

The Signal



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Newsletter of the World Association for Infant Mental Health

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DOUBLE ISSUE

We have combined six months of Signal articles into one big issue. The first three papers were presented at a symposium organized at the University of Padua by Dr. Graziella Fava Vizziello on Child Maltreatment. The Editor welcomes future submissions related to this important topic. The fourth article presents the elements of developmental "first aid."

CREATING SUPPORTIVE APPROACHES FOR NEW PARENTS:

Experiences of an Early Infancy Prevention Project

by *Maria Concetta Scavo*

Working in the field of infant mental health involves the meeting with a new clinical population (parents and children ages birth to three years) and with a new working subject (the nature and the quality of interactive and relational exchanges). What follows is the achievement of creative and completely new methodological and theoretical considerations. The considerations emerging from the recent

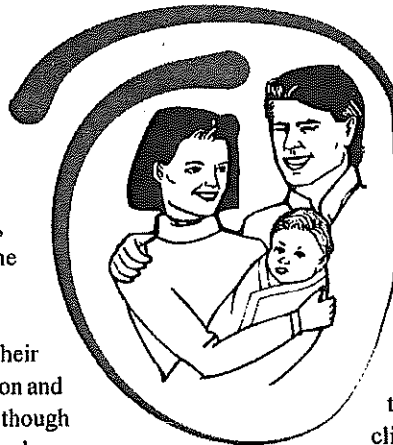
clinical experiences in this field have encouraged, first of all, the merging of approaches rather than their differentiation and distinction, though these approaches relate to very different patterns of thought and working models.

The specificity of this field enabled the working out of comparable interventions thanks to the presence of common elements which are due to the particular nature of the clinical system, represented by the events linking parents and children over the stages of growth (Stern-Bruschweiler and Stern 1989). A deep understanding of the features of the new complex working subject demands remodeling the setting and the instruments of intervention, which must be reviewed in order to

face the peculiarities of demands and needs characterizing this critical stage, which affects the life of adults and their small children.

This is the reason why the various models, from the more closely psychoanalytical to the interactional or behaviorist ones, seem to converge, in their turn, into an integrated clinical system where concurrence rather than differences is more frequently demonstrable. The dynamic interdependence existing between the various elements in the parent-child clinical system makes a therapeutic intervention towards any element either the mother or the child; either the relationship or the interaction; either the representations of one's own inner world or the manner of behavior lead to a change of all the other elements, too (Stern-Bruschweiler and Stern, 1989).

It is surprising then to realize the homogeneity in the efficacy of the interventions which face the system



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from different points of view and of entrance. That is, the psychodynamic model focuses primarily on maternal representations, the behaviorist model focuses primarily on interactive behaviors, and those who observe the meaning of the affective exchanges from a dynamic point of view, focus on the nature of relationship. Finally, infantile psychoanalysts and developmental psychologists focus on the child's qualities and the developing construction of his/her inner world.

Stern (1995) has suggested to us that the putative efficacy of different therapeutic approaches may be based mainly on their non-specific features, that is, the ones common to all therapies. Non-specific features of treatment, after all, include the process of how help-seeking is responded to. In addition, therapeutic approaches in infant mental health share a concern with common problems existing in this area of intervention, namely, parenthood, birth of the baby, and the ongoing development of relationships between parents and children. This area of focus influences the modalities and the possibilities of facilitating child development. These treatments also concentrate on the aspects of the adults' past concerning their own infantile experiences, their old family relationships, and their mechanisms of identification and counteridentifications with their own parental figures. It is a warm area, capable of mobilizing resources which enable a parent to understand his/her child's needs and, therefore, to raise the child and to love him/her. It is also an area which allows fantasies and ghosts of one's own infantile past to re-emerge, which may interfere with parents' educational functions and with the qualities of the relationships involved in the child's development. Fraiberg (1975) reported the painful interference of the nursery's ghosts,

unwelcome guests emerging from the parental past which crowd around the cradle and also around the peculiar developmental stages during the child's growth.

Working on the ghosts that may alter the development of the relationship with the child and, consequently, the quality of his/her growth is the main goal of the different interventions made in the field of infant mental health.

This is the field in which the repetition and co-action of distorted relational modalities, for which the child becomes the object of transfer. That is, the parent and child together relive the conflicts of the parental past. The violence and abuse which are often committed against children are deeply rooted in the interplay of ghosts and interactive modalities which affected the parent's infantile life. They also are caused by the ways and the extent to which the parents have identified with these ghosts.

