



The Signal

Vol. 17, No. 3

Newsletter of the World Association for Infant Mental Health

July-September 2009

Systems consultation: a clinical tool joining up research and clinical practice

By

*France Frascarolo-Moutinot
and Nicolas Favez*

An important way of demonstrating what is favourable or not to child development in terms of family functioning, is to combine research and clinical intervention. By doing so clinical practice becomes an object of research and conversely research brings useful results and tools to clinical practice.

Towards this aim, we have developed consultations known as "systems consultations" during which semi-structured situations are used that allow an evaluation with a therapeutic aim (using video-feedback and other methods

tested in family clinical practice) whilst collecting data for research evaluation. Family interactions are video-recorded and can be micro- or macro-analysed subsequently, depending on the needs.

SYSTEMS CONSULTATION

Description of systems consultation

Systems consultation consists of family functioning assessment consultations, usually over two sessions, at the family's request or that of a therapist. During the first session, the family, the therapist¹ and the consultants of our research unit meet. After a period of introduction that is of great importance in establishing the therapeutic alliance, the family gets involved in family games which are video recorded. Then the questions that led to the consultation are asked by the therapist and/or the family. For example, the therapist can put into words a question-request such as: does the child and the family's condition require ambulatory treatment? At the second session, involving the same people, having studied the videos and identified the relevant resources as well as the problems, we show interactive sequences illustrative of the family's resources and difficulties. Extracts of video footage are therefore viewed and discussed. The family members are invited to talk about their experiences during the games and/or spontaneously having seen themselves in the films. The consultants then give their answers to the questions they

¹ If there is a network around the family, it is the maximum of people from the network who are invited.

had been asked based on the images shown. Finally, the consultants work out, with the family members as well as with the therapist if there is one, a few ideas for the next steps as to overcome the difficulties expressed during the first session or revealed during the video replay. Finally, all the participants sign authorizations for the use they agree we may make of the videos (research and/or teaching-training). Note, however, that in the case of a family which is involved in therapy, we deliberately stay unaware of their case records and possible pathologies to avoid biasing our evaluation.

Aims and principles

Our aims, for research as well as for clinical practice, are the observation and assessment of different aspects of communication within family:

- the family alliance, that is, how the family forms a team to execute a task, in this case playing together and creating moments of shared pleasure;
- intersubjective communication (or the sharing of internal states) which is inseparable from visible interactions, even if it is only inferred from the observed behaviour;
- the baby's skills, especially in terms of communication,
- besides the game that is privileged through our scenarios, other functional domains, such as attachment, setting of limits, etc.

At this point we would like to specify the principles that we find essential in systems consultation. First of all, assessment is also an intervention; these are two inseparable aspects of consultation. Second, our assessment and thinking is based on

Contents

6	Susz, Kalsish, Kushilevitz, Orenstein & Raviv: "Who ate my porridge?" -A glimpse to the Mother - Infant bond through the feeding scene
12	Cherro Aguerre: Salvador Celia: Latin America resilient friend
13	Tyano: Book review
14	Stone: Finding hope in despair: The story of Charlene and Jay
18	President's perspective
19	Editor's Perspective
22	From the Kauppi Campus
22	Affiliates Corner

observable behaviors as captured by the films. Third, establishment of a therapeutic or research alliance, depending on the circumstances, seems essential to us in order to allow the family to function at its best and consequently to identify its resources clearly. Fourth, we assess resources as much as problems since we establish the intervention, on the one hand, in recognition of the difficulties that the family expresses and, on the other, in identifying their resources. Fifth, video feedback, allowing the expression by the family members of their feelings when watching themselves at play, is essential so as to verify that our observations are valid in the subjects' opinion. Finally, the signature of the authorization to use the films shows the families and the therapists both our ethical standards and our respect for them.

SITUATIONS OF OBSERVATION

Several situations are available that allow assessment of the family system at different stages (prenatal, one child, several children) and at the different ages of the child. Before describing these scenarios, let us point out that in addition to the family system as a whole, it is also often judicious to observe the dyads which form the family, be it the couple in a conflict discussion task as Weiss & al. (1975) conceived, or those made up by each parent with the child separately and, consequently, out of view of the other parent.

The Lausanne Trilogue Play and its adaptations

The Lausanne Trilogue Play is one of the situations that we developed to systematically observe the interactions between two parents and a baby. In this scenario, the parents and the baby, installed in a triangle at a distance promoting dialogue, are invited to play together as a family, as they usually would, following a script in four parts. First of all, one of the parents plays with the child while the other is simply present, then the parents reverse roles, then the three of them play together and, finally, it is the child who is in the position of participant-observer in front of his parents who are talking to each other. So this script allows the exploration

of all the possible threesome configurations (Fivaz-Depeursinge & Corboz-Warnery, 1999).

While keeping the play structure in several parts, the LTP can be adjusted to the child's development: toys or objects (such as socks and little spoons) can be introduced, the child's seat will be different depending on postural development (baby's seat, high chair then normal chair), the instructions can include narrative elements from the age of four, and so on (Favez et al., 2006). The LTP can also be adjusted to families including more than one child. The script is the same: one parent plays with the siblings while the other one is participant-observer, the parents reverse their roles, the family members play all together, finally the children play while their parents talk. The families receive toys (as many lions, ducks and telephones as family members).

The LTP was also adjusted to the prenatal stage, asking the expectant parents to enact their first encounter, as they imagine it, with their baby after the birth (Caneiro and al., 2006).

The triadic games are assessed with the help of a macroanalytic coding system, the FAAS (Family Alliance Assessment Scales, unpublished manual), bearing on the following dimensions: participation, role organisation, focussing, warmth and affective contact, communication errors and their resolution, co-parental coordination and finally the child's involvement.

The Picnic Game (PNG)

To complement the LTP, we have conceived a less structured scenario closer to daily life: the Picnic Game. Meals represent a window for the observation and assessment of family interactions, sometimes used in clinical practice. However, filming meals at home turns out to be costly in time and resources. Moreover, the variability of meal contexts (space at disposal, length of the meals, points of view, etc.) makes comparisons between families difficult, and cannot guarantee sufficient controls for using these situations for research purposes. To compensate for these two pitfalls, we conceived the PNG (Frascarolo &

Editorial Staff

Editor:

Miri Keren

Production Editor:

Minna Sorsa

Copy Editor:

Hiram E. Fitzgerald

Editorial Board:

France Frascarolo

Bernard Golse

Antoine Guedeney

Mirjami Mantymaa

Campbell Paul

Kaija Puura

Martin St. Andre

Mark Tomlinson

Elizabeth Tuters

Charley Zeanah

Hisako Watanabe

Jean Wittenberg

President's Perspective:

Antoine Guedeney

From the Kauppi Campus:

Pälvi Kaukonen

Kaija Puura

Minna Sorsa

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

All opinions expressed in *The Signal* are those of the authors, not necessarily those of WAIMH's. Permission to reprint materials from *The Signal* is granted, provided appropriate citation for source is noted. Suggested format: *The Signal*, 2009, Vol 17, No.3 WAIMH.

Favez, 2005), a scenario in which the family is asked to pretend having a picnic.

This situation permits appreciation of the family's capacity to play for fun (implicit aim of the game), to be creative, to modify constraints such as the quantity of food that the children have to "eat" and their good manners. However it relates to daily life situations such as setting the table, tidying up at the end, leading the children to respect the spatial limits defined for the game, etc. The two aspects "game" and "daily reality" are complementary and make the observations all the more rich.

On a carpet of 4 by 4 metres (or less depending on the space at disposal), delimiting the space they can use, the family has at its disposal a bench, a table, chairs, toys and a toy tea set. The instructions invite them to pretend play at a picnic during about a quarter of an hour and to tidy up when they are finished.

This situation, videotaped in its entirety, can be used with any family with no restriction of age nor of the number of people (including babies as well as grand-parents).

The game is assessed with the Re-PAS (Revised Picnic Assessment Scale, unpublished manual), composed of the nine following dimensions: participation, (inclusion of the participants), allocation of leadership, structuring of the task and transitions, richness and fluidity of the configurations, co-parenting, marital exchanges, limit setting, family warmth and finally autonomy of the child(ren) sub-system.

Note that the situations used, such as the Lausanne Trilogue Play, the Lausanne Family Play and the Picnic Game, permit assessment not only of global family functioning but also of sub-systems', in particular co-parenting, axis of the family (McHale, 2007). Certain aspects of the marital system are also observable, as are the relationship of each parent to the child or children and sibling relationships within the family.

CLINICAL ILLUSTRATION

The family presented here is made up of three children (two boys, respectively 7 and 5 years old and a 2 and a half year-old girl). The parents spontaneously asked for a consultation because they were concerned about the position of the middle child who harassed his parents with questions and was difficult to please. The question that they asked themselves was: does each child, and in particular the middle child, have his own place in the family ?

We asked them to perform the Lausanne Family Play and the PNG and it is the contribution of this latter to the understanding of their family dynamics that we will outline.

Description of the game

The boys take their bags enthusiastically to go on the picnic in contrast with the daughter who shows herself to be grumpy. Having taken a few steps, the parents announce that they have arrived at the picnic place. The father and then the mother invite the little one to take her bag that the father has been carrying. For a while, everyone investigates the toys contained in the children's bags. When the little one steps off of the carpet for a moment, the mother invites her to come back in and the father insists. She leaves again and this time it is the older brother who tells her to come back, and the two parents confirm.

Then the parents go to set the table, with the girl's help, while the boys are playing. This done, the boys are invited to come to the table. The mother says "have a nice meal" several times, but it is not repeated by the others. The father invites them to say "cheers" and says "cheers" to everyone; the parents exchange a smile of complicity and the mother also says "cheers" to the children. The two parents agree to refuse the first time the younger boy asks to leave the table, but accept when the older one also wants to go to play. The time of the meal is very short (a bit less than two minutes) and they do not say what they are eating. The parents stay at the table with the youngest child for a while. The younger son calls them out several times to show them things. Then the parents tidy up the dishes and go and sit beside each other on

the bench. On several occasions, their movements are synchronised and their postures similar. The father suggests to the younger son playing with the little one. The mother repeats the request but the girl answers that she does not want to. The parents show that they are available, but do not play. The oldest one plays on his own but is not (self) excluded. The younger son seeks out his parents frequently to show them things. At one point, the parents look at each other and exchange smiles. The mother finishes this moment of complicity by kissing her daughter's hair.

The oldest child says he wants to perform a pirouette which the mother refuses. But the father not seeing any reason to refuse, she agrees. So the boy does it watched by his father who encourages him.

After a while, the father signals the end of the picnic and the mother supports him. The younger son does not want to finish but the mother disputes with him. The father goes and helps him tidy up his toys but respects his desire to do that by himself. When everything is in order, they pretend to leave.

Analysis

The resources that we have pointed out are the following:

- the parents support and validate each other mutually in their role as parents. They can, therefore, count on an active and supporting co-parenting (see how they set the table and tidy up together and the episode where the two parents ask the little one to come back into the field of vision).
- they set a clear framework within which the children can demonstrate independence (they show interest in what the children are doing and answer their solicitations and questions; they repeat the rules related to the scenario and the rules of politeness such as the use of "please", etc.)
- they do their utmost to put in place rituals ("cheers", "have a nice meal"), useful in strengthening family links.

