

THE SIGNAL

Newsletter of the World Association for Infant Mental Health



When a little means a lot

By Astrid Berg

Introduction

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

In 1995 the first ever conference on Infant Mental Health in South Africa took place – it was the brain child of my late colleague, Mara Sidoli, a child analyst from Santa Fe; she had come to South Africa to train a group of young analysts and introduced

us to the technique of Infant Observation. She showed us a video tape and it was this video tape of Baby Susan that was the beginning of infant mental health in our country. The conference that followed was a local effort, but, because we had no one who could talk on this field, it relied almost exclusively on the presence of our international visitors to make it the success that it was. I want to acknowledge a few of those original participants who are here today – thereby closing the circle:

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

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

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

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

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

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

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

Contents

Berg: When a little means a lot.....	1
Schejtman, Huerin & Duhalde: A longitudinal study of dyadic and self affective regulation and its link with maternal reflective functioning along the first 5 years of life.....	6
Affiliates Corner: The Affiliates Council with WAIMH moves forward	10
Maguire: Advocating for a National Infant Mental Health Strategy for Ireland; Progress to Date	12
Gutman Avner: Return from South Africa - A personal view on my experiences in the dark continent. Impressions of the WAIMH Congress, Cape Town, April 2012.....	13
Frank: It takes a village to raise a child, It takes a child to raze a village.....	17
Zero to Three Corner/ Schafer: The infant as reflection of soul: The time before there was a self.....	18
Editor's Perspective.....	21
President's Perspective.....	22
From the Kauppi Campus -News from the WAIMH Central Office	24



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From the Kauppi Campus -News from WAIMH Central Office

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

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

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

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

The Developmental Niche

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

Parents have ideas and ideals within which they wish to raise their children. These socialization goals create scenarios

for particular developmental trajectories. Heidi Keller from the University of Osnabrück in Germany has extensively researched the differences between 5 groups of people: 2 leading a traditional rural village life in West Cameroon and in India and 3 from western urban middle-class families in Europe and the USA. (Keller H, 2007)

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

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

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

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

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

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

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

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

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

A nation in transition

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

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

However idyllic this family situation may be on one level, there are limitations which are present in all rural, traditional settings: young men and women want employment; they want access to better health care and, if they have children, want formal education for them. They come to the cities where more possibilities exist, but the consequences are often not desirable. The rupture with the known community and family can leave a profound gap: no longer do men take

responsibility for their wives as is the case where traditional marriage rituals and resultant family involvement act as buffers. Mothers are left uncared for, exposed to the hardships of daily living in semi-formal settlements; they are separated from their mothers and elders, and thus do not have the benefit of the advice that would have been given to them and upon which they would have relied. Modern foods in the form of yoghurt and corn flakes beckon as nutritious, easy to give alternatives to the more laborious preparations of traditional porridge and vegetables. The result is a vulnerable infant with faltering weight and an equally vulnerable mother. And soon it becomes clear that the failure to thrive in many cases is not just about food or poverty but that there are psychological issues that play a role.

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

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

Cultural mediation

Cultural mediation emerged in the late 1970’s as a formal profession; it was a public health intervention in response to the large number of West African immigrants that had settled in France. The mediator’s role was not only to translate, but more importantly to bridge social worlds. According to Bintou, the first cultural mediator in France, interpretation only is repetition; cultural mediation is the

translation of ideas, of linking two cultures through creating relationships. (Sargent C & Larchanche S, 2009)

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

What emerged from this study were several important findings:

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

Dr: Is she HIV?

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

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

CM: when you were pregnant?

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

CM: Is it because you have a boyfriend?

Pt: No, but I don’t know

CM: What is it that you don’t know?

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

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

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

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

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

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

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

Yielding Control

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

A case example

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

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

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

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

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

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

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

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

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

In conclusion

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

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

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

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

What does this mean for WAIMH? The essence of what I tried to convey remains –we cannot assume to know it all when other people have lived knowledge of a particular context. Let's make links globally, let's listen to each other and let's put into practice what we say we believe, namely that the needs of human infants are the same, but that there are different

ways of rearing infants –let's get to know these, let's respect them, but at the same time we need to tell the world know what we are continually learning about the beginning of life.

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A longitudinal study of dyadic and self affective regulation and its link with maternal reflective functioning along the first 5 years of life

By

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Introduction

A major challenge that human beings face across the lifespan is to reach homeostasis between physical and emotional states in response to a myriad of difficult situations. Homeostasis, or balance, requires achieving affect regulation. Affect regulation (AR) has been defined as the capacity to control and modulate emotional responses (Fonagy et al., 2002). Infants cannot do this alone. Rather, they are motivated to regulate their emotions within the context of interaction and relationship with a caring adult, most often their parents. They communicate with and co-create intersubjective states with their caretakers (Tronick, 1989). Dyadic regulation (DR) implies that affective regulation is supported by both the adult and infant and enables the child to progressively modulate increasingly complex states of mind, scaffolding in this way the achievement of affective self-regulation. Parents, as auxiliary adults, provide "hidden regulators" (Hofer, 1995) of infant states of consciousness and work as agents of affect transformation, repairing negative affects and collaborating to support the infant's regulation. Therefore, the infant's affective organization simultaneously depends on his/ her own regulatory capacity and the regulatory scaffolding provided by the caring environment (Tronick, 1989). Hence, if dyadic regulation successfully occurs, the infant may achieve the capacity to control and modulate his/her own negative emotions, building his/her own capacity for affective self regulation.

While achievement of dyadic affect regulation and the transition to affect self-regulation have a positive impact on healthy development, frequent affective misregulation and negative affects may produce developmental drawbacks and defensive closure. Tronick (2005) suggests that infants require energy in the form of meaningful communication about the world to coherently organize

their states of consciousness and that another human being is the privileged partner to continuously co-create new meanings. Two minds can reciprocally generate, communicate and integrate meaning increasing coherence and driving development. In this co-creation of complexity and meaning, the dyadic primary bond is essential. Parental disposition to carry out the nurturing function is crucial for development. In this line, we are studying how parental reflective capacity can contribute to the making meaning process and how this can relate to the infant's ability to symbolize and engage in symbolic play.

Parental Reflective Function (PRF), as closely related to the concept of reflective functioning (Fonagy & Target, 1998), is a specific feature of mental functioning considered as an essential aspect of the way parents can understand and signify their child's behaviors (Slade et al., 2004). PRF refers to the parent's capacity to recognize that the infant or toddler has mental states, feelings, thoughts, and intentions of his own and is related to the parent's sensitivity to understand that both their child's and their own behavior and emotional displays are connected in meaningful ways.

Slade (2004) suggests that a mother's capacity to hold in her own mind the notion of having feelings, desires, and intentions allows the child to discover his own internal experience via his mother's experience. Thus maternal reflective functioning constitutes a relevant contribution to the child's capacity to regulate his own affective displays and reparation of affective disruption.

Dyadic making meaning process and affective regulation have a central role in building the infant's capacity to organize. Different contexts of dyadic play can provide a privileged position for the observation of such a process. The experience of playing in the first years of life facilitates the emergence of the self and subjectivity, and provides a sense of trust in oneself and in the other. The mother-infant free play expands interactional opportunities and presents a complex pattern of dyadic affective matches and mismatches (Tronick, 1989).

Through play the child not only achieves self-affirmation, a sense of agency and develops self-representations, but also experiments with feelings of joy and pleasure, allowing an expansion of his/ her exploratory actions (Dio Bleichmar, 2005). Moreover, through dyadic play both child and adult live real mental experiences. This scenario takes place throughout infancy and childhood. As Keren and colleagues, point out (Keren et al., 2005), symbolic play is a process that unfolds in time with clear sequential relations between the parent's facilitation of child symbolization and the complexity of the child's symbolic expression. Within the particular modality of "pretense" the child can perceive how the adult reflects about mental states. This mentalizing attitude of the parent provides the child with a representation about contents of both his and his parent's mind (Fonagy & Target, 1998). During play, the adult can offer the child a link between reality and "as if" - ideas and feelings, showing that they can share an experience that "suspends" their asymmetrical situation in the real world (Sroufe, 1996, 2002).

In previous studies (Schejtman et al., 2006; Huerin et al., 2006; Duhalde et al., 2010), we have described some specific features of the building of the capacity to being alone in the presence of other (Winnicott, 1971) and their link to the achievement of affective self-regulation and the way in which mothers are a part of this process, conforming a playing zone both for the infant and the mother. Microanalysis of videotaped mother-infant play interactions and analysis of interviews with mothers allowed us to suggest inferences about the way in which child's play and dyadic play relate to both dyadic and self affective regulation. Likewise, follow up of the same sample, studying a group of children that reached preschool years, gives the opportunity to examine the relationship between affective regulation and symbolization in the light of maternal reflective functioning at different ages.

In this paper, we present new findings from our ongoing longitudinal research on the relationship between Maternal Reflective Function, Dyadic Affective Regulation (DAR) and children's Affective Self Regulation (ASR) in the first 5 years

of life, and their link to the development of symbolic play. In this presentation, emphasis will be on the relationship between maternal reflective functioning and dyadic play at two different ages of the children: 6 months and 30-40 months old.

