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Observational situations of interactions in families of four and more people

By France Frascarolo, Hervé Tissot & Nicolas Favez, France

Introduction

Mother-baby relationships have been studied in natural conditions (Stern 1974 ; Fogel, 1991), as well as with the help of various observational paradigms such as the « Strange Situation » (Ainsworth, Blehar, Waters et al., 1978) or the «Still face» (Tronick, Als, Adamson et al. 1978; Tronick, 1989). Then, in turn, father-baby interactions have been studied using similar paradigms (Lamb, 1976 ; Parke, 1978 ; Yogman, 1981). The goal of all these observations was to understand the influence of parents on the development of the child and they have allowed us to foreground the links between disturbances in the interactions between parent and child and deviations in the affective and cognitive development of the child (Sameroff & Emde, 1989).

The studies of parent-child pairs have produced much but they cannot isolate the contribution of the family as such. According to the principles of the systemic theory, the family should be considered as a unit in itself, following its own course and having its own particularities. The experience of the child with both its parents cannot be reduced to the sum of its experiences with each parent. When they are both together with her there emerges a new dynamic that gives specific qualities to their interactions. Family functioning should be taken into consideration, when it comes to the understanding of the child's development (Parke, 1988 ; Hinde & Stevenson-Hinde, 1988; McHale, Kuersten & Lauretti, 1996; Mc Hale & Fivaz-Depeursinge, 1999 ; Cowan & Cowan, 1992 ; Emde, 1991), and, on occasion, the creation of a pathological progression (Bowen, 1972 ; Minuchin, Rosman & Baker, 1978 ; Jacobvitz & al, 2004).

The 'Lausanne Trilogue Play' has been perfected to study, as its name suggests, three-way family interactions. In this semi-standardised situation, the parents are invited to play with their child following a four-part scenario. One parent plays with the child watched by the other; then they reverse their roles; all three play together; finally, it is the child's turn to be talk together. This situation allows the observation of coordination and sharing of affects among father, mother and child (Fivaz-Depeursinge, Frascarolo & Corboz-Warnery, 1998; Corboz-Warnery, Fivaz-Depeursinge, Gertsch-Bettens et al., 1993) in all possible permutations of the trio. In addition to the triadic system, several sub-systems may be analyzed: the co-parental couple (the parents in their interactions with the child), the parental sub-systems (the father-child and mother-child dyads) and finally the marital dyad (husband and wife talking in front of the baby). Different versions have been conceived to adapt to the emergence of new abilities in the baby, such as the manipulation of toys and, later, the appearance of language. It is ideal for the study of communication between parents and child (Favez & al., 2006 ; Favez, Abbet & Frascarolo, 2006). One may even study the transition to parenthood as there is also a version of the LTP for use before birth in which the future parents play with a doll representing the expected baby.

However, as its name implies, the LTP is valid only for three people. Since many families include several children, it is important to create appropriate situations that permit continued observation of the family after the birth of younger children, in order to capture the emerging qualities of the family system. Thanks to such situations, we may follow longitudinally, by observing the expansion of the family, not only those systems and sub-systems already mentioned, but also the interactions at the heart of sibling relationships that are important in social development (Tilmans-Ostyn & Meynckens-Fourez, 1999). The Lausanne Family Play (LFP) situation, as well as the Picnic Game (Frascarolo & Favez, 2005), in which the family is invited to play out a picnic, have been designed to satisfy

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Contents

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the participant-observer while her parents talk together. This situation allows the observation of coordination and sharing of affects among father, mother and child (Fivaz-Depeursinge, Frascarolo & Corboz-Warnery, 1998; Corboz-Warnery, Fivaz-Depeursinge, Gertsch-Bettens et al., 1993) in all possible permutations of the trio. In addition to the triadic system, several sub-systems may be analyzed: the co-parental couple (the parents in their interactions with the child), the parental sub-systems (the father-child and mother-child dyads) and finally the marital dyad (husband and wife talking in front of the baby). Different versions have been conceived to adapt to the emergence of new abilities in the baby, such as the manipulation of toys and, later, the appearance of language. It is ideal for the study of communication between parents and child (Favez & al., 2006 ; Favez, Abbet & Frascarolo, 2006). One may even study the transition to parenthood as there is also a version of the LTP for use before birth in which the future parents play with a doll representing the expected baby.

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Situations of family games

1. The 'Lausanne Family Play'

The 'Lausanne Family Play' (LFP), a situation inspired by the 'Lausanne Trilogue Play', (Fivaz-Depeursinge, & Corboz-Warnery, 1999), was conceived to permit the observation, analysis and evaluation of the interactions at the heart of families with more than one child. It is suitable for children from the time when they are able to sit upright in a high chair and up to 12-13 years of age (given that the required activity is a game with toys). The parents and their children are installed in a semi-circle around a circular table. The parents are seated opposite each other on a diagonal and the children are divided between them in a semi-circle. The children's chairs are suited to their development (high chair, normal chair).

The technical equipment is made up of three cameras ; the first (general view) records the whole family to observe the posture and body orientation of the different family members as well as the distances between them (whether they lean toward each other or not), the second films one parent and half of the children and finally the third films the other parent and the other half of the children. These partial shots, closer up than the general view, allow the rough capture of facial expressions. The three recordings are synchronised and compressed into a single image. The scenario is as follows.

> We invite you to play as a family, as you normally do, by following these instructions : in the first part one of the parents plays with the children while the other is simply present; after a while you will reverse the roles, the parent who was simply present will play with the children while the other is simply present. After a moment, you will all play together. Finally, in the fourth and last part, the parents will talk together and the children, for their part, will continue to play. You will decide when to pass from one part to the next. Usually this all takes about a quarter of an hour. You will signal to us when you have finished.

Some toys are provided: a family of lions (the lion, the lioness and as many cubs as there are children in the family, a family of ducks (idem) and as many dummy portable telephones as members of the family.

If the LFP is being used for research purposes, it is recommended to request

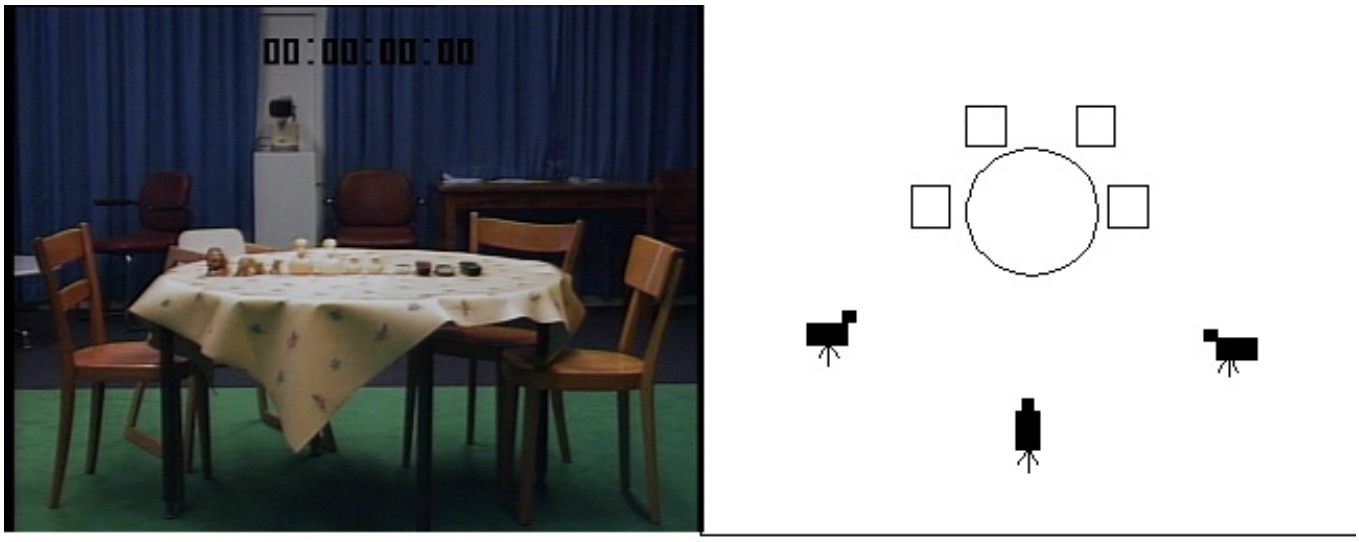

Figure 1. Setting of the LFP (general view).

between one family and the next that the mother and the father begin as the active partner alternatively so as to counterbalance any possible ordering effect. By contrast, if the goal is clinical, the decision as to how they organise themselves is left to the parents.

This game is highly structured; the defined positions of the parents and children (who control the distances between them) as well as the four part scenario impose a strict framework. For parents who are unaccustomed to play as a family and uneasy in symbolic games, to find themselves with the toys and at a distance favourable to visual and expressive exchanges is sometimes stressful. For others, by contrast, thanks to the obligatory framework that structures activities and interactions, this may be reassuring.

A clinical analysis of the whole game may be achieved by concentrating as much on the entire family as on each of the sub-systems that make it up. The family and co-parental alliances are thus priority targets of observation and evaluation. Besides, whereas each of the parts may be analyzed, we may observe in addition the transition from one part to another to see how the parents make decisions and set up the passage from each part to the next.

Coding with the help of an adapted version of the Family Alliance Assessment Scale (FAAS; Lavanchy-Scaiola et al, 2009; Favez, Lavanchy Scaiola, Tissot, Darwiche & Frascarolo, 2010) may be used, particularly in a research context. The tool allows the assessment of the family functioning through the concept of family alliance, defined as the degree of coordination between family members achieving a task (Fivaz-Depeursinge & Corboz-Warnery, 1999). The evaluation is made, then, on the basis of seven scales; 1 – participation (inclusion of partners), 2 – role organization (regard for the scenario and of parents' roles versus those of children), 3 – focalisation (sharing of a common centre of interest and co-construction of games), 4 – family warmth (sharing of affects), 5 – communication mistakes and their resolution, 6 – co-parental co-ordination and, finally, 7 – child's involvement.

2. The Picnic Game (JPN) (PNG)

A large carpet (about 4m x 4m) defines the picnic area in which are arranged a table, as many chairs as members of the family, a large and stable bench, a big basket containing a toy teaset and as many toy sacks as there are children (see Figure 2). The parents receive the following instructions:

> We ask you to play at going on a picnic. Imagine that you arrive with your children in a park. The green carpet defines the area of grass that you may use. Organize yourselves as you wish to prepare the picnic. Then you have the picnic. There are some toys and you may use everything that is available. You are asked to tidy everything away when you are finished. Take your time, usually about a quarter of an hour. Call me when you are finished.