Regarding the respective places in the family of the children, the oldest one seems very well-behaved and reasonable. He is self-sufficient, but takes an interest in what is happening around him (for example, he reminds his sister not go beyond the carpet).

As for the middle child, he creates linkages within the family. Indeed, by asking questions and showing things to his parents, not only does he establish his place in the family, but he also creates connexions between all of them by attracting their attention. As for the youngest child, she shows independence without necessarily excluding herself. She knows how to oppose (refusal of the bag at the beginning and of the suggestion that she play with the younger brother) and she also knows how to “feel good” with the others (as when she goes to sit between her parents on the bench).

We identified one difficulty in this family’s functioning, namely that by wanting to secure each one’s own place in the family too much, it is perhaps the family as a whole that suffers. The parents, always available and ready to answer everyone’s needs, create few moments of shared exchanges between all of them (for example, the failure of the “have a nice meal” of mother because father was taking care of the boys; or the “cheers” which occur in a series of two-way “cheers” and not by including everyone at the same time). This absence of a common main interest or activity shared by all, prevents a real affective communion between them. This lack of affect sharing between all family members risks to hinder the development of a real sense of family and sibship.

RESTITUTION

During the restitution the parents said that they clearly recognized their family in the video and that everyone behaved in a normal way.

First of all we underlined the parents’ skills, their willingness to do well and their success. To answer the question of everyone’s place in the family, we showed that the youngest child is already quite independent and that she knows how to occupy her place. We underlined that it is perhaps by his questions and solicitations, that the younger son occupies his place and that his way of doing things creates links between the family members. We invited the parents and the mother in particular, to see his rebellious behaviour in a positive way because, although they can be trying for the parents, it is also a way of establishing one’s place in the family. We pointed

out that the oldest child is perhaps the one who is least demanding and that it is therefore important to validate what he does and says (as the father did with the pirouette). This remark touched the father by recalling his own history as an oldest child. We also told them about our concern over the position given to the couple and especially to the mother who is completely devoted to each of them. Her husband claimed to be pleased that we underlined that because it is also his own point of view. The mother was overcome by emotion.

We explained to the parents that we wondered whether by wanting to guarantee each individual his own place in the family, it was not finally the family as a whole that suffered and we showed them, as examples, the occasions where the parents say “have a nice meal” and “cheers”.

We concluded by asking the parents not to take the middle child’s behavior and especially his questions, against themselves but rather to see their positive side as reinforcement of links within the family. We underlined their qualities as parents and their motivation to do well and, this being so, we suggested they allow themselves more relaxation and pleasure, stressing in particular that the mother take care of herself (for example through a regular activity that she likes). Finally, we suggested activities in common such as family games.

CONCLUSION

We have given an outline of the usefulness of systems consultation in assessing family dynamics, not only from a research perspective but also for clinical or even therapeutic purposes.

Indeed on the one hand, by using semi-standardized situations for which coding systems exist, we can collect data for scientific studies (comparison between groups of families, longitudinal studies, study before a certain life event versus after it, or pre-/ post-therapy). On the other hand, by offering an insight into what family resources and difficulties may be in play activities resembling daily life, it gives a very useful point of view in clinical practice.

Systems consultation can therefore be a meeting ground of researchers and clinicians; to which each one, while maintaining his own objectives, can bring his skills and can be enriched of those of the others in a fruitful exchange.

Finally, viewing the films with the family enables us to address certain difficulties or simply different aspects of family life such as limit setting, distribution of daily tasks, everyone’s place in the family, etc. Indeed the film is a preferred support in discussing family problems and resources. It is important to underline that, during the viewing, parents, like those of the family presented here, often indicate that their own behavior and that of their child(ren) are typical of their daily experience (for example, the child who sits for a long time at table, the marital couple’s self-effacement in favour of the parent-child relationship, etc.).

References

- Carneiro, C., Corboz-Warnery, A., & Fivaz-Depeursinge, E. (2006). The prenatal Lausanne trilogy play : A new observational assessment tool of the prenatal co-parenting alliance. *Infant Mental Health Journal*, 27, 207-228.
- Favez, N., Frascarolo, F., Carneiro, C., Montfort, V., Corboz-Warnery, A. & Fivaz-Depeursinge, E. (2006). The development of the family alliance from pregnancy to toddlerhood and children outcomes at 18 months. *Infant and Child Development*, 15, 59-73.
- Fivaz-Depeursinge, E., & Corboz-Warnery, A. (1999). *The primary triangle. A developmental systems view of mothers, fathers, and infants*. New York: Basic Books.
- Frascarolo, F., & Favez, N. (2005). *Une nouvelle situation pour évaluer le fonctionnement familial : Le Jeu du Pique-Nique (A new situation to assess family functioning: the Picnic Game)* Devenir, 17, 141-151.
- McHale, James P. (2007). *Charting the Bumpy Road of Coparenthood Understanding the Challenges of Family Life*, Washington DC: Zero to three.

“Who ate my Porridge?”

- A Glimpse to the Mother – Infant Bond through the Feeding Scene

By
Elishiva Susz, Tzippy Kalish, Irit Kushilevitz, Ruth Orenstein and Anat Raviv

The paper was presented in the WAIMH conference in Paris, July, 2006.

Psychoanalytical consciousness has assimilated feeding as a paradigm for metaphor, in that it serves both as a developmental model and as a metaphoric idea in relationships (Piontelli, 1992).

Winnicott (1960) believes that babies are born with a potential for true self, the emerging of a unique personality which develops in a holding environment provided by a good-enough mother. Winnicott maintains that there is no baby without a mother. The unit for understanding psychological development is the mother-infant dyad, which is a psychological construct that is simultaneously primitive and mature, representing different levels of psychological development. Growth is a function of the development of the mother-infant dyad into a mother and an infant.

According to the Theory of Attachment, emotions act as behavioral signs for the caregiver, indicating physical or psychological stress in a child (Bowlby, 1969). If the caregiver assumes a defensive mode, misinterprets the child's affect or ignores it, the child remains in a state of distress and disequilibrium. The caregiver must be able to contain the infant's overwhelming emotions, know the infant's physical and psychological needs, become accustomed to the infant's perspective, and arrange the outside world so that it accommodates the infant. Attunement to the infant must take into account

that the infant is a psychological entity with mental experiences. Thus, the caregiver reflects on the infant's mental experiences and re-presents them to him or her, translated into actions that are comprehensible to the infant (Fonagy, 1991).

Daniel Stern (1985) further expands the issue of attunement, using musical terms (tone, rhythm, and melody) to emphasize the inter-subjective relationship between infant and parent. Benjamin's (1991) description of the initial relationship between mother and infant contains both recognition and foreignness. It is clear to the mother that the infant recognizes her, discerns her as "my mother," and prefers her look, sound, smell, and flavor. This is not merely a projection of mother on the child, as this process relates the infant to its past within her body and to its future outside of her, as a separate person. At the same time, the mother is somewhat unsure of the nature of this new being. The paradox is greatest in the first days postpartum – the infant is part of her, totally familiar, and also completely new and foreign. The mother's feeling is "You, who are mine, are also someone new outside of me." The mother feels loss because the baby is no longer inside her and she cannot care for it as she cares for herself. Sometimes the mother represses this reality, and feels that her baby is the most wonderful baby ever, and it is as easy to care for Baby as it is to care for herself. This process of acquaintance contains both togetherness and otherness.

According to Winnicott (1957), feeding an infant is a practical fulfillment of mother-infant relations. It is not merely a physical and physiological matter, but includes the emotional bond between mother and baby. Mutual understanding can be immediate or might happen after a struggle between the two. The feeding process develops simply when the emotional bond develops naturally.

For the good-enough mother and her healthy, full-term baby, feeding is an important component of the bond between two human beings; it is a process in which mothers learn about their babies and babies learn about their mothers. In its natural state, the baby "knows" the desirable amounts of food, and the desirable time to eat it. The mother can let the baby make decisions according to his or her capability as she can easily supply whatever she is supposed to supply and provide with milk and care.

Furthermore, says Winnicott (1957), the good-enough mother provides a setting for feeding, within which the baby forms quiet experiences, being held lovingly by a person who is not over-worried, anxious, and stressed. Regardless of outside events, she is there within the setting and as part of it, and derives joy from the intimacy forming between herself and her baby. The touch of the mother's nipple and the baby's mouth creates an idea in the baby's brain, forming the imaginary image of what is to come. The mother's ability to put herself in her baby's place and feel the baby's needs is what ultimately leads the baby to discover the person within the mother, and then the person within itself. For a baby to adapt to the mother the mother must adapt to the baby.

This paper will describe several styles in which the mother-baby bond develops during the first year of life, using feeding time as an illustration.

The paper is based on infant observations carried out over one year. The hour-long observations began at birth and took place once a week (as per Williams, 1997).

The first meeting with the parents was a prenatal one, and was aimed at setting up the observations as a noninvasive system for the purpose of learning about infant development. As work progressed, the role of

the observer became clearer to the parents, and their expectations of having an in-house expert and advisor, or conversely, their anxiety of being judged, both dissipated when they saw the observer's behavior and stance. Often, the observer's attentive presence intensified the parents' interest in the details of their child's development.

We had gathered a great deal of material, and decided to examine the various issues exposed and explore one in depth. Our chosen focus is feeding- at birth and towards the end of the first year of life, as a measure of the development of mother-infant bond. The question was raised as to the facilitating and obstructing factors that could describe the events in the bond during these first months.

We expected to find change and development taking place in that special dance between mother and baby over the year, even in those dyads where the first observations revealed initial difficulties in mutual adaptation. Obviously, mothering during the first year of the baby's life exposes any mother to complex emotional challenges. Taking this into account, we observed the four dyads.

SHIRLEY: FIRST CHILD, BORN TO PARENTS IN THEIR THIRTIES

Shirley, age 3 weeks

Shirley started crying. Her father turns her so that she is stretched out on her stomach along his arm, looking about through his bent elbow. He explains to the observer that this is the latest position he found to relieve her stomach aches. "She really loves it." Father asks Mother "When was Shirley last attached?" Mother is calculating. Father suggests that Mother nurse Shirley as he passes the baby to her. Mother is not yet ready for nursing and Shirley already seems to be suckling though her shirt. Mother offers her breast and Shirley begins nursing. Suddenly, it is quiet.

A few minutes later Shirley begins to cry. Mother moves her to the second breast and explains to the observer that Shirley knows what she wants perfectly well... Mother adds that during pregnancy they already knew,

by her movements, that she had a strong character. Shirley nurses rhythmically. Mother talks, but looks at Shirley. Shirley loses the nipple. She begins rooting on the breast with her whole face. Mother leans over and now Shirley manages to grasp the entire nipple and resumes her rhythmic nursing. She looks very calm now, nursing slowly, her body relaxed. Mother removes the breast from Shirley's mouth and puts the baby on her chest. Shirley is asleep, her mouth wide open. Occasionally she opens her eyes and immediately closes them. Mother strokes Shirley's face very gently, and, while stroking says how amazing it is that Shirley already has character and that there is a difference in her relation to her father and to her mother: Father is the one she plays with, all she wants from Mother is "my tit." She asks out loud, "So what should I be doing with all my creativity?"

