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INTERVENTION PROGRAMS FOR PREMATURE INFANTS:

CONSIDERING POTENTIAL MECHANISMS FOR CHANGE

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Over thirty years of research on the effectiveness of intervention programs for premature infants has produced substantive evidence that intervention, in general, has a favorable impact on subsequent development. Multiple studies of preterm infants who receive proprioceptive, tactile, vestibular, kinesthetic, auditory, visual, rhythmic, or multi-modal stimulation in the neonatal period have documented that such infants fare better than nonintervened control infants on a wide range of outcome variables. Improved functioning for

treated infants has been noted on immediate and short-term physiological measures such as reduced number of apnea events, improved oxygenation, faster weight gain, and earlier discharge, and on neurobehavioral development end points such as improved motor maturity, habituation to sound and light, and orientation and state organization. Similarly, positive long-term effects of various intervention programs have been reported, including improved cognitive and social functioning up to two years following intervention.

Most striking, however, is the fact that beyond the near universal consensus that intervention has some impact on development, there is little consensus regarding the specific mechanisms underlying the reported improved outcomes, the specific intervention regimens that best fit infants of various conditions, severity of illness, chronological age and/or birth weights, or the conceptualization of the developmental processes modified by the intervention efforts. In fact, the broadness of the definition of "intervention" and the great variability of its application raises serious questions regarding both theory and practice (Mueller, 1996).

Even more puzzling is the fact that intervention programs, which are based on opposite theoretical assumptions and consider other programs as contraindicated or potentially harmful, demonstrate similar favorable outcomes on exactly the same measures.

Apparently, central to this confusion are the conflicting assumptions whether premature infants suffer from deprivation of the sensory stimuli they were programmed to receive in utero, or whether, conversely, they are overloaded with sensory information that they cannot process properly after having been deprived of the containing and buffering environment of the womb. The two sides of this debate have inevitably led to opposite recommendations for the type of intervention. For example, there are the reports of successful intervention programs based on increased sensory stimulation of the premature infant such as Field's massage therapy (Field, 1995). In contrast, other approaches, such as the synergistic-regulatory perspective of Als (1986), consider the amount of stimulation preterms receive as excessive and recommend a reduction of stimuli which overwhelm the preterm infant's immature neurological system. The

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puzzling fact is that studies on both increasing and reducing sensory input report improved outcomes, be they short-term physiologic measurements, neonatal neurobehavioral scores, or long-term measurements of higher cognitive functions. As such, given the fact that there is an inadequate understanding regarding the basic mechanisms of how intervention affects development, serious questions must be raised considering whether the mere attention and increased care offered by all intervention programs result in repetitive cycles of (nonspecific) increased care and thus, subsequent improved development.

BASIC METHODOLOGICAL CONCERNS

Previous reviews of intervention studies have also noted a variety of methodological flaws that have precluded full interpretation of the results. The most basic relates to the often unclear or unspecified theoretical basis of the study (Korner, 1990). Strikingly, authors frequently do not hypothesize what mechanism of development is lacking or abnormal in the premature infant and how the proposed intervention will remedy this deficit. As noted, theoretical perspectives contrast in their general outlook on the state of the premature infant. Whereas some consider such an infant as a fetus deprived of sensation, auditory stimulus, and rhythmicity of the womb, others view it as a baby deprived of the normal dyadic interaction and stimulation usually afforded in the home setting—contrasting approaches that dictate opposing styles of intervention. Furthermore, this polarity of concept regarding the premature infant itself ignores the fact that the birth process alters the course of pre- and perinatal development in an as yet not fully understood way. Thus, even if it were possible to imitate the intrauterine environment, it might not necessarily

be the optimal environment for an infant born prematurely. Additionally, most studies do not address the theoretical consideration whether the reported gains are transitory or stable (McCarton, Brooks-Gunn & Bernbaum, 1997). Commonly, studies examine differences between intervention and control until discharge, and infants are not followed further. The question thus remains whether nonintervened control infants achieve similar outcomes, though somewhat later, and whether this delay affects at all long term development. A recent meta-analytic study by Zahr and colleagues (1992) noted that while intervention has a greater effect on the sicker rather than the healthier infants, the differences between intervention and control groups were significant at four but not at eight months; a finding that lends support to the “transitory impact” hypothesis. Alternately, the scarcity of longitudinal data on a single outcome measure precludes the recording of later-appearing effects. Similarly, long-term studies of preterm infants have frequently noted disorders only when the children reached school age (Hack, Taylor, Klein et al., 1994).

An additional weakness in many studies relates to the variability in methodological rigor among studies, which preclude a straightforward comparison of the findings of different reports (Mueller, 1996). Given these theoretical and methodological considerations, this paper aims to review the reports on the effect of intervention on premature infants not according to specific programs or measured outcomes, as customary in review articles, but according to the underlying mechanisms hypothesized or implied to be responsible for the change in developmental course. In this way, the goal is to contribute to the conceptualization of theories regarding the neurodevelopmental status of the preterm infant and the processes of how and why intervention impacts on such development in the critical postnatal period.

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INTERVENTION PROGRAMS AND INFANT STATE

State Organization

Since the pioneering work of Wolff (1996) and Brazelton (1973), state has been conceptualized as the mode by which the infant relates to the environment and as the behavioral expression of biological processes such as circadian rhythmicity and physiological maturation. The organization of state reflects an underlying integration of a variety of neurophysiological systems that facilitate information processing and is the precursor of attention and affect. Disorganization of state, observed as both a disproportionate amount of transitory or active sleep states and/or a disregulated sleep-wake cyclicity, is among the central indicators of the degree of immaturity and/or severity of illness of the premature infants (Holditch-Davis, 1990; Thoman, 1986). Horowitz (1990) suggests that all types of intervention affect development through their impacts on the stability and variability of state. Theoretically, this perspective implies that the goal of intervention is not that of adding missed experiences to a deprived infant but in assisting his/her readiness to extract information from the environment by organizing the cycles of active information intake and of rest. As such, Horowitz suggests that the repetitive-rhythmic component in varied intervention programs, such as waterbeds, stroking, rocking, breathing bears, massage therapy, or kangaroo care, help increase infant attention to the environment by providing "external regulators" (Field, 1994) that allows the infant resources to respond appropriately to both internal and external stimuli.

A number of studies support the proposition that the underlying mechanism by which intervention programs affect the infant is by impacting on state organization. Of

interest, however, is the fact that there are different responses between intervention and control groups regarding state. Programs that are stimulatory in nature, for instance massage that applies active and strong strokes, show an increase in alert states, while those that aim at soothing and rhythmic self-regulation, for example providing rocking or water beds, result in increased quiet sleep. Scafidi and colleagues (1986) showed an increase in the frequency of active alert states during two hours observation following ten days of massage therapy. White-Traut and associates (White-Traut & Nelson, 1988; White-Traut, Nelson, Burns et al., 1994; Burns, Cunningham, White-Traut et al., 1994) showed an increase in alert states following multi-modal stimulation including proprioception, kinesthetic, vestibular, massage, and social interaction. Similar findings were reported by Oehler (1985) following a multi-modal stimulation program. On the other hand, skin-to-skin contact (kangaroo care) has been shown to increase the amount of quiet sleep states both during and following the period of contact (Ludington, 1990; Ludington-Hoe & Swinth, 1996). Infants who were exposed to a breathing bear (a device placed in the isolate and programmed to breath in synchrony with the infant) showed a larger proportion of quiet sleep states five weeks after discharge (Ingersoll & Thoman, 1991). Variability of state, in addition to state stability, is an additional index of infant maturity. Bernard and Bee (1983) showed that infants who were placed on rocking beds had an improved range of state score on the Neonatal Behavioral Assessment Scale. Finally, some researchers suggest that a more mature state control, to which intervention effort may contribute, helps the development of premature infants by making them more competent social partners which, in turn, increases the amount of maternal social contact and active stimulation (Berard & Brazelton, 1990; Horowitz, 1990). This observation is supported by the

finding of Eckerman and associates (1995), who showed that sick and very small preterm infants are distressed by social contact. The combined evidence support Horowitz's (1990) proposition that different types of intervention programs alter different aspects of infant state but all lead to a reorganization and maturation of the entire state system and, subsequently, to improved outcomes.

Self-regulation

An emphasis on self-regulation appears in the theoretical framework of Als' individualized care intervention program (Als, 1986; Als, Lowhon, Duffy et al., 1994). Her synergistic-regulatory model focuses on the hierarchical construction and organization of systems of the human newborn as they unfold throughout gestation. In the intact newborn systems function in coordination with one another. In the preterm the immaturity of systems affects both the discrete functioning as well as the integration. In particular, this is expressed by the poorly developed physiologic inhibitory mechanisms; a situation that leads to the infant's inability to regulate state and to respond appropriately to environmental stimuli. This inability to regulate response to stimuli in turn interferes with the development of perception. The therapeutic approach calls for a marked decrease in the level of stimulation from the caretakers, particularly aversive stimuli, and to an individualized developmental program, which provides care and contact based on the infant's signals, including state. In addition, generalized physical environmental stimuli such as light and sound levels are reduced. The therapeutic value of this approach has been documented in various studies that have shown that preterm infants show aversive physiological (decreased PaO₂ or TcPO₂) and behavioral (aversion, restlessness) responses to handling (Harrison, 1997; Eckerman, Oehler, Hannan et al., 1995). In contrast, individualized care

programs that minimized handling and stimuli and clustered nursing procedures to periods when the infant was responsive resulted in better pulmonary function, neonatal behavioral performance, and higher cognitive development and social skills at eight months (Fleisher, Vandenberg, Constantinou et al., 1995; Als, 1986; Als, Lowhon, Duffy et al., 1994). This approach considers the "goodness of fit" between the infant and the caretaker (Gilkerson & Als, 1995). While attractive on a practical basis, the individualized nature of the program and the lack of a standardized therapeutic protocol have raised serious questions as to its basic assumptions, in addition to the potential for bias in the findings (Silverman, 1994). As the active intervention component is so variable from infant to infant, the "success" of this approach may in reality be the absence of stimuli rather than any specific intervention.

There is evidence from other sources supporting the basic premise that premature infants in the NICU suffer from over, not under, stimulation. Becker and colleagues (1991) provided an intervention program aimed at the facilitation of self-regulatory abilities, including reduced environmental sound and light, clustering care to enable longer periods of sleep, and monitoring the infant's stress and social cues. Results show better performance for the "intervention" group on rate of weight gain, shorter hospitalization, and better performance on the Neonatal Behavioral Assessment Scale (Brazelton, 1973), in particular on the reflex and self-regulatory scales. The failure to minimize such stimuli may well interfere with the infant's self-regulatory capacities and neuro-development. Thus, it is logical to recommend that if the premature infant's system cannot integrate the abundance of noise, light, intrusive touch, and handling provided in a typical NICU, "intervention" should aim at the reduction of

stimulation so as to facilitate the infant's self-regulatory capacities.

INTERVENTION AS TARGETING SENSORY DEPRIVATION IN PREMATURE INFANTS

As compared to intervention programs that aim to facilitate self-regulation by means of "limitation on input" (Turkewitz & Kenny, 1982), several intervention methods propose the exact opposite, i.e. sensory enrichment. These programs are based on the underlying assumption that preterm infants suffer sensory deprivation, which limits normal physiological and mental development and thus, these stimuli should be externally supplied. Two underlying theoretical positions can be sensed from the proponents of such sensory enrichment programs. The first draws on the tradition of the maternal deprivation literature, beginning with the pioneering work of Harlow (1958), and the second is based on the Piagetian theory (1936/1953) of cognitive development and the hypothesis that sensory-motor intelligence serves as the foundation of cognitive development. We will return to the topic of maternal separation in the discussion of the kangaroo care intervention, and will show that this perspective implies the need for both increased stimulation (maternal) and decreased stimulation (non-maternal). Yet, both the maternal deprivation and Piagetian thinking assume an underlying critical period perspective, implying that missed experiences at specific points in development have irreversible effects on later growth.

