

The Signal



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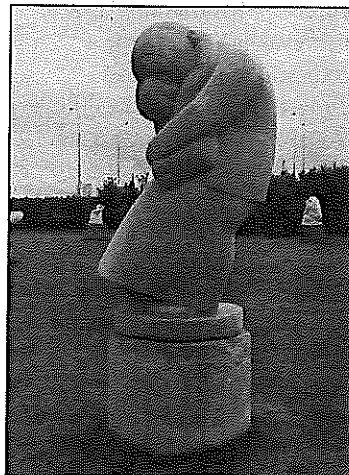
October—December 1999

Holding: Its Practical Application in Infant Mental Health Services

by Deborah Weatherston, M.A.

Donald Winnicott, noted pediatrician, developmental specialist and psychoanalyst, wrote frequently about the care that mothers provide to their infants. How a mother holds and handles her baby was of great interest to Winnicott. How she presents herself to her baby as a primary figure for relationship was of equal interest. Holding, handling and relating were essential components of mothering care that Winnicott studied and discussed in many of his lectures and publications throughout his 40-year career (Winnicott, 1965a; 1965b).

Holding is a concept central to emotional health and growth. Well-held, the baby feels safe in his/her mother's embrace. Well-held, the baby is confident that his/her physical and emotional needs will be met. Within this



relationship, the baby learns to watch and imitate, signal and to respond (Brazelton et al, 1974). Organized around his/her mother's face and voice, and safely held, the baby identifies his/her feelings and learns how to express his/her needs. Dependent on this stable and consistent relationship, the baby identifies with his/her mother and discovers who he/she is. Attentive to the baby's wants, moment to moment, the mother is devoted to her baby's care. Reassuring and comforting, she offers support, protection and appropriate stimulation. Reliable and predictable, she provides continuity of relationship and care. The holding experience leads to health and self-confidence

as the baby grows into the toddler who is able to stand on his/her own two feet.

Contained within this very brief description of the holding experience are words and concepts that are embedded in infant mental health theory and practice. Good-enough mothers are seen as attentive, devoted, reassuring, comforting. Healthy relationships are described as consistent and need fulfilling, offering opportunities for appropriate stimulation, expression of feelings and continuity of care. Babies help to contribute to the exchange by being well organized, attentive, responsive, and self-confident.

Building a Model to Support Caregiving

Understanding the importance of caregiving practices that nurture and protect infants and relationships, Selma Fraiberg designed a treatment model in the late 1960's to enhance them (Fraiberg, Shapiro & Adelson, 1976; Fraiberg & Adelson, 1977). Regarded then as a unique approach to the treatment of very young children and families, the Fraiberg Model, defined by the term, infant mental health, continues to offer a way of working that is

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unique. It extends an intensive and comprehensive set of strategies to support caregiving relationships, helping parents to hold their babies—physically, emotionally and verbally—reducing the ominous risks to the baby of delay, abuse and/or perpetual neglect (Lieberman & Pawl, 1990; Pawl, 1993; Weatherston, 1995). The approach embraces early developing relationships, holding parent(s) and infant together in the intimacy of their own homes and nurturing their strengths. Upon entering each family's world, the infant mental health therapist has an endless number of opportunities to watch the parent(s) and infant in interaction together, to understand and hold their developing relationship(s), to encourage their competencies and to offer a therapeutic context for trust and support (Fraiberg, 1980; Fraiberg, 1987).

Infant mental health therapists have a solid commitment to relationship-focused services and may choose from an array of strategies for intervention: emotional support, concrete service support, developmental guidance, advocacy, and infant-parent psychotherapy (Lieberman & Pawl, 1988; McDonough, 1993; Weatherston & Tableman, 1989; Wright, 1986). What follows is a brief summary of each of these major components, with references to holding.