Any family can play the PNG, whatever the number of children and their respective ages. One camera is sufficient for recording it, but several may be used. This situation may be filmed at home but, in that case, standardization may be weaker.

This situation requires of the family a playful and creative attitude, but it also includes some day-to-day tasks like setting the table and tidying toys. The framework provided is extremely flexible. Only the spatial limits are clearly defined. Everything else is in the hands of the family.

The evaluation is carried out in two ways. First in a clinical way by answering the following questions:

1) Participation: are all family members included?

2) Distribution of leadership: do parents frame the interactions or do the children take control? How do the parents share leadership? Do we observe parentification?

3) Structure of the task: are the different parts of the game distinguishable (for example preparing the picnic, setting the table, having the picnic, and so on)? In other words, does the game tell a whole story or is it chaotic? Does the game present originality? Are the family members creative?

4) Fluidity versus rigidity in the management of parents, parent-child(ren) and child(ren) sub-unit(s). Are several configurations observable throughout the game according to different tasks or is one mainly observed? For example, mother taking care of the youngster while father takes care of the older child during

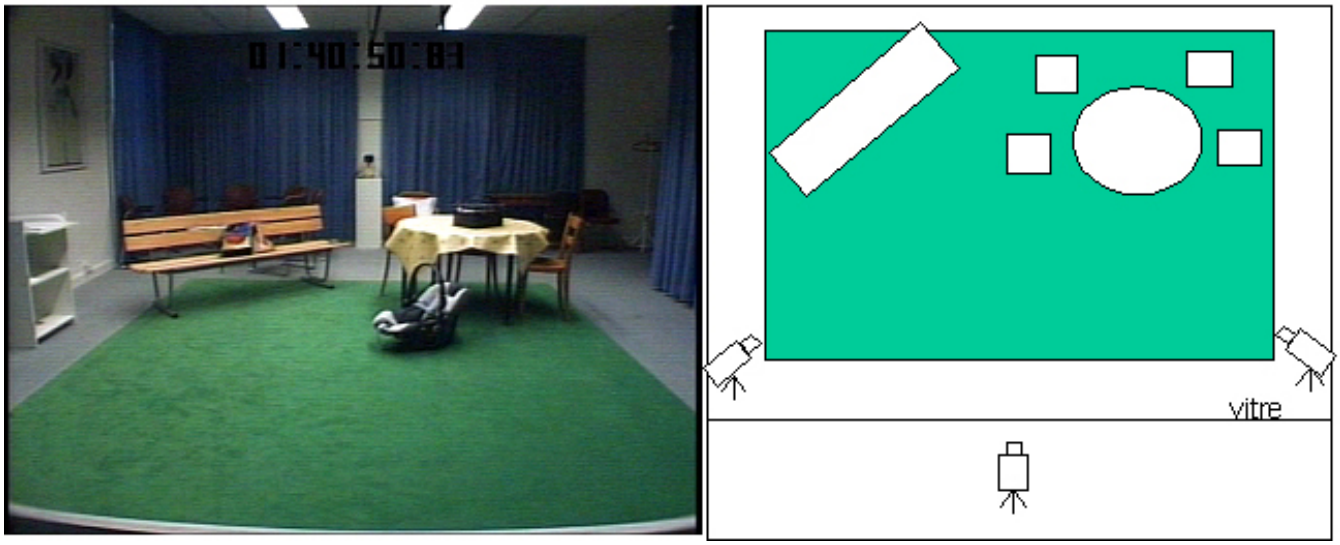

Figure 2. Setting of the PicNic Game

the picnic as well as during play or are they all together most of the time, versus several configurations fluently changed according to various tasks?

5) Co-parenting: do parents work together and support each other in their parental tasks? Or do they work in parallel? Or are competition or hostility observable?

6) Marital relationships. Given the influence of the quality of marital relationships on family interaction, we look for marital couple relationships inside family activities. Do parents share moments of intimacy with positive affects as marital partners besides being parents or, when they speak to each other, is it only in a parental context. Do they directly speak to each other or is it always via the children?

7) Limit setting. Are the parents rather lax, authoritative or authoritarian? Do they set clear limits and make the children respect them?

8) Family warmth. Do family members share positive affects, do they express their affection to each other? Are all members of the family giving and/or receiving positives affects or are some of them rather excluded or cold?

9) Autonomy of the child(ren) sub-system. Are the children constantly under parents attention, of their own will or because the parents tend to control them, or do they have their own space and activities?

Afterwards The Picnic Game may be the object of coding with the help of the RE-PAS, a system of evaluation on several scales by Likert in five points taken from clinical evaluation.

Illustrations, family games

We are now going to give a summary description of two LFPs and two PNGs so as to illustrate the different facets of family interactions as they may be observed with these two tools.

1. Lausanne Family Play, functional interactions (father, mother, 6 year old daughter Lara and 13 month old son John)

Having looked at the available toys, the mother proposes telling a story by enacting a role-playing game. She is the director of the zoo, John her assistant and Lara in charge of the lions. She starts the game by telephoning her daughter to order some lions. She integrates the behaviour of the youngest into the game (for example, when he touches the ducks, she says « He's asking if you have ducks too »). While Lara deals with the lions, the mother explains to the little one what has happened. The daughter then telephones her back to tell that she is there, at the bars with the lions. The mother says she is coming. She greets Lara turns toward John and explains the situation. In this way the mother takes care alternatively of each of them, while keeping the guiding thread of the story and inviting exchanges between them.

After a while, the mother announces a transition by saying that she is calling the lion-tamer and she telephones the father. The father accepts the role given him by the mother and continues the game by proposing to give the lions a bath. Then father and daughter make the lions enter in a truck using the ducks as baits. They deal with the animals then the father announces a transition by proposing to telephone the director. Lara telephones her mother and invites her to come with John.

The mother approves and begins the stage where they all play together. After a moment of sharing over what the father and daughter have done in the preceding stage, there is a moment of hesitation when they don't know quite what to do. The father asks for help in staging a circus act with the lions. The mother proposes that they jump over the ducks. The three get started and work together to prepare a show. They laugh together over a « failure ». John follows attentively and becomes excited. They reach a moment of affective sharing between the four. Then the mother announces a transition by telling Lara « You are going to play by yourself for a moment ». The father confirms this and adds « You can play with your brother ». The parents give all the toys to the children.

The discussion between the parents starts with difficulty but after a moment they start an exchange about the coming evening. The father proposes finishing the game and, as the mother approves, he calls the consultant.

Analysis: game clearly structured, clear framework given by the parents, the four parts are executed distinctly, integration of the two children, story jointly constructed by the parents and the elder child, the four partners achieve moments of affective sharing.

2. Lausanne Family Play, problematic interactions (father, mother, two sons – Jack (eight) and Tom (four)

The father announces that he is starting and asks Jack to name the animals. Tom

tries to draw his mother's attention but she stands still and does not respond. The father quickly runs out of ideas but doesn't enter into the game proposed by the elder child (to stack up the lions). He tries to telephone Tom who does not reply but tries again to include the mother. The father quickly gives way to the mother with a discouraged tone: « OK then, go ahead ». The mother enters into the game asking the children what they would like to do. Without waiting for their replies, she proposes that they sing. Jack starts but the mother doesn't listen and plays at telephoning with Tom. Jack starts a fight among the lions who are trying to eat the ducks next to Tom. The children stage a battle between the animals that the mother attempts to calm. The father intervenes to say that the children should play by themselves. Jack recalls the instructions by emphasising that they should now all play together. So, they play with the animals staging battles and rescues. The parents insist on the fact that it is the lion parents who should protect the little ones. After a moment, Jack recalls that the parents should talk together. The parents comply but keep looking at the boys who play, each by himself.

Analysis: The parents have difficulty in setting the framework and respecting the scenario (cf the recall of the instructions by the elder child). Both father and mother have difficulty in initiating games with the children but they manage when they all play together. Co-parenting shows some gaps but is not competitive.

3. Picnic Game, functional interactions (father, mother, daughter Sarah (six and a half), son Terry (three and a half).

The parents announce that they are going on a picnic by car. They start off side by side and invite the children to get in the back and all four go forward together. Having arrived, they hold hands to cross the road. The father proposes seeking out a good spot. The mother points out one where there is a bench beside the lake. The father suggests that the mother prepares the picnic while he takes care of the children. The mother prefers leaving them to play by themselves while they prepare the picnic together. The father agrees and they enjoy themselves. The children discover the toys in the bags and from time to time show the parents what they have found. The father asks the children if they would like to go swimming in the lake. Sarah takes off her sandals for swimming, puts on her swimsuit and asks her father for her armbands. He blows them up and puts them on. He does the same for Terry. He tells them to give their mother a kiss before going into the lake, which they do. The mother says she wants them to put on some sun cream, the daughter fetches it and the father reminds them not to forget their noses. Sarah dives into the water. Terry copies her and the father joins in. They swim together and the mother waves to them. When they get out of the water, the father shakes himself dry and gives the children a towel to dry themselves. The mother announces that everything is ready and they can start eating. The children come and sit down around the tablecloth. The father gives everyone something to drink and proposes a toast to the pleasure of being there. The mother says the coffee is very good. The mother serves everyone some chicken, salad and pasta. They wish each other « bon appétit » and then eat. Afterwards the parents say it is time to go home and they all start tidying up. The father concludes by saying that the picnic was delicious and they had a good day.

Analysis: the game, rich in symbols, tells a coherent story. Each member of the family fulfils a role. The parents are coordinated and support each other. There are moments of affect sharing among all of them.

4. Picnic, problematic interactions (father, mother, daughter of six, Jennifer, and son of three, Mark)

The father and the children settle down on the carpet and the mother asks if it is wet. The father replies that it is a little damp but alright. The mother gets out Mark's toys while the father sets the table and Jennifer occupies herself. The father starts to serve food and holds out a plate to his daughter who lets it fall. The father cries out « you've dropped everything ». The little one says « no, nothing fell down ». Then she refuses the plate that her father offers her again saying that she doesn't want any salad. She takes a plate and goes to serve herself something else. The father then offers the plate to the mother. She takes it but makes a disgusted face « it's a bit wasted, this salad » and there is an exchange of smiles between mother and daughter. The father serves Mark but he doesn't take the plate and carries on playing. Jennifer takes some coffee and says it is rather strong. The mother says the coffee isn't for her and tries to take the cup away but the daughter says it is hers and the mother leaves her alone. The mother asks if there is some dessert and the father suggests gathering some strawberries but the mother replies that it is too hot. Jennifer takes her swimming stuff and sets out to swim. When the mother tells her not to put her head under the water, that is what she does. The mother declares that everything needs to be tidied up but Mark refuses to help. The father tells the mother that there is no hurry. When they leave, the mother doesn't want Jennifer to carry the basket with the dishes but she doesn't take heed. The mother insists and demands that the father not let her carry it because it is very heavy. The father says « It's not important » and doesn't intervene.

