank behavior and withdrawal, are atypical. These empirically-based characterizations of typical and atypical infant jealousy drive fresh questions about jealousy’s fundamental form and function. They also hold out promise of further revelations through investigative attention to development within supra-dyadic social contexts. In sum, this handbook on a powerful human emotion is mind opening, carving out new avenues for stimulating research as well as clinical interventions. I consider it a must for infancy professionals.



President's Perspective

By Antoine Guedeney



Dear colleagues and friends,

The summer was, again, a time of major crisis. Then financial crisis hit hard, and everyone is concerned for the future of children and the way to deal in Europe and in the US with the amount of debt. Strict budget regulation already has and will continue to have impact on the level of health related expenses. Mental health expenses, prevention programs, research programs are likely to suffer cuts.

But there was more to that: global warming sort of disseminates and increases the strength of storms, tornados or drought. So we are faced with an extreme situation in Ethiopia, with women and infants walking distances to reach camps, suffering thirst and hunger, and dying... Japan has resumed its activity with astonishing courage and dignity after such a serial of catastrophic events. We will be eager to hear from our Japanese colleague experience, if they can join us in Cape Town. Recently also, on a different sort of catastrophe, a whole country has been stricken by the blind shooting in the Oslo island of some of the smartest and politically aware young people in Norway, plus bombs exploding in the middle of this quiet, peace full city. The shock in Norway is immense, as almost everyone knows someone who is linked with some of the families hit. And again comes the endless question: what is the sequence of events and influences, the risk factors and absence of resiliency factors leading so such a personality disorder and to such isolation into such a distorted trend of thoughts with such an absence of empathy?

9/11. Ten years ago, everyone remembers this day, the incredulity, the shock while looking repeatedly to these images of planes hitting the towers and of the towers going down. We were all of us New Yorkers then. One of the remarkable things in 9/11 is the ability of a human group to sacrifice for unrelated other human beings, as much as to consider some other human beings as non human and to kill them without remorse. New York firemen got into mankind history for going up the towers when knowing they had little chance to escape, just because they were firemen and because it is their duty and honour. Just as the two thousand Russian 'cleaners' did in Chernobyl. This is the specific ability of man to kill the other for other reasons than survival as well as to cooperate, empathize and sacrifice even for strangers.

In these different events, WAIMH has worked as warm and efficient network to share experience, feelings and to provide help. Our world congresses are the place where we can think of the way to increase our speed and effectiveness of reaction in front of such events.

So Cape Town is coming soon, now with the dead line for submissions being on Oct 15. The concept of mentalizing is a great one for a general theme of the congress. We hope people from all over the continent will be able to come and gather and share in Cape Town. We have a lot to learn from the studies and from the programs lead in South Africa: there is a very young population there, with problems on a big scale but with a lot of energy and capacity for adaptation and invention. We will implement our new way of sharing on training, with the Training Village, just before the regular precongress events.

In Cape Town, we will have two days of board meeting, which will enable us to make plans for work till the next congress in Edinburgh 2014 and plan the elections to the board. The board has worked hard in the last months, particularly examining bids from international conference organizers. The board was looking at ways to reduce costs and increase effectiveness in the preparation of congresses, which is always a difficult task to organize between Professional Congress Organiser, WAIMH Central Office and Local Organising Committee. With some congresses the WAIMH has gained and with some lost money some brought extra money to WAIMH (Leipzig, for instance, but also Melbourne as I forgot to mention in the precedent Signal). The question was: could hiring an International Congress Organiser for a longer term make organizing a world congress simpler and less expensive? After a lot of consulting and reflection the board considered that choosing an ICO was not timely now. The board will continue to help LOC's choosing a CO and signing a good enough contract.

Finally, we will have our first board meeting online soon, thus reducing costs to the organization.

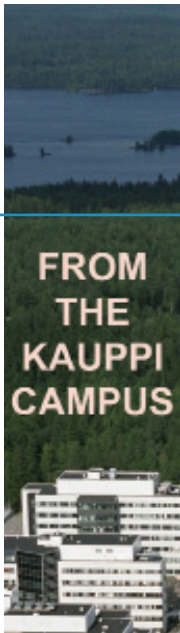


Cape Town, South Africa
Cape Town International Convention Centre 17 - 21 April 2012



From the Kauppi Campus -News from WAIMH Central Office

By Päivi Kaukonen, Kaija Puura and Minna Sorsa



In Finland we in the WAIMH Central office staff are experiencing the autumn, with the dark winter time approaching. As WAIMH is a global multicultural association connecting colleagues from different seasons and continents, we wish also to appreciate seasonal and cultural differences.

On the last page of the Signal we announce the nominations and applications for WAIMH Awards. At World Congresses WAIMH recognises members across the world who have made important contributions to the infant mental health community. Please be active, since the deadline is November 30.

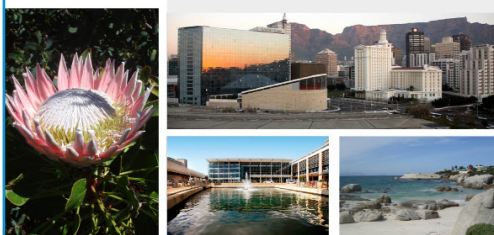
The Cape Town congress abstract submission closes October 15. The submission process has been quite

fluent. We encourage as many of you as possible to participate in the congress, which looks like becoming a great success, with the amount of presentations being at least the same as in the 11th World Congress in Yokohama, Japan (2008). As you may already know, the Cape Town registration site has opened and the Early Bird rate for members closes on Dec 31.

