

THE SIGNAL

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What have we learned from cases where we felt we did not do enough or felt we failed?

By Frances Thomson Salo Ph. D, Dilys Daws Ph. D, Antoine Guedeney, MD, Campbell Paul FRANZCP, Astrid Berg FCPsych

Introduction

Frances Thomson Salo

This paper is based on a Symposium presented at the 12th WAIMH Congress in Leipzig, Germany in June 2010.

The presenters of the symposium, coming from London, Paris, Capetown and Melbourne, who respectively work in an outpatient setting, a paediatric tertiary hospital and child protective services, discuss those cases where they felt that

they may have missed something in the work, or failed in their intervention, in order to extrapolate further clinical learning. Difficult countertransference feelings such as anxiety, guilt and shame have also been explored.

The authors present an overview of when is a failure perhaps not a failure, or the helpfulness of rupture and repair (Benjamin, 2009). Bearing in mind Winnicott's statement about how private settings enable intensive psychotherapeutic work, in contrast with what can be achieved in public health settings, we discussed in this symposium cases where clinicians felt unsatisfied with the outcome of the treatment, and cases where the patients expressed disappointment

Each of the authors addressed their own specific clinical domains and approaches: Dilys Daws through her experience as a child psychotherapist, Antoine Guedeney from his experience with very difficult cases where the clinicians' countertransference and system issues are in complex interplay, Campbell Paul from his experience with the sick and dying infant and his or her family and Astrid Berg with her long term clinical work with those tragedies when a young child loses a parent. The main focus of the symposium was to discuss the clinicians' part in failed cases.

For instance, how to distinguish between what is 'good enough' and what is not 'good enough, such as saying too much or too little, doing too much or waiting too long to make a diagnosis and to take action. Failures with child protection cases are often the result of the clinician's failure to keep the whole story in mind and/or to impact the system and to speak out about the infant's needs. Countertransference feelings of powerlessness and paralysis towards disorganised families may

predispose to projective identification with patients or the system. There needs to be a review of the formulation so that it informs the work, and a capacity to recognise when a clinician has made too hurried a diagnosis and not fully understood the dynamics (the dialectic between knowing and not knowing) (Gold & Stricker, 2011). A major point is the clinician's capacity to view parents' lack of cooperation as a reaction to his/her failure to recognize their need for time in order to develop trust.

This symposium strengthened the need for reflective peer supervision, in order to keep the "good- enough" balance between too much frustration and too much gratification of patients. Dawson (2011) conceptualized the stuck therapeutic situations as a series of traps which are possible because 'clinicians want to maintain a view of themselves as helpful and benevolent, making experiences where they are dismissed or seen as malevolent particularly difficult to reflect upon (p. 36)

Additional issues have been addressed in this symposium, such as defining the time when the therapeutic aim has been achieved, getting feedback from the parents themselves (Birch, 2008), defining the role of the supervisor, and deciding the length and intensity of follow-up that families experiencing difficulties need.

Error and repair

Dilys Daws

Dily Daws's generation of therapists have realized today their lack of awareness of the very existence of child sexual abuse, that was in fact the explanation for their lack of improvement in spite of intensive therapy. The children would go on being restless, uncommunicative, at odds with the therapeutic relationship, or showing explicit sexual behaviour. As

Contents

Thomson Salo, Daws, Paul & Campbell: What have we learned from cases where we felt we did not do enough or felt we failed?.....	1
Compagnone & Jean: Systemic analysis of group affiliation: Clinical uses of the SAGA...9	
Gonzalez-Mena & Briley: Improving infant mental health in orphanages: A goal worth considering	14
Affiliates Corner.....	17
Priddis: Australian Association of Infant Mental Health (AAIMHI)	18
Zero to Three Corner/ Birch: Core concepts in infant-parent psychotherapy	21
Editors' Perspective/ Writing about failures with difficult cases	25
Presidents' Perspective.....	26
From the Kauppi Campus -News from the WAIMH Central Office	27
xx.....	28



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Dily Daws recalled: "Were they psychotic, we wondered? We spent hours in their company but the sad truth is that we did not ask them the most important questions that would have helped them to tell their unbearable, unthinkable story:.

Josie, I felt fondest of, was an 8 year-old girl in care whom I saw at our Day Unit twice weekly, and then once weekly at the Clinic for 2 to 3 years. The Clinic had close contact with several children's homes in the area. The staff of the home seemed warm, caring and supportive of the therapy. Josie made a 'home' in my therapy room - on the inside of the door to her locker she stuck a list of her toys.

20 years later, Josie, now with 2 children both on the child protection register, sued the local authority for thousands of pounds of compensation for sexual abuse in the children's home. The case went on for months, years, and nothing was proved. The local authority managed to lose the Clinic file with my unsuspecting notes.

Was this a case of abuse, accurately recalled when she had vulnerable children herself, was it opportunistic for the money, or was it a more general feeling that there should be compensation for a childhood spent in care? This wild child was felt to be unfosterable and unadoptable. If there was abuse was it current in the children's home, or earlier in her family? Her escort to therapy loved her, and so did I, but only for an hour a week. She was the one child that I had a serious fantasy of taking home and looking after properly. Perhaps I knew that I was failing in what she really needed - understanding and knowledge of her actual experiences."

Tronick (1989) talked about 'the normal, often-occurring miscoordinated interactive state as an interactive error, and

the transition from this miscoordinated state to a coordinated state as an interactive repair (116). This concept may be valid for therapist-patient interactions, as well as for parents and infants. Feeling misunderstood may be an intrinsic part of the therapeutic work, in other words, getting it wrong may be part of the process of getting it right. How comforting that even our mistakes may turn out for the best!

Dily Daws reports her therapeutic experience with Jessica and her 4-month-old baby Thomas:

Thomas had been born by IVF from an implanted donor egg and Jessica told me of the distress about him not being her baby genetically.

In the first meeting I collected them from the Baby Clinic. Jessica was holding Thomas outwards in a sling, and both looked at me. I noticed but did not remark on their likeness. In the meeting Jessica started by telling me of the implanted donor egg and her distress about this. I said, a bit confused that I had thought how alike they were, and she agreed that people said that. I asked if Thomas looked like his father and she said he did. I asked if she looked like the father and she again said yes. We had a moment of wondering together about this likeness.

The next meeting was 6 weeks later after our summer holidays. Jessica talked more about her feelings about Thomas not being 'her' baby genetically and about Thomas' liveliness, which was apparent and very attractive. I then made my big mistake, and said that it was a generalisation but sometimes when mothers were depressed their babies were very lively to help cheer them up. I immediately felt I should not have said it. A theoretical point, not a timely felt one, and certainly not one discovered between us. The next week they were late. In the room Jessica

said she was angry with me for last time - what I had said about depression and liveliness. I said that I had worried that she was not coming because of that. She said, "I thought you would." We laughed a bit, but she said she was upset that I was wrong. I said perhaps it was useful that she could think I was wrong but could still come and make use of it. She was then able to talk more about the IVF; she had her own embryos, but had had a miscarriage. The doctor said she had a better chance of carrying an implanted embryo to full term - her own frozen embryos still exist. She also talked about her very difficult critical mother, and I wondered if the decision to use an implanted egg was also to disconnect from her own mother, I had just seen the film, *I've Loved You so Long*, where a mother adopts for this reason.

The next time she said how helpful this had been and told me how traumatic the birth had been. She had needed a caesarean, had a haemorrhage and a blood transfusion. She remembered her partner crying, thinking she was dying. After all this she could not move and they asked, "Don't you want to hold your baby?" She could not move to pick him up and no one offered to put him in her arms. She said she could not bear to look at the birth pictures because she and the baby are apart. They were being looked after separately. I said, "They were saving your life." In a later session she told me her partner was desperate for them to have another baby. I asked if that would be dangerous for her. She said, "Thank you for asking that."

My acknowledgement of how life threatening the birth was helped the work become less emergency

focused and we moved on to the separateness between Thomas and herself, and to going back to work in a legal profession that she loves. The conflict between her wish to keep him close, his growing independence and indeed her own wish to separate brought back some of her agonising about whether he really was her baby. She talked about her fear of having to tell him one day and what that would do to their relationship. I said keeping him so close now was because of her fear of losing him. I said he was supposed to grow up and leave her one day. I said I wondered if it was easier that he was not a girl, and that carrying a female embryo that was not her own might have been harder. Perhaps as a boy he might care less about whose egg it was - that was women's business. She laughed and said her partner thought that, too.

There was also a long journey to the United States to see the father's parents. She began one meeting by saying how angry she was with me for the previous session when she had told me of her mother-in-law's wish for them to go straight to stay with them. I had no idea what it was like to travel overnight with a baby, be exhausted and need to recover. I said I had sided with the grandparents and we both smiled, as complices.

Dily Daws goes on wondering:

"Why have I chosen this case as one to apologise for? This was a successful, indeed enjoyable piece of work although based on a mother's extreme distress that natural conception could not produce a live baby. I think that my crass mistake in the second session, of making a probably correct but completely mistimed interpretation was my defence

against the distress she had come to tell me about. Perhaps also I had come up with a bit of theory to make up for my profound ignorance of the complexity of IVF. I had not previously taken in the meaning of egg donation and that there are no inherited maternal genes. Jessica's anguish included the feeling that her mother-in-law was blood-related to her baby, while she was not. A colleague pointed out to me that serum passes from mother to baby through the placenta. How much had she indeed made him her own in the womb? The fact that I could apologise and settle down to attune with her was perhaps helpful in changing her perception of her mother. As I became a therapist who could be wrong but still useful, so her mother changed into someone who offered welcome help and insights. To balance this, her mother-in-law became more infuriating. I think the separateness that my mistakes implied also allowed us to look at the separateness between her and Thomas in a less fraught way. When I said about the birth, "they were saving your life," she could give up some of her projected fury with the obstetric staff for treating Thomas and herself separately. She could move on to the ordinary life process of separating.

Dily Daws felt the main mistake she had made in this case was to say too much. She reported another case, where she felt she said too little:

"I recently saw a mother Mildred and her 2-month-old baby Fraser, where I did badly miss the point. Mildred is from a war-torn country. In the UK she has been raped by more than one 'uncle' and has HIV. The conception of the baby was not from a rape, and did not cause the HIV. In our first meeting she told me a story,

not of rape but of having been defrauded of all her savings, and being further tricked into getting into debt. Listening to this story of a tragedy unfolding, my blood ran cold. I was physically affected by hearing the story and could hardly bear to listen. It actually felt as bad as many of the stories one hears of rape or near-death births. I asked about other times when she had been helplessly drawn into a sacrifice of her self and learnt of emotional abuse and denial of her identity. I learnt that the father of the baby had refused to allow the name she had chosen for her son and insisted on one that had no meaning for her. As we talked I noticed that Mildred rarely looked at the baby. His buggy was placed so that I could not see him and because of the urgency of her story, and the shame with which she told it I did not, as I usually would, pay attention to him. In the next couple of meetings she talked of her shame about losing her savings and that Fraser's buggy was second-hand. She had lost the money that would have bought him a new one, and had to pay back her debts. I was full of indignation on her behalf and told her of the government scheme to help people in debt, including condoning some debts to banks. The health centre had someone who could advise her on this. I see myself as a very sensible therapist in touch with the environment. Mildred said she preferred to pay off the debt.