Strategies That Offer Guidance and Support

Emotional support is compassion offered to a parent who faces a crisis with a baby. Alone or without emotional reinforcement, a parent needs someone who is willing to listen and be helpful, who offers reassurance at a time when there is little, and who helps to contain the many feelings that threaten to make caregiving difficult. The infant mental health therapist

communicates a capacity to hold the parent, the infant and the new relationship. The therapist does this with actions and also with words. She/he arrives at the parent's home when she/he says she/he will be there. She/he watches and listens carefully to all of the details. She/he is undivided in her attention, reliable and predictable. In responding with empathy, the therapist may also speak for the baby, his/her need to be comforted following a difficult experience or to be picked up, stroked, comforted with words. She uses her relationship to create a context in which the parent and infant, together, feel safely held. The image of a mother wrapping her arms around her baby for affection and protection comes to mind. The offering of emotional support through an infant mental health intervention is so close to the holding experience that Winnicott describes.

Concrete resource assistance refers to the meeting of basic needs for food, clothing, medical care, shelter and protection. The infant mental health therapist who feeds or clothes or finds housing for a family, assures them that she/he cares about them and wants to support them. The provision of very tangible things offers clear proof that the therapist wants to hold the family together, to keep them from falling apart. Significant to the practice of infant mental health, this is basic to Donald Winnicott's concept of holding.

Developmental guidance is the offering of information to a parent about the baby's development and specific needs for care. The infant mental health therapist enriches the parent's understanding of the baby through shared observations, videotaped feedback, modeling of appropriate interaction, and sugges-

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tions for playful response. An opportunity to watch and respond to the baby with the therapist at her side, helps a parent to begin to appreciate the uniqueness of the baby, to feel more confident, to ask questions and to celebrate changes, week to week. The therapist is careful to identify the parent's caregiving strengths and support new confidence in handling the baby well. The infant mental health therapist is respectful of the developing parent-child relationship. She/he does not intrude or overwhelm, threaten or advise. Instead, the therapist speaks for the baby within the context of the parent-child relationship and guides the parent to interact and respond. With Winnicott as her guide, the therapist holds them with consistent presence, attention and words.

Advocacy is a fourth strategy that extends the infant mental health therapist's role in identifying the baby's needs for attention and consistent care, as well as the parent's responsibility to provide that care. The therapist may speak for the baby who has no words or the parent who is often silent and overwhelmed. As an advocate, the therapist works to keep them safe, protects and supports often in systems that make decisions about a baby's care or a parent's right to raise a child. Again, we use the words safety, protection, support, familiar to us now as integral to holding and to the practice of infant mental health.

Infant-parent psychotherapy may be the treatment of choice in instances where emotions are intense and parental conflicts about the baby, complex. Watching and listening carefully, following the lead of both the parent and infant, the infant mental health therapist gently explores thoughts and feelings that are awakened in the presence of the baby. In an attempt to understand, the

therapist may ask questions. "What is it like for you when the baby begins to cry?" "How do you understand what he wants or needs?" "How did you learn to feed him in just that way?" "Who was there to hold you when you were just your baby's size?"

Answers often lead to the telling of stories that explain the parent's present difficulties and past pains. In the quiet of the kitchen, the therapist holds the feelings that a parent has surrounding the care of the baby and offers emotional response. In the intimacy of the home, parent and therapist discover how a family falls in love with a baby and problems they encounter along the way. Within the context of the therapeutic relationship, parent and therapist feel safe enough to explore the relationship with the baby and establish parameters for affectionate care.

As Winnicott said in many different ways, "The holding environment provides a sense of safety and trust that depends upon the reliability of the caretaker and the affective communication between caretaker and child" (Goldman, 1993, p. xxi). This description is closely related to the relationship that an infant mental health therapist extends to the family. It permits the restoration of health and growth for both the parent and infant through infant-parent psychotherapy within the context of a holding relationship.

In summary, each strategy illustrates how an infant mental health therapist holds a family with a baby. As Donald Winnicott frequently reminded clinicians throughout his life, holding feels like mothering. The infant mental health therapist does the things that a mother does: protects, nurtures, notices, sustains, supports. When she/he does it well, mothering care improves and there is greater hope that the infant will flourish.

Holding Within the Context of Relationship

Crucial to the effectiveness of strategies within the infant mental health model is the working relationship that develops between each therapist and parent (Lieberman & Pawl, 1993). Respectful and consistent, the practitioner listens carefully, remains attentive to each parent's needs, identifies with the parent, allows feelings to be expressed and offers an empathic response. Within the safety of this relationship, parents feel well cared for and secure, held by the therapist's words and in her mind (Pawl, 1995).