Much could be accomplished in this sense by making early interventions which can provide support and unburden the child from the parental ghosts and fantasies. If a society really wants to protect its children, Bowlby said, it must begin to care about parents in order to prevent the parents' past from becoming the children's ineluctable fate.

What do parents need? The principle that the disorders of the mother-child relationship are separate entities, psychic phenomenon independent of the mother's health or pathology, which we may approach with aimed interventions is used as a guide to modify that specific independent system in the mother's mind, Stern (1995) named the motherhood constellation. The latter is a sort of psychic organizer of parenthood, which predisposes to an unusual mental state compared to the previous

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functioning of personality, and that characterizes the emotional and relational aspects which differently combine over all stages of the child's development.

We felt the necessity to rely upon a system of support, benevolent and protective, capable of supplying parenthood with the useful helps to

of different supportive interventions during the past 5 years.

In designing the interventions and the activities, we tried to adopt different approaches to support the quality of relationships which support children's development. In order to do this, we devised different proposals which met, with varying

particularly feels the need for allies at home, in the neighborhood, or in the town, with whom to share and actively support the child's growth.

When parents meet experts and pediatricians, who always have shared with them the concerns and the responsibilities for the child's future, they are provided with a constructive

forum in which to encounter initial supporters in their educational path as parents.

Advice to Parents, and *The Group Meeting for Parents* introduce the psychological



If a society really wants to protect its children, Bowlby said, it must begin to care about parents in order to prevent the parents' past from becoming the children's ineluctable fate.

face so demanding tasks. It is a system defined by Stern as a matrix of support capable of establishing a positive influence on the relational modalities towards the child and also capable of representing a benevolent and containing transfer object for the parents. It might be said that working out a program of preventive interventions for early infancy means entering the suggestive domain of the motherhood constellation and the attempt of offering a matrix of reliable, differentiated, and available support.

A matrix of supportive interventions for parents

Following parents' cares over the developmental stages of the child by supporting them during inevitable obstacles and also assisting them to cope with critical situations along with personal, environmental, and institutional emptiness that sometimes occur constitute the guidelines at the core of the interventions and the supporting activities of our prevention program. The Early Infancy Center, which was set up in January 1995 by the Venice Municipality and the Municipal Social Policy Office, have provided a variety

degrees and diversified scopes, the various needs of parenthood.

Understanding Children, The Town for the Child, and Informing Parents are three different programs that may represent an attempt at transmitting a new oral tradition of the knowledge of the child, but also they provide opportunities for meeting and discussions in which parents and professionals exchange information on the needs, the problems, and the resources which are needed to bring children up.

With *Understanding New-Born Babies*, a place is offered to parents so that they can meet to express their doubts and anxieties soon after the delivery, and look for suggestions to face their difficulties. The effort of actively caring for children makes parents feel they are particularly in need of exchanging opinions on daily behavior and, consequently, on all the concrete problems concerning feeding, pains, weaning, and regular functioning, in other words, on all the child's events. The fear of not being adequate for assuring the child's survival and protecting his/her health predominates the parent's emotional scenery. For this reason he/she

dimensions of the evolutionary path which encourages parents to exchange opinions with other parents to discuss the problems of daily life and to get suggestions about the questions of child growth and development.

Following maternal care for the child and the careful attention to the quality of his/her growth, interventions are provided. These range from straightforward development guidance to more significant crisis intervention. Furthermore, the intervention also may involve a parent-child intervention related to a crisis situation. Furthermore, it also may involve of parent-child psychotherapy carried out in the natural context of the family and home. The need of the clinical situation is determined by the clinician who develops the intervention plan.

During our advising activity, we are able to respond promptly to parents' concerns. Parents positively use this opportunity to obtain advice, which is intermediate between the more routine pediatric domain and the more specialized neuropsychiatric domain. In these sessions, the main problems we have to cope with are disorders of the child's behavior and
(continued on page 7)



Psychological Abuse in and towards Childhood

by Dr. Med. Lenio Rizzo

The concept of abuse is not the same as the concepts of violence or maltreatment, though in the case of these two latter concepts and their relative phenomena, there are some similarities. Furthermore, these concepts cannot be limited to mere physical abuse, because sexual abuse must be included, and we must consider negligence or neglect, as well as psychological abuse in order to refer to agreed upon conventions in the fields of health, welfare and rights that make these distinctions.