Shirley, 1 year old. At the time of the observation Mother is back at work and Ruthie, the nanny, cares for Shirley.

... Ruthie, the nanny, goes to the kitchen and calls out loudly to Shirley that she's taking the food off the flame so it will cool. Shirley begins to whine a bit, saying, "Ot, ot."

Ruthie tells her it is still hot and they'll have to wait. Shirley turns to the observer and blows "ffff... fff..." Shirley tries to walk but falls on her behind, and sticks her finger into a loop at the back of her shoe. Ruthie says, "Shirley is pret..." and Shirley answers "ty." Ruthie says to her, "Shirley is cle..." and Shirley answers "ver." Ruthie invites her to come to the living room until the food cools, gives her shape-sorting toy, and takes the objects out of the box. She places them far from Shirley. Shirley takes one of the objects and she and Ruthie start a game - Shirley puts the shaped objects in the box [through the correct, matching opening]. Ruthie applauds, Shirley looks at the observer who smiles at her.

At some point, Ruthie goes to the kitchen and prepares a plate for Shirley and another, empty plate. She seats Shirley in the highchair and ties a bib around her neck. Ruthie uses a tablespoon to feed Shirley. She first puts a few carrots on her plate and

warns her that they are hot. Shirley takes the carrots with her own fingers and eats them voraciously. Ruthie gives her soup with noodles. One noodle falls on to Shirley's hand and she plays with it while she opens her mouth wide. Initially it seems clear that she's enjoying the food. A few minutes later it seems Shirley is full. Now, every time Ruthie tries to feed her she opens her mouth, closes it on the spoon, and shakes her head sideways. Ruthie gives Shirley a carrot to give to the dog. Shirley throws it to the dog. Ruthie now gives her pieces of chicken and tells her to give them to the dog. Shirley looks at the chicken, brings the pieces close to the dog, just about giving it to him, and then puts it in her mouth. She repeats this several times. Although she seems full, Ruthie keeps on giving her food. Shirley says an emphatic "No!" to each spoon, until she ends up turning her head every time Ruthie tries to give her soup. Footsteps are heard outside the house; Shirley blows a kiss, sits up straight, looks at the front door and starts calling, "Dada, Dada."

SHIRLEY: DISCUSSION

In early life the atmosphere during feeding time was full of Mother's necessary and healthy amazement with Shirley - maternal preoccupation (Winnicott, 1956). The feeling is that Shirley must have been familiar for a while (denial of foreignness), special, with a will of her own - a product to be proud of. Mother appears in this aspect as a mother who already feels the need to know her daughter, a deep, mystical knowledge. This knowledge would give Mother a feeling of confidence in her inner resources and confirm her inner voice - this alongside the feeling that Shirley must fit into the patterns of expectations that Mother had constructed for herself. Nursing is relaxed and in tune with Shirley's signals and rhythm.

Superficially, Father seems attentive, involved, and supportive. However, he is not sufficiently attentive to Mother's personal rhythm and to the pace of the attachment between herself and Shirley.

Shirley reacts serenely to her mother's adaptation to her. The feeling of reciprocity in the process is tangible.

At the end of the first year, despite the

fact that it was technically impossible to observe a feeding scene with Mother, we found important elements in the interaction between Shirley and the nanny, and these could be indicative of Shirley's development within the significant relationships.

The atmosphere is pleasant and playful. There is amazement, availability and mediation on the adult's part for Shirley's difficulty to wait, in a way that helps her use symbolizing and play to do so. Feeding is orderly, and has a defined space and time. At the same time, there are both feeding and the space for self-feeding, which contribute to Shirley's joy of the process.

Clearly, Shirley knows how to define what she wants and signals in ways that allow her to activate the human environment for her own needs. She enjoys overall happiness, her eyes sparkle, and she is playful. Both her motor and her verbal skills are well developed for her age.

SAM: FIRSTBORN SON TO PARENTS IN THEIR LATE TWENTIES. BORN BY CESAREAN SECTION

Sam, 2 weeks old

Mother sits cross legged on the bed in the bedroom, nursing Sam. He nurses vigorously, his eyes open, looking at Mother and holding the fabric of her shirt. Nursing is through a silicon nipple atop Mother's nipple. The phone rings. Mother answers. She talks loudly. Sam keeps on nursing. More phone calls, all of which Mother answers, while holding Sam to burp him and then moves him to the second breast for the rest of the feed. She says to Sam, "What's the matter? You've gotta know that you have a hyperactive mother. Get used to it." Sam does not seem to mind the surrounding commotion. He nurses vigorously. Sam watches Mother with interest. There is eye contact between them. He responds to the telephone ringing by turning his head to the sound. His gaze is also turned to other items on the bed. Within the busy atmosphere Sam's small voice indicates his wishes to his mother.
Sam, 8 months old

Mother decides to give Sam a quick

"fruit meal" before she leaves in the morning and before she wakes her husband who is supposed to stay with him. She has no time to mash fresh fruit, and says she'll "take a shortcut." She brings a jar of reddish baby food. Mother begins to feed Sam while he sits and plays inside his playpen. Sam is happy with the food although he has not yet asked for it. Even before she started feeding him, he opens his mouth and makes chewing motions when he sees Mother with the jar. Very soon, Sam and the playpen get dirty, and a large quantity of the pureed food spills onto Sam and all around him. Mother tries to gather the spillage into a cloth diaper in her hand, but the diaper, too, becomes red very rapidly. Mother relates to the fact that Sam is getting dirty, says something about it, but does nothing to change the conditions. Sam begins to put toys in his mouth with the food. They too get dirty. Mother says that Sam is no longer hungry. When she stops feeding him he gripes a little. Mother puts him in his walker and Sam goes merrily on his way.

SAM: DISCUSSION

During Sam's early life, the atmosphere in the bedroom where he was fed was busy and crowded, managerial in character. Mother gets herself organized quickly. There is no time or place for anything. With Mother, everything happens simultaneously. There is also no space for the post-cesarean pain. She is Doing and Acting all at the same time. There is also no time for a learning process of nursing, and the quick answer, therefore, is the silicon nipple. This nipple may serve as a means to distance Sam from her and to push away the feelings that skin-to-skin contact could evoke. Mother's message to Sam is that she will not change. He has to adapt to her, which, indeed, he does. Sam is very alert. He's already "on his mark," surrounded with stimuli, and continues nursing.

At eight months, Sam's feeding is still influenced by Mother's needs and schedule. The dominant feeling is that of lack of holding, of something not gathered. There are no comfortable physical conditions, and now, too, there is no physical contact between Sam and Mother. The uncomfortable feeling is also a result of confusion

between different areas – Sam gets his food in a playpen full of toys. There is no separation between play areas and eating areas. Mother tries to do everything quickly, but her speed indicates lack of adjustment, sloppiness, and inaccuracy. Now, too, Sam adapts himself and even eats happily, even if he has shown no signs of hunger. Sam also confuses things – he puts a hard toy in his mouth while his mouth is full of food.

DAN: FIRSTBORN, BORN AFTER TREATMENTS FOR INFERTILITY TO PARENTS IN THEIR FORTIES

Dan, 2 ½ weeks old

Dan is on his side, his eyes open, his legs tucked up to his abdomen, shakes his hands and spreads out his finger, tilts his head sideways, opens his mouth and moves his tongue about. Dan begins to cry and mother takes him in her hands and asks him, "Are you hungry?" She kisses his face and hands and sits on the bed to nurse him. She rocks herself and him, talks softly to him, and when she does not succeed she says, "I guess he is not hungry" and puts him back in the crib. Dan is restless, contracts his legs toward his abdomen. Mother takes him out of the crib again and he makes a snorting sound. She says she's afraid he has asthma, but the doctor said he did not. She massages his abdomen lightly and puts him back in his crib. Dan contracts his legs again, cries, and she goes out to the kitchen to prepare a bottle for him. She comes back, takes him out of the crib brings him close to her body, kisses him and places him in a feeding position. Mother puts the bottle's nipple into his mouth, but Dan refuses to suck. She explains that Dan does not eat more than necessary, or he spits up. She lifts him to face her, strokes his head, while telling about the pregnancy and birth.

Meanwhile she puts Dan back in the crib and says with a smile, "Now you'll listen to the news." She turns a knob on a toy radio that plays music. Dan falls asleep.

Dan, 1 year old

Dan is in Mother's arms. A dish with banana and cheese is on the table. Mother's face is cross and she says

Dan is vomiting. "Maybe the cheese is too cold." Mother sits down, Dan on her lap, close to her at a 130° angle. She brings the teaspoon to his mouth, he tries to move it with his hand, and she puts his hand behind her back. "Come on, Dan, eat, be a good boy." When he moves his head she said, "Come on, Dan, don't make trouble. If you don't eat I'll give you a bottle. Do you want a bottle?" Mother looks helpless. She puts him in his crib. Dan cries and she takes him out again. Dan is on her lap, in a near-supine position, one of his hands incapacitated behind her back, his other hand holding hers. Mother brings a spoon to his mouth; Dan swallows and licks his lips. Mother is very tense, accompanies his mouth movements with her mouth. She continues to feed him but is tense and angry when he does not respond immediately. "Come on, eat, be a good boy." After a few teaspoonfuls Dan tries to sit up, makes a sound, and swallowing motions. Mother gets scared, "Enough, enough, eat nicely." Despite this she keeps on feeding him and again Dan tries to sit up and cough. Mother tenses up and says he makes coughing sounds to get attention, she says to Dan, "Stop, if you don't stop I'll smack you." As feeding lingers, Dan is less compliant. Mother says, "Fine, enough," but goes back to feeding until she gives up and puts him in his crib.

DAN: DISCUSSION

During Dan's first weeks Mother is restless. She listens neither to her intuition nor to Dan's signals. She expects Dan to help her, clearly indicate if he is hungry, and when the answer is not sufficient for her, or does not calm her, she immediately moves into action, alternating between breast and bottle, between taking him out of his crib and putting his back in it. Dan, who has been through two rounds of feeding without actually eating, is put back down and falls asleep. Mother has doubts about herself and her ability to function as a mother, and expects Dan to provide her with assurances of her good mothering.

There is a gap between Dan's behavior and Mother's level of stress. Dan seems calm and does not cry much. At the same time, he does not cooperate with Mother's feeding initiatives and deals with her intensity and

restlessness by falling asleep.

At the end of the first year, the feeding scene also lacks enjoyment and dialogue, and instead is accompanied by stress and struggle. Mother is tense, helpless, and uses various ways to urge Dan to eat. He has to be "a good boy," to eat, so that Mother will feel like a good mother. That Dan would reject the food is intolerable to her, to the point of threatening to smack him. Dan responds with discomfort, with an attempt to change positions, and by coughing. Mother is alert to Dan's signals, to his diminished compliance to eating, but continues to feed him, despite saying out loud "Fine, enough." She also listens to the cough but interprets it in her own way.