Analysis: The game tells a rich, coherent story but the younger child is not always integrated. Several conflicts emerge and a mother-daughter coalition against the father can be seen. Co-parenting is weakly coordinated or even conflicting with uncertain limit setting. There is no sharing of affects among them all.

These four contrasting descriptions show the richness of observation that can be achieved in these semi-standardized and complementary situations concerning the information they provide.

Discussion

Although both situations are play-based, inviting shared pleasure and creativity, they present important differences. The LFP provides a relatively constrained framework : the table and chairs as well as the closely defined positioning of the partners (parents on each side of the children) determine the distances between partners and, partly, their orientation. Again, a scenario defines everyone's roles (active or third-party observer) and the partners with whom they interact in each part. Only the content of the game is left up to the family's imagination, even if the toys are imposed. By contrast, in the JPN the framework is much more free since the partners are invited to organize themselves as they wish ; they prepare the picnic they want ; the meal may be taken on the ground, on the bench or at the table, before or after a phase of play with the toys. The partners settle beside whomever they wish and move around as they choose. And so on. Again, the PNG is based on a real life situation but strongly formalized which allows observation of the « habits » of the family (setting the table, tidying, eating etc.)

Remember too that there is no lower age limit for the PNG whereas the LFP requires that the youngest children are able to sit upright (in a high chair). Finally, it is difficult to stage an LFP with more than three children which is not the case with the PNG in which one can even include grandparents or other family members.

Overall therefore, the LFP offers a more rigid framework for interaction than does the PNG. This stricter framework is more suitable for some families than for others and allows us to see how a family may cope with the adaptation to a constrained framework which can be stressful. For some of them, the scenario and the obligatory body position (seated) appears as a limiting obstacle that prevents the game from unfolding. For others, who manage to overcome these limitations, exchanges unfold at verbal and expressive levels and the family members manage to enjoy themselves – which demonstrates good flexibility in a family system that manages to adapt to new situations. However, it should be noted that, on the contrary, some families presenting difficulties in coordinating themselves seem to benefit from the imposed framework as guidance that structures their games. In this case, the situation gives valuable information about the family's resources and its ability to improve its functioning when the offered context is structured.

With its « pretend » aspect, the PNG is greatly appreciated by certain families who manage to draw back from the context of observation and let themselves play and enjoy themselves together, but less by others who are perhaps more embarrassed to playact or ill at ease with symbolic games.

The perspectives of these two games are also quite different. Given that, in the PNG the families have freedom of movement and positioning, the images are more generic and close-ups unreliable. On the contrary, in the LFP closer views may allow coding of gaze and emotion more easily.

During video feedback the respective content of the LFP and PNG facilitate the start of discussion of different subjects ; with the openness of daily life (task sharing, meal-time rituals, limit-setting for children etc.) offered by the PNG and the window on symbolic games and the capacity to share pleasure given by the LFP.

These particularities, specific to the two games, emphasize that they are complementary and offer a sound basis for using them together as much for clinical as for research evaluation.

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Reconsidering parental sexuality, and infant sensual excitement and greed: what is lost in infant mental health without these concepts?

By Frances Thomson Salo and Campbell Paul

> '... the sexuality of care so the children would be confident and safe during the night" (Michael Ondaatje, 2000)

Introduction

We suggest that in infant mental health some important concepts - those of parental sexuality, and infant sensual excitement and infant greed - are relatively neglected. We think this is a significant gap and we describe some manifestations. We also think that Infant Mental health therapists and classical psychoanalysts often seem to describe different theories about infant sexuality in the earliest years, although the former generally show more awareness of expressions of infant anger and rage (particularly in feeding difficulties). We are curious about this and invite readers to consider the implications and complexity these concepts add.

We would especially like to acknowledge Dr Ann Morgan's contribution to this paper, as well as that of the Infancy Group of The Royal Children's Hospital, Melbourne.

We define the terms briefly as follows and discuss them more fully in the course of the paper. By 'parental sexuality' we mean that quality in a parent of being sexual and capable of sexual feelings. By 'infant sensual excitement' we mean that quality of excited gratification that might have an intensely pleasurable if not an almost lusty quality to it. By 'infant greed' we refer to intense longing or desire such as in voracious eating and while Winnicott (1975) viewed greed as a normal part of human endowment, parents and therapists often view it more ambivalently. If the concepts of parental sexuality and infant sensual excitement and greed were more widely used, therapists could potentially gain access to a more resonant countertransference as well as a fuller understanding of the parents' history and experience, and that of the infant. The baby as subject with his or her own intense desires would emerge more fully (Thomson Salo & Paul, 2007).

In reconsidering the psychoanalytic concept of infantile sexuality in the first year from an infant mental health perspective we suggest that the connection between the mother and the infant can be highly exciting for them both. This connection is needed to start the baby as a person off well. For the processes of separation-individuation and reflective thinking to fully take place, both mother and infant need to pull back from the other. The connection may have been erotic for the mother but the exciting and functional aspects of feeding need to be porously separate for her in particular. If she cannot make the turn back to the father, there may be a pull towards an intimacy with the infant that could border on being perverse (Welldon, 1980).

We do not discuss the contribution of environmental and genetic factors (such as the baby's temperament and personality). We are also aware of the cultural limitations of our present perspective and nothing we say should be taken as blaming of parents.

When the care of infants has hindered a healthy investment in their bodies a number of important clinical consequences may follow. For example, with babies in Neonatal Intensive Care Units, the many traumatic oral interventions often lead to difficulty in feeding. If therapists recognise the totality of the infant's bodily endowment, they could then focus on helping the infant find the excitement in feeding as much as on questions of technique and attachment. It may be helpful here to give a vignette of an infant with feeding difficulties. We return to feeding difficulties at the end of the paper.

Clinical vignette: Harry

Harry, aged 17 months, is the second son of a young couple whose respective families live overseas and interstate. The presenting problem was that Harry was solely breast-fed and took no other nutrition. He refused the bottle and other solids and he did not mouth objects or toys. Attempts to encourage him to feed orally other than with the breast were unsuccessful. His growth and development fell away dramatically at around 13 months of age. At the time when Harry started to lose weight, he was feeding at his mother's breast constantly. He would have a breast feed up to 25 times each day. It seemed that both mother and infant were in a pattern where the breast was symbolic for everything: comfort, settling to sleep, food, closeness.

Perhaps for his mother the breast became a way of having him 'disappear'. For Harry too, the breast was not an exciting, stimulating or nutritious source of energy or vitality or life, but also a way for him to plug himself up and disappear. Part of the task of the therapeutic intervention had been to try and help Harry develop some desire of his own. It seemed that his mother was missing aspects of an adult relationship with her husband that had previously been missing in their relationship. While there were aspects of the couple relationship that were not known or understood, it was known to be tense and difficult at times. The mother also felt very depressed at times. She seemed ambivalent about Harry (she may have wanted a girl). Harry's father, during a feeding intervention when Harry was demanding the breast, made a joke about the ownership of the breasts - that they belonged to the father.

Parental sexuality

We only outline what has been observed of parental and infant sexuality, rather than their fantasies. A mother's sexuality may be expressed towards her infant in her pleasure in breastfeeding, which can be highly exciting for them both, as Swain (2008) indicated in discussing neural circuitry. There is a surge of pleasure toward the baby from the mother which starts him or her off well. Babies who are cuddly and clinging in a moulding way are described as cute. Sometimes the contact with the baby where mother and baby are almost eating each other is highly sexualised; for the mother it may be more exciting and important than anything she experiences elsewhere. As Ann Morgan (23.4.08) said, "It is pretty powerful because it is private in the nursery." Friedman (1996) noted that breastfeeding, with increases in oxytocin, involves not only pleasurable

fantasies of fusion with the infant, but may also involve erotic or sadomasochistic fantasies of being tied down to an insatiable infant.

While novelists may describe a baby being the greatest love affair of a woman's life, one father wrote, "I did feel some of my wife's sensual needs were temporarily being fulfilled by the little one. The pair of them had a connection you could almost describe as erotic, it was so physical and intimate. Sometimes this rankled with me; mostly, however, I realised that everything was just as it should be" (Molitorisz, 2007, p. 23). The baby 'excites her but frustrates – she mustn't eat him or trade in sex with him' - one reason she may 'hate' her baby (Winnicott, 1949, p. 74). Because of a mother's preoccupation with her infant, she may initially be rejecting of the father.

Ann Morgan (4.9.07) elaborated the dilemma, "When there is a real connection between the mother and the infant, it is highly sexual - the dilemma is that the baby needs it, but what does the mother do with it? - because fundamentally she has to desexualise it. It starts with the sexual excitement on the mother's part, and the baby has to give place to the father, and the father has to claim it back from the mother. For the mother, everything is sexual but she represses it. The only way for the mother to pull back is if she reawakens the sexual connection with the father. She needs to break it, to withdraw what is exciting, without upsetting her baby's pleasure and mastery in the feeding and in his or her relationship to the body. The baby has to give it up and struggles with that, especially in the next 12 months. For the process of separation-individuation and the process of thinking to take place, both mother and baby need to pull back from the other. It is partly out of an awareness that if the baby is going to go into the world, they have to face giving it up."

But there is a relative societal de-erotization of motherhood because of anxiety generated by the erotic mother-infant dyad (Mann, 1997. See also Lebovici & Kestemberg (1993) on the distinction between 'sacred' and erotic breasts).

The father's sexuality and the baby

The father wishes to reclaim his wife sexually, and the couple often early express a wish to make another baby quickly. When the father comes between an over-close tie between mother and infant, that breaks that exciting connection.

James Herzog, a Boston psychoanalyst, discussing the way fathers interact preferentially with their babies, suggested they tended to be 'over exciting' and tossing the baby up in the air, catching them, tickling them, blowing raspberries, rubbing their beard over their belly (Herzog,1980). He also commented on the ordinariness of some sensual experiences that fathers may have in the handling of their own babies. This is rarely talked about although the Israeli psychoanalyst. Abigail Golomb (pers. com. 24.7.08) said that some fathers report becoming excited when witnessing breastfeeding.