As a result of numerous clinical observations, specific physical findings indicative of physical abuse are becoming clearer. It is estimated, for example, that 1/200 of all pediatric inpatients have suffered physical abuse, and there is some indication that the number seems to be increasing. Similarly, although specific physical findings are less reliable, clinical guidelines are being specified both with regard to the sexually abused child and the abusing adult. On the other hand, the same cannot be said for psychological abuse.

Indeed, up to now, either only weak and insufficient definitions of psychological or emotional abuse (or circular and redundant ones) have been forthcoming. As a consequence, it is not infrequent to find that judges include moral cruelty among their evaluations of families who maltreat children, while it is very rare that psychological maltreatment is suspected to be at the origin of the

problem during judicial proceedings. However, not wanting to fall into the sphere of relativism devoid of solution, I propose that the term psychological abuse should accompany and include all the other forms of maltreatment, thereby constituting the general context and representing all that which in negligent behavior, sexual abuse or physical violence against childhood reaches an unbearable level.

A Split-Like conflict

With regard to what happens at a social and collective level, is it perhaps not true that the common denominator of the various situations in which violence is committed on the image of childhood and in real life situations, where children are maltreated, physically and sexually (through famine, poverty, child labor, perverse practices, horrors of war), in different environments and geographical areas, constitutes also what causes prejudices to childhood on a psychological level?

On the one hand, we negate childhood, through refusal, abandonment, strong instigation to assume degraded roles, and even murder. On the other hand, we exalt in triumphant images of childhood, considering it to be a source and an object of continuous seduction. We study, care for, know as never before, and consider childhood to be the foundation of civilization in the future. This is the

general observation that I draw, not only from contemporary macro-events of this global village, but also from what is happening quietly in education. There, many possibilities, though highly praised, are actually sacrificed on the altar of a more conformist and neurotic homogeneity.

These contradictions also can be found within the health system, especially when often adequate considerations of the psychic developments of recovery are not considered as meaningful as important technological successes. I have been able to draw the same observation from consultations with families whose long desired and expected child can become the target of such projections, thereby obstructing his path in life. Childhood, therefore, is the center of a radical conflict which manifests the splitting process. It requires attention both at an individual level and at a social being level. For this, we must depend on elements obtained from specific analysis of individual cases to lead to more general and widespread comprehension.

Why and How of Abuse

What is behind psychological abuse, which co-exists with each act of maltreatment thereby rendering it an ubiquitous premise? In order to explicate psychodynamic mechanisms in acts of abuse and aiming to understand these very phenomena, I would like to make use of the work of some authors who have described the common phenomenon in which adults

who were abused as children themselves, in turn maltreat their heirs and other children.

Selma Fraiberg (1975), in an article on problems obstructing a good mother-child relationship, observed during clinical work with highly problematic family groups the phenomenon she described as ghosts in the nursery. The presence of these representations from the past condemn parents to re-enact the tragedy of their own childhood, including the most terrible aspects, on their own children, thereby rendering the latter the silent partner. In order to explain the constancy and energy of repetition, Fraiberg demonstrated not only how the parents used an intense repression of affect associated with their childhood experiences, but also how, at the same time, they developed a pathological identification with those who aggressed against them and threatened their own egos.

Sandor Ferenczi (1980) already had described the oniric figure of the wise baby in some of his work in the 1930s. This baby was able to maintain profound debates though still small. Furthermore, it constituted, according to Ferenczi, the differed representation of an agony that the patient had experienced, like the effect of a sexual trauma undergone in early childhood. The consequence is the splitting of the person of the patient, on one hand, as the child offended in a sensitive part who eventually becomes brutally destructive, and on the other, a very wise baby who, without sensitivity, returns in oniric representations. According to Ferenczi, it is due to the effect of danger that the sense of guilt of the latter, accompanied, however, with a repression of hate itself. A paralysis of the will occurs, submitted to that of the aggressor, and, it has often been observed, the abused individual splitting mechanism, as the

child feels innocent and guilty at the same time, as well as discouraged from manifesting his own thoughts.

The Use of Childhood as Abuse

The mythical figure of the wise child that emerges from splitting, introjection and repression mechanisms, is understood to account for the transmission, from generation to generation, the sufferance, passion, guilt, and, at least, of the repetition of putative psychic traits necessary for subsequent abusive behavior.

