Vol. 20, No. 2 | March - June 2012

THE SIGNAL

Newsletter of the World Association for Infant Mental Health

When a little means a lot

By Astrid Berg

Introduction

It is auspicious that I should be making this presentation at the end of a conference which represents the culmination of where we have come to in the field of Infant Mental Health in South Africa. I want to thank you all for having made this possible.

In 1995 the first ever conference on Infant Mental Health in South Africa took place – it was the brain child of my late colleague, Mara Sidoli, a child analyst from Santa Fe; she had come to South Africa to train a group of young analysts and introduced us to the technique of Infant Observation. She showed us a video tape and it was this video tape of Baby Susan that was the beginning of infant mental health in our country. The conference that followed was a local effort, but, because we had no-one who could talk on this field, it relied almost exclusively on the presence of our international visitors to make it the success that it was. I want to acknowledge a few of those original participants who are here today – thereby closing the circle:

Suzanne Maiello, Hisako Watanabe, Lynn Murray, Peter Cooper – thank you for helping with this first conference and for coming again. In 2002 a second conference was organized and Dilys Daws joined us as well as Joan-Raphael Leff. They too are here today… and thank you and so many other colleagues and friends who have since have become involved and who have been extraordinarily supportive –

What has happened since 1995? Those heady beginnings of the New South Africa, when our nation was in its infancy – politically we have now reached adolescence and are struggling with those very issues familiar to us in this phase of the life cycle.

Infant mental health in South Africa is also maturing – the Conference here is testimony to that. There are many national initiatives which serve to increase awareness of the importance of the first three years of life. We have 2 active affiliate associations: the Western Cape and the Gauteng Association for Infant Mental Health. Ububele is an example of what can be done with a vision, good will and commitment. Founded in 1999 this non-governmental organization has developed models of community based health care which address the emotional trauma of South Africa's past. Out of this developed their Parent-Infant Programme which is developing novel ways of engaging mothers and infants.

I am grateful to Nicola Dugmore's careful historical account of the emergence of infant mental health, and particularly parent-infant/child psychotherapy in South Africa. She reminds us that in fact infant observation started out already in the late 1980's in Johannesburg – led by Zelma Joffee with a support of teachers from the Tavistock Clinic Model. (Dugmore N, 2011) This influence from abroad from various sectors continues to enrich, teach and stimulate us.

However, we have to be mindful of the fact that as much as we can learn from our colleagues abroad, we can equally or even more so learn from our colleagues and fellow citizens here. If psychoanalysis and psychotherapy is to be developed as a credible approach applicable to our context, then we have to be ever mindful that psychoanalytic assumptions are not used to the detriment of the people that we are trying to serve.

Living and working in a country where there are not only enormous economic disparities, but also enormous cultural and language differences, we as mental health professionals face many challenges… One of the most profound challenges is that of meeting 'the other' - in essence it is the challenge of life: for the self to engage with an other – it is that on which our whole development is built as we know only too well.

In South Africa we have a unique situation: Colonialism was the beginning of Apartheid. We need only to read how the European explorers described the indigenous people they met – be that in Africa, Australia or the Americas, to know that they were seen as exotic, but inferior others in terms of being less 'civilized'. In South Africa this pervasive attitude became institutionalized in 1948 with the beginning of Apartheid laws and policies. We have now moved out of these and are able to be one with the other on an equal level in terms of rights and opportunities.

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The Signal is a quarterly publication of the World Association for Infant Mental Health. Address correspondence to Miri Keren (ofkeren@internet-zahav.net).

However, have we truly dismantled and discarded our colonial attitude? Have we truly stopped to project our shadow, our inferior, disowned parts onto the racially 'other'? Do we indeed realize that our world view is not shared by all?

I had not appreciated these realities – certainly when I started my work in Khayeltisha I was far away from truly seeing and hearing my fellow citizens – it is a fact that shames me, but that I have to face. How did I learn?

I learnt through my engagement with the work with mothers and infants at the Service which I started in 1995. And I knew that I could only do that work if I understood as best as I possibly could of where the mothers and babies were coming from, what their life contexts were. And this I could only do through working closely with a person who knew about my patients' beliefs, values and who could help me translate – not only from isiXhosa into English, and vice versa, but help me to get to know the culture in which my patients were embedded. This is more than understanding about poverty, or bridging language differences – it is about obtaining a deep knowing about another system of values and priorities where much is the same, but much is also different.

It is about this that I wish to expand as it is in my view the essence on which any work with caregivers and infants in this country and perhaps in other parts of the world will either stand or fall. Often not that much is needed - a little can mean a lot - but that little has to be an attuned, mindful little. I will focus more on the actual interaction between therapist, cultural broker or mediator, and patient. I will not address the larger or deeper cultural issues, but will limit myself to interactional mechanisms.