The challenge to hold parents and infants, to observe and listen, to contain the emotions within interactions and relationships and to understand them is considerably difficult. Central to the therapist's ability to hold parents and infants within the context of the infant mental health intervention is the supervisory relationship in which the therapist feels protected and safe, too (Shanock, 1992; Schafer, 1996). Devoted and invested in the infant mental health therapist's work with each family, the supervisor serves as a continuing source of reassurance and support to each infant mental health specialist. The supervisor encourages the expression of thoughts and new ideas. She/he helps the infant mental health specialist find words that shape the experiences in each family's home.

The Infants and Families Served

In reviewing many articles about infants, parents and jeopardized relationships, it is clear that the impediments to adequate caregiving are serious and emotionally overwhelming. Many of the babies are

constitutionally vulnerable—premature, underweight, irritable, difficult to comfort or feed. They may be failing to gain or thrive. Described as sorrowful babies, they are unsmiling, silent, gaze aversive and difficult to engage. They may have a disability or chronic health condition that is life threatening. On the other hand, some of the babies are wonderfully competent, responsive and robust. Their contributions to the caregiving relationship are numerous. However, they are referred for infant mental health services because their parents are overwhelmed, preoccupied, or seriously depressed. Overburdened, these parents find it far too difficult to hold or feed or comfort their babies. They may have histories of early and unresolved losses that make the care of a baby troublesome. Major clinical concerns include histories of abandonment, extended separations in early childhood, placement in foster care, abuse or neglect at the hands of primary caregivers. The overlay of poverty in many homes increases the risks.

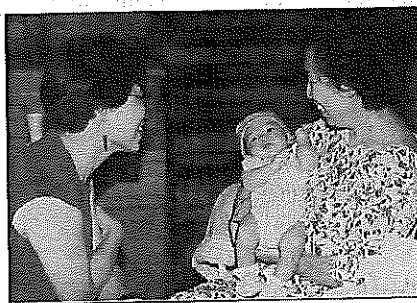
Helping Through Holding

Infant mental health therapists are asked to enter many homes, sit beside parents and infants, carefully watch interactions and behaviors, understand the subjective experience of each, listen to difficult stories and restore relationships. They are carefully trained not to interfere with the mothering care, not to handle babies and not to offer advice (prematurely). Rather, they are trained to watch and wonder (Adelson & Fraiberg, 1980; Fraiberg, Shapiro & Cherniss, 1980; Lieberman & Pawl, 1993; Muir, 1992). "What about the baby?" "What makes the caregiving so difficult?" "What explains the parent's current struggle?" Many

clues lie in the non-verbal exchanges between parent and infant, reenactments of an earlier relationship or a courageous attempt to illustrate some painful aspect of caregiving that the parent experienced long ago. Other clues are offered through parent's stories, many of them disturbing and painful to listen to.

Supervisory Support

It is easy to understand that the infant mental health therapist must be supported somewhere. In order to



continue the arduous task of holding and sustaining others, she/he must be held and sustained as well. Some have written elegantly about the importance of supervisory support for effective, relationship-focused infant and family interventions (Fenichel, 1991; Kennel, 1996; Norman-Murch, 1996). Others mention discussing a clinical case with a consultant or supervisor (Blos & Davies, 1993; Fraiberg, 1980; Lieberman & Pawl, 1993; Weatherston, 1995). Some report that reflective supervision prevents "burnout" and strengthens commitments to relationship-focused services for young children and families (Bertacchi, 1996). By most authors' descriptions, reflective supervision, in which a therapist feels held (in all of the ways we have discussed holding) is essential for the development of the therapist as well as for optimal growth

and change within young families.