In a later meeting Fraser cried and she picked him up and held him to look out of the window. This time I did comment that she did not look at him. She was surprised and said that she had a cold and she did not want him to see her looking like that. I said she was important to him and I

thought he would really like her to look at him. It did not occur to me to say that she might feel that the HIV has damaged her so much that she does not want him to see that. Because of the drugs for the HIV she is unable to breast-feed him. I wondered where the outrage about this has gone? As Fraser has learnt to sit up I have asked Mildred to let him out of the buggy to sit on the floor near us both. I played with him, handing toys to him and taking them back. I invited Mildred to join in and she said how much she enjoyed it. The next time she spontaneously put him on the floor. Fraser looked at me and held out his arms. I said to Mildred that he remembered our game after a gap of two weeks. The shame of the loss of the money seemed to recede and Mildred talked about her return to work. She has a degree and has worked in an administrative job, but in the recession seems unable to get back into this. She works as a carer, and travels for up to 2 hours to do piecemeal jobs of ½ - 2 hours, travelling between clients' homes. I have said how exploited she is letting herself be, and she has started to feel this, and now refuses the ½ hour jobs.

Until writing up the case, I had not noticed how systematically I have avoided talking about the effect of the HIV on Mildred's relationship with Fraser. HIV is an exquisitely shameful state and is often kept a secret. Patients ask for it not to be in their notes. A general practitioner told me that patients treated in a specialist unit may not tell their own doctor about it. With good referrals I sometimes feel that I am supposed to know about the HIV but not to discuss it. The loss of a future that the loss of the money represented to Mildred must be

much more located in the loss of a healthy body that could nurture her child; she might always feel she would be a source of contamination and danger to her child.

Lessons from foster care situations

Antoine Guedeney

As Antoine Guedeney explained, an infant in foster care and their parents evoke very complex and mixed feelings in the infant mental health team, as the situation of a neglected, sometimes abused or distressed child evokes both attachment and caregiving or internal working models (IWM) in each member of the team. In such situations, our IWM conflicts, as do those of the child and of the parents. If a baby alone does not exist, nor can an individual alone integrate such complexity: the group is needed to take up a position, after careful and independent clinical assessment. When such a position cannot be reached, then we find ourselves in a difficult position between conflicting identifications, leaving a child in a parentified position or having failed to address major safety issues with the parents.

Three cases of 'half-failure' in foster care situations

Antoine Guedeney suggested in the vignettes that follow that the main difficulty was to accurately assess the level of disorganization in the child, probably because of countertransference attachment issues, which are, themselves, difficult to open with the team

Case 1: The B family

The mother, Mrs B, suffered from psychosis, with Major Depressive Disorder, and had a past history of neglect and abuse in a foster family. The father was illiterate, with a low IQ, and was the unrecognized son of a German soldier. He first married Mrs. B's mother and then fathered three children with Mrs. B, a boy and

twin girls. Mrs. B was on her own with the girls soon after their birth and she asked for placement of the three children. After the children had spent one year in an institution, she asked for them to return home, which was arranged. After she experienced a long depressive episode, the second of three placements of the children in another institution took place, followed by their placement with a foster family. Mrs B claimed for the children to be returned to her full-time.

The main challenges presented by this case included acknowledging the fear roused by Mrs. B in the team members, keeping in the team's mind the clinical story as a whole, in order to make out of it an organized script, and assessing the children's status.

Case 2: The failed evaluation of the extent of disorganization of attachment in infant and mother:

M was born of an episodic encounter between his mother, Mrs E, who experienced psychotic episodes, was intelligent and well supported by her family, and his father who suffered schizophrenia and was described as isolated and aloof. M received good caregiving for 8 months until his mother had an acute psychotic episode. He was placed for 18 months in an institution, and then returned to his mother. She had several further delusional episodes but he was not placed again until Mrs. E went to the police and disclosed she had abused him. We were bothered with the fact she did not disclose this to us, the therapists...Ongoing full time foster care with mediated visits by his mother was arranged.

Case 3: Feeling helpless in front of the judge's decision:

Mrs. N is the mother of a 4-year-old girl, S, and a 2-year-old boy.

She has a Borderline Personality Disorder, with a past history of foster care and abuse, and of becoming involved with men who abuse her. She was verbally abusive of her daughter S, who shows disorganized attachment and role reversal, with speech and learning difficulties and considerable agitation. The father who is drug addicted is in jail, and was only interviewed once. Effective treatment of S was delayed by her mother leaving to be close to her own mother and going back and forth between her own mother and her children. S. looked emotionally disturbed, and her brother had violent tantrums. The social worker obtained a placement order in a residential institution. The children spent 5 years in this institution and significantly improved. Unfortunately, their mother will soon regain custody, in spite of her unstable condition.

The team felt they failed at evaluating accurately the level of the girl's disorganization. They also felt surprised, depressed and powerless when the judge decided to give the children back to their dysfunctional mother, on the basis of the social workers' reports that showed an improvement in the mother's parenting skills.

These three failed cases led Antoine Guedeney's team to take several steps in the management of foster care situations, in the light of the special countertransference processes embedded in these very complex situations:

1. Group reflective supervision: one clinician alone cannot hold in mind all the aspects of the situation.
2. Team "attachment" meetings
3. Assessment and treatment of such complicated cases should be done by two separate teams or at least by different members of team.

Lessons from working with very sick infants and their families

Campbell Paul

Campbell Paul said it can be very hard for us to think about our mistakes. For the very young infant with relationship and developmental problems the consequences of an insufficient intervention may be severe. The clinician working with very sick and hospitalised infants can at times feel very confused and overwhelmed by the intensity of issues confronting each of the child, the family and the therapist.

It may be that we feel we are not able to deliver what is the optimal service for the baby and her parents. We may feel we have not done enough to understand or ameliorate the distress experienced by the baby's parents and her carers. The acute paediatric hospital is a complex, fluid and changing human system. The stakes can be very high with disability or death as possible outcomes for sick infants. An opportunity to talk openly and reflectively with colleagues is essential. Infants with chronic illness, often have a long term relationship with a paediatric hospital. This provides an opportunity for the infant mental health clinician to monitor and evaluate the effect of their input when it occurs early in the baby's life. Parents and the child herself provide powerful feedback about how constructive or otherwise we may have been.

Some common mistakes which may occur in this clinical context include at the conceptual level:

- Letting the family feel their problem is too hard
- Idealizing the infant or the parents
- Having no feelings towards the infant or the family: disavowal of countertransference
- Doubting our responsibility and capacity
- Losing the family who perceives the clinician as making them feel worse: how to help parents feel the gravity of the situation, yet not have them feel overwhelmed
- Being too intrusive or too avoidant of contact with the with the baby
- Talking too much with the parents, and not engaging the baby

Still, the therapeutic process involves

making mistakes: we must experience taking risks in our interactions with the baby, taking chances; this is what the ordinary parent does. The therapeutic process also involves the process of rupture and repair (Beebe, 2010; Tronick, 1989). The therapist's interactions may seem silly or may seem 'sloppy' as discussed by Stern (2010). Taking these risks is an essential part of engaging the infant with a view to therapeutic understanding.

These failures are important to be aware of, since they are especially relevant to those very young children who demonstrate autistic defences in the hospital context.

At 3 months of age Anna was assessed for poor development and poor muscle tone. She had multiple investigations, neurology consultation and an MRI and all with normal results. At 6 months she was referred to infant mental health by a paediatrician because of possible autistic/developmental disorder and she was excessively floppy. Her mother's concern was, "She doesn't look at me and she is very alone and won't play with other children. She has no social gaze." Over time her mother reveals that she really experiences major depressive symptoms and feels alienated and distant from her husband and her family. Her daughter constitutes for her a real experience of oppression. We offer approximately second-weekly infant and psychotherapy and later time-limited infant and psychotherapy group. Anna and her mother come regularly, but we do not see Anna's father. Despite the interventions in our belief that Anna does not have an autistic disorder and mother does receive such a diagnosis from other professionals, and from a Web-based clinical service. We found the use of videotaping sessions and reviewing these afterwards to be a powerful way of trying to understand some of the issues that the child and

how frequently we may miss the essence of the interaction during therapy session itself. For us as therapists it can be disturbing to see how often we appear to "miss the mark" with the child's communicative response, and misunderstanding the parents experience.

Paediatricians referred a 2 ½-year-old boy, Charles, who had been admitted to hospital because of severe constipation. The ward staff noticed that he appeared difficult to engage and was preoccupied with the television, his favourite show was one which featured a transparent face with only eyes and mouth. His parents related the tragic story about their prolonged infertility. Charles was conceived at the time of the distressing death of the family dog. There was a brief moment when the parents were able to relate what their son meant to them. A clearer picture of severe autism emerged. At a 15 year follow-up Charles has profound autism with minimal language and sometimes very difficult aggressive behaviour. He and his mother have remained locked in a dreadful symbiosis. Could we have done more an earlier stage? It seems in retrospect that his parents were not able to mentalize the un-mentalizable (Slade 2009). Reviewing a family video of his first bath in the maternity hospital it was clear that he was an extremely dysregulated infant whose parents were unable to read and respond to his anguish. Could we have helped his parents

Extraordinary devotion from parents is often seen among parents of very sick babies: They give up much of their life for their sick baby. Parents may feel they can not afford to let the baby out of their mind lest she die: but may not see the baby as a person. We need to allow them to express intense ambivalence at times and also to allow for hate. Parents' devotion can

be a problem for the staff, who may feel intensely watched and criticized. It can make it feel uncertain as to who decides on the baby's best interests and treatment : her parents or the hospital team. The staff may feel they are in competition – raising the question 'Whose baby is it, anyway?'

What have we learned along years of work with sick infants and their parents? Generally families are available and receptive to mental health intervention: despite initial fears, they do want to know what their troubled baby is feeling and thinking. Perhaps we underestimate the resilience of parents and siblings in the face of an extremely ill infant or one who dies. This resilience may be related to what role parents have had in being with their sick or dying infant.

For the clinician, regular discussion within a team where clinicians feel respected and trusted, where playful and creative discussion may occur, around even the most distressing and grave situations, may be among the main protective factors for making fewer mistakes in these painful and distressing situations.

