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DEVELOPING A CULTURE FOR CHANGE IN GROUP ANALYTIC PSYCHOTHERAPY FOR MOTHERS AND BABIES

By Jessica James, London

Introduction

In this paper I will describe a phase in the life of a weekly slow open psychotherapy group for mothers with their babies. Clinical material is used to illustrate a group's therapeutic potential when its culture becomes sufficiently secure. We see the process of this development from a group session in which the setting is tested and fails, but four, eight, and nine months later creativity and growth become increasingly possible for the mothers and babies. Our technique has been evolving as we work as co-therapists bringing different backgrounds and training. I am a group analyst and my colleague is a child psychotherapist. The group's

growing solidity has been mirrored by the refining of our own understanding and unfolding expertise. We have gradually made progress towards realising the full and rich potential of this therapeutic modality with mothers and infants.

Layers of Dependency

An analytic therapy group is an unfolding drama, not unlike the hurly-burly of family life. In our group we usually have four mother and baby dyads (sometimes five and occasionally three), who join the group for as long as they need it, perhaps six to eighteen months. At first the group may seem to be a shocking event, comparable to the birth of a baby. It is like chaos, and newcomers - or people told about it, including readers of this paper - may find it difficult to concentrate on interactions generated from such different angles and directions. The behaviour of a new participant - like that of a neonate - appears inchoate, and she requires the help of the therapists and mature group members (babies as well as mothers) to create meaning out of seeming meaninglessness. "We must perceive every human being as developing a cultural consciousness as part of their nature" (Trevarthen, 1993). At first, in days after birth or in early stages of group psychotherapy, this perception is a

leap of faith. Without sensitive and confident handling, psychotic anxiety can proliferate. Early groups are comparable to infants struggling to achieve a sense of being and unity in the first weeks of life (Nitsun, 1989). A good enough environment of a holding mother is required to meet the absolute dependence, to tolerate periods of deprivation, otherwise there will be "unthinkable anxiety" about falling apart and totally losing touch (Winnicott, 1987). In mother and infant group psychotherapy such imagery is particularly resonant with layers of dependency and anxiety interwoven literally as well as symbolically.

We recommend group psychotherapy for mothers who are referred, or refer themselves, to our service with babies less than eight months and who are able to commit to regular attendance for at least six months. The presenting concern is an impaired capacity for ordinary maternal preoccupation. Adjustment to parenthood has been dominated by over-riding traumas, which may include painfully re-evoked childhood experiences, inadequate current support, or unresolved recent and past loss. These symptoms are manifest in the mother and reflected in the baby's affective state or functioning. Like all parent-infant psychotherapy there is competing

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helplessness and ambiguity about who is the patient. A group offers a compensatory or corrective attachment setting through holding and validation (Stern, 1995). There are a multitude of attachment objects as well as a huge cast of previous generations. Attention is given to a mother's destructive preoccupations or ruminations so as to release her availability to her baby's needs. But change often occurs most effectively through the group experience itself. "The problem is dropped in favour of the passionate discussion of an involvement with the shifting roles, relationships and behavioural communications that make up the system of the group itself.... This process alone, this becoming part of the group (as opposed to attending it) is sufficient to effect change" (Garland, 1982). The port of entry to such "passionate discussion and involvement" is fluid. As the clinical material shows this differs according to phases in the group's life, the needs of individuals, current dynamics, and the counter-transference responses of the therapists. Babies cut through usual adult restraints and, unless extremely traumatised, demonstrate unconscious feelings and intensify passion in group relationships.

Familiarity and Attachment in the Setting

A sufficiently mature group culture takes time and repetition. The early phases are entirely devoted to establishing a setting where people matter to each other. At intervals this will need rebuilding when the group is in a shaky phase or if there have been impingements such as breaks, endings, or newcomers. Every opportunity is taken to interpret the group's significance as an attachment object. We determinedly convey that the group exists as an entity and that all its members, including the therapists, belong to a shared web of connections. Every interaction that suggests this is re-enforced and

highlighted positively. We are establishing its culture, a historic tradition of a rich collection of ideas and experiences to be shared, passed down, and communicated. This is analogous to the most fundamental turn-taking and socialising communications between parent and infant (and especially relevant within the inherent layers of dependency in this group). "The infant's cries obtain appropriate responses, physical gestures elicit reciprocal gestures, cries and gestures are interwoven into narratives and plays and the infant begins to enter into human culture" (Pines, 1998).

Attention to simple practical details forms the background to what become the "narratives and play" of the group culture. Such behind the scenes activity is akin to the feeding, sleeping, and nappy changing cycles that are the basis and "reciprocal gestures" of parental care. The smooth, familiar running of our external provision ensures that internal anxiety is fuelled as little as possible. Primitive bodily and infantile states are what constitute the living group. Babies arrive in arms and, ultimately, move to investigate and discover the limits of every nook and cranny in the room. There are "poo" and sick, breasts and mush, all sorts of noises, and, eventually, words. Everyone sits on a carpeted floor with cushions and toys. Each baby has a mat to symbolise their presence, whether or not they have grown out of staying on them. The mothers and therapists remain more or less (mothers usually less) rooted to their cushions. Timing is consistent, including the means of entering and leaving. The setting, and our interventions within it, models parental attention by being firm, but not rigid, and valuing the interplay between disorder and order as the material for our work. The individual (and group) capacity or incapacity to use the actual boundaries of space and time provides crucial insight into unconscious

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mechanisms. As will be illustrated in the clinical material, any destabilising activity is an opportunity for the members to re-enforce and strengthen attachments between each other in the setting. The first scenario portrays a shaky group which is trying, and failing, to incorporate a newcomer. Later examples are of settled phases where the challenges of comings and goings become interwoven into the group's cultural fabric.

Assessment and Preparation

For prospective members group psychotherapy raises complex hopes and fears associated with contrasting, often split, representations of "mother." Writers on group psychotherapy equate groups with maternal imagery (Foulkes, 1964). In fantasy a mother and baby group may be the quintessential mother. For some the "group mother" suggests comfort, care, and nurture, whilst for others it implies an insufficient, depriving, or engulfing experience and, like maternal mood, there may be inconsistency. We meet mothers for whom being together with mirror images of themselves is an unpalatable prospect. The fear is of being burdened, rather than relieved, by communality and shared experience. Conversely, other mothers imagine becoming a member of a group will magically solve all previous problems of isolation or unsatisfactory relationships. In both cases there is the danger that the group becomes a repetition of earlier failures in attunement. Whilst a baby gives hope, and is a leveller cutting across difference, there must be no illusion that this mother and baby group is tea and sympathy. Some mothers are unsuitable and others need a longer period of preparation than the usual three or four sessions. The group's aim is, in many ways, to tolerate ambivalence: "Maternal ambivalence signifies the mother's capacity to know herself and to

tolerate traits in herself she may consider less than admirable - and to hold a more complete image of her baby" (Parker, 1995). But a sufficient capacity to bear the ups and downs, desires and disappointments, and less than admirable aspects of group life is required before joining this type of group analytic therapy. We nurture zeal and enthusiasm, but also need to be restrained (the therapists as well) in our preparation and assessment.

Working as Co-Therapists

Our relationship is integral to a secure enough group culture. We bring our own professional backgrounds as well as style and personality. With increasing confidence we have found our differences advantageous rather than threatening. The balancing act - in the space between conflict and ease - has become both creative and testing. When functioning effectively we are a collaborative parental model for mothers and infants who have inconsistent or absent experiences of parents themselves. The gleam in our eyes, our pleasure together, our capacity to play, laugh, and cohere has ripple effects on the group's interactions and the solidity of its culture. This is crucial to our endeavour and faith in the group as a setting for containment of anger, anxiety, depression, and thought. We provide a balancing function for each other where one therapist's loss of belief or comprehension can be counteracted by the other's more hopeful energy and perception.

Whilst conjoint working gives freedom for spontaneity and getting caught up emotionally, there are also times when we find ourselves inhibited by the other therapist's critical gaze. Eye-contact helps and is the first port of call in sticky moments. In ideal circumstances temporary acting in with the unconscious is possible in the knowledge that (usually) the other retains a thinking stance. We aim to

have fluid roles that are not set in stone. Although division of labour, splitting and projection is part and parcel of our therapeutic enterprise, we regard any opting out of whole group activity as a disturbance which is material for investigation. The following vignette illustrates this.