The Developmental Niche

This is a theoretical framework by which we can study the way culture regulates the micro-environment of the child; culture being "the shared way of life of a group of people". (Berry JW, Poortinga YH, Segall MH, & Dase PR, 1992) (p1). Within this niche there are 3 major sub-systems: the physical and social settings, the culturally regulated customs of child care and child rearing and the psychology of the caretakers.(Super CM & Harkness S, 1986) It is on the latter that I will focus on in this presentation.

Parents have ideas and ideals within which they wish to raise their children. These socialization goals create scenarios for particular developmental trajectories. Heidi Keller from the University of Osnabrück in Germany has extensively researched the differences between 5 groups of people: 2 leading a traditional rural village life in West Cameroon and in India and 3 from western urban middle-class families in Europe and the USA. (Keller H, 2007)

She was able to demonstrate two prototypes which represent distinct models, encompassing two different socialization goals: namely the independent model which focuses on autonomy and the interdependent model which focuses on relatedness. The coherence and consistency of these two styles has been apparent in the research done with the groups.

These two models lead to different parenting styles and have different socialization outcomes:

Proximal parenting consists of mainly body contact and body stimulation (interdependent style) and is associated with a conversational style that is minimal, directive and repetitive and that focuses on rules of behaviour.

Distal parenting consists of face-to-face contexts and object stimulations and is associated with an elaborate conversational style which focuses on the mental agency of the infant and supports independent socialization goals.

The interdependent model focuses on the health and physical development of the baby whereas the independent model focuses on the baby's ability to be separate and to be able to be alone.

Multiple caretaking or alloparenting varies amongst these two groups. Infants who grow up with an interdependent cultural model of parenting usually experience the network of a large family and kin; whereas those growing up in an independent model experience being parented mainly by mothers and fathers only. And even if this is not absolute (in that the independent model infants also are exposed to alloparenting), the different parenting styles persist. The study on these environments, particularly the 2 prototypical environments – namely rural, subsistence-based ecologies where families closely cooperate for their joint economy and where formal education is low, and the urban, middle-class, Western families in which everybody is supposed to develop his or her own talents and where formal education is the norm – these highlight the different ways in which parents think of their children and consequently raise them. However no

culture is static and the factor which most contributes to development and change is education.

Formal, school-based education differs from indigenous educational systems in significant aspects – both in content as well as mode of learning. Cognitive functions are segregated from emotional aspects of thought, the learning process is child orientated and curiosity is stimulated – all very different to the informal education received at the hands of parents and families, which is more of an apprenticeship which encourages the child to fit in with what is expected from its kinship group.

Further down the line, formal education for mothers changes the availability of economic opportunities and life styles – it encourages the trend toward smaller, nuclear households and delayed childbearing – thus formal education is 'the engine of change' (p 264) and initiates a trend toward the cultural model of independence.

A nation in transition

What does this research mean for our situation in South Africa? We are a nation in transition on many levels.

Large sections of our population are in the midst of change: moving from rural settings into urban dwellings and life styles. These are the parents and children that become the most vulnerable and whom I encounter in my work. Many of the women who come from villages in the Eastern Cape were themselves brought up within an extended family where they received much physical comfort and nurturance; they played and talked, not so much with their mothers, but with the siblings and other children; they learnt through observing what the elders did; they knew that what mattered was how you got on with others, that the good of the community was what was important. Once married they were embedded in the families of their husbands who would, in the ideal cases, provide support for them and their children.

However idyllic this family situation may be on one level, there are limitations which are present in all rural, traditional settings: young men and women want employment; they want access to better health care and, if they have children, want formal education for them. They come to the cities where more possibilities exist, but the consequences are often not desirable. The rupture with the known community and family can leave a profound gap: no longer do men take responsibility for their wives as is the case where traditional marriage rituals and resultant family involvement act as buffers. Mothers are left uncared for, exposed to the hardships of daily living in semi-formal settlements; they are separated from their mothers and elders, and thus do not have the benefit of the advice that would have been given to them and upon which they would have relied. Modern foods in the form of yoghurt and corn flakes beckon as nutritious, easy to give alternatives to the more laborious preparations of traditional porridge and vegetables. The result is a vulnerable infant with faltering weight and an equally vulnerable mother. And soon it becomes clear that the failure to thrive in many cases is not just about food or poverty but that there are psychological issues that play a role.

It is about the mother's sense of self, her sense of having agency, her sense of self-efficacy. It is this that we need to restore. In my clinical sample 72% of mothers had to concurrently contend with at least four major life stressors and 35% had a depressed mood and 28% of infants were withdrawn. (Berg A, 2012) So, they may land up with a mental health professional who wants to help by providing psychotherapeutic input. How can this be done in a way which meets the mother and child where they are at?