Joshua aged 49, is the father of Daniel, a 14-month-old boy who was diagnosed with leukaemia and spent most of his life in and out of hospital. Joshua and Daniel's mother were separated at the time of Daniel's conception. Joshua visited occasionally as his two older children with the same mother lived with her. It was on one of these occasions that Daniel was conceived, outside the continuity of the earlier marital relationship. Daniel's mother was preoccupied with caring for three other children and found it difficult to look after Daniel with his high level of medical needs. Joshua gave up his job and assumed primary responsibility for his son's daily care. When asked why he had done this, he said, "My son, he is the product of my pleasure: he didn't ask to be born but is my absolute responsibility." For this father, the act of conception and the responsibilities that came with it are reinforced by the presence of his son. The sexual activity of his former wife and himself remained in his mind as he thought about his son.

Commentary on the 'Baby Crazy' video

Two fathers and their wives talk to the interviewer on video about the birth of their children. The first father is from an Italian background. He and his wife are a well-to-do, middle-class young couple who had done well in their careers. His wife explained how she really wanted to experience the pain of childbirth and to scream and yell out and let people know that she was having a baby, just like her grandmother and great-grandmother had done! The father was extremely proud and he talks about the birth of his son and watching him on the bed in the labour ward. He had been taking a video and someone had moved the nappy from under the boy's genitals; he did a big wee, with urine streaming up into the air. His father exclaimed with glee, "It works just like his old man, look at him, just like his old man!", as he commented on his son's penis which had an erection at the time.

Another middle-class, well-educated couple talked about the birth of their first daughter. The father held her gently and kissed her on the head in a sensual sort of way. He related the process of watching her being born out of her mother's body. He said he could see her head coming and then her body and feet. He then said, "I thought something was wrong! I wasn't sure what it was! It looked like there was something missing! And then I realised that she was a girl!" At this point he looked very sheepish and cheeky as he made a joke about the anatomy of his daughter and how different it was from him. He was not shy about commenting on the sex and the physicality of his daughter's body. Indeed when the couple were about to give the baby her first bath it was "daddy" who was going to do it. His wife and the nurses had prepared a bath and he dunked her gently in the water. His wife said, "Don't forget to wash the good bits! They're the good bits down there!"

At least then, it was not a problem for this couple to talk about their little girl's genitals. For them the process of giving birth was still fresh in their minds and they were able to talk about sexual organs. After all, the father had been present during the birth and seen his baby daughter miraculously appear through the canal which had also been the source of her conception. They seemed to have a very comfortable loving relationship and it was in this context that they seemed comfortable to talk about genital sex, even in relation to their baby. These parents were also extremely proud of their baby daughter.

It seems in the context of this joyous excitement about their baby, sexuality is not a foreign or degrading concept, rather it is to be given respectful yet playful recognition as an essential part of life. It seems that both of these couples were comfortable with their own sexuality, making it easy for them to relate to all of their baby's body in an accepting and creative way. These parents appeared well adjusted, thoughtful parents. Our hypothesis is that as they are able to adopt a healthy approach to their understanding of the whole of their baby's body, including their aggression and sensuality, their son and their daughter will have a more integrated and manageable handle on their own 'drives'.

Infant sensual excitement

Infant sensual excitement in the first year is not often reported, although there is less difficulty acknowledging sexuality in the second and third year. 'Babies are wonderfully sensual beings: delicious, soft, cuddly, kissable, touchable, and after two months full of smiles, giggles, and gurgles. They play and tease and suck contentedly.' (Diamond et al, 2007.) With gaze, the opioids kick in, making it one of the most powerful experiences. This basis in sensual excitement can be so intense - the love in the infant's eyes by 4 months of age can be almost embarrassing for an observer. Sensual excitement in the whole of the infant's body is different from that in masturbation as there is the joy of finding the other.

i) Skin erotism

The mother's 'sensual enveloping stimulation awakens the infant's sexuality ... playing, patting, stroking, diapering, cuddling, clinging, kissing and holding and gazing' (Diamond et al, 2007: pp.9, 16). The infant's desire is reignited by the mothers' enjoyment of caring for their body, particularly the erogenous zone of the skin.

ii) Breastfeeding

The intense pleasure that can be present when the infant is held to feed by his or her mother is sometimes whitewashed, as for example when it is referred to as 'nursing'. This is not to devalue bottle-feeding, but rather that we are tracing one particular line of bodily sensuality. Babies can suck just as lustily and greedily at the bottle.

Feeding is an interaction between two people. Winnicott described the breastfeed from the baby's perspective: 'The baby eventually gets the illusion that this real breast is exactly the thing that was created out of need, greed and the first impulse of primitive loving. Sight, smell and taste register somewhere, and after a while the baby may be creating something like the very breast that the mother has to offer' (1964, p. 90). A 6-month-old baby was described by his mother as "being into her breasts" as if it was sexual. One baby who fed at the breast with excited, almost ecstatic sucking, her eyes almost closed, was observed to become a sensual, wriggly toddler. (We do not discuss excited biting at the breast where the overlap with the baby's aggressive wishes may be more easily observed.)

A mother's enjoyment of breast-feeding

But for the mother, breast-feeding may have a similar powerful sexual, sensual set of associations. How does she accommodate these feelings without feeling guilt or that the act of breast-feeding is forbidden or dirty? For women who have been sexually abused, however, and that may be a significant percentage of mothers who are referred for therapeutic intervention, the breasts may be inextricably caught up with the experience of earlier abuse, with resulting shame and confusion.

iii) Sensual thumb sucking

While many babies use thumb sucking as a comfort to ground themselves, we rarely hear of very young babies engaging in sensual thumb sucking, apart from Piontelli's (1992) account of the foetus who was observed licking the placenta, and after birth sucked her thumb with a passion close to that of a love affair.

iv) Masturbation

Therapists and infant observers rarely report masturbation in first year but at some point then babies usually discover their genitals and if they have the opportunity will explore them with pleasure, touching and rubbing them. Fonagy (2008) reported a survey in which all the boys' mothers reported erections in their sons from birth onwards and 80% of the mothers of girls reported genital excitement in their daughters from 3-6 months onwards. One observer noticed that 6-month-old babies clearly enjoy being massaged around the scrotum in a way that was different from being massaged elsewhere. Another mother reported that her 12-month-old son, while on the breast having "a lovely time playing with the nipple", would often reach down to his genitals to fondle them with a look of delight. And Ben Bradley (pers. comm 23.4.08) reported an 8-month-old girl in one of his babies trio groups who while looking at a boy with desire would swiftly reach her hand down to her genitals, with a sense of this being somehow sexual. Fonagy (2008) suggested that mothers do not mirror or mark sexual excitement, unlike the way they may mark other emotions. Presumably this is part of reining back the sensual 'surge' which can be safely contained in a discreet way in breastfeeding.

v) Giggling, tickling, driving the infant to a climax of excitement

At times this may seem to have an intensity consistent with an orgasm. Sometimes watching a person being tickled leaves the onlooker feeling very uncomfortable. Is this sometimes the case with babies being tickled? Are we projecting into this situation something sexual? Is it likely to be sensual, of the order of intensity of an adult experiencing a climax of sensation?

Infant greed

Do therapists view greed pejoratively as negative, as one of the 'seven deadly sins'? A parent recently expressed the view that she was so desperate to have a baby, to have someone to be with, love and care for, that her desire felt bad. It was as if her greed and selfishness in wanting to have a baby constituted a sin in itself.

Winnicott (1975) viewed greed as part of positive normal human endowment and mothers sometimes do, too, seeing it as 'good'. Greed could be viewed as a lust for life, as potentially life-enhancing, and as part of a baby's passionate endowment and wanting to be related to others. Antoine Guedeney, (pers. comm., Aug 2008), saw it as 'good' aggression.

In discussion with the author, Alexander McCall Smith, regarding his character, Bertie, he reminded us that the mother said, "When you were a little baby yourself - and remember, that's just six short years ago - yes! 6 - you tended to be - how shall we put it? – guzzley.. and you bit mummy a little hard, making mummy a little tender. You don't remember that, do you? (McCall Smith, 2007)."

Discussion

While the Infant Mental Health 'baby' is often viewed as arriving as if born with many remarkable cognitive capacities (which Liam O'Connor (pers. comm.) once referred to as having an Apple Mac quality), this is different from the sexuality which the classical psychoanalytic orientations view the infant as possessing, and from the sensuality explored here.

If infants enjoy breastfeeding and enjoy their body generally, this would be a good basis for their sense of identity, self esteem and enjoyable sexuality. The British psychoanalyst, Rosine Perelberg (2007), wrote that, "The 'right' amount of erotism is crucial, so that it is not too much, overexciting the child, or too little, without an erotic investment for the baby, which is also so crucial for its relationship with its own body."

A 'sensual-sexual system' has been suggested to operate in the first year as a signal system that helps in building secure attachment (Diamond, Blatt & Lichtenberg, 2007). And Lichtenstein (1977), linking sensuality with identity, wrote: 'The 'non-procreative sexuality' with its emotional eroticism between mother and infant helps the creating of the child's identity through

the heightened sense of being that comes with sensual experience.' Some therapists suggest a bidirectional influence between sexuality and attachment. Security or insecurity in one system affects the other system (Holmes, 2007; Lieberman, 2007).

It often seems easier to see the relational aspect of babies' dyadic and triadic relationships, rather than their sensual nature in their passionate attachment: "I need and love YOU." One father asked the Maternal and Child Health Nurse if his 4-month-old son could be jealous of the parents "being intimate" – when the baby was lying on the bed beside his parents he cried loudly whenever his father touched his wife's breasts (McWilliams, pers. comm.14.8.07). Male observers have reported 15-week-old girl babies acting flirtatiously with them. And while gender often seems relatively ignored in Infant Mental Health in the first year, yet by 6 months there is often a difference in the quality of the sensual excitement with which babies respond to adults.

More resonant countertransference and a fuller understanding

Being more aware of parental sexuality, infant sensual excitement and infant greed can lead to a more nuanced view of the parents' and infant's history and development. Therapists are less likely to feel that some infant sensual manifestations are inexplicable or just 'autoerotism'. A medical practitioner did not want to think about having seen a mother apparently absent-mindedly gain pleasure in rubbing her 10-month-old daughter's genitals when cleaning them. But if we can think about it, we might understand better the experience parent and infant share.