I am moved to intervene with a baby (who is seen falling in the first scenario and is later described as the 'unremitting' baby.) My instinctive conclusion became "enough is enough." We had tried positive reinforcement of interactions between him, his mother, and others, but he is now fourteen months and struggles to sustain contact with anyone or anything. I take authority. He brings me a car and, almost by chance, a wheel spins in his hands. I spin the wheel more concertedly. He looks fleetingly at me. I say, "Yes, you can do it too." He spins a little more. I exclaim, "You are turning the wheels too." He looks pleased, and we stay spinning wheels together for some time in silence. At the same time his mother is talking, and her talk is increasingly frantic. She's telling us about fears that her son's father will influence her son and that she is not a good mother. She says, "He'll say I'm a terrible person, and I feel insecure and vulnerable." My co-therapist alerts us to what is happening. She says to me, "You are having a struggle between listening and wanting to play." I respond, "I was helping him to stay somewhere." The mother says, "I sensed you were giving him attention. He seems happier. Maybe it's the attention I don't give." Her son catches my attention again, he gives me the car back and indicates he wants more, talking animatedly. The discussion continues between mothers on the theme of competition with fathers. The son moves away from me and becomes engaged with another toy. My co-therapist returns us to the action here, commenting to the mother, "We've got competition here.

I was sitting right ahead and couldn't ignore the little glances you were giving Jessica." Another mother says, "I felt uncomfortable that you were challenging Jessica."

We continued to talk about the feelings raised by this pairing, fragmentation, and subsequent "conflict" between the therapists. Reactions differed, with some mothers scared it might escalate into a row or punch up like in their families of origin. Things were said about therapists (fathers) who set themselves up as "better players," expose inadequate mothers, and give special care to one group member. My co-therapist formed a temporary alliance with the others in relation to me, the "attentive player," who absented herself from the group. Competition is not confined to the mothers and exists between myself and my colleague. Was I setting myself up as the best mother? Was my co-therapist's intervention meaningful but also attacking? We must be continuously aware of the fine line between our own constructive and destructive impulses. There was also delight in the "played with" baby's new found vigour. The apparently short-lived experience of attunement had a dramatic effect which was sustained in his relationship with his mother and acknowledged by everyone. Our increasing trust and relaxation made it possible to articulate our differences inside the group which, as in this instance, can be productive.

The clinical material that follows is taken from four sessions over a period of nine months.

"We Leave the Group Unsupported"

There are four mothers with their infants, ages between six and sixteen months. One group member and baby joined six weeks previously.

The newest group member is talking: "Often we leave the session unsupported or misunderstood or, perhaps, left." Her baby is in her arms. Another is being rocked by his mother who is standing. Having said this, she sits down and turns to face away from everyone. She puts a bib on her daughter and proceeds to feed her. Another mother places her six-month-old on his front propped up by a cushion. Almost at the same time as doing this, she responds, "Aren't they feelings we encounter in our relationships with our partners or in life anyway?"

Then the baby on the cushion rolls off it and falls with a loud bang as his head hits the floor. He wails and is picked up and comforted. "Oh, oh. Alright, alright." The therapists watch and look concerned. Other mothers busy themselves with their own babies more avidly. The "dissatisfied" new mother rocks and strokes her daughter. The "feeding" mother glances round briefly, then turns back to resume the meal. The crying abates and is followed by silence which is broken by my co-therapist: "He fell with a big bang almost at the very point you were talking about being unsupported by the group. You were saying that sometimes you leave with very painful feelings. I'm making a link between the fall and how you sometimes feel." The baby just fed crawls away from her mother towards others. Her mother pats her hard on the bottom a few times, tries to give her another mouthful of food, then returns to where she was sitting keeping her eyes fixed on her. The dissatisfied mother continues talking about her concern for the mother whose baby fell. "There was something you brought up at the last minute and I felt you were left unsupported. Then I couldn't remember what it was the next week" She places her daughter on her back on the floor especially gently. She is facing her and she kisses her. The baby who fell is now

in his mother's arms faced outwards. He is wide-eyed and looks into space with a dummy in his mouth and an uneasy calm.

I ask the mother whose baby has banged his head about her resignation and its relationship with the resignation about the group: "You say, 'Oh well, it's like that,' then he falls. We're trying to work out if you're sensitive enough. You've told us that you're pushed to the limit in the middle of the night. When does it become too many bangs? Mothers feel worse and left in the air in this group. It's really important this is brought up. How can we help prevent this and the bangs?" Her reply is to tell us that her sister is also worried about the bangs. She's told her about them over the phone. The mother says, "I thought, 'What can I do? I'm doing all I can.'" The dissatisfied mother wonders, "Has your sister witnessed what these particular bangs are like?"

This is a group which isn't safe and dependable at the moment. A relatively new group member is voicing the paucity of support available and her view isn't countered. No hope is expressed, and aloneness, in the group or everywhere else, becomes regarded as inevitable. The women turn their backs and attend to their own babies. The body language and activity are tacit agreement that no one wants to try to understand fellow group members' plights. The dissatisfied mother persists in thinking about everyone else's lack of support. Getting involved doesn't seem worth the risk if the security of long standing participants is so precarious.

The baby's hurt expressed the group's pain with dramatic force. Others have become - perhaps like the baby herself - disassociated. The new group member's freshness of view is sensitive. The therapists are left to be concerned and to take up the meaning

of this distress, whilst the other mothers give their own babies ultra careful attention so as to distance themselves. Their children are used as shields between them and the painful feelings. The "fed" baby gets a hard, cross pat when she moves away, probably because she's leaving her mother exposed without her. The new member's baby is placed down lovingly, as if to say, "I'm not like you. I'm looking after my baby properly." It is too dangerous to make contact between one another in this group. The web of relationships is fragile. Anxiety is free flowing and barely contained.

The therapists try to provide what's missing. My colleague has linked the painful feelings with the baby's fall. I'm attempting to improve matters by strengthening the whole group's capacity, as well as the falling baby's mother. But my comments veer towards being judgemental in their desperation: "We're trying to work out if you're sensitive enough." My use of "we" is intended to be inclusive so as to value everyone's contributions and the connections between them. My positive affirmation is also meant as inclusive: "It's really important this is brought up." Nevertheless, the tendency persists for the bang to be moved out of the group, with the new group member's retort: "Has your sister witnessed what these particular bangs are like?" It's as though we're witnessing a crime committed by an offender with whom we don't want association. The baby's pain is a mirror image of each other - mothers that can't protect their babies - that is not welcome. Implied also are reverberating feelings about this "intruder" member who has joined the group recently and, furthermore, expresses things we can't bear to see or hear. We're threatened by the possibility that this group is failing its members. Everyone, including the therapists, refrains from confronting this and insecurity reverberates. It

has become too risky to talk about the bangs and distress happening right now to fellow group members. Expectations are low with unsupportive groups and falling babies.

*"We'd Better Say
Something, Everybody"*

Four months later there were five mothers with babies between five and twenty months old. The dissatisfied mother has left (at that stage in the group's life dissatisfaction was intolerable) and two other pairs have joined.

A mother, who has an older daughter, is explaining about an outburst with her at her mother's house: "She always misbehaves there." She is talking energetically and loudly as she tells us about this. We hear that the row escalated into her going "mad" and "losing it." The adults are listening attentively to this energetic talking about someone else's row. Another mother asks, "What did your mother say?" And we discover: "She didn't say a word. She didn't say anything. I was so upset."

As this story is told, the babies are interacting with their own mothers, except for the baby whose mother is taking the floor. This baby is enabling his mother to hold forth by running to and fro with a doll and necklaces to engage me. The mother of the baby who fell in the previous scenario is particularly interested in this story. She never had a mother remotely available for her. Her son (now ten months) crawls towards the mother and daughter (16 months) who were feeding in the previous vignette. The girl has a doll which grabs his interest, but his mother ensures her daughter keeps it. She gives him something else and builds bricks with her daughter, separating her from the exploring and interested baby. This is a familiar scene at this stage in their therapy, that she views her as

requiring her total care and attention. However, unlike in the previous scene, her back is not turned to the others and she asks an occasional question.

My co-therapist says, "So we had better say something, everybody." Someone wonders what she wanted her mother to say. Meanwhile the action heats up between the exploring baby and the mother and daughter dyad with the bricks. Her daughter is taken onto her knee and she says, "That's yours." She puts her arms across the front of this baby, between his unremitting desire and exploration, and her daughter. The baby's mother says, "Come on, here's your pile," but doesn't move from her position against the wall some distance away. Her engagement is with the story being told. Attention to her son is perfunctory and the son, in turn, remains relentless in his interest elsewhere. Sympathetic noises continue about the distressing incident between a grandmother, mother, and daughter outside the group.

Then we have an outburst within the group. My co-therapist says, "Don't let's forget this discussion, but I think something happened here." The "protective" mother explodes. She gesticulates with her arms and shouts out to the mother of the exploring baby (who was the one we saw fall with a bang as a six-month-old in the previous scenario): "I wish you would take him away. It's upsetting her." Her mother calls out "Come on," and there's no response. She comes over, picks him up, and places him on the floor between her legs. In silence she gets bricks and builds intently alongside her son, facing away from the outburst. I'm looking towards them and have forgotten about the baby I've been playing with who reminds me of his presence by

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WAIMH *Affiliate News*



The French-speaking WAIMH affiliate group: Its history, functioning, and present problems

By Professor Bernard Golse (President of the group)

The French-speaking WAIMH affiliate was created in 1994 by Serge Lebovici and I; Antoine Guedeney and Michel Soule were also among the co-founders. I remain the President of this very lively group and it is one of my greatest professional pleasures. The WAIMH francophone group is keen to contribute to the life of the international association and in particular to bring in its own special emphasis, especially in relation to the field of psychopathology.