Tactile Stimulation: Massage Therapy

The application of touch and massage to preterm infants is based on the maternal separation research and the psychoanalytic and attachment

theories that emphasized mother-infant contact as central to the infant's physical and emotional growth (Bowlby, 1969; Frank, 1957; Harlow, 1958). Field and colleagues extended this concept and developed a massage therapy intervention program and applied this to infants with various conditions such as prematurity, HIV and cocaine exposure, and birth to a depressed mother, and noted that massage promotes growth and development and has a favorable impact on the general clinical course of these children (Field, 1995; Schanberg & Field, 1987). In particular, treated infants had better weight gain, spent more time in the active alert state, had a more mature range of state, and had better habituation and motor maturity scores (Scafidi, Field, Schanberg et al., 1986). Other studies have demonstrated that massage improves the infant's information processing in an auditory-visual habituation task (Cigales, Field, Lundy et al., 1997).

Massage therapy is built on the role of touch in early development and in the development of the parent infant-relationship. Touch comprises one of the central constituents of the mother-infant coregulatory system—the process through which mother and infant coregulate social encounters—although its role has yet to be explored in depth (Tronick, 1996). In a cross-cultural survey on mother-infant interaction, Richter (1995) found that touch, gaze, and affective vocalization were the three interactive components found in all cultural settings, with traditional societies utilizing more tactile contact and Western societies emphasizing more distal modes of coregulation. The complementary nature of these coregulatory components may be observed when one or more interactive channels are blocked. For instance, mothers of deaf infants use more touch during play to complement for the lack of vocalization (Koester, Brooks, & Traci, 2000), and touch predominates the interactions of mothers and congenitally blind infants

(Urwin, 1984). Using the still-face paradigm, infants typically reacted to maternal still-face with social withdrawal, whereas when maternal touch was maintained, infants' attention and affect remained unchanged, suggesting that touch can hold the interactive flow when the other components are removed (Stack & Muir, 1992). However, mothers of premature infants, unlike those of blind or deaf infants, do not increase the level of touch to compensate for their infants' difficulties in maintaining gaze and affective synchrony. To the contrary, in home observation of preterm and full-term infants, it was found that mothers touched and approached their premature infants less frequently (Davis & Thoman, 1988). Thus, supplementing touch to infants who normally receive a decreased amount of touch may be beneficial for later development.

The effect of massage on growth in premature infants may also be related to the increased secretion of growth hormone secondary to the stimulation (Schanberg & Field, 1987) and to its impact on adrenocortical and sympathetic functions (Kuhn, Schanberg, Field et al., 1991). The effects of massage on cognitive development is hypothesized to be related to its impact on the autonomic nervous system through the increased secretion of norepinephrine and its effect on attention and memory secondary to an elevation of the infant's level of arousal (Cigales, Field, Lundy et al., 1997). These observations are consistent with Horowitz's (1990) and Brazelton's (Bernard & Brazelton, 1990) proposition that all types of intervention affect development via their impact on the better organization of states.

However, several methodological and clinical issues remain. Bernard (Bernard & Brazelton, 1990) and Gorski (1983) observed that although most infants do not show negative

physiological reaction to massage, some may collapse immediately after the massage session and go through a period of disorganization. This suggests that relatively little is known about when stimulation reaches a point of overstimulation and disrupts the infant's precarious physiological balance. These authors thus strongly suggest that data from the post-stimulation period must be included in any research protocols, particularly for defining those conditions and situations where touch therapy is contraindicated or should be limited. From a methodological viewpoint, it should be emphasized that research on massage therapy has not, to date, examined the differential impacts of massage on SGA infants who have been shown to have an aversive reaction to touch as compared to older AGA infants. Furthermore, Scafidi et al.'s (1993) observation that massage therapy resulted in a better increase in weight gains following tactile stimulation in the sicker infants suggests that specific sub-populations may benefit more from such intervention.

An additional methodological problem is the fact that although massage therapy is based in part on the maternal separation literature, massage provided by mothers and nurses has been treated as comparable therapy. However, since maternal touch has been shown to differ from other caretakers' touch (Miller & Holditch-Davis, 1992; Eidelman, Hovers & Kaitz, 1994), there may well be differential outcomes from maternally provided massage therapy, especially as a result of the mother-infant attachment processes. As mothers' and nurses' touch had different effects on infant state and communicative behavior, the issue of who provides the tactile stimulation should be taken into consideration in developing such stimulation programs and in interpreting the results.

To address this issue, a recent research study from our laboratory (Goldstein-Ferber et al., 2002) compared three groups of premature infants: infants

massaged by their mothers, infants massaged by the nursing staff, and controls matched for medical risk and family demographics. We found that physiological gains, in terms of shorter hospital stay, improved weight gains per-calorie intake, state organization, and hospital discharge were comparable for the two massaged groups, and both groups had higher gains as compared to the controls.

Rose et al.'s (1979) findings that there was no significant change in a preterm's heartrate in response to tactile stimulation, as compared to a full-term's tachycardiac response further raises the question whether the premature infant senses and integrates tactile experience in the same way as a full-term. Additionally, since most of the massage therapy research (as with other intervention therapy programs) is not longitudinal in nature, it is hard to determine if there are truly any long-term sustainable outcomes (McCarton, Brooks-Gunn, Bernbaum et al., 1997).

Finally, it is also not clear whether massage therapy carries a unique effect on physical or cognitive development, or its effects are included within the general framework of multi-sensory programs. This issue was considered by Garcia and White-Trout (1992) who compared the efficacy of tactile stimulation and multi-sensory (oral, tactile, olfactory) intervention on VLBW infants' recovery from apnea, and showed better state organization and quicker reinitiation of respiration in the tactile arm of the study, but not in the multi-sensory intervention group. These findings suggest that there are unique effects of tactile stimulation which are yet to be fully clarified.

Sensory Enrichment Programs

These programs are less specifically directed toward single sensory stimulation but rather employ a broader range and variety of stimuli. Several such multisensory enrichment programs have been reported, and some have followed infants till two years of age (Resnick, Eyler, Nelson et al., 1987). Although not explicitly stated, these programs are based on the developmental hypotheses inherent in both Piaget's (1936/1953) and Gibson's (1962) thought: that the infant's experience with perceptual and motor cognitive operation lays the foundation for more sophisticated representational thought, and that restricted opportunities for perceptual and motor experiences naturally available both in-utero and at the home may slow cognitive development. Partly supporting these hypotheses is the fact that several sensory enrichment programs have shown better cognitive development to treatment infants when children were 8 to 24 month old. Scarr-Salapateck and Williams (1973) provided infants with a combination of visual, tactile, auditory, and kinesthetic stimulation as well as instructions to mothers and repeated home visits and found that the experiment group showed improved cognitive and social performance at 4 and 12 months. Since the program also involved support and education for the mothers it is hard to discriminate influences that were directly on the child from those that function via better maternal care. Rice (1977) showed improved cognitive performance at 4 and 12 months on the Bayley following multi-sensory stimulation in the hospital. A similar large-scale multi-sensory program was conducted by Resnick and colleagues (1987) which noted improved Bayley performance at 24 months. It is possible that infants who received sensory stimulation did particularly well on the Bayley, a test that presents infants with a multitude of stimuli in different modalities and assesses their

adaptive reactions and explorations to changing environmental inputs. Finally, the fact that improved cognitive development has been reported also by intervention programs which restrict rather than supplement stimulation supports the conclusion that further research is required to determine the unique contribution of sensory stimulation to cognitive growth.

Multi-sensory programs were found to have an impact on social development as well. White-Traut and associates (1994) found that feeding interactions were more positive between mothers and infants who received intervention. Solfkoff et al. (1969), in one of the first studies on intervention, showed that mothers of the intervention group provided a more optimal home environment, a finding similar to those reported by Rice (1977).

Arguments against this type of program ensue from the concept of the sequential development of the senses (i.e., that sensory systems develop sequentially building on existing sensory modalities) (Korner, 1990). In reality, most sensory programs offer multisensory interventions regardless of the infant's gestational age or stage of perceptual development. Stimulation is often offered in a multi-sensory way and the stimuli are not introduced gradually in order of development. For example, as information processing is known to be poorly developed in premature infants, the behavioral feature most difficult for these children is the integration of information from several sources. Thus multi-sensory stimulation programs may well be developmentally inappropriate. Similarly, it is questionable whether enriched information is advantageous at all or if limitation on sensory input is more adaptive in the first stages of perceptual development (Turkewitz & Kenny, 1982). Further, very small

premature infants are not capable of handling social interaction and show gaze aversion and distress signs when in face-to-face position (Eckerman, Oehler, Hannan et al., 1995). These findings suggest that multisensor intervention programs should be at most administered with caution and continuous monitoring.

Intervention Based on the Ontogeny of Sensory Development: Proprioceptive and Rhythmic Stimulation

Programs that are specifically directed toward proprioceptive development and rhythmicity, such as waterbeds, rhythmic rocking, and breathing bears address the issue of the sequential development of the senses and aim to target the earliest level of perceptual development. On a theoretical basis, one may argue this type of stimulation provides both enrichment and organization, as proprioceptive and rhythmic intervention mimics the stimulation and sense of containment available in the womb. Korner (1990), who conducted several studies on the effects of waterbeds, bases her intervention program on Gottlieb's (1976) theory that addresses the relationship between experience and structure formation in a structure-function evolutionary perspective. Animal studies support this concept particularly the notion that specific environmental stimuli can alter brain differentiation and thus ultimately development (Philbin, Ballweg & Gray, 1994; Spinelli, Jensen & DePrisco, 1980). Similar electrophysiologic changes were documented in human infants treated with a structured stimulation program (Buehler, Als, Duffy et al., 1995). According to this theory, specific experiences are necessary in order to induce a hard-wired system to function, and specific sensory experiences should arrive at the time when the specific perceptual system has finished its development

and is ready for processing. Korner (1990) thus emphasizes that an intervention program should aim at the currently developing sensory system, according to the child's postconception age and not just provide stimuli for its own sake.

The first sensory modalities to develop in utero—the proprioceptive and vestibular systems—are assumed to provide a better foundation for subsequent sensory development and self-organization. Further, Korner (1990) suggests that the effect of tactile stimulation on development is due to the rhythmic and proprioceptive component inherent in tactile intervention programs and shows that waterbeds reduce apnea and improve sleep in premature infants. Thoman and Ingersoll's studies with the rhythmically breathing bear doll showed that infants "learned" to keep in tune with the bear and their state organization was better at five weeks post-discharge (Ingersoll & Thoman, 1991; Thoman & Ingersoll, 1993). Bernard and Bee (1983) in an experiment in which four groups were assigned to rocking beds noted that the outcomes varied according to the degree to which the infant controlled the rhythm. Results showed better range of state and orientation on the Newborn Behavioral Assessment Scale, and higher scores on the Bayley at two years for all groups, with the group that received both contingent and patterned rocking scoring the highest. Most intervention programs, however, include proprioceptive and rhythmic stimulation as part of a more general multisensory intervention, and the specific effects of rocking on development are hard to disentangle. Several authors have emphasized the need to consider the sequential development of the senses (Als, 1986; Horowitz, 1990; Rose 1990). Studies of the environment of nurseries have noted that the premature infant's immature sensory modalities such as hearing and vision are overstimulated, whereas the early maturing vestibular

and tactile sensors are understimulated, and they suggest that this observation be included in designing and evaluating intervention programs (White-Traut, Nelson, Burns et al., 1994). Thus, it is clear that the relations between vestibular, rhythmic, tactile, and other sensory-enrichment or sensory-limiting approaches need to be further explored from both theoretical and practical perspectives.