HANNA: YOUNGER SISTER OF A SEVERELY DISABLED 6-YEAR-OLD BOY

Hanna, 1 week old

Hanna is sitting in an infant seat on the floor and crying. Mother imitates the sound of crying. Hanna stops crying for a moment, and resume it. Mother brings a bottle of formula mixed with cornstarch. She takes Hanna out of the infant seat, sits down and lays Hanna on her lap, so that they have eye contact. Mother strokes her hair and comments that her brother's hair is lighter. She puts the bottle in Hanna's mouth. Hanna sucks heavily, with effort. The thick liquid drips slowly. Mother checks the nipple and comments gruffly, "You're playing with this like a pacifier. It's not a pacifier, it's food." She brings the bottle back to Hanna who sucks forcefully. A few minutes later Mother lifts Hanna to a sitting position and asks for a smile. Hanna's head nods unstably, her eyes close and she smiles a bit. Mother puts Hanna on her shoulder and pats her gently. Two or three minutes later she lays her across her knees. Hanna's movements are sharp as she searches for the bottle, she finds it and sucks noisily. Mother mentions that at the Well-Baby Clinic they told her that Hanna is gaining weight too rapidly, and had recommended a smaller portion. She treats this with disdain, and says she adds cornstarch to the milk. "If she wants to diet, she can do it when she's older." She remembers how small her brother was at birth, and

that he reached Hanna's weight only around age 10 months. Mother lifts Hanna to a standing position. Hanna is very unstable, her legs buckle and her face is gloomy. Mother turns to her, "How about saying something to Mommy? Do you know that Hanna talks a bit?" Hanna hiccups and burps, milk oozes out of her mouth. Mother puts her into the infant seat. Hanna cries loudly. Mother says that the burping is unpleasant for her, and turns on the mobile in front of Hanna's face. Hanna moves her hands uncomfortably and one hand hits the mobile. Her gaze is at the ceiling. She tries to change position. Mother rocks the infant seat with her leg, and slowly, Hanna falls asleep.

Hanna, age 1 year and 3 weeks

Mother serves a glass of tea. Hanna sits on the rug, looks at the observer and says, "mmm." She crawls over to the observer and reaches out for the glass. The observer moves the glass and warns Hanna that it is hot. Hanna turns to a small plate and puts it into her mouth, finds a small crumb on the rug and puts it in too. Mother goes out to the kitchen to prepare a bottle for Hanna. She returns and imitates Hanna, "mmm." Hanna crawls toward her and sits at her feet, but Mother is talking to the observer and paying no attention to her. Hanna bursts out crying. Mother bends over to her and apologizes to her that she did not notice that she had reached her. She gives Hanna the bottle and a cookie. Hanna sits on the floor, alternating between drinking from the bottle and biting off of the cookie. She changes position, sits on her knees, straightens her back and continues drinking. Mother reaches to her and tells her to show the observer how her walking is improving. She lifts Hanna, stands her up, and supports her from behind.

Hanna, eating, does not want to budge. She is not comfortable but she stands and smiles. Mother urges her along, demonstrating the way to take a step. She is disappointed and scolds Hanna, seats her on the rug and sits herself on the couch. Hanna crawls toward the couch, pulls her bunny – which has a pacifier tied to its tail. She puts the pacifier in her mouth, mumbles, bringing her face close to it. Mother calls her but Hanna stands leaning on the couch, her head on the bunny and her eyes closed. Mother says that sometimes Hanna just falls onto the floor like that and falls asleep. She

calls Hanna again. Hanna half wakes and dozes off standing, leaning against the couch. Mother remembers that the nurses at the Well-Baby Clinic told her to dilute the orange juice with water. She mentions with disdain that they don't know Hanna who likes it thick and sour and she has no intention of changing that.

HANNA: DISCUSSION

When Hanna was first born the atmosphere seems pleasant and smiley; there is much talk, although the talk is aggressive and carries multiple meanings. The scene opens with Hanna's signaling that she is hungry. Mother responds by imitating the crying. The imitation is cute, but is also a tease. It contains recognition of the crying but also denial of its essence. There is softness and warmth in Mother's contact with the baby, but she does not allow herself to give herself to Hanna. The feeding scene is often interrupted by Mother's actions. To a great extent, Mother does not behave like a recent parturient who is trying to understand her daughter and respond to her. She feels she knows the girl. It seems that this "knowledge" is premature, and less suited for Hanna's developmental phase. The healthy baby brings up harsh memories of the brother's difficult development. Possibly, Hanna is supposed to alleviate Mother's anxiety, grow up quickly, and be strong.

Mother declares that she knows what Hanna feels and needs. Nevertheless, the milk is thick and suits neither Hanna's age nor weight. The fact that sucking the thick milk is difficult for Hanna is not a signal for Mother to adjust the type of food for her. While ignoring Hanna's signs, she stands her upright, wants her to talk and smile, and thus disrupts her eating.

A year later the pattern is repeated. There is no relating to Hanna's neediness and smallness, but rather an expectation that she will participate in the adults' activity. Mother alternates between ignoring Hanna on the one hand, and using her to relieve her own anxiety about Hanna's normal development on the other hand. When Hanna does not respond to her she scolds and moves her away. Hanna finds her own independent ways to cope and be comforted.

GENERAL DISCUSSION

Feeding can conceptualize processes that enhance or obstruct the development of the maternal-infant bond during the first year of life. Feeding is a reality and a metaphor of the intimate connection between the two partners – a mother and her baby. We will address three axes:

1. Foreign – familiar
2. Transformation of anxiety
3. Creating an intermediate space as a measure of normal development

Axis 1. Foreign – familiar

During the first year the mother must simultaneously contain the fact that the baby is familiar to her ("her flesh and blood," a family member) and foreign to her (with his or her own character, tastes, and space) (Benjamin, 1991).

The feeling of foreignness and familiarity is first experienced on the physiological level. In the beginning of pregnancy the baby is a "foreign object." The mother's body works to assimilate the baby into it, recognize the baby as part of her body, or her body will attack it as it does any other foreign object. The baby ripens using maternal resources for nourishment. The birth process is a cooperative one. When the baby is born it is "a stranger to the world." The process of acquaintance begins with the question: Who does the baby look like? Who does the baby resemble in character? This takes place simultaneously with inner negotiations within the mother between the fantasy baby and the real one – the "familiar" baby that the mother had formed in her mind during pregnancy and the real one. The mother must relinquish the familiar, fantasy baby to meet the real, foreign one, a baby who elicits anxiety in her, among other feelings. This is the starting point from which she once again must turn the baby into someone familiar, "one of the family." This is a complex dialectic process.

If the baby is "too familiar," there is the danger of denial of the baby's foreignness and separateness, turning the baby into an extension of the mother. Conversely, if the baby is experienced as a foreigner and there is a denial of his or her familiarity, there is danger that processes of alienation

and closing off will occur.

Shirley's mother experiences her daughter as a familiar baby, but also as a baby with strong character. This maintains a double holding of both sides of her mutually. The result is secure holding and containment, as well as tolerance for small failures without overwhelming anxiety.

Sam's mother keeps him at a distance by using the silicon nipple, thus rendering him more foreign than familiar. She denies potential intimacy between them and it is up to him to take care of acquaintance and of adjusting to her temperament.

Dan's mother is full of such intense anxiety with his existence that she does not allow herself to hold and examine either the foreign or the familiar at a more realistic level, but rather carries on dialogues with herself. Dan remains an unfamiliar stranger, reacts with passivity and retreats into sleep.

Hanna's mother makes a division between that which is familiar and that which is foreign in her daughter. There are rapid transitions from foreignness to familiarity and vice versa, which confuses the system and paralyzes it: When the child is too familiar there is no space for her needs, they are only understood through the mother's point of view; when she is foreign, mother is alienated and distanced.

Axis 2. Transformation of anxiety

Many theoreticians address the anxieties that accompany the beginning of life – both mother's (Stern, 1985) and baby's (Klein, 1930). The main anxiety is the question of the baby's survival. Klein (1930) and Bion (1967) claim that babies project annihilation anxiety onto the mother in a process of projective identification. In a process of reverie (Bion, 1967), the mother employs detoxification to process, digests the anxieties and returns them to the baby, so that the baby, too, may digest it. The mother, too, is busy with the question of whether she will be able to keep the baby alive.

Stern (1985) lists four themes that occupy mothers in a normal process of their formation into a mother:

1. Life growth theme – Will she

manage to keep the baby alive?

2. Primary relatedness theme – Will she be able to form an authentic emotional bond with the baby and will this connection ensure the baby's emotional development in ways that are desirable to her?

3. Supportive matrix theme – Will she know how to create and facilitate the support system required to attain these functions and turn them into reality?

4. Identity reorganization theme – Will she be able to change and adapt her self-identity to her definition of a mother?

In a normal process of developing the mother-baby bond, these initial anxieties will give way to other anxieties and different issues of coping that will arise during the subsequent stages of development.

Shirley's mother is gradually learning to rely on her inner resources and develops inner serenity that reflects on her daughter. She perceives Shirley as a big alert baby, with a strong character, and in doing so has the security that Shirley will live. At the same time she develops her ability to allow the baby a life. Situations of potential anxiety are handled calmly and securely, which allows her attunement and repair when needed. Mother has the ability to create and facilitate a support system that helps her cope and contain both Shirley's anxieties and her own, enabling growth.

Sam's mother faces her baby's and her own initial existential anxieties through denial. There is no space for pain after a surgical birth. There is an immediate need to see Sam as a big, surviving boy. Feeding is done amidst much commotion, inattentive to "little Sam." His infancy turns into background noise. Mother is not busy reorganizing her identity as Sam's mother, but demands that he adjusts to her personality.

Dan's mother copes with existential anxiety – both in the beginning of life and at the end of his first year – by projecting her anxieties on him. At the same time, she does not manage to make room for reverie for his anxieties. She shoves his anxieties back into an ever-developing circle of projection, which results in the development of alienation and loneliness for both of them. Thus, even at the end of the first year, Dan

is still put back in bed without eating. Mother, in her loneliness, does not manage to develop support systems that will enable her to fulfill maternal functions in different ways.

For Hanna's mother, existential anxieties are exacerbated by the real experience of true threat because of her disabled son, and raise a real question regarding her ability to create a healthy child. In her encounters with Hanna, Mother protects herself against these anxieties by disengaging from Hanna and her smallness, and by denying her own need for reorganizing her identity as a mother of a healthy child or for receiving help from support system at home and outside. The processes of disengagement and schism deepen over the year. The more Mother tries to push Hanna to grow, the more Hanna regresses and her development halted.

Axis 3. Creating an intermediate space as a measure of growth

So far we have discussed the axis Foreign – familiar and Transformation of anxiety. Now we would like to address the third axis. It is important to distinguish between this axis and the previous Foreign – familiar one. While the first axis relates to the inter-subjective experience between mother and baby, this third axis relates to the intra-psycho domain, and allows the baby to create, within itself, the distinction Me – Not Me. We assume that there are mutual influences between these two axis.

Winnicott (1960) related to the intermediate zone of the experience as a source of development, a place for authentic expression of self. What enables mother and baby to create such a space?