Doing too much: When does infant-parent psychotherapeutic work end? When life starts with a trauma – implications for the therapeutic relationship

Astrid Berg

According to Astrid Berg, having a baby constitutes probably the most highly charged time in the life of parents:

We know that pregnancy and the perinatal period are often accompanied by an 'affective upheaval' (p.25) even in the most normal and stable women (Slade, Cohen, Sadler & Miller, 2009). This emotional time is also felt by the rest of the family such as father and grandparents. If during this already tumultuous time, an unexpected event, a crisis, a trauma occurs, it is superimposed on this already unstable system. Engaging in a therapeutic relationship at such a moment is thus one fraught with intense emotions on both sides – that is, the collective transference from the patient and family as well as the countertransference coming from the therapist. Astrid Berg elaborates on these countertransferential processes:

The countertransference – doing too much and assuming too much

The tragedy of many family's situations are deeply moving. The death of the mother during the early phases of the child's life constitutes a crisis of unequalled intensity. The grief over the loss is compounded and amplified by who is left behind: namely, a human being in its most vulnerable phase of life. The birth right for 'absolute dependence' on 'the live mother and her womb or infant care' (p84) (Winnicott, 1990) is suddenly and irretrievably taken away. In cases of parental suicide or violent death this level of crisis often precipitates immediate and unusual intervention on the part of the therapist.

The therapist who comes in from the outside gets pulled in, and is often compelled into action that he or she may, under less fraught circumstances have resisted. Who gets seen when may become muddled because of the sense of collective urgency and distress. So it may happen that the first consultation takes place not at the clinic or consulting room, but at infant's home. For example, following the murder of his wife a distraught father calls on a therapist, requesting the presence of a professional when he tells his pre-school and toddler boys about their mother's death. How can one insist on an office interview in the heat of this moment?

Similarly, who gets seen and consulted may be wider than would usually be the case and include extended family and house-help, nannies or au pairs. Because of the desperateness that this primal loss evokes the usual protective boundaries of the therapeutic frame may momentarily be broken.

The loss of a mother of a young child is traumatic, traumatic in the sense that it causes upheaval in the psychical organization of those who are left behind. The upheaval is more than in other phases of the life cycle because of what this loss represents to the child and family: namely the violation of an inherent human birth right to be cared for.

The devastation that this reality brings to the surface is a compensatory impulse of rescue, of wanting to save. This 'saviour complex' reaches into deep levels of the psyche, layers which can be called archetypal in the sense that they are universal human impulses. Jung described a complex as being a feeling-toned 'image of a certain psychic situation which is strongly accentuated emotionally...this image has a powerful inner coherence... [and]...a relatively high degree of autonomy.' (p96) (Jung, 1969) The complex

is something that 'can have us' (ibid); in other words, we are not always conscious of it and certainly not in control of it. This urge to help an 'abandoned' infant can pull us into the realm of these powerful affects and resultant urges to go along with these and 'act out'.

Psychoanalytic writers do mention the 'saviour complex' in terms of idealizing the analyst and seeing him/her as the saviour (Steinberg, 1988) and, in a similar vein where mirror self-object countertransferences may be at play (Köhler, 1984), that is, the idealizing is mutual and comes from both the patient as well as the analyst. These situations are often precipitated by the psychopathology within the patient which in turn finds a 'hook' within the analyst. However, the argument brought forth here is that the saviour complex that is constellated because of a tragic human situation – that is, an actual traumatic loss during infancy - reaches realms which lie beyond personal psychopathology. The 'image of a certain psychic situation' is that of an infant out in the cold, so to speak. It would evoke a response of urgency and action in most human beings – in this sense it is dimensions which are transpersonal or archetypal.

In the beginning this urge is of benefit to the child and the family – they do indeed need someone who is committed, who will walk the extra mile in the sense of being flexible, available and reliably present. It may lead to an ongoing, long therapeutic relationship which initially is stabilizing and containing. The family and child find comfort in going back to the 'original object' as it were, because of the strong affective ties that have been built around the initial trauma. And thus the cycle of what could be called 'benign mutual' projective identification of 'saviour and being saved' continues.

But, families and children heal with time, the helpless infant becomes an active pre-school child, the surviving parent may find a new partner and life becomes normal again. Are we as therapists always sufficiently aware of these positive developments that are occurring with our patients?

Or, put in another way: are we as therapists sufficiently in touch with our own saviour complex and the family's development to know when the time has come that they are no longer needed in the same way as before? When is it time to stop and to let go?

There is no clear cut-off age and it is an individual case-by-case decision. One

of the difficulties of many cases is that the contact may be intermittent and in different modalities. The fluidity which was necessary in the beginning may eventually lead to an ongoing blurring of boundaries of therapeutic spaces. But sometimes there are signs within the therapeutic system that evolve and that could serve to alert the therapist.

Family relationships may have stabilized, and 'the infant' has become a pre-schooler, needing to enter the stage where work takes over from play. This may be the point when a hand-over should occur, when, if necessary, one should let an 'outsider' do a fresh assessment of the child. 'Hanging on' to the child may not be of help – the original therapist may not have the objectivity to look at the child in a sufficiently dispassionate way.

Beginnings in infancy are powerful and they evoke 'wildness within and between', to quote Joan Raphael-Leff (2003). In these cases of early trauma the 'wildness' has to do with a prevailing need to help, to be a continuous, consistent, good-mothering presence for the baby who had lost a parent in a tragic manner. This attempt at compensation may work for the first few years, but then it can become corrupted: the growing child needs more than a nurturing therapist – she or he may need an educational assessment and a more objective psychological evaluation. The original therapist may not be the appropriate person to give this. The 'wild' beginning of our young patients' lives and its effect on us as therapists may be one of the explanations of why we may realize this too late and end up doing too much.

To conclude, talking and thinking about failed cases and repressed difficult issues at each WAIMH conference, could be a very beneficial experience for trained and experienced clinicians, as well as for the younger ones. We all remember how, as trainees, the lessons we most remembered were those of a senior clinician talking about his/her failures (eg. do not initiate discussion of drugs on the phone with patients; take a break when you begin to raise your voice with patients; be careful when you get angry about a case, etc.)

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Astrid Berg
Red Cross War Memorial Children's Hospital & the University of Cape Town

Dilys Daws
43 Heath Hurst Road, London NW3 2RU

Antoine Guedeney
Hopital Bichat Claude Bernard, AHP Paris, & University Denis Diderot, Paris VII

Campbell Paul
Royal Children's Hospital, Melbourne , Infant Mental Health Group, The University of Melbourne, and Murdoch Children's Research Institute

Integrated Mental Health Service, Royal Children's Hospital, Melbourne

Frances Thomson Salo Murdoch Children's Research Institute & Royal Children's Hospital, Melbourne
Dept of Psychiatry University of Melbourne, and Murdoch Children's Research Institute

Systemic analysis of group affiliation: Clinical uses of the SAGA

By Philippe Compagnone

Maître de Conférences en Psychologie
Clinique, Université de Bordeaux2

Catherine Jean

Psychologue du Développement

Introduction

SAGA was initially developed for use in clinical setting for family therapies. Adapted from the FAST (Family System Test) developed by Gehring (1992), SAGA examines family representations of their dynamic relationships and social organization. Following our initial explorations using the FAST, we sought to develop a more user friendly systemic tool capable of assessing both affinities and power differentials of family social ecology (Crook, 1970; Strayer, 1984) in both clinic and research settings. In its current version, the SAGA serves as a floating object establishing « an experimental and exploratory field that family members share with therapists» (Caillé et Rey, 2004, p 49).

As a clinical procedure, the SAGA offers a concrete illustration of Minuchin's structural perspective on family dynamics (Minuchin, 1974). Family dynamics depend both on alliance relationships (mutual affinity and support) and on lines of authority (influence and decision making). The family is viewed as a dynamic system characterized by repetition of transactional patterns between members establishing how, when and with whom different individuals can relate. These patterns, more or less stable, reflect explicit or implicit reciprocal adaptation and bargaining between family members.

In order to access the family structure, Minuchin defines the concept of boundaries as the rules by which someone participates in a subsystem. These rules secondarily define how and where the authority lies. Characterizing the boundaries enables the characterization of the family functioning. Within a system, the boundaries between the different subsystems can either be clear, permeable or rigid. According to this approach, proper functioning within different subsystems implies clear boundaries. Every family subsystem is said to have

specific tasks and make specific demands on its members. The boundaries have to be sufficiently marked to allow the personal development of each member of a particular subsystem protected from interference by other subsystems, but also sufficiently opened to allow communication and interaction between subsystems and with the social world.

Families are subject to both internal pressures coming from developmental changes of its different members and to external pressures from the social world. The functionality of a family depends on the abilities of family members to mobilize appropriate transactional patterns when internal and/or external conditions demand adaptive restructuring. Although relationship styles, such as enmeshed relationships and/or social disengagements (Minuchin, 1974), do not in themselves determine the health status of a family, from a family dynamic perspective, such transactional patterns can be viewed as factor of vulnerability in case of demand for change.

In enmeshed relationships, boundaries are too permeable and family members become over-involved and entwined in one another's personal and emotional life. Interference between subsystems increases (knowing each other's secrets, being continually attuned to each other's feelings). Family members have strong feelings of loyalty and belonging and little autonomy. A small demand on one member has an immediate impact on the whole system. On the other hand, rigid boundaries define the disengaged style where family members share a common home but operate as separate units with little interactions or exchange of feelings. Often family member have strong sense of personal autonomy, but lack a feeling of belonging or being in connection with each other. In such cases, the level of stress must often be quite high in order to mobilize the entire family network in a collective adaptive response.

The function of the family, as a mediator with the social world, is to provide a context where each family member can develop a sense of identity, balancing feeling of belonging and feeling of autonomy. Centripetal functions protect family members and enhance their feeling of belonging. Centrifugal functions promote individuation

processes and prepare children for their future emancipation, developing self-competence, social skill (co-operate, compete, resolve conflict) and autonomy (emotional, economic and social). So, ideally boundaries have to be all together flexible, confining and permeable to allow for the necessary interactions for the system to function (as a living cell). If the boundaries are too permeable, the system loses its integrity, if they are too rigid the exchange with the context is too poor and the system's entropies goes up (Salem, 2005). As a dynamical system, only pathogenic and dysfunctional families maintain a fixed balance between centripetal and centrifugal forces. Periodically, most families go through life cycle transitions or crises, requiring adjustments, in particular with positive feedback promoting new behaviors. The expressions of a child's autonomy represent such natural crises when boundaries have to be re-negotiated within the family. During its evolution a family goes from balanced to unbalanced phases. A dysfunctional family is a system responding to external and internal demands by reification of its functioning. Thus, a main factor for the adaptation of a family is its degree of openness to internal and external information (Salem, 2005).

The concept of boundaries can easily be assessed from two dimensions: cohesion and hierarchy. Cohesion indicates who is with whom, in other words this variable underlines the different subsystems in the family. Hierarchy brings to light the issues of authority and leadership within the family system, as well as in its various subsystems. In assessments of family cohesion and family hierarchy, tools such as FAST or SAGA provide a picture of the family in different contexts in order to help the therapist elaborate a notion of current family functioning. Highlighting transactional patterns and boundaries, this information facilitates the formulation of hypotheses about the functionality of family transactions and family organization. In the structural approach the therapist contribution is to remodel the boundaries: he clarifies diffuse boundaries and opens the rigid ones.