However, it is also important to note that even some benign behavior, whether in education or welfare, can express a pedagogic or therapeutic passion similar to the sufferance terrorism experienced within the family. In this case, the child is reduced to the wise baby through introjections of the unconscious sense of guilt of the adult and determining, as in all other cases, both a traumatic and an aggressive experience of the baby's intense need for help. This is most apparent in the baby's expression of his/her initial physiological inadequacies.

Responses to the infant's dilemma, I think, may well shape what the infant carries forward into subsequent relationships. In other words, as a consequence of how the infant is welcomed or refused, heeded or repressed, how that extreme need for help (which Sigmund Freud called *Hilflosigkeit* [Helplessness]) has been responded to, may be crucially important. Each person, in fact, identifying himself with adults nearby, will be able to welcome and protect, or on the contrary, repress, even with abuse and violence, those fragile aspects that exist within every child.

Furthermore, another wide-spread and improper use made of childhood is

also to maintain the practice of unheeding the internal cry through the repetition of a piercing and ill-natured shout, thus perpetuating the transmission of guilt and misdeed, as in the case discussed by Fraiberg. What, indeed, the wise baby is testimony to is the unconscious hate with regard to the infantile which each of us has known and which deals with the wonderful child that is reborn within every little man.

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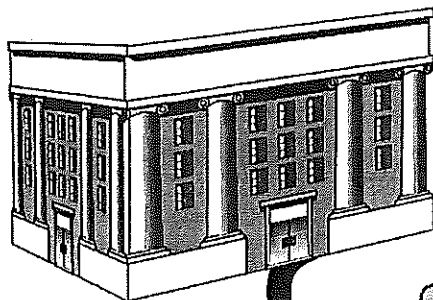
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CHILD ABUSE/NEGLECT: *A Discussion*

There are increasing requests by the Juvenile Court to the local mental health services for assessments or for expert reports about families where child abuse is suspected. The involvement of the Court is becoming more and more frequent as a way of reaching unreachable families and to communicate with them. Referrals can be made by members of the family themselves, by social workers, or by others.

Sometimes these families are known to the services, but very rarely are receiving a proper therapy (in that case it wouldn't be necessary to go to Court, because the consciousness of the problem and the demand for change would already be satisfied, producing a regular clinical setting). They usually are just ordered to the service, and in this case, the therapist to whom they are assigned will be different from the one who conducted the assessment.

Often for these families a therapeutic process with the usual means and setting is not available. The abusive relationship is connected with power and with annihilation of psychological resources: the abusive relationship destroys the victim as a person, so in the psychotherapeutic work you find it difficult to let both the abusive and the abused assert oneself. These are the kinds of challenges and obstacles that we need to find a way to overcome.



At the beginning of my career as psychologist, I considered these patients untreatable, or social cases. In any case, they were different from psychological patients. I thought it impossible to conduct treatment when therapy was contaminated by control. Now, I understand things differently. Procedures established by clinicians who work in this area, such as those set up by the psychotherapists of the Centers for Child Abuse in Milan and Bologna constitute a new therapeutic approach.

First of all, these situations must be recognized as challenging and problematic. Initially, this involves overcoming substantial denials (of events, of their severity, of joined affections, of responsibility, of the consequences for the victim, etc.). Parents must come to acknowledge that they have problems that are inextricably linked with the perpetrated abuse/neglect. We can achieve this aim by means of significant legal action, the denouncement and the warrant.

It might be a case of suspected abuse, or of verified abuse, and the

child might be, or about to be, removed from the family. In either case, we are asked to assess the availability of change of the family and to plan interventions.

We cannot state that the therapeutic procedure employed is not psychotherapy, simply because it begins in such unusual circumstances. Rather, it is just a different therapeutic process. The legal frame creates a

strong, real,
concrete,
powerful
structure,
which can
help
maintain a

psychological working through. For the people involved in it, it enables us to prevent thoughtless action and to create a distinction between having and acting upon impulses. In this sense, it may be compared to a therapeutic community for drug addicts, in which impulses may be experienced but not acted upon.

On the other hand, it is not exactly a compulsory setting. It would be impossible to force people to come and talk. Rather, we think of it as an authoritarian setting. The setting stops people from acting for a while, allowing them to acknowledge themselves and to understand why they behave as they do, hopefully eliciting empathic processes toward oneself (including metacognition) and also towards children.

