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Thinking Three: Coparenting and family-level considerations for infant mental health professionals

By: James P. McHale, University of South Florida at St. Petersburg and Amy E. Alberts Tufts University

In this article, we spotlight an important paradigm shift that has begun to influence clinical research and practice over the past ten years. During that time, an increasing number of infant mental health professionals have broadened their clinical lens beyond mother- and father-infant dyadic relationships and beyond background marital conflict in the family to appraise the family's co-parenting and family group dynamic. Assessing coparenting and family group process is itself not a new enterprise for clinicians who have been trained as family therapists, of course. But the renewed theoretical focus in our field on multi-person relationship processes as distinctive forces in socialization and infant development has been an increasingly provocative and fruitful one. For the first time, our understanding of triadic family processes is now grounded in careful clinical science. And findings emanating from several research programs in the United States, Europe, and other sites around the globe have collectively provided the beginnings of a roadmap for practicing clinicians and for clinical scientists studying infants and their families.

Our aim in this article is to acquaint infant mental health professionals with this work by summarizing some key developments that have emerged in this field of research in recent years. We emphasize work from our own lab but ground these developments in the broader conceptual and empirical network that has both inspired and challenged us.

From Two to Three: Re-emergence of a Family paradigm

During the last decade, many clinicians and researchers working with infants, toddlers and their families have rediscovered the significance of interpersonal relationship dynamics operating within the multi-person family unit. Why do we say "rediscover"? There are several reasons. First, despite the predominant focus in the burgeoning infant mental health field on mother-infant dyads, clinicians working from family systems perspectives have tirelessly championed the irreducible primacy of the full family unit, with a special focus on family triangles (Bowen, 1961, 1972; Bell & Bell, 1979; Donley, 1993; Kerr & Bowen, 1988) for more than fifty years now. Second, the mother-father-child triad has always been central in psychoanalytic thought, discussed with regard to a range of adaptations including separation-individuation (Henderson, 1982), splitting in the service of ambivalence (Juni, 1995), and navigation of the oedipal crisis (Brickman, 1993; Ermann, 1989; Frank, 1988) — though the notion that the intrapsychic process of experiencing a triad (which Stern, 1995, held should most aptly be termed "triangulation") is of importance during the infant's first year of life has typically not been a central theme in psychodynamic theory (Abelin, 1975; Lemche & Stoeckler, 2002).

Third, and sometimes obscured in the recent enthusiasm for new empirical studies of coparenting and triadic processes in families with infants, is

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the fact that developmental scientists first charted systematic study of the behavioral dynamics of mother-father-infant triads a quarter century ago (Clarke-Stewart, 1978; Lamb, 1977; Belsky, 1984). Though much of this early work was descriptive in nature and focused on prototypical family exchanges rather than on individual differences per se, many landmark discoveries surfaced during this somewhat short-lived period of concentrated research on interpersonal process within the triad. Especially pertinent to readership of this journal was the documentation of intervention effects on the quality of coordination within mother-father-infant commerce (e.g., Dickie & Gerber, 1980). And fourth, the multiperson unit comprised of parents and infant was a de facto area of concern for many researchers engaged in the study of the transition to new parenthood during the decade of the 1980s (e.g. Belsky, Lang & Rovine, 1985; Cowan & Cowan, 1992; Feldman, Nash & Aschenbrenner, 1985; Grossman, Pollack, Golding & Fedele, 1987), though only a few of these groundbreaking studies (most notably, that of Lewis, Owen & Cox, 1989) actually examined individual differences in triadic process.

Despite the prominence of these important writings, family-level conceptualizations in our field nonetheless languished on the periphery of mainstream clinical research and practice until just a decade ago. Then, from amidst this fertile background of conceptual thought and empirical data on the family triad emerged a ground-breaking, fresh new approach – one that has come to offer important and concrete new insights aiding in the perennially difficult challenge of systematically conceptualizing and intervening in multiperson family units. This work first began to emerge in the early 1990s, amidst a zeitgeist ripe for such an approach. For example, in a 1990 paper commenting on the responsible assessment of key processes in structural family therapy (among them cohesion, collusion, triangulation, and detouring) in work with families, Nelson and Utesch soberly articulated that which all practicing clinicians knew well – that the more abstract the concept, the more removed from reality it becomes, and hence the greater the inference required to interpret it. By contrast, the more concrete the concept, the more easily it can be observed directly. Similar concerns had been voiced earlier by Green, Kolevzon and Vosler (1985) in their dissemination of an investigation guided by the current state of family research; indeed, a few years later these same authors pointed out that a "limit of concordance" may exist when researchers compare varying raters' assessments of a given family — and that methodological and/or scaling strategies designed to maximize agreement may be not just fruitless, but actually diversionary (Kolevzon, Green, Fortune & Vosler, 1988).

Family Group-Level Dynamics: Views from Family Study Laboratories

Guided by such real-world concerns, Elisabeth Fivaz-Depeursinge, along with colleague Antionette Corboz-Warnery and a team of other clinician-scientists collaborating at the Centre d'Etude de la Famille (CEF) in Lausanne, Switzerland brought to fruition a painstaking and careful series of investigations during which they had sought to capture family group-level dynamics by scrutinizing and describing mother-father-infant triads at play. Working from the "ground up" as anthropologists might, but guided as well by clinical wisdom and by a head for "systems" thinking, Fivaz and colleagues systematically documented variations in the essential body and gaze formations engaged by the men, women, and infants who contributed to their studies. They did so as they observed these individuals engaged together in a deceptively simple, semi-structured face-to-face play interaction, which has since come to be known as the "Lausanne Trilogue Play" (or LTP).

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Charting the orientations of the three family members' torsos and pelvises, the gaze of their eyes, and the nature of the affect contact among them, the researchers came to identify a hierarchical structure inherent in the flow of interaction signifying their readiness to interact and their degree of engagement in the family process (Fivaz-Depeursinge & Corboz-Warnery, 1999). More specifically, they came to recognize that unless family members oriented comfortably toward one another (an observation involving the formation created by the positioning of each person's pelvis), they were unable to achieve or sustain meaningful interpersonal commerce as a threesome. And unless the family members kept to particular roles that had been assigned to them by the experimenters during a pre-session orientation session (for example, remaining "present" – without interfering – during the "2+1" Parts of the assessment; see Fivaz-Depeursinge and Corboz-Warnery, 1999), they could not achieve a collaborative, well-coordinated triadic process (for an extension of this work to couple-therapist triads, see de Roten, Fivaz-Depeursinge, Stern, Darwish and Corboz-Warnery, 2000).