The feelings awakened in the infant mental health therapist as she/he observes and responds to families are intense and varied (Wright, 1996). Anger, disappointment, frustration, hopelessness, sorrow or despair may threaten to overwhelm even the most experienced infant mental health clinician. As Wright describes, parents and infants induce these feelings of rage, hopelessness, sorrow, etc. in the clinician. The opportunity to process these feelings is essential for the therapist's emotional health and family's growth. Recognition of the feelings, conversation about them and understanding of their origins is important in every infant mental health case. Without a context in which to reflect on what she/he experiences, weekly, the infant mental health therapist is at continuing risk for failing to hold and protect the family. She/he may defend (understandably) against very painful feelings by turning away from the family, failing to "see" neglect or abuse, shutting down, closing a case before the work is finished or leaving the job altogether. At the worst, rather than providing a context in which parent and infant feel safely contained, she/he may continue the cycle of abandonment and loss so often at the root of a disturbed infant-parent relationship. In sum, effective caregiving seems to require holding within multiple relationships for effective infant mental health intervention.

Holding Within a Clinical Case

Holding, a concept important to Donald Winnicott over 40 years ago is clearly central to the construction of infant mental health principles and practices as designed by Selma Fraiberg. What follows is a discussion of several home visits to illustrate the

practical applications of holding within a clinical intervention.

The Smith Family

The Smith family was courageous to let me come into their home. The baby, Rick, was 3 months old at the time the referral was made to the infant mental health program. His brother, Jay, was 2 years old. The parents, Sarah and Mike, were young and uncertain about meeting the needs of their children.

A social worker in a developmental assessment clinic expressed concern about Sarah and Rick when they brought Jay into the clinic for physical therapy services. The pediatrician had recently diagnosed Jay as having cerebral palsy and significant developmental delays. The social worker observed that Sarah looked quite depressed. She couldn't pay the kind of attention to her healthy baby that the social worker expected. In fact, Sarah seemed preoccupied and inattentive to the baby, showing little pride in his sturdy body and his efforts to begin to reach or smile. She was worried and referred the family to the Infant Mental Health Program where there was a staff person who could make home visits and provide follow-up, relationship-focused care.

Several days after receiving the social worker's referral, I called Sarah up. I introduced myself and asked if she would like me to come out to her home. I told her about our services and she agreed to meet me at 2:00 p.m. the next day, although she sounded hesitant and somewhat forlorn.

A First Home Visit

I arrived when I said that I would be there, 2:00 p.m. I knocked at the door and was met by a barking dog and Sarah. Sarah led me down a steep

stairway, to a small basement apartment, three rooms wide. Unsmiling and tense, she offered me a cup of coffee before we sat down on a large, overstuffed couch. The baby, Rick, slept in the corner of the living room, in a portacrib. Blankets swirled around him. His pacifier was close to his mouth. Jay, the toddler, was up and awake, ready to greet me with an engaging smile. Clothed in a diaper, he was stretched out on the couch. "An easy, agreeable baby," I thought, except that he was two years old. He could not sit alone without support or handle toys or reach with intent. He appeared to be delayed by many, many months. I wondered how she had managed before the diagnosis had been made. Who had listened to her worries about the baby who could not walk or sit or talk?

"How have things been going for you with two children to take care of?" I asked.

"It's not easy. I don't have much help. Mike's not around a lot of the time, with work and school and all that. It's mostly just me and the kids really."

"You've not had an easy time," Sarah, "I replied, using her words. Jay grew quite animated as Sarah talked to me.

"I guess he wants something to drink," Sarah said suddenly. She got him a cup, held it to his mouth, and helped him to gulp, spilling most of it on his chest and on the couch. She wiped him up gently, stroking his hair. She lifted him on to her lap, his legs dropping halfway to the floor.

"So much work," I thought to myself.

"Such a good baby," Sarah said out loud.

"You know him well, Sarah, just what he wants and needs," I observed to her.

Sarah continued to talk, hurriedly, about Jay and his needs for her care.

She had a great deal to say, as if no one had invited her to talk in quite some time. She needed to do the talking and I needed to listen. This would be the first order of business if I were to understand the problems here and how I could be most helpful.

As I sat in the darkened basement room, I felt hidden away, unable to see the sunlight or to see neighbors nearby. "Tomblike," I said to myself. Sarah explained that they had once lived in the mountains with wide-open spaces around them. "We live hidden away, now, in shame," Sarah later said to me.