Aims of the WAIMH Francophone Group

The aims of the WAIMH francophone group were clearly reaffirmed during the last WAIMH World Congress in Amsterdam. The group brings together researchers and clinicians of early childhood and the perinatal period in order to remain abreast of international advances in the field, to reflect upon them and to discuss them from a European perspective, with particular reference to psychopathology, and to contribute to progress by the work of the different teams to which our group members belong.

There are now about 220 members coming from all parts of France. About ten members are from Belgium, and they are also members of the Belgian and Luxembourg group, and eight members are from Switzerland, hence the reason our group is called "francophone" and not only the "French" group. The members belong to different professional fields: child and adult psychiatrists, child and adult psychologists and psychoanalysts, nurses and paediatric nurses, midwives, childhood educators, social workers, and so on. We organize three or four meetings a year, each one being devoted to a specific topic. For instance, the themes of our last meetings were "Prenatal psychiatry," "Atypical situations in the field of perinatal psychiatry," and "Attachment and narratives," and the next one will be on "Intersubjectivity."

A Bulletin is regularly published including the work of our quarterly meetings. Different committees have been set up in order to increase exchanges and links with colleagues from abroad: the committee for South America is coordinated by M. Botbol, for Africa by M.-R. Moro, for Central and Eastern Europe by D. Cupa, and for Far East countries (the most recent one) by F. Weil-Halpern. There are also several clinical groups, working on different topics such as Prenatal Psychiatry (S. Missonnier and M.

Soule), Conjoint therapies (F. Jardin), Clinical assessment and evaluation (A. Guedeney, D. Rabain).

For us, it is important not to be working in a parochial way during our quarterly meetings, but on the contrary, to be keen on regularly inviting foreign speakers who will enrich our reflections and the group's conceptual and methodological dynamic. It is true that our invitations have been perhaps a little more scarce for our last meetings because these invitations do have a certain cost, and we were still at that time in a period of discussion with the central WAIMH office. The new arrangements we are considering from now on should enable us to quickly and reliably resume this obviously desirable tradition.

The Contribution Issue

It is true that relations between the WAIMH francophone group and WAIMH international have been a little clouded over the past two years by this issue of the financial "refund" to be made to the group from the sum of subscriptions to WAIMH, which we found insufficient to allow the group to function adequately. At the same time, we do not wish to engage in an endless "battle," and I believe we must be pragmatic, particularly since Antoine Guedeney has explained to us that WAIMH international feels

that the principle of a "refund" is excellent (to stimulate the dynamic of the affiliated groups), but that WAIMH also felt strongly that the percentage applied to all of the groups for the "refund" should be the same in order to remain equal.

Antoine Guedeney noted that there may be a small margin for negotiation, but that in any event, we must not consider that the amount of the refund could alone guarantee the financial balance of the WAIMH francophone group. Each group affiliated to WAIMH international must therefore build its own financial autonomy and we have, to that effect, considered two realistic solutions in order to not increase the amount of the subscriptions to the group. Firstly, some term group meetings could charge an admission fee for participants who do not belong to the group, and secondly, the biennial seminar of the Francophone group (directed by M. Soule) could from now on be organised annually, but alternating between Paris and a provincial city, to share the burden of organisation more fairly. It is important to underline here that it is this seminar that, thanks to the success it has always had, alone ensures almost the totality of the group's income.

The importance of our links with WAIMH

This is one of the most sensitive points of the group's life. I believe that most of the WAIMH francophone members feel comfortable in our group, yet at the same time it is possible, and even probable, that a certain number do not well understand the interest nor the importance of our belonging to WAIMH international. There are at least three reasons for this:

1. A lack of enthusiasm for the two publications of the Association: *The Signal* and *The Infant Mental Health*

Journal, in part because not everyone is necessarily fluent enough in English.

2. The registration fees for the World or Regional Congresses not being advantageous enough for members of the international association.

3. A lack of consideration for the contributions of the francophone group in the make-up of the programs of the different Congresses; this has been particularly felt at the past two in Montreal and Amsterdam.

In reality, our membership of WAIMH can not be reconsidered, and it should be noted that during certain board meetings, and even during meetings of the whole group, a majority clearly stood out to reassert upon several occasions our commitment to this membership, which guarantees us the possibility of voicing our thoughts in the international movement of ideas.

The question and aim today is therefore to transform this possibility into a reality.

As far as the make-up of the programs of the future Congresses is concerned, we are aware of the efforts that Antoine Guedeney made in Amsterdam in this respect. As for the registration fees to Congresses, we hope that this question will be taken into account by the newly nominated executive board for the next four years. Finally, concerning *The Signal* and the IMHJ, we must undoubtedly make efforts ourselves in this direction, since these are invaluable resources both for communicating our own views and being open to the ideas of others.

We have therefore been considering the creation of a WAIMH francophone/ WAIMH international interface committee, in order to think about the various steps that might be taken to become more active in the important domain of communication (contacts to make, translations, IMHJ, and *The Signal*). We would envisage this as a small group composed of a number of

dynamic people, fluent in English and interested in making contacts and establishing connections. I can now add that, as readers of *The Signal* will be aware, there is a recently established section specifically addressing the life of the different affiliated groups, and it is also possible that the IMHJ will be including a regular column for the sharing of particular clinical experiences that are not necessarily more formal pieces of research.

The position and weight of the affiliate groups in WAIMH

This is an extremely important question that WAIMH is perfectly conscious of, since across the world the affiliated groups total up to nearly 4,000 members of which only a small number are fully-fledged members of WAIMH. This takes into account the groups that are affiliated (like ours) but not the individuals who compose these groups, since a significant number of WAIMH members are not members of any particular affiliate group.

There is, therefore, a real problem about ensuring proper representation, since the many members who are responsible for the life of the affiliated group are often not themselves members of the international association. These groups must be efficiently represented.

They are represented at present in a general manner at the executive board of the international association by our very competent and very sympathetic Brigit Jordan (Australia), but this is not sufficient, and we must undoubtedly press for more specific representation of each large region of the world.

Furthermore, we must pursue our efforts to federate European affiliate groups. This would allow groups that are geographically close to get

to know each other better and to share a certain number of common interests and goals. Unfortunately the meetings that were planned in Jerusalem and Pisa could not take place, and it was decided in Amsterdam to plan a new reunion in Paris. This meeting will take place on 25 and 26 January 2003, and will be organized by Sam Tyano (Israel), Massimo Ammaniti (Italy), and myself, as the second Paris meeting of the different European affiliate WAIMH groups. This is for us a very important "rendez-vous," and I am pleased to see that each European group has readily accepted our invitation which will give us a new opportunity to exchange views and discuss them together.

This, then, summarises the main information that I wished to convey about the WAIMH francophone group. I am sure it is clear that I am very proud and very honoured to be at the head of this group, with so many outstanding colleagues working with me in the general perspective of WAIMH.

Bernard Golse, President
WAIMH Francophone Group

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dropping a toy onto my lap. The mother who exploded is tearful. She stands up holding her daughter to get a tissue for herself. She jogs her up and down, then sits again. I say, "It's upsetting you." The mother is apologetic and says she doesn't know why it's upsetting her so much: "I think she's this completely neurotic baby. If anyone comes near, she makes a fuss." Then she becomes angry, turning towards the mother of the "unremitting" baby: "I was feeling just now I should ask you to take him away. But I couldn't because I thought you should notice what was happening." The unremitting baby's mother responds by retorting to her baby, "It's chaos,

and you don't even notice." There's opportunity to say more. We examine the replay in the group of the conflict from outside which moved to the inside. My co-therapist points it out, "You wanted your mother to take action. To give comfort either to you, your daughter, or both of you. Someone needed to take control." I agree, "Action was required round here." All the adults' attention is grabbed by what we are saying. We dare to name what's happened now. The unremitting baby starts crawling back to where he was. His mother swiftly pulls him back onto her knee. The "outburst" mother is clutching her daughter with a doll on her knee. Co-therapist: "Yes, there was something that you couldn't say here. Did you think it would sound too aggressive?" She replies, "I thought it would sound rude. But it was silly, it ended up sounding more rude and aggressive than if I'd said something earlier." The "shouted at" mother is somewhat mechanically building bricks to keep her son occupied and out of nuisance. He is restrained behind his mother's legs, faced away from the highly charged emotion of the mother and daughter who are rejecting him. Someone comments, "You seem a bit shocked." She responds, "No, well, it's just him, he doesn't understand. If I say no, he will want to go back there. I just have to divert him, basically."