KANGAROO CARE: INTEGRATING THE SEQUENTIAL, SENSORY, AND ORGANIZING COMPONENTS INTO THE PARENT-CHILD RELATIONAL CONTEXT

Continuous skin-to-skin contact or, as it is affectionately called, kangaroo care has received favorable recognition as a new infant care technique. Initially developed as an alternative care system in countries with limited health care systems (Whitelaw & Sleath, 1985), this technique has recently been adopted by many nurseries in the developed world. Typically, premature infants who have reached physiologic stability and who no longer need major respiratory support are put on their mother's chest (ideally between the breasts) in a fashion that allows for continuous skin to skin contact and facilitates thermal stability. In addition, breast-feeding is enhanced, physiologic parameters are improved, neurobehavioral maturation is enhanced, and parent-infant attachment is reinforced. Randomized and nonrandomized clinical studies have demonstrated both the safety and benefits of this technique (Charpak, Ruiz-Palaez & Charpak, 1994; Charpak, Ruiz-Palaez & de Calume, 1996; Colonna, Uxa, da Graca et al., 1990; Sloan, Camacho, Rojas et al., 1994). In particular, increased periods of quiet sleep, stable thermal

regulation, and improved respiratory states have been reported (Acolet, Sleath & Whitelaw, 1989; Anderson, 1991; Bauer, Sontheimer, Fischer et al., 1996; Ludington-Hoe & Swinith, 1996). Of interest, paternal kangaroo care as compared to maternal kangaroo care can equally improve the neonate's status (Bauer, Sontheimer, Fischer et al., 1996).

Two mechanisms may be proposed in an attempt to understand what dynamics underlie premature infants' improved outcomes from kangaroo care. The first refers to the unique integration of the self-regulatory and stimulatory approaches. The second relates to the impact of kangaroo care on the developing parent-child relationship, an aspect all too often missing from other intervention strategies.

Integration of Regulatory, Sensory Enrichment, and Vestibular-Proprioceptive Experiences

Kangaroo care has the potential to integrate the polarized approaches to intervention previously outlined and, as such, to facilitate physiological stability, neurobehavioral maturation, social-emotional development, and cognitive growth. The outcome of this integrative process is the regulation and organization of infant state. It has been shown that stimulatory programs, such as massage therapy, increase alertness while proprioceptive-rhythmic programs increase quiet sleep. Kangaroo care, which combines and integrates both approaches, increases both alertness and quiet sleep (Anderson, 1991; Ludington-Hoe & Swinith, 1996). Although most studies on kangaroo care report anecdotal observation or case studies, a growing body of observations suggest that kangaroo care promotes neurobehavioral development, state organization profiles, and thus may increase attention and self-regulation (Affonso, Bosque, Wahlberg et al.,

1993; Anderson, 1991; Ludington-Hoe & Swinth, 1996). Thus, if the central argument between theorists is whether to stimulate a deprived infant or diminish stimulation to an overstimulated infant, the uniqueness of kangaroo care is that it provides an appropriate balance between the understimulated, tactile-proprioceptive system and the overwhelmed, later-developing sensory modalities. The particular value of kangaroo care is its consistency with Gottlieb's (1976) theory on the sequential development of the sensory system (i.e., the proprioceptive-rhythmic skin-to-skin contact provides the containing experience and minimizes the overload of visual and auditory stimuli). This approach is also in accordance with Als' (Als, Lowhon, Duffy et al., 1994) minimal handling program as it shields infants from the ongoing aversive stimulation of the nursery and its caretakers.

A recent longitudinal study conducted at our laboratory demonstrated the long-term gains to the infant's self-regulatory, social, and cognitive skills. The study included 146 infants: 73 who received kangaroo care for at least one hour daily during at least two consecutive weeks and 73 control infants, matched for birth weight, gestational age, medical risk, the amount of maternal milk, Apgar score, and family demographics (maternal and paternal age and education, birth order, and maternal employment).

The study was based on the aforementioned perspectives and examined specific outcomes—rather than addressing mere cognitive development—in an attempt to study the mechanisms that link intervention and outcome. First, in accordance with the self-organizational perspective, it was hypothesized that skin-to-skin

contact would enable the premature infant to have the entire range of "maternal proximity" experiences, including the mother's smell, touch, rhythmic movement, voice, and unique social style, while being contained. These experiences were expected to contribute to the organization of state and consequently to improved self-regulation. Indeed, it was found that infant state improved following kangaroo care. Infants were observed for four consecutive hours prior to kangaroo care and again at term (Feldman, Weller, Sirota & Eidelman, 2002). We found that in the kangaroo care group there was a steeper increase in quiet sleep and alert wakefulness states and a more marked decrease in active sleep. This points to the contribution of skin-to-skin contact to the consolidation of infant state around the two ends of the arousal continuum—full sleep and active wakefulness—and the reduction in indeterminate states, such as active sleep. Furthermore, it was found that kangaroo care contributed to the organization of the biological clock, and infants who received kangaroo contact showed more regulated sleep-wake cyclicity.

Secondly, in accordance with the perspective on the sequential development of the senses, it was expected that the kangaroo care method would provide a more appropriate balance between vestibular and proprioceptive stimulation through the mother's movement, while buffering the effects of overwhelming auditory and visual stimulation that characterize the nursery environment. This improved balance was expected to enhance infants' self-regulation. Results showed that at three months corrected age infants were better able to manage negative emotions while confronted with aversive stimuli and were better able to modulate reactivity in accordance with environmental demands. At six months of age, infants who received kangaroo care were better able to sustain exploration of objects

during joint play with the mother and showed longer periods of shared attention with the mother. These findings point to the contribution of mother-infant skin-to-skin contact to the infant's attention and self-regulatory abilities in the first six months of life.

Finally, at six months of age, infants who received kangaroo care showed better cognitive skills, as assessed by the Bayley Scale of Infant Development (BSID-II) (Bayley, 1993). Improved performance was found on both the mental and motor subscales of the BSID-II. We suggest that the improvement in infants' cognitive development resulted, in part, from the gains in state organization, attention, and emotion regulation observed in the first months of life. However, it is important to consider the fact that kangaroo care is the only intervention method that involves the mother, and improved infant cognition was predicted not only by the infant's alertness and self-regulation, but also by the mother's improved sensitivity and reciprocity to the infant (Feldman, Eidelman & Sirota, *in press*).

In a second study, we compared 35 infants who received kangaroo care for one and a half hours daily for at least 14 consecutive days with 35 matched controls. Infants' vagal tone, a measure of heart rate variability that indexes the functioning of the autonomic nervous system, was taken prior to the initiation of kangaroo care and again at term. We found that whereas no differences were found prior to kangaroo care, treated infants showed higher vagal tone at term age (Feldman & Eidelman, *submitted*). These findings are intriguing and indicate that the kangaroo care intervention can impact on the infant's brain development, not only on behavioral measures.

Parent-Infant Attachment

An additional central advantage of the kangaroo care intervention method is the opportunity it provides for continuous and intense parental-infant contact. This feature is missing from most other intervention methods, and, all too often, the question of whether the intervention is provided by the mother or nursing staff is ignored. Incubated premature infants often spend long, perhaps critical weeks without full contact with their mothers and full mother-child contact, as afforded by kangaroo care, may reverse some of the long-term effects of separation at birth.

Although longitudinal studies on the effects of kangaroo care on mother-child relationships have not been conducted, research and anecdotal reports suggest that early mother-infant contact has a positive effect on the developing relations of parent and child. Following kangaroo care, mothers have a stronger tendency for breast-feeding and maintain breast-feeding for longer periods (Anderson, 1991; Hurst, Valentine, Renfro et al., 1997). Anecdotal observations suggest that following kangaroo care parents feel stronger attachment to the infant (Colona, Uxa, da Graca et al., 1990; Charpak, Ruiz-Palaez & Charpak, 1994; Gale, Frank & Lund, 1993). Mothers in kangaroo programs report better adaptation to the birth of a sick premature infant (Affonso, Bosque, Wahlberg et al., 1993). Generally, mothers preferred the kangaroo approach and were more satisfied with it as compared to standard incubator care (Legault & Goulet, 1995). Kangaroo care is thought to provide mothers with a sense of efficacy, afford contact with their infant, increase parental confidence in caring for the infant, and offer some reparation for the disrupted bonding process (Anderson, 1991). These conclusions are often based on personal impressions from conversations with parents and not on

systematic research. However, kangaroo care is a promising method as it has the potential to integrate the self-regulatory, minimal handling, tactile stimulation, sensory enrichment, and vestibular-containment perspectives within the setting of parent-infant physical contact.

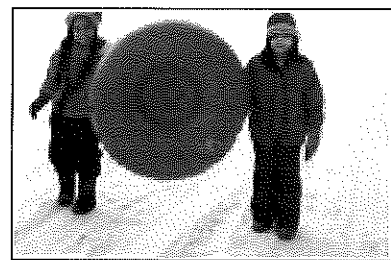
Results from our study provide support for the hypothesis that kangaroo contact increases the mother's attachment to her infant, her sensitivity during mother-infant interactions, and her ability to read and respond to infant cues more adaptively. Mothers and infants were videotaped when the infant was discharged from the hospital, and at three and six months corrected age. At three months, families were visited at home and father-infant interaction was also filmed, as well as a triadic mother-father-infant interaction. Skin-to-skin contact with the infant improved maternal and infant social behavior. At term age, mothers were more adaptive to the infants, touched the infants more frequently, looked at the infants more often, and showed more positive affect. Mothers were also reported to be less depressed and perceived the infant as less abnormal. At three months, interactions of both mothers and fathers of infants who received kangaroo care were more optimal. Parents were more sensitive during interaction, while showing less intrusive behaviors, and interactions were more reciprocal. Interestingly, during triadic interactions both mothers and fathers in the kangaroo care group provided more affectionate touch to their infants (Feldman, Eidelman & Sirota, in press). Finally, at six months mothers were more sensitive, consistent, and appropriately stimulating of their infants in the kangaroo care group.

Importantly, the improvement in the mother's behavior was paralleled by improvement in the infant's social attention, alertness, and involvement.

At term age, infants who received kangaroo care were more alert and less withdrawn. At three months, these infants showed more positive engagement and less negative emotionality at play with both mother and father. At six months, infants in the kangaroo care group were more socially involved and initiated more interactive bids as compared to the controls.

SUMMARY

Given the lack of evidence-based data to substantiate any specific intervention program for the care of the premature infant, clinicians charged with the care of the newborn must balance their enthusiasm for intervention with concern for doing more harm than good. Our review of the published literature on such programs has revealed a lack of a generally accepted underlying hypothesis to support any of the proposed programs. Most interventions do not emphasize the active role of the parent in caring for the infant. Furthermore, the absence of well-designed long-term outcome studies precludes any conclusions regarding the stability of the reported gains. Despite these caveats, kangaroo care, in its unique integration of the stimulating and containing approaches along with the active role of the parent, may well provide the best technique for the care of the growing premature infant. Our own study provides evidence to support this perspective and shows substantial, long-term effects of the kangaroo care intervention on both the child's self-regulation, attention, and cognitive skills as well as on the mother's responsiveness and investment in her infant.



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INTERACTIONS BETWEEN INFANT OBSERVATION AND CLINICAL INTERVENTIONS ARISING DURING SHORT-TERM THERAPY WITH CHILDREN UP TO 3 YEARS OLD¹

By Joanne Giasson, Alain Lebel &
Micheline Reid-Perreault

Translated by Rose Dymetriszyn

*"Good objects are always thinking."
Margaret Rustin*

Parents' worries about their children are too often enmeshed in a long history, difficult to disentangle. When we learn about a child's history from its parents (once a referral has been made to child psychiatry), we often discover that the problems began in the first or second year of the child's life. By the time a professional is consulted, the problems are deep-seated and family interactions are mired in maladaptive patterns. To intervene with the goal of changing these patterns becomes costly in time and energy.