SAGA description

SAGA is a three dimensional test where little puppets (8-12 cm) representing each member of the family are placed on a circular board (diameter 45 cm) divided into 41 colorful (yellow and red) squares. The SAGA provides the dynamical representation of the organization of the family from the point of view of one or all the members of the family in three situations: typical functioning, interpersonal conflict and ideal functioning.

In the case of the collective assessment with all the family members, each member of the family puts in turn his/her puppet on the board. Then, each member has the possibility to change the place of any puppet, as he/she wants. The process continues until every body is more or less in agreement with the result. Once the puppets are in place, the family points out with tokens who decides and how often (to what level with red token) and who has influence and how often (to what level with blue token). The same representations are requested from the family in a situation of conflict (using a practical example from the family's life) and in identifying what would be the ideal situation (if everything were possible...). To record each representation, it is easier and faster to use photographic snapshots. It will be possible to use these pictures any time later during the therapy.

Cohesion is measured in terms of the distance between pairs of puppets on the board. Hierarchy is indexed in terms of the number of red or blue tokens estimating the power of decision or of influence of each family member. From a research perspective, different variables can be derived depending on the immediate objective. For example it is possible to assess the cross generational coalition when comparing the cohesion from one dyad parent-child to the parental dyad. Comparing child and parental hierarchy can reveal hierarchy reversals. However, in clinical context, we do not need such quantitative evaluations. A qualitative assessment from the analysis of what went on during the session and from the pictures of the SAGA placements in the different social contexts is sufficient to provide useful therapeutic hypotheses concerning family functioning.

Clinical illustration

CREAF (Resource Center for Child, Adult and Family) is a non-profit organization offering individual and family therapy. Our team is composed of professional therapists from different theoretical and practical backgrounds (Cognitive and Behavioral Therapy, Psychodynamic analysis, as well as Family Therapy). CREAF favors brief therapy (about 10 sessions over ten to fifteen weeks) to help individuals and families in the elaboration of a plan for optimizing use of their own resources when coping with crisis. When the declared reason for consultation concerns a specific child, a first therapist sees him or her, usually with both parents present. (Unfortunately, only one parent (usually the mother) too often accompanies many children). Once the therapeutic alliance is established the first therapist is able to propose a session with the participation of a second therapist. This session is organized with SAGA mediation in order to clarify dynamic relationships within the family. The joint session with two therapists occurs only once. With the help of information available from the SAGA, the second therapist attempts to provide a second perspective and complementary information on both the family system and on the prevailing family/therapist relation (here we see a similarity to the "gossip" approach). The findings from this joint session are ultimately integrated by the first therapist in the elaboration of a therapeutic project for the family. In this context, SAGA serves to generate and to circulate information pertinent to adjusting both the family system and the more complex system of collective therapeutic support.

Case study

A therapist, trained in developmental psychology, first met with Peter and his mother when Peter was 2.5 years old. He had begun pre-school the previous month and his mother was concerned about certain behavioral problems, both at home and at school. The mother complained about constant conflict between her and her son, who provoked and aggressed his younger sister (13 months old). Teachers at school described Peter as a difficult child. The purpose of

the first therapeutic sessions with Peter and his mother was to reassure the mother concerning her own parental skills and to reframe her perception of the apparent problems in terms of developmental explanation of early psychosocial stages. As a child between 2 and 3 years, Peter was seen as temporarily caught in a negativistic period, where he could be expected to resist parental demands in order to assert his emerging autonomy. After a short session with the mother about parenting, the first therapist was able to see Peter alone to help him understand his emerging autonomy and to cope more effectively with daily separations from his mother. After three sessions, the mother was considerably reassured and more confident about her capacity to cope with Peter's tantrums. During the same period, Peter gained more assertiveness at school and in his relationships with adults. At this time, the mother talked about her own difficulties concerning her role as a wife since the birth of her last child. She saw herself as a dedicated mother unable to allow others to assume the care of her children, including even her husband. With respect to their conjugal relation, she complained about the distance of her relationship with her husband. Often when he was at home, she would invent chores to isolate herself, rather than to engage into communication with him. With this new topic in mind, a meeting with a second therapist was planned around the SAGA to assess the position of each member in this family of four. The goal of this joint session was to clarify the boundaries of the conjugal and parental system from those of the children system.



Figure 1. Illustration of the SAGA in a clinical case study. Upper left panel: Puppets chosen by Peter and his family (P = father, M = mother, Pierre = Peter, E2 = Peter's sister). Upper right panel (1B): Positioning of the puppets and influence tokens on the SAGA board in a typical situation. Lower left panel (1C): Positioning of the puppets and influence tokens on the SAGA board in the conflict situation. Lower right panel (1D): Positioning of the puppets and influence tokens on the SAGA board in the ideal situation.

Description of the SAGA

The entire family was present (father, mother, Peter and his sister) with the two therapists. Throughout session, the little sister remained on the coach between her parents (even though she had the opportunity to play with different toys arranged in a play area). Peter remained near his mother, but as far as possible from his father. The parents alone decided the placement of the four puppets on the SAGA board, as well as the attribution of token of influences associated with each family member (under 6 years old the instructions can be difficult to understand). Peter's activities

alternated between looking at what his parents were doing and playing with toys.

Typical situation

The mother placed her puppet in the center of the board with her two children closer to her than to her husband. She commented, "I am feeling single". The father agreed, but he placed his puppet closer to his daughter's figure, reinforcing his withdrawal from the relationship between Peter and his mother, the son's puppet was arranged with his back to the father (Figure 1B). Regarding differentials in to decision-making power, the mother gave herself

9 tokens, while the father gave himself only one. Peter received 5 tokens for influence, his sister 2 and the father 1. At this time, the father commented that he had been working a lot, leaving the house early in the morning, coming back late in the evening. The mother described herself as exhausted by the day at home alone with the children.

Conflicting situation

Two kinds of opposition were described as typically arising in the family: Conflicts between the parents and conflicts with the children. The common

conflicts between the parents usually started with an argument between Peter and his father, the mother intervening before their resolution of the conflict. The position of each member of the family was changed as shown in the pictures of Figure 1C. Concerning the power of decision during the conflict the mother got 5 tokens and the father one. The involvement of Peter in the conflict situation led to him being given 5 tokens for the influence.

Ideal situation

The mother hesitated at length, pointing out her ambivalence and difficulties at allowing her husband a place too close to the children. Eventually, speaking together the parents agreed on their common desire “to restore the peace” in their family. They then placed the parental puppets close to one another in front of the children’s. All four puppets being placed within the inner most circle of the board (Figure 1D). The power of decision was represented by 4 tokens for the mother and 3 for the father. 2 tokens of influence were given for each child.

This brief session using the SAGA allowed the formulation of a series of different topics as systemic hypotheses:

1. The interference of the mother in the relationship between the father and their children, which prevented the father to assume his paternal position with his children. This dynamic placed Peter in a situation where he often provoked conflict with his father in the presence of his mother.
2. The strength of the relation between Peter and his mother and the difficulty, for both, to accommodate to mutual separation. Such a situation could engender a conflict of loyalty for Peter because he may feel that he betrays his mother when he gets along with his father or another adult.
3. The difficulties for the father to assume

his place near his children because he suffers from a feeling of “rejection” by his son.

At the end of the SAGA session, parents and therapists agreed on the need to work on the couple in order to clarify the boundaries between the parental system and the children system. Peter was again having some difficulties at school, the mother insisted on the need for him to continue seeing the child psychologist. Both therapists interpreted this demand as the need for the mother to be reassured while facing the task to focus on her couple. Finally, two sessions during the following month were needed to assure that the mother has integrated the various topics highlighted during the SAGA session. The impact of the parental communication and of the maternal exhaustion made it particularly difficult for the mother to link to the family’s ambience and to Peter’s behavioral problems. Little by little the mother accepted the idea to focus less on her son and to take more time for herself and for her couple in order to live again as a woman and as a wife and not only as mother. She also accepted to renew the trust in her husband and to separate from her highly controlling position in the family, especially concerning the children’s education.

Interpretation

This case study highlighted the importance for a systemic approach when working with children in difficulty, especially with regards to how these difficulties impact and involve the whole family. The situation described here illustrated the difficulties of separation between a mother and her child, accentuated by the beginning of schooling (usually, in France, when the child is around 3 years old). In this case it signaled the first true separation between Peter and his mother. From the behavioral difficulties of her son, the mother, little by little, became aware of the dysfunction in their family and accepted to engaged into a family session around the SAGA. Such a session would not have made sense at the beginning of therapy. It was first necessary to reassure the mother concerning her son’s behavioral problems and her own parenting skills. Similarly, more time was necessary after the SAGA session in order to allow the mother and the father to integrate the information generated by the SAGA.

This series of therapeutic sessions revealed to the mother her tendency to over protect her son and her particular difficulty in accepting his emerging autonomy, which was less apparent in her relation with

her daughter. The mother admitted the unique place that Peter had assumed in her live. The birth of Peter had allowed her “to fill a void” and “given her an identity”. In the same time, during individual sessions, the behavior of Peter indicated an urgent need to be supported by adults, showing a lack of confidence in relationships and the difficulty to accept the relationship constraints imposed by his mother. Thus, while the first therapist worked with individual sessions on the self-confidence and on the autonomy of Peter, the family session, using the SAGA, allowed placing these behaviors in the context of family dynamics. A central issue for the mother was accept the father assuming his place within the family, helping her to extricate herself from an over enmeshed relationship with Peter. The readjustment of this triangulation seemed to be a joint solution offering each person a means for correcting the dysfunction of family roles. It offered the possibility to open and to explore family members’ roles in the larger social world (especially the school for Peter, and personal activities for the mother).

During the SAGA session, the father was more involved with his children and was able to clarify the boundaries between the different sub-systems of the family. The father clearly expressed his desire to support his wife in the education of the children and to establish a closer relationship with his son. It was also possible to move onto the difficulties for the mother to trust her husband and more generally to accept to share decision-making power in the education of her children. As a floating object, SAGA revealed issues and difficulties for Peter in his process of autonomy associated with his mother’s anxiety about separation, related to her fear that her son would no longer need her. This situation led Peter, by loyalty and with the concern to protect his mother, block his exploration the surrounding social world and his emotional investment in the school setting. The therapeutic task essentially became to clarify the boundaries between parents and children, and to restore the father as an agent of separation between his wife and son promoting the autonomy of the child.

Conclusion

The unexpected appearance of the SAGA as a game (color of the board, puppet, token) jostled the usual markers and seemed to break down many defensive strategies of resistance and opposition during the course of the family therapy

session. If the game aspect of SAGA especially attracts children, the parents were not insensitive to it. The family can have an impression of sharing quality time around this game. Thinking and feelings can be expressed (by verbal or non verbal communication) without blaming anyone. Each member was able to position him/herself giving and receiving information with other family members.