A dam of feelings has overflowed and burst. Their expression has been possible in this increasingly stable culture where connections have developed between group members. This conflict is a manifestation of irritations that have built up. The individual's preoccupation and the topic under discussion - "She didn't say anything" - has meaning for everyone. It is tipped into consciousness by a fight brewing between mothers over their babies' behaviour. The message has been conveyed that strong feelings are permissible. Unlike these mothers' past histories and experience, violence neither escalated nor got swept under the carpet. Although the newer mothers

weren't central players in this action they are present within a group which - unlike in the previous vignette - gives promise. This setting is sturdy enough to withstand difficult feelings. It's obvious that people care about each other.

This was a pivotal point in the "rowing mothers and babies" therapy. It also provided a testing ground for this group's dependability as a secure base. Everyone returned for a post-mortem. The raw feelings - evoked by the babies - cut through niceties and enabled a rich seam of transference enactments for all to see. It became a group event and part of its history to revisit, rework, and hold in mind in the group's ether. We experienced first hand the consequences of avoiding conflict, not just through an outside event, such as this one of a row (albeit fresh and affect laden). The "protective" mother was able to keep her anger alive for subsequent weeks. This differed from her usual tendency for going under, isolated with guilt, misery, and depression. With renewed confidence, and much more effect than any therapist (with the full force of emotion), she expressed convincingly the attachment between this mother and her "unremitting" baby. This is how she put it the next week: "Usually there's an invisible thread between mothers and babies, but it seems to be missing." The timing and accuracy of her insight was valued by everyone - the mother and her "unremitting" baby especially (see below). About her own baby, she says, "She's just this completely neurotic baby." But her neurotic, guilt ridden mother has begun to trust and allow her own feelings. Crucially, also, her daughter benefits from the increasing capacity to trust and value her feelings and, during their attendance, this flows over into

their relationship. She was the mother, in the previous scene, who gave her daughter the hard, cross pat when she crawled away and left her bereft. In a later vignette we'll see her with a daughter being admired as her own lively person.

The mother of the "unremitting" baby has tendencies to cut off and despair. Four months previously she responded to her baby's fall: "Oh well, he's like that," and her stance is continued: "Well, it's just him." His large eyes stare vacantly as he sits either immobilised or energetically involved in another mother's material. This incident, and its aftermath, faced her with her own contribution to the strong feelings in the group. Her life has been full of rejection, as portrayed by her baby's seeking of rejection and the other mother's perception of the "invisible thread" that seems to be missing. The continuation of this secure-enough therapeutic environment offers reworking and change. Her strategies, by now familiar, of distancing herself - such as from the angry mother and daughter's orbit, or from her son's needs - are being exposed and questioned. Through other group members, the therapists, and, above all, her "unremitting" baby's persistence, she is encouraged to find ways of renegotiating relationships, with less recourse to giving up, retaliating, or searching for more immediately fascinating distractions.

Abandonment: "We've Been Pussyfooting About It"

A further four months later, it was the third week after a two week break. There are four mothers and babies. The babies' ages ranged from nineteen to six months. A new mother and baby girl had begun three months earlier. This mother has a son whom she left behind when her marriage became intolerable to her eleven years previously, when the son was two

years old.

The recent mother is telling the group about her current relationship with her son who is now aged thirteen. She tells us that her son avoids his new half sister: "He's not really interested in babies." After a while my co-therapist asks about her son's name: "You know, I don't know the name of your son. It's always 'he' or 'my son'." We're told the name - which, for the purposes of this paper, is John - and others agree that they didn't know either. The mother looks towards her daughter and lifts her up. She squirms and is resisting. I look at her and also put out a hand to touch her. There is silence. Then a lively child captures our attention.

This lively child is the daughter (now 19 months) of the mother who "burst out" in the previous vignette. She is moving back and forth to a chair, saying "chair" and pointing to it. We admire her: "Isn't she grown up?" Then another baby crawls over looking intentional. He catches my eye and I say, "Are you going to it now?" His wish for the chair evaporates and he returns swiftly to his mother. He found me intrusive. Another baby ventures over. It's the baby (now 13 months) we saw first falling and then "unremitting". Last week the chair was one focus of his continuing insatiability. Someone says, "We know you like the chair." His mother tells us, "He's better here this week. He didn't want to be here last week." She says she is worried about her son's lust for new things in every situation and is concerned that he is bored. This idea is questioned. Co-therapist: "Bored is a funny word for a child that age." A discussion develops about the meaning of boring. We watch the "bored" baby trying to get on the chair. He persists, but is frustrated and makes noises. He looks a pitiful sight at the bottom of this unreachable chair. His mother goes over and puts him on it. Again he's not satisfied and sits with his mother reaching towards the window.

He can't keep still and nothing seems good enough. His restlessness is settled briefly by a breastfeeding that lasts one minute.

My co-therapist talks in relation to this material: "Any child when he feels OK inside himself can create more and more interest in the same environment. I think that's true for adults as well, isn't it?" Group members are questioning the "bored" baby's mother about her own contribution to her son's behaviour. She deflects us back to the unnamed son. Quite abruptly, she asks about a photo. "Do you have a photo we could see of John?" More is told. Again it's reported that John doesn't like babies. Then John's half sister alerts us to her. She turns over. We look and lots of comments are made: "Hold on tight." "Gosh she rolled over!" and her mother leans down towards her face and asks her, "Do you want to play?"

The mother of the baby who found me intrusive, has been mostly quiet. Our engagement moves in her direction when she is asked about her silence. She says she's tired, but also unsettled and not sure why she can't join in. Looking at the mother of the "lively" girl, she says, "One thing that struck me last week was you saying you were a bit angry about the break." This mother says, "That's a bit of an understatement." There's laughter and the quiet mother continues: "It was frightening to realise how I'm not in touch with that anger." We agree that another's anger has provided helpful recognition. Freed up by expressing her anger, she links her fear of anger to a disturbing sense of excitement with her father whilst she was growing up. It continued with her baby's father when their relationship went wrong. Then she reproaches me for something I said the previous week which felt critical and intrusive. Like her son, who moved away from the chair at my approach, she finds me intrusive.

The children are beginning to engage. They are clapping and moving rhythmically to a musical box, helped along by each other as well as the adults. The mothers talk about expressions of boredom being connected to fear: "I used to go to mother-and-baby groups and think they were boring. It was an excuse to myself why I'm not enjoying it." "I can't see a way to change this excitement that came from a terrifying background and spilled over into relationships." The mother whose baby was described as bored in the group is saying nothing. Her baby is becoming slightly more settled now. Instead of flitting from person to person, object to object, he's interacting with another child and her mother. There's eye contact and smiles as he sits on his mother's knee jumping with the rhythm of the musical box. The children are lively - plates are banged together, rattles are rattled energetically - whilst the mothers are quietly reflective. There is this silent moment, then someone says, "This is quite important stuff."

Up until this point we had avoided talking about the "abandoned" son. As one group member put it later, "We've pussyfooted around it." Now the group is beginning to face thinking about this abandonment. A solid group culture, combined with this woman's emerging accessibility, meant that questions began to be asked. I had reached out with my hand to touch her baby, feeling protective towards her mother whose daughter is manifesting her internal squirming and resisting. Our silence at that point suggests our awareness of their vulnerability and also, perhaps, our identification with it and John who was nameless. The lively child is a welcome release, especially as she is usually the one who clings, or is clung on to, by her mother. Whilst the mother of the abandoned son brings her preoccupying secret into the open, her daughter becomes animated and

grabs our attention by turning over. We're all interested: "Gosh! Hold on tight!" perhaps compensating for her half-brother's lack of interest, as well as her mother's own struggle to risk becoming attached to her. She's saying: "Look at me, I'm a person." Her own and her mother's place in the group has tended to be on the outside, even if not nameless. Now her mother looks into her eyes and talks to her directly: "Do you want to play?" She's daring intimacy with both her daughter and the group.

There's didactic talk about the idea of "boring." The "bored" baby's mother resists contemplating this and bounces the discussion back to the abandoned son's mother. The son who was nameless in the group, is also herself. They have an affinity as she, too, was abandoned by her birth family. The inner pressure of her own abandonment is compelling and it returns us to the subject. Like her "bored" son, she tends to manage life by having an often creative lust for new things. Asking for a photo is another way of wanting to find out more and having the "abandoned" son fleshed out and not forgotten.