For these reasons, we opened a clinic to provide brief psychotherapy for families with a worrisome infant or toddler (0-3 years old) in February 1994. We were inspired by the model of the Under Fives Counselling Service of the Tavistock Clinic in London (Pozzi, 1999; Miller, 1992). This method of early intervention emerged from psychoanalytic infant observation, as elaborated by Esther Bick (Bick, 1964; Haag & Haag, 1995) and further developed by Martha Harris (Harris, 1976, 1980; Miller, Rustin et al., 1989) for training child psychotherapists and psychoanalysts.

Infant observation was first proposed as a mode of training in psychotherapy and psychoanalysis by Esther Bick in the UK, at the end of the 1940s. For one to two years, once weekly, keeping to a set time and with a set duration, the observer visits the family

home to study the child's interactions with the people closest to him, without interfering in any way with the child or his parents and without videotaping or jotting notes during this period. The purpose is rather to immerse oneself in the prevailing affective climate of the home.

Such an experience has proven itself fundamental in the conceptualization of our own program. To further our own experience and thinking, we continue to research and discuss issues arising from infant observation within the framework of an ongoing seminar, which began in 1992.

SYMPTOMS AND REQUEST FOR HELP

Recalling Winnicott, Hopkins (1992) stated that in the infant there can be no individual psychopathology. She explained further that the best treatment approach considers the infant's symptoms within the overall context of the parent-child relationship. Thus, worried parents may seek professional help for symptoms that at first glance do not appear to be linked to a psychological basis. Complaints may be related to

- regulatory functions such as issues around eating or sleeping;
- attachment or soothing difficulties;
- indescribable and uncontrollable fears;
- difficulties in achieving appropriate developmental milestones (these may be delays or failures in the expected developmental framework such as achieving sphincter control and toilet-training, following unexpected life events such as coping with parental

separation, or with the birth of an infant with special needs); and finally,

- somatic derivatives of psychological conflicts.

We have broadened our service to respond to the needs of obstetric departments, especially around issues of pregnancy, delivery, and the immediate postpartum period, so that we can address any predisposing factors to poor bonding experiences in the newborn.

Aware of the possible repercussions on future generations of parental difficulties in mourning the loss of a foetus due to a miscarriage, or the death of an infant or of another family member, we also make ourselves available to any parent experiencing such a loss. We need to appreciate how negative an impact unresolved grief can have on the couple or on the child, especially on a child of tender years, where a physical or psychological loss can cause havoc in the development of the personality.

TIMELY INTERVENTION *From the Child's Perspective*

Many authors have contributed to our understanding of attachment (Bowlby, 1969, 1973, 1980) and the early interactions between the infant and his parents (Cramer, 1985; Cramer &

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Palacio-Espasa, 1993; Lebovici, 1983; Stern, 1985). We have learned that the infant is actively shaping his "self," elaborating his own interactional style and his own patterns of affective regulation right from the very first emotional exchanges with his attachment figures. Bowlby's studies (1988) have proven how crucial it is to establish a trusting attachment for the subsequent development of the child as well as to prevent caregiver aggression and neglect towards him. We have noticed that up to the age of two and a half, before internal representations become firmly established, the child retains a remarkable plasticity in his behaviour. This is a considerable asset to therapeutic change (Hopkins, 1992).

From the Relational Perspective

Winnicott (1969) and Bion (1962) have each written of the importance of holding and container-contained processes for psychical life to emerge in the child. The concept of holding refers to the consistency and stability of care usually provided by the maternal object, necessary during the first few months of life. The container-contained model alludes to the capacity of this maternal figure to bear the intense affects felt around her infant, whether they be affects of crying or excitement. The maternal figure, through her capacity for reverie, takes into herself these affects so that she can transform them in a such way that, when returned to the infant, they can be more easily assimilated and tolerated.

For example, a mother who says that she is a "bad mother" to her infant because she makes him wait while preparing his bottle is identifying with some true feelings of the child. But because she is not overwhelmed by her child's cries, she helps him tolerate his rage and helplessness. So, little by little, the infant is brought to integrate something human, a basis for the development of understanding and

empathy. The role of the father, in his containing function of the mother-infant dyad and in his coming-between function in the separation-individuation process, is also critical in the development of the child as well as providing a protective factor against entrenched pathogenic situations.

From the Parents' or the Family's Perspective

The birth of a new child inevitably unsettles the lives of all family members whether parent or sibling, including people around them such as grandparents. For a start, the new birth brings back into question issues of personal identity as well as issues related to internalised parental objects. To welcome the newborn, parents must grieve the child imagined while in the womb (Lebovici, 1983). Furthermore, the child also becomes the bearer of parental projections, which will undoubtedly influence the dynamics of the parent-child relationship. However, along with the child newly introduced into the family, there also come new opportunities of being in touch with and dealing with these fantasies and projections.

The significant changes brought on by the pregnancy and delivery and the new adjustments made to the uniqueness of the newborn unsettle the usual defensive coping mechanisms of both parents, allowing for a new attunement to be made to the newborn and to the type of care that he will require. In particular, the mother during this turbulent period shows herself to be in a state of psychical openness where "unconscious fragments come to consciousness" (Bydlowski, 1997). This state which can be likened to Winnicott's (1956) "primary maternal preoccupation" allows the mother to be more available to work through psychical processes. However, whilst the presence of the infant can facilitate psychical elaboration during clinical intervention, it may also lead to particular difficulties. For Debray

(1987, 1991) the insufficient working through of an issue by the mother or the father, brutally highlighted once more by the birth of the child, often precipitates an overflow in the psychosomatic economy first in the mother (which encompasses all that concerns the infant at this early stage), which is then passed on to the father, finally developing into symptoms in the child. Psychosomatic economy is understood to be the fine balance established, on the one hand, by the affective and psychical life of the organism, and on the other hand, by the regulation of somatic functions such as sleeping, eating, and eliminating. Should any stressful event arise, this fine balance can be broken leading to physical disorders of all kinds.

We are frequently consulted when there has been a failure, more or less serious, in the internalisation of a "good enough" parental object, as this can precipitate failures in the development of well-sustained parenting skills. Fraiberg (1980) was one of the first authors to describe how parts of the parents' relationship history can be repeated, through a specific child, into the next generation. She used the metaphor "ghosts in the nursery" to describe this transgenerational phenomenon. These ghosts arising from the parents' pasts come to haunt the child, unconsciously chosen to be a partner in repeating a conflict-ridden relationship. These visitors enable unresolved conflicts stemming from the parents' childhoods to be carried over yet again to a subsequent generation. Thus, the present reactivates the past; working through it and its ensuing release provides hope for a future relatively free from repetition-compulsion. Early therapeutic intervention, involving parents and children together, can sometimes enable a surprisingly swift conclusion to transgenerational conflict repetition which, if postponed, could result in entrenched patterns, difficult to reach.

OUR FRAMEWORK

Parents are urged to refer their child to the clinic themselves. They often come after seeing their family doctor or through their involvement with the local community services centre (Centres Locaux de Services Communautaires [CLSC]). After a brief phone call, an appointment is made within the days or weeks following. Although we would prefer that all family members be involved in the first meeting, we accept whoever comes, so that we will not inadvertently make it more difficult for parents to get the help they have sought out.

We offer a series of five meetings, more or less evenly spaced in time. Thus, we are forced to determine quickly what is the predominant issue underlying problems in the family. In spite of these limitations, we believe that we offer sufficient time for the family to elaborate the various issues and to work them through. Because these meetings are spaced in time, family members can give more thought to what was discussed during the meeting and they can also try out new ways of relating to each other. Sometimes we will consider setting up a second series of appointments. If a longer period of therapy is deemed necessary, we will refer a parent, the couple, or a child to another therapist or to our day treatment centre. We seek to offer to the parents the proper conditions conducive to thinking things through. We try to stimulate their capacity to observe their infant and to trust what they perceive and feel. In a nonjudgemental, containing, and attentive atmosphere, we believe the parents will open up more readily about the problems they are experiencing with their infant or toddler. In providing the parents with the appropriate environment and sensitive observations, we can help them little by little to regain their capacity to reflect, in other words, to regain their capacity for reverie as Bion would say, a capacity lost through

stressful events or because of being in touch with the infant's primitive anxieties.

This does not mean that we become "super-parents" in the know, which could further undermine parental confidence or provoke senseless confrontations. Rather, we take on the difficult task of containing feelings of anguish, anger, disappointment, discouragement, and sometimes even hopelessness, while still preserving our ability to think. This is essential if we are to help parents to find their own solutions. When parents feel listened to and supported in their parenting tasks, when they know that there will be no blaming or criticising, they can come out of their isolation with more hope that things can change for the better.

We recommend that two therapists be present for each meeting, so that the multiple interactions that take place in the room can be witnessed by at least one of them. This way of working also allows parents and children to become more or less close to one or other of the therapists. In turn, each of them can more easily fluctuate between identifying with the infant or child, or one or other parent. In addition, one therapist can be more preoccupied with the content of the interview while the other observes what is going on. Because intense affects can be discharged and primitive anxieties can be difficult to contain at any one of these meetings, the presence of a co-therapist also makes it easier to bolster the capacity for reflection of each therapist. Finally, the presence of two therapists may provide more of a model of a benevolent parental, or grandparental, couple and create more of a transitional space to think things through. Besides, given the increased complexity of interactions when there are more than two people in a room and the short-term nature of our involvement, it makes a lot of sense to have more than one therapist to help recognise and address the issues.

Like Debray, we believe that there is no contraindication to early therapeutic intervention in the father-mother-infant triad. Intensity of symptoms is not a good predictor of severity of pathology since symptoms can disappear quickly. Their intensity may reflect, rather, the primitive, instantaneous, and intense nature of the communications of the infant with the mother and father. Indeed, often when the parent feels listened to and understood, the infant's symptoms rapidly subside.

THE INTERACTION BETWEEN INFANT OBSERVATION AND THERAPEUTIC INTERVENTION

For Debray, a decisive factor in treatment lies in the quality of the transference/counter-transference established by the family with the therapists. It is only once certain psychic conflicts come into the transference relationship between parents, child, and therapists in a genuinely live way that the family begin to engage in a real analytic process. Infant observation prepares us well for this type of clinical work as it is also based on the detailed study of countertransference.

Careful monitoring of the feelings aroused in the therapists by the infant, sibling, and parent (or any adult in a parenting role), constitutes a pivotal part of our work. The counter-transference guides us in understanding what the various protagonists are trying to convey. The therapists must try to contain maternal and paternal anxieties whilst at the same time trying to provide some containment for the toddler through the structure of their play activities. Even more, though, it is the affective state of the therapists that can come to influence the young child, who will gradually register their quiet availability, manifested through their

way of listening—a way that tries to contain intense instinctual discharges, allowing them to be put into words or even, at best, to be worked through.

MEETING WITH LOUIS

Louis' mother brought him to our clinic when he was six months old. Despite having just achieved the milestone of sitting upright, he was already attempting to stand up. His mother was also pushing him in this precocious way of developing so that she could be sure that he would not grow up to be dependent on welfare, as were other family members.

Louis was trying hard to hang onto his mother's gaze or voice in this way, but each time his motor skills would fail him. When he would fall and cry, his mother would pick him up for a few seconds, chase away the pain, and put him back on the floor. She would not allow herself to pick him up or cuddle him, as she was very concerned that when treated this way in childhood one became dependent in adulthood and incapable of achieving anything. Similarly, even his using his pacifier or his putting his fist in his mouth brought on her concerns for his future and were actively restricted. Both therapists saw a child forever on the brink of falling, pushing himself to the limit of his budding abilities whilst being encouraged even further in this direction by a mother who feared dependency.

Despite this there was something about this mother that we found endearing. She told us about being abused by her father and worrying that she, in turn, would find herself abusing her son. As for us, our task was to tolerate and contain the intense affects aroused during the interview, without judging this mother who had constantly been criticised and mistrusted in the past. If we had intervened with the child directly, she would have perceived it as a tremendous put-down—yet one more

experience of being judged and lectured. We believed that to help her, we needed to encourage her to trust other adults who in turn could help her.