Method

Sample and procedures

The sample of this study included 48 mothers, between 19 and 39 years old, with their healthy babies, 23 to 31 weeks of age, 50% boys, 50% girls. The inclusion criteria for mothers were the completion of a high-school education and medical check-ups at least twice during pregnancy. The exclusion criteria were maternal disease or illness, pregnancy, birth and puerperal complications and infant's disease or illness.

Mothers were recruited through the infants' pediatricians, who invited them to participate in a study of normal child development. Once a mother accepted the invitation, a senior psychotherapist of our team called her to make an appointment to see her with her infant at our lab. In total, 21 mothers of the original sample were enrolled and went through the interview, but only 17 agreed to be videotaped with their 30-40 months old infants.

Procedures: Mother-infant (6 months) play interactions were videotaped in two interactive situations: 3-minute Face to Face (FF) interaction situation, 5-minute Free Play (FP) interaction with toys.

When infants were between 30 and 40 months old, mothers were interviewed

using the PDRII (Slade et al., 2005), a 90 minutes semi-structured interview aimed at assessing Maternal Reflective Function. In addition, mother-infant dyads were videotaped in a 15-minute free play interaction situation with a set of toys (Keren et al., 2005).

Measures

Maternal Reflective Function (MRF) was assessed through the analysis of the transcriptions of the Parental Development Interview PDI-RII (Slade et al., 2005). The analysis of the interviews was conducted under the supervision of Prof. Arietta Slade by two certified coders, A. Zucchi and V. Huerin. Maternal reflective functioning was scored as Negative, Lacking, Questionable or Low, Ordinary, Marked, Exceptional.

Measures at 6 months

In order to analyze dyadic affective regulation at 6 months the 3 minute face to face (FF) mother-infant interaction was micro-analyzed second by second using the Infant and Caregiver Engagement Phases Scoring System (ICEP) (Tronick & Weinberg, 2000); interrater reliability was 79.4% (percentage agreement) and 0.64 (Cohen's Kappa). Also, the 5 minutes Free Play (FP) mother-infant interaction was analyzed every 5 seconds, using the Free Play Scale (Tronick, 2003), an adaptation of the ICEP Scale. Interrater reliability was 84.3% (percentage agreement) and 0.55 (Cohen's Kappa).

Dyadic Affective Regulation measured variables (both in FF and in FP situations): Mother expressivity (positive, neutral or negative affect), Infant expressivity (positive, neutral and negative affect) and dyadic matches and mismatches

(Match: mother and infant are in the same engagement phase and share the same affect expression).

Measures at 30-40 months

The 15-minute, videotaped sequences of mother-child play when the children were 30-40 months were segmented into 45 fragments of 20 seconds and codified through the Interactive Play Scale (Duhalde et al., 2010). This coding system considers three aspects of mother-child play. 1) Mode of mother/child interaction, including the following dyadic categories: Convergence (mother and child are engaged in the same play agenda, they share affects related with play situation), Divergence (mother and child find it difficult to share a playing agenda), Non-interactive play (mother and child display a parallel play situation). 2) Affective misregulation signs (impulsivity/aggression, cry/complain and inhibition/ withdraw). 3) Child's level of symbolization during play, including the following categories: Functional play (no pretend mode, when play and use of objects during play do not transcend their conventional functions), Basic symbolic play (just pretend mode), Complex symbolic play (pretend mode characterized by role attribution or by substitutive use of the object). Interrater reliability for these variables was Cohen's Kappa= 0.94.

Results

Maternal Reflective Functioning (MRF) distribution: 9 mothers (37.5%) presented Questionable-low MRF, 11 mothers (45.8%) presented 5 Ordinary MRF, 4 mothers (16.7%) presented 7 Marked MRF. No mother presented MRF under 3 or over 7.

Dyadic affect regulation at 6 months.

Table 1. Affect regulation in FF and in FP situation (n=48, % of the valid coded time).

	Mothers' Positive affect	Mothers' Neutral affect	Mothers' Negative affect	Infants' Positive affect	Infants' Neutral affect	Infants' Negative affect	Match States	Mismatch States
Face to face	86%	14%	0%	15%	82%	3%	31% (16% is positive match)	69%
Free play	83.1%	16.91%	0%	12.1%	86.6%	1.3%	28,4% (12,5% is positive match)	71.6%

As seen in Table 1, in the Free Play (FP) situation at 6 months mothers spent 83.1% of the valid coded time displaying positive affect, 16.91% displaying neutral affect, and 0% negative affect. These proportions are very similar to those displayed in the Face to Face (FF) situation where they spent 86% of the time in positive affect, 14% in neutral affect and 0% in negative affect. Likewise, infants presented a similar distribution of affect in both studied situations. In FP situation they spent 12.1% of the valid coded time in positive affect, 86.6% in neutral affect and 1.3% in negative affect. In FF situation infants spent 16% of the valid coded time in positive affect, 82% in neutral affect and 3% in negative affect. In both situations we found that dyads spent most of the time (66% in FF, 71.6% in FP) spending the rest of the valid coded time in mismatched states, where the most common mismatch was the mother displaying positive affect and the infant displaying neutral affect.

Patterns of mother-child interaction at 30-40 months. When children were 30/40 months old, mother and child spent 61% of the valid coded time in play Convergence, sharing a playing agenda, while 11.7% of the valid coded time they were in Divergence and the remaining 27.3% of the time they displayed a Non-interactive play (parallel play, 9%; only child playing, 16.3%; or only mother playing, 2% of the total valid coded time).

Affective Misregulation. 8 of the 17 (47%) mother-child dyads at 30-40 months presented at least one misregulation sign such as impulsivity/aggression or inhibition/withdraw. We found no misregulation signs in the remaining 9 dyads.

Child's level of Symbolization during play. Children were engaged in symbolic play (either basic or complex one) 69.2% of the time (30.2% of the total time they displayed basic symbolic play and 39% of the total time they displayed complex symbolic play. The remaining 30.8% of the valid coded time was divided between functional play (24.3%) and no play (6.5%).

Links between Maternal Reflective Functioning and Affective Regulation at 6 months. While no relationship was found between MRF and mother-infant affective display in the face to face situation at six months, it was found that in the free play situation, mothers with ordinary or marked MRF were less positive and more neutral than mothers with low MRF (Positive Affect 75.2% vs. 92.8%; Neutral Affect 24.8% vs. 7.2%) (K&W test: $p < 0.05$). Moreover, dyads whose mothers reached an ordinary or high MRF ($n=14$) presented

more positive matches (14.7%) –mother and infant expressing positive affect in the same segment of time- than dyads whose mothers reached a low MRF ($n=7$): 8.9%.

Links between Maternal Reflective Functioning and Affective Regulation at 30-40 months. A meaningful relationship between MRF and mother-child mode of interaction was found at 30-40 months. Parallel play was higher (10% vs. 5%) in mothers with low MRF ($p > 0.05$ Mdn Test) and a tendency shows that Divergent Interactive Mode is also higher among Low MRF mothers (14% vs. 9%) ($p > 0.1$ Mdn Test). Also interesting, regarding children's affective misregulation signs, we found that while in the case of mothers with low MRF 4 over 6 (67%) children presented at least one misregulation sign. In the case of mothers with ordinary or high MRF, only 2 of the 11 children (18%) presented any misregulation sign.

Relationship between Affective Dyadic Regulation at 6 and 30-40 months. We explored the existence of a longitudinal correlation between dyadic regulation variables at 6 months (matches and mismatches) and mother-child modes of interaction during play at 30/40 months (Convergence-Divergence). Results showed no direct relationships between the mentioned variables.

Discussion

Results showed that at 6 months of age, the infants and their mothers are in a dyadic positive matching state around 16% of the coded time. This finding was similar in the Face to Face (FF) and in the Free Play (FP) situation and is similar to Tronick's work on mismatch as a normative feature of mother-infant interaction, suggesting that a healthy interaction is messy and more based on reparation of mismatches, rather than an idealized matched and synchronous interaction (Tronick, 2005).

Regarding Maternal Reflective Function (MRF), No relationship was found between MRF and mother-infant affective display in the face to face situation at six months. In the Free play situation, mothers with ordinary or high MRF were less positive and more neutral towards their infants than mothers with low MRF and at the same time these dyads showed more matches than dyads with low MRF mothers. Thus, it might be inferred that reflective mothers are more capable of modulating their own affect or emotions in face of their infant's neutral or positive affect, and are more attuned to the infants' affective neutral display and initiatives, encouraging distal exploration with toys. When a sensitive and high reflective mother offers objects, expansion of the

interaction and communication takes place, adding complexity. We can also add that the FP situation, as more expanded than FF, enables a higher possibility to study the presence of more complex interactive and subjective variables.

Even though we didn't find a direct relationship between MRF and frequency or complexity in children's symbolic play, some findings require our attention. Taking into account, of course, the differences regarding quality and complexity between both situations, at 30/40 months, we reported (Duhalde et al., 2010) that the presence of misregulation signs was more frequent in dyads mostly engaged in functional play while dyads without misregulation signs display more complex symbolic play. This finding is linked to the finding that in low reflective mothers dyads there were more misregulation signs. A higher divergent mode of interaction enables us to create an indirect link between maternal reflective functioning and level of symbolization in the dyadic play.