Then abandonment comes into the group more directly. The excitement (fear?) moves into the room. We abandoned them over the break, and their anger - expressed directly by one woman last week, and now in silence by another - is alive. The juxtaposition of boring and exciting is meaningful here now. This theme is developed. We discover that the "intruded upon" mother and baby are carrying strong feelings which have caused them to withdraw out of anger and fear (and which can get translated into boredom). This mother talks directly by confronting the therapists about the break and things we have said wrong. The developing engagement and attunement between the adults results in a similar experience for the children who become rhythmic and settled. Even

the "bored," hitherto flitting baby is held in this moment of contact with others. There's mutual recognition of its significance: "This is quite important stuff."

"I Wasn't as Receptive to You as I Might Have Been"

Two weeks later this theme of abandonment is revived and pursued more energetically.

The "intruded" mother brings up the subject again. She says she has thought about her silence and realises she feels hostile to the mother who abandoned her son. She makes the connection to her own experience. Her partner and baby's father abandoned them a few weeks after birth. She is estranged from her own violent father and had not been able to tell him of her son's existence: "It's my problem, but you brought that issue into the group. I wasn't as receptive to you as I might have been. It wasn't just that you were new." The "abandoning" mother asks her to say more, indicating she can bear it. Others contribute their own feelings of hesitancy. It gets described as "deep down criticism." The therapists re-enforce what is being said: "This is really important. It's what you feared. It's really good you brought it up." Then we go further. The "abandoning" mother: "This is part of the reason people don't know about John. I've got to cope and deal with that." She's tearful and is using her son's name as the feelings flow. Whilst talking her daughter wobbles. She helps her fall gently and articulates what is happening: "Oopsy daisy! oopsy daisy!" And another mother does interpretative work: "Is there part of you who feels like that (self-critical)?" She replies, "I think so," and leans back against the wall.

For a while we focus on helping this mother contemplate her own self-judgement. The babies let us talk.

Two are pretend making tea, babbling and responding to each other. She is assuring herself that her abandoned son isn't damaged: "He hasn't been upset about it." The therapists wonder if upset would be intolerable and bring upset back into the group: "Do you think it would be helpful to hear more about the criticisms and feelings here? Or would that be intolerable?" She says she welcomes ideas to help her talk to her son or make explanations to others. Another mother shares having had her own desperate feelings which got to fever pitch and resulted in thoughts of killing herself and her daughter. She says, "It's strange, I never thought of leaving her." She points out that even though her mother was always there, she too felt abandoned. Then she's able to reach out to applaud this mother's efforts to do her best: "It sounds as though you've been really thoughtful about him." Other group members provide reassurance and comfort. This frees the therapists to probe further:

"Did your desperate feelings ever get to the extreme we've just heard about? Did you think of harming yourself or John?" Mother: "No, not really. I planned the leaving all out. I was stressed and unhappy. I wasn't eating at the time and lost so much weight." She's stroking her daughter and is tearful. Another mother: "It sounds as though you saw that as the only solution." Mother: "It seemed the only way." Me: "You didn't have the words and no one picked up the signals." Mother: "'No, I couldn't speak to my mother about it." Co-therapist: "You must have felt abandoned by the people who loved you."

This is powerful. Critical feelings are being acknowledged about each other inside the group. The "intruded upon" mother's previous silence was not simply anger about the group or the therapists. After time to reflect, returning to a continuing session

(with a flat and apparently inconsequential intervening one), there is evidence of our enduring commitment. This mother has thought about her hostility towards the mother who abandoned her son. Judgement and self-judgement rebound. The "abandoning" mother's deeply felt disapproval of herself has become more pernicious since the birth of her daughter. As she declares this, she is in touch with her collapse. Previously we've noticed her mother's loss of contact with her when she talks of John. This time, with the resonance in the group, she reaches tenderly, voices what is happening ("oopsy daisy") and assists her lowering to the floor. Her own bodily movements are similarly responsive. Usually her place is in the middle of the room, sitting stiffly and awkwardly with her big lump of a baby. Now she's accepting the support of the group and relaxes back into the cushions and wall.

This setting has enabled both empathy and analysis. Criticism hasn't been simply "out there." Mothers have shared and spoken about their own intolerable feelings, of those generated by the present as well as the past. No one holds the monopoly on abandonment, in fantasy or reality. It has meaning for everyone. We are told about it occurring when mothers abandon their children in actuality, but also when mothers are there but unavailable in family life: "My mother was always there, but I felt abandoned too." In our group, as well, we've seen - although not made explicit or interpreted at this stage - how this mother, who abandoned her son, took time to gain a position with her baby inside the group. They remained precariously poised on the outside for some time (around three months) and there were tendencies for their abandonment within it. Signals, through body language as well as words, became evidence that they were gradually available for intimacy

and embrace. Forced entry was avoided in this sufficiently mature group culture and, when entry came, important feelings were evoked for everyone.

Conclusion

I have used clinical material to demonstrate cultural embeddedness as a pre-requisite for change in an analytic group with mothers and babies. Attention to simple details, belief in the process, careful assessment and preparation, vigilance in the co-therapist's relationship and the drip, drip, drip of reliability formed the backdrop. A facilitating culture was established and tested for its holding and containing capacity. The thorough use of this (group) object, and the multiplicity of relationships within it, has been shown leading to movement and progression. Vignettes were presented from group sessions over a nine month period to illustrate the continuity of building and rebuilding, failure and success, destruction and survival of this group as an attachment setting.

Mothers and their infants arrived precarious, fragmented, and at-risk of falling apart. Movement or separation - to relative dependency - was mobile and tenuous. In the first scenario chosen, "We leave the group unsupported," the group's identity was indistinguishable from that of its fragile members. Its potential for integration or change was inconceivable and unformulated. Mothers and babies displayed their fractured, disassociated, and despairing modes of function, and the group struggled to meet their needs. Refuge was taken in busyness with babies and talk that avoided the pain and difficulty actually there in the room. The therapists also strained to address and stay with the events and action unfolding in the session, with their faith in the process diminished by the force of insecure projections.

Following sessions portrayed a sturdier group culture, where a place of safety was formed with others who are "in touch." "Falling for ever becomes the joy in being carried" (Winnicott, 1987). "Falls" are risked, both literally and symbolically, and met by concerned others prepared and able to "carry" each other. Cycles of collapse and recovery were repeated time and again as vehicles for engagement with the group as a reliable, sometime joyful, "group-mother." This passionate involvement was accessed from various angles. Mothers brought pre-occupations from current and past lives which were linked to the action in the room. A row from the previous day was re-enacted by babies and, then, between their mothers: "We'd better say something, everybody." A mother's abandonment of an older son, entrenched with years of self-criticism, gradually emerged into the light of the on-going group: "We've been pussyfooting about it". This theme of abandonment reverberated and included babies being held tenuously - and at risk of abandonment - there and then. With time to reflect, a few weeks later, judgements about abandonment were owned and borne between group members: "I wasn't as receptive to you as I might have been." This included venturing to question the behaviour of mothers and therapists within the setting. We saw babies (mothers and therapists?) in their raw immediacy growing up and living through shared experiences which were re-visited and re-worked. I have presented a phase in an analytic group in progress, to immerse readers in the flavour, ebbs and flows of its culture.

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JESSICA JAMES is a Group Analyst working with the Parent Infant Project

at the Anna Freud Centre. Address for correspondence : Anna Freud Centre 21 Maresfield Gardens NW3 5SH. email : sara.mitchell@annafreud.org

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The Tavistock and Portman NHS Trust A Tavistock Clinic Conference

Pathways To Change: Clinical Interventions with Infants, Young Children, and their Families

25, 26, 27 March 2004

Fee: £245

Venue: Tavistock Centre, London

Advance Notice

This International Conference aims to provide a forum for a multi-disciplinary exchange of ideas about theory, technique and research relating to clinical interventions with families and their pre-school age children.

The programme will include international speakers and contributions from past and present members of the Tavistock Clinic Under Fives Counselling Service, and coincides with the launch of our book on clinical work with Under Fives.

We are calling for contributions from centres describing a range of approaches to this clinical work. Please register your interest in contributing by sending a brief abstract to:

Louise Emanuel
Conference Committee
Tel: 020 7435 7111
Email: lemanuel@tavi-port.nhs.uk

Further information:

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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@pbarrows.freemove.co.uk Thanks.

The Anna Freud Centre - Parent and Infant Project International Study Day

Parent-infant psychotherapy: psychoanalysis, attachment and the neurosciences

November 1st 2002

This was the fourth annual Study Day held by the Parent and Infant Project, and it took place this year as part of the 50th anniversary celebrations of the Centre. The topic was chosen with our psychoanalytic heritage in mind and with an eye to the future. Parent-infant psychotherapy, as a clinical speciality, is at the interface of psychoanalysis, attachment, and infant developmental research. Relational trauma, attachment disorder, and derailed development were the foci of the presentations and discussions.