Child observation helps to develop this containing function of the therapists. At the same time, observers can also sometimes find themselves in situations that are close to unbearable.

OBSERVING ETIENNE

The following material is taken from an infant observation. It is an excerpt from the 25th observation of Etienne, then seven and a half months of age. The child is observed with his father. The mother had just stepped out to take a shower:

«Etienne looks at his father with interest while he sits down at the end of the table to eat his breakfast and read his newspaper. Etienne holds out his arms to him, smiling and trying to catch his attention. His father does not look up from his newspaper, and Etienne, sitting in his high chair, proceeds to explore his toys. A few moments later, Etienne brings his fingers to his mouth and bites them as if his gums were hurting. He loses patience but tries to contain himself by bringing his two hands together and then putting them back in his mouth. Dolefully, he looks at me once in a while, then at his father. He starts to whimper a little louder and his father responds with something like: "No, Etienne, Daddy will not pick you up. Daddy is reading his newspaper." I, as an observer, try not to provoke Etienne any further. I also have to try to contain myself. I feel Etienne's frustration and that of his father. Etienne starts to cry, and his father gets up to find the pacifier. He yells to the mother, "Where is the pacifier?" and almost immediately finds it in the living room. After rinsing it, he gives it to Etienne who calms down while sucking. Under Etienne's continued gaze, the father finishes his breakfast

and goes back to reading his newspaper.

Etienne's left arm gets entangled in the ribbon of the pacifier attached to his pyjamas. In lowering his arm, it pops out of his mouth. He takes the ribbon, pulling on it, and tries to put the metal clip into his mouth. I worry that he will hurt himself by biting the clip. He releases it, sucks on the ribbon, and starts to whimper again. His father gets up to give him back the pacifier and says, "Ah! There's no way I am going to finish this newspaper if I have to always get up to give you your pacifier!" I feel ill at ease, and I also imagine that the father must be wondering how come I do not involve myself with the boy, playing with him or, at the very least, giving the pacifier back to him.

While Etienne sucks on his pacifier, he scratches the leather of his high chair with his nails. Then, he stretches his arms toward his father in a Vee shape and moves his hands, his fingers coming together as if to say, "Pick me up." He then puts his right hand behind his right ear and pulls his hair. His father, seeing this, mockingly, starts to imitate him. Etienne, now looking away from his father, puts both his hands over both his eyes in a peek-a-boo way. I believe the father is touched by these last few gestures. Etienne starts to fuss again as if tired. His father says, "Well, I think you are pretty tired, and I'll put you to bed." He takes away the little table from the high chair while he tells the mother that Etienne is tired. She acknowledges his statement but is rather surprised that the child could be tired so soon. The father lets his wife take over and goes to his office downstairs. While the mother repeats out loud that Etienne is tired, she replaces the little table and waits a bit longer before carrying him to his crib. She talks to him a bit longer and Etienne regains his sunny disposition.»

One of the benefits of infant observation is that it teaches us to delay doing anything in these trying situations. In fact, the regular weekly visits allow us to observe how families set about finding their own solutions. In Etienne's particular case, father and son eventually found their own equitable solution. Subsequently, Etienne was seen playing with a circular, while his father read his newspaper.

MEETINGS WITH CAROLINE

During consultations at the clinic, when the therapist begins to understand what is going on, he has to choose not only what he will share with the family and what he will verbalise out loud, but also what is preferable not to say, leaving it as "understood." To find the right words, that is, the words that will convey most specifically the affect, at the most propitious time, is not easy. But, when it all comes together, we witness a most effective therapeutic intervention, in that the process of symbolisation is set back in motion.

A mother in her thirties came for help with her tiny newborn, Caroline, a few weeks old. She was terrified that her baby would be sexually abused. She found herself caught in a dilemma: either she begins to care for the infant, bonds with her and puts up with her cries, or she leaves her in the care of others, but in the throes of intense dread that the baby will be horribly abused. She cannot stay alone with the child at night because she cannot trust even herself not to hurt the child, overwhelmed as she is by her dread of acting out her thoughts.

During a very long first interview, we helped her put into words how helpless one can feel when faced with a newborn who cries, and one does not know what the source of the discomfort is and what to do to soothe her. The mother, then more settled, told her own story of having been

sexually abused in childhood by an overbearing father and her own overriding concerns that the same fate would befall her baby. She also dreaded the possibility that she might hurt the child herself and that she would end up having to put her into foster care, as she had been herself. With this in mind, she wondered about the wisdom of even bonding with the child in the first place. Another pivotal issue addressed in this first interview was conveying to the mother that there is a great difference between having a violent thought and acting it out; and that putting these thoughts into words could even help protect against this.

In following meetings, the mother expressed how much this first interview had helped her: she now was recognising the first signs of bonding in Caroline towards her. Her grooming had improved; she no longer looked dishevelled and depressed. She was able to take care of herself. Furthermore, she was even able to entrust more of the care of the newborn to Caroline's father.

OBSERVING BENOIT

The idea of how really helpless a parent can feel when faced with a distressed newborn came after observing Benoit and his mother as she attempted to breast feed him in the best possible way. The infant was refusing to feed from the right breast, no matter how it was offered to him. His systematic refusals were followed by intense crying spells. As these difficulties continued over several weeks, the observer was brought in touch with deep helplessness, sometimes identifying most with the mother, sometimes with the infant. Subsequent elaboration within our discussion group allowed the observer to integrate more fully the experience and to avoid taking any misplaced action, which could have aggravated the already high tension between mother and infant.

Here is an excerpt from the third observation session of Benoit, then 27 days old, and his parents:

«...Benoit had cried a good part of the night and his parents are exhausted. Benoit is sleeping at the beginning of the session and his mother is reading *How to Breastfeed Your Child*. Benoit awakens slowly, and his discomfort grows bigger again... His mother invites me to the nursery where she settles herself to offer him her right breast. Benoit is already crying, she urges him verbally to be a bit more patient. She tells me that sometimes he can suckle for three to four minutes at a time, then he becomes frustrated. She has to soothe him before putting him to the breast again. Benoit is lying on his back and the mother bends over him to put her right breast in his mouth. He suckles eagerly but chokes after just a few swallows. The mother picks him up for a few seconds and then quickly puts him back to the breast. He starts suckling again while gazing directly at her. She looks very uncomfortable in this leaning-over position, her back totally unsupported.

The father comes in a little later and inquires about Benoit's feeding. He comments on his wife's position, but she tells him that this is the only way she has found to help Benoit suck her right breast satisfactorily, and yet he still experiences distress. Benoit continues to feed for a few more minutes. The father tries to bend the mother's leg so that she can feel more settled without disturbing the newborn. After a few minutes, Benoit stops, let's go of the breast, starts crying, and cannot be soothed. I have the impression that Benoit cannot hang on to the breast on that side. The mother tries to soothe him by holding him vertically, near her shoulder, but only for a few seconds at a time. She tells me that the first time he cried like this she could have cried right along with him. She was feeling so helpless in calming him. Then the father comes along, takes the baby, and the mother

lets him because she knows that once her husband leaves for work it will be a very long day indeed with her distressed son. However, the father attempts to soothe him for only a few minutes then hands Benoit back to his mother. She starts to sing to him. He looks surprised at her voice and calms down for a moment more.»

MEETINGS WITH OSCAR

In a consultation, it is difficult to tease out what to interpret in the chain reaction of simultaneous and complex interactions going on at any given time. Often enough, we can only echo in words what the infant is enacting for us. (It is only in retrospect that we come up with what would have been the most effective interpretation!) What can be expressed in his presence is, however, only one aspect of an encompassing whole. Thus, with some parents, the most appropriate interpretation is an observation of how the therapist perceives the infant, leading them in turn to change how they interact with their baby. New space is created for the baby to grow into and to develop further.

Until now, at the age of three, Oscar has grown up almost without any limits set by his parents. The mother is wary of leaving alone his one-year-old sister while she is continuously haunted by her worries of frustrating Oscar. He only has to start a meltdown to make his mother concede to his whims. Because of her training as a teacher of children with special needs, who are older and more difficult, the mother undermines any attempt made by the father to set limits on Oscar. Teary-eyed, the mother admits to being overwhelmed by her son's behaviour, shaken in what she believes to be right and pushed to the limits of her coping skills. She feels very guilty constantly taking care of Oscar while neglecting Oscar's little sister who, in fact, asks for very little attention.

In day-care, Oscar shows difficulty in keeping up with his peer group; he is oppositional, conflictual, and babyish. His language skills are limited and he is not toilet-trained. During the interview, the therapists are forced to put limits on this rambunctious child by keeping the door of the office closed. This they do quite naturally and reflexively. Yet, again, this time inadvertently, Oscar triggers conflict between his parents, as they cannot agree on how to limit him. The mother expresses great dismay at our intervention, even though we feel that this limit-setting was quite unremarkable. She pronounces us too strict. She bursts into tears and describes her father as a tyrant who terrified and mistreated all of his daughters and his wife. She ends up acknowledging her fear that Oscar will grow up to be like her father. She describes all of her ways of placating and pacifying Oscar to avoid his aggressive outbursts at all cost. Then, suddenly, it dawns on her that she has confused "being firm" with "being aggressive." After this interview, Oscar's symptoms abate rapidly; the daycare centre wonders whether he has been medicated.

At the following meeting, the mother talks about how it is still hard for her to deal with Oscar's meltdowns. When she needs to intervene, she freezes and is unable to think. Whilst she is talking, Oscar triggers another issue for her to consider, by playing innocuously with a plastic knife. The mother begins to cry, having recalled a traumatic memory. While she was pregnant with Oscar, she saw in the newspaper that a friend had been stabbed and died horribly at the hands of her teenage son. She went on to say that she had known this young man as she had babysat him when he was a child. She remembered how spoilt he had been. She voiced her worry that Oscar would end up just like him, stabbing her at fifteen, especially if she frustrated him too much. She expressed tremendous distress in dealing with her son's temper

tantrums, then linked this to her own feelings of aggression as she recalled wishing to kill her father when she had been a teenager. She had never talked of these things, not even with her husband.

Without the child's presence in the meeting, and without our careful listening (evenly balanced between the child and his parents) we would have missed the details of the child's behaviour and the parental affective responses, especially triggered in the mother. With these tools in hand, we were able to address rapidly the conflictual knot, to release it momentarily so that the child could be allowed to pick up where he had left off in his development, as Oscar did, following the meetings.

For some children whose parents separated earlier on, sometimes even before their birth, the clinical interview constitutes a first reunion of the parental couple, where the child can feel included simultaneously in a maternal and a paternal lineage. The fact that the young child can see both his parents reflect together about his welfare in a contained atmosphere forms a valuable experience. A ten year old girl once said, "If I could remember my parents being together, just once, then maybe I could sleep better at night."

Putting into words, making sense of, decoding... all of these allow parents to identify themselves temporarily with their newborn in distress or with the toddler they once were and reach the underlying fantasies being expressed through the child's symptoms and behaviour. As in a crisis situation, in the here and now of the interview, fantasies that are brought up can be expressed and worked through in complete safety.

MEETINGS WITH MATHIEU

On the same day that they requested help, we saw Mathieu, then aged 17

months, with his mother and his paternal grandmother. The mother felt totally baffled by his behaviour. For a month Mathieu had been hitting his head on any hard surface around him at the very least experience of frustration. This behaviour occurred for the first time after he was left alone with a babysitter for a whole weekend for the first time in his life. Since that weekend, Mathieu would cling to his mother for dear life when previously he had been able to leave her to go to play by himself for a while. The mother felt discouraged, stifled and overwhelmed by her son, whom she cared for by herself and with very little respite. The father worked a lot and preferred to relinquish the care of his son to his own mother when it was his turn to have Mathieu. The mother would have liked her son to see more of his father. She related how, as the sixth child in the family, she had had limited contact with her own father, a man she described as harsh. She continued to be very troubled by the messy separation of her parents, which had happened a year ago, because it remained an intensely conflictual relationship.