In a very short and strictly predetermined period of time, usually a few months, a process of restoring one's experience is accomplished, by understanding the links of family history (in three generations) with abusive behavior. How else could we subject this kind of patient to clinical use of psychological tests, such as the

Adult Attachment Interview, or to interpersonal observations, etc.?

The therapist can develop the assessment together with patients, show and explain to them the outcomes, in transparency, with single individuals, couples, whole families. At the conclusion of the assessment, s/he can read them the report, before sending it out, making a therapeutic restitution and working through it. Initially, the therapist might receive a negative reaction from the family, but if the process is conducted well, this may give way to a growing acceptance.

A young woman, Sylvia, was sexually abused for years by her father. During the assessment, she came to understand why she experienced this relationship; her older brother understood why he provoked his father to beat him; the youngest sibling understood his feeling of being lonely; the mother understood why she denied everything (with reference to her own experience as a child). Finally, the father was given opportunity to understand why he needed to hold absolute power over everyone, in order to keep his narcissistic madness from destroying the whole family, and therefore, to accept separation from the family.

Teaching/educating cannot be separated from understanding in these cases. What is clear is that social intervention alone is insufficient—we need to find a therapeutic way, either in cases of removal or in cases of the child remaining with the family.

The child is an active subject of the assessment in these cases. The child's role in the family must be understood in order to appreciate the relational context of abuse/neglect. Of course, the therapist has the whole (indirect) power and responsibility to explore and to come to know and understand this role.

Another challenge is integrating complex and multiple services required by families in these situations. The different services involved are less segregated than in the past, but their roles are always distinct. The question is how to integrate them effectively without reducing their impact or clouding their focus.

In the psychological services, another therapist eventually will conduct (or arrange) the therapy, artificially dividing the two parts of the process (that is, understanding why on the one hand, and understanding how to get on on the other).

There may be families who are incapable of such a process of forced valuation: will it be possible to find other ways to reach them effectively? This is our challenge for the future.

Editor's note:

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(CREATING SUPPORTING APPROACHES FOR PARENTS continued from page 3)

the psychosomatic functional disorders. Another important area of concern involves requests for support when maternal depression or relational difficulties within the family context are present.

Home Support represents the most targeted activity of our Center; it also represents the optimistic spirit on the possibility of breaking off the maladaptive continuum by introducing prevention into the places where disorders develop and by offering an early intervention to support the family in its natural environment. The working model we adopted stands halfway between the child observation model of the London Tavistock Clinic and the early intervention model of the mother-child relationship named Psychotherapy in the Kitchen by Fraiberg (1980). The latter is particularly effective in those multi-problem situations which can endanger the relationship with the child in its context. Under these circumstances, the continuous presence of the professional in the family context encourages the establishing of an important tie with the mother, a sort of good grandmother transference which supports and molds parental functioning.

During our experience, we noticed that our initiatives deeply met the needs expressed by parents. Home intervention particularly proved to be an effective instrument of support and prevention.

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Developmental First Aid

..... (when X-mars the spot)

by John Kirkland, Ph.D.

Let's take the second part of this expression first. We are familiar with the idea of "First Aid". For instance, work places are required by law to have available a first-aid kit. And most homes have some form of first-aid equipment available even if it is little more than a clean needle for removing splinters, a tampon for stopping bleeding, or an aspirin for giving pain relief. Then there are "first-aiders", ordinary people trained in a range of basic life-supporting skills and available to offer assistance to those who suffer misadventure.

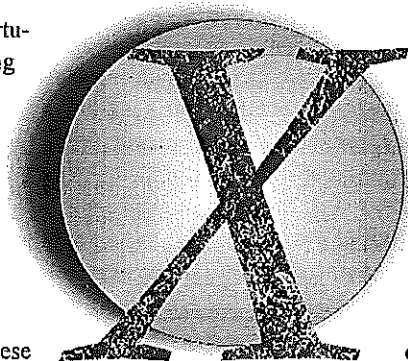
By "developmental" is meant those positive and negative things which happen sometime during the course of our lives and which then tend to have an ongoing effect. Negative examples include preventable childhood communicable diseases such as polio which if left unchecked may result in a life-long restriction. There is a raft of possible physical damage possible in any setting. More often than not with timely intervention these mishaps are able to be put right. For instance, under the right conditions broken limbs can be repaired. But unseen physical effects such as those arising from contaminated food or other environmental pollutants are less direct and thus less able to be remedied in the short term. Only recently have developmental effects from passive smoking been acknowledged.