Working from these data, Fivaz and colleagues ultimately came to specify four distinctive, and clinically meaningful family alliance "types", capturing the essence of the triadic dynamic and the level of distress inherent in the observable family process. These alliances, which are termed "disordered", "collusive", "stressed", and "cooperative", have served as the centerpiece for ongoing studies guided by such diverse and important aims as establishing the prototypical stability of these different alliance types through the infant's first year and on into the toddler years; testing the malleability of alliance types to targeted clinical interventions; and establishing the extent to which children's own coping and adaptive efforts are molded and shaped by the unique types of family climates in which they are acculturated by their parents.

In this last set of aims, the Lausanne group has been joined by a handful of other laboratories around the world, including our research team. Prior to forging, during the late 1990s, what has been an exhilarating and remarkably productive alliance of our own with Fivaz and her colleagues at the CEF (as well as with some of their collaborators in a broader international system of family researchers within the "Trilogie" network), we had been at work ourselves puzzling over the dynamics of mother-father-infant triads — first at the University of California at Berkeley beginning in the mid-1980s, and then later at Clark University over the past decade. Our investigations of "coparenting" dynamics were inspired most directly by the school of structural family therapy (and in particular, by the writings of Salvador Minuchin), but owed as well to some of the more creative scholarly contributions of other leading family scientists of the early 1980s – most prominently, those of David Reiss, Jerry Lewis, and David Olson.

A theme prominent in Minuchin's (1974) articulation of adaptive family structure was the centrality of cooperation and solidarity between the different adult parenting figures responsible for the upbringing of the family's children. Minuchin's conceptualization of the identities of these heads and architects of families was an appropriately flexible one, as he worked with and wrote about multi-generational (as well as other, what at that time were termed "non-traditional") family forms, as well as nuclear family structures. This notion of coparental solidarity was also central in Lewis' theorizing (e.g., Lewis, 1989); Olson's most enduring contribution was to underscore the complementary (but in some ways also distinctively different) role of cohesiveness within the broader family unit (Olsen, Sprenkle & Russell, 1979; Olson & Gorall, 2003).

The results of our initial studies of coparenting dynamics during the infant's first year, which we discussed first at the 1992 gathering of the International Conference on Infant Studies, bore some striking parallels to the discoveries emanating from the CEF. Among the families who had taken part in studies at Berkeley were several in which one of the parenting partners (typically, though not inevitably, fathers) were not fully integrated into and engaged with the family interaction, leading researchers to characterize the family dynamic as one characterized by marked discrepancies in levels of parental involvement (McHale, 1995). In another subgroup of families, the two parenting partners were indeed both engaged, but in a manner that was poorly coordinated, often intrusive, and at a greater extreme, competitive and oppositional. Other families did not exhibit such dramatic patterns of disconnection or miscoordination, but were themselves oddly striking in their affective tone – though many could be described as polite, they shared in common a striking, pervasive lack of pleasure, zest, or joie de vive.

And then there was the opposite: a handful of families that was certainly much in the minority, in which all members of the triangle — mother and baby, father and baby, and mother and father — shared cooperative, playful, and seemingly effortless interactions radiating of genuine warmth and what we have called "positivity". In more recently completed studies of children during the toddler years, as well as in families with preschool aged children, we have also documented these same features of the family process – cooperation, warmth, competition – together with other central features of the family's group dynamic, including child- (in contrast to parent-) centeredness, and the aforementioned disparities in levels of parental involvement (McHale, Johnson & Sinclair, 1999; McHale, Kuersten-Hogan, Lauretti & Rasmussen, 2000; see McHale, Kuersten-Hogan & Lauretti, 2000, for review). More importantly, in all of these investigations, these

coparenting and family group processes emerged as important correlates, and sometimes prognosticators, of child adjustment (McHale, Kuersten & Lauretti, 1996).

Some Core Working Assumptions

The replicability of these findings concerning the distinctive roles of coparental and family group dynamics (described in some detail in McHale et al., 1996) prompted us to examine and articulate some of the underlying assumptions guiding our work. Without question, driving the various studies we have undertaken are several core guiding beliefs and suspicions. Perhaps the most important fundamental guiding belief, informed by the clinical contributions of S. Minuchin (1974) and others, is that time-limited but intensive study of the family group as an interacting unit possesses great potential for revealing several essential, core principles about that family group's functioning. A second, related suspicion has been that in many of the families for whom our detailed observations indicate that one of the parenting partners is not fully "hooked in" as a co-parent, or, alternatively, that one or both of the co-parenting partners cannot refrain from intruding upon or undermining the other's parenting efforts, the family's parenting alliance is not on solid footing, and coparenting solidarity is at issue for them. Over the past several years, numerous studies linking marital distress to these sorts of coparenting difficulties have borne this suspicion out (Belsky, Crnic & Gable, 1995; Floyd, Gilliom & Costigan, 1998; Frosch, Mangelsdorf & McHale, 1998; Katz & Gottman, 1996; Kitzmann, 2000; Margolin, Gordis & John, 2001; McHale, 1995).

A third hunch has been that certain early-emerging coparenting and family patterns, if carried on over time, will come to erode children's certainty and security in the essential integrity of the family unit itself (c.f. McHale, 1997; for related theoretical arguments, see Cummings & Davies, 1996; Byng-Hall, 1995). It is important for dyadically oriented clinicians to take note that we are referencing here a "family-level" security among children, and not insecure caregiver-child attachment relations; the two may or may not be related. Certainly included among the family patterns that may sensitize child sensibilities and concerns about the integrity of the family unit are the dynamics of overt co-parental disengagement or antagonism; in such cases child insecurity may be especially keen. Beyond these extremes, however, we have also come to believe that the risk of insecurity is likewise present in many other families where there is not a disengaged parent or a contentious coparenting pair - but where our observations reveal the somber, joyless family group process referred to above. In these low harmony, low positivity families there are very low levels of inter-adult cooperation or of any vibrant, positive affective connection among the family's various members.

Especially prominent among this latter group are quietly angry and/or "depressive" families in which clinician-researchers find no evidence of pleasure, collective spirit — or cohesion, in Olson's terms. But there are also many families within this group that are less clearly dispirited but in which both parents' attentions are focused exclusively and intensively on the child – and not on one another. Dyadic parent-child relations observed within such family group interaction may be colored by varying degrees of positive affect – but the interactions lack any accompanying evidence of warmth or pleasure expressed between the adult partners themselves.
Such families have proven to be very commonplace in our studies, and we have termed them "child-at-center" families (McHale, Lauretti, Talbot & Pouquette, 2002). While we know little about these families, their unique origins, or their guiding family scripts as of yet, we are in the process of examining whether, when, and why child insecurity may ultimately surface in certain subsets of these families — and whether child distress once documented is best predicted by the particular family-level dynamic we've described (i.e., by the intensive child focus and absent inter-parental connection), or by some other family risk factor or combination of factors.