Greater awareness of parental sexuality, infantile sensuality and greed help attune more accurately to our countertransference and to interpret from it. For example, the child psychotherapist, Stella Acquarone (1987), described having sexual thoughts about a tiny baby and using these to frame an interpretation which reached the mother affectively and began a helpful intervention. Baby Janet was 5 days old, did not want to feed and was losing weight. Acquarone looked at the baby and thought, 'What a sexy face!' which she decided to say. The mother asked, with tears in her eyes, if this was normal and said that from the moment the baby started sucking her breast, she felt very aroused sexually which was a very confusing experience, and full of frustration. She would reject the baby and felt the baby hated and rejected her in turn and refused to suck from the breast. Acquarone thought the mother was very vulnerable and felt like cuddling her, and suggested that perhaps she would like to be held and cuddled. Acquarone also suggested that perhaps the baby was experiencing the same sexual feelings as her mother. The baby immediately started to feed better and both mother and infant began to enjoy breastfeeding. The Health Visitor reported that the mother's understanding of her infant increased.

If an infant is viewed as inherently joyfully sensual, the driven or defensive nature of some symptoms might be understood differently. "What is important is the separation of the child from the mother, it's got to be from a sexual base – it excites them together. The baby doesn't think of it as sexual, it's the connection with, and the joy in the body and the nipple in the mouth which is climactic, and both have to give it up. The absolutely dynamic and important way that separation comes about - how do you separate but still love and be loved? One mother said, 'It's so, so, so frightening'" (Morgan, pers. comm. Dec 2007).

An infant who feels desperate because of separation anxiety or abuse might use sensuality defensively to preserve the possibility of health. A baby boy only sucked from one breast for 18 months as a way of coping with his anxiety. If infants get stuck in an autoerotic pattern (such as sucking their own tongue or skin) this may be a way of staying emotionally alive until therapy is available (see McDougall, 2000, in connection with adult patients).

What can go wrong?

Depression attacks the excitement in the other. If the mother is not in love with her infant and the infant with the mother, they do not feel close and the infant turns away. If the infant does not expect this pleasure with the mother, feelings are dampened down and the interaction becomes asexual. This disappointment with the mother may affect later sexuality.

The British analyst, Malcolm Pine (1985), discussed a link with false self development. 'Depressed mothers can only reflect a joyless lifelessness and, unable to mirror other feelings, may evoke in response from the infant a false self, which is depressed in compliance with the mother….. Later on in life this split between the true and false self may appear in the form of sexual difficulties…. The "true self" core may cry out for recognition, often through a symptom of sexual difficulty in which exists the sex that speaks for the buried central lost self (p. 24)'.

Motherhood may open the door for a woman to experience a perverse development, to use the infant, whether male or female, as a sexual object with which to excite herself. If she cannot make the turn back to the father, she may become stuck in a perverse state of mind. (Welldon, 1980). It is possible that the erections that some fathers' experience around their newborn babies, as reported by Fonagy (2008), may also open a similar door.

How are the concepts of sensuality and greed helpful with serious feeding difficulties?

A mother shows her love for her baby in the experience of feeding him or her. When there are feeding difficulties, the fate of the baby's erotism is crucial. Being more aware of this may give us additional ways of intervening:

- One mother, for example, asked why her baby did not drink from the bottle. The therapist said "Why would he? He is missing the softness and pleasure of the breast" and his mother said, "Good boy", patting him and the difficulties eased (Meehan, pers comm, 2007).
- When mothers experience shame, disgust, anxiety, rejection, impatience and anger during breastfeeding, therapists may aim to help them develop some pleasure. As part of an intervention we might convey that breastfeeding could be enjoyable, implicitly holding out hope that it might be possible in the future.
- An important clinical application is with babies in Neonatal Intensive and Special Care Units, whose sensual excitement and greed are often affected. The handling that they have received may have prevented or distorted healthy investment in their bodies: they may have experienced many traumatic procedures to their mouths, and when expected to breastfeed show little excitement which often leads to difficulty in feeding. Rather than focus on questions of technique, such as latching on, therapists could focus on helping the infant find the excitement in their mouths and in feeding. "The infant who is on a nasogastric tube does not have to work for the feed which normally results in the turn to

the mother. With a tube, it is too hard to make this turn to the mother and (as with masturbation) the infant does not have to think of, and rely on, the other" (Morgan, pers. comm. Dec 2007).

- One important clinical consequence is a mother's difficulty in experiencing pleasure in breastfeeding an infant with a birth defect in the sexual organs.

Other issues

- Another important clinical consequence might be the impact of a parent's distorted sexuality and aggression on their infant's sense of gender identification contributing to gender identity disorder. (See Coates & Moore [1997] on the development of gender identity disorder.)

- Other extreme examples of when parents' distortions of sexuality directly impinge on the infant include mothers with a history of having been sexually abused who become extremely anxious about their newborn baby's sexuality, projecting distorted ideas directly into the moment-to-moment care of their infant. One mother became emotionally detached from her infant and developed a severe obsessive compulsive disorder with frequent checking and rubbing of her daughter's genitals. This girl's sense of self was significantly disrupted.

Attachment is lifesaving, but to ignore the sexuality of the infant and their parents is to do so at their peril. This is not to say that we must talk about sexuality without discernment! Or we may not talk about it at all with some infants and their families. However, it must be something that is available to be used within the space of the mind of the therapist. In infant-parent therapy, we need not necessarily act upon these apparent desires of the baby and parents, although sometimes connecting with an infant, facilitating his or her sense of aggression or excitement or arousal in the presence of the parent may be most helpful. The psychoanalyst, Antonino Ferro (pers. comm., 2008), described an analogy of the therapist's mind as a kitchen where many things slush around in various states of preparation but the therapy work itself is out the front restaurant, where a properly thought-about and prepared meal is presented to the diner. So we should be able to reflect upon the issue of sexuality in a way that is helpful to the infant and the parent.

Conclusion

Infants need a healthy concept of their own body developing from the beginning. This means allowing for their own feelings of excitement, exuberance, aggression, sensuality and sexuality. These feelings should be able to be experienced and accommodated, not feared, repressed and subject to re-emergence later in the course of development. They should be able to be accommodated in a way that desire is not experienced as disorganising (or as sinful). Therefore, including these concepts in our approach is not only an academic exercise. Rather, it should be helpful for infants and their parents as they battle the ups and downs of development in a world where sexuality and aggression are responded to with intense ambivalence and, where there is profound duplicity, with even more shocking results. If we avoid the concept of sexuality in our work with infants and parents, it could leave the parents with an unnecessary burden, which is not expressed and not able to be worked through. This may also leave the infant with a distorted sexuality projected into them. Repression of the excitement, greed and related feelings, similarly as with repression of 'drives', is not necessarily in the service of the individual and society.

To summarize, being more aware of the concepts of parental sexuality, and infant sensual excitement and infant greed and how they affect infant and parents in mutually reinforcing ways, both positively and negatively, could extend our understanding and assessment, particularly information coming to us from our emotional responses and countertransference. In this way it could help us design interventions that might be experienced as not only more helpful but also more empathically resonant with the whole person of the infant and their parents.

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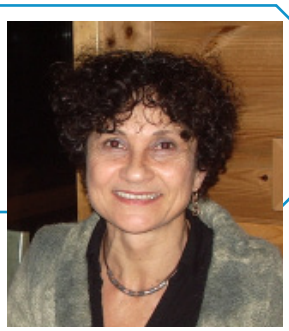
Editor's Perspective

By Miri Keren, M.D.



Infantile sexuality and family functioning: Is there a link?

The papers in this Issue about parental and infantile sexuality, ways of observing family functioning in general and, more specifically ,in the case of maternal post partum depression, may look unrelated. Actually, from my perspective, they are related.

To start with, as Frances and Campbell wrote, not only is the individual parent's own sexuality in play with the infant's libido, but also the conjugal relationship. The topic is mainly unspoken, because it may underlie incestuous and homosexual urges. Still, in our clinical practice, we may find those cases where sleeping difficulties and/or prolonged breast feeding in fact reflect the parental (often, but not always the mother's) difficulty to "separate but still love and be loved" on the body level, in the context of an unsatisfying conjugal relationship. It may be difficult for the clinician to raise the issue, in part because parents who come to infant mental health professionals are reluctant to think deeply about their sexual relationships and unconscious fantasies, preferring to formulate problems, such as breast feeding and/or sleep problems, as inherent in their infant's characteristics. This is where the Lausanne Triadic Play and the Lausanne Family Picnic, as observational tools, become interesting. These very structured procedures often open a window to unconscious, non verbal, processes that underlie the observed parental behaviors. For instance, the fourth part in both procedures, reflect the conjugal relationship, regardless of the content of the parents' talk. In our experience, "forgetting" to do the fourth part often unconsciously reflects a significant conjugal difficulty. In some cases, prolonged breast feeding may not only be the consequence but the cause of the marital discord, when the father unconsciously reacts to the eroticism embedded in the mother-infant interaction. We have also seen the opposite situation, where father's co-sleeping with his infant daughter had a veiled sexual connotation, and was related to a disrupted marital relationship, for instance secondary to postpartum maternal 'blues". Some women actually have sexual relationship mainly to have a baby, and lose interest in their husband after the child is born. Taking care of the baby then becomes the mother's pretext for keeping her distance from the father. Single mothers may be at a greater risk than partnered mothers of unconsciously erotizing their relationship with their infant, when their single parenthood is the result of intrapsychic difficulties with sexuality and intimate relationships with men.

And what about our own counter-transference? In order to discover those situations where the infant's symptoms actually reflect erotic investment in the parent-child relationship in the context of a disturbed marital relationship with unspoken sexuality issues, we need first to be aware of our own thoughts and feelings about an infant's sexuality.

More generally speaking, we definitely need to think more in terms of looking for links between infant's symptoms and family functioning (Mc Hale, 2007; Keren et al, 2010). Family functioning may be assessed with observational tools that open windows to unconscious processes and with semi-structured interviews (such as the McMaster Family Functioning Interview (Epstein et al, 1978), that reflect the family members' conscious perception of their own relationships and functioning. For instance, in our clinical practice, we have found that looking at the parents' body formation during a triadic session often opens for us a window to their unconscious, or at least unspoken, feelings one towards another, towards their infant, as well as towards the therapist. In parallel, we have learned to become more aware of our own non-verbal body language, towards each parent and towards the infant: Where we sit, how much we lean forward, towards whom, how much distance we sit one from the other. The videotaping of such sessions is very useful for reflective supervision on these complex parallel processes.

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News from the WAIMH Affiliates Council

Affiliates Corner May 2011

First, we want to extend our deepest wishes and support to colleagues and families in Japan who are amidst managing the aftermath of the devastating environmental crises. In addition we know that many of you have contributed to funds to support the re-building efforts and we thank you for this.