Just as important as providing conditions for healthy physical growth

is providing opportunities for sustaining and extending what's known generally as positive "socio-emotional" development. Here we are dealing with "feelings", how these might be accidentally damaged and how a sense of deep hurt can be carried forward into the future, possibly influencing a whole life course. It is well known that children who suffer an unexpected loss of a mother figure will mourn for a person no longer available to comfort them. If this loss is not handled well, if there are no other familiar people to whom child may turn for securing a "sense of home", then this experience can warp a person's capability to get on with others even years later.

As in the medical sense there are specialists for these extreme cases, where early trauma is possibly working itself out in unconscious ways and requiring the services of professional intervention from therapists or counsellors.

But there are many instances where developmental first aid is sufficient. Again, as in the medical analogy, if treated promptly, properly and without too much fuss there is a good prognosis for healthy outcomes. There might still be a few tender spots or stiff joints but if these are taken care



of and nursed properly there are not usually any severe after effects.

Christmas we are told over and over again is a time of goodwill, of giving to others and enjoying their company. But events have a tendency to

easily and unexpectedly get out of hand. No doubt many of us are able to recall a particular Christmas we'd rather forget, a Christmas we'd sooner have done without in spite of the presents. Even so, this is continually rubbed in year in and year out with the "one size fits all" mentality. For many people Christmas becomes a well-publicized black calendar mark, an annual reminder of things once enjoyed but now lost, forever. Under such trying circumstances anybody can easily forget the simple Christmas message of new life and new chance, of tolerance and of peace.

Christmas is often a time of additional stress for many children and their families. Quite apart from the common and trivial anti-climax of not receiving an expected or desired present, children can be placed at risk by unthinking and uncaring adults.

Children are frequently caught in the cross-fire between hostile parents, as unwilling and innocent victims of circumstance. Unless attention and planning has been given to their full

involvement over this period then children, particularly those of separated parents, remain uncertain about care arrangements and this rubs off. They become unsettled.

Many non-custodial fathers personify Dickens' Scrooge. They have no sense at all about how much it costs to keep a child. They feign ignorance about the importance of providing adequately. They use actual and real threats of withholding financial support. They string out a continuous line of accusations. They blame their children for something that's nothing to do with the children. And possibly worst of all, they fail to keep their promises. There are few hurts so great for a child as to be forgotten by a parent who fails to pick them up at the agreed upon time. Waiting, waiting, waiting with fading hope is sheer torture. These are cheap tricks that leave lasting impressions upon young minds.

A trained first-aider coming across an unconscious person follows the cardinal A B C procedure (Airway, Breathing, Circulation). Adapting this into a socio-emotional developmental frame we have another A B C namely: Availability, Belonging and Care.

An available adult is one who is accessible for contact and cuddles when needed by a child. Like the air we breathe, availability is felt as a relaxed supporting presence. When provided adequately it leads to a child trusting that another stronger and wiser person will be there to help should the occasion arise.

A child who feels he/she belongs has a base from which to explore as well as one to return to afterwards. This "sense of belonging", of "home" no less, is the unseen thread which eventually weaves a growing child into the family net.

Care is much more than providing for physical welfare, important though this is through the life course. Emotional care is the opposite of neglect and abuse. It includes providing appropriate social and personal opportunities for a child to experience a wide range of positive and negative emotions. Through nurturing these experiences in a safe setting children may give vent to the joy of life as well as learn to control intense feelings of hate and anger without hurting others.

In summary, availability, belonging and care are the basic requirements for developing healthy socio-emotional relationships. Once adults are aware of these essential features the rest is fairly easy because there are hundreds of flow-on ways to apply them in age-appropriate settings. To use another analogy, availability, belonging and care are as three major life themes. How these are played out in any particular family is a variation of what's possible. These themes become the trinity, providing both the frame for and the measure of life-long relationships.

We can all offer basic developmental first aid to others, we do not need any particular training. Christmas-time provides an occasion to remember; our challenge is to help ensure it leaves a positive trace for all concerned. It is a simple message; peace to those of goodwill.

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Defining infant mental health . . .