At all times, SAGA acts as a mediator of communication between therapist and the family and among family members. From a clinical perspective, SAGA serves as a floating object as defined by Caillé and Rey (2004). "Floating objects take the place in the meeting. They are the symbol of this meeting and will represent the trace of this meeting" (p23). Notion of trace is reinforced with SAGA by the possibility during the therapy to refer back to the different situation pictured. The consideration of the SAGA as a floating object implies, in the context of a clinical approach, the necessity to adapt the procedure depending on the personal approach of each therapist, even if it is proposed as a codified technique. In the clinical context, the use of SAGA provides considerable additional information beyond the calculation of the proposed variables. Information can be gleaned from observing the placement order for puppets, modifications of initial arrangements, discourse of family members, visual attention, and even selection of puppet for each family member. Each therapist will be able to use these indices depending on his/her own theoretical framework. In order to explore these different aspects, typical follow-up questions are proposed (www.saga-support.org).

The SAGA leads the family into meta-cognitive reflection about its knowledge of itself. Each member of the family can consider family relationships in different ways. The diversity of the representation seen in the different contexts shows the flexibility of the family. This capacity becomes a resource for the therapist who can use it to promote necessary changes. The ideal situation allows for the family members to uncover possibilities they had not foreseen. Following Ausloo's (1995) recommendations, the therapist using the SAGA did not propose specific solutions for the family, but instead empowered the family in their effort to find their own solutions using their own resources.

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Philippe Compagnone

Maître de Conférences en Psychologie Clinique

Université de Bordeaux2

Thérapeute des couples et des familles

Centre Ressource pour l'Enfant, l'Adulte et la Famille

[philippe.compagnone\(at\)u-bordeaux2.fr](mailto:philippe.compagnone(at)u-bordeaux2.fr)

Catherine Jean

Psychologue du Développement

Centre Ressource pour l'Enfant, l'Adulte et la Famille

Improving infant mental health in orphanages: A goal worth considering

By Janet Gonzalez-Mena and Laura Briley

A group of individuals from the USA and France have been dedicated to sharing the knowledge, wisdom, and research of the late Dr. Emmi Pikler, Hungarian pediatrician and researcher. In 2003, they established a nonprofit entity under the name of Pikler/Loczy Fund USA (PLUSA).¹ This article is about the steps they are taking related to their goal. There are Pikler-inspired residential nursery homes in Hungary as well as in other countries. In Pifo, Ecuador; Etienne Moine and his wife Maria del Carmen Vasquez have built a beautiful children's home. It is called *Nuestro Hogar* ("Our Home"). Delfena Mitchell directs Liberty, an impressive residential program for children in Belize which was built and supported by Marcelle Delahaye who is from the UK. Also, the Founder of Whole Child International, Karen Gordon, is using the Pikler approach in orphanages she has been working with in Nicaragua and El Salvador. All of these individuals have been to the Pikler Institute and trained with the professionals there.

Who was Pikler?

Dr. Emmi Pikler went to medical school in Vienna in the 1920's. Dr. Pikler was influenced by her professors Clemens Von Pirquet and Hans Salzer. With their views on physiology and prevention she used their teachings and developed into a very successful family pediatrician during the 1930's in Budapest. Her first book for parents was designed to help parents understand their children's needs and their role in meeting those needs. That book, written first in Hungarian is called "Mit tud mar a baba" (What Can the Baby Already Do?) The German translation is called *Friedliche Babys – Zufriedene Mütter* (Peaceful Babies-Contented Mothers). Pikler taught about respecting babies and allowing them freedom of movement to explore their environment. She also warned not to force a child's development but to respect their individual rhythms.

1 PLUSA was not the first or only Pikler Association. The first was the Association Pikler-Loczy de France. There are associations in Argentina, Austria, Italy, Hungary, Netherlands, Spain, Switzerland, and Germany as of this writing.

The parents learned how successful their children were with their own sense of security and self esteem. This gave parents peace of mind to see how well their children did in school and later in life. Those children, called "Pikler Children," have long since grown up. Pikler was so successful and revered by these families that after World War II in 1946, the Hungarian government asked Dr. Pikler to start a residential nursery home for young children who had lost their family or had been abandoned during the war. She took on this formidable task and under her leadership it became a model program as well as a research and training center visited by people from all around the world. It was first called the National Methodological Institute but in the 1980's it was renamed The Pikler Institute in honor of Dr. Pikler. It was also informally called "Loczy" after the street where it was located. Dr. Judit Falk, the Director of the Pikler Institute after Dr. Pikler, wrote an article called "Forty Years of Loczy" for the *Sensory Awareness Foundation Bulletin* which focuses on Emmi Pikler's life and work. In it, she discusses the underlying principles of the Institute. The success of the Institute was recently validated in the July-December 2010 Issue of the *Signal* in the articles which were written by Konicheckis, Vamos, Golse, Tardos, and Keren who discussed important elements of the Piklerian pedagogical approach.

What does Pikler's work have to do with infant mental health?

The answer to that question is everything! Pikler was aware, as was Freud and many others up to the present, of the significance of the infant and toddler period of development and learning. As the motto goes "The first years last forever." Even the leadership of Head Start, a nationwide program for low-income children and families in the USA came to see that preschool is too late. A recent expansion of Early Head Start shows that the national program is now focusing extensively on ages 0-3 in addition to preschool.

Pikler's goal was to create an approach to caring for children in an institutional setting for the first three years, an approach that allowed children to leave the program with a sturdy, clear,

healthy, individual identity as a doer and learner. In addition, as anyone who ever observed at the Pikler Institute can attest, each individual child became an active, contributing member of their group. The observer from the USA might see the group was rather larger than is recognized as appropriate in their country; however, considerably smaller than many groups seen in orphanages around the world. This observation is based on the experiences of the authors of this article, both of whom have seen a number of orphanages. Though the group at the Pikler Institute was not a family, the idea was to prepare the children to live in a family as well-adjusted members. To accomplish such a goal required careful selection and extensive training of caregivers as well as intensive ongoing support. Pikler was clear that a special kind of relationship between children and caregivers was a must – a relationship that was close enough to create an ongoing attachment, but not so close that the child would suffer when leaving the institution and the caregiver. The Institute had a primary caregiver system and a continuity of care approach as advocated by J. Ronald Lally and Peter Mangione of WestEd's Program for Infant Toddler Care at the Child and Family Studies Center in Sausalito, California. An additional note is that Lally and Mangione may well have had that idea reinforced by Magda Gerber. Gerber, a leading infant expert in the United States, was influenced by Pikler, who was a friend, and colleague of hers. Dr. Pikler and Magda Gerber stayed connected even after Gerber left to live and work in the United States.

Pikler was in agreement with Dr. Charles Zeanah (2010) that every child deserves a family; she never asserted that institutional care was as good as a family. But she was clear that as long as there are institutions with infants and toddlers in them, they should be the very best possible. Of course, the controversy of orphanages versus foster homes is alive and well today and is a hot topic among policy setters, funders, and other leaders, as well as infant mental health experts. If Dr. Pikler were alive, she'd be shaking her head at the unfortunate outcomes of foster care in the USA. According to the organization Children Now, "foster youth have an especially high incidence of mental illness. Nationally, the incidences of post-traumatic stress disorder is higher among children who have aged out of foster care

(22%) than among American war veterans, (6%) for Afghanistan war veterans and (12-13%) for Iraq war veterans."

There are several serious problems with most foster care in the USA today. One is attachment, which is a focus of Piklerian theory and practice. It's clear that a secure attachment is vital to the brain development that goes on in the first three years. Lack of attachment can have serious effects on mental health, later relationships as well as general development, growth, and learning. The problem lies mainly in the foster care systems, where children might be moved from one foster home to another and can have a succession of multiple foster parents and siblings. Another problem with the system is that foster families may lack training and ongoing support. The Journal Zero to Three from the national organization, Zero to Three in the USA, devoted a whole issue to the subject of foster care and the difficulties.

At the Pikler Institute those systemic problems so common in foster care, problems such as attachment, training, and support, were intensely addressed throughout the 65 years of the Institute's existence. Long-term positive outcomes were a focus for all the years of the Institute. Pikler proved that it is possible to have excellent outcomes for children in institutions. The follow up research has shown that the children who were at the Pikler Institute for their first 3 years became successful, contributing adults in society (Magyar Pszichologiai Szemle, 1972. 29, 3-4, pp. 488-500. Hungary).

The work of the Pikler/Loczy Fund USA

Although members of the PLUSA board have all been to Budapest to study and observe, plus several have consulted with orphanages in various countries since the 1990's, we want to provide a more recent history. The World Forum On Early Care And Education (World Forum Foundation) conceived by Bonnie and Roger Neugebauer of Exchange Press has put on conferences around the world since 1999. At the 2007 Forum in Kuala Lumpur, Malaysia; a workshop session on orphanages brought together people from a number of countries. Representatives from Tanzania, Ecuador, Indonesia, Israel, France, USA, and Singapore who went to the World Forum went also to a special training in Budapest in 2008 conducted by Anna Tardos, psychologist, Director of the Pikler Institute, and daughter of Emmi Pikler.

Then in 2009 the next World Forum took place in Belfast, Ireland, where a pre-conference meeting brought some of the group together who had originally met in Kuala Lumpur. They formed a working group called "The Rights of Children in Children's Homes". As a working group, they agreed to write a book based on their experiences, views, and visions of what children in children's homes need in order to preserve their mental health by growing, developing, and learning in positive ways through forming a healthy identity, attachment to caregivers, as well as attachment to the group they are in.

Two years later the World Forum met in Honolulu, Hawaii in May, 2011. The Working Group came together once again for a two-day meeting before the conference began. They continued discussing their goals and how to achieve connecting with institutions throughout the world. The book for institutions is now in process under the leadership of Elsa Chahin, a long-time member of both the working group and the Pikler/Loczy Fund USA (PLUSA) group.

One of the members of the working group, Delfena Mitchell, is the Director of a children's home called Liberty in Belize. Through her efforts, the First Lady of Belize, Kim Simplis Barrow, came to the World Forum and spoke at the opening plenary session. Members of the PLUSA board met with her and the CEO of the Belize Ministry of Human Development and Social Transformation, Judith Alpuche. Through the meeting and discussions, they began organizing a conference in Belize for people who work in institutions in the Caribbean Islands as well as South America. The conference will be conducted in English and Spanish. Plans are underway to have the conference in October, 2012 in Belize.

Why invest in orphanages?