In her mind, the pregnant good-enough mother sees herself and her baby both as integrated and separated. Thus she leaves space for whatever will form, without predetermining what it is that will form, holding and carrying the anxiety of the unknown. She allows her baby to form the space Me-Not Me without vengeance or premature separation. A mother who responds with sensitivity and with correct timing to a baby's signals allows the baby to feel that he or she has the space to create themselves and can realize

this developmental direction. A baby who will not be given this space will have to compromise on a concrete, limited role, or retreat into a private world of fantasy. Lack of sufficient intermediate space will damage the development of curiosity, the desire to investigate, as well as symbolizing and play.

In the initial feeding process, Shirley's mother already relates to the intermediate space, and to play and creativity. It comes as no surprise, therefore, that at the end of the first year Shirley operates within this space. She signals her desires in a clear, age-appropriate manner.

Sam's mother message to her son is that he has to fully adjust himself to her, and therefore, no space was formed for Sam's otherness. The feeding scene at the end of the first year finds Sam sitting in the playpen – the play space – surrounded with toys, but he is expected to eat there. This does not create space for pleasure – neither of play nor of food.

Uncertainty creates overwhelming anxiety in Dan's mother, and this does not allow her to remain in an unknown space. She does not have the inner space for not knowing. In her encounters with Dan she "knows" even before she looked and checked. Mother's "knowledge" renders Dan lonely, misunderstood, and sends him to bed hungry. At the end of the first year anxiety brings out aggression in Mother, and she threatens to smack Dan. Dan is revealed to us as a passive child, he touches toys, but his lack of play is noticeable.

Hanna's mother is confused. Her words seemingly convey representations of the intermediate space (play, smile, movement, talk), but her actions eliminate the possibility that such a space will develop. There is confusion in the words themselves, as they match expectations from a bigger girl. Mother's actions relate to Hanna in ways that are inappropriate to her age and needs. Even after the first year, relations between Mother and Hanna remain as they were in the neonatal stage. It is not surprising that Hanna's motor, language, and play development are arrested.

CONCLUSION

Through descriptions of the feeding episode, this paper presented various aspects of the maternal-infant bond. We described a spectrum of maternal-infant bonds as they were expressed in feeding in the beginning of the baby's life and at the end of the first year. Feeding was chosen because it is rich in detail, and is a paradigm that represents maternal-infant bond on both the concrete and the metaphoric levels.

Our expectation was that at the end of the first year of life mutual changes and adjustments would take place between mother and baby. There are many prisms through which different multilayered emotional realms might be revealed, mutually influencing each other. We chose to relate to adjustments in the mother-infant dyad during the first year through the dialectics of foreign and familiar, transformation of anxiety, and formation of intermediate space. Clearly, there are other factors which have not been described in this article and can reveal other emotional realms.

The spectrum we showed includes a good-enough style, one which enables normal development, and various forms of relationships where obstruction and formation of development-arresting, pathogenic

factors were observed. The article bolsters the current trend toward preventive intervention at the earliest stage possible, and emphasizes the advantages of assessment by observation and the importance of observing the mother-infant dyad.

Elishiva Susz is a senior psychologist, from Tel – Aviv, Israel.
Tzippy Kalish, M.S.W. is a psychiatric social worker from Tel – Aviv, Israel.
Irit Kushilevitz, M.A. is a clinical and developmental psychologist from Haifa, Israel.
Ruth Orenstein, M.A. is a clinical psychologist from Tel – Aviv, Israel.
Anat Raviv, M.A. is a clinical psychologist from Tel – Aviv, Israel.

References

- Benjamin, J. (1988). *Bonds of love*. New York. Pantheon Books
- Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. New York: Basic Books.
- Bion, W.R. (1967) The theory of thinking. In: *Second thoughts*. London, Karnac Books
- Fonagy, P. Steele, M. Steele, H. Moran, G.S. & Higgit, A.C (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal*, 12, 201-218.
- Klien, M. (1937). *Love, guilt and reparation. The writings of Melanie Klein: Vol. 1*. London, Hogarth Press.
- Pionteli, A. A. (1992). *From fetus to child*. New library of psychoanalysis, 15, Ed. Spillius, E. B. London. Tavistock/ Routledge
- Stern, D. N. (1995). *The motherhood constellation - A unified view of parent infant psychotherapy*. New York. Basic Books, a division of Harper Collins Publishers, Inc.
- Williams, G. (1997). *Internal landscape and foreign bodies*. London, Tavistock Clinic Seris.
- Winnicott, D. W. (1949). *The child, the family and the outside world*. London.
- Winnicott, W.D. (1956) Primary maternal preoccupation. In: *Collected papers: Through paediatrics to psychoanalysis*. London, Karnac books.
- Winnicott, D. W. (1960). Ego distortion in terms of true and false self. In: *The maturational processes and the facilitating environment- Studies in the theory of emotional development*. London, Hogarth Press.

Renew your WAIMH membership

Online at www.waimh.org.

For further information on membership,
please contact WAIMH office
at office@waimh.org.

SALVADOR CELIA: LATIN AMERICA RESILIENT FRIEND

Writing about the death of a friend is a very painful task. I cannot imagine Salvador dead, because his image is strongly linked to vitality, energy and the desire to do. I refuse to remember him in any other way than with his arms widely open, his warm smile or his attitude of attentive, reflective and respectful listening, or expressing his assertive modesty when it came to defend his points of view.

In Latin America, he has always been the Great Pioneer in the mental health field. When most of us were only concerned with the disease, he was also interested in health and its promotion. When our therapeutic repertoire included almost exclusively psychotherapy, he was exploring other enriching resources. When the typical medical career in the region began with the study of the dead body, he claimed that it should start with a birth. And he did so when he taught in the Medical Faculty, promoting the mother-baby relationship from the very beginning.

I do not intend at all to make an enumerative counting of his many merits. My written lines are emotionally touched from the scenario of my grateful memory of such an active and productive human being. For many years, Salvador was the Director of the famous and innovative *Escolinha* which served atypical children.

He was a hard worker capable of dealing with different issues while eliciting positive emotions around him. He was a man with great charisma, his whole person radiated empathy. He was committed to the disadvantaged, sensitive to the needs of others, a hard humanist, and he became a tireless fighter for social justice. As a great organizer, he created different multidisciplinary working groups.

As a generous teacher, he was seriously interested in research and scientific developments in the field. He created the paradigmatic Project Life (*Proyecto Vida*) in an

old ceramics factory, and then had to accept with resignation the political incomprehension that dismantled it. As an enthusiastic promotor of the theater festivals in Canela, he defended the association of art and education.

I met Salvador and Isabel, with whom he formed such a lovely couple, in the 70s at the clinic of Prof. Luis E. Prego Silva. From then on each year, once in Porto Alegre and once in Montevideo we met Prego's and Salvador's working teams in order to discuss clinical cases.

With Salvador it was impossible to meet without healthy fun and enjoyment. In one of these meetings, in which more than once we finished the day dancing, he saw that I was wearing a white jacket and blue trousers. He put a white hat on my head, pointed to me and exclaimed: "Look! 'The Malandro' !!! (after a character in Chico Buarque's opera.) Everybody laughed, and for many years he continued calling me 'The Malandro'".

During the last decades we met in many meetings, conferences and congresses both in Uruguay and Brazil, as well as in other parts of the world. We always enjoyed the reunion, share projects, discussed plans and made jokes.

The first World Congress we shared was IACAPAP's in Dublin, 1982, then came Paris, Lugano, Kyoto, Buenos Aires, Chicago, Punta del Este, San Francisco, Venice, Modena, Tampere, Stockholm, Aix-en-Provence, Montreal, Marburg, Hamburg and Berlin in 2004.

It was in Kyoto, 1990, that we both proposed to bring together the three international associations: IACAPAP, ISAP and WAIMH. In 1991, in Buenos Aires, Juan Miguel Hoffmann agreeing with that proposal brought together WAIMH and ISAP. It was until 1993 in Punta del Este that we could meet the goal of bringing together the three associations, which gave Salvador and myself much

satisfaction. Unfortunately, that spirit of unity and coordination could not be sustained as we would have liked but we still hope for it.

Human beings are what we love, what we do and what we leave behind, and some of those inheritances are anecdotes that give a different and more intimate dimension to the individual.

During the day previous to the congress of Aix-en-Provence, Natalia and I decided to invite Salvador to St. Remy, where we knew Caroline of Monaco lived. Salvador began to joke with an invented but vivid story with hilarious fables and absurd situations between himself and Caroline during the whole promenade that gave us a lot of fun. Another usual joke was to ask me if I was still taking Viagra, in a very loud voice in front of everybody. In Stockholm, returning to the hotel after a scientific activity with Ioko and Kozuke Yamazaki, he delighted us imitating a very particular tour guide who showed us the city. In Venice, at a Meeting of IACAPAP, Ernesto Caffo invited us to dinner at a typical *Pallazzo*, home of a very wealthy executive of the industry. We arrived to the old and beautiful building by boat, we lost Salvador for a while, and when we met him again he was singing a duet of Italian Canzonets with the homeowner who he was meeting for the first time.

Salvador is alive in us and will continue to live every time we uphold social justice, and each time we work for the best development of the human baby, and fight against discrimination, or embrace a social cause with a bit of his extraordinary intensity. I will always imagine Salvador with his open arms, receiving us with a friendly hug and saying, in his perfect Spanish with Portuguese prosody: "everything is possible if we try together, brother"

*Miguel A. Cherro Aguerre,
Montevideo, July 2009.*

Literature Monitor



BOOK REVIEW

L'avenir de la Psychiatrie de l'Enfant (*The Future of Child Psychiatry*), by Yvon Gauthier, M.D., Professor Emeritus in Psychiatry, Montreal University Medical School, Past President of WAIMH, Quebec, Canada.

Reviewed by *Sam Tyano, M.D.*
(*Professor Emeritus in Psychiatry, Tel Aviv University Medical School, Israel*)

Yvon Gauthier, a Canadian Child Psychiatrist, or more exactly an Infant Psychoanalyst, invites us through the reading of his book on Child Psychiatry, to join him on an exceptionally rich and interesting journey along the development of Child and Infant psychiatry. We are used to read either scientific books that bring new clinical and/or research knowledge, or autobiographies aimed at describing a piece of past or recent history. In his book, Gauthier takes us into the history of Infant Psychiatry through his own professional milestones. This is an account, not only of our own profession, but also of how babies became thought of, in different parts of the world, and more specifically in Canada, with a Québécois flavor in it...

The author starts with the description of his own professional training, that reflects the main milestones in the development of the field of Infant Psychiatry, a field that is at the intersection of Psychiatry, Pediatrics, Obstetrics and Perinatology. This is by positioning at this very intersection that our clinician will find his/her professional identity. The author takes us what I would name "Continuing Education", meaning traveling from one center to another, searching for the State of the Art in the understanding of the baby's emotional development.

For instance, the author retraces the history of Psychoanalysis, while focusing on transition points, such as from Adult to Child Psychoanalysis, and later to Infant psychoanalysis. One

of the special flavors of this rich and scientifically well-ground book is that one feels along the pages Gauthier's core identity as a psychoanalyst, even when he writes about the most recent findings in neuro-imaging...

Gauthier shares with us his own life events that have contributed to the conceptualization of his clinical work, and have enriched his teaching. For instance, it is through the fine observation of the complexity of siblings relationship in real life, that Gauthier has been one of the first teachers to emphasize the role taken by siblings conflicts in the development of the child and later, in parental projections clinicians often observe in clinical families.