Second, over the next couple of months the Presidents of each affiliate will be sent a survey to complete with their Executives, on behalf of their affiliates. This survey aims to construct a clearer picture of the training and educational needs of affiliates, to facilitate knowledge-sharing across affiliates and to find ways to bolster WAIMH membership across affiliates.

Third, you may have noticed the word is now out regarding WAIMH Congress, April 2012 in Cape Town, South Africa. As plans unfold, there is much evidence to suggest that this is going to be a wonderful richly textured congress. Abstract submissions are open as of 1 May and we encourage each of you to consider submitting an abstract or participating in other ways to the success of this Congress.

Finally, we are always keen to hear from any of you about the activities/projects that you are engaged in. Big or small, it is news to be shared through the mailing list that is actively managed by the central office at office@waimh.org. In addition, if there is an issue that you want support with, drawing on the collective wisdom and expertise of the affiliates is another way to express our shared membership.

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

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The pediatric consultation: A first encounter with infant mental health

Affiliates Corner

By Nahir Bonifacino (Psychologist, Psychoanalyst), Dora Musetti (Child Psychiatrist),Andrea Plevak and Magdalena Schelotto (Pediatricians), Uruguay

Introduction

This project is being carried out in Uruguay, a little country located in the south of South America, between Argentina and Brazil.Uruguay has a population of 3.300.000 inhabitants and half of them live in the Capital City (Montevideo).

At present, substantial changes in the Public Health Policy are being introduced in our country. There is high interest in the implementation of programs for the promotion of health and education about health at the primary level of care. These programs, many of which are already in progress, are especially aimed at infants and their families. Tools and training to detect early indicators of deviations from healthy development are very useful for the purpose of these programs.

Our project offers the possibility of early detection of risk indicators in healthy emotional development during the first years of life. We are part of an international network of teams working with the Alarm Distress Baby Scale (Alarme DétresseBébé, ADBB) under the supervision of Prof. A. Guedeney, Paris, France. One of the main goalsof this projectis to intensify the application of an interdisciplinary approach (pediatricians, day care center staff and infant mental health professionals).We wish to promote a more integrated perspective of the infant's health by expanding the knowledge that pediatricians have about healthy development in the first years of life. In this way these professionals can become agents of health prevention and early detection.

All the children in our country attend

monthly pediatric consultations during the first years of life. This makes the pediatrician the professional with the closest contact with the baby and his/her parents, and, as a result, he is an important reference for the parents. This project considers this regular pediatric consultation as a first approach to infant mental health.

With this in mind, we offer pediatricians a training with the ADBB scale which has been validated by several teams in different countries and is easy to apply after a brief process of training. This instrument, which we hope is user - friendly, consists of a systematized observation of the baby that has been elaborated for the early detection of risk indicators in emotional development (A. Guedeney, 2001).

In case indicators of risk are detected, and once any possible organic cause for this situation is discarded, this project intends to provide the pediatricians trained in the use of the scale with resources that will enable them to carry out an intervention. These interventions, oriented by the results obtained in the application of the scale, will be implemented in the course of the following regular pediatric consultations and they will be aimed at improving the general condition of the baby. This will be developed further on in the text. The scale will be applied again to these babies, five months after the first application, in order to reassess their condition. This will give us a hint as to how effective the intervention was.Those babies who display signs of severe sustained withdrawal will be referred for further more specific evaluation in view of the high risk this may imply for their healthy development. The general aim of the project is to promote an interdisciplinary model of early intervention for infants at the primary level of care.

Objectives

General objective

Early detection of risk indicators in early emotional development in babies aged between 2 and 24 months, during the pediatric consultation.

Specific objectives

1) Early detection by the interdisciplinary teamof withdrawal signals in infants aged between 2 and 24 months using the ADBB scale. (Alarme Détresse Bébé. Guedeney, 2001)

2) Training pediatricians in ADBB scale and the provision to them of the necessary resources to implement an intervention with the babies who showed withdrawal signs. These interventions will be oriented by the result obtained in the scale.

3) Evaluation, of the degree of reversibility of the withdrawal signs as a likely result of the intervention through the pediatricians.

4) Expansion of the application of an interdisciplinary approach and promote a more integrated perspective of the infant's health, making pediatricians aware of the infant emotional life and expanding their knowledge about healthy development in the first years of life.

Background

Over the last few decades, the study of the emotional development during the first years of life has become more and more relevant. Different investigations about several aspects of early infancy have agreed in considering this period as especially sensitive and essential for the development of the human being (Bowlby 1969, Brazelton 1975, Stern 1985, Guedeney 1997, Fonagy 2002).

These studies that came from different disciplines, have allowed health professionals to improve their knowledge about factors and conditions that promote or hinder a healthy development. It has been a challenge for health professionals to put these new scientific advances into practice in the creation of useful instruments for their application in the early detection of health problems during the first infancy.

Video-recorded observations of interactions between mother and baby (Brazelton, 1975) and "still-face" experiences (Tronik, 1978) among others, have shown a baby who has capacities from the very beginning, can show initiative in the interaction with the environment, and has a special sensitivity in the relationship with the other, but at the same time has a very limited range of resources to react to interaction disturbances: protest and withdrawal.

Withdrawal has been considered a natural defense mechanism used by the baby since his first moments of life, in order to regulate the interaction (Brazelton, 1975). But, in certain situations, this resource becomes permanent in the infant's interactional pattern and inhibits the infant's capacity to be engaged in an interaction with his environment. This situation could hinder the infant's physical, cognitive, affective and social development, because the unfolding of his potentialities – in Winnicott´s words - requires, among other conditions, his own active participation (Winnicott, 1960).

Withdrawal in the infant is a sign that points to a disturbance in the dyadic relationship that the baby isn't able to solve properly (Guedeney, 2004). This disturbance could have different causes that will have to be investigated, and may have its origin in organic or relational difficulties to be found either in the parents or in the baby, or in a failure in the synchronization between them.

This research project assumes that withdrawal, as a clinical phenomenon, is a first symptom of pathology in infancy: depression, developmental delay, attachment disturbances, anxiety, post-traumatic syndrome, sensorial difficulties, abuse, etc (Guedeney, 2007), as well as a sign of a potentially dangerous medical condition. This constitutes an important indication of risk for infant development. The progressive nature of its installation in the baby's relational pattern makes its early expression hard to detect and easily overlooked in the clinical observation without the help of a specific instrument to detect it. All this justifies the use of the ADBB scale (Alarme Détresse Bébé, A. Guedeney, Paris, 2001) which offers an organized and systematized look at the baby, in order to detect early signs of withdrawal which may be the first indicators of a possible future pathology.

Methodology

Participants

ADBB scale was administered to 73 babies from two populations between the ages of 2 and 24 months according to the range of age in which the scale was validated (Guedeney &Fairmann, 2001).Half of these babies attended their pediatric consultation with one of the pediatricians of our team in a Primary Level Medical Health Center of the metropolitan area of Montevideo, which is dependent on the Public Health Ministry. During four months all the babies within this range of age who attended consultation were evaluated.

The other half was integrated by all the babies between the ages of 2 and 24 months who attended the Day Care Center

of the main Public Pediatric Hospital in Montevideo. In the latter case we offered the parents an evaluation through a pediatric consultation that was performed by another pediatrician of our team.

In both populations only healthy babies were included in the project in order to reduce the number of variables to be considered in this sample. Premature and sick babies were excluded. Both populations of infants belonged to families in the average or below average social – economic layer of our society. An important difference between the two populations was that in the case of the Day Care Center, all the babies spend six or more hours a day in the center. Meanwhile, only 9% of the babies from the Medical Health Center attend a one–hour weekly workshop in a Community Center with their mothers. We had no control group, and this is a main limitation of this pilot.

Instrument

ADBB scale is a simple instrument, as far as time and resources are concerned, making the scale accessible for different health professionals after a brief training process and easy to apply in an ordinary situation such as the pediatric consultation with the parent and baby together. It constitutes a guide for the observation of the baby, integrated by 8 specific items, to be observed by the pediatrician during the pediatric consultation(facial expression, eye contact, general level of activity, self – stimulating gestures, vocalizations, briskness of response to stimulation, capacity to engage a relationship, capacity of the child to attract).Each item can be coded from 0 (no withdrawal signs) to 4 (extreme withdrawal). A total score of 5 or more is considered optimal in detecting infant social withdrawal. (Guedeney & Fairmann, 2001)

This instrument has a good internal coherence (Cronbach is 0.83), and it includes the counter - transferential experience of the professional involved in the evaluation, which provides with a dynamic and clinical profile that enriches the information the tool offers. This characteristic, and its vast possibilities for prevention and education in the field of health during the first infancy, have generated in our team great interest in this instrument.

Since 2001, the ADBB scale has been in the process of validation and use by interdisciplinary teams in different countries, with the purpose of doing research, promoting education about healthy development in infancy with attention to the early developing relationship between babies and parents (www.adbb.net). In South America, this experience began in Brazil in 2004 (Lopes, 2004). In the region of the Rio de la Plata in particular, Argentinean professionals, who have a close relationship and regular scientific exchanges with us, have been working for the validation of the scale since 2006 (Dr. Monica Oliver and Cols. Mental Health Department. German Hospital. Buenos Aires). In Uruguay, the experience with the scale began in 2006, with the work of our interdisciplinary team integrated by a psychoanalyst, two pediatricians and a child psychiatrist.

Procedure

All the babies were assessed during the pediatric consultations with the presence of at least one of the parents. Parents who agreed to participate in this experience were properly informed about it and signed an authorization for the eventual use of the tapes in training and scientific events. The video – recorded material was used by our team for the detection of withdrawal signs through the 8 items of ADBB scale.

Infants with withdrawal signs (score more than 4 in the scale), were evaluated again 15 days later, to confirm the score. If the sesigns persisted the pediatrician first tried to detect organic factors that may be causing them (sensorial difficulties, sickness, severe pain, malnutrition).
If there were no organic conditions, a relational disturbance was considered the possible cause of the withdrawal signs.
If a relational disturbance was the case, we implemented a series of interventions aimed at improving the general condition of the baby. These interventions, oriented by the results obtained in the application of the scale, were carried out by the pediatrician, in the course of the following regular pediatric consultations. The purpose of these interventions is to raise parental awareness of the infant's health and to promote new resources that can strengthen their capacities to facilitate a healthier relationship with the baby.
.Babies with ADBB score > 10, in addition of this intervention, were referred to a more specialized evaluation considering them in a high risk situation for their development.