In the first section of the day Tessa Baradon, Miriam Steele, and Allan Schore gave introductory statements from their respective disciplines. Tessa Baradon presented profiles of relational trauma as observed within the consulting room. The first was that of the infant and mother "imprisoned in depression" – the "Dead mother, dead baby" complex described by Green (1980) and Bollas (1999). Where the baby is born into such a relationship he manifests a decathexis of the maternal object from the earliest weeks and months. The second aspect of relational trauma is demonstrated in cases where ordinary maternal ministrations are experienced as toxic by the baby. Through "unconscious

communication" (Balint, 1992) conflict permeates the handling and holding of the baby, and the mother's state of mind is perceived and internalised by him. Another profile of relational trauma is embedded in hostile and distorting maternal projections, as described by Fraiberg and colleagues (1975). Here the "ghosts in the nursery" hijack the trajectory of normal love and hatred to that of sadism and ruthlessness, and feelings of persecution and murder are passed back and forth between mother and baby. Tessa ended with some thoughts about the reproduction of the past in the therapeutic situation, in traumatising transference-countertransference transactions, and the importance of the therapy in processing inchoate states of mind of both mother and baby. The therapist's "reverie" may also be the first locus of their joining and integration.

Miriam Steele addressed the contributions made by attachment theory and research to the understanding of intergenerational influences upon parent-infant psychotherapy. Some of the basic tenets of John Bowlby's theory which have withstood the test of time include the biological basis of parent-child relationships, the notion of internal working models of attachment relationships, and their role in regulating affect within and between individuals. Miriam Steele then addressed the contribution made by Mary Main with the advent of "disorganised" attachment patterns in infancy and the shift from a focus on observed behaviour (in infancy) to inferring the qualities of parents' representations of their childhood via

the use of the Adult Attachment Interview. The empirical link demonstrated between the state of mind of the parent and the observed attachment behaviours of the child has brought about a meaningful dialogue between psychodynamic clinicians and a range of disciplines. A specific contribution that has been brought to our clinical understanding by the development of the Adult Attachment Interview is the notion of resolution of mourning with respect to a previously experienced loss or traumatic events (e.g., abuse). The ability to resolve traumatic events and experiences may be one of the most important contributions the Adult Attachment Interview will make in the clinical domain.

Allan Schore discussed how current developmental neuropsychology and affective neuroscience are now studying the neurobiological mechanisms that underlie relational trauma, unconscious communication, and the intergenerational transmission of a risk for psychopathology. The research and theoretical connections between pre- and postnatal mother-infant experiences, critical period brain growth, and later adaptive and maladaptive coping capacities are now tightly coupled. This work strongly supports the notions that early attachments indelibly shape the personality throughout the life span, and that early interventions will have not only immediate effects on the dyad, but lifelong effects on structural development. He described how early nonconscious emotional communications represent right brain-to-right brain transactions of facial

expressions, tone of voice, and bodily gestures. Attachment represents the interactive regulation of the right brain, which is in a growth spurt from the last trimester through the second year of life. The right brain thus represents the biological substrate of the human unconscious.

The discussion of the statements emphasised the role of the father in affect regulation in mother-infant trauma, as well as offering a different specific relationship with the baby. There was agreement about the importance of the father-infant relationship and of triadic relationships, while recognising the uniqueness, and often primacy in the early months, of the mother-infant relationship.

The clinical presentations included digital video material of the therapy. The first was given by Robin Balbernie on "Room for only one more: a failure of bonding when twins over-stretched the caregiving system." In the case described Robin discussed ongoing work with a mother who felt ordinary loving feelings for one of her premature, boy twins, but was almost entirely rejecting of the other. In the course of the work, which started when the twins were 6 months, it became apparent that the rejected twin represented to his mother an older child who had died, and that becoming attached to a baby, whom mother felt would die, was too much for her to risk. It also seemed, however, that her hatred towards the rejected twin, and the guilt for this in mother were difficult to shift. Robin adopted Susan McDonough's model of Interaction Guidance, whereby he selected video clips for discussion with the mother. Although sometimes despondent in his countertransference, he was careful to work with the mother with sequences in which something positive had happened between her and her rejected baby. Despite the therapeutic input to the family and other provisions, the rejected twin has been

put on the at-risk register and may be removed permanently from his family. In the discussion of this clinical presentation, Allan Schore emphasized that this was a very high risk case because the baby's prematurity made him more vulnerable and because the effects of neglect are most lethal in terms of brain cell death. A referral at the age of six months was already very late for this baby's development. The case demonstrates the importance of recognizing the somatic and affective as well as the cognitive aspects of severe developmental psychopathology in the first year of life. Special emphasis was placed upon the early manifestations of dissociation. The audience grappled with the level of psychotherapeutic input possible within a NHS-Surestart setting – to some it seemed invaluable in and of itself, to others it seemed desperately inadequate to facilitate real change. The interlinking of personal and institutional themes of rejection/ejection and abandonment were also noted.

The second clinical presentation was given by Judith Woodhead, entitled "Toxicity and attachment: surviving trauma and murderousness in the mother infant relationship." The case was of a Kosovan refugee and her baby daughter – age four months. In this dyad, trauma from the mother's past was woven into her interactions with her baby. Particular focus was given in the paper to the feeding situation whereby the baby would only take the bottle when lying on the floor with her face averted from her mother. The video clips tracked the baby's avoidance of her mother and ambivalence towards her mother's handling, expressed in her wanting the bottle and rejecting it. Judith's interventions focused on scaffolding maternal and infant feeling states and enabling both to feel held within the therapeutic relationship. Gradually the mother was able to replace the bottle with her

face and body, and her daughter responded joyously to this. Miriam Steele added information about the mother's Adult Attachment Interview, which was conducted as part of the intake process. This mother was categorised as dismissing and unresolved. In his commentary on this case Allan Schore viewed this as a high-risk case, with a positive resolution of the dyad's traumatic mutual disengagement. The successful clinical intervention demonstrated how the relationship was the focus of the treatment, and how the psychobiologically attuned therapist acted to enhance the mother's regulatory capacities, and thereby helped her co-create with the child a growth-facilitating environment for the infant's right brain attachment structures. The clinician's countertransferential capacity to hold the mother's anger and the infant's hopelessness were key to the advances in affect regulation in both.

The discussion from the floor of both presentations looked at risk factors and how to work analytically with them to create growth facilitating contexts. The role of the AAI and neuroscience in informing the therapeutic intervention was raised. The theme of how to work with both the mother's pathology while working with the baby was also addressed. This was then linked to a theme from the morning's discussion in which it was suggested that in some cases couple therapy is more powerful than parent-infant psychotherapy in addressing and mitigating relational trauma.

In summary, over 100 participants attended this study day and many more applied. This reflects the growing interest and vital importance of early intervention and, in particular, the psychotherapeutic work in the relationship between parents and their infants. This work draws upon theory, research, and clinical practice from the disciplines of psychoanalysis, attachment, and the neurosciences. The two presentations demonstrated

different models of intervention and the need for flexibility according to local circumstances and theoretical paradigms. Clearly the field is ripe for more thinking and development.

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First International Meeting on Toddler Groups, Anna Freud Centre

As part of the Anna Freud Centre's 50th anniversary celebrations, the toddler group team hosted its first international toddler afternoon event on 31 October. Our aim was to exchange ideas with other professionals working with this particular age group, and to gauge the level of interest in meetings of this sort. Attendees ranged from child analysts running toddler groups to therapists working individually with various age groups, and members of the UK's SureStart program for young children. We were delighted with the large turnout which included visitors from Australia, Peru, South Africa, Scandinavia, Russia, and the United States.

The first paper was presented by Jenny Stoker, written by the AFC toddler group team—Nancy Brenner, Justine Kalas Reeves, Valli Kohon, Jenny Stoker, and Marie Zaphiriou Woods. It showed the significance of play during toddlerhood for the growth of

the personality, and the role of our toddler groups in promoting mutual pleasurable play between parents and toddlers. We described mother-toddler dynamics that facilitate as well as impede growth-promoting play, and how toddler groups can offer thinking as well as transitional space when, for example, a mother's playful capacity is compromised. Using examples from our toddler groups, we strove to bring to life various writings that have influenced our thinking, particularly Winnicott, but also Anna Freud, Melanie Klein, and Anne Alvarez. Our paper also reflected on the many interventions we employ, from helping mothers to join their children in play, to verbalising strong affects in mothers or toddlers, just to mention two.

Within our team there were diverse backgrounds and theoretical points of view that made working on the paper a fascinating endeavour in itself. These differences also led to some hilarious moments, as when one of us argued that using the term "epistemophilic instinct" was too long and jargony, while another showed its roots in Freud's writings and its lifelong implications for curiosity and learning. Having had to trim it for this half-hour presentation, we are presently preparing it for publication.