At the Cape Town congress the presidency of WAIMH will be passed from Antoine Guedeney to our current President Elect Miri Keren. After the congress the Board of Directors will elect a new President Elect, but before that all the members of WAIMH shall elect one new Director to our Board of Directors to replace Antoine as a Board Member. The Central Office will launch the election by calling for nominations. All WAIMH members 2011 will have the possibility to nominate candidates this autumn and to vote for the new Board member in an online electronic voting procedure in the beginning of next year.

13TH WORLD CONGRESS

BABIES IN MIND - THE MINDS OF BABIES: A VIEW FROM AFRICA



CAPE TOWN,
SOUTH AFRICA
APRIL 17 - 21, 2012

Cape Town, South Africa
Cape Town International Convention Centre
17 - 21 April 2012
WORLD ASSOCIATION FOR
INFANT MENTAL HEALTH

We would like to challenge each one of you to market the congress and to inspire your colleagues to join us in Cape Town.

For the first time ever individuals and organisations, eg affiliates, can donate participation fees to persons from developing countries. The Sponsor a Delegate –program has been developed by the Local organising committee in Cape Town, South Africa. Read more in the Congress website!

As you can read in this Signal, our Board member Deborah Weatherston from the Michigan Affiliate has made an initiative for creating a Celebrating the Baby -week. Maybe we could join her initiative and organise a day or week with the same theme of celebrating babies and their families in all the affiliates around the world! So please read the guidelines on page 17, and join the events internationally October 24-28, 2011!

CALL FOR NOMINATIONS/ APPLICATIONS FOR WAIMH AWARDS



Every two years, WAIMH recognizes members from across the world who have made very important contributions to the infant mental health community. WAIMH Award Committee encourages nominations from a variety of disciplines and settings around the world, e.g. health, mental health, early care and education, early intervention, hospitals, colleges and universities, legislatures, etc. Nominations are invited for each of the following award categories:

1. WAIMH Award

Given in recognition of significant contributions to the World Association for Infant Mental Health, either directly or through one of the WAIMH Affiliate Associations.

Past recipients of the WAIMH Award

Serge Lebovici; Justin Call; Eleanor Galenson; Robert Emde; Hiram Fitzgerald; Sonya Bemporad (1996); Joy Osofsky (2000); Dilys Daws (2002); Sam Tyano (2006); Campbell Paul and Brigid Jordan (2008); Astrid Berg (2010)

2. Sonya Bemporad Award

Given in recognition of significant contributions to the advancement of social and public policies that contribute to the mental health and overall benefit of infants, toddlers, and their families. Nominees typically are not involved in service delivery or scientific or clinical studies of infants. Legislators, officials, advocates, media representatives, foundation directors, and concerned citizens may qualify for the award.

Past recipients of the Sonya Bemporad Award

Paul Steinhauer (2000); Salvador Celia (2002); Betty Tableman (2002); Pamela Linke (2006); Matthew Melmed (2008); Tuula Tamminen (2010)

3. Serge Lebovici Award

Given in recognition of significant contributions to the international development of infant mental health. Nominees typically are individuals who have been actively involved in collaborative efforts that have cross-national implications for infant mental health.

Past recipients of the Serge Lebovici Award

Myriam David (2002); Michel Soulé (2006); Daniel Stern (2008); Charles Zeanah Jr. (2010)

4. René Spitz Award

Given in recognition of significant lifetime contributions to clinical and/or experimental research on topics related to infant mental health. Nominees typically are individuals who have made substantive scientific contributions to the interdisciplinary field of infant mental health.

Past recipients of the René Spitz Award

T. Berry Brazelton (2002); Robert Emde (2006); Takeo Doi (2008); Mechthild Papousek (2010)

Required nomination support materials

1. A 250-500 word statement indicating why the nominee should receive the award.
2. A copy of the nominee's resume, vita, or biographical sketch. If you are nominating a group, provide a complete description of the group and its members as well as a brief history of its relevant activities.
3. Three letters of support from individuals who endorse your nomination.

4. Submit all nomination materials in one packet and mail it to the WAIMH Central Office postmarked no later than **30 November, 2011**.

Applications are invited for the following award category:

New Investigator Award

The purpose of the WAIMH New Investigator Award is to recognize and encourage promising new investigators in infant mental health. The applicant must be a member or sponsored by a member of WAIMH. The applicant must have earned a university degree no more than eight years prior to the application deadline. The individual selected as new investigator receives a cash award, a plaque, and acceptance of his/her paper for publication in the *Infant Mental Health Journal* (this involves exposure to the peer review process as a way of assisting the investigator's professional development). In addition, the new investigator must be prepared to present his or her work at the following world congress.

Past recipients of the New Investigator Award

Ann McDonald Culp (1996); Laurie A. Van Egeren (2000); Kaija Puura (2002); Claire Vallotton (2006); Wakako Sanefuji (2008); Elita Amini Virmani (2010)

Required application support materials

1. A cover letter on institutional letterhead indicating that you want to be considered for the New Investigator Award competition.
2. One copy of the applicant's curriculum vitae or resume.
3. One copy of the abstract submitted to the program committee of the congress.
4. Four copies of an original unpublished version of the paper described in the abstract.
5. A sponsor's letter if you are not a member of WAIMH. The sponsoring letter must be written by a member of WAIMH.

There will be no exceptions to the **30 November, 2011 deadline**. Send the entire application packet to the WAIMH Central Office.

WAIMH will forward applications to the awards committee.

Direct any questions to: Päivi Kaukonen, Executive Director (ed@waimh.org).

Send nominations/applications to:

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