The infant mental health field is relatively young and continues to expand, evolve, and define itself. Infant mental health focuses on the social and emotional well-being of infants and their caregivers and the various contexts within which caregiving takes place. Infant mental health, therefore, focuses on relationships; infant development is conceptualized as always embedded within emergent, active systems of relationships. By definition the infant is born into a social world (Bell, 1968; Rheingold, 1968). . . .

Infant mental health is rooted in the understanding that developmental outcomes emerge from infant characteristics, caregiver-infant relationships, and the environmental contexts within which infant-parent relationships take place. From an infant mental health perspective, "parents are looked at as interacting participants in the developmental process, which does not permit a dichotomization of nature and nurture" (Shapiro, 1976, p. 4). Winnicott (1964/1987) captured the essence of the caregiver-infant relationship when reflecting upon his prior comment that there was no such thing as a baby, "meaning that if you set out to describe a baby, you will find you are describing a baby and someone. A baby cannot exist alone, but is essentially part of a relationship" (p. 88).

from The WAIMH Handbook of Infant Mental Health, Vol. 1, pp.4-5



President's Perspective

Yvon Gauthier

As usual at this time of the year I had the privilege of being a visiting professor in France, working with several teams in perinatology. Several questions were of major interest to me in various meetings I had with professional groups. I will try to summarize them here.

1. Once more I was quite impressed by the work done by child psychiatrists in close collaboration with obstetricians and various professionals working in Maternities. I had already described this experience in Montpellier (cf my article in the *Signal*, vol. 3, no. 1, 1995) and referred to it again last year in my President's Perspective (the *Signal*, vol. 7, no. 1, 1999). We know from several clinical and research observations how important is childbirth for all women, but particularly it seems for women who have had difficult times in their own childhood. Quite often it is around the birth of a new child—not necessarily the first one—that memories come back, that painful experiences are relived, that a desire is intensely felt to make sure that this new child is not going to be mistreated, and is going to have the kind of childhood that the mother was not allowed to have. Psychiatric consultation and psychotherapy often are the instrument to reach such experiences and integrate them into the current events. But it is also the role of professionals working in a Maternity ward to create the kind of “containing environment” which allows a mother

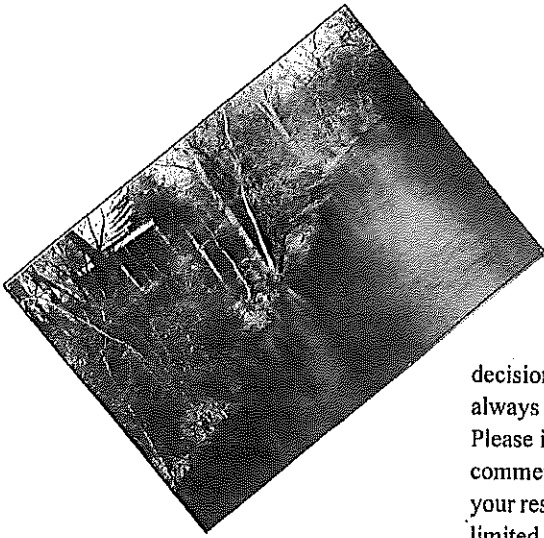
to feel “taken care of enough”, that she can find those inner resources needed to care for her child, and then, if necessary, proceed at a later time to a psychotherapeutic experience.

2. Early infancy-perinatology is a field where clinical activities are in the hands of several types of professionals who are the ones to have a direct contact with infants and parents. They are thus quite often the one person to whom a parent will talk, with whom a parent will feel that he/she is listened to, with whom a parent will establish a relationship which may have very positive effects. This is a problematic situation for many colleagues who feel that this sort of relationship can be securely established only with a psychiatrist or a psychotherapist, to whom the patient should be referred. But quite often the patient does not feel that she can relate to another person, the referral then will not be followed up, and thus a therapeutic experience may be lost for a long while. Of course we are here touching the whole question of training of professionals in early mental health, so that what “has to be said” can be heard by a “listening ear” who is trained, though not necessarily by a psychotherapist.