A recent study of ours (Duhalde et al., 2010) showed that when children are 30-40 months old there is a positive relationship between convergent interactive mode –mother and child acting together- and the level of the symbolic play as reflected in the children's play. On the other hand, the higher amount of divergent interactive mode and more frequency of misregulation signs were related to a lower level of symbolization in the child's play.

Even if MRF did not show a direct or global link to the child's level of symbolization during play, an interesting finding that should be further explored showed a higher presence of affective misregulation signs and higher divergent mode of interaction in dyads whose mothers show low MRF. The child's affective misregulation signs involve rejecting expressions, complaints, and impulsivity that are frequently disrupting the playing scene and consequently not facilitating symbolization.

It seems that when adults are less reflective, they can probably be less empathic or somewhat intrusive and misregulation may bring disruptions that hinder the construction of greater symbolic complexity in the playing scene. From a qualitative analysis point of view, these interruptions can be connected with the emergence of anguish or distress that cannot be solved within the playing scene itself.

In this study we have not found a direct link between dyadic matches and mismatches at 6 months and convergence

and divergence at symbolic play at 30-40 months. Play at 30-40 months presents higher complexity and the assessed convergence-divergence is then a more complex and subtle construct than the matches-mismatches assessment conducted in the 6 months study. On one hand this result might be due to the small number of dyads that took part in the second stage of the research. But also, although we are aware of the crucial importance of the first year of life as related to the constitution of psychic structure, it might be thought that not everything is defined during the first months of life due, among other factors, to the capacity and possibilities of recurrent reparation of mismatches and the achievement of a more attuned bond with the mutual experiences and this particularly in a sample composed by a low risk population like the one presented here.

Conclusions

Maternal Reflective Functioning is a theoretical construct that refers to a complex aspect of psychic functioning and the found results should be considered under the light of such complexity. We need to deepen our comprehension about the subtle mechanisms through which the differences in MRF are expressed.

According to these results, we also plan to deepen the study of maternal variables. We are now studying the incidence and contribution of specific maternal styles of interaction during play, namely restrictive or facilitating maternal style (Keren et al., 2005), and studying their link to reflective functioning.

Taking into account the fact that our findings relate to a normative, low risk, non clinical sample, this study suggests that even normal development is complex. Dyadic and maternal variables are related in different ways that may facilitate or interrupt symbolic enrichment in infancy and early childhood. The next step is to compare our healthy sample to a high risk one.

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The Affiliates Council with WAIMH moves forward

Affiliates Corner

June 2012

WAIMH really takes to heart its Affiliates and the Affiliates provide a strong dynamic energy for moving WAIMH increasingly out into the world. The Cape Town Affiliates Council meeting was attended by 30 Affiliate representatives, several groups interested to develop new Affiliates, and several WAIMH Board members. The meeting by all accounts was successful and presented the Affiliates and the Board with an important opportunity for developing a shared direction and action plan for the next two years.

The agenda was based on the findings from the two Affiliate Council surveys conducted over 2011 which provided descriptions from each Affiliate in regard to their current activities and their needs. As a result, three main themes emerged from the Affiliates Council meeting: 1. The facilitation of interactions between Affiliates; 2. The expansion of WAIMH benefits for Affiliates and; 3. The facilitation of input of Affiliates to the various WAIMH scientific and advocacy activities.

First, in nearly 30 countries, Affiliates work hard to meet the needs of their members, their Affiliates' supporters and their broader communities in the domain of infant mental health. Affiliates expressed the need to expand their communication with one another in order to support their actions and to facilitate the development of new Affiliates in under-served areas of the world. It was decided that the social media Facebook would be trialed as way to support Affiliates. An initial exploratory team of Lynn Priddis and Catarina Furmak was established with the intention to run a WAIMH Affiliates Facebook trial beginning in the latter part of 2012.

Further, as a way to increase our formal sharing of resources across the Affiliates, it was agreed that a working party would continue what had been begun on the development of a WAIMH resource on infant mental health matters, in the response to disasters. A work group was established including: Maree Foley, Nese Erol, Hisako Watanabe and Martin St-André. Other initiatives to be explored included: fundraising to support affiliates; "adopt an affiliate" programme; and developing a global lens on infant mental health.

Second, Affiliates voiced that they wanted to be nurtured by WAIMH. As a result the new open access format for Signal will allow Affiliates to broaden the dissemination of infant mental health news within their communities and will contribute as an incentive for Affiliates members to join WAIMH. Similarly, the WAIMH Board approved an initiative to explore the possibility of recording some of the scientific content at the Edinburgh 2014 congress. This in turn would enable Affiliates to have access to the content of WAIMH congress plenary conferences creating an opportunity to go over this precious scientific material within their own local scientific programming.

In addition, Affiliates also wanted to have access to the names of potential clinical consultants or trainers. In response, the WAIMH Board discussed the possibility of specifying alongside the "WAIMH membership profiles" (within the WAIMH website), an individual member's availability to provide clinical advice or training; including what specialties of consultation they might offer. Further, to support the dual thriving of our WAIMH-Affiliates relationship, a sub-committee chaired by Kai von Klitzing will investigate the feasibility of piloting modalities for facilitating and for creating incentives for Affiliate members to become also WAIMH members.





Third, the WAIMH Board and the Affiliates voiced the wish for Affiliates to provide a broader input in WAIMH's scientific contents. In response, the Affiliates Council responded with interest two initiatives: 1. The creation of an Affiliates Council-driven event for the Edinburgh congress, coordinated by Maree Foley, Martin St-André, Julie Ribaud, Nese Erol and Pamela Segel; and 2. A survey distributed to the Affiliates regarding their input for the development of a statement regarding infant rights initiated by the Board and chaired by Miri Keren.

Finally, a well-functioning Affiliates Council operates with the Affiliate presidents continuing to be accountable to the Council and to WAIMH with reference to the WAIMH bylaws. For this purpose, council members responded positively to two propositions: 1. That a survey be sent to all Affiliate presidents regarding a finer grained role definition of the roles and responsibilities of Affiliate presidents, and of the Affiliates Council Chair and Representative. 2. That a consultation process be started in preparation for meeting in 2014 regarding the current Affiliates Council election process by-laws. When we gather again in Edinburgh, it will have been four years since the initial election process was trialed, with this time creating a potential space to consider if the current by-laws regarding the voting process need to be revisited or not. We agreed that the current voting system provides a solid base from which to enable this issue to unfold in an unhurried way, until any clear alternatives arise.

The creation of the Affiliates Council provides a rich opportunity for the Affiliates to have a real input in WAIMH's activities and projects. All WAIMH members and presidents are invited to continue partaking in making the Affiliates Council a lively place for generating actions impacting infant mental groups across the WAIMH family.

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Photos (page 10-11) from Affiliate Council meetings in Cape Town in April 2012 by Minna Sorsa, WAIMH Central Office.

Advocating for a National Infant Mental Health Strategy for Ireland: Progress to Date

Affiliates Corner

June 2012

By Catherine Maguire

President

Irish Association for Infant Mental Health

The following account is a synopsis of the progress on an Infant Mental Health Policy Paper by a Working Group co-authored by Voluntary and Statutory health service providers and the Irish Association of Infant Mental Health. Its objective is to advocate for a National Infant Mental Health Strategy which will be informed by the latest research and evidence base in infant mental health principles and practice. The document has also been informed by discussions from an Infant Mental Health Policy and Practice Forum chaired by the Minister of State at the Department of Health with responsibility for Primary Care. The Forum included participants from a wide range of clinical, community and policy backgrounds.

The document titled "Tus Maith, Leath na hOibre - A Good Start is Half the Work" outlines the critical period of infancy and infant mental health in building strong foundations for life. It defines the vital role which the first three years presents in building strong foundations for healthy social and emotional development across childhood, adolescence and adulthood.

In Ireland, infant and toddler mental health is not a specific policy objective within Irish health service strategy documents.

Active monitoring of early childhood physical health takes place under the remit of immunisation programmes and child health surveillance, yet similar close monitoring of infant and toddler social and emotional health does not exist in the same format.

There are decades of knowledge and research evidence available regarding early social and emotional development. We are only beginning to see this knowledge base reflected in our early childhood strategy documents. While this is a welcomed development, much more is required. It is

critical that infant mental health practice and principles underpin a comprehensive early childhood strategy.

Prevention and early intervention principles are frequently cited at a theoretical level. Yet, their specificity regarding infant and toddler development and early caregiving relationships are not translated at a practice level regarding what is required to effectively promote and support caregivers in their vital roles with the zero to three population.

This policy paper presents policy makers and senior decision makers with a significant opportunity to gain a

Key Policy Components

Description of Infant Mental Health, providing the international evidence base for strong early foundations

Understanding what contributes to social and emotional health and the importance of the primary relationships, supportive communities and healthy environments.

Outline of research and evidence base, and the provision of a shared language for policy makers and practitioners

Workforce capacity building- need for a trained workforce with the capacity to integrate scientific evidence into clinical practice.