The secret to the success of Pikler lies in the comprehensiveness of the theory, practice, and extensive research which combines to make an effective approach. The other factor relates to the careful attention to attachment over the period of time the child is in the institution. Through the special kind of relationship that Pikler conceived and the practices that assure it, children gain a strong sense of security. Examples of the practices include caregiver interactions plus a system of primary caregivers and continuity of the group and caregivers over the period of their residency. That feeling of security allows the children to explore and experiment (play) on their own and within the group

without constant attention or interruptions by adults. One has to see the way children get along with each other and the extent of their play to truly appreciate it. One also has to see the one-on-one caregiver attention each child receives during those essential activities of daily living (sometimes called caregiving routines) such as diapering, dressing, grooming, bathing, and feeding.

Out of home child care in groups was once a controversial subject years ago in the USA when great numbers of mothers who had not been in the workforce joined it. Harming children was regularly cited from many sides of the controversy. The belief was that children, and most especially infants and toddlers, belonged at home in their families. Since then we have research that gives us guidance on how to create quality child care programs – even for infants and toddlers to avoid harmful effects. Unfortunately, the USA is still not among the nations who are doing an extraordinary job in supporting working families with universally available, high quality out-of-home group care. It's not that we don't know how to do it, but we lack the resources and support; however, Pikler's approach to infant-toddler care (and the research behind it) has been influential to child care in the USA and throughout the world. One such program in the United States is Day Schools in Tulsa, Oklahoma. It is operated by PLUSA's Founder, Laura Briley. She uses the Pikler approach in her NAEYC accredited schools. Programs that understand and use Pikler practices stand out from the average child care program for infants and toddlers. More current research needs to be done in these programs that are using these approaches. It's not enough to give testimonies about the effect. One of PLUSA's missions is to begin the research and we would invite anyone with an interest to contact us.

Orphanages are a fact in the world, just as out-of-home child care became a fact. As long as there are orphanages, the Pikler/Loczy Fund USA is determined to find ways to improve them!

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- University of Pittsburgh, Office of Child Development , Christina J. Groark and Robert B. McCall. www.dil.sched.pitt.edu/ocd/
- Whole Child International, 11726 San Vicente Blvd., Suite 222, Los Angeles, CA 90049. www.wholechild.org
- Zero to Three, is a national resource center in the USA designed to support healthy development and well-being of [infants](#), [toddlers](#) and their families. www.zerotothree.org

Renew you WAIMH 2012 membership online at www.waimh.org! There are two types of memberships:

1) Professional and 2) Student. The Signal is a WAIMH membership benefit, but the Infant Mental Health Journal is ordered at an additional cost. Go online www.waimh.org.

News from the WAIMH Affiliates Council

Affiliates Corner

December 2011

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Maree Foley, MPhil (Dist)
Affiliate Council Representative
maree.foley@vuw.ac.nz

Martin St-André, MDCM
Chair of Affiliate Council
martin.st-andre@umontreal.ca

Australian Association of Infant Mental Health (AAIMHI)

Affiliates Corner
December 2011

By Lynn Priddis

National Chair (AAIMHI)

The Australian Association of Infant Mental Health (AAIMHI) is a vibrant affiliate of WAIMH that comprises around 500 members from all over the vast Australian continent. Our AAIMHI history, like that of our country, is one that is maturing; it is advanced in many ways and young in others. AAIMHI developed from two separate state organizations in 1992 so that currently five of the six Australian States and one of two Australian Territories have their own branches that are affiliated with the National body. The sixth Australian State, Tasmania, is building interest in Infant Mental Health by co hosting the first Tasmanian Infant Mental Health Conference in November 2011 (visit our website www.aaimhi.org) for a snapshot of our association.

By way of background for WAIMH readers, Australia is a land of contrasts: In our schools we learn that it is both the world's smallest continent (a vast land that is twice the size of Europe) and also the world's largest island (spanning three oceans) and it is one of the most isolated countries in the world. Our indigenous people have a complex social system and highly developed traditions that reflect a strong affiliation with the land and that include deep care for their babies and children. Traditional values are slowly being rediscovered after Australian Aborigines suffered enormously over many decades with the advent of European settlement. Initially these settlers were mostly British convicts and their keepers, who had to endure long sea voyages to settle here. Infants and babies born into this new land were likely to have had to grow up with an independent and competitive spirit to survive harsh conditions, unfamiliar to their grandparents. Today we are a multicultural nation with many complex stories of migration and settlement.

It is likely there is a great deal in the Australian history, in the character traits of those who survived and in its geographical features that contributes to the Australian character and to the way

we parent our children. One value Australians share is an enjoyment of gatherings of like-minded people, where over food and drinks ideas and information are shared. In this spirit many of us regularly travel tens of thousands of kilometers to attend WAIMH congresses and thousands of kilometers to attend those in our own country. We value conferences as celebrations and opportunities for bringing people together in order to build relationships, re-establish connections and to share experiences. The inaugural mental health conference was held in Australia in 1991 and they have been held mostly on an annual basis since each time by a different host state on behalf of the National body. Our most recent national gathering was for the 17th National AAIMHI conference and was held in Perth in May, 2011 and this will be the focus of this article.

As with WAIMH congresses, every Australian AAIMHI conference is unique, governed by the context in which it occurs and the committees who take responsibility for making it happen on behalf of the National body. Sometimes they are run by AAIMHI alone and on other occasions they are co hosted. They are mostly held annually, with each state having many smaller gatherings throughout the year. A quick look at our newly developed website (inspired by the WAIMH website) will show that there is considerable activity around the country. Some states have monthly Saturday morning presentations where members enjoy case



Louise Newman is an ambassador for the rights of infants and children in Australia.



Shaun Tan is Australia's recent Oscar winner, who presented his picture book "The Red Tree".

presentations and discussion; others have evening presentations where members network around wine and nibbles and enjoy varied presentations by representatives of the many disciplines in AAIMHI. One really interesting presentation was on physiotherapy and IMH, with the support of members this presenter has now submitted an abstract to the WAIMH congress in CapeTown. A particularly energetic state affiliate inspires us by frequently running one and two day trainings for its members to build knowledge and capacity. More established affiliates share ideas and provide support to newer ones and to those who are struggling with adversity from natural disasters.

We all value and enjoy coming together for the National conference. In 2011 the conference was called: 'Growing up solid: Integrating emotional and mental health throughout infancy, childhood and adolescence' and was a Bi-National conference co-convened by Australian Association of Infant Mental Health (AAIMHI) and the Royal Australian New Zealand College of Psychiatry (RANZCP) Faculty of Child and Adolescent Psychiatry. The title and co host arrangement reflected our commitment to the integration of understanding and treatment of mental illness from infancy to adulthood, encompassing different perspectives, organisations and cultures. We actively encourage a indigenous presenters to show case their work at all our conferences, with the indigenous stream growing each year. We are also forging closer ties with WAIMH affiliates in neighboring countries beginning with New Zealand, where we share news, enjoy transferable member benefits and plan joint initiatives.

The 2011 "Growing up solid" conference was held in luxury; we like to nurture and pamper as best far as possible those participants and members who travel long distances to contribute. The setting was a five star hotel in central Perth (a cosmopolitan, western seaboard city on the banks of a wide, clean, blue river) in May (a Mediterranean climate). It had been about ten years since Western Australia had last hosted the National conference, partly due to the perceived convenience and cost efficiency of having it more centrally located. Planning for the conference began about two years earlier as we explored the needs and desires of members and worked hard to make it attractive enough for interstate members and interested practitioners and researchers from New Zealand (our neighbor and frequent partner) to travel West, especially in times of global recession. Although Australia is still managing the international global

financial situation relatively well, and Western Australia with its rich mining assets is perceived to be one of the richer states, those of us in the service professions feel clearly the effects of a two-speed economy. We were very nervous as to whether participants would be supported financially with the costs in flying to Perth and the necessary leave from work to attend. By the final stages of conference planning, with major sponsorship support from the Government of WA, especially our newly created Western Australian Mental Health Commission and from the Princess Margaret Children's Hospital Foundation as well as local exhibitors and advertisers and with registrations coming in steadily we were assured of solvency.

The conference attracted 430 participants from Australia and New Zealand across all allied health professions from the government, non-government and private sectors. It clearly appealed to clinicians, academics, researchers and policy makers in infant, child and adolescent mental health.

Highlights of the conference included:

Two exciting training based preconference workshops:

- The attachment-focused AMBIANCE coding system developed in Dr Lyons-Ruth's lab which classifies atypical



Lynn Priddis had the possibility to meet personally with Oscar -winner Shaun Tan.

parent-infant interaction.

- The use of the Parent Development Interview (PDI) developed by Arietta Slade and represented at the conference by Michelle Slead from the Anna Freud Centre

Presentations by Keynote speakers, specifically

- Professor Sir Robin Murray from the Institute of Psychiatry at Maudsley Hospital, Kings College and University of London, kept us all in not only in our seats at the end of a long day but enthralled by his humorous, colloquial and understandable explanations of epigenetics (crudely put it is about mechanisms and influences on the expression of genes) particularly in relation to the development of Schizophrenia.
- A/Professor Karlen Lyons-Ruth from Harvard University wowed our policy makers with her clearly articulated evidence base for intervening early to prevent disorganized attachment styles in early parent-child relationships and later showed us how to recognize these patterns.
- Dr Astrid Berg: Child Psychiatrist from Cape Town and co-convenor of the next WAIMH congress, emotionally

touched everyone with her journey in establishing an IMH service in South Africa.

- Michelle Slead presented clear evidence on use of the PDI with prison populations and later held a question and answer informal seminar on using the PDI in all sorts of research for a hungry bunch of prospective researchers and clinicians.
- Florian Zepf a newly appointed Professor of Child Psychiatry from Germany was invited to present his study on chemical (serotonin) transmission in children in relation to mood memory and attentional disorders. His presentation connected him with a network of like minded practitioners in Australia and gave him an opportunity to enjoy this combined conference in all its collaborative glory.
- Shaun Tan: Australia's Recent Oscar winner held hundreds of us transfixed with a journey through his picture book "The Red Tree." Long queues for book signing kept Shaun trapped for hours. Shaun in a quiet and understated manner vividly conveyed the experience of depression and loneliness through his art in ways that left us feeling vitally alive and involved and hungry for more of his stories.

The conference closed with a bang with an energetic panel discussion on Infant Rights. Professor Louise Newman from Monash University in Victoria, Australia, spoke passionately about the rights of infant refugees, topical in this 'lucky' country where "border protection" has been seen by some as more important than humanitarian responses to refugees. She was joined by; Mr Jarrod McKenna,

a theologian from Perth who fired this discussion further; A/Professor Campbell Paul from Melbourne University who spoke on infant rights in hospital settings; and Astrid Berg who again highlighted the plights of infants in South Africa. The buzz at the end of the conference was palpable with over 250 registrants still vitally engaged throughout this last session of the conference.