The baby, Rick, began to stir in his bed. He awakened, but didn't cry. Eventually, he started sucking noisily on his fingers. Self-absorbed, Sarah did not notice that he was awake. She didn't know that he was hungry and needed to be fed. She continued talking about being here alone, the outsider. "My family lives far away. They haven't ever been to see us. They haven't even seen the baby yet."

"Would you like to see them, Sarah?" I asked.

"Yea, I guess. We're not close or nothing. I moved out a long time ago. But I miss my Mom. I'd like her to come."

"You'd like to see your mother, wouldn't you?" I restated quietly.

"Yea, I would. It's lonely here. I don't have time to really meet people."

I responded by saying, "It wouldn't be easy to care for two little boys when you're feeling lonely." She grew pensive and drew Jay in closer by her side, protectively.

Rick began to cry now. Sarah made no eye contact with him, no effort to talk to him from across the room or to comfort him. Irritated, Sarah finally got up to get a bottle from the refrigerator. Without warming it up, she gave the cold bottle to Rick, propping it with the blankets beside

his head. It was a sobering picture. What made it so difficult for her to hold and feed this beautiful, healthy baby? What could explain her distance and irritation? How did Jay's disability affect her developing relationship with 3 month old Rick? What other losses were awakened as she cared for both babies in this darkened apartment? There were many questions that danced about in my head.

Before the hour ended, I asked Sarah if she would like me to come back again to see her and the children. She said that she thought she might like me to come back. "No one ever comes," was her response to me.

"How would next Tuesday be? Again at 2:00 p.m.?" I wondered. She nodded her head, somewhat tentatively. I left my name and agency number, inviting her to call if something came up before our next visit.

A second visit

As often happens, both parents were there when I arrived on my second visit. Mike sat with us for the first half-hour. He wondered who I was and how I could help Sarah. "She's lonely, you know," he told me. "Her family's not here and I'm gone a lot."

"You've not always lived here, have you?" I asked.

Sarah then spoke about happier times when they had lived far away, climbed mountains and walked the beach. She spoke with a good deal of animation. "We thought we would have our baby and stay there in the sunshine for the rest of our lives."

"It didn't turn out the way you expected, did it?" I replied.

"No," Sarah said quite sadly, "not at all." She went on to talk in greater detail about Jay's birth. "He was overdue and I was under a lot of

stress. They induced me. They made Mike go out of the room. I remember that the baby turned blue and they whisked him away. I couldn't even see him for one day. They said he was fine and just sent us home."

"You had such a difficult hospital experience! How frightening for both of you."

They continued to share the details of those first weeks at home with Jay. Although the referral had been made for Sarah and for Rick, it was clear that Sarah needed to talk a great deal about her first child, Jay, and I needed to listen.

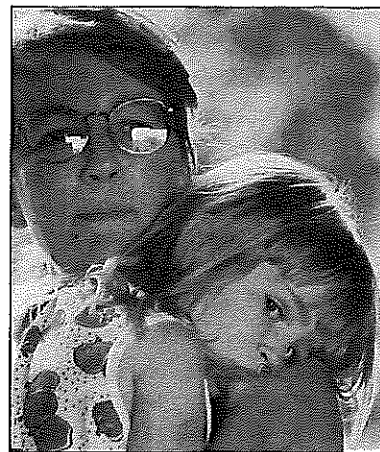
Mike soon left for work, saying that he would see me again. Rick was fretful and needed to be changed. After I listened to Sarah for a while, she was able to turn her attention to him, diapered him, then set him down on the floor. Jay also needed her attention. She responded to Jay's tiniest gesture or cue, a grunt or a shaking of his head. "Do you want some juice? Do you want to get up? Do you want to get down?"

The need for mothering felt extraordinary that afternoon. Both children expressed intense longings for attention and affection.

"The children need so much from you right now, don't they?" I observed. I knew that Sarah needed a good deal of nurturing before she would consistently meet the needs of both children. As I left their home, I was aware of feeling exhausted, emotionally drained. I knew that Sarah must be feeling exhausted, too. I would have to remember that. We set a time for our next visit, Tuesday at 2:00 p.m.

Later, as I discussed this new case in supervision, I was taken quite by surprise as I thought about another mother and her two children, about the same age as everyone in this household. That mother, of course, was me.