The social and economic rationale for integrating IMH into public health policy

Developing Policy recommendations specific to the relevant parts of the statutory sector which hold responsibilities for child and family programmes.

clearer understanding of the principles underpinning infant's mental health and invites and challenges them to address the significant deficits present across all points of health service delivery.

Infant mental health practice has an important contribution to make to more cost-effective health, education and social services, presenting Government with an opportunity to make a sound economic investment whilst at the same time delivering on best practice with infants, toddlers, their families and carers.

The development and implementation of a national infant mental health strategy promises significant child, family and public health outcomes. Benefits include promotion of the psychological health and well being of young children, the capacity to sustain good mental health across the lifespan and reduction in the prevalence of mental health illness across childhood, adolescence and adulthood (Shankoff & Phillips, 2000, Schore, 1994). Broader social and economic benefits will also be achieved at a whole population level through the investment and allocation of resources in infant mental health (Allen 2011).

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Return from South Africa - a personal view on my experiences in the Dark Continent

Impressions of the WAIMH Congress, Cape Town, April 2012

By

Neta Gutman Avner

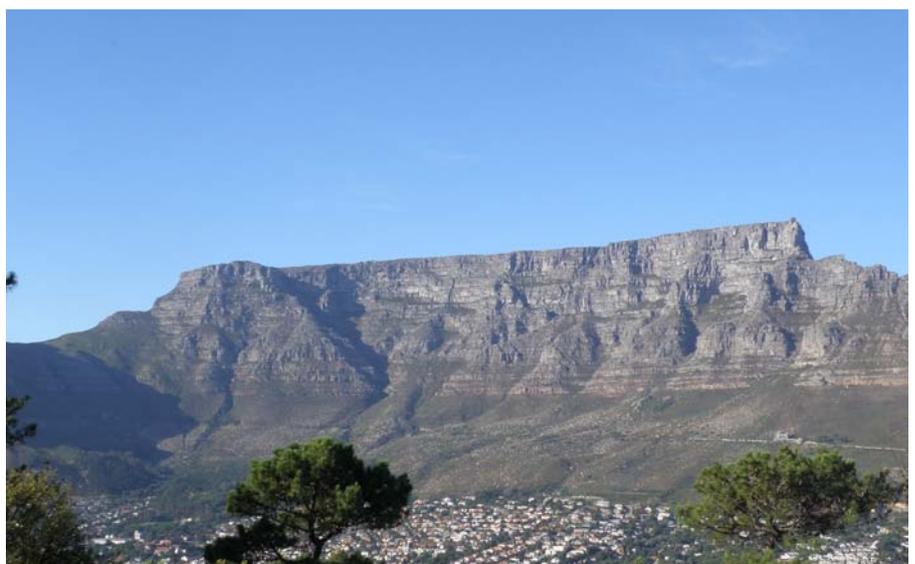
President, WAIMH Israel Affiliate

One of the side benefits of attending the congresses of the World Association for Infant Mental Health (WAIMH) is the opportunity to discover new countries, be exposed to new cultures, and visit places that would probably not be my top priority as a tourist or vacation destination.

South Africa is truly a beautiful country—with infinite vista, spectacular views, exotic fauna, rich flora, and breathtaking sunsets. At the same time, however, it is also a world of huge contrasts and disparities. Take, for example, the black shantytowns (“townships”) that stretch for kilometers on the outskirts of the cities. It is difficult to imagine how human beings can live and survive in such conditions; the luxurious and well-tended villas surrounded by electric walls and gates; the tense atmosphere and repressed violence in Johannesburg; and the sights that are hard to get out of your mind: young women sitting with babies in their arms at intersections on the outskirts of the city, as if waiting for something—perhaps some ray of hope; or barefooted children, who leach onto you, begging for a few coins to buy food.

Even Cape Town, considered a safe and quiet city, does not inspire a relaxed atmosphere as soon as night comes. It is true that the city is situated on a marvelous bay, surrounded by wooded mountains; Table Mountain rises majestically above it and offers a magnificent view of the city from its summit; it has one of the world’s most beautiful botanical gardens; and the port area, which has been impressively restored, features exclusive stores and numerous coffee houses. Yet all this could not dim the slight feeling of discomfort and fear while walking in the streets in the evening.

The Thirteenth Congress of the World Association for Infant Mental Health took place at Cape Town’s very modern and impressive Congress Centre, located in



the heart of the city's commercial district. A special atmosphere characterized the congress's opening session - the excitement, typical of the opening of any congress, was accompanied by a sense of expectation for something more, something else, a different experience. ...

During the evening, I met warm, smiling people, easy to connect with. The organization was superb and the excellent and plentiful food enhanced the pleasant and special atmosphere.

The congress was truly fascinating and professionally enriching. We were exposed to the findings of cutting-edge research and listened to interesting lectures about infant mental health all over the world. The congress also succeeded in connecting us emotionally to the heart of the Dark Continent and provided a deep perspective on the human tragedy taking place there. Through exciting lectures we heard about the misery of hundreds of thousands of infants and mothers. The local lecturers succeeded in imparting the moving experience of Cry, the Beloved Country.

As usual in conferences of this nature, the five days of the congress included dozens of theoretical and clinical lectures as well as diverse panels. However, it was the three lectures at the opening session that made the deepest impression on me.

The first talk, "From South Africa with Love and Forgiveness: Journey through Violence and Back," was given by Pumla Gobodo-Madikizela, a professor of psychology at the University of Cape Town. An impressive black woman, she served on the Truth and Reconciliation Commissions, set up in South Africa in 1995, the year after Apartheid was dismantled. Their role was to research, document, and denounce the injustices perpetrated by the former regime, as well as the acts of terrorism by the black organizations that fought against the regime. The goal was to compensate and rehabilitate those injured during the Apartheid era, on both sides. The commissions endeavored to let victims tell their stories and help those who committed crimes admit their guilt, with amnesty for those who confessed fully.

In her lecture, Pumla Gobodo described deeply moving therapy groups involving a confrontation between victims - black women who had undergone major trauma, whether personally or by the loss of loved ones - and white officials of the Apartheid regime who had abused and harmed them or their family members. She tracked the unconscious processes that enable the formation of an empathic bond between victim and aggressor and can lead to



forgiveness and understanding of the remorse.

The second lecture was very different. Dr. Olayinka Omigbodun of Nigeria, president of the International Association for Child and Adolescent Psychiatry and Allied Professions (ICAPAP), ascended the podium wearing colorful traditional dress and delivered her lecture in a confident and loud voice, almost shouting, rather like a preacher in the public square. Her lecture was entitled, "Reducing the Burden of Infant Health Problems in Africa: Our Collective Responsibility!"

She presented harsh data on child mortality and mental health in Africa as a whole and in South Africa in particular. Some of these data are well known; others are new. However, the direct and cutting way in which she presented them made it impossible to repress or ignore them. For instance, Africa has the highest child mortality rate in the world. Unlike other Third World countries, South Africa has not been successful in decreasing the infant mortality rate: 20% of live-born infants die before age of five; 30% are born with defects, complications, or some sort of developmental problems; 20%–45% of pregnant women suffer some form of emotional problems; and only half of all

infants are breast-fed.

Omigbodun also presented data about the condition of women in Africa and the stress they are living in. Many mothers are teenagers; in Nigeria, for instance, half of the girls are married by the age of ten (!); a very large percentage of mothers and their babies are abandoned by the fathers immediately after birth. Separation, divorce, and single motherhood all of these are unacceptable in African society; women who have been abandoned by their men are considered to be prostitutes and are humiliated and looked down upon by society and their families. Children who do have fathers generally have no connection with them until the age of 10 to 12. If we add to this the malnutrition, the horrifying living conditions, the absence of medical checkups during pregnancy, the lack of supervision of delivery conditions, and the prevalence of polygamy - we can only begin to imagine what it means to be an infant in Africa.

Another astounding fact: in all of the vast country of Nigeria, there is not a single infant mental health center!

Summing up, Olayinka Omigbodun called for enlisting in the cause and taking responsibility for infant mental health.

She spoke about the great challenges involved: teaching and training parents, endeavoring to decrease risk factors; being more sensitive to infants' psychological and social needs; training and raising professional staff; and building health and education programs.

The opening session ended with a lecture by Marc Tomlinson, head of the psychology department at Stellenbosch University in South Africa. In his lecture, "One Hundred Fifty-Five Million Infants and Children in Search of an Evidence Base: Thoughts towards an African Research Agenda," Tomlinson surveyed three studies conducted in South Africa: one of them on Attachment, another on the characteristics of the mother-infant bond, and a third about postpartum depression (whose prevalence is 35%–41%!). Since the medical, professional, and research staffs in the field are scarce and it is difficult to reach remote and isolated locations, in order to perform professional and clinical work, Tomlinson and his team enlisted women from within the target communities and trained them to serve as liaisons with the local mothers. In addition, he spoke about building infrastructures for developing models for therapeutic intervention for young children in Cape Town's disadvantaged neighborhoods.