A highlight of organizing this conference was the easy going nature, humility and professional approach of all the conference presenters. Michelle Slead committed to presenting at the conference whilst pregnant for the first time and carrying twins. This might have been enough to cause many amongst us to change our plans and cancel. Not Michelle. She booked her room complete with two bassinets, and with the support of her husband she made the epic journey to Perth from London (20 hours +) with her young twins. Needless to say once here there were many willing hands to hold them. Somehow Michelle made it all look manageable and even as if her whole family enjoyed the experience. Karlen Lyons Ruth and her co presenter in the AMBIANCE training Elisa Bronfman were accommodating of all requests made of them. Elissa had always planned to leave early after meeting all her commitments but even so managed to fit in an additional welcome talk to staff at our sponsoring hospital. Shaun Tan arrived with his Oscar in a pillow case and delighted the crowd by passing it around and having it stand on the bench as he spoke (See my photo with Shaun). Robin Murray chatted with all finding an endless supply of anecdotes to illustrate the most complex concepts.

There was unanimous feedback from presenters and participants and organizers

that the hot lunches, morning and afternoon snacks were delicious. Providing food is a tradition – those who travel must be nurtured and many a collaboration has been born over an afternoon cup of tea or coffee.

My favourite feedback

Congratulations on a fabulous conference. I can't remember many where I've wanted to be there all day every day.

Is this unique? I've never seen so much good thinking by so many people in so many professions in one place.

I am amidst an SPSS data analysis and noticing that I am staring out the window thinking about you, your team and the wonderful Perth Conference. Thank you for your gift of preparation and all that you put on offer to us as participants – stunningly wonderful conference.

The seeds sown throughout the conference presentations and discussions will continue to enrich the thinking and work of us all

What a fabulous conference. You must be so proud. Can we talk? (Member Parliament)

I've just worked out a research idea, I sat there listening and... I need to talk. This conference is amazing.

Personally I found it one of the most intellectually satisfying conferences that I have been to.

I hope this brief account inspires further initiatives amongst other affiliates who are considering dipping their toes in to convening a conference as a way of nourishing their members and building inspiration and motivation to advocate for the mental health of infants.

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Introducing the debate from left to right: Louise Newman, Astrid Berg, Campbell Paul and Jarrod McKenna.

Core concepts in infant–parent psychotherapy

By Marian Birch

From conception through the third year of life, there is, in Winnicott's (1960) pithy phrase, "no such thing as a baby." There is, rather, the dynamic, nonlinear system (Sander, 1975) of the infant-and-caregiving environment. The caregiving environment is, most immediately, in most cases, the mother; equally critically, it is the web of familial, social, and economic relationships and resources that support the mother so that she is able to find within herself the psychological and physical resources to successfully rear a healthy, happy, and competent child. A mother can no more parent successfully without such environmental support than an infant can thrive and grow without a mother (Hrdy, 1999).

The tasks of the infant–parent psychotherapist include addressing internal obstacles that impede the parent from accessing the support she needs, as well as practical assistance in identifying and accessing available resources. When babies grow up and have their own babies, their capacity to find and accept the help they need from others is directly and strongly correlated with the kind of caregiving they received as infants. In terms of attachment theory, a securely attached infant grows up to become a mother who is able to use relationships with others to meet her need for support. An anxiously attached infant, barring intervening help, becomes a mother who has significant constrictions in her ability to do so. The infant with no organized attachment strategy is likely to become a mother with no organized strategy for obtaining the support she needs, and who, in powerful and automatic ways, perceives others as threatening, not helpful. Similarly, the mother's representation of her infant and her ability to be sensitively responsive to her infant are shaped to a significant degree by her own early experience and the way it is registered in her psyche (Main, Kaplan, & Cassidy, 1985).

Our intention, as infant–parent psychotherapists, is to expand the mother's range of choices in both spheres: in response to her infant, and in meeting her own psychological and practical needs.

When the infant–parent dyad is not working well, it is often because the mother has rigid defenses against being

ZERO TO THREE Corner

The following excerpt is from the first chapter of *Finding Hope in Despair: Clinical Studies in Infant Mental Health*, edited by Marian Birch (ZERO TO THREE, 2008). 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* explores the limitations of infant–parent psychotherapy by examining six different "treatment failures" using a unique format for reflective discussion. In the following excerpt, the editor describes the core concepts, techniques, and challenges of therapeutic intervention with infants and very young children and their families.

aware of and experiencing what Tronick (1998) called "a dyadic expansion of consciousness" within the dyad. On the mother's side, this dyadic expansion of consciousness, when accessible, provides her an entrance into a long-forgotten world of primitive nonverbal feeling and experience that permit her, for example, to distinguish a hungry cry from a tired cry, or, in the case of many mothers in developing countries, to unerringly hold the baby out at arm's length at the moment just before he pees.

When a mother cannot tolerate this primitive way of knowing, it is usually because she received inadequate help, when she herself was an infant, in tolerating, managing, and regulating her own primitive preverbal feelings. Thus, in her infancy, she experienced her affects as overwhelming and traumatic, not as reliable signals to herself and her caregivers about needs and wishes. Her infantile distress and arousal met with neglect, abuse, intrusion, projection, and negative attributions. Furthermore, her subsequent experiences may not have afforded her an opportunity to revise her early, infantile ways of coping with these failures of caregiving with more mature and adaptive mechanisms.

This is the help that we come, as infant–parent psychotherapists, at the 11th hour, to offer. Our objective is to exorcise the ghosts in the nursery, which cloud the mother's perception of and ability to respond to her infant. But, of course, these selfsame obstacles are the chief impediment to the mother's accepting any help we have to offer.

We cannot expect the mother to have a "realistic" view of our helpful intentions and purposes in intruding ourselves into her life, any more than she has a realistic view of her baby's motives for occupying so much of the territory formerly known as her life. We do not take her wariness, hostility, and evasive vagueness personally. We do not waste too much breath trying to persuade her that we are different from the others—the parents, teachers, doctors, social workers, and so forth—who have disappointed her in the past. Instead, we try to understand how she experienced those disappointments and how they shaped her, and in our way of doing so we try to offer a different experience of being listened to, understood, and cared about.

This importantly includes acknowledging and perhaps even apologizing for the inevitably intrusive, humiliating, and insufficient aspects of our presence in her life. It also includes acknowledging that our interest, caring, and helpfulness are professional. In the brutally crude terms of one of my clients, we are paid to care. This falls far short of what our clients want—and may need.

It cannot be overemphasized how sensitive, deeply personal, and intimately tied up with self-esteem and her evil stepsisters—self-doubt and self-loathing—is the territory that we presume to enter. Often we come with only a flimsy and awkward excuse for an invitation. "Your CPS [Child Protective Services] worker, or your pediatrician thought you needed help." How special does that make a mother feel?

We, as therapists, do not like to think about this. We have our own self-esteem issues and probably would not be doing this kind of work if we did not have some fairly deeply rooted need to help. To be effective, and to survive as infant–parent psychotherapists, we have to let go of this need, or at least, loosen its grip.

The current dominant model is that we help parents become more sensitive, responsive, and protective of their babies through the therapeutic relationship itself: We have to become more sensitive, responsive, and protective of the parents. In the words of Jeree Pawl, we “do unto others as we would have others do unto others” (J. Pawl, personal communication, October 30, 2007).

This doing unto mothers what we hope mothers will do for their babies— provide sensitive, attuned, and comforting responses—has been described by Fonagy et al. (2002, p. 403) as “the creation of an interpersonal situation where the potential for reflective function could be specifically and safely exercised.” We believe that our cumulative interactive exchanges with the mother help her to think about her own and her infant’s feelings and experiences as meaningful and understandable by another and by herself. We are trying to provide an attuned, supportive relationship, a holding environment, a container within which the mother can reflect on and resolve some of the obstacles to attunement, mutuality, and growth in her relationship with her infant.

Work with infants and families is tremendously challenging. It requires us to keep a therapeutic focus and balance in the often chaotic, distracting, and disturbing settings in which our clients live. To maintain such balance, it is absolutely essential to have ongoing consultation, supervision, and training.

There must be dedicated time for the therapist to think about the system she is trying to join—time away from the infant–caregiver system and the multiple and often conflicting demands it makes for her attention and intervention. She also needs help seeing herself in the system, such as the opportunities that individual supervision and clinical case review with peers and consultants can provide.

The therapeutic challenges we face

In her radical innovation in psychoanalytic practice, what she referred to as “psychotherapy in the kitchen,” Selma Fraiberg and her colleagues (1975, p.

394) grafted a set of techniques that had long been central to the practice of nursing and social work onto an essentially classical, ego psychological model of psychotherapy. These techniques were home visiting, case management (including referral and advocacy), and educational guidance. Furthermore, Fraiberg et al. (1975) defined the patient of infant–parent psychotherapy as the dynamic relationship between an infant and his or her caregiving environment. This was a conceptualization that was far closer to family systems theory (Bateson, Jackson, Haley, & Weakland, 1956) than to the American ego psychoanalysis to which Fraiberg et al. claimed allegiance. Stern (1995) 20 years later likewise defined the patient of infant–parent psychotherapy as the infant–parent relationship.

Fraiberg et al.’s (1975) “parameters,” or special modifications of classical psychoanalytic practice, emerged in the 1970s and ’80s, in the same historical context as other adaptations (e.g., Heinz Kohut, Kurt Eissler, and Harold Searles) to the classical mode of a rigorously “neutral” analyst who facilitated psychological change through interpreting the patient’s free associations and, in particular, “resistances” and “defenses” (Mitchell, 1988). The classical model was viewed as effective only for “neurotic” patients—those whose problems stemmed from maladaptive efforts to manage unacceptable impulses. Its practice and its failures had led to increasing awareness of different kinds of emotional problems that required different techniques (Fonagy, 2001). The rehabilitation of John Bowlby and Melanie Klein, both of whom emphasized the central motivational role of relatedness, from the status of psychoanalytic pariahs, which they had endured in the 1950s and ’60s, also began in this period.

Fraiberg et al. (1975) explained that their parameters, their new techniques— (a) home visits, concrete and emotional support, and developmental guidance; and (b) dyadic relationship as patient—made it possible to offer therapeutic services to families who lacked the inner and outer resources required to come to office appointments. This was initially discussed in terms of the logistical difficulties frequently facing parents with infants. It gradually became clear in practice, however, that the inability to access center-based services often reflected deep-seated distrust and disorganization in relationships. Such techniques were seen as concrete, operational statements of the therapist’s implicit and explicit offer to meet the family where and as they were. Again, the goal of this practice

was to engage distrustful caregivers in a therapeutic endeavor on behalf of the infant.

The practice of home visiting provided an incredibly rich and immediate access point or “portal of entry” (Stern, 1995) for collecting clinically relevant data. After an hour in a family’s home, the therapist often was privy to data that would take years to gather in an office setting—if, in fact, it could ever be gathered there at all.

It has seldom been acknowledged, either in infant mental health or in psychoanalysis, just how much these adaptations changed the therapeutic situation. Let us examine, then, the further implications of these innovations for the therapist’s understanding of her role and of what is supposed to be happening in therapy.