A fourth key hypothesis guiding our studies is that, beyond the impact that certain family processes may have on the child's felt security with and within the family unit, there are any number of other potential routes via which distinctive coparental and family-level dynamics come to shape unique patterns of infant, toddler, and child adjustment. For example, as toddlers become adept verbally and begin to interiorize parental rules, directives, and expectations, many fortunate children encounter only fleeting and occasional dissonance in their coparenting figures' rules and directives, with consistency, predictability, and coordination between the coparents dominating in their daily lives. Others, however, are forced to contend with badly misattuned sets of expectations promulgated by the different coparenting individuals in their lives.

For those children with parents on completely different wavelengths about whether it is acceptable for the young child to express anger, about whether even routine independent exploration and mistakes are growth-promoting or dangerous, about whether meal-time, bed-time, and other routines are structured and immutable or fluid and capricious, and so forth, internalization of rule-governed behavior for the toddler is a challenge. Early on, if inter-parental dissonance becomes a regular family theme, toddlers may show evidence of mild to moderate disruptions in self-regulatory skills. Taking a longer view, having to master and live by very different sets of rules and routines for different family figures and circumstances may ultimately come

to encourage greater secrecy and deception and perhaps even disruptions in moral development.

These are a few of the core assumptions guiding our investigations. It is also important to emphasize, however, that while we have been emphasizing the impact of coparental dynamics on infant and toddler development, the child likewise has an impact on the developing family group dynamic (McHale, Kuersten-Hogan & Rao, 2004). This is true both of global characteristics such as temperamental difficulty (McHale, Kazali, Talbot, Rotman, Carleton & Lieberson, 2004), and of moment-to-moment behavioral transactions embedded within the family process. In a masterful dissection of infant affective sharing and triadic competencies, Fivaz-Depeursinge and colleagues (2000) demonstrated that 4-month-old infants who witnessed a greater capacity for triangulation (affective sharing with both parents in rapid succession) were more likely to belong to cooperative family alliances. Whether Fivaz's data are interpreted as indicating that the infants benefited from a more effectively functioning alliance, or whether they are taken to indicate that emergent infant capacities came to drive the development of the alliance is a moot point, as infant and triadic development evolve in lockstep fashion. Clearly, it is short sighted to fall into the trap of thinking principally about how coparenting patterns shape infant and toddler development, as the relationship between family-level and child characteristics is a tightly interwoven dialectic.

Macro vs Micro: What do Clinicians Attend to When Evaluating Early Coparenting Process?

The Fivaz et al discovery concerning triangulation and infant contributions in the LTP, following in the footsteps of their prior reports regarding the meaningful minutiae of physical and affective contact during triadic sessions (Fivaz-Depeursinge, Frascarolo, & Corboz-Warnery, 1996; de Roten et al., 2000) ignited for several of us a newfound appreciation for the important clinical insights that can be provided by micro-genetic analyses of family interaction. They also heightened our curiosity about what exactly it might be that clinician-researchers have been taking note of in our own studies when they determine that one family is warmer, more cooperative, or more competitive, than another. To begin addressing this question systematically, we set out in a recent project to scrutinize one small sub-set of the many possible micro-exchanges embedded within our family interaction sessions, in an effort to establish whether such micro-events contributed to separately obtained global, clinical impressions of the family rendered by expert clinician researchers intimately familiar with our evaluation system. As a starting point for this work, we selected three co-parenting dimensions (family warmth; co parental cooperation and competition) that have proven particularly important in our past empirical studies and that are reliably detected by trained clinical observers.

We then drew upon family interaction data sampled during an adapted variant of Fivaz-Depeursinge and Corboz-Warnery's LTP procedure, gathered from 50 families seen in their homes three months after the arrival of their first-born infants. 24 of the families we worked with had had a first-born daughter, and 26 a first-born son. During the visit, researchers guided the family through the adapted LTP assessment, which consisted of the following three interactions: 1) a brief face-to-face interaction involving one parent and the baby, with the second parent in the role of "third party" — "present" but not active; 2) a parallel interaction involving the second parent and baby with the first parent assuming the role of "third party"; and 3) a triadic interaction in which all three family members were active.

For the purposes of our microanalysis, we examined family process data obtained during Part 3 of the LTP, the mother-father-infant triadic interaction. During this segment, the two parents engaged together with their baby for approximately two minutes, without any specific directives concerning how the play itself should be structured. The full interaction was videotaped and coded following the home visit. During the coding phase, two sets of trained, independent raters provided either (a) ratings of specific behaviors and sequences embedded within the session (see below); or (b) global clinical judgments of inter-adult competition, cooperation, and overall family warmth observed during the session (using Carleton, Rotman, & McHale's 2000 rating system, itself adapted for families with younger infants from McHale and colleagues 2000 Coparenting and Family Rating System, or CFRS).

We decided upon the particular sequential phenomena to examine in this study following several "open", unstructured formative viewings of the triadic interaction videotapes. These formative viewings were completed for the purpose of identifying patterns of behavior within the interactions that might later be captured within a structured coding system. After several viewings, it became evident that the triadic sessions were actually comprised of several distinct interactive bouts. Typically, these bouts proceeded as follows: someone (either the baby or one of the parents) would make a bid (through directed verbalization, gaze or touch) and establish contact with someone else. Engagement would continue either until someone became bored or broke the set – or, until the family member who had not been included in the dyadic interaction insinuated his or her way into the flow. Such efforts to join then prompted reorganization, and a new interactive bout began.

The micro-analytic coding scheme we devised to capture these interactive phases documented all initiations, specifying the initiator of each new

interactive bout (mother, father, or baby); a "simultaneous initiation" code was later added to capture rare instances when the two parents simultaneously initiated an interaction with the baby. Each sustained interaction, regardless of duration, was documented as a single episode. Recorded in the coding system were: (a) how the person who had been addressed responded to the initiator (i.e. by noticing and responding to the bid, or by ignoring it); and (b) what the third family member who had been "left out" of the approach sequence did following the initiator's approach. Since it often happened that initiators summoned babies away from an ongoing engagement with the other parent, we also examined (c) how the "left" parent dealt with this "abandonment" (i.e. deferring or holding back, remaining involved at the same level of intensity, or intensifying stimulation of the baby); and (d) how the initiator responded if the baby ignored their bid and continued their engagement with the other parent (i.e. deferring so as to give the dyad interactive space, or persevering in efforts to attract the child).