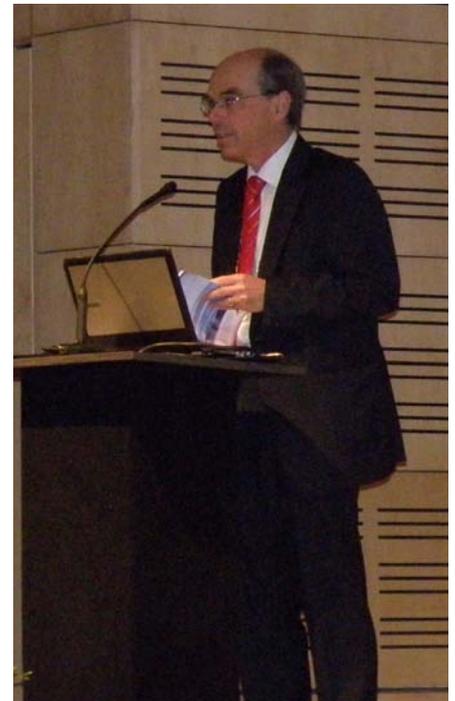


I have no doubt that such an enriching, fascinating, and emotionally charged opening session could have taken place anywhere else. Everyone in the auditorium felt powerfully connected to the fact that he or she was in South Africa, and to the stirring encounter with the complexity, contrasts, and enormous social, economic, cultural, and human disparities that exist between the Western society of abundance and the poverty of the African Continent.

During the congress, it was difficult to choose from the rich variety of theoretical lectures, clinical presentations, symposia, and panels. Many of them were about cross-cultural influences and post-traumatic reactions to extreme stress situation. One of the most important insights that I took away from the congress has to do with multiculturalism, an issue that is very familiar to us in Israel: that is, that when the therapist and the patient come from different cultural backgrounds, the gap may be large and impede communication. In this context, we heard about clinical interventions with the First Nations in northern Canada, with tsunami survivors in remote areas of Indonesia, and with black communities in Harlem, New York.

The common denominator of all of the clinical presentations, despite the unique features of each, was the sensitive approach to a different culture. We heard about willingness to learn about and become familiar with the unique lifestyle of local residents; about attempts by the therapeutic staff to adapt to the others norms and about the importance of doing the encounter in the patients' natural surroundings; and that no unfamiliar and foreign language, mode of behavior, criteria, or standards should be imposed on them. This humane professional approach certainly provides a lot of thought with regard to the work we do here in Israel.

In the same context, from the lecture by Prof. Astrid Berg, one of the main pioneers of Infant Mental Health in South Africa, on mother-infant psychotherapy in South Africa, I learned that in order to make contact with a mother in a foreign language, it is not enough to have an interpreter to translate the words; rather, there is a need for a genuine cultural mediator who is present for the entire course of therapy and who understands the mother's mentality, is familiar with her lifestyle, and can help the therapists deal with their own fear of the unfamiliar, the unknown, and the unexpected, so that they can be more attentive to the other - the patient - in their meeting. At the congress, we also heard about clinical projects taking place in various



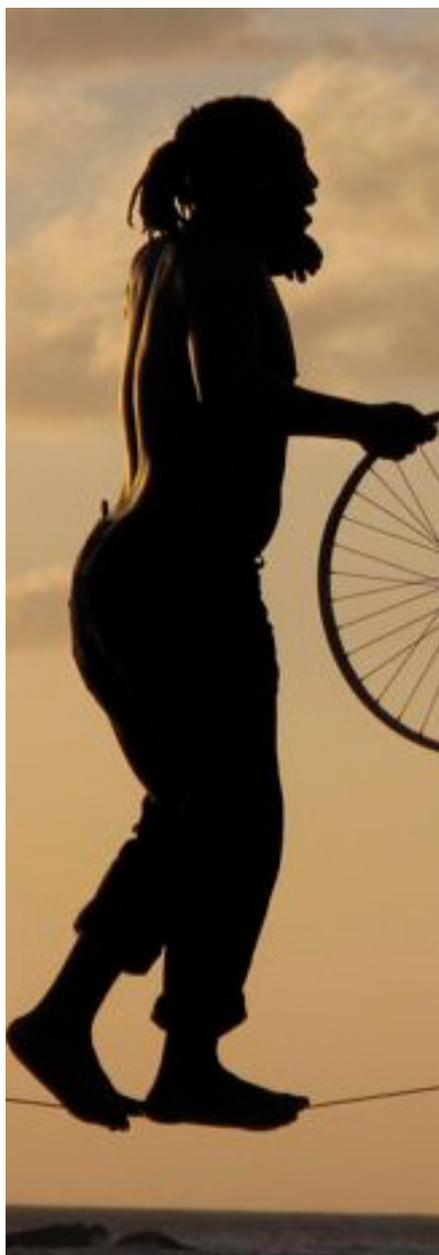
Photos (page 13-16) from WAIMH 13th World Congress in Cape Town by Minna Sorsa, WAIMH Central Office.

areas in South Africa, where the therapeutic staff goes into the townships and, against all odds, attempts to connect with the population, detect depressed mothers, and provide support and guidance. It was touching to hear that sometimes the staff brings pots of food as a way to get in touch and connect with the hungry mothers.

Nearly two months have passed since my return to Israel and I am still preoccupied with the issues related to the extent of responsibility that the Western World bears towards the mothers, fathers, and infants in Africa.

I also ponder the question how we can contribute even if only a little bit, to the sad situation that exists in the area so close to our hearts - Infant Mental Health, in a country that touched us so deeply.

Africa's cry truly did penetrate deep into my heart!



It takes a village to raise a child It takes a child to raze a village -Art and psychology in conversation

By Elzan Frank, Curator

Exhibition during the WAIMH 13th World Congress in Cape Town. Supported by the SASOL Art Museum, University of Stellenbosch

Sponsor: Jeanine Beukes

The emphasis on the mother-child bond positions other influences in an infant's life on the periphery. A mother is embedded in her personal context, at the same time she is a child of her Zeitgeist and socio-political realities, all of which influence her child-rearing belief-system. Fathers, present, absent and fantasized, play their part. Many infants are looked after by secondary caregivers; they, in turn, respond from within their own contexts. An infant's world is affected by a multitude of miniscule and mighty factors; war and crime and affluence and poverty and culture and Zeitgeist, noise and nutrition and love and rejection, together with many others, inform the contours of their landscapes.

Post feminism, post modernism, post communism and now post capitalism, we are in the generation of complexity and chaos. The world has become double-helix shaped; intertwined, inter-connected and inter-disturbed. We are alert now, this generation of psychologists; to the information that we are not isolated individuals, from within individual families and with individual destinies. Human infants, like all life on earth, are exposed to the vicissitudes of the times and the responses of multiple others. From the beginnings of our being, we are to be bombarded by a tower of Babel of inputs; increasingly we will be confronted by a maze of possibilities. To get to adulthood relatively intact, we will indeed have to use our wits. Indeed it will be more than a village that raises the child. It can be those



Photos by Elzan Frank.

Art: **Jan Vermeiren, Manneke.** (2010).

Photo by Deborah Weatherston.

The infant as reflection of soul: The time before there was a self

By

William M Schafer

Private Practice

Ann Arbor, Michigan

This article is a series of personal reflections on infancy, which I view as a period during which profoundly essential human spiritual experiences occur, albeit episodically and without reflective consciousness. These spiritual experiences lie at the core of what most traditions call the soul, but they become gradually veiled as we build the psychological structures of so-called maturity. These structures greatly increase our capacities to do and to understand, but they do so at the cost of diminishing our original state of energy, openness, and joy. We, however, gradually accept the loss as normal and inevitable, as the way things are rather than as an indication of something lacking in our perception. Our entire understanding of humanity is thus diminished, including our understanding of infancy. Infants frequently hint that they are capable of experiences we no longer commonly enjoy. But having lost touch with such experiences, we can no longer recognize them. Accordingly, we cannot nurture them in our children. Eventually our children lose touch with these experiences as well, and the cycle begins again.

If we want to change this cycle, we must look at infants with new eyes. We must acknowledge them not only as our students but as our teachers, and we must open our hearts and minds to their manner of being in the world instead of focusing entirely on training them to adopt our own ways. What might this change of viewpoint allow us to see?

What might we learn about the manner in which we have understood (or failed to understand) human development? How might we view the potential role of infant studies in bringing about this new vision?

ZERO TO THREE Corner

The efforts to recognize and advocate for the protection of the human rights of infants call attention to the inherent value that babies bring to society. In this thought provoking article (Zero to Three, Volume 24, Number 3), the author explores the spiritual dimensions of infant experience and the life-changing learning that being with babies can bring. Copyright ZERO TO THREE. All rights reserved. For permission to reprint, go to www.zerotothree.org/reprints.

Three spiritual elements of infantile experience

If we look at children between the ages of 0 and 2 years with these new eyes, we might observe three elements of infant experience that we formerly overlooked or misunderstood. These elements are presence, joy, and awareness of others' awareness.

Presence¹ is the first such element of infant experience. Because it appears in experience prior to any thought or concept, presence is difficult to describe except through a series of negations. It is that presence to oneself without which nothing else could be present. It is pure awareness—void of content, free from all internal commentary, judgment, comparison, fear, or desire. Such is the awareness that I observe in a calmly alert newborn, whose tiny body seems wholly absorbed in sensations that are still fresh, unlabeled, and unburdened by the weight of prior experience.