The author makes us walk along the introduction of the main notion of the dialectics between genetics and environment, between the individual's and his/her transgenerational intrapsychic processes, between brain and psychoanalysis. This description is based on a concise but precise mentioning of the main thinkers in the field, while each one of them has added a piece to the puzzle of understanding the baby in general, and more specifically the role of his/her first interpersonal experiences in the development of his/her future personality.

Following the description of the history, comes the clinical part, that is so intrinsic to Yvon's person. Each chapter treats a topic, illustrated by a clinical vignette. This is through these vignettes that the reader discovers Gauthier's wide clinical wisdom, especially relating to psychosomatics and maltreatment in infancy. This is also through this clinical lens that the author presents his main views about Social psychiatry and community infrastructure networks.

Then, comes the history of the different intervention modalities in infant psychiatry, dyadic as well as triadic, while trying to analyze them in the light of psychoanalytical concepts. This, in itself, throws a different light

to the child's developmental portrait and raises contingent questions related to the treatment approaches.

Yvon Gauthier concludes his discourse on the integration of the old and the new theories of development, by claiming that the child builds him/her self by and through the Other. By becoming a Self though the Other, he/she will be able, later, to take care of another One, the same way that his/her parents could empathize with him/her, recognize his/her needs and desires, his/her withdrawing and approaching movements, treat him/her as another Self and not as a part of themselves. This is the history of the development of a true and full Self.

To conclude with a personal note, I would suggest to include this remarkable book in any infant clinician's professional book arsenal.

Finding Hope in Despair: The Story of Charlene and Jay

By
Julie Stone

Winnicott (1960/1980) famously reminded us “there is no such thing as a baby.” The parent or caregiver is central in the infant’s world and well-being. However, there are times when the interpersonal world of infant and caregiver becomes fraught with conflict and miscommunication, times when the needs of the mother are in conflict or in competition with what her child needs for healthy development.

I have chosen to write about Jay and his mother, Charlene, because our work with them painfully illustrates the dilemma and difficult-to-resolve therapeutic challenge of keeping the needs and experience of both infant and caregiver in mind without being drawn into the sometimes destructive drama being played out between them and without colluding with one against the other. In our work, as a team of two therapists working with Jay and his mother, this difficulty became intensified rather than being highlighted and better understood.

For the relationship between mother and infant to be “good enough” and to serve the infant’s healthy development, the loving feelings must outweigh the hateful. The loving and mutually satisfying shared experiences between mother and infant must outnumber the hateful and painful experiences of misattunement, miscommunication, and misunderstanding.

When the mother is feeling that her baby is telling her she is not good enough, how can she manage to stay present to the baby? What happens? The mother may protect herself from the unmanageable or threatening experience in some way, by cutting off from the raw feeling, distancing from it psychologically, or dealing with the

threat to self by externalizing it and blaming someone else. Sometimes, she blames the baby. Charlene’s pursuit of a diagnosis to explain Jay’s behavior and developmental delays brings into sharp focus the inherent tension in all therapeutic work between assigning a diagnosis and seeking a dynamic understanding of the child’s experience of the world and his parent’s experience of the world.

That the infant has a mind and seeks to make sense of his world through interaction with the minds of others informs all of my clinical work. Charlene’s need for attention and narcissistic bolstering made it seemingly impossible for her to put Jay’s experience and his imperiled development at the center of the treatment. She saw and experienced Jay as a burdensome child, difficult and damaged. Charlene had come to believe that Jay “had autism.” To her this meant that Jay had “something wrong with his brain” that rendered

him unable to love and be loved like “normal children.” She held little or no hope for Jay’s development, and saw him as destined to a life of impaired communication, robotlike interaction, and bizarre—at times “out of control behavior”—that made no sense. Charlene believed that Jay’s behavior was determined by his biology, and that there was little she could do except be supported in learning how to “manage him.” Reputedly, her belief was shared by Jay’s grandmother and by one of the staff at the child care center Jay attended for many hours every week.

Charlene’s conviction that Jay was autistic had prompted her to seek eight assessments for him prior to our involvement. He had been assessed by three different pediatricians, working in different parts of the health service, as well as by a developmental psychologist, two speech pathologists, an occupational therapist, and a physiotherapist. None

ZERO TO THREE Corner

The Center on the Social and Emotional Foundations for Early Learning (CSEFEL) is a federally funded national resource center designed to support early care and education (ECE) providers in addressing the social-emotional needs of children birth through age 5. Recent research has found that an extraordinarily high number of young children are being asked to leave early childhood settings because of their behavior. In the article below, the authors describe the Pyramid Model, a framework of recommended practices to help ECE programs support the social-emotional competence of young children and address challenging behavior.

Therapeutic intervention with children and families is not always successful, but the professional literature does not often address treatment failures. Yet all clinicians at one time or another will face challenging cases and disappointing outcomes. To address the need for more information about how to handle challenging cases, *Finding Hope in Despair: Clinical Studies in Infant Mental Health* (edited by Marian Birch, published 2008 by ZERO TO THREE) explores the limitations of infant–parent psychotherapy by examining six different “treatment failures” using a unique format for reflective discussion. The author of each case study provides the facts of the case and the feelings generated by the failure of the intervention. Each case study is followed by a chapter of analysis by another clinician who offers insight on the lessons to be learned from the case. The following article is excerpted from a chapter in *Finding Hope in Despair*.

found his presentation consistent with a diagnosis of autism. Jay's hearing had been assessed; concern about his excessive dribbling had been investigated. Many organic illnesses had been explored and excluded.

The third pediatrician who was asked to assess Jay became alarmed as she gathered together all of the information available in the hospital and outpatient charts. She was concerned that Jay's frequent presentation to health services was communicating something important that needed to be thought about. She referred this troubled mother and son to the Mental Health Services to see if they could help Jay and his mother make sense of what was happening in their family. Despite the findings of previous assessments, Charlene held onto her belief that Jay had autism. I suspect she hoped the Mental Health Services would see what others had not.

My first meeting with Jay was when he was 26 months old and his mother brought him to a hospital Mental Health Services department, where I spent time consulting. Charlene and Jay alone came to the appointment. A child psychiatrist in training was assigned to meet Jay. He had limited experience in assessing children under 3 years, and asked that I join him for the interview.

My colleague and I discussed how we would cofacilitate the assessment. It was agreed that he would primarily engage with Charlene, focusing on her story and observing her and her interactions, and I would engage primarily with Jay, focusing on his story and observing him and his interactions. One of our goals for this initial meeting was that both Jay and his mother would experience that they and their story were important to us.

After introducing himself to Jay and to Charlene, my colleague engaged Charlene. He was warm and sympathetic, listening thoughtfully and asking pertinent and important questions. Engaging Jay proved more difficult. We heard that from the time Jay was 2 months old, his young mother, just 19 when he was born, had taken him to many professionals for consultation. She was "worried about him." She wanted to know

"what was wrong with him." Since birth, his mother said, Jay slept poorly, he fed and gained weight poorly, he responded and interacted poorly. She thought he was "angry and irritable with her." She believed her young son "hated her."

In telling us that she believed Jay hated her, Charlene was alerting us to something very important about her experience as Jay's mother. I wondered if she needed her son to carry her hate, and whether her belief about Jay's feeling toward her was a replay of the hateful relationship she had had with Jay's father and the heartbreak she experienced when her own father left "without saying good-bye" when she was 2 years old. Might she not have felt that he hated her too? What I did not think about was that Charlene might have firmly closed the door on the possibility of a loving connection with Jay.

Jay sat on the floor where his mother placed him. He was stiff and seemingly lifeless. He had no curiosity for the array of toys that were available to him, and he made no reference to me. He did not return my gaze, and seemed not to register my greeting. Indeed it seemed that I was not there to him, and that his mother was right in that Jay was not present to the world around him.

I was undeterred. I continued to talk to him quietly, commenting and translating into simple language for him aspects and themes of the dialogue that my colleague and his mommy were having. My interest in Jay was not dependent upon his interest in me. I could wait quietly, undemanding in my expectation that, given time, his curiosity and interest would be aroused by my interest in him and his experience.

Toward the end of the interview, Jay made a few furtive glances toward me. He looked from the corner of his eye. His face did not register any emotion. However, as they were leaving, he briefly looked directly at me and said, "bye-bye." His mother was delighted, saying proudly that she had just taught him to wave good-bye. My heart sank. Charlene's claim to the one meaningful communication that Jay offered in our first meeting was an ominous indication that perhaps

she experienced his accomplishments only in terms of their narcissistic value to her as an accomplished mother and not in terms of any empathic understanding of Jay's experience or wish to communicate.

Perhaps the most striking thing from this first meeting was how utterly enchanted my colleague was with Charlene. He was full of sympathy for her and very concerned about how she could manage Jay's "difficult behavior." He found her articulate, thoughtful, and "clearly a very concerned mother." The Jay alive in his mind—demanding, destructive, and difficult—was very different from the Jay I had been with. His enchantment with Jay's mother was at odds with my impressions of a needy, preoccupied, and self-absorbed young woman whose own needs seemed to leave little room for the needs of her child. My colleague and I had met a very different mother and a very different baby.

Jay's father, Errol, was absent from his life. He had been a heavy drug user, mainly intravenous amphetamines. Charlene reported that Errol's behavior was erratic and at times extremely violent. She said Errol's violence escalated after Jay was born. She finally left him, taking her son home to her mother. Charlene said Jay suckled at her breast "for hours." Errol would become enraged by this. On the occasion that precipitated Charlene's departure, she said Errol had grabbed Jay from her breast and flung him onto the bed beside her. She was shaken and shocked, and left quietly the following morning.

By contrast, her new partner, Al, she said, could not do enough for her. When asked about his relationship with Jay, she replied, "He loves Jay." This was at odds with her reporting how she once took Jay to the local hospital demanding some respite from Jay's constant demands and neediness. At that time, Charlene had explained that Al was at the end of his tether. He was threatening to leave her unless she could "shut the kid up." Charlene told us she hoped to have another baby, and believed that Al would be a "wonderful father."

I was left with many concerns. My colleagues who had previously

assessed Jay had identified problems in his relationship with his mother; Charlene and her son were clearly not relating well. My colleagues had noted the violent and traumatic early months, and suspected that Jay experienced posttraumatic symptoms and was extremely anxious. They noted developmental delays, particularly in his communication. Jay's expressive language was rudimentary, but he was building his vocabulary slowly and using the words he did have appropriately, sometimes using two and three words together. He articulated poorly and was sometimes difficult to understand, although his jargon had a communicative prosody and was thought to be used contextually and appropriately. Jay often seemed to "phase out," and his attention was variable. At times, he was difficult to engage. His receptive language was assessed as being disrupted by his variable attention, but he was observed to respond appropriately to simple requests and to follow the conversation.

After my meeting with Jay, I thought his flat, lifeless presentation suggested he might be seriously depressed. Charlene certainly seemed motivated to "get some help," and was rightly worried about how she would manage when she had another baby.