Interventions

Point to the capacities that the baby displays and draw the parents´ attention to the aspects of his/her development that could be improved in view of the results of the scale.

Promote verbal interchanges with the baby.

Work with the parents about the baby's development to help them support the baby's acquisition of new skills.

Watch the video with the parents, drawing their attention to the initiatives of the baby and to the aspects of his/her development that could be further stimulated and impacts the baby's capacity to interact and enter into a healthier relationship.

Refer isolated or depressed mothers to a community center in the neighborhood so that they can participate in mother – baby workshops.

After the pediatrician's interventions during each monthly consultation, and approximately five months after the first application of the scale, the babies were re-assessed by the team with a second application of the ADBB scale in a new video – recorded pediatric consultation.

Institutional intervention: in the case of the day care center, we hold interdisciplinary working sessions with the caregivers to discuss how to promote the development of the babies in view of the scores obtained in the scale.

Results

The experience of three years in the application of the scale has shown similar results found in international investigations carried out in different cultural and social environments (Guedeney-Fermanian2001; Milne–Greenway–Guedeney-Larroque 2008).

In our research, both populations of babies which were evaluated (Day Care Center and Medical Health Center) showed the same behavioral profile without any significant difference in the square chi (0.068), and therefore the overall study sample included 73 babies (Figure 1).

In this population of babies, 25 % presented withdrawal signs in the first assessment. Minor withdrawal signs (scores 5 to 10) were detected in 19% of the babies, and 6% of the babies presented more severe and evident withdrawal signs (scores > 10).

We could follow up 14 of the 18 babies that had presented withdrawal signs, because of changes in their address or in the place that they receive medical assistance. We couldn´t follow up 3 babies with a score from 5 to 10, and 1 with a score > 10.

In the second assessment, we found that all the babies with minor withdrawal signs (scores between 5 and 10) fully

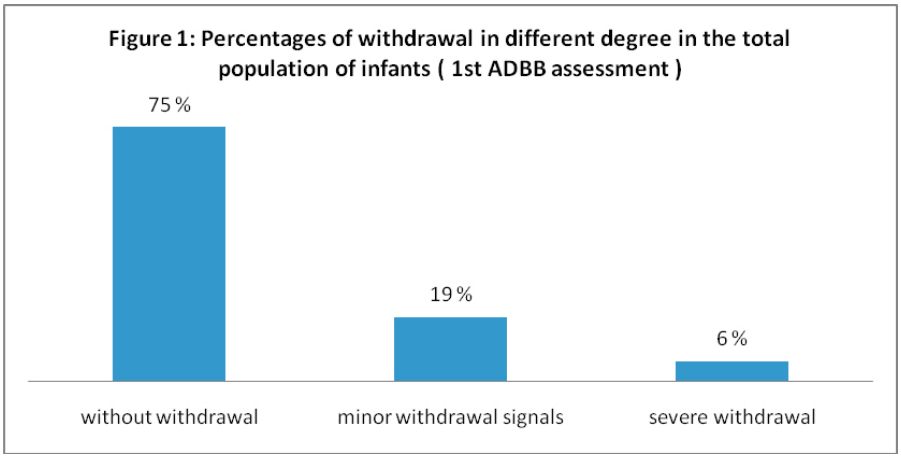


Figure 1: Percentages of withdrawal in different degree in the total population of infants (1st ADBB assessment)

Figure 2: follow up of the infants with ADBB score >4 in the first assessment. Comparative score between the 1st and the 2nd ADBB.

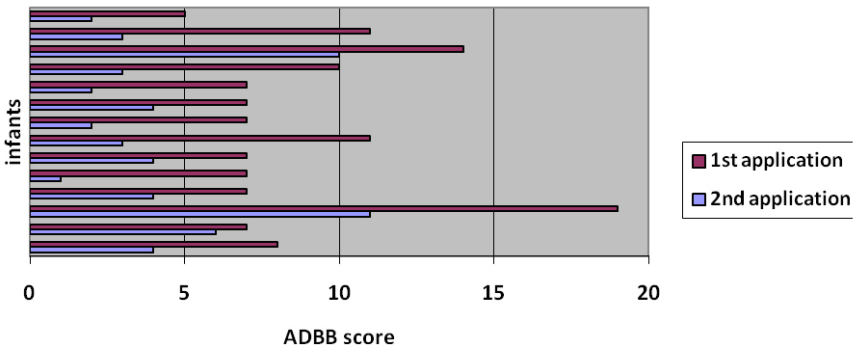
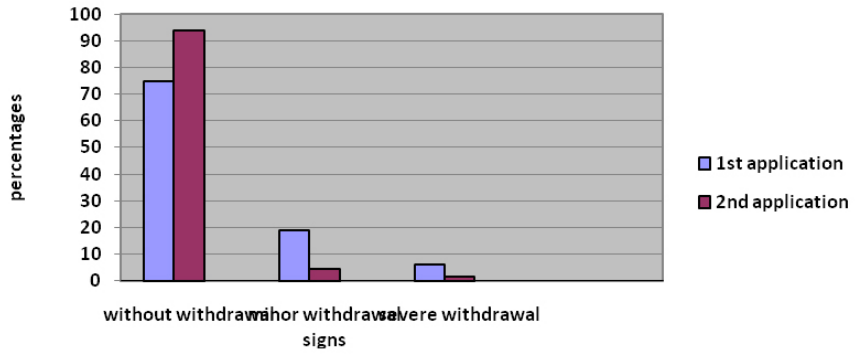


Figure 3: improvement of the overall results after the intervention with the infants who showed withdrawal signs and were reassessed.



improved their condition, except for a baby girl who was undergoing a difficult emotional situation because of the recent divorce of her parents. The effect of the intervention was more varied in the babies that presented more severe and evident withdrawal signs (score > 10). (Figure 2)

To measure the impact of the process of intervention and follow up, we carried out a comparative analysis of the results obtained by these babies in the first application of the scale and in the second one.In the second assessment five months after the first application, we found that all the babies who had first presented withdrawal signs in different degrees (25% of the entire population) showed total or partial improvement (Figure 2).All the babies with minor withdrawal signs (score between 4 and 10) fully improved, except for a baby girl who was undergoing a difficult emotional situation because of the recent divorce of her parents. In the case of babies with severe withdrawal (score > 10) who were in a referral process to be evaluated and eventually treated by specialists, we observed that the effect of the intervention was more varied. Even when in all these cases there was a certain reversibility of the withdrawal signs, in most of them it wasn´t enough to recover the health state of the baby. A more precise study about this population of babies will be worked by the team with a larger population.

If we consider the scores obtained in the second application of the scale, we observe, that the percentage of babies without withdrawal signs increased from 75% to 94%, and the percentage of babies with withdrawal signs in different degrees decreased from 25% to only 6% (with 4.5% of the babies with minor withdrawal signs and 1.5% with major ones) (Figure 3).

Discussion

This study has several limitations. Firstly it is necessary to work in the future with a methodological design that include a control group to try to measure in a more precise way the impact of the intervention in the condition of the baby. We also need to work with a larger population of babies that allows us the assessment and follow up to a higher number of babies with sustained withdrawal signs. We are starting a new study with this purpose.

In our population the percentage of babies with withdrawal signs is higher than the one detected in the studies carried out in France (11 %), Israel (11,6%) and Finland (4 %), but it is lower than the results obtained in Australia (27%). It is possible

to consider that the high percentage of babies with withdrawal signs found in the population we evaluated might be influenced by the socio – economic situation of their families, which could be identified as a population at risk. This hypothesis must be confirmed by further research.

This experience has provided us a first perception which suggests that the majority of the infants with withdrawal signs could present a reversible condition and they could recover their developmental capacities before this situation becomes pathological. At a preliminary glance, this improvement seems to be the result of the intervention and follow up by the pediatrician integrated in a team with mental health professionals, in the primary level of care.

Based on this experience, we observed that once the difficulties detected in the baby are pointed of to his caregivers, it becomes the beginning of an intervention that engender their recognition of new resources that will help at improving the baby's condition. In the future we may offer pediatricians training aimed at deepening their knowledge in the specific items of the scale and being more focused in their intervention to the unique characteristics of each infant and parent.

Conclusions

Through this experience, we have observed that the application of the scale in the pediatric consultation allows for a more global and systematized perspective of infant development and relational capacities. In the context of the services provided to the community of babies and parents in Uruguay, this is a start for increasing the awareness among pediatricians and parents of the infant's needs and development, and of the potential for change.In the light of these preliminary results, we aim in the future to look more precisely at the content of the intervention, especially for those infants with high scores of sustained withdrawal signs.

Acknowledgments

The International Psychoanalytic Association and the Latin American Psychoanalytical Federation elected this Project for the 15th Research Training Program which was held in the University College of London in August 2009, and this participation was supported financially by both institutions. Dr. P. Fonagy and Dr. R. Emde were the mentors of this project. We thanks to their contributions and the ones from the fellows of the program to continue with a new step of our study.

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Advocating for a national policy on infant and early childhood mental healh within the Irish Health Services

By Catherine Maguire

The early years provide a unique opportunity to intervene. Investment in infant and toddler social and emotional health not only benefits the physical and psychological health of our young but also has long lasting benefits for the future of society and the economy (Dube, Feletti, Dong, Giles, & Anda, 2003). Extensive evidence based research, especially neuro-scientific studies stress the critical importance of this developmental period, however its integration into clinical practice within the Irish Health Services has to date, been a slow and difficult process (Centre for Effective Services Report, 2010).

Current legislation and strategy documents (Vision for Change, 2006; The Agenda for Children's Services, 2007) underpinning service delivery, all advocate an early intervention and prevention approach for the promotion of childhood mental health. However, policy documents lack the necessary specificity regarding what precisely this early intervention prevention approach should constitute of, or the model of service delivery to achieve this objective. Furthermore, policies directing clinical practice tend to have a reactive focus following prevalence of pathology or crisis and targeted preventions for infants and toddler mental health have become less visible in service delivery or in budget allocations.

Policies too, struggle to incorporate research and neuro-scientific studies into practical strategies, often policy makers may not having the appropriate clinical backgrounds to succinctly interpret how research translates into practical applications (Nelson & Mann, 2011) at primary secondary and tertiary levels of service provisions.

Similarly, indicators of infant and toddler risk and problem presentations are often not recognised, raising questions regarding training and workforce capacity for all disciplines in frontline clinical service.