The infant appears to be utterly and simply present to the moment and to the experience it offers. Indeed, the infant seems not just "present" but, more accurately, seems to embody presence itself. This quality, more so than any other, brings to mind the idea of "soul" as it is described by so many traditions.

A calm, alert newborn is present in this manner, not by choice, but because his experience necessarily lacks organized memories of previous similar experiences, expectations of what his new experience

1 Presence, in the sense used here, points to an experience similar to

Stern's "global subjective world of emerging organization [operating] out

of awareness as the experiential matrix from which thoughts and perceived

forms...will later arise." (Stern, 1985, p. 7)

should or should not be like, or desires that the experience should end or continue. The infant, without knowing it, is simply present to the miracle of being that is unfolding within him. He can maintain this presence, of course, only as long as a supportive holding environment functions around him.

Joy is the second spiritual element of infant experience. It is felt as a strong sense of being open and drawn toward something or someone in wonder, curiosity, and interest, without any fear or impulse to reject. I recall sitting in an airport recently, watching a 6- or 7-month-old baby in a little cart while her mother waited in line to buy a cup of coffee. The little girl had caught the gaze of a woman seated at a table perhaps 20 feet away. She smiled at the woman, her whole face radiating a power that could have propelled her across the space between them had she not been strapped into her seat. The woman, for her part, was enchanted by the child. The amazing thing about this scene, however, was not the woman's engagement with the child, but the baby's fascination with the woman. What about this total stranger filled this little girl with such joy? It was not any "objective" quality the woman possessed. To be sure, she had somehow caught the baby's attention, perhaps with her own smile or because of some bright color on her clothing. But these are precisely the qualities we adults usually notice for only milliseconds and then disregard as we pursue our continual search for something "really" satisfying to us. The baby's capacity to abide in such a joyful state originated not in the woman, but in the baby's own manner of perceiving. She was simply there and aware. She neither waited nor wanted; she neither judged nor compared. Her joy did not depend on the object perceived; it resided in the act of experiencing. Joy as defined here is the natural, inevitable consequence of presence.

Awareness of others' awareness is the

third element of infant experience that we often misunderstand. This is the realization that one is not alone, that other centers of awareness exist who are similarly present to their own experience. In the developmental literature, researchers give this realization considerable attention, often touting it as the crowning achievement of human development, the psychological *tour de force* that sets us apart from all other species. We are fairly sure we observe its rudimentary presence in the facial expressions given by a 4-month-old to his mother's face, shown on the television screen of a child development laboratory. These synchronies of shared affect will soon develop into the capacity for shared attention.

I remember watching this shared attention blossom in a 7-month-old girl who waved her arms like a choir director while her mother sang a familiar song. Whenever her mother stopped singing, the little girl stopped moving her arms. Two weeks later, I saw the little girl introduce a fascinating variation to the game: She stopped waving her arms 5 seconds after her mother began singing. Her mother obliged her by falling silent in mid-syllable. The little girl grinned, waited, then waved her arms again to make her mommy begin singing again. A few seconds later, she stopped waving and laughed when her mother once more fell silent. This awareness that "you-are-also-aware-as-I am" seems to emerge at about 8 or 9 months. It is accompanied by a burst of purposeful communicative signaling by the baby, and a strong parental sense that "she has become a person!" It will develop even more fully a year or so later with the advent of symbolic communication through language.

We can routinely observe these three elements of presence, joy, and awareness of others' awareness in infants whose minds and bodies are sufficiently "held" by their caregivers.

We have often noticed how these three elements culminate in a 14-month-old toddler who bestows his Dalai Lama smile on each of his fellow customers from his supermarket cart. We are charmed—as we should be—by the accomplishment. Yet we seem oddly unconcerned about its passing by the time the child reaches the age of 3 or 4.

Ego development and the loss of infantile experience

The calmly alert infant is present: that is, she is utterly, simply, and without distraction present to her experience of the moment. Yet before long she begins to realize that her experience of being present is not continuous. Disruptions occur. Some are caused by events in her body, in her feelings, and later, in her mind. Others are caused by the inevitable failures of the surrounding environment. These discontinuities threaten (Winnicott, 1965b, p. 47, used the term "annihilate") the infant's sense of "going on in being." She reacts by creating memory traces and familiar patterns that allow her to escape the pain of constantly going "out" of being. These tiny anticipations and recollections gradually replace the flow of interacting in the present moment and turn into an array of apparently stable "objects"—the infant's body and all the things impinging on it. Eventually, these objects seem more real to her than the flow of interactions that generated them. They become her primary reality. This is the nature of the human mind. It takes what is, at root, a dance of cosmic energies and turns it into tangible objects—mommy, daddy, bottle, me. Eventually the mind will do the same thing to itself, turning what is fundamentally pure awareness into a self-enclosed solitary consciousness. The mind will then label, and ultimately desperately defend, this consciousness as "my feelings," "my thoughts," "my self."

One way to describe this process is to say that over time the soul establishes a basic identification with the Ego. Presence, which is simply awareness of Being's interplay and movement, is gradually veiled. Without even noticing the transition, the infant's experience changes profoundly: "I who before was Being's joyful presence to itself am now an Ego, concerned with my own survival."

From one perspective, this transition is quite an accomplishment. A functioning body map, a sense of "myself" in space and time as a source of movement and coordinated activity, a set of reliable expectations about how other things behave and affect me—these are no minor achievements. We appropriately devote time, effort, and money to the study of how these expectations occur, and we determine what to do about it when they occur unevenly or with difficulty. But we shouldn't forget that they also come at a price. The loss of presence is the first payment of that price. The Ego, constructed in order to provide continuity and stability, turns into a kind of cave. The cave has two major rooms called the

past and the future. In them, we hide from "now," which is the only moment that is real.

The loss of presence has inevitable consequences for the experience of joy. As the flow of interaction solidifies into the Ego and the surrounding world of objects, the child finds it harder to remain open to every experience without fear or feelings of rejection. His brain automatically compares each present experience to all similar past ones and to their effects on himself. It categorizes experiences as pleasant or noxious, desirable or unwanted, experiences to be extended or experiences to be ended as quickly as possible. This ability to compare current to previous experience, based on the effect that such experiences had upon the organism in the past, is again extraordinarily important to development. It provides the basis for learning and is an aid to survival. Yet once again, it comes at a price.

That price is the mind's automaton-like habit of making comparisons. Within milliseconds, each moment's experience is judged and the verdict rendered: "This experience is good; I want it to continue," or "This experience is bad; I want it to end." It all happens so fast that we usually don't notice that a space actually exists between the perceiving and the judging. We notice only the wanting or not wanting—and the wanting erodes the capacity for joy. If we have a bad experience, we can't wait for it to end. If we have a good one, we want more of it and we worry that it might stop. Either way, joy—the sense of being drawn to our actual experience in wonder and curiosity without fear or repulsion—is veiled. We end up living lives in which most of our time is spent wanting to be in some other moment than the present one. In Winnicott's (1965b) terms, we have learned to "react" rather than to "be."

The veiling of presence and joy in turn affect the infant's developing awareness of others' awareness. He notices that not every experience of being seen by another is a joyful attunement provided by a parent who is simply allowing the infant to have his own experience. Sometimes he notices disapproval or anger, or worse yet, that no one is even noticing him. Without a strong sense of presence or joy upon which to rely, the infant does the only thing he can—he finds ways to maximize his chances for evoking others' approving awareness while minimizing the likelihood of provoking disapproving or failed awareness.

This strategy marks the beginning of the search for love. And once again, we find that development, even that which we call normal development, is two sided. The

capacity to allow, to notice, and to enjoy the loving attention of others is a powerful, positive force in human development. But the search to locate, acquire, and maintain that loving attention can be very problematic. To maintain her relationship to those who she believes are important to her, the infant becomes someone she is not. She learns not to cry or not to laugh, not to run too fast or to talk too loud. She learns what to say and what not to say, what is good or beautiful and what is bad or ugly. She even learns what to feel and what not to feel. By the time she has learned this last lesson, she no longer needs parents to keep her in line. She has developed what Winnicott (1965a) called a False Self, internally regulated by values she has not personally chosen.²

As I read Winnicott, the False Self is an inevitable result of even healthy Ego development. Extending his line of thought, we can say that the development of the False Self also marks the beginning of the soul's veiling, alluded to in so many creation myths as an original fall from grace, caused by the desire to possess secret knowledge of immortality. We lose our joyful awareness of being with others because we are afraid that we are each ultimately alone and cannot survive the full weight of the experience.

It is curious how little attention we adults pay to this loss. It is truly odd that we do not protest more than we do our failure to enjoy experiences we so regularly observe in our babies. We seem to accept this as the "normal" state of affairs. The absence of joy, mirrored back to us in so many ways by our society's underlying emptiness and depression, seems natural. By the time most of us reach adulthood, we have not only lost the capacity to regularly access states that we achieved routinely as infants, but we have also lost awareness of that loss.