In several ways, the dominant model of infant–parent psychotherapy obscures and complicates the issues of informed consent and professional boundaries. The adaptation of home visiting forfeits one of the key features of office-based psychotherapy, namely, the patient indicates his engagement in a therapeutic endeavor by his physical presence (Clarkin, Kernberg, & Yeomans, 2006; Greenson, 1967). In addition, the formal setting of an office—often with signs, diplomas, and professional books—conveys implicitly that the therapist is offering specialized skills and services. Home visits and case management services (e.g., helping to locate housing or complete legal paperwork) make it more difficult to communicate clearly that the goal of therapy is to help the caregiver to overcome internal, mental obstacles to growth. The special quality of the patient’s transference and the therapist’s countertransference feelings and enactments (Bromberg, 1998), as a kind of “play” that occurs in the protective haven of the therapy, is easily obscured when the therapist actively seeks to engage the family in its own setting. The caregivers’ wishes that the relationship with the therapist would actually function, on a permanent basis, as a replacement for their own tormented ties to their families of origin are implicitly validated by this active, unconditionally accepting approach. Further complicating matters, our emotional availability to the caregivers is actually far from unconditional: We are motivated by a primary goal of promoting the infant’s healthy development, not the optimal future for the caregivers.

A further consequence of working in the home, with a dependent infant present, is that it is much riskier to invite and work with profoundly regressive and intense

feelings and states. An office offers the safety of a private, anonymous haven that the patient chooses to come to and that she can leave behind. Likewise, the therapist in an office can be emotionally engaged with the patient's intense and primitive material safe in the knowledge that the hour will end, there are no lethal weapons on site, and the patient is almost always able to pull himself together and leave, or at least sit in the waiting room until he can. In our work with parent–infant dyads, we are always titrating the depth to which our dialog can go against the ever-present physical and emotional need of the infant, as well as our own sense of safety (Lieberman, 2000).

The hypothesis that the therapist's provision of warm, sensitive, attuned responsiveness leads to the caregiver's enhanced capacity to provide the same to the infant has led to an emphasis on strength-based, supportive interventions (Fraiberg, 1980; McDonough, 2000; Olds, 2005; Pawl, 1995). This approach is a far cry from the often painful "interpretations of resistance" prescribed by the old classical model (Greenson, 1967). We try to find something positive and growth-promoting to admire and validate in the parent–infant relationship. Although we often observe situations and interactions that profoundly disturb us, we also often feel that we cannot address them directly lest we lose the fragile alliance with the caregiver. Finding the boundary between being supportive versus colluding with subtle forms of neglect and maltreatment can be extraordinarily difficult. If we believe in the unconscious, it is inevitable that our concealed feelings of worry, revulsion, anger, and fear have an impact even though we do not openly express them. We need better ways to think about that (displaced) impact.

Like the public health nurse, and like the social worker, the infant–parent psychotherapist may provide developmental guidance and concrete support. However, rather than being ends in themselves, these activities are understood as ways of establishing the kind of relationship with the infant and its caregivers that, because it is sensitive, nurturing, and warmly positive, facilitates the caregivers' abilities to relate to the infant in similar growth-promoting ways.

This trickle-down effect is beautifully captured in Jeree Pawl's (1995) koan-like "do unto others as you would have others do unto others." It is presumed to work by altering the caregivers' internal working model of relationship, rooted in their own infancy, so that it is more flexible, hopeful, and generous and less rigid, fearful, and

withholding (Lyons-Ruth, 1998; Main & Hesse, 1990; Slade, 1999).

This can work beautifully when there is a clearly identified parent or caregiver who claims the child; and when this caregiver or parent has a psychological makeup that permits him or her to alter and soften lifelong unconscious strategies for maintaining psychic coherence within the timeframe set by the infant's inexorable developmental processes.

The therapist must also be able to maintain a balance in her attention to and investment in both caregiver and infant. Therapy must focus on optimizing this relationship as opposed to the oft-wished-for happy ending for one or the other of the dyad (Seligman, 2000).

What happens if one or more of these conditions are not met?

Contemporary writing about psychoanalytic work with adults and children has been marked by a very dramatic and rich expansion of the concept of countertransference. Writers such as Stephen Mitchell (1988, 2000), Thomas Ogden (1986), and Philip Bromberg (1998), to name but a few, have vastly enlarged our understanding of the ways that, in Freud's terms, "the analyst turns his unconscious like a receptive organ to the unconscious of the patient" (1912, p. 118) and uses the behaviors, thoughts, affects, images, and impulses that are evoked in him as a rich source of "data" about the clinical situation. With these discoveries has come a profound acknowledgment of the fallible humanity of the analyst; that, in the words of Harry Stack Sullivan (1953), "We are all much more simply human than otherwise" (p. 32). Harold F. Searles, a psychoanalyst renowned for his Herculean efforts to treat schizophrenic patients psychoanalytically, has eloquently complained that the more classical view of the neutral and abstinent analyst requires the analyst to be a person who somehow transcends the ordinary human vulnerability to confusion, envy, destructiveness, and perversity, and is able to listen to extraordinarily painful and disturbing material with the serenity of a Mother Teresa.

With few exceptions, within the field of infant–parent psychotherapy, the therapist is still expected to be superhuman in this way. Yet infant–parent psychotherapy evokes what are arguably the most intense and disturbing countertransference responses imaginable.

Intimate work with an infant in distress is guaranteed to stimulate the therapist's loving and protective feelings. To a

lesser extent, the kinds of narcissistic hungers that are assuaged by producing a healthy child, the longings and impulses that Erikson (1952) so graciously called generative, are also engaged. When the child is actually in a life-threatening predicament, as may be the case in medical crises or instances of parental or institutional neglect or abuse, these countertransference feelings take on a terrifying immediacy and power.

In 1999, Arietta Slade wrote the following:

Therapy concerns itself over and over again with loss, separation, and reunion—both in its consideration of such events in patients' lives, and in the constant separations and reunions that are intrinsic to the therapeutic process. And just as losses, separations and reunions have meaning for patients, so do they have meaning for therapists. Similarly, just as being cared for may be quite evocative for patients, so may the experience of caring be evocative for therapists. Many therapists have suffered early loss and abandonment; naturally, they will vary in the degree to which they have reconciled and come to terms with these experiences. And, regardless of the degree to which a therapist has come to terms with his or her own early experiences, different patients will engage the therapist's attachment dramas in different ways. (p. 589)

When a child or infant is dangerously uncared for or maltreated in his family, finding the appropriate therapeutic stance can be very challenging. On the one hand, these situations seem to call for an intense level of therapist activity. The ethics of standing by as a child appears to slip away into physical or psychological death is tricky. On the other hand, activity may be a defense against thinking and feeling, including thinking that, in reality, the therapist's power and influence are often very limited. Sometimes it seems there is no other option than standing by; at other times, one's most sincere and strenuous efforts are unavailing. There are few things more painful and difficult in life than watching helplessly as a beloved child slips away. The feelings are not just feelings

of grief, but inevitably of failure and self-reproach.

Adults are supposed to be able to protect and care for children. Perhaps, given the actual impossibility of the task, we are supposed to have illusions that we can. Anyone whose career has involved him or her for any length of time with high-risk infants and their families has had such comforting illusions remorselessly eroded. Again and again, we have seen children we have grown to care for overwhelmed by circumstances beyond our control, and we see the window of opportunity for growth and healing in a place of safety slam shut. To continue in this work is to find a way to bear this without burning out or shutting down. This is the challenge we all face.

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Editor's Perspective

By Miri Keren, M.D.



Writing about failures with difficult cases

At the most, we can talk and think about our failed cases at a symposium in a friendly context, such as WAIMH conferences, but “real” papers about this issue are practically nonexistent. This is probably due to the fact that peer-reviewed journals are not interested in publishing purely clinical observations. Indeed, in the majority of cases, we cannot even create a research design to study failed cases, because, by definition of therapeutic failures, the therapeutic alliance is poor, and getting the consent for filling up questionnaires and being videotaped is almost an impossible mission! As a consequence, the access to publication in a peer-reviewed journal will most probably be denied and most of us do not even try! On the other hand, this is a crucial issue, because we may go on thinking in terms of the parents’ resistance to change, or we may have to change our therapeutic methods!

In the introduction of “The Motherhood Constellation”, Stern wrote “In brief, it seems that different forms of psychopathology are paradigmatic for different clinical approaches, both theoretically and technically. At each major new encounter with an unexplored illness or never-before-treated clinical population, new treatment approaches emerge. And these invariably have implications for the existing approaches”(1995, p.2). In order for the emergence of new approaches to happen and for the process to be fruitful, i.e. to lead to new conceptualizations of the best treatment for specific difficult clinical situations, we need to develop a method of analysis for failed cases. For instance, we could create a structured micro-analysis of the therapeutic processes that led to the failure, including, and may be especially, the non-verbal, less conscious, micro-events that take place between the therapist, the parent and the infant. Since we never know in advance which cases will become a therapeutic failure, this would obviously require videotaping ourselves during the psychotherapeutic sessions, on a regular basis (and not only in the context of a research protocol). I find that most of the psychotherapists are quite reluctant to do this and the team meetings around the difficult cases are still very much dependent on the way the therapist presents the case. The discussion becomes very different when based on the observation of a videotaped session. The observation itself needs to be standardized so that therapies of difficult cases can be compared. We have become quite good at developing observational tools for the parent-infant interactions. I think time has come to do the same for therapist-patient interactions.

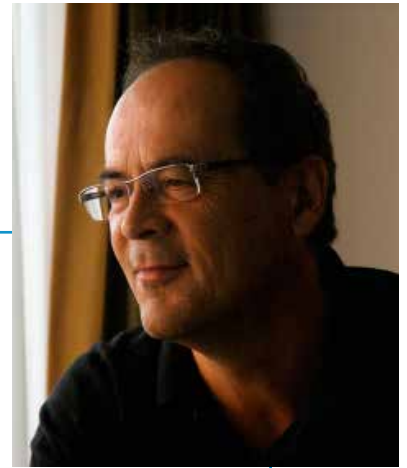
A first step in the process could be to dare to spread among ourselves and to show these experiences of failures, for instance by creating a “tradition” of giving them a special space in our future WAIMH congresses.

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President's Perspective

By Antoine Guedeney



Dear colleagues and friends,



13th World Congress
of the World Association for Infant Mental Health
Babies in Mind – the Minds of Babies: A View from Africa

Cape Town, South Africa
Cape Town International Convention Centre 17 - 21 April 2012



WORLD ASSOCIATION FOR
INFANT MENTAL HEALTH

From the Kauppi Campus -News from WAIMH Central Office

By Päivi Kaukonen, Kaija Puura and Minna Sorsa

FROM
THE
KAUPPI
CAMPUS



13TH WORLD CONGRESS

BABIES IN MIND - THE MINDS
OF BABIES: A VIEW FROM AFRICA



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WORLD ASSOCIATION FOR
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CALL FOR NOMINATIONS/ APPLICATIONS FOR WAIMH AWARDS