Several members of the audience gave comments following the paper. The difficult task of defining play was raised, with both suggestions and criticisms of some of the authors we quoted. Jaak Panksepp's notion that all mammals have a play seeking system was mentioned, and Piaget's definition "play is the work of the child" was highlighted. Anna Freud's developmental line from the body to the toy was considered unsatisfactory for its suggestion that toys are a substitute for the mother's body rather than interesting in themselves. Another audience member commented that there were some forms of trauma that could not be talked about, and

wondered if play in the toddler groups gave us access to them.

The second paper was written by Kerry Kelly Novick (an AFC alumna) of Ann Arbor, Michigan, and described the Alan Creek School's use of groups for parents with toddlers attending their twice weekly toddlers classes (as they are called there). Novick described how the idea for the twice monthly parent groups evolved. When they began running their toddler classes, the teachers noticed that they frequently had lengthy phone calls in the evenings with the parents needing to discuss their toddler and parenting difficulties. However, when an actual appointment was offered, the parents were highly resistant. The offer of an individual appointment was gradually understood by Alan Creek staff to threaten separation-individuation processes going on in the family as well as the parents' self-esteem-as-parent, so the following year they offered the parenting groups as an option. They finally decided to make the parenting groups part and parcel of the toddler programme offered. The leaders of these groups are volunteer analysts or candidates and meet twice per month with the toddler parents, more if required. Novick's paper described the profound changes parents in the group felt they had undergone as a result of the groups, and how at year's end, the parents became quite close to one another, openly linking parenting difficulties to their past experiences. They have observed that when parents are unable to use the group, this can be a diagnostic indicator of difficulties requiring more intensive help.

In the discussion that followed Novick's paper, there were questions about the differences between the AFC toddler groups and the toddler classes at Alan Creek. We discussed Alan Creek's policy of discouraging the adults from speaking over the children's heads. This seemed quite foreign to us at the Anna Freud Centre

where we encourage parents to use one another as sources of support in our group, and where leaders help children understand what they're feeling by verbalising their affects, sometimes directly to them, but at other times to the parents. Novick's response was that they considered it impolite for adults to discuss a child in front of that child. However, she said she thought the actual differences between the two approaches were probably not as big as they seemed, and provided an example to show how a parent and teacher had spoken of a boy's progress to him in the class. Another big difference that was raised in the discussion was about the more structured and educational sound of the American toddler classes (it was even noted how they are called classes rather than groups) in comparison with the AFC groups which provide a relatively unstructured setting in which parents and toddlers can discover new ways of understanding and interacting. People queried the extent to which differences in American versus British culture contributed to different emphases, as well as what, if anything, was at stake in the differences.

Despite the fact that the two papers were very different, one about the significance of play in toddlerhood, another about the role of parent groups in toddler classes, their point of intersection addressed how to help parents manage the regressive pulls of raising toddlers so as to promote healthy toddler and parent development. It was clear that for all the people present who run such groups, there was a deep wish to continue comparing and discussing toddler groups, no doubt because of the opportunities provided by such work for prevention. I will speak for myself in saying that the discussion came to an end too quickly, and I shall look forward to our International Toddler Group meetings in years to come.

Justine Kalas Reeves



LITERATURE MONITOR

Books

Haag, M. & G. (2002) *Esther Bick's Method of Infant Observation vol. 1* Available by mail order only. 47 euros. 445pp. Further information: Gisele.jubin@wanadoo.fr

Cramer, B., Robert-Tissot, C. & Rusconi, S. R. (2002) *Du bébé au préadolescent*. Paris: Odile Jacob. 26 euros, 309pp. Bertrand Cramer writes: This book contains the description of the problems, vicissitudes and surprising results of a longitudinal study. 53 mother-infant dyads had been treated in brief joint psychotherapy for functional disorders before age 2. An outcome study undertaken at a mean age of 16 months old had investigated the effects of the therapy. Ten years later, the authors found these dyads and evaluated them, using many different instruments including clinical interviews with parents and children.

The book focuses on several questions: what are the continuous and discontinuous factors? What is the fate of early functional disorders? What are the pathologies at preadolescence? Among the more interesting results: a high prevalence of diagnoses at follow-up; a high rate of treatment episodes between infancy and preadolescence; the most stable and consistent items are: intellectual performance in tests; maternal representations of the child and of

themselves in their maternal role. Symptoms in early childhood tend to be unstable, with not much continuity over years. There are few correlations between specific symptoms in infancy and diagnoses at preadolescence. In view of the importance of maintained parental meaning attributions and attitudes, preventive and therapeutic efforts should address parent-child interrelations, in dyads consulting in infancy.

Papers

Beebe, B (2003) 'Brief mother-infant treatment: psychoanalytically informed video feedback'. "By applying the specificity of interactive regulation identified by microanalysis of videotape into the psychodynamic treatment of mother-infant pairs, basic research can be translated into clinical practice". *Infant Mental Health Journal* 24 (1): 24-52.





President's Perspective

Peter de Chateau

In January I had the privilege to attend the second meeting in Paris of the European affiliates of WAIMH. This meeting was organised and sponsored by Bernard Golse and his department, and I want to thank him and his co-workers once again for their wonderful generosity. Some 45 participants from different European affiliates were invited and present. The program of this two-day meeting consisted of an interesting blend of research presentations, discussions of clinical work, and organisational topics. Most of the groups also presented a short overview of their recent national or regional activities. These will hopefully be published soon in *The Signal*.

Of special interest were the discussions around representation of the affiliates within WAIMH. Until the year 2000 our organisation had several vice-presidents representing various regions or continents. It was obvious however that this system for a variety of reasons did not work very well. Therefore, it was decided to increase the influence and importance of our affiliates. The system of regional representation through vice-presidents was abandoned. A special representative for the affiliates was appointed to the Executive Committee. This representative should both bring specific affiliate issues to the board and at the same time give feedback to the affiliates. Many participants of the Paris meeting expressed their wish for a strong European voice within WAIMH, either through their national affiliates or through the formation of a federation of European affiliates of WAIMH. In addition, the balance

between research and clinical presentations at congresses and in the *Infant Mental Health Journal* was stressed. A possible increase of clinical communications in *The Signal* was also supported. This last issue has already been discussed in the Executive Committee and with the editorial staff of *The Signal*. Over the years there have been ongoing debates in our organisation about this balance between clinical work and research presentations in the journal as well as at our congresses and meetings. This is most likely due to the fact that our membership and the many members of our affiliates have different backgrounds, working conditions, wishes, and needs. It will never be completely possible for any organisation to meet all of these hopes and desires. But bringing this topic into the open and discussing a solution will undoubtedly influence the further development of our organisation.

In less than a year from now WAIMH will hold its Ninth World Congress in Melbourne, Australia. When you will read this issue of *The Signal* you will have received the call for papers and an invitation to submit your contribution to the program. I do hope that many of you will take this opportunity to continue to be in contact with the latest developments in our field. The theme of the congress is very timely: "The Baby's Place in the World." It urges all of us to work on the globalisation of WAIMH by making contacts with and bringing in new countries as members of our organisation. Another important event in Melbourne will be the election of a number of members to the Executive

Committee. Since we are a constantly developing international and multidisciplinary organisation it is of great importance that members use their democratic rights and are active by voting for their representation to the board.

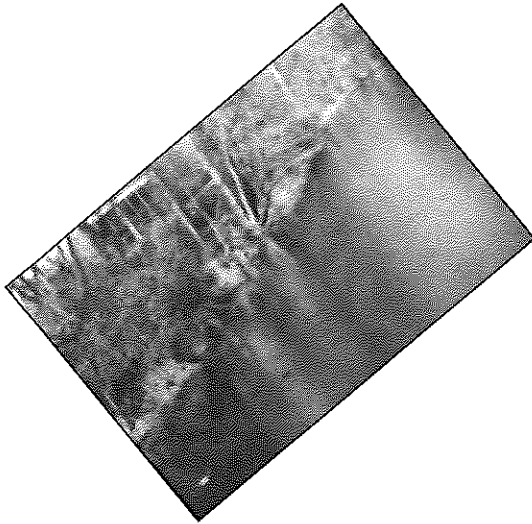
Finally, I'm glad to announce some exciting news. Paris is organising the Tenth World Congress of WAIMH in the year 2006. Congratulations! Looking ahead, I would like to encourage other countries to come forward as candidates to organise one of the future congresses of WAIMH.

Announcing the **Call for Presentations** for "Promoting Positive Development in Young Children: Designing Strategies That Work", **Head Start's 7th National Research Conference**, presented by the Administration on Children, Youth and Families, U.S. Department of Health and Human Services, in collaboration with Xtria, LLC; Columbia University's Mailman School of Public Health, and Society for Research in Child Development to be held **June 28-July 1, 2004** in Washington, DC.

The Call is available at <http://www.headstartresearchconf.net>.

Proposals are due on June 27, 2003.

For more information, please contact Bethany Chirico; hsrcc@xtria.com; 703-821-3090 ext. 261.