Most adults no longer even consciously seek presence. We seem content to remain wrapped up in internal commentaries about how this moment is interesting or boring, or good or awful, about how well or how badly we are handling it, about

² Here, Winnicott (1965a, p. 147) writes that even in normal development,

"when the degree of the split in the infant's person is not too

great, there may be some almost personal living through imitation, and it

may even be possible for the child to act a special role, that of the True

Self as it would be if it had had existence."

what happened last night or what we are going to do next. We are so accustomed to living under the compulsion to keep the internal commentary going that we rarely notice its compulsive nature. We finally admit that something is wrong only when the internal voices grow so loud and raucous as to attack us, or when the boredom or pain grow so intense that we cannot bear to wait for tomorrow, or when the hopelessness lies so heavily upon us that we can no longer even contemplate tomorrow. When the absence of presence grows this intense, we call it a disease, give it a diagnosis, and offer a treatment. The duller, more daily lack we simply call life. Perhaps that calmly alert, vibrantly alive newborn is inviting us to challenge this complacency.

In most adult life, the sense of joy is noticeably lacking. We seldom experience the immediacy and openness of being fully drawn toward whatever experience is at hand. In place of joy we accept a somewhat duller substitute, which we call "feeling happy." Even this we usually experience as a memory of some past pleasure or as a daydream of some future one. In fact, many of us would think it distinctly odd to meet a person who was simply happy to be "here." What would you really think if a colleague came into your office and whispered, "Isn't it wonderful simply to be here this morning?" As adults, we tend to believe that this kind of joy is suitable only for small children who don't know any better. Adults also routinely transform the wonderful achievement of awareness of others' awareness into something not so wonderful. For much of our adult life, we don't experience awareness of others' awareness as a joyful sharing of the miracle of consciousness. Instead, we tend to experience it as a rather painful set of internalized preoccupations about what others think of us, want from us, or might do to us, or what we think about them or need from them. Most of the time, we accept this state of affairs, too, as normal.

Acknowledging the spiritual dimension of human development

During the 20th century, most theories of development were silent about the experiences described here and about their loss over time. The most prominent theories (for example, Piagetian theory) focused heavily on the acquisition of cognitive and motor skills. Those that did concern themselves with emotional development (such as psychoanalysis) were more concerned with understanding psychopathology and saw the Ego mainly as the executive apparatus of the rational

self. Few theories said very much about human development during the fifth or sixth decades of life and beyond. In the United States in particular, we seemed interested in understanding how to promote only those soberminded, goal-directed coping skills that would enable people to become productive workers leading economically independent lives. During the second half of the century, attachment theory signaled a welcome shift in the direction of emphasizing the importance of human relatedness. But even attachment theory paid little attention to the price regularly paid for admission into the human social club.

What accounts for this collective oversight? I believe that it is at root our historical inability to come to terms with the spiritual dimension of human development. For 500 years, the west has been unable to bridge the widening gap between science and faith. In their struggle to survive the onslaught of scientific progress, proponents of organized religion have been reluctant to support empirical inquiry into the psychological dimensions of human experience. In their struggle for scientific respectability, psychologists have been timid about emphasizing those dimensions of human experience that indicate a yearning for more than just biological survival.

Perhaps today we can envision a new synthesis. Philosophers and theoretical physicists have begun to converse about the interchangeability of matter and consciousness. This dialogue has not yet percolated down to the level of standard academic psychology, much less to the world of concrete programming for young children and families. But it is becoming clear that the old war between fundamentalist soul-saving and postmodern myth-bashing is just that—an old war. It would be a wonderful thing indeed if leaders in the field of infant studies would play a role in fashioning this new synthesis.

Such an idea is not entirely fanciful. Babies by their very existence call us back to something we all sense we have lost. They do not enchant us simply because they are "cute" but because they awaken in us a thirst that sleeps deep within some wellspring of yearning that we know we have neglected. Babies are meant to challenge some of our ideas of "normal" and to teach us not to be so blasé about our adult experience.

After all, why are babies born? On the biological level, the reason is fairly clear. They are born because cellular life is genetically programmed to senescence and needs periodic refreshing.

But what about the psychological level? What are babies supposed to re-freshen within the human spirit? I suggest that they come to remind us that we, too, once were present and filled with joy in our awareness of others' awareness. If so, a complete theory of human development cannot uncritically assume that the mental life of the infant is simply a state of deficiency waiting to be remedied. Nor can it assume that the remedy is the set of cognitive and emotional skills that enable the infant to become an efficient but hassled adult just like us. Such a theory also needs to pay more attention to the ongoing developmental tasks of adult life. These tasks do not end with parenting our children only to the point that they can successfully reproduce. To go only this far toward understanding ourselves simply ensures that we and our offspring shall continue the cycle of falling asleep to humanity's deeper intuitions and aspirations. We need to broaden our view of parenting to include an openness to the forgotten dimensions of life revealed to us by our infants. If we let them, babies can teach us a lot about capacities we lost during childhood. If we are willing to receive it, they can give us the incentive we need to go about the difficult task of recovering these capacities and making them conscious, deliberate, and enduring elements in our adult lives. If we become purposefully and mindfully present, joyful, and aware of our mutual awareness, we can become clearer and purer reflections of Being's full radiance. To the extent that we complete this ultimate developmental task, we become, in the words used by the Purepecha of central Mexico to describe true shamans, "mirrors so clear that those who gaze into them can see all the way through to the other side."

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Editor's Perspective

By Miri Keren



This issue of *The Signal* comes after the 13th WAIMH Congress in Cape Town, South Africa. Each year following each WAIMH conference, we have tried to bring to our members some of the material that was discussed during key lectures and symposia, as well as some personal impressions from participants, especially to those who have not had the opportunity to attend it. From my own point of view, I was deeply impressed by the strength of African mental health clinicians to find creative ways to instill hope into despairing situations of extreme poverty and adversity. I thought of these clinicians' resilience as their ability to see beyond the risk factors and invent intervention strategies that are not written in our Western textbooks for parents and infants in extremely adverse situations. It is like being able to see the sun hiding behind big, thick, and dark clouds.

"Minding our Babies" was the theme of the conference, as it is the core of our daily work. Making our societies to mind our babies is another story...and implies that we need to go one step further to "translate" this psychological concept into words that can be easily understood by all policy makers. This is why Infant Mental Health policy papers from different Affiliates and countries, such as Catherine Mc Guire's (Ireland) and the ZERO to THREE (USA), are so important.

Besides the importance of having a written policy statement, like any declarative document, it is essential to include the action steps that translate policy into practice. Otherwise, health or mental health or early care and education policy makers may very well agree with the principles, but won't necessarily know how to support them or take the action steps necessary to put them into practice.

As mental health clinicians, many of us are trained to facilitate the being" and the "reflective Stance," more than the "doing." I personally think that this gap is one of the reasons that explains why many talented clinicians stay in the clinical setting and let "others" deal with the politics of health or mental health or early care management at the policy or societal level. To put in action our main concepts of infant mental health is really not an easy task! For example, it may be difficult for the Argentinian Health Minister to put into action the implications of Clara's study on the link between self and interactive regulation with reflective functioning and healthy development.

Just as WAIMH has many years of history, *The Signal* has gone through several editors, with different agendas. I have been in charge of the editorship for the last 4 years and I have been lucky to be given the opportunity to make it move from the format of a Newsletter, to a more scientific and clinically-oriented publication where WAIMH members can feel free to bring their knowledge and experience for readers to share. In addition, we have now the tradition of inserting two "Corners": the ZERO to THREE one... thanks to Stephanie Powers... and the Affiliates one, thanks first to Mark Tomlinson (South Africa), then to Martin Saint Andre (Quebec, Canada) and Maree Foley (New Zealand)! *The Signal* does not have the strict standards of a peer reviewed journal, such as the *Infant Mental Health Journal*. Still we have tried to maintain a "good-enough" scientific level.

On the personal level, it has been for me a very special intellectual, as well as emotional, experience. Indeed, reaching out to authors in search of interesting papers is not an easy task. Most WAIMH members are very busy and for many, and for me, as well, English is not our native language. I was lucky to have the continuous help of a few colleagues, very committed to WAIMH, such as Minna Sorsa, Hi Fitzgerald, and Debbie Weatherson who worked very hard on the editing. Minna learned to use a new software that enabled us to change the external look of *The Signal* into colored, broad-spaced columns and pictures that resonates extremely well with *Infancy*... This is why we have felt a bit proud like new parents each time *The Signal* is published and is sent to you! I also wish to thank our Editorial Board that has tried to keep their promise to send us two papers per year... Because I became WAIMH President at the Cape Town Conference, this is the last issue that I will oversee as Editor of *The Signal*. I have asked Debbie Weatherson to take over the Editorship of *The Signal* and she will take the lead; Hi Fitzgerald has agreed to assist. Expect many more changes that reflect the growth of this important and ever-expanding world organization!