Charlene and Jay were offered a place in an infant mental health program where I also spent time. Charlene and Jay were told that the program would focus on helping them relate more enjoyably with one another, and that we would collaborate with them and all the other people and agencies involved in supporting Jay's development. Charlene seemed keen to come. However, just prior to the first appointment, she telephoned to tell us that the family was moving to a town 100 miles away because Al had a new job. I did not meet Jay again for more than a year.

Then, out of the blue, Charlene telephoned and asked if she could still bring Jay to the program. Charlene had put on a lot of weight, and she looked pale and tired. Jay too looked pale and tired. I greeted Jay and reminded him we had met before, saying it was "a long time ago, when you were much younger; you have grown." He stared at me wide-eyed

and quizzical, seeming to listen, but he did not respond in any discernable way.

Over the course of three assessment sessions, Charlene explained she had walked out on her relationship following her discovery that Al had begun a sexual relationship with a woman at his new place of work. She said Al had become increasingly cool, preferring to spend his evenings with this woman than to be with Charlene and Jay. She said he seemed to have lost interest in her, adding, "he was never very interested in Jay." Charlene had returned to the city. She and Jay were again living with her mother until she could find "something that would suit them."

Charlene was hurt and angry. She felt overlooked and discarded by Al. Where once she had spoken of him only in glowing terms, now it seemed he was without any positive attributes. With the force of her anger and disappointment focused on Al, Charlene seemed softer in her concern about Jay. This may have been because she could "blame" Al, which gave Jay some respite.

Charlene now reported that Al had "never liked Jay", a very different story to the one she offered at our last meeting. She said he was very cruel to Jay, particularly when he had been drinking. Charlene reported he had been physically and verbally abusive of Jay. She said that Al would taunt Jay, ridicule him, physically provoke him, and then laugh before becoming angry. Al would hit Jay if he lashed out or became angry in return.

When asked what she had done when this behavior was occurring, Charlene replied that sometimes she would join Al in taunting Jay. She added, "I should have stopped him, or reported him for child abuse." I wondered what stopped her and if Jay was offered up to Al's violence as a way of protecting herself. Despite the anger she was now feeling toward Al, Charlene described a perverse coalition of parental figures against the child in saying that she sometimes joined Al in taunting Jay. I wondered if there was ever a time when Al had joined with Charlene in an alliance in which together they could think about Jay and his needs. It seemed unlikely. I wondered too what Jay made of his experience in this

family and how we might make sense of this young mother's complex need to be loved and what experiences she had that led her to choose men who treated her and her child so cruelly.

Now reflecting on this case, many years later, I wonder what stopped me from further exploring the protective concerns that I had about Jay's safety in the care of his mother or from thinking more clearly and courageously about the limits to this young mother's capacity to provide Jay with a good-enough emotional environment in which to grow and develop. Was I seduced by this mother's seeming eagerness for help, and so rendered unable to think the terrible thought that Charlene really might not be able to find in herself a sustained and genuine longing for Jay to be happy? Maybe Jay's delayed and stunted development might be meeting a need in her, and maybe, in turn, Jay's distorted behaviour had become his most potent and effective means of engaging his mother and so, in this way, it came to serve him too?

While Charlene was talking about the events of the past year, from time to time I spoke to Jay, commenting on the conversation that I was having with his mother. Jay remained aloof, but he seemed to listen closely. On the one occasion he reached out toward a toy, his mother remarked, "Jay doesn't play; he is not interested in toys." He soon let the toy drop. Even in a softer space with Jay, Charlene was unrelenting in her negative attributions of Jay and his behavior. It was painful to witness and to be with. I felt a deadening within myself and again wondered if this gave some clue to Jay's experience.

Another colleague, Vicki, an experienced senior clinician, was invited to meet with Charlene to ask her more about her losses and to explore her hopes for the future. Whilst Vicki was talking with Charlene, Jay and I shared some time in the room where we had met previously with his mother.

After a brief reflective discussion with Vicki, we offered to work with Charlene and Jay, both individually and together. In our infant-parent program we often worked in this way. Our experience was that the joint work, the child-parent therapy, was

often enhanced when both parent and child had a space in which to have a therapist's undivided attention before coming together for the joint relationship work. Many of the mothers we saw were overburdened and needy; almost all of them would have benefited from individual psychotherapy. Most of these women, however, were not ready to consider such a referral, and services for them were limited. What we offered was a space in which the therapist supported the mother to think about her child(ren).

Although the therapeutic plans were discussed with Charlene and she appeared to accept them, we failed to appreciate how fervently she continued to hold on to the idea that Jay had autism or to understand why this was so important to her. Her goal of ultimately receiving this diagnosis for him was at odds with the one we had identified for him and thought we were working toward together.

One week, Charlene arrived excited to share with us her pride in Jay. They had been invited to join in celebration for an uncle's birthday. Previously such occasions had been "a nightmare" for Charlene—Jay usually screamed and generally created havoc. On this occasion, all had gone well. Many people had congratulated Charlene on the "marvelous job" she was doing; Jay had been "great." Charlene had enjoyed him, and it seemed they had enjoyed the outing together. Vicki and I were delighted, and hoped that this was the promise of more harmonious family music to follow.

However, it did not last. Except for brief glimpses of the possibility of something being different, for the most part, Charlene took no pleasure from Jay or in his increasing vitality. She believed that he liked seeing me only because I "let him do what he wanted." It was not the case that I let him do whatever he wanted, though I tried to let him know it was all right to want whatever he wanted. The limits of the therapy room were very clear, and Jay knew them and accepted them. I do not think I was overindulgent of Jay, but his mother certainly did.

After 8 months of working together regularly, Charlene telephoned Vicki

to announce that she and Jay would not be coming back. Finally Jay would receive some "proper help," as he had been diagnosed with autism. I was flabbergasted, as was the rest of the team. Vicki admitted later she had an inkling "Charlene was up to something." She knew that Charlene had been seeing a psychologist who "was very helpful" to her because, she said, he knew she was "the mother and must be in charge." Charlene's sense of not being taken seriously by me was perhaps echoed in her rubbishing the work Jay and I were doing together by bringing it to an abrupt and premature end. She said they would not be coming back. It was as though she could not value any of the work we had shared.

Over the ensuing weeks, Vicki and I attempted to engage Charlene. We invited her and Jay to at least say good-bye. We were concerned about what sense Jay would make of never seeing us again; another abrupt and traumatic ending. In a telephone conversation with Vicki, Charlene said as it was some weeks since Jay had seen us, he had probably already forgotten who we were. What we had offered had been pushed aside, discarded, and reviled. This felt like the repetition of a destructive pattern we had not thought about clearly or fully enough in our work with Charlene and Jay.

Finally, brokenhearted, we had to concede we had been sacked and there would be no opportunity for reparation. Charlene had demonstrated a remarkable capacity to engage service providers and to split them into good or bad, helpful or unhelpful, supporting her or undermining her. Yet we failed to really see and think about the split that had widened in our team. The pediatrician who first made the referral to mental health services stated her concern that Jay's frequent presentation to health services was communicating something important that needed to be thought about. She was right. Despite our best intentions, we missed some very important opportunities to do this thinking, and so failed Jay and his mother.

Reference

Winnicott, D. W. (1980). The theory of the parent-infant relationship. In D. W. Winnicott, *The maturational process and the facilitating environment* (pp. 37–55). London: Karnac. (Original work published 1960).

Copyright 2009, ZERO TO THREE. All rights reserved. For permission to reprint, go to www.zerotothree.org/reprints. To purchase copies of the book, visit the online e-store at www.zerotothree.org or call +1- (800) 899-4301 .

President's Perspective

AKKO WAIMH Regional conference Election in Leipzig



Dear colleagues and friends,

*Leipzig, then Cape town, then
Edinburgh*

Our Leipzig WAIMH congress is coming soon! This will be our 12th one. The Executive committee has just decided that the 2014 congress, following the 2012 in Cape Town, will be held in Edinburgh, Scotland. The Jerusalem bid was very strong, but we chose to apply our rule to alternate between Europe and the rest of the world, in order to minimize the financial risks.

AKKO regional meeting

We had an Executive Committee meeting in Jerusalem, after a wonderful WAIMH regional congress in Akko with high-level presentations, with a special focus on the complex issue of infant mental health in a country at war; Israeli Arabs clinicians presented their experience with working with traumatized populations from both sides. The Signal will publish some of these Akko presentations in the next issues.

Our new bylaws

Our organization has accomplished a major step recently by adopting renewed bylaws, specifically aiming at increasing the active participation of the Affiliates representatives in the Board. This will promote, we hope, a better connection between your society and the others', while WAIMH is a common frame to share thoughts and experience, to build together plans for teaching, for social policy and for clinical intervention.

We will soon launch a brief survey for you to tell us more about what each affiliate is, and what it wants to achieve. We will give you the results

of this survey in Leipzig and in the Signal.

Now the Affiliates have two members out of the 7 voting Executive Committee members: the Chair of the Affiliate Council (will be elected in Leipzig) and the Affiliate Council executive at large (Mark Tomlinson from South Africa, functions in this position until 2010). This step is aimed at giving the Affiliates a strong voice in the Executive Committee (president, myself; president elect, Miri Keren; secretary treasurer Campbell Paul, Deborah Weatherston, Kai von Klitzing and Mark Tomlinson).

What is the EC? What is the Board?

The Executive Committee has the task to run the association and has legal responsibility; the EC is helped by the Board, with the EC being part of the Board plus ex officio members as the Executive Director Palvi Kaukonen, the Editor of the Signal Miri Keren, the Editor of the IMHJ now Hiram Fitzgerald for 3 years, Past President Tuula Tamminen, Program Committee Chair Neil Boris, Past Program Committee Chair Hiram Fitzgerald and Kaija Puura as Associate Executive Director and Advisor. So some functions are held by same people for the sake of efficacy, with minimum cost of meetings for WAIMH. The EC meets annually and the Board biennially at the occasion of the world congresses, but the EC and the Board work continuously through e-mail and Skype.

The Infant Mental Health Journal is now one of the best references in Infancy, thanks to the work of Joy Osofsky. Hiram is taking over for 3 years, with a renewed editorial board, with the goal to achieve electronic submission, inclusion into Medline and make the journal even

more accessible to high level clinical contributions as well as evidence based intervention studies. The journal is still one of the very few truly interdisciplinary one, and one of the cheapest available for the members of WAIMH.

Now the association is run through the central office in Tampere Finland, with Minna Sorsa being your contact person. The web site has been changed and the system for electronically submitting and reviewing papers for congresses is working and under continuous development. The Signal is your journal, waiting for your communications and papers with the description of your association and of your own pioneers in the field of infant mental health in your country and cultures. Miri Keren, the Editor, and Minna Sorsa, the assistant to the Executive Director in WAIMH Central Office, are there to help you editing your papers.

So, we look forward to hearing from you in preparation of the Leipzig Congress. The final word is: Affiliates, do come to Leipzig!

Please remind that you need to be a member of WAIMH to vote and be elected on the board as an affiliate council chair or an affiliate representative, so please check your membership and the one of your representative in Leipzig.