I was overwhelmed by Sarah's longings for comfort and attention, her neediness for company in the absence of her own family's care. I had not thought about my own loneliness as a young mother in quite a number of years. I felt sorrow for Sarah's firstborn who had serious disabilities and would always need her care. I remembered a baby in my own family who had been too vulnerable to survive, my twin. I felt worried for



Sarah's youngest baby who was at risk for being overlooked because his mother was depressed.

I felt incredibly vulnerable. "Was I up to this task?" Again, I mused. This must be a question that Sarah asks every day. "Am I up to this task?" The supervisor, my trusted guide, listened carefully. He helped me to separate my own experiences from Sarah's and to return with empathy and the courage to offer continuing support.

A third visit

When I arrived for my third visit but Sarah wasn't there. I left a note telling her how sorry I was to have missed her and the children. I told her that I would call her later in the day and set a time to come again.

I reached her by phone. She seemed surprised that I would call, still tentative in her belief that someone would really listen or be consistent in a response. "Would you like me to come on Friday, Sarah?" I asked. Luckily, I had that extra time available.

"Yes, that would be fine," somewhat surprised that I really had followed through.

A fourth visit

Our missed appointment gave me a chance to acknowledge that "it is not easy to let a stranger into our lives, to tell someone we hardly know important things about ourselves or our children. You are quite brave, Sarah." I reminded her that I would be able to visit in their home for a year, and that I would come every week.

"You can help me, can't you? I've never been through this before, you know, with Jay. He didn't cry so much. He was an easy baby," said Sarah with considerable expression.

"We can talk about both babies, Sarah. We can start wherever you want to begin."

Discussion

I have become preoccupied with the concept of holding as it relates to the practice of infant mental health. It is so easy to organize my thoughts around Winnicott's writings about holding. Holding is what the baby needed his mother, Sarah, to be able to do, reliably and affectionately. Before she could hold him, in all of the ways that Winnicott uses that term, Sarah would have to feel held herself, nurtured and protected by someone who would listen and be emotionally available to her. As the infant mental health therapist, I took my cues from the baby and returned, week after week for two years to hold them all in many

ways – physically, verbally and emotionally.

Holding was essential for the baby's development and survival. Sarah began to show me, as early as the second home visit, that she could hold Rick, briefly, on her lap, and that she could respond, fleetingly, to his discomfort and cues. Rick, at 3 and 4 months, could communicate his distress and respond. Rick in turn held Sarah with his cries and cues and settling down when needs were met. Within the context of this fragile relationship, he began to organize and watch his mother's face and voice. As Sarah grew more attentive to Rick's wants, he grew assured of her presence and her changing capacity to provide "good enough" mothering care.

As for Sarah's ability to hold Jay, that shifted, too. She began to encourage his development, to wonder about and celebrate small but significant steps to independence, e.g. sitting him in the high chair to eat, encouraging him to reach and explore toys, enrolling him in a center-based program for early intervention, supporting his self-confidence. She held him with her words and with her emotions, not only through physical contact. This was possible as she grew trusting of my relationship and able to depend on me to offer her verbal and emotional support. Effective mothering required holding at multiple levels.

What were some of the outcomes? The baby grew to be a sturdy, smiling, active toddler. Within the first few visits, he began to turn his face toward his mother and to smile. Jay, too, grew sturdier and more independent. He learned to sit and feed himself and eventually to walk with much help from his mother who celebrated these significant milestones. The seeds were

planted in the first few visits as Sarah showed me that she could place Jay safely in a high chair and help him to hold his cup. Within the context of a safe and nurturing therapeutic relationship, Sarah grew attentive and nurturing of both little boys. The children also expressed themselves within the safety of this warm, nurturant mothering relationship. In my mind, they came "to life."