As indicated, for the global clinical ratings trained clinicians used the system of Carleton et al. (2000) to evaluate their overall impressions of inter-adult cooperation, antagonism (competitiveness), and family warmth. Cooperation scores captured the extent to which partners supported one another's initiations with the child, through affirmative comments (e.g., "hey — look what Daddy's doing!"), through physical or verbal co-action (swinging the babies hands in unison, singing a song together), or through benign support (i.e., watching actively, with interest, but refraining from doing anything that would distract the baby's attention from the parent with whom they were already playing). Competition scores reflected the degree to which parents interfered with one another when they were addressing the baby. Such intrusiveness could be conveyed either verbally (e.g., by commenting, "Look at Mom, don't look at Dad"; voicing, "Dad, I don't want to do that" on behalf of the baby; singing to distract baby's attention from the other partner) or behaviorally (e.g., by touching, tickling, etc., while the baby was engaged with the other partner). Family Warmth scores reflected consistency and genuineness of positive affective exchanges among family members. To receive the highest scores, warmth needed to be conveyed between parents as well as between parents and children.

Our hunch that clinicians' attention was being captured largely by the degree of coordination between parents at the level of interruptions (followed by ongoing activities including continuing stimulation vs. deference) was partially borne out in the pattern of associations that obtained between the micro and macro ratings. Perhaps not surprisingly, the clinical judges in our study were more likely to rate families negatively when the co-parenting partners interrupted one another more frequently. Specifically, the greater the number of interruptions of partner-baby interaction, both by mothers *and* by fathers, the more likely clinicians were to rate the family interaction as antagonistic or competitive (see Tables 1 & 2). In addition, clinicians rated triadic interactions as lower in *warmth* when

TABLE 1
Associations Between Micro and Global Ratings of Mothers' Behaviors: Pearson Correlations

Micro Ratings	Coop	Comp	Family Warmth
Mother initiates an interaction while baby and father are engaged	0.0	.31*	-0.1
Mother defers when baby does not respond to her initiation	-0.08	0.23	-0.24
Mother perseveres when baby does not respond to her initiation	-0.13	0.27	-0.22
Mother quits interaction with baby when father interrupts	-0.19	.33*	-.29*
Mother maintains level of engagement when father interrupts	0.04	0.06	-0.06
Mother intensifies her stimulation when father interrupts	-0.06	.30*	-0.03

* Correlation is significant at $p < .05$ (2-tailed)

Table 2
Associations Between Micro and Global Ratings of Fathers' Behaviors: Pearson Correlations

Micro Ratings	Coop	Comp	Family
Warmth			
Father initiates an interaction while baby and mother are engaged	-0.12	.33*	-.30*
Father quits when baby does not respond to his initiation	-0.26	-0.08	-.30*
Father perseveres when baby does not respond to his initiation	0.18	.32*	-0.01
Father quits interaction with baby when mother interrupts	-0.17	0.19	-0.24
Father maintains level of engagement when mother interrupts	0.17	0.08	0.22
Father intensifies his stimulation when mother interrupts	0.25	0.06	0.25

* Correlation is significant at $p < .05$ (2-tailed)

fathers interrupted preexisting dyadic interactions between baby and mother. However, these same judgments of family warmth were not significantly influenced by *mothers'* interruptions (see Table 2).

Beyond the sheer number of interruptions, certain sequences of behavior were also clearly linked to clinicians' global impressions. For example, clinicians rated family systems as more competitive when fathers showed greater propensities to persevere in trying to engage the baby following an unsuccessful initiation (see Table 2). Somewhat paradoxically, though, these same data also indicated that families in which fathers pulled back and *deferred* or disengaged when their infant did *not* respond to their initiation were rated by clinicians as lower in familial warmth.

So father's efforts to join and their responses when rebuffed were very salient to clinicians — but it wasn't at all clear what the best recourse for an ignored father was! When he persisted, judges saw competitiveness; when he disengaged, they saw a lack of warmth. This finding may not be too far from the course for bewildered first time fathers attempting to find their place in the new three-person family system. These data also underscore the role of infant behavior in affecting clinicians' ratings – when infants ignored fathers' interruptive bids rather than responding, clinicians made more negative judgments about the coparental process no matter what fathers did. When infants ignored mothers' bids, coparenting ratings were not as reliably affected by the mothers' subsequent responses (though as Tables 1 and 2 indicate, the magnitude of several pertinent correlations for the mother data were not substantially different from those for the father data, as several associations approached significance).

Last we imply that it was principally fathers' behavior swaying clinician ratings on all fronts, however, it is important to emphasize that our data also suggested that there may be some salience attached to what mothers do once they've been interrupted by fathers. Recall that the more frequently fathers deferred after their initiating bids to the infant had been ignored, the more likely the family was to be judged low in warmth. Paralleling this finding, our data indicated that the more mothers deferred and drew away after fathers interrupted their interaction with the baby, the more likely the family was to be judged low in warmth (see Table 1). Oddly, maternal deference was also linked with global ratings of competition, a finding we cannot fully explain. Finally, and certainly not surprisingly, co-parenting teams were judged to be most competitive when mothers' *intensified* their stimulation of the baby in the face of an interruption by the father, rather than deferring and making room for the interaction.

In reflecting upon these data, we found it interesting that sequences triggered by fathers' behavior were particularly influential in the formation of clinical judgments (see Table 2). That is, families were rated as more antagonistic whenever fathers interrupted, regardless of whether mothers responded by pulling back from their interaction with the baby, or by intensifying their stimulation of baby. With respect to fathers' engagement with the baby, families were rated as more antagonistic in cases where fathers persevered in attempting to join mother-baby interactions if the infant did not respond to an initial interruptive attempt at joining, but as *less warm* when father retreated from the interaction following his interruption when baby did not respond. Collectively, these data hint that fathers' behavior may be particularly salient to clinicians ostensibly evaluating *family* processes and interaction patterns.

What are the implications of the finding that in the early post-partum months, clinicians may attend differentially to patterns of interaction launched by *father's* behavior rather than patterns triggered by mother's behavior when assessing coparenting and family process? As we have argued elsewhere (e.g. McHale & Fivaz-Depeursinge, 1999), early caregiving is inevitably seen as the province and domain of women, even in an era when father involvement among men in many Western societies has dramatically increased. It is perhaps not surprising then that it is fathers' efforts at engagement within the family triad, whether enabled or rebuffed by mothers, that captures the attention of even clinicians who have been explicitly trained to evaluate the joint process between coparenting partners. It is also of special note, though probably not surprising, that clinicians' evaluations of the coparental process are likewise adversely affected the more frequently infants rebuff the initiating bids of their parents.