BY THE RED CEDAR

I have not written a commentary for WAIMH for several issues, so it is time to share many of the things that have been happening in the Central Office. Let me first address our financial situation. As everyone should know from past issues, WAIMH experienced a heavy financial loss in our conference in Montreal. Our investment of \$50,000 and a deficit of \$29,000 resulted in a net loss of nearly \$80,000. Of course, our investments have suffered as well through the recent recession and the very poor financial markets that have persisted. To counter these losses, I took several steps to preserve the basic operational soul of WAIMH. First, I moved Tina Houghton from 100 percent time as WAIMH's employee, to 100 percent time in my office at Michigan State University. I then allowed WAIMH to purchase 40% of Tina's time. The net effect is that we reduced WAIMH's financial obligation to Tina by more than 60% (because 60% of her fringe benefits also moved on to the university). Second, we stream-lined every facet of WAIMH's operation so that we could focus on publication of the *Signal*, dissemination of information to the members, and development of the Melbourne Congress. Third, we

put a hold on reimbursements to Affiliates until all accounts from Amsterdam are settled. Amsterdam was a very strong Congress in many ways, not the least of which was financial. We received a \$29,000 reimbursement for our expenses in Amsterdam, and there is a strong probability that we will receive more. We will move to make the reimbursements to Affiliates as our top priority, with support for the Melbourne Congress as the next priority. Fourth, I moved the WAIMH Central Office from the Institute for Children, Youth, and Families, to University Outreach so that it is directly in my administrative unit with access to our printers, xerox machines, and other technologies. This enables me to provide even stronger support to WAIMH as it struggles through its financial difficulty. Fifth, the Board of Directors approved an increase in dues to help offset our losses, but more importantly to help position WAIMH to develop more strongly during the next few years. For example, we have developed a Web-based on-line submission format for our congresses. This will reduce substantially our use of paper. We have upgraded the web page and established on-line publication of the abstracts for world congresses. Such abstracts will now be officially linked to the *Infant Mental Health Journal* although published on the Web page, not in hard copy. All abstracts and the congress program will be available on the Web as well.

For our congress in 2006, we should be nearly 100 percent on-line with submissions. We are exploring computer conferencing as a means to reduce the need to have face-to-face off-year meetings of the Board of

Directors. If successful, this will substantially reduce travel and maintenance costs, while simultaneously making it possible to increase the number of directors' meetings.

We have managed to pull WAIMH through some very difficult financial problems, but now we seem to be on the up side and are busy preparing for the Melbourne congress. The Call for Papers is on the Web (www.waimh.org), and you can see that we greatly simplified our web page address. In addition, we have mailed out nearly 8000 hard copies to the congress mailing list. You will be hearing much more about the congress in the months to come. We have excellent plenary speakers, a hard working and diligent Local Organizing Committee in Melbourne, and a superb Program Committee. Because this is our first attempt at on-line submissions of abstracts for the congress, please provide us with feedback about problems you may have trying to submit. It is only with such feedback that we can improve the forms so that folks from all over the world have equally successful experiences.

By the Red Cedar columns will continue to appear in all issues of *The Signal* again, and will focus on the Melbourne Congress. I invite anyone with questions or concerns to contact the Central Office so that we can either take care of such concerns, or bring them to the attention of the Board of Directors.

I hope that you all find a pathway to peace in this troubled world.

Hiram Fitzgerald

CHILDREN'S & WOMEN'S HEALTH CENTRE OF BRITISH COLUMBIA

DEPARTMENT OF CHILD & ADOLESCENT PSYCHIATRY
C4-4480 OAK STREET, VANCOUVER, B.C., CANADA V6H 3V4
PHONE (604) 875-2010 FAX (604) 875-2099

Infant Mental Health Fellowship Advertisement

We are inviting applicants for the year 2004 to the Infant Mental Health Fellowship Program at Children's & Women's Health Centre of BC with its affiliate The University of British Columbia.

Goals:

The fellowship program will emphasize on mentoring the trainee to achieve optimal understanding of infant and preschoolers' emotional health in the context of his/her milieu. With an emphasis on interdisciplinary communication, learning of different assessment and intervention techniques and research procedures, the candidate will be able to fulfill the role of advocate in the field of infant mental health. This program is funded for one calendar year and offered in intense sequential modules. There is an expectation of working with a multidisciplinary team and fulfilling a research component.

Physician Applicants

- *psychiatrist with a fellowship in the Royal College of Physicians and Surgeons of Canada or*
- *is eligible to take FRCP examination*
- *has completed mandatory child psychiatry training*
- *holds a temporary license with the local regulatory body (The College of Physicians & Surgeons of BC)*

Developmental Pediatrician

- *has completed the fellowship program of the Royal College of Physicians & Surgeons of Canada or*
- *is eligible to sit for the FRCP examinations*
- *has completed mandatory core training in developmental pediatrics*
- *has a temporary or equivalent license from the local regulatory body (The College of Physicians & Surgeons of BC)*

Allied Health Professionals: Nursing, Occupational Therapy, Psychology, Social Work, Speech & Language Pathology

- *Candidates should hold qualifications in their respective fields at the Masters level, from an accredited University and training recognized by their local certification body and be eligible for registration with their professional organization.*
- *Candidates should have minimum of three years experience working with infants and toddlers.*

Time Commitments:

1. *Minimum of 1 calendar year*
2. *Candidate must attend minimum of eleven academic months continuously.*
3. *Ideal duration would be 18 months.*

Applications should be received by July 15th 2003. Email to Francesca Wilson at fwilson@cw.bc.ca. FAX number is 604-875-2099.

The 16th Annual Bank Street College Infancy Institute

Bank Street College Infancy Institute
610 West 112th St.
New York, New York 10025

The 16th Annual Bank Street College Infancy Institute will be held on June 17, 18, and 19, 2003, at Bank Street College, in New York City. With over 30 small-group workshops and 3 full-day seminars, the Institute addresses a host of issues from brain development and supervision of childcare staff to activities for toddlers, sensory integration, and caregiver-parent relations.

Visits to exemplary infant/toddler programs are also planned.

This year's keynote speaker, Dr. Kathy Hirsh-Pasek, is a noted authority on language development and quality childcare, and Professor of Psychology at Temple University. She will talk about "Breaking the Language Barrier: How Children Develop Their First Language."

Fee for the three days is \$275 and a limited number of scholarships are available.

For more information, or to request a program, contact Carla Poole or Merrill Lee Fuchs at: 212-875-4728 (phone); 212-875-4753 (fax); InfancyInstitute@bankstreet.edu; or check www.bankstreet.edu after March 1st.

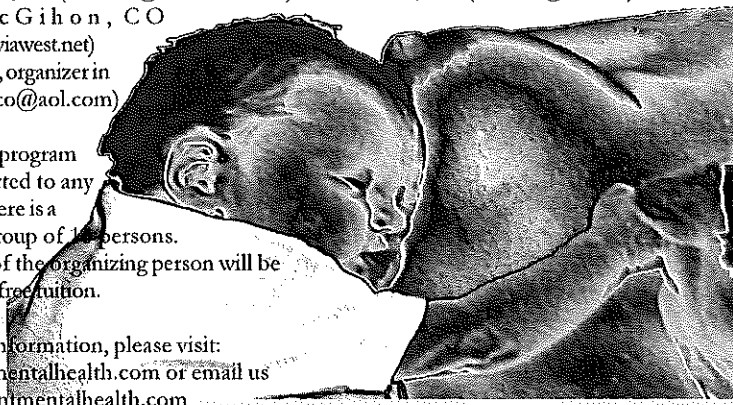
INFANT OBSERVATION

London based School of Infant Mental Health offers 1 and 2 year infant observation seminars using Esther Bick's and Tavistock small group model. Format combines in-person and video conference meetings. A certificate is awarded upon completion. Diploma Programs in Infant Mental Health and Infant Parent Psychotherapy also offered. Curriculum integrates knowledge from Psychoanalysis, cognitive, and behavioural psychology, neuroscience, and attachment research.

Following the experience in Denver, Santa Fe, and New York we are now organizing in Charlotte, NC to start in the fall. Inquiries about these seminars and training: Sandi Christofferson, ND (christos@stellamnet.com) Susan Schutz, MN (sschultz@iass.net), Denny McGihon, CO (dmcgihon@viawest.net) Sarah Lincoln, organizer in CO (sarahlinco@aol.com)

This training program can be imported to any location if there is a committed group of 10 persons. The efforts of the organizing person will be rewarded by free tuition.

For further information, please visit: www.infantmentalhealth.com or email us at info@infantmentalhealth.com



**WORLDASSOCIATION
FOR INFANT MENTAL HEALTH**
University Outreach and Engagement
Kellogg Center, Suite 27
Michigan State University
East Lansing, MI 48824-1022

Tel: (517) 432-3793
Fax: (517) 432-3694
fitzger9@msu.edu
hought17@msu.edu

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