The paternal grandmother told us that she had lost her husband due to cancer four years ago. She had married her adoptive father, thirty-three years her elder, after her adoptive mother died. They only had one child together, Mathieu's father.

Thanks to the receptive climate we established, we were able to elucidate and talk about the links that existed between the toddler's symptoms and distress and the personal histories recalled by these two women. They were then able to identify with the child's distress by reflecting on their own childhoods. Subsequently both parents attended the interviews without the grandmother. We believe that the two parents came to the four remaining meetings because both mother and grandmother had felt heard and understood.

In the following meetings, we talked about the problems that had come with the pregnancy and birth of Mathieu: gestational diabetes and considerable weight gain in the mother and Mathieu's premature birth at 36 weeks of gestation. Barely twenty-four hours after his birth, Mathieu was rushed to a special neonatal unit in a children's hospital while his mother remained in the hospital where she had delivered her child. The newborn remained in an incubator for a week, tube-fed because he could not coordinate his breathing and sucking. For the first six months of his life, he had to remain connected to a breathing monitor because of threatened apnoea.

As regards Mathieu's self-destructive behaviour, soon after the family requested help, he stopped banging his head completely. However, he was now noisily refusing to be put in his crib for his afternoon nap, although he had no difficulty going to bed or sleeping at night. The mother chose not to make this an issue. She allowed him to rest on her lap, while she rocked him for an hour. In this way, the mother was allowing Mathieu to be connected again, but this time to her own body. Thus, she created a space, a container to receive his catastrophic fear, perhaps of falling endlessly. But this time, rather than being plugged in to a cold machine, causing shock and pain, Mathieu could be plugged into the warm, receptive body of his mother, as well as into her psyche.

These family interviews allowed us to acknowledge the primitive anxieties surrounding Mathieu's first year of life. The very real difficulties in his separation-individuation process could be addressed. We helped the parents become aware of their inevitable disappointment with their real-life son because of the gap that existed between their fantasied child and their real-life one. We supported the mother in her struggle to come out of a depressive state, all the while supporting the father's attempts to be

more available and accommodating to Mathieu, to put himself at his level so that he could play with him. Finally, by being involved, we believe that we helped the mother to free herself from an unconscious identification of Mathieu with an older brother of hers, who had been severely disabled from neonatal anoxia.

CONCLUSION

Our clinic allows for an early and brief involvement to enhance the interactions of the infant or toddler with his parents, to rapidly defuse any crisis, and to prevent the triggering of a potentially pathological chain reaction. It effectively complements other services, whether they be social, paediatric, or psychiatric, in promoting the early identification of psychopathology and delays or failures in development in the very young child and, additionally, helps coordination with these other services in providing care to the family unsettled by a new birth.

Infant observation in the family setting constitutes an important learning tool that helps inform our way of working in the clinic. To witness the growth of a little being who also acts and thinks, as well as the creation of new relationships within his family, provides a solid grounding for any future clinical intervention; but it also stresses the importance of coping with uncertainty, as we are exposed to intense emotional experiences whilst consciously refraining from taking any action.

This approach prepares us to be involved with families in difficulty: first, by favouring the myriad identifications possible with any of the family members; second, by teaching therapists to think, or rather to continue thinking, in the midst of the chaos brought on by multiple and complex sets of interactions, while resisting the pressure to intervene as an all-knowing professional who

attempts to restore order by forcing the family to a single solution. In this way, our clinical approach resonates well with psychoanalytic infant observation, and we are enriched by their mutual interaction.

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Conference Reports:

A major part of the remit of *The Signal* is to keep WAIMH members abreast of recent developments in the field. It is hoped that this new section of *The Signal*, together with the "Literature Monitor," will be helpful to readers in this respect by updating them on the latest conference presentations from across the globe and the most current literature of note. The success of both these sections, however, will very much depend on members' contributions, so please email me with details of any interesting articles/books/videos that you come across and write-ups of any conferences you may have attended. Send to: paul@pharrows.freemove.co.uk Thanks.

AN APPRECIATION OF "INFANTS IN CHANGING CULTURES" CAPE TOWN, 3-5 APRIL 2002

As we emerged on the first day for the lunch break, the rousing beat of Marimba drummers playing traditional African music was a delightful reminder of the different context in which I found myself, far from my London life. Many delegates spontaneously jived to the rhythm, as others milled around the tables where beadwork and other crafts were displayed. These times were sociable and lively, but once the plenary sessions began a serious focused atmosphere prevailed.

I thought that the structure of the conference (divided into one day on "Risk and Resilience," one on "Research," and a final day on "Psychotherapy and Other Interventions") helped to contain what could have felt like an overwhelming number of ideas, issues, and presentations. Many themes and ideas intersected and could be revisited as the conference progressed, especially issues relating to cultural diversity, which were thoughtfully introduced in the first talk by Linda Richter: "Strengthening Infants and Children." Richter described the diverse ways in which parents attempt to strengthen and protect their children from harm, which are often culturally determined. Yet she suggests that it is the "mindfulness" of the caregiver, her motivation, and her ability to be in touch with her baby's needs that determines the success of the contact and, in this way, is universal.

The impact of the HIV/AIDS problem in South Africa on families with babies and young children was inevitably a major focus of the conference, and the symposium on HIV and its meaning for the mother-infant dyad, with participants from England, Italy, and South Africa presenting their research findings, was moving and powerful. I found the video footage of one mother's experience in a Soweto clinic during her ante- and peri-natal period, as she lives with the uncertainty about her baby's HIV status, almost unbearably painful. Yet she receives comfort and support from the parents' group she attends and is enabled to express feelings of love and gratitude as well as of depression and loss. This sense of hopefulness, creativity, and rigorous endeavour in the face of shocking adversity was the prevailing atmosphere of the conference, ensuring that a healthy tension between hope and despair and a serious yet lively sharing of ideas and skills could take place in a spirit of great cooperation.

We are delighted that Astrid Berg, Leslie Schwartz, and Mireille Landman, who all made such interesting contributions to the conference, will be visiting London in the near future to present their work to staff and students of the Infant Mental Health Service of the Tavistock Clinic and wider audiences. We hope to maintain a lively contact with participants at the conference.

*Louise Emanuel
Infant Mental Health Service
Tavistock Clinic, London*

CAN WE BEAR TO LOOK? CULTURES: OTHERS AND OUR OWN MELBOURNE, 2002

Professor Linda Richter's visit from South Africa to Australia enabled those in the Victorian group of the Australian Association of Infant Mental Health (AAIMH) to continue their rich discussions on infants and their culture. Over the past year, our AAIMH meetings have included presentations and films from colleagues from Vietnam, Somalia, and India. Professor Richter was in Melbourne just before the Amsterdam Congress of the World Association of Infant Mental Health (WAIMH), where she was a plenary speaker. At our AAIMH Scientific Meeting we were rewarded by her talk on "Infants and the South African Experience." Her discussion on culture and the infants' experience, her work on promoting resilience using brief interventions, and her analysis of why cultural inquiry may be missing were very informative.

During her two-week visit to Melbourne Professor Richter gave several lectures at the Royal Children's Hospital and offered consulting times with staff. She had been invited to be a Visiting Infant Mental Health Scholar at the hospital by psychoanalyst Mrs. Thomson-Salo and child psychiatrist Dr. Campbell Paul, following her video-workshop at the WAIMH 2000 Montreal Congress. She was also able to meet specialists working in the field of trauma and human trafficking as well as international and community child health experts.

HER MISSION AND HER MESSAGE

Professor Richter is the Executive Director of the Child, Youth and Family Development Research Program at the Human Sciences Research Council and Professor in the School of Psychology at the University of Natal in South Africa. Also as a child psychologist she is very involved in research, treatment, and advocacy in public policy development for infants and young children in South Africa. Her research in many areas of child development includes risk and protective factors for child and adolescent health and developmental outcomes, women's health and well-being, psycho-social aspects of sexual and reproductive health including HIV/AIDS, social science methodology, and the theory and practice of psycho-social intervention and evaluation. In addition she has been a consultant to the government of South Africa and to the World Health Organisation. Currently she is interested in the stressful and protective factors for children at risk in the face of severe adversity and malnutrition. Integral to her work is looking at ways in which mood and affect are communicated between caregivers and babies and how they influence decline and recovery in extremely vulnerable children.

She stated that one of the most important tasks of her agency was to find ways to persuade government authorities and international funders to develop and implement health care policies that encourage the promotion of resilience amongst the poorest and most deprived groups of children. Professor Richter has harnessed her extensive experience to show how brief interventions with children, ones that are both successful and achievable, can promote survival and improved resilience. She does this by using a trauma and attachment framework to encourage local people to work with extremely emotionally and physically deprived infants and children. Her films demonstrate the power of brief

interventions, delivered by attuned non-professional workers whose role is to offer empathic connections to mothers and infants.

FILM AND FIELDWORK WITH DEPRIVED INFANTS AND CHILDREN

Professor Richter wanted to show us something of her own work in the area of reaching deprived and emotionally shut down infants and children. She and her husband, psychologist Dev Griesel, have made a number of films which poignantly picture distressed infants helped by focused attention from caregivers. Carrying on the work of Renee Spitz, who filmed infants in America and Mexico, and James and Joyce Robertson (Karen, 1994), whose groundbreaking films are still being watched 50 years after they filmed children in hospitals and homes in England, Richter and Griesel's films have enormous potential to influence health funding bodies. Made in Angola, the films were tools to demonstrate to crisis funding organisations the vital necessity of providing and resourcing good psycho-social caregiving in addition to medical and nutritional assistance. Some of the children we saw in her films were potentially so depressed and non-responsive that they seemed beyond help, yet the films show that humane contact can save lives or prevent some children from living a tortured isolated life under the assumption that they are unreachable. One infant captured on film was barely distinguishable from a pile of rags, with flies buzzing over a small amorphous heap of cloth. We watched what happened to this little infant, whose drive for life appeared extinguished, as she was drawn back into life by a caregiver's gaze, care, and touch. These superb films moved the Melbourne audience, many of whom sat in awe at the power of such interventions.

Indeed, it was the indigenous field workers trained not as infant mental

health clinicians but as facilitators for these infants, who engaged the infants sufficiently that they were able to reemerge into a relationship. Though it sounds a bit magical, the videos are testimony to their capacity to reach these lost infants with the humblest of interventions.

As Spitz's and the Robertsons' films changed practices, albeit slowly, we have great confidence that Richter and Griesel's films will be able to persuade aid organisations that it is vital to direct money to the psycho-social aspects of Third World health.

CULTURE, WHAT CULTURE?

In her AAIMH talk Professor Richter concentrated on developing further understanding of culture, which she described as "agreed ways of doing and thinking about things, not limited to ethnic culture." She spoke of the conundrum that despite the rubric of cultural sensitivity on mental health agendas, there is not a high priority on research and enquiry into parent-infant cultural practices. She mentioned that in April this year an infant mental health conference in Cape Town had the title "Infants in Changing Cultures." Despite the stated emphasis on culture she was disappointed that a more thorough examination of cultural practices was not undertaken, even in the multicultural environment of South Africa. Although there is a burgeoning interest in cultural studies in other fields, there is neglect of the topic in the wider infant mental health research network. At the Cape Town conference Professor Richter spoke on "Strengthening Infants and Children"—a direct translation of an expression in isiZulu of practices to strengthen the neonate and the young infant against a variety of mishaps that can endanger health and well-being. Many of these practices involve the use of "mutis"—local herbal and manufactured substances intended to prevent wind, ward off evil forces, attract the benevolence of ancestors, and so on. The substances used have

a fascinating history that can be traced through slavery and colonialism and have since been adapted locally. She regards the longevity of these practices for mothers and infants as attempts at control and empowerment (a form of knowledge appropriation).