We present these data principally for heuristic and illustrative purposes, and to underscore the utility of microanalytic tracing of sequences as a tool for understanding how it is that clinicians come to their overall clinical judgments about families. We recognize limitations inherent in the coding system we developed, relative to more finely honed schemes such as that of the Lausanne group. For example, our categorization of parents' reactions to interruptions (intensifying, sustaining, or deferring engagement) was a relatively crude one, not attempting to make distinctions of when deferments might constitute mild disengagement and when they might constitute continuing interactive readiness. In Fivaz and colleagues work, such distinctions are made (e.g. when one parent leans forward and the other back in the 3-togethers, the coparenting partners are said to fail to display equal interactive readiness). Moreover, our focus only on interruptions and behavioral sequences following the interruptions did not take into account critical processes of affective attunement and synchronization, features that have proven important in prior work (e.g. Horner 1985; Stern 1990; Schore 1994; Thelen & Smith 1994). We know from

Tronick's (1989) work, for example, that when caregivers are poor at repairing breakdowns in dyadic interaction, there is a marked decline in interactional synchrony. Though the data described above did not directly address this issue, it appears from the patterning of associations between the micro and global ratings that similar processes may have characterized triadic processes as well – the greater the number of breakdowns, interruptions, and false starts in communicative encounters clinicians observed among members of the triad, the more likely they were to judge the coparental alliance critically.

Coparenting, Triadic, and Family Group Evaluations: Implications for Clinicians

So how are any of these findings of practical use to clinicians? Recently, we have discussed in some detail what we view as the essential clinical implications of the first decade of coparenting research (McHale, Khazan et al., 2002) and we will not reiterate all of these at length here. We will, however, highlight a few key points that we believe capture the spirit of this work and its relevance for practicing infant mental health professionals. First, it is important that clinicians working with families recognize that triadic interactions, which highlight the parents' coparental capacities and propensities, reveal something unique and important about the family's modus operandi. It is not possible to guess what sorts of coparental or family group dynamics will be in evidence from observations of the individual mother-infant and father-infant dyads alone (McHale, Kuersten-Hogan, Lauretti & Rasmussen, 2000). Similarly, clinical evidence indicating the presence of severe conflict or disengagement in the marriage certainly suggests that problems will be seen in the coparental relationship (Belsky et al., 1995; Katz & Gottman, 1996; Margolin et al., 2001), though the form these coparental problems take do not always mirror or recapitulate the nature of the difficulties the marital pair is experiencing (McHale, 1995). For these reasons, a thorough evaluation of the child's socialization environment need necessarily involve family group assessments.

Existing data also indicate that such evaluations are of incremental value in understanding child behavior problems (Belsky, Putnam & Crnic, 1996; McHale, Johnson & Sinclair, 1999; McHale & Rasmussen, 1998). That is, documenting coparental distress can help illuminate why certain children experience problems with adjustment, not just when parenting problems exist, but also when there do not appear to be any major disruptions in dyadic parent-child relationship functioning per se. It is also important, in evaluating the coparental alliance, to go beyond brief observations of families of the sort we have been describing here to probe parents' beliefs about the coparental partner. For many of the destructive communications between parents and children that shake the older child's sense of security in the stability of the coparental unit and family group take place in private, during one-on-one communications between parents and children about the absent coparental partner (McHale, 1997). Parents are aware of their propensities to be disparaging in this way and are often open to sharing them with clinicians and researchers. Children, too, as young as 2 ½ or 3 can be useful informants and capable of communicating their sense that something is amiss in the family group during structured family doll placement assessments (McHale et al., 2002; McHale, Neugebauer, Asch & Schwartz, 1999).

These things said, it is also important for those working with young families to recognize that normatively there is a period of family destabilization that is often reflected in the family group process during the early months of new parenthood (McHale, Khazan et al., 2002). Relative to levels of coordination and affect sharing observed between the coparental partners during the prenatal period, early family process is more disjointed and fraught with miscoordinations (Fivaz-Depeursinge & Frascarolo, 1999). The state of our empirical work thus far is not such that we can be prescriptive or provide unequivocal guidelines concerning definitive thresholds beyond which clinicians should view families at risk. Indeed, we are quite some time away from being able to advance evidence-based practice in working with family triads. At the same time, however, there have been some informative articles outlining case study interventions using the LTP or variants of the LTP procedure and relying on video recordings and interaction guidance (McDonough, 1993) that have been published, including some in this publication (e.g. Hedenbro, 1997; Keren, Fivaz-Depeursinge & Tyano, 2001). Such interventions typically aim not just to increase engagement and attunement with the infant, but also to delimit intrusiveness, competitiveness and interference, while promoting interparental cooperation.

The main consideration for clinicians evaluating coparental and family group process is, of course, to estimate the nature of the family alliance. Whether working within Fivaz-Depeursinge and Corboz-Warnery's (1999) fourfold scheme of such alliances as being disordered, collusive, stressed, or cooperative, or guided by classic family therapy notions of disengagement and enmeshment (which can often be seen in the very same family interaction), coalitions, triangulation, and scapegoating, the data with which clinicians work are the same. At the extremes, clinicians observing the triangular family process note intrusive behavior and/or detached uninvolvement. More commonly, however, clinicians should be attentive to more modest signs of stress, noting such signs as family members postural orientations, signifying their readiness to interact; the ongoing quality of the

family's affective tone (warm and pleasurable, negative and antagonistic, somber and joyless) – including the connection between the adult parenting partners, the frequency of interruptions (with a greater number signifying numerous failed efforts to join), and relatedly, the affirmation (or rebuffing) of the joining parents' bids by the engaged parent. These are all features of the interactive process that can be underscored and pursued with parents, and placed within the context of the significance of a strong coparental alliance in promoting healthy infant development. The next frontier for this field of work will be marshaling evidence of the incremental value of strengthening coparental and family alliances among couples in distress. As we have suggested elsewhere, the coparental alliance may be a more acceptable point of entry and intervention to parents than the marital relationship per se (McHale, Khazan et al., 2002).

In Closing: Where We are, and Where We're Going

Valuable though the recent empirically based work may be, findings from these investigations are probably not particularly startling to seasoned clinicians – especially those who have been trained as family therapists. Using the gains and insights from this work to move toward evidence based practice, however, is indeed an important new frontier and one that research to date suggests may be a very fruitful enterprise. Striking upon the best blend of interactive guidance and more direct, conventional therapeutic interventions with the marital dyad is a pursuit that awaits interventionists and clinical researchers in the years ahead.