What helped me to sustain this intervention in-home for more than two years? I met regularly, twice monthly, with a senior consultant who held me, provided me with a relationship in which I felt safe and able to talk about my work, including Sarah and her family, for two years. Certain that my professional needs would be met, I was able to watch and listen and consistently respond. Knowing that I could depend on the consultant's guidance and support, I was able to offer the same to Sarah. Her pain surrounding the birth and care of her firstborn was intense; her grief threatened to intrude on her mothering tasks. The non-verbal exchanges were difficult, too. In order to sustain Sarah, I had to feel sustained, too. Anger, disappointment, frustration, hopelessness were part of most early home visits with Sarah and her family. I needed to give voice to these feelings as they surrounded me. I needed a place to sort these feelings out and restore my hopefulness. Without this, I was at risk for failing to sustain the family through their crises of early development and relationships. That was the same risk that threatened Sarah. The parallels within infant and family services are extraordinary and important for us to listen to.

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Editor's Note: Deborah Weatherston, MA is Director of the Infant Mental Health Program at Wayne State University's Merrill-Palmer Institute



President's Perspective

Yvon Gauthier

In March of 1980, WAIMH (then the World Association for Infant Psychiatrists and Allied Disciplines--WAIPAD) held its first International Congress in Portugal (Cascais). The Year 2000 then marks its twentieth year of existence. We are thus approaching an important anniversary which should be celebrated at our Montreal Congress in July. It is also an opportune time for reflection on our goals and purposes and on the means we have to achieve them.

Our scientific and educational purposes are defined primarily in WAIMH's bylaws. I believe that our Congresses held every 3-4 years have been very successful in reaching professionals from various disciplines and providing for the exchange of knowledge. The merger of WAIPAD with the International Association for Infant Mental Health (IAIMH) in 1992 was a most important move. Although each constituency represented differing milieux and backgrounds (WAIPAD was stronger in academic milieux while IAIMH had more members coming from the front-lines), the two were united to pursue similar objectives.

When we consider the International meetings as well as those held at the Affiliate level, we certainly can see that we are reaching more and more professionals at all levels to convey knowledge, and to support efforts to young families with their infants in those crucial early years.

In recent years, the *Infant Mental*

Health Journal, developed under the direction of Joy Osofsky, is now reaching more and more subscribers, and has become the most important Journal in our field. The publication of *The Signal* four times a year also makes an important contribution to our membership.

After considering this history and the current situation, the Executive Committee has come to the conclusion that a new step is necessary at the organizational level, with consequences that could be important at other levels. We feel that Affiliate Societies are currently in a distant world, and that, if they could feel closer to the parent organization, they could be more supported in their essential work with their members.

To achieve this, Presidents of Affiliate Societies, together with their Vice-Presidents, will be called to take part in the deliberations of the Board of Directors at each International meeting (and hopefully in the off year,

if WAIMH can financially afford it). Their contribution would thus be acknowledged and they could bring back to their constituents information, and policies which are elaborated at the governance level.

WAIMH's bylaws also talk about charitable purposes, without mentioning specific details and instruments. We have necessarily been rather absent from this area as an Association, though individuals have been active at a more personal level in situations of crisis. It is our belief that we could be more involved. Statements could be prepared on the occasion of specific circumstances to present WAIMH's views. We are not the UN, but we could sometimes influence the UN and its constituents, and our governments, by taking clear positions about infants and young families.

This 20th anniversary could then be a turning point in WAIMH's history. I will be writing directly to the Presidents of our Affiliate Societies to tell them of our desire to have them more involved at the Board of Directors level.

Your comments about WAIMH's goals and purposes, and about our recent decision will be much appreciated.

COLLABORATION

A mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals.

The relationship includes a commitment to mutual relationships and goals, a jointly developed structure and shared responsibility, mutual authority and accountability for success, and sharing of resources and rewards.

—Michael Winer, in *Collaboration: What Makes it Work*,
Amherst Wilder Foundation, p.39

W A I M H

Call for Nomination of Board Members

According to our bylaws, a nominations committee has been appointed and is soliciting suggestions for four open positions on the Board of Directors spanning the four years—2000-2004. Nominees must be current members of WAIMH who are willing to commit the time and effort involved in serving.

To make a nomination fill out the following form:

1. State the name of the nominee and his or her country.

Has the suggested individual been contacted and consented to serve?