How do we bridge the many divides of economic power, formal education, and different models of childrearing? How do we aid mothers to value what is positive in their parenting ideals, but also adapt to what we know today about infant development and needs? All mothers want their children to receive formal education and for this they need to be given the opportunities early on not only to develop motor and cognitive skills, but to have a sense of autonomy and be able to speak out. Object stimulation, vocal stimulation, face-to-face dialogue so necessary for the development of the brain and mind need to be provided, not so much by others in the community as would be the case in a rural setting, but now by the mother herself. How do we convey this in a manner that is digestible?

Cultural mediation

Cultural mediation emerged in the late 1970's as a formal profession; it was a public health intervention in response to the large number of West African immigrants that had settled in France. The mediator's role was not only to translate, but more importantly to bridge social worlds. According to Bintou, the first cultural mediator in France, interpretation only is repetition; cultural mediation is the translation of ideas, of linking two cultures through creating relationships. (Sargent C & Larchanche S, 2009)

I have had the good fortune of having worked together with such a colleague over the past 17 years. Our partnership came to the attention of Claire Penn, research professor and director of the Health Communication Project at Wits University; she was intrigued by the high compliacance rate, that is 75% of mothers returned for follow-up visits and she decided to study what we did in sessions. The interactive and language dynamics of ten mediated interviews were explored using qualitative methods and video-recordings of interactions and interviews with participants. [1]

What emerged from this study were several important findings:

1. The cultural mediator spoke far more than the doctor. The one reason for this being that there were side conversations, or asides, between mediator and patient, as well as mediator and doctor and these were often left untranslated. The other reason being that the mediator phrased her questions in such a way as to make them gentler and thus acceptable to the patient. In the African language there is a way of speaking about things, particularly about matters close to the heart, which are said in a more circumspect and careful than is in English, in the western, or at least my personal style. For example the following extract:

   Dr: Is she HIV?

   CM: Can I ask something, are you both well?

   Pt: No I went for an HIV check and they said I'm negative.

   CM: when you were pregnant?

   Pt: Yes they said I'm negative but even though I have a baby I want to check again

   CM: Is it because you have a boyfriend?

   Pt: No, but I don't know

   CM: What is it that you don't know?

1 Penn, C; Berg A; Watermeyer J. Capturing good practice: Linguistic indices of cultural brokerage in interpreted child psychiatry interactions – submitted

Pt: The other thing is I had TB when I was young.

This conversation then went along a line which I, the Doctor, had not asked about, but which was to reveal important information.

At other times the conversation will be between the doctor and the mediator, but always done in such a way as though the patient does understand.

2. Another important aspect is what linguists call the "quotative". It is an utterance produced by the mediator which is preceded by a marker such as 'the doctor is asking', or 'the doctor says' – it is a way that the mediator sets herself apart from her own talk.

An example would be "the doctor says you must be worried about your husband" – in this way the difficult statement is made, but it is the 'doctor' who is saying it, not the mediator with whom the mother has the primary relationship.

The underlying feature in all of this is that of the doctor or therapist yielding control – giving the control or part of the control to the mediator.

Yielding Control

The medical model focuses on the defect of the patient which is then diagnosed and treated according to an established protocol. The power is clearly in the hands of the doctor who is the one to possess the required knowledge. Psychoanalysis has changed this traditional doctor-patient relationship from one of authority to one of partnership. (Rayner E, 1991) The doctor knows as much or as little as the patient and thus both patient and therapist are involved in an exploration of what is going on for the patient. It is this sense of mutual respect and equality that underpins most psychotherapeutic endeavours and is what is being practiced in our service. Thus while yielding control is a move away from the medical model, it is not novel. However, yielding control to a third person, the cultural mediator is what is under consideration here.

A case example

Baby L was referred to us in May last year, she was 4 months old at the time, and her mother was 36 years old. She has a 15 year old daughter who lives with family in the Eastern Cape.

Mother was referred by a doctor in the community who had noted that she looked worried. To us she could only say that she has 'many stressors'. She is HIV positive, but she is not yet sure about her baby's status. We observed a well cared for infant, but mother's handling of her baby was unusual and disturbing. First she tried to hand me the baby on entering and as she sat down she let L sit on the table next to her, only holding her on one arm; the staff had noticed that she had been quite rude to them. Baby L was however delightful, she was well nourished and made instant eye contact and communicated through smiling and babbling. While very concerned about mother's mental state, we were reassured by her infant's well-ness and simply asked them to come back in 2 weeks time.

When seen again the mother continued to look distracted and her behaviour was disturbing – she and the infant made no eye contact, she would give an abrupt, disconnected kiss, but have no further contact. She briefly took her on her lap, but was not at all following the baby's cues. Upon my remark that the baby was beautiful, she sat her back on the table. Even the news that her baby was HIV negative did not elicit much of a response – she continued to be bored, distinterested and angry. Upon questioning she said that she did not want the pregnancy and that the boy friend had left her – she acknowledged her anger and we wondered whether she might be depressed. We talked around the fact that the contact with her child was important for the baby, but did not say more than that.