As with all other work in the infant mental health field, it will be crucial for those undertaking such pursuits to keep in mind that all parents want to do the best they can for their babies, and that some dissonance in views about how best to raise children are probably almost inevitable and even desirable. Quite often, impediments encountered in the family group process may stem from both individuals working to effect a different state of affairs than they themselves encountered in their own origin families – but perhaps unwittingly doing so at cross-purposes with one another's efforts. In working with families to promote greater positivity, organization, and cohesion, it will remain critical that interventionists relate to parents on the basis of partnership, not power, modeling the co-constructed relationships they wish to promote.

Beyond these emerging practice-related issues, of great conceptual interest are two related topics sparked by recent empirical work on the family triad. The first stems from the finding that meaningful family group patterns begin to consolidate even in the earliest postpartum months. In recent years, theoretical discussions of early parent-infant interactive processes (usually involving discussions of dyadic dialogues) have highlighted such distinctions as whether dyadic interaction should be seen as truly reciprocal, with even very young infants bringing affective communication capacities, or whether they are largely unilateral, with parents enacting this reciprocity (Kaye, 1982); and whether communication is best seen as largely linear, with information transmitted and decoded, or whether it is co-regulated, with an aggregate pattern emerging from this co-action. Though our position is that triadic interactions are most appropriately conceptualized as a creative dance, susceptible to being continuously modified by the continuously changing actions of each partner (Fogel 1993), available data from the longitudinal studies of Fivaz-Depeursinge and her colleagues substantiate that meaningful aggregate patterns do emerge from this mutual co-action.

Second, available data do clearly support family communication as a co-regulated activity. Though reports from various studies of coparenting dynamics have sometimes erred in the direction of focusing on the parents rather than on the infant's participation (see McHale & Cowan, 1996), data from completed studies of early triadic process are clear that infants themselves help shape these dynamics. They certainly do so by virtue of their temperamental propensities (McHale, Kazali et al., 2004). But also, as this study and prior reports from Fivaz and colleagues reveal, they do so directly through signaled inclinations to engage (or not) with parents during triangular family commerce. Indeed, emerging data from the investigations of Fivaz-Depeursinge (1998; 2002; Fivaz-Depeursinge, Favez & Frascarolo, in press) reveal that infants as young as 3-4 months of age are already showing the capacity to shift gaze, affect and attention between the two parents in a coordinated manner (see also Nadel & Tremblay, 1999).

This latter finding, concerning even very young infants' nascent capacities for handling triangular interactions, is perhaps one of the most provocative discoveries emerging from research on early triadic interactions. It is consistent with recent conceptual positions that suggest a primary form of intersubjective communication on the part of infants (Rochat & Striano, 1999; Stern, 2000) from the earliest months – one that precedes, and perhaps even sets the stage for, the understanding of intentionality. Indeed, Fivaz-Depeursinge (Fivaz-Depeursinge, Favez, Lavanchy, de Noni & Frascarolo, in submission; Fivaz-Depeursinge, Favez & Frascarolo, in press) has persuasively made the case that infants are members of multiperson relationship systems from the moment of birth on, and hence the capacity to manage more than two-person interactions from the outset and to establish threesome or collective intersubjectivity among the members of a social group would be advantageous. Triangular interactions afford possibilities not present in dyadic exchanges, including social feedback provided by a third party and an increase in the

number of possible interactive contexts, thereby multiplying the possibilities for imitation and convergent experiences (Fivaz-Depeursinge, 2001). Though this line of investigation is as yet in its infancy, it promises a very fruitful avenue for future work on the relevance of the primary triangle.

We hope that this review of recent studies of the family triad enhances the attention that infant mental health professionals pay to the complex, multiperson relationship dynamics and processes guiding infant development. This work is truly in its infancy and promises many exciting adventures on the horizon.

University of South Florida,
St. Petersburg
140 Seventh Avenue South
DAV 249
St. Petersburg, Florida 33701
FAX 727-553-4526
e-mail: jmchale@stpt.usf.edu

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IMH TRAININGS AROUND THE WORLD

The Signal will be running a series of pieces through the next year featuring examples of IMH trainings around the world. Please send any submissions for this section to paul@pbarrows.freeserve.co.uk

AUSTRALIA:

Graduate Diploma in Mental Health Sciences - Infant and Parent Mental Health

Master of Health Sciences - Infant and Parent Mental Health

Faculty of Medicine Dentistry and Health Sciences, and the University of Melbourne

By: Assoc. Prof. Campbell Paul, Dr. Brigid Jordan, Frances Thomson Salo

These courses were set up in 1996 at The University of Melbourne, one of Australia's oldest established universities. The Graduate Diploma is the foundational qualification and a prerequisite for undertaking the Masters course.

The Graduate Diploma and the Masters developed out of clinical and teaching work of the Infant Mental Health Group at the Royal Children's Hospital headed by Associate Professor Campbell Paul. The Infant Mental Health Program also offers M.D. and Ph.D. by thesis.

The course curricula were developed to meet a gap in available training as no other courses in Australia at that time prepared clinicians for the specialized field of infant parent psychotherapy. The Diploma provides theoretical and observational foundations for beginning to work with infant mental health problems and draws on the disciplines of psychiatry, developmental psychology and psychoanalysis for its theoretical basis. It is a one-year full time course. The Masters course aims to provide a thorough knowledge of the principles and practice of infant mental health and equip students to directly apply the knowledge and skills gained to intervene effectively with infants and families presenting with infant mental heath problems.

These courses are aimed at health care professionals working in the infant mental health field, who wish to develop their understanding and clinical skills in working with infants and parents or who are interested in participating in service development, delivery and evaluation. Both courses focus primarily on the baby and infant/parent relationships and provide training in skilled assessment and intervention with infants and families.

Nearly one hundred students have graduated with the Diploma and a smaller number have completed the Masters, as it is a more intensive clinical training. Students have come from a range of professional disciplines and include General Practitioners, Psychiatrists (child and perinatal), pediatricians, child psychotherapists, marital therapists, maternal and child health nurses, speech pathologists, occupational therapists, physiotherapists, social workers, clinical psychologists, early childhood educators, pediatric nurses, psychiatric nurses, a geneticist, policy advisers, and child protection social workers. This multi-disciplinary mix enriches students' learning from each other. In recent years we have been able to offer both courses by distance education using video and printed materials and telephone link-up to Infant Observation seminars. This has enabled students from as far away as West Australia and remote rural communities to enroll and we have inquiries from students in Asia for the upcoming academic year.

THE GRADUATE DIPLOMA

Infant Observation

Infant observation is the major component of the Graduate Diploma course and is taught according to Esther Bick's model. Students develop observation skills, which are fundamental to all therapeutic work, and they gain an appreciation of their own responses and how to use these in working with infants and their families. The weekly seminar develops this understanding and the skills of observing and provides a basis for subsequent discussion of the literature on infant observation and the applications of this method. As the core faculty currently treats over two hundred infants a year, this influences the interpretation and understanding of the material brought by the student observers. In addition to understanding transference and counter transference phenomena, there is an emphasis on understanding the developing mind of the infant, the infant's perspective, and the infant's relationship with the observer and reaction to being observed.