2. Provide a brief biographical sketch of the individual.

3. Describe in a few sentences the strengths you believe this individual would bring to the Board and to WAIMH.

4. List the names and addresses of a few colleagues who endorse your nomination.

5. Name of the person making the nomination _____

Deadline for nominations is: March 1

Send your nominations to:

***Hiram E. Fitzgerald, Executive Director, WAIMH, Kellogg Center #27
Michigan State University, East Lansing, MI 48824-1022***



WAIMH

Affiliate News

Australia

An advocacy committee within AAIMH has recently become involved with the National Initiative for the First Three Years. This initiative, which coincides with the first three years of the century, has as its goal the development of a multi-disciplinary institute. The institute aims to call attention to the importance of early childhood so that governments and communities will create appropriate policies and supports to promote

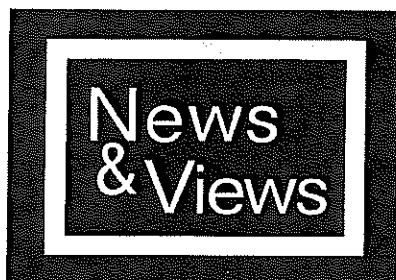
optimum experiences for those critical years of development.

United States

The Maine Association for Infant Mental Health will hold its annual conference on May 11-12, 2000. Dr. Charles Zeanah is slated as a key-note speaker on the conference theme "Addressing stressed attachments during infancy and childhood." Dr. Zeanah will meet the preceding day with Maine's mental health clinicians, and others who work with various

aspects of child protection law and custody cases.

The Michigan Association for Infant Mental Health has scheduled its 24th annual conference for May 7-9 in Ann Arbor, Michigan. This year's conference will focus on the long view with the theme "20/20: A clear vision for millennium babies." Children born in the year 2000 will be twenty years old in 2020. How might current policies and practices support or hinder their functioning at the age of 20? For information call 1-734-764-4276, or email ptully@umich.edu



Germany

March 28-April 5 and September 7-15. University of Cologne, Germany. *Training in the Adult Attachment Interview (AAI)* directed by Patricia M. Crittenden, Ph.D.

March 30-April 5. University of Cologne, Germany. *Training in the "Care Index"* directed by Patricia M. Crittenden, Ph.D. For information on either program call 49-221-470-4684, fax 49-221-470-4684 or email: ruediger.kissgen@uni-koeln.de

Jerusalem, Israel

October 29-November 3, 2000. Jerusalem 2000 Congress. The

conference theme is "The Promised Childhood." The Congress will offer professionals involved in the care of infants, children and adolescents a multi-disciplinary and international forum combining plenary, keynote and invited symposia on a wide range of clinical, research and psychosocial aspects. For information call: 972-3-514000, or email childhood@kenes.com

Denver, Colorado, USA

London, England's School for Infant Mental Health is now offering 3 trainings from its new location in Denver, Colorado, USA.

- **Day Workshop: Early Interventions.** Thursday, February 21, 2000. Assessment of infant and parent-relationships using infant observation and reflection.
- **Short Course: Promoting Therapeutic Interventions with 0-3's.** A 15 hour experiential and reflective course with videos to promote knowledge about the

subtleties to take into account when intervening with babies and their parents in different settings.

- **Intensive Weekends:** Infant Observation Courses, Clinical Seminars, diploma courses in Parent-Infant Psychotherapy and Infant Psychiatry are offered over 4 weekends beginning Spring 2000.

For information and registration, contact Sara Lincoln, (Denver) at 1-303-691-6140 or fax 1-303-691-980.

New York, USA

June 13-23, 2000. Dr. Alice Honig's 24th Annual National Quality Infant/Toddler Caregiving Workshop. The workshop is designed to help people seeking an understanding of infant development and practical training in infant caregiving. It will demonstrate the necessity of integrating the different developmental domains so that caregivers may see and interact with the whole child. For information call 1-315-443-3273 or email: partime@uc.syr.edu

International Development



- Sponsors WAIMH memberships and *Infant Mental Health Journal* subscriptions for individuals from developing countries.
- Extends the influence of infant mental health to countries now developing new approaches to issues of infancy.
- Makes it possible to build capacity for promoting the well-being of infants and their families.

Beacon Scholarships in 1999

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FOR INFANT MENTAL HEALTH**
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