Professor Richter cautions us that we can easily be misled into ascribing "culture" only to others, especially people perceived to be "exotic others," people who can be thought to be less developed and less rational than ourselves. This can lead us to being blind to our own cultural imperatives. Her inquiries in Melbourne led her to visit two chemists, and she found that "gripe water" was widely used for infants, as in other parts of the world where such medicines are multimillion dollar industries. It poses the questions: What do we know of these practices? and Why do studies on infant crying seldom mention the methods many people use to calm babies and deal with fretfulness? In this sense she feels we need to work more to understand local cultural practices surrounding infancy.

Concerning our own Australian culture regarding infants, we find a lot of talk about "controlled crying" methods of sleeping as well as the risks of co-sleeping. How much of these views are steeped in cultural antecedents? Amongst the middle class, Anglo-Saxon babies probably have not slept predominantly within their parents' bed for centuries, yet Asian infants regularly do so. In the seventeenth century those who had the means to employ them used wet nurses to feed their babies. Now we consider this both quaint and monstrous. What will future generations think of our controlled crying culture, begun in the mid-1980s? AAIMH has been vocal in the need for a closer examination of what kind of messages we are teaching our new parents. Many of these parents are starting parenthood in their mid-thirties, unlike three decades ago when the average age of first time mothers was in the low twenties. Is the

popularity of the controlled crying model of sleep related to this older demographic of parents, who are used to their adult sleep routine? Are we sanctioning a message which says, "Don't respond to prolonged infant distress" (i.e., "Wear them out before they wear you out")? These are some of the loudest cultural messages about infants of our age in Australia and elsewhere. Many infants need help to settle and to learn to manage being alone to sleep. Circumstances such as the baby's age, temperament, and environmental factors are often overlooked by techniques which require a rigid formula of parental withdrawal during infant distress. The AAIMH newsletter has been a forum for dissent and examination of controlled crying, but perhaps we have overlooked doing so from the viewpoint of parents and infants from different cultures.

THE TWINNING OF FANTASY AND RITUAL

Professor Richter spoke of infancy being a period of diminished control for caregivers. Parents and caregivers get anxious when babies' temperatures rise, their skins cover in rashes, their stools change colour, and they cry for uncertain reasons. The anxiety attached to these difficult-to-read signals provides fertile ground for fantasy. Rituals exist as ways to give meaning and approbation to these fears. Professor Richter proposes that in this context she sees rituals as "attempts to guard against possibilities, to avert illness and accidents, to safeguard and strengthen children so that they may survive and thrive."

Rituals for infants involve the use of substances such as gripe water and tea, and creams, and also routines around sleeping and feeding, and so on. There is much we need to know about these activities and the beliefs that generate and maintain them. Have we grown accustomed to our own hegemony, as if infancy is only what

professionals say it to be, and not what is acted out in homes, passed on by family, women's groups, and even health professionals? For example in South Africa, enemas for babies—a highly undesirable practice from a medical point of view, but commonly used—can be seen as attempts to deal with the insecurity that comes from caring for a small child. These insecurities are frequently not allayed by sophisticated health care systems, which overlook parents' beliefs and the practices that underlie them. These anxieties and rituals need to be understood and worked with more explicitly.

CULTURE: BLINDESS AND INSIGHT

Professor Richter proposed four ways of understanding knowledge and blindness related to cultural influences and differences:

1. Cultural Blindness

She asked whether or not we have blocked ourselves off from cultural knowledge, in the sense that it seldom seems to be a central area of enquiry. Do we, as professionals, become complicit in not enquiring, and thereby give the message that cultural difference is not to be known/not relevant? Referring to her own observations when teaching paediatric medical students, she described encounters between mothers with babies where the information about breast feeding missed entirely the implicit cultural models people have in their minds as evidenced by their owning baby bottles. Is this related only to inexperience or just to insensitive health care professionals? Whatever the explanation, the cultural values of both the recipients of health care and the providers can go unexamined, and yet these cultural values may have the greatest power over people's behaviours. For example it is the view of some health providers that infants should be exclusively breast fed for four to six months, with no need for supplementary water, juice, or formula

for babies' thirst. Yet mothers are raised on the view, passed on from generations, that babies get thirsty and will be in need of these other fluids. This raises the complexity of what to do with cultural beliefs that differ from the edicts of allopathic medicine, and how then to manage the clash of cultural beliefs. Such cultural beliefs are pervasive and widely held, also in multicultural Australia, and yet how frequently do we deal with them in our encounters with clients around the infant's health and development?

2. Power of Cultural Belief Systems

Professor Richter hoped to see informed cultural studies undertaken on how to best align folk practices with public health messages in ways that do not undermine the best efforts of caregivers to nurture their infants. She suggested that those parents/caregivers who are guided by coherent belief systems, even if they are not scientifically "accurate," may be able to act with greater awareness and purpose in the care of their infants than women who do not have such guiding belief systems. The cultural narrative itself may give the caregiver some containment in managing the unknown.

3. Social-Cultural Beginnings

Another way of understanding more about cultural influences is based on Colwyn Trevarthen's work on Mother-Infant (M-I) interchanges, which have within them the infant's acquisition of culture. Trevarthen (2001) contends that "human beings are not merely social, they are inherently cultural. Infants are born with motives in their complex brains that lead them to learn through communicating about intentions, interests and feelings with trusted companions, and to interpret with them a common reality.... The so-called 'complex' emotions, the interpersonal sense of 'pride' in admired accomplishment, and 'shame' in being misunderstood or disliked, are part of the innate human moral

condition." The interchanges that many of us study are profoundly cultural in the sense that the infant is not just acquiring language and cognitions but highly particular and perceptual ways of thinking, feeling, and saying in their shared exchanges with intimate caregivers.

4. The Politics of Unexamined Culture

Professor Richter questioned whether we are paralysed by cultural relativism—the idea that each culture does things differently and well, considering the goals inherent in human activity in that culture. But this position ignores inherent gender inequality around the world, social injustice, political corruption, underdevelopment, and exploitation—all of which put children at risk. Do we accept the burka for young girls, who can become so vitamin D deprived that their nutritional status permanently impoverishes them physically? If we take no stand on genital mutilation are we respecting culture or avoiding the pain of dealing with our own moral/ethical confrontations?

She then went on to challenge some of the prevailing beliefs in the IMH world, put forward by distinguished academicians based on work done in Samoa, Kenya, and Uganda. For example, she questioned the belief that proto-conversations, in which caregivers treat infants as communicative partners, do not occur amongst these non-Western groups. This needs serious examination, according to Professor Richter, because her observations do not support it. How can our theories of language acquisition and socialisation, which are assumed to be universal, allow the possibility of human social groups lying outside such theories?

INCLOSING

Professor Richter's AAIMH talk and films showed us the energy and commitment she has for clinical interventions, research, and teaching,

and that she combines this with a knowledge of the political and historical background necessary to make a difference in such a complex world region. Alongside multiple references she told lively stories of controversial encounters in the field. She also affirmed our own AAIMH commitment to working with those from other places. She gave meaning as to why we sometimes do not look culture in the face, and why as infant mental health workers we are compelled to do just this.

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FRONTIERS OF PRACTICE II:
THE NEW DIALOGUE
BETWEEN ATTACHMENT
THEORY AND BRITISH
OBJECT RELATIONS - A
CLINICAL PERSPECTIVE
WASHINGTON (USA)
SEPTEMBER 12-14, 2002

It is customary in summarizing a clinical conference to focus on the significant ideas put forth and by whom. Departing from this format, here we describe how the conference unfolded as a creative event and elucidate the psychoanalytic concepts that served as the foundation. The results of the conference from a process perspective were both anticipated and surprising. This article is an attempt to summarize both aspects.

Frontiers of Practice II was held in Bellevue, Washington, USA, September 12-14, 2002. The overarching purpose of the conference was to promote a dialogue about Attachment Theory and British Object Relations from a clinical perspective. As organizers, we wanted to provide a setting that stimulated clinical thinking among the participants as well as the presenters. The creation of a space for dialogue was in many ways the primary goal of the conference, and this goal provided an organizing principle that informed all of our decisions with respect to the design of the conference, including whom we invited as presenters.

In considering the kind of environment most conducive for thoughtful dialogue, we returned to Bion's notions of reverie and containment. Reverie is the open and dreamlike receptiveness to experience and to associations, which allows for very rich apprehension of the meaning of events. Containment refers to the active processing of raw, unmentalized experience into a form that can be thought about and worked with in oneself or in a relationship such as psychotherapy. Both elements require

a certain amount of safety and time. Our assumption of the need for close attention to holding and containment came from our experience as clinicians and the belief that hearing case material would inevitably stir primitive anxieties in all who attended the conference. It has long been noted that one of the factors inhibiting thinking is overwhelming anxiety. We felt that if we could create a conference environment that addressed the need for containment of primitive anxieties then we might also witness a more productive dialogue among presenters and participants. Thus, we designed the conference to respond to these needs.

At the first Frontiers of Practice conference in Virginia in 2001, Pamela Sorensen offered her thoughts about Transition Facilitating Behavior as a bridge between Attachment Theory and British Object Relations. She described the way an attentive mother helps to ready the infant for changes and suggested that talking the infant through the transitions promotes the mindful holding which leads to a secure attachment. In this spirit, we provided comments throughout each day on the process of shifting from one topic or activity to the next, on the kinds of impact the cases seemed to be having on the participants, on the difficulties faced in grappling with new ideas, and on the evolution of the conference itself as having a finite life of its own.

In order to emphasize discussion among conference participants, we assigned seating at round tables of six to eight seats. Membership at each table was constant throughout the conference allowing participants to get to know at least the members of their small group quite well. The format provided time for group discussions after the case presentations but before the formal panel responses. This enabled participants to air their thoughts when they were fresh, and it created a context so that difficult material in the cases could be worked

through in a small group setting, thus allowing space for thought. An experienced clinician, who had been prepared beforehand to expect the stirring of primitive anxieties, led each discussion group. Specifically, the facilitators did not function as "experts" on the material. Rather, they took an active interest in what participants thought and felt about the material and acknowledged the emotional impact of the painful case material. Feedback from participants shows that the discussion groups did provide safety and time for containment and for thought, and the participants voiced their appreciation for this unusual format.

Another uncommon design feature was arranging for a discussion group for the presenters facilitated by our discussion group coordinator, Marianne Robinson, LICSW (psychoanalyst, Northwest Psychoanalytic Society Study Group, Seattle, Washington). This presenter group was initially conceived as a seating arrangement (someplace for presenters to sit and relax while participants discussed the material) rather than as a place intended for serious discussion. However, what occurred was surprising. When given a place to converse, facilitated by a group leader, the presenters were as eager as anyone else to delve into the material with one another. The respondent panels, which followed the discussion group time, were directly influenced by the passionate discourse that occurred in the presenters' small group.

The overall format of the conference was to alternate between a clinical presentation from an Attachment perspective and another from a British Object Relations perspective. This sequence was repeated twice. We solicited case material from senior analytic candidates in Seattle and submitted their papers to presenters anonymously. Thus, selection of material was made on the basis of the material itself and not the reputation

of the particular author. In addition, we sought case material that would illustrate work with mothers and infants and with adults. We included clinical material with an adult for two reasons. First, we believe that primitive mental states are observable in adults as well as in infants. Second, we wanted to affirm the concept that developments in infant mental health are highly relevant to psychotherapy and psychoanalysis with adults as well as with children.