Infant observation runs for the academic year and seminars can continue after this by arrangement with seminar leaders. The possibility of an Honors stream to continue the observation for a further year is being explored.

Theoretical Subjects

Students are introduced to the theoretical foundations for understanding all aspects of the infant's development and infant/parent relationships. Methodologies with which infants have been observed and studied are examined and students become familiar with key psychoanalytic and psychodynamic concepts and models for understanding the infant and family experience. There is a particular focus on the work of Winnicott, Klein and Bion as well as leading contemporary Object Relations theorists and clinicians. Theories of child rearing including cultural aspects, how family and social context impinges upon the infant's development, and some common problems of early infancy are also examined. Students are introduced to the techniques used in communicating with and assessing infants, and examine the different models of treatment and some of the therapeutic results of such intervention.

Teaching materials and resources are drawn from historical as well as current sources from the UK, Europe and the Americas. In this way, students are introduced to the pioneers of the field such as Darwin, Spitz, Engel, and Fraiberg, as well as the rapidly proliferating number of contemporary clinicians and researchers.

MASTERS BY COURSEWORK

The Masters course is structured as a part time course over two years to ensure that the academic and clinical training is integrated with the students' own clinical work and personal development. There are seven subjects (each of which has a take-home examination of 3,000 words) and a minor thesis (externally examined) of 12-15,000 words. Each Masters student is allocated a Mentor from the Core Faculty with whom they can discuss their progress in the course.

Outline of Masters Course:

The Psychopathology and Infant Mental Health Practice subjects are taught on alternate weeks to ensure linkage between the materials in each subject.

Clinical Seminar (Year 1 and Year 2)

Students present their own clinical work in the seminar groups and are expected to bring videotape of their work when it is their turn to present. The seminar discussion of the student's clinical work focuses on selection of appropriate assessment techniques, specialized assessments (including assessments of parenting capacity and protective assessments), the selection of appropriate treatment techniques, recognition of the implications of treatment including legal aspects, the development of skills in different therapeutic modalities (infant parent psychotherapy, infant psychotherapy, developmental guidance), understanding the therapeutic process including transference and counter transference phenomena, referral and liaison skills, advocacy skills, the place of the infant mental health worker in health and welfare systems and cultural and gender issues in clinical work.

While this seminar does not substitute for professional training and needs to be supplemented by other experiences it lies at heart of each student's journey in clinical work.

Psychopathology (Year 1 and Year 2)

This subject encompasses the clinical features, etiology, epidemiology, severity and prognosis of regulatory disorders, psychosomatic illness, attachment and interactional problems, reactive disorders, parental psychopathology and infant mental health problems where infants have a medical or surgical illness, developmental disorders or have suffered trauma, neglect or abuse.

Infant Mental Health Practice (Year 1 and Year 2)

This subject focuses on the clinical and theoretical knowledge base for infant mental health practice including principles and practices of assessment and diagnosis, models of infant parent psychotherapy, treatment planning, therapeutic consultations, prevention and early intervention, consultation liaison, and social policy and public health implications of infant mental health practice.

Research Methods and Minor Thesis

This subject equips students to utilize and contribute to research in the infant mental health field, identify research needs and formulate research questions, and be able to select research strategies to appropriately answer research questions in the field of infant mental health.

Students are expected to conduct a research project and write a thesis of 12-15,000 words on a topic pertinent to infant mental health practice. Theses topics in the past have included: autism, action research in a mother baby hospital, the relationship between maternal fantasies in pregnancy and subsequent feeding relationship, early infant parent relationships and toddler behavioral disturbances, mothers experience of 'controlled crying' methods used in a mother baby hospital, and the feeding relationship for infants with feeding tubes.

Admission Criteria

Students for the Diploma are selected from applicants with degrees or equivalent training in medicine, psychiatry, psychology, nursing, social work, speech pathology or other related health disciplines. Applicants are expected to have at least two years clinical experience, and should be currently working or anticipate working with babies, toddlers and their families.

Students undertaking the Master of Health Sciences (Infant and Parent Mental Health) require an Honors pass in the Graduate Diploma Mental Health Sciences (Infant and Parent Mental Health) or an equivalent qualification. Students need to be currently working with infants and their families and have demonstrated an appropriate level of clinical competence and expertise.

MASTERS BY RESEARCH, DOCTOR OF PHILOSOPHY and MD

These research degrees are also offered to suitably qualified candidates. An MD student is currently following up a cohort of infants admitted to the hospital with persistent irritability.

Faculty and Teaching

In addition to A/Prof Campbell Paul, the core faculty comprises Frances Thomson-

Salo and Brigid Jordan, PhD. Frances Salo is a psychoanalyst who trained with the British Psychoanalytic Society and is a training analyst for the Australian Psychoanalytic Society. Brigid Jordan is a Psychiatric Social Worker and Infant Parent Psychotherapist, Consultation Liaison Psychiatry Program at the Royal Children's Hospital. Guest lecturers are drawn from the Infant Mental Health Program at the Royal Children's Hospital and other Infant Mental Health Programs and visitors from interstate and overseas. The location of the Faculty in clinical programs in an acute tertiary pediatric teaching hospital setting allows for fresh clinical teaching with case illustrations constantly being updated.

Conclusion and Outcomes

The establishment of these courses has increased the recognition of the field of infant mental health as a specialized field of practice. Faculty participates in teaching on the medical undergraduate courses, and on the child and adult psychiatry and child and adult psychoanalytic psychotherapy training program.

Student feedback from both courses has been consistently positive. Students report that the courses enable them to become more competent and sensitive clinicians and that participation in the courses has led to considerable personal development. Experienced clinicians including maternal and child health nurses have described how the infant observation experience, in particular, has changed the way they look at and interact with infants. Some students have changed the emphasis of their clinical practice, an example being a pediatrician moving from General Pediatrics to concentrating on an infant mental health practice.

MICHIGAN, USA:

Plan for the ENDORSEMENT of Professionals in the Infant and Family Field Developed by the Michigan Association for Infant Mental Health

After years of dedicated work by members, and with support from the W.K.Kellogg Foundation, the Michigan Association for Infant Mental Health is proud to announce a new initiative... the MI-AIMH Endorsement for Culturally Sensitive, Relationship-based Practice Promoting Infant Mental Health!

First, an overview of what the Endorsement is all about...