Antoine Guedeny



Infant & Child Mental Health at Brown University

Infant & Child Mental Health
Post-baccalaureate Certificate Program

Summer Workshops
Intensive training in specific
assessment tools and interventions

Beginning Summer 2009

For complete program details visit www.brown.edu/ce

Offered by the Brown Center for the Study of Children at Risk, The Warren Alpert Medical School of Brown University, Women & Infants Hospital, and Brown University Office of Continuing Education



EDITOR'S PERSPECTIVE

About WAIMH intention to prepare a Declaration of Infant Rights

Robert N. Emde, well known to most of us, has submitted to the Board of Directors in Ako this last September, an impressive report with key available documents, and his own perspectives on the WAIMH intention to prepare a Declaration of Infant Rights. This follows a preliminary discussion on the topic, that took place in Yokohama (2008).

In general, the very need of declaration of rights arises when, for any reason, somebody in the society realizes they have become not for granted. Therefore, the very existence of a Declaration of Infant Rights is significant and important in itself, as was the Universal Declaration of Human Rights, adopted by the UN General Assembly in December 1948 (probably not by chance after the horrors of the Second World War). Though the articles, as reviewed by Bob Emde, typically begin with the word "everyone", the declaration referred mainly to adults and their rights for protection against slavery, degrading treatment, discrimination, arbitrary arrest and invasion of privacy, rights for freedom of speech, thought, religion, movement, rights to work and leisure, and rights for security.

One had to wait for 10 years to see the Declaration of the Rights of the Child, adopted by the General Assembly of the UN in 1959. Ten principles were stated, though brief, general and more moral in tone than leading to specific actions. Still, it included important items, such as entitlement to growth and healthy development, with adequate prenatal care, nutrition, and medical care, provisions for children with special needs, right for education and play, right to be loved and supported by parents and society in general, and especially in times of adversity.

Emde has summarized these 10 principles into five basic rights of infants and young children: 1. for health and social-emotional development; 2. for positive learning experiences. 3. for caring relationships (with a special right for attachment relationships). 4. To benefit from their culture; and 5. To receive effective help in times of suffering.

In the light of these, one may wonder whether the infant's rights are in fact different in essence from the

older child's, and whether we need a Declaration of rights specific to Infants. Though indeed these five basic rights apply to children of all ages, the relative lack of awareness that infants are capable of emotional intelligence and consequently develop non verbal, mainly somatic symptoms of emotional distress in adverse situations, creates the need for a Declaration, specific to infant rights, in general and more specially the emotional and developmental ones. Bob Emde concluded his



comprehensive report with the following recommendations to the WAIMH Board:

1. To form an initial list of rights, after affirming the infant rights as articulated in the UN Declaration of Human rights and in the Convention on the Rights of the Child and adding points not covered in these documents.

2. To facilitate active dialogues that will ultimately lead to the improvement of the initial list of Rights. In order to create such a dialogue, there is a need to connect and collaborate with those who have already been involved in global human rights work, such as the UN Committee on the Rights of the Child, that is an independent group of experts, together with the Society for Research in Child Development, professional groups such as Zero To Three, WHO, IACAPAP, etc... and some non governmental organizations such as Amnesty International, Human Rights Watch and Global Exchange. This collaboration will enable WAIMH to learn about experiences of other groups in promoting human rights. In parallel, this learning process needs to be culture-sensitive, in order

to find ways of applying universal human rights within varying cultures and political systems.

3. Putting into action: identifying places where infants rights are at risk or are clearly violated, and planning for intervention strategies.

For example, this may be extremely relevant to infants who live in areas of political violent conflicts. In these places, infants, toddlers, and children from both sides of the conflict, suffer from PTSD, family breakdown, parental depression and anxiety, etc.. with their known long term developmental and emotional sequelae. One could imagine WAIMH acting to increase the awareness of both societies in conflict to the impact of the conflict on their infants, so that early signs of emotional distress would be detected and treated. In that way, WAIMH putting into action the Declaration of Infant Rights, would obviously not impact on the conflict itself, but could, perhaps, lessen the violation of the infants' rights, that is inherent to growing in a chronic violent conflict. From my own perspective as a mental health professional living in a country in war, this kind of action seems to me

as mostly relevant to WAIMH central aims...

I would like to conclude with Bob Emde's final questions, and invite all our members to reflect on them and share with us thoughts and experiences, so that the Signal can serve as means of information exchange:

1. Are we to prioritize where we consult as WAIMH members and how we consult based on our declaration?
2. How do we assert infants rights when other rights, such as freedom of speech, press, religion, assembly are violated? Or when life itself is denied?
3. Is there a hierarchy of human rights?
4. How do we deal with cultural variation?
5. How do we deal with political resistance to asserting infant rights?

Your feedback, as WAIMH members, is very much solicited. Please send it to Mark Tomlinson (markt@sun.ac.za), who is chair of the Infant Rights Task Group, to myself (ofkeren@internet-zahav.net) and with a copy to the WAIMH office (office@waimh.org).

Invitation

It is with great pleasure that we invite you to participate in WAIMH's forthcoming world congress.

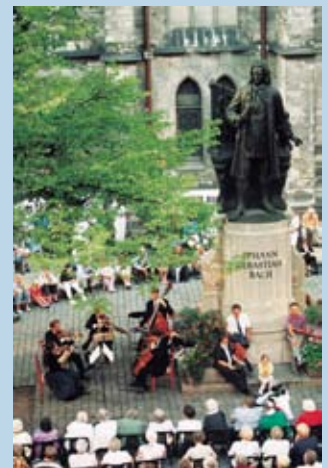
The central theme of the Leipzig congress will be „Infancy in Times of Transition“. Transitions are essential to the lives of young children. For the individual infant, there are transitions from intra-uterine to extra-uterine life, from early forms of relatedness to more specific object relationships, from the preverbal to the verbal self, and many others.

Within the family, there are transitions from dyads to triads and to broader family relationships. The city of Leipzig, where I live and work, has seen a major transition of the political system over the last 25 years, from the collective system of a communist dictatorial state to a free market economy and democracy. This change was hard won by the people, but it has also brought some insecurity into family lives. Young children are the first to be influenced by these kinds of social transition. And we, as mental health professionals, try to help families and infants to cope with these changes, which involve opportunity and risk at one and the same time.

We are looking forward to welcome scientists and infant mental health experts from all over the world, in an exchange of scientific research, clinical experience, theoretical thinking and social political ideas. And we promise: because of its great tradition of liberal open mindedness and scientific curiosity, Leipzig will be a good place to meet.

For further information on WAIMH 2010, please contact: Congress Registration, Exhibition, Organisation: INTERPLAN, E-mail: waimh2010@interplan.de, Website: www.waimh-leipzig2010.org

We look forward to seeing you soon
Kai von Klitzing, MD
Professor of Child and Adolescent Psychiatry,
University of Leipzig
Chair of Local Organizing Committee



Information and news from the Central Office



Dear WAIMH members

The year 2009 has been very busy here at the WAIMH Central Office at Kauppi Campus. After the office transfer we have worked very hard developing the WAIMH website together with Tina Houghton and Carl Raymond from Michigan State University and the staff at the Internet4Associations. Because of the Leipzig Congress, we have been developing an electronic submission system customized specifically for WAIMH. All problems have been fixed, and we believe that the end result is going to be wonderful and something we can successfully use for many years to come.

Developing the electronic submission system usually does not go without some problems, as some of you may have noticed. We have received feed-back that adding additional presenters data and copying the abstract text have been difficult. The main problem turned out to be that the additional presenters data were not saved, if their e-mail data were not filled in! Unfortunately it took quite a while, and many meetings until the coding was corrected. The system has been planned to be as

easy and flexible as possible to WAIMH members, who can use their membership logins for filling in data, and much of their information is pre-filled. However, this means that changing your personal data in the Congress submission area, also changes your data in the membership register. Please remember that the logins and passwords are for personal use only!

The development of the affiliate pages of the website have had to wait their turn, but in time they will also provide new possibilities for WAIMH to serve you. We would like to remind all our affiliates that even now you can send information to the WAIMH website about events you are organising. You can also read the past issues of Signal on our membership pages, and search information of WAIMH members, if you wish to establish contacts with members in other countries.

Please note that it is time to renew your membership, which you can easily do on our website. The membership goes yearly from January to December, and if 2009 is not yet paid for the system automatically offers the current year first for payment. We encourage you to tell about our organisation to your colleagues and friends working on the field of infant mental health, and ask them to become members, too. One remarkable bonus of becoming a member is that you can order the Infant Mental Health Journal for a reduced price. The Journal is slowly but steadily becoming more prestigious and influential, thanks to the persistent work of editor Joy Osofsky and new editor Hiram Fitzgerald. WAIMH membership together with the journal is truly a good bargain.

And finally, the 12th World Congress of WAIMH in Leipzig, Germany is nearing. The program will be rich in knowledge, and the social program in music! So come to Leipzig, and encourage your colleagues and friends to come and experience the inspiring and unique atmosphere of WAIMH World Congress.

With our warm greetings from the cold, snowy Finland.

Minna, Kaija & Pälvi

AFFILIATE CORNER

The 12th WAIMH congress will be held in 2010 (www.waimh.org). The Yokohama congress (2008) was a great success, thanks to Hisako Watanabe and her team, with 2000 people attending from all over the world including a large Asian contingent. We also had a number of countries and affiliates represented that had not participated previously. WAIMH has recently adopted a set of new bylaws, specifically aimed at strengthening the role and increasing the powers of affiliates by increasing their input to the Board of Directors (BoD) and the Executive Committee (EC) of WAIMH. According to the new bylaws we now have a new organizational body called the Affiliate Council (AC). The Affiliate Council is comprised of the presidents of all WAIMH affiliates.

The Executive Committee has seven voting members, four of them elected by the members of WAIMH. Two members of the seven will be special representatives of affiliates: the chair of the Affiliate Council and another affiliate representative (now Mark Tomlinson from South Africa, EC member till 2010). This gives the affiliates a strong voice in the Executive Committee. The Executive Committee consists of Antoine Guedeny (President of WAIMH); President-Elect Miri Keren; Secretary-Treasurer Campbell Paul; Kai von Klitzing and Deborah Weatherston and Executive Director Palvi Kaukonen as ex-officio member. The Executive Committee has the task of running the association and has full legal responsibility for decisions.

The EC is assisted by the Board of Directors which is comprised of the members of the EC plus as ex-officio members the Past-President Tuula Tamminen, the Executive Director Palvi Kaukonen, the editor of Signal Miri Keren, the editor of the IMHJ, now Hiram Fitzgerald for the next 3 years, the Chair of the Program Committee Neil Boris, the Past Chair of the Program Committee Hiram Fitzgerald and Associate Executive Director Kaija Puura as advisor. As is evident, some people have several functions in order to increase the effectiveness of WAIMH without adding additional costs (fewer meetings). The EC meets annually and the BoD biennially during the world congresses, but the EC and the BoD work continuously through email and Skype. The election of the Affiliate Council chair will take place in Leipzig next June 2010. The first meeting of the Affiliate Council will take place during the Leipzig congress, and there will also be time for the affiliate presidents and the members of BoD and EC to meet one another.

We hope the new structure and bylaws will facilitate better connections among and between affiliates and with WAIMH in order to share thoughts and experiences, to build plans for teaching, for social policy and for clinical interventions.

Antoine Guedeny
President of WAIMH

Mark Tomlinson
Affiliate Representative of WAIMH