The case material was presented in different ways, depending on the preference of each presenter. Robert S. Marvin, Ph.D. (Director of the Parent-Child Attachment Clinic, University of Virginia, Charlottesville, Virginia), used videos of a treatment group from the Circle of Security project in Spokane, Washington (see *The Signal*, October/December, 2001, pp. 6-11, 14). Pamela Sorensen, M.A.C.P. (Director of the Under Fives Clinic University of Virginia), collaborated with clinician Judy K. Eekhoff, Ph.D. (psychoanalyst, Northwest Psychoanalytic Society Study Group and Secure Beginnings therapist), to write a paper alternating the clinical material from an at-risk family with the commentary. Thus, the paper was itself a dialogue. Margaret Rustin, M.A.C.P. (Head of Child Psychotherapy, Tavistock Clinic, London), responded to an adult case presented by Tony Hacker, Ph.D. (senior analytic candidate at the Seattle Psychoanalytic Society and Institute). Betsy Rubin, Ph.D. (private practitioner in Denver, Colorado), showed videos of her attachment research with toddlers in medical treatment. The form of the presentations reflected a classical difference between Attachment Theory and British Object Relations: the attachment clinicians used research methods—the videos—to show the interventions, and the psychoanalytic clinicians used history and detailed process notes to recreate the tone of the treatment. The difference in emphasis between research and clinical work appears to continue

to affect both the form of treatment and the way the treatment is portrayed.

Similarities and differences between the two models were explored after each clinical presentation and small group discussion, when a panel of three or four respondents convened to discuss the case and compare the two types of treatment. The panel members were chosen from among the presenters: Drs. Marvin and Rubin, Ms. Sorensen, and Mrs. Rustin. They were joined by Maxine Anderson, M.D. (head of Northwest Psychoanalytic Society Study Group), and Ken King, M.D. (head of the Seattle Psychoanalytic Society and Institute). Several points of difference came from their discussions. We feel that the freedom to grapple with differences and to articulate opinions in front of the large group came in part from the ambience resulting from serious discussion in the small groups. Also, because the respondent panel followed the group discussion, the presenters had added time to explore their thoughts in “rough draft” before speaking to the large group.

Having established the structure of the conference, we can now say a few things about the nature of the discussion and the questions raised in dialogue about the clinical application of these two theories. One such difference centers on the abiding question in the treatment of infants and caregivers: Who is the patient? In the Circle of Security model of Attachment treatment, the parent is the patient. The mother (or primary caregiver) views the videos of her toddler, and finds new ways to see the child accurately and to respond symmetrically. In the Secure Beginnings Program model of British Object Relations treatment, the dyad is the patient, and interpretations are made to the mother and her infant. The difficulty experienced by either the caregiver or the infant is assumed to reflect a difficulty in the other. If the mother's behavior is distressing to the child, the infant may be addressed

directly by the therapist who counts on the infant's understanding of the non-lexical communication. In addition, the therapist assumes that what is said to the actual infant in the room is also heard by the infant part of the mother. In this way, the infant within the mother is held at the same time as the dyad is being held and addressed. Occasionally in both modalities, the mother's early experience of her relationships is evoked, and must be worked through therapeutically in order for her to become free to respond empathetically to her child.

Another difference between Attachment and British Object Relations treatment is the length of time treatment lasts. Attachment treatment tends to be shorter in duration and often occurs in groups. Treatment from a psychoanalytic perspective like British Object Relations may continue for some years, especially with adults. Kathryn Barnard, R.N., Ph.D. (Director of the Center for Infant Mental Health and Development, University of Washington, Seattle), commented in her remarks on moving from programs to policies that granting agencies are usually not willing to fund longer-term work.

A more internal difference between the two treatments involves the place of countertransference in the therapy hour. From the background of Infant Observation there is an emphasis on attending to countertransference signals and coming to understand them. Both Drs. Eekhoff and Hacker demonstrated in their cases the important role of the therapist's felt resonance with the experience of the patient as information about the state of the patient. While countertransference feelings unquestionably are present in Attachment treatment, the emphasis is not on their role in informing the interventions of the therapist.

The dialogue between the two approaches is new, and many areas are as yet inadequately explored—the

similarities and differences between internal working models and internal objects, the respective understanding of defenses, similarities and differences in treatment of adults, to name a few. Michael Rustin (Professor of Sociology at the University of East London) reminded us of the importance of looking at complex patterns of interaction in order to avoid the temptation to oversimplify causality. His caution is important to bear in mind when comparing two complex ways of thinking about human development. Many participants left the conference wanting to continue the dialogue. Here in Seattle, Infant Observation is offered from two perspectives: the Tavistock Clinic model at COR Northwest Family Development Center and the Anna Freud Center model at the Seattle Psychoanalytic Society and Institute. The heads of each center are planning ongoing talks together. Other outcomes unbeknownst to us may be occurring as a result of discussions spawned during this conference. We invite interested readers to check the conference website, which at the time of this writing is still active. Articles from the conference are available to anyone who wants to see them at <http://capps.wsu.edu/frontiersofpractice>.

We hope that this summary of how the conference was conceived and organized, as well as who presented and some of the main points of discussion, will encourage others to continue the dialogue regarding infant mental health and its application to clinical work with infants and adults in a way that honors the presenters' and the participants' need for holding and containment. When containment occurs, we have found that it fosters an exceptionally rewarding learning environment for clinicians at all levels of experience.

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President's Perspective

Peter de Chateau

Our Amsterdam congress now lies already some time behind us. Once again I would like everybody involved in any part of its success to accept my deepest thanks and great appreciation for all you accomplished before, during, and after the congress. Without the many members on our panels and committees and the participants, speakers, and all others this would not have been possible. Most of your reactions have been very positive, and a whole congress dancing to the music from a reggae band was most certainly astonishing as well as a novelty to WAIMH—Thank you, Amsterdam.

Of course a good and successful congress also has its mishaps, and Amsterdam was no exception to the rule. I am referring to the Saturday

afternoon. Here we changed the sequence of the different parts, and most unfortunately not all the participants and presenters were informed beforehand due to a misunderstanding about this change in the order of appearance. I myself deeply regret this error and do hope that those involved in this mistake will accept my apologies.

Otherwise most of the activities went very well, and we had some very fruitful working days in the Executive Committee meetings. We discussed again the goals for our organisation, the duties of the Board of Directors, future congresses, our affiliates, membership issues, financial status both actual and future, the organisational structure of WAIMH, and both *The Signal* and our journal.

Announcement:

Caen, France, March 13rd-14th, 2003

6th Congress of the Société Marcé Francophone (SMF)

GROSSESSE, EMOTIONS ET COMPORTEMENTS : Le retentissement sur l'enfant.

PREGNANCY: AFFECTS AND BEHAVIORS : Impact on the child
Language: French

Topics: Substance use and abuse, maternal stress, their impact on mother and fetus. Assisted Medical Procreation. Pregnancy in borderline and schizophrenic women. Role of culture, family history and women past-history. Medication and/or psychotherapy during pregnancy. Eating disorders and pregnancy. Hostility against the fetus.

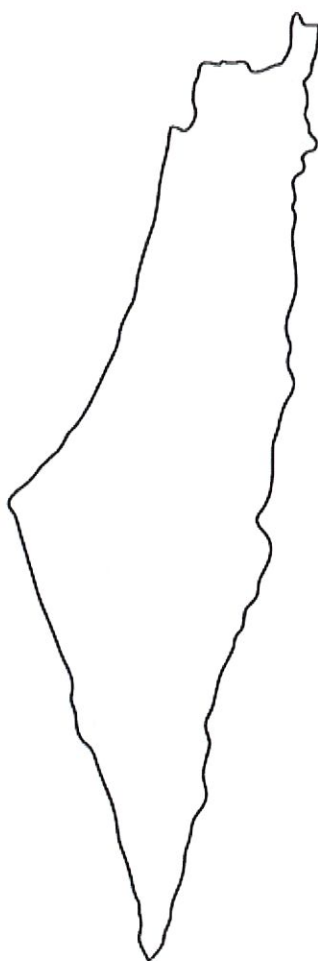
Please contact: Dr Dayan J.

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WAIMH *Affiliate News*

ISRAEL



The WAIMH Israeli Affiliate

The WAIMH Israeli Affiliate was created some two years ago, with the aim of enabling meetings of all the professionals who evaluate and treat infants around the country. We have now some 140 members. The first annual meeting was held in December 2001, with the format

of a two-day conference, on the theme of "Early Relationships." We had two guests from abroad, Prof. Yvon Gauthier (Montreal) and Prof. Jean Wittenberg (Toronto), each giving a plenary lecture. Prof. Gauthier talked about the social implications of the theory of attachment, and Prof. Wittenberg described a very interesting modality of treatment of early relationship disorders, called "Supportive Expressive Therapy for Parent and Infant Relationship Disorders." In addition, we had several workshops held by Israeli colleagues.

A few months after the conference, we published our first Affiliate Newsletter (in Hebrew), with a summary of the content of the conference, and the announcement of our next meeting, planned for December 2002. Its main theme will be "Other Parenthoods," meaning all the various family structures and ways of reproduction. Dr. Patricia Beatens from the Reproductive Medicine Center in Brussels will be our guest.

Besides its scientific activities, the Affiliate puts together multidisciplinary teams who have done an impressive amount of clinical work in these last five years all over the country with the implementation of new Infant Mental Health Clinics, with the expansion of already existing community networks (all of these

based on an intensive use of the Well-Baby Clinics network, a free and obligatory facility for preventive developmental pediatrics), and with the implementation of a two-year course in Early Childhood Psychiatry at the Medical School of the Tel-Aviv University.

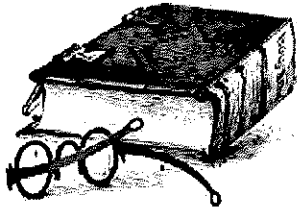
Dr. Miri Keren
WAIMH Israeli Affiliate,
Secretary

**WAIMH'S 2004
WORLD CONGRESS
WILL BE HELD IN
MELBOURNE
AUSTRALIA
JANUARY 14-17,
2004.**

**THE CALL FOR
PAPERS WILL BE
MAILED IN
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**HOPE TO SEE YOU
THERE!**



LITERATURE MONITOR

Books

Parent-Infant Psychodynamics - Wild Things, Mirrors & Ghosts (2002)

Joan Raphael-Leff (ed.) A reader including Fraiberg's 'Ghosts in the Nursery' and papers by Winnicott, Trevarthen, Tronick, Murray and many more. Available from Whurr, 19B Compton Terrace, London N1 2UN. TEL: 0044(0)207-7359 5979 FAX: 0044(0)207226 5290. E-mail: info@whurr.co.uk

Infant and Toddler Mental Health (2002)

J. Martin Maldonado-Duran (ed.) Contributors include Fonagy, Hoffmann, Lieberman, Watanabe, Minde, Lebovici, McDonough and Fivaz-Depeursinge.

American Psychiatric Publishing Inc, Washington & London.

The Social Toddler (2002)

Helen and Clive Dorman. A sequel to *The Social Baby*. pp. 304; 1700 colour pictures. Hardback: ISBN 190327530X, £19.99 UK; 24.40 USA/Can; 25.61 Aus/NZ. Paperback: ISBN 1903275385, £15.99 UK; 19.28 USA/Can; 20.26 Aus/NZ. Contact <http://cpshopping.co.uk/socialtoddler.asp> and add WAIMH in reference box (on customer details page).

The Legacy of Winnicott: Essays on Infant and Child Mental Health. (2002)

Brett Kahr (ed.) London & New York: Karnac.

The Cradle of Thought: Exploring the Origins of Thinking. (2001)

Peter Hobson. Basingstoke & Oxford: Macmillan.

Articles

'Maternal stress beginning in infancy may sensitize children to later stress exposure: effects on cortisol and behavior' Essex, M.J.; Klein, M.H.; Cho, E. & Kalin, N.H. *Biological Psychiatry* 52(8): 776-784.

Abstract: Preclinical studies demonstrate that the neonatal environment can permanently alter an individual's responses to stress. To demonstrate a similar phenomenon in humans, we prospectively examined the relationships of maternal stress beginning in infancy and concurrent stress on preschoolers hypothalamic-pituitary-adrenal activity and later mental health symptoms.

Conclusions: These results link the findings of preclinical studies to humans by showing that exposure to early maternal stress may sensitize children's pituitary-adrenal responses to subsequent stress exposure.

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