It is from this context and the absence of early childhood mental health policies globally (WHO 2005; Shatkin & Belfer, 2004) that a Working Group comprising of Statutory, Voluntary and the Irish Association of Infant Mental Health have now joined together to advance a policy for infant and toddler mental health. It is a first step towards a collaborative working relationship with Government Ministers responsible for the national policies and strategies which underpin health, mental health and children services.

The work of this Group will support legislators and policymakers to translate scientific research knowledge into a strategic policy on early childhood mental health. It is anticipated this document will clearly define and specify the range of services and workforce capacity required to enhance mental health and wellbeing in early childhood.

This work will also be supported at local level by the Irish affiliate presidency, which has commenced a consultation process with fellow affiliate presidents of WAIMH to seek their ideas and experiences to date in developing infant and early childhood policy.

It is anticipated that this process will not only nurture and support early childhood policy initiatives in Ireland, but also stimulate other affiliates to also expand their range of activities towards advocacy.

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Book review

By Yoav Kohn

A Bridge Indeed

Parenthood and Mental Health. A bridge between infant and adult psychiatry (Editors Sam Tyano, Miri Keren, Helen Herman and John Cox, Wiley-Blackwell 2010).

Pregnancy, birth and the first year of life indicate a major transition process - both for the infant, the newly formed human being, and for the adults who become the baby's parents. A bridge is formed between non-existence and existence, fantasized baby and a real person, fantasizing parents and responsible caregivers. A bridge is also formed between the embryo, fetus, newborn, infant and the adults who created this individual and will be responsible for its needs. In "Parenthood and Mental Health" Tyano et al. have indeed succeeded in describing in both detail and depth this unique process. At the same time they have established a bridge between researchers and clinicians who study and treat infants, children and adults.

This scholarly and updated book is a very broad collection of chapters written by top experts from all over the world, describing a wide range of aspects including challenging pregnancies, delivery and infancy from the perspectives of both the infant and the parents. A range of approaches are presented - neurobiological, medical, psychiatric, psychological, social, cultural and legal. Normal and abnormal, common and unique phenomena are addressed. For example, research findings on normal variations in mothers' and fathers' orientation are presented in Chapter 1. Immediately following is a review on research concerning the surprisingly "competent" fetus in regards to its cognitive abilities. A myriad of situations are presented to illustrate the complexity of pregnancy and the effects on the parents' preparation for a new role, the care of infants and development in the first year– single parenthood, surrogate pregnancies, unintended pregnancies, adolescent pregnancies, psychiatric disorders during pregnancy, substance abuse during pregnancy, perinatal loss, and others?"

The second half of the book is dedicated to normal and abnormal processes in the first year of the infant's life. Mishaps such as postnatal maternal and paternal psychiatric disorders, exposure to trauma, poverty, immigration, medical problems in both infant and parents and more are explored.

The book ends with chapters describing the interactions between the infant and parents and treatment modalities to intervene and improve these interactions. The concluding chapter deals with "implication for facilitating 'good-enough parenting' in the twenty-first-century world", namely how the mental health of infants can be improved in resource constrained settings, directly and indirectly, through the improvement of parents' mental health.

The authors of the various chapters present a very updated and thorough review of scientific knowledge, in a clear and easily readable manner. The book is indeed suited for adult or child mental health professionals who do not have a specific specialty in working with infants, and vice versa, for infant mental health professionals with less experience in working with older children and adults. In this manner it stimulates awareness and collaboration between clinicians who treat different family members of the newly born infant. Such a bridge will surely enhance well being and treatment success. It will also promote collaborations between researchers who study different aspects of behavior and development in different age groups - to the benefit of scientific knowledge and clinical practice.

Yoav Kohn, MD

Director, the Donald Cohen Child and Adolescent Psychiatry Department

Jerusalem Mental Health Center, Eitanim Psychiatric Hospital

Hebrew University-Hadassah School of Medicine

President's Perspective

By Antoine Guedeney

Cape Town, 2011

This will be a major event for WAIMH! We very much want to make it a success with a large audience coming from all over the world to meet with our South African colleagues. Much is at stake since it will be our first World Congress in Africa. The goal is to increase our membership and influence there, and to develop training and research exchanges, through a very active South African WAIMH affiliate. We expect the audience to be around 600 people. We very much hope that all WAIMH members and affiliates will be represented.

Palvi Kaukonen, Kaja Puura and I made a site visit to Capetown just before Easter where we met with Astrid Berg and Mark Tomlinson, the leaders of the South African WAIMH affiliate, and with the conference organizer (CO). We attended an infant mental health day in the children's hospital , organized by Astrid Berg, which gathered 90 people from all over South Africa.

Cape Town is just fantastic. It is really Africa's Riviera, plus the warm African welcome and easy way of getting in touch!

It is very safe, with the congress site and hotels just by the seaside or within 5 minutes from the waterfront. We will have the best venue we ever had in a large convention building with a lot of light and space, opening directly on the Table Mountain. Weather at this time of the year is just fine with extraordinary crystal clear light and cool temperature. Organization by local Conference Organizer Deborah McTerr is precise and we will have lunches included on the spot. Of course social programs will include many possibilities: to watch the Big Five (the great wild animals), go to the famous vineyards by the Cape, or to the Victoria Falls. We will have a great gala dinner outside of town.

But the main reason, apart from making a lifetime trip to South Africa, is that what is going on in South Africa related to infant mental health taps directly into our main WAIMH goals. South Africa has been and still is experiencing major societal and political changes. The economy is thriving, but there are many inequalities as well. Immigration from other nearby African countries is huge, with 10,000 immigrants arriving each month. Violence is a major concern, between and within communities. The HIV rate of infection is high. Studies and interventions are very active and provide us with data and propositions that are very welcome to more developed countries that are faced with financial restrictions on the health and prevention systems.

Another reason for attending is that we will be implementing in Cape Town a new frame for exchanges on training during our congresses. There will be a pre-congress training village in the only hospital (Red Cross Memorial) dedicated to children in Africa. We will then have our regular pre-congress day. In Cape Town, the board will meet and new people will step in; we will prepare fro the next congress in Scotland and we will have chosen a stable CO, which should save us time and money. The affiliates will meet and share the results of the surveys actively launched by their representatives, Marin St André and Mary Folee. We will talk about how WAIMH can react and help when catastrophic events occur, such as earthquakes in New Zealand and in Japan.

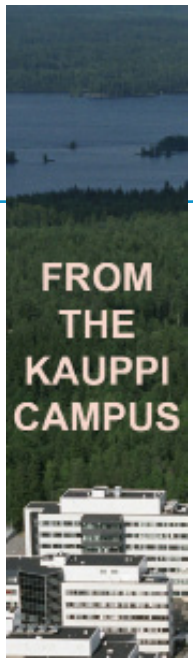
The Program committee PC has put up a fantastic program. We have a lot to do, to share and to enjoy with one another. So get prepared now and I will see you in Cape Town.

Best wishes

Antoine Guedeney

From the Kauppi Campus -News from WAIMH Office

By Pälvi Kaukonen, Kaija Puura and Minna Sorsa



Dear WAIMH members,

The preparations for the 13th World Congress in Cape Town are well on their way and the Call for Papers has been sent out to you all. As has been the WAIMH custom, the president of WAIMH Antoine Guedeney, executive director Pälvi Kaukonen and associate executive director Kaija Puura made a site visit to Cape Town in April 2011. The Local committee, chaired by Astrid Berg, gave us a warm welcome. We also met the leading people from the professional congress organiser, Deborah McTeer and Mohamed Jaffer in the Congress Centre. The Congress Centre CTICC is a modern, spacious and beautiful venue for our congress, with a lovely inside garden in the foyer/restaurant section. This time we can also enjoy our Congress lunches together, as they are included in the participation fee. The highlights of the scientific programme of the Cape Town Congress will be sent to you in the form of Cape Town Newsletters, that will soon start coming to your email-boxes from time to time.

The social progamme of the Congress will include get-together party at the CTICC restaurant/foyer area. Since it is Africa, we will also have a drumming session organised for those interested in trying drumming together with local drummers. The Congress dinner will be at the Moyos, which is a wonderful outdoor restaurant at the Stellenbosch wine area. There will be an African buffet and lovely local performers singing in traditional and modern music both in Xhosa language and in English. This time it will be easy to combine business with pleasure as there many things to see and do in the Cape Town itself and in the surrounding areas. The Congress has a tour organiser Robin Troup, with whom we have planned smaller and longer tours for accompanying persons and delegates. The Table Mountain is a must, there is a huge, beautiful Botanical Garden, and also lots of wonderful vineyards for wine tastings. For children there are sea lions to be seen lazing in the Waterfront in the middle of the city and a nice Aquarium to go to. More daring may choose shark seeing…You can also prebook a safari from the link Robin Troup has created for WAIMH Congress participants (See Early Bird and Tour Specials in http://www.wildlifesafari.co.za/early_bird_specials.php).

All in all, the Congress preparations are being well handled by the local team and the site itself is certainly very nice. Cape Town people are helpful and friendly, food is good and restaurant rates are lower than in Europe.

Finally, we wish to remind you that the Call for Papers is open and you can submit your abstracts electronically until September 15th, 2011. Do come and share your experiences, clinical and research work with other colleagues in Cape Town. Like it was sung in the popular song: "It´s time for Africa!"

Enjoy your summer or winter – whichever season one is up on your side of our globe!

You can find the program highlights and other info in the Call for Papers:

http://www.waimh.org/files/callforpapers/CfP_WAIMH_CapeTown2012.pdf

PROGRAM HIGHLIGHTS

13th World Congress
of the World Association for Infant Mental Health
Babies in Mind – the Minds of Babies: A View from Africa
Cape Town, South Africa
Cape Town International Convention Centre 17 - 21 April 2012
WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

Plenary Presenters

Olayinka Omigbodun (Nigeria), Mark Tomlinson (South Africa), Arnold Sameroff (United States), Linda Richter (South Africa), Neil W. Boris (United States), Astrid Berg (South Africa)

Plenary Interfaces

Interface I: Interaction guidance (Susan McDonough, USA) versus Dance therapy (Suzi Tortori, USA), discussant Miri Keren (Israel)

Interface II: 'Who is the patient? Baby? Parent? Family? Parent-infant Relationship?' Tessa Baradon (UK) and Björn Salomonsson (Sweden), discussant Kai von Klitzing (Germany)

Invited symposia

IACAPAP symposium: Child Rearing Practices Across Cultures: Impact on, and understandings of Infant Mental Health, chair Olayinka Omigbodun (Nigeria)

The impact of postpartum depression on infant and child development: an elucidation of mechanisms, chairs Lynne Murray (UK) and Peter Cooper (UK)