Three weeks later baby L was on her lap, and closer than before, but mother remained disconnected – the biscuit given to L was taken by mother. But mother was saying she was feeling a bit better since coming to us, though there was little evidence in the way she handled her child. I was growing very concerned, but was reassured by what my colleague's plan that we should just go on, continue seeing her and speaking to her about her anger and her baby in small doses.

When seen last in January this year she was looking well, L was continuing to thrive and there now was a close physical bond between mother and child. Although mother had admitted to her anger at the father for denying his parenthood and deserting them, she was now able to say that she was angry with L in the beginning, but this anger is now less. "I am enjoying her now".

I want to lift out a few points from this case:

Firstly, I would not have been able to deal with the anxiety within me concerning the mother without having the support of Nosisana – together we decided how to proceed and our decision was to take it step-by-step, to be slow and minimal in what we say and simply ensure that she would come back. Nosisana knew about my concerns and I left it to her to translate these into a language that mother could hear and take in. We were both questioning the mother's mental state: was she intellectually compromised? Did she perhaps have another illness like epilepsy? Did she suffer from a psychotic illness? Or was this her personality? All of this we constantly held in mind while at the same time trusting the process and trusting that things would unfold in time. You could see from the clip that I was at times helpless, did not know what to say and had to hold the tension of not actually seeming to be doing anything for this couple.

It demonstrates also how long it takes for links to be made and acknowledged – I had from very early on suspected the mother was projecting her anger towards the father onto this baby, but we could not even get near her anger initially, so it had to wait until she could make the link herself and thereby release the child.

Thirdly, we did not simply sit back and not provide mother with information about her infant's emotional needs – we spoke about the need for connectedness, for being spoken to and related to. But this was done in small bits and in the context of this mother's emotional availability.

In conclusion

In this presentation I have focused on the need to work together with a colleague who has a lived knowledge of the world in which the mother has grown up in and the challenges she is facing in a time of cultural transition. In the context of historical inequity in South Africa it is vital to have a technique which breaks traditional asymmetries. By yielding control the therapist makes the cultural mediator into a true co-therapist. A word about the concept of the 'third': Britton wrote about the theories and professional training as the 'third object' in his mind, one that held him in the moment of the clinical situation. (Britton R, 2004) In the situation I have described there is an externalization of the 'third'; the verbal dialogue is not an internal one, but an external one, resulting in a trialogue, that is between patient, cultural mediator and

doctor. In addition the focus is on the interactive processes which the infant provides us with – all of these factors, the trialogue, the focus on the interaction contributes to the facilitation of a moment of meeting which Stern has described, a moment which offers a new way of looking at the world, a new intersubjective context. (Stern DN, 1998)

Not only are mother and infant brought closer together, but also the 'life world' of patient and therapist, black and white persons, traditional and urban cultures, English and isiXhosa.

This is the only way in which we can truly live mult-culturalism and celebrate diversity.

What does this mean for WAIMH? The essence of what I tried to convey remains –we cannot assume to know it all when other people have lived knowledge of a particular context. Let's make links globally, let's listen to each other and let's put into practice what we say we believe, namely that the needs of human infants are the same, but that there are different ways of rearing infants –let's get to know these, let's respect them, but at the same time we need to tell the world know what we are continually learning about the beginning of life.

References

Berg A (2012). Infant-parent psychotherapy at primary care level: Establishment of a service. South African Medical Journal, 102, 582-584.

Berry JW, Poortinga YH, Segall MH, & Dase PR (1992). Cross-cultural psychology: Research and Applications. Cambridge: Cambridge University Press.

Britton R (2004). Subjectivity, Objectivity, and Triangular Space. Psychoanalytic Quarterly, 73, 47-61.

Dugmore N (2011). The developoment of parent-infant/child psychotherapy in South Africa: A review of the history from infancy to maturity. Journal of Child & Adolescent Mental Health, 23, 75-90.

Keller H (2007). Cultures of Infancy. New York: Taylor & Francis.

Rayner E (1991). The Independent Mind in British Psychoanalysis. London: Free Association Books.

Sargent C & Larchanche S (2009). The Construction of „Cultural Difference" and Its Therapeutic Significance in Immigrant Mental Health Services in France. Cult Med Psychiatry, 33, 2-20.

Stern DN (1998). The Process of Therapeutic Change Involving Implict Knowledge: Some Implications of Developmental Observations for Adult Psychotherapy. Infant Mental Health Journal, 19, 300-308.

Super CM & Harkness S (1986). The Developmental Niche: A Conceptualization at the Interface of Child and Culture. International Journal of Behavioral Development, 9, 545-569.