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

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.

By Teresa Ostler

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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.

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 built 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 of 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-seek and created a relationship with a statue.

Hide-and-seek, 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 Videofeeback 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 huger, 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?

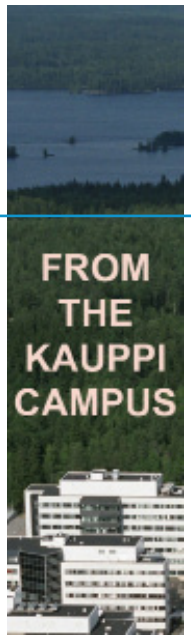
9/11. Ten years ago, everyone remembers this day, the incredulity, the shock while looking repeatedly to these images of planes hitting the towers and of the towers going down. We were all of us New Yorkers then. One of the remarkable things in 9/11 is the ability of a human group to sacrifice for unrelated 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.



From the Kauppi Campus -News from WAIMH Central Office

By Pälvi 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.

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.

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!

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.

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.

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

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

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. Réne 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 Réne 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: Pälvi Kaukonen, Executive Director (ed@waimh.org).

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