President's Perspective

By Miri Keren

It is with great humility and honor that I am stepping into the position of WAIMH President. It is the kind of thing I did not even dare to dream about, when, 19 years ago, I started my fellowship in Infant Psychiatry at Brown University (Rhode Island, USA). I have special thanks to give to Tuula Tamminen and Antoine Guedeney who have played very significant roles in my career. As long ago as 1995, at the WAIMH Congress in Tampere, Antoine said to me, in his special semi-nonchalant way, "You know, Miri, it would be a good idea to create an Israel WAIMH Affiliate." (I did this, of course!) In 2002, at the WAIMH Congress gala dinner in Melbourne, Tuula said to me, in her characteristic way of conveying ideas, "We women have important things to do for WAIMH," and I wondered what she meant...

This is exactly how Tuula says and does things... and indeed, in recognition for her extraordinary service on behalf of babies, families and infant mental health professionals, she received in Cape Town the title of Honorary President of WAIMH. Bob Emde, one of the pioneers in the field of infant mental health, and himself a very active Honorary President, transformed the formal awards and honors ceremony into a creative, loving and humoristic (exactly the way a "real" infant mental health person should be!) event by composing this song and singing it to Tuula:

"So Tuula, Thanks",

(To be sung by all with beautiful, joyful, well-known melody by Jean Sibelius)

So Tuula, thanks

For helping us... to grow.

Your high ideals

Have been an inspiration

To guide us on

For infants, and beyond

(repeat)

Your high ideals

Have been an inspiration

To guide us on



For infants, and beyond.

(Poem): "Tuula Leading ...
Sensible"

More than 'almost breeze'

More than that.

Being alive

And sensible.

Take a deep breath

Inspiration.

Open eyes and look

Vision.

Open ears to the world

Listen.

You are a surface

Be touched.

Smell and taste

What's meant to be

And not to be.

Feel.

Feel the music around you

The chords of harmony and
dissonance.

Feel the hopes of others and their
pain

Feel the love of children and their
cries

Feel the drum beats of Africa

And yes ...

Feel playfulness and wonder.

Sharing and caring

Living is giving...

Tuula:

Being alive and sensible

Leading...

Thank you.

Antoine's presidency has been for me the opportunity to learn not only the tasks embedded in the WAIMH presidency, but also the ways to do things...of course with the continuous help and support from Palvi Kaukonen, WAIMH Executive Director, and from Kaija Puura, WAIMH co-executive director, at the WAIMH office in Tampere. I wish to take this opportunity to let our members know that these



functions require a huge amount of work hours inbetween, as well as during, our congresses. It is important to know that Palvi and Kaija do all of this on a voluntary basis, in addition to their heavy clinical and administrative duties in Tampere. THANK YOU!

I feel very privileged to be at the head of our new WAIMH Board of Directors who are, in my eyes, the optimal "mix" of highly skilled clinicians and scholars. Kai von Klitzing has been elected President-Elect (and has already started to share with us his wisdom and experience in replicating the successful conference we had in Leiptzig in 2010 as we look ahead to the 2014 conference in Edinburgh), Karlen Lyons-Ruth has been nominated as the President's Executive-at-Large, and Astrid Berg will serve as the President's Special Advisor. Campbell Paul has agreed to continue in the role of Secretary-Treasurer. Debbie Weatherson will be in charge of The Signal editorship. Martin St Andre and Maree Foley continue their great jobs respectively as Affiliate Council Chair and Affiliates Council Representative. Finally, Antoine Guedeney will remain my mentor, in his new position of Past President!

The way I see my role over the next 4 years of my presidency, is based on the belief that we do have, as mental health, health, and early care and education professionals, the very special role of "talking for the baby" in our societies, including, and maybe especially, in societies in conflict

(as in Israel where I live myself). Our main goals, tasks and actions that have been targeted by the Board during our first meeting at the end of the 2012 Cape Town Congress, include the following:

To continue to push forward the process of composing an Infant's Rights Declaration. We will summarize the discussion of infant's rights/values that took place at the WAIMH pre-congress meeting in Cape Town in a draft proposal that will be sent out to all WAIMH members and Affiliates for review and comment. We will then finalize the document and initiate collaboration with other organizations that have already dealt with rights declarations. The goal is to reach the 2014 WAIMH Congress in Edinburgh with a clear WAIMH statement in collaboration with others.

To continue and expand our "interactive trainings" in the context of WAIMH pre-congresses, regional congresses that we would encourage our Affiliates to organize, and in collaboration with other World Associations' congresses (IACAPAP, ISAP, WPA) that might become interested in infant mental health. Karlen Lyons-Ruth will be in charge of putting in place a research training institute. Affiliate to Affiliate trainings will be encouraged by the WAIMH Board.

To expand WAIMH to Eastern Europe (for instance Hungary, with a very big Roma community that is poor, has no access to education, and are socially isolated),

Asia, Africa, and the Middle East, through "interactive training institutes"; and mutual invitations to congresses (such as WAIMH invited representatives from India). For each place, we need to have a "mediator" colleague, such as Zack Boukydis in Hungary, Savita in India, Wenhong Chen in Shanghai, Corean and Taiwan colleagues, and myself with the Palestinian and Arab Israeli (with the help of Astrid Berg and Elizabeth Tuters).

To continue the work started by the DC 0-3R Task Force, under the leadership of Bob Emde and Helen Egger, and compile a DC 0-3R Casebook with the help of experienced clinicians from different countries and cultures.

This list shows that we have plenty of work ahead...and we like it!

Finally, I wish to thank Astrid Berg and Mark Tomlinson for having put together such a very special WAIMH Congress in South Africa. Indeed, in addition to the scientific quality of the congress, they gave a special touch, with a unique cultural and societal dimension, that made the conference become a real and powerful event, important personally and professionally to all of us.

With gratitude and in celebration of the work of WAIMH,

Miri Keren

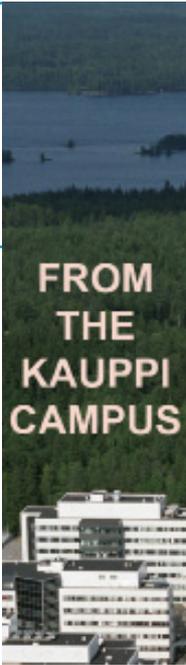
Renew you WAIMH 2012 membership now! Note, that there are two types of memberships:

1) Professional and 2) Student. As a WAIMH member you may also subscribe to the Infant Mental Health Journal (IMHJ) at a reduced rate. Go online www.waimh.org for both membership and subscription to the IMHJ.

From the Kauppi Campus -News from WAIMH Central Office

By Päivi Kaukonen, Kaija Puura and Minna Sorsa

FROM
THE
KAUPPI
CAMPUS



Dear WAIMH members,

here on Kauppi campus the spring has turned into a glorious, green summer. It is time to tell you the news and impressions from the 13th World Congress of WAIMH in Cape Town, South Africa. This was the first WAIMH congress ever spanning to Africa and it was unique in many ways. The Congress brought together 694 delegates from 39 countries, including India for the first time in WAIMH history, and participants from Burkina Faso, Zimbabwe, Malaysia and Thailand. The opening talk of professor Pumla Gobodo-Madikizela on the process of reconciliation in South Africa was moving and one part of creating the warm atmosphere we experienced throughout the Congress.



During the Congress we held the biannual WAIMH Membership Meeting and the Minutes of the meeting will appear on the WAIMH website. Adjunct to the Congress two Board meetings took place. After the first Board meeting Antoine Guedeney stepped down to Past President and Miri Keren commenced her presidency in Cape Town. Dr Karlen Lyons-Ruth started her term as a WAIMH Board member.

The second Board meeting included organisation of the new Board and a new President-Elect was elected from among the Board of Directors. The Board of Directors was in total agreement and elected Professor Kai von Klitzing from Leipzig, Germany as the new President-Elect. Congratulations Kai!



Photos by Deborah Weatherston.

After the Congress we sent an evaluation form to the delegates and received 119 responses. These active delegates gave an overall rating of 4.5 to the Congress on the scale from 1 (poor) to 5 (excellent). The responders gave particularly positive feedback on the master classes and plenaries, as well as on the variety on the content of the Congress. The responders were also very happy with the venue and organisation of the Congress, and with the assisting staff. The most common complaint was about the programme being too full and rushed, making it difficult for the delegates to choose from so many things they would have liked to see and hear. The responders also gave their valuable advice on what we should include in our future congresses. It seems that many would wish to have dancing and singing during the congress, so maybe we will have a chaille in Edinburgh! The ideas for the scientific programme included more opportunities for interactive sessions between researchers and clinicians, and also more time for discussion in plenary and symposia sessions. There were so many suggestions for presentation themes that we will not list them here, but all the feedback will be sent to the Programme Committee and taken into account while planning the 14th WAIMH World Congress. Our warm thanks to all responders!

The WAIMH Board can proudly make two announcements: The Signal Newsletter was changed into an Open Access publication. This means that anybody can now upload any Signal they wish. The newsletter is available on the WAIMH web-page www.waimh.org. The second important item is that the Infant Mental Health Journal is now available also online for all WAIMH members with an additional Infant Mental Health Journal subscription.

The Office will be on vacation during July, and after that we are happy to welcome Ms Leena Kiuru to our team once again to work as our Administrative Assistant while Minna will concentrate on her research for a period of time.

With summer greetings,

Päivi, Kaija and Minna