3. Autism still is a most complex problem. A strong tendency is to consider this syndrome a “neurobiological entity”, which has long enough been mistreated by child psychiatry and psychoanalysis in attributing to

parents an important role in the development of the symptoms. There is also a strong trend toward early diagnosis of this syndrome and detection of early signs of the disorder, through videos often made by parents during the early months and years of their child's life. In a seminar which was using this technique, we reviewed two cases. In one clinical case thus reviewed, one couldn't easily push aside the environmental etiology when one heard how the mother wanted to get rid of this child through the whole pregnancy, and how she was not able in the early years to protect him against the attacks of two older brothers, while the father was almost completely absent. One is not surprised to see this little boy—maybe fragile in the first place—retreat in his own world at the age of four. As we continue trying to understand this complex symptomatology, it seems to me most important not to throw away too rapidly the kind of understanding that was obtained from a good psychodynamically-oriented clinical observation, and to develop around these children, as around so many complex disorders of early childhood, the open mind that does not fall into the trap of constant polarization between adverse camps.

Such questions are at the center of preoccupations of several clinical teams with whom I worked in France and will evidently be part of symposia and posters at our coming Congress. It will be interesting to see how such questions are dealt with by teams coming from various cultures. I was able to observe a variety of approaches in Paris, when a clinical case was presented to the WAIMH European Affiliate Societies that were meeting for the first time. Such experiences are most useful and I hope we will be able to repeat them in Montreal.



From the Red Cedar

Hiram Fitzgerald
Executive Director

FORUM FOR TOMORROW

[Recently we solicited opinions from WAIMH members about issues of concern to them relative to WAIMH's mission to promote optimal development for infants and their families. We are using the comments received to stimulate discussion among the members about WAIMH's mission. Our goal is to publish debate about these issues. We will also carry this out on the WAIMH Listserve. Although the original comments were anonymous, published commentaries must be signed by the author. Because these are personal statements editing will be minimal. Of course, final

decision to publish a commentary always resides with the editorial staff. Please identify which issue your comment addresses when you send in your response. Commentaries will be limited to 500 words, or two pages double spaced.

The first three issues I selected are sure to provoke response. Why not share your reactions with the rest of the membership? Send your commentaries to me at the WAIMH central office and let the discussion begin!

On Political Activism:

"While I am in full sympathy with the WAIMH mission..., I don't think the central issue—promoting the optimal development of infants and their families—can be tackled without addressing the wider environment in which they exist. However apolitical I am myself, I believe nevertheless, that

we must now learn how to implement our experience and knowledge with political activism. Therefore, I would welcome studies as well as support and leadership that would help WAIMH, as well as its members, to become a voice that is indeed heard among the makers and shakers of this world."

On WAIMH's Disciplinary Focus

"I suggest that WAIMH look at the development of infants who are healthy from the point of view of behavioral development. I feel the organization is too dominated by psychiatry and psychoanalysis and therefore more focused on mental illness than mental health."

On WAIMH's Research Perspective

"[I believe that WAIMH should] shift from treatment to prevention models. WAIMH should work with other organizations in pioneering preventive intervention studies in infancy and early childhood. Collective strength and educating the public and funding agencies is required."

Defining infant mental health

as the ability to develop physically, cognitively, and socially in a manner which allows them to master the primary emotional tasks of early childhood without serious disruption caused by harmful life events. Because infants grow in a context of nurturing environments, infant mental health involves the psychological balance of the infant-family system.

—Maine AIMH 1997, cited in WAIMH Handbook of Infant Mental Health Handbook, vol 1, p. 25

News & Views

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

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making connections

Besides affording an extraordinary opportunity for learning, WAIMH's World Congresses serve another important function--they provide a rich environment where linkages are established between infant mental health specialists from diverse points around the globe. An article in the Spring 2000 issue of *Everyday's Child*, the newsletter of the Maine Association for Infant Mental Health, illustrates this point.

Karyl Condit, a board member of the Maine Association lives half a world away from Julie Campbell in Sydney, Australia. But not too long ago, however, they met for the first time in Sydney. The connection between Karyl and Julie began in Finland at World Congress 6 in 1998. It was there that Julie picked up a copy of *Everyday's Child* and subsequently became a subscriber.

When Karyl mentioned to Ed Hinckley, the editor of *Everyday's Child* that he was going to Australia, Ed suggested that he contact Julie Campbell. And so he did.

Julie invited Karyl to attend her class in Infant Mental Health at the New South Wales Institute for Psychiatry where she was teaching a Post-Graduate Diploma program in infant mental health. Karyl took advantage of the opportunity to learn something about infant mental health in Australia and to give news of infant mental health work in Maine. Karyl concluded her travelogue with the comment that: "I felt right at home with the group of infant mental health students in that classroom and marvelled that, even being half the way around the world from one another, we shared a common passion for the well-being of parents and young children."

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