The intent of the MI-AIMH Endorsement Process is to recognize and document the development of infant and family professionals within an organized system of culturally sensitive, relationship-based, infant mental health learning and work experiences. Endorsement by the Michigan Association for Infant Mental Health (MI-AIMH) will verify that an applicant has attained a specified level of education, participated in specialized in-service trainings, worked with reflective guidance from mentors or supervisors, and acquired knowledge to promote the delivery of high quality, culturally sensitive, relationship-based services to infants, toddlers, parents, other caregivers and families.

The Process

The process begins when a potential candidate calls or e-mails the MIAIMH Central Office to inquire about Endorsement. The office will send a general Endorsement brochure and a Preliminary Application. The candidate then returns the Application, along with the application fee, to the MI-AIMH Central Office. Upon review of the application, the Central Office confirms at which level the candidate is applying and forwards the informational packet to the candidate, including Competency Guidelines and all of the materials needed to complete the application. The office also assigns each candidate a MI-AIMH advisor to assist with the application process. The candidate creates his/her professional portfolio, submits it to the Central Office for review and prepares (if applying at Level 3 or 4) to take the written examination.

*The portfolio consists of a list of all relevant educational experiences accompanied by an official transcript from all college courses, degrees and/or certificates; a description of in-service training experiences relevant to culturally sensitive, relationship-based practice promoting infant mental health; a description of all paid work experiences with/related to infants, toddlers, caregivers and families; a list of reflective supervision experiences (Levels 2,3, and 4); three professional reference ratings; and a signed Code of Ethics.

*The written exam is a three-hour exam made up of multiple choice questions and clinical vignettes. Designed by university faculty and experienced infant mental health professionals and field tested by practitioners in the infant and family field, the exam focuses on knowledge and direct service experiences promoting infant mental health.

*A three-member panel, appointed by the MI-AIMH President and the Endorsement Committee Chair will review all of the materials in the portfolio and review the written exam (appropriate at Levels 3 & 4). The panel will take all of the materials into account when making recommendations to the Endorsement Committee regarding endorsement.

The MI-AIMH Endorsement Competencies

The MI-AIMH Endorsement Committee worked closely with systems specialist, Valerie Brown, to develop competencies and behaviors demonstrating competency within the infant and family field at each level of endorsement. The process was ambitious and took place over several years.

The committee first reviewed the knowledge and competencies for infant mental health specialists that the Michigan Association for Infant Mental Health recommended in 1986. Committee members referred to these competencies when identifying competencies for infant mental health specialists working within an Early On (early intervention) framework. Training specialist Valerie Brown convened focus groups across the state to further specify infant mental

health specialist competencies and behaviors. A subset of infant mental health professionals kept work journals and submitted them for review. All of the materials were collected and, with guidance from Ms. Brown, the committee reached consensus on competencies and behaviors demonstrating competency at levels 3 and 4. They worked similarly to develop competencies and behaviors for levels 1 and 2.
The review process was time-consuming, complex and required many revisions by committee members, MI-AIMH board members and professionals in the field.
The end result is a 30-page document that suggests the depth and breadth of the infant and family field, beginning with the infant and family associate and specialist and continuing with the infant mental health specialist and mentor.
The competencies and behaviors demonstrating competency offer guidance to individual professionals entering the infant and family field, to university faculty and in-service trainers, as well as direction to program supervisors and administrators who have a commitment to building quality services for infants and families in multiple service settings and at various levels of risk. The competency document may be ordered separately through the MI-AIMH Central Office (dkahraman@guidance-center.org) for $20.00 plus shipping expenses.

A summary of the requirements for the four levels at which candidates may be endorsed appears below in the box:

Although designed by Michigan practitioners and policy makers, the MI-AIMH Endorsement is relevant to providers beyond Michigan's state borders. Many WAIMH Affiliates have expressed interest in the MI-AIMH Endorsement- we invite your inquiries! This is a pioneering effort on behalf of strengthening the infant and family work force promoting infant mental health.

When asked why they wanted to earn the MI-AIMH Endorsement, practitioners explained:

"It validates that we really have the special knowledge and skills to work with infants and families."

"It will assure that well-qualified people will be hired into our infant and family programs."
"The Endorsement offers a pathway to individual development in a rapidly growing field."

"Once under way, the Endorsement will assure that the work we believe in - infant mental health - will continue!" "It protects the way that early intervention services are delivered to babies and families."

Information about the competencies and the endorsement is posted on the MI-AIMH web site. Just go to www.mi-aimh.msu.edu and click on "About us." You may also call the MI-AIMH Central Office for more information at 734-287-1700 x 1133 or contact DKahraman@guidance-center.org

	Level 1 *Infant Family Associate*	**Level 2** *Infant Family Specialist*	**Level 3** *Infant Mental Health Specialist*	**Level 4** *Infant Mental Health Mentor*
Educational Experiences	Associate's Degree	Bachelor's Degree	Master's or Ph.D.	Master's, Ph.D., or MD
In-service Training	30 hours	30 hours	30 hours	30 hours
Signed Code of Ethics	yes	yes	yes	yes
Reflective Supervision and/or Consultation	N/A	Minimum 24 clock hours within a 2 year time frame	Minimum 50 clock hours within a 2 year time frame	Minimum 50 clock hours within a 2 year time frame
Reference Ratings	3 (at least 1 must meet requirements for Endorsement at Level 3 or 4)	3 (at least 1 must meet requirements for Endorsement at Level 3 or 4)	3	3
Written Examination	no	no	yes	yes
Examples	Childcare worker, play group leader, Doula	Early Head Start home visitor, early intervention coordinator, intensive care nurse, parent educator, child welfare worker, health care staff	Healthy Families home visitor, prevention services specialist, clinical nurse practitioner, early childhood specialist, mental health clinician	Infant and family program supervisor, administrator, researcher, faculty member, policy specialist, physician

WAIMH *Affiliate News*

United Kingdom Association for Infant Mental Health

Individually and collectively, a lot of energy from members of AIMH (UK) has been devoted to trying to create a political and professional climate favorable to infant mental health. This has travelled along two parallel tracks, broadening awareness of the need for specialized early intervention services and disseminating the idea that the relevant knowledge and philosophy should be a component of already existing provision.

As an example of the latter approach, delegates from the committee have presented a submission to a Parliamentary Group (composed of peers, MPs and representatives of parenting groups) on the importance of including an IMH component in the training of Health Visitors. Another opportunity is offered by the new Sure Start government initiative (similar to Early Head Start in America), which is designed to put in extra resources for vulnerable children under the age of four. Each Sure Start project serves a limited area of high-risk, and is funded for three years. Relatively few of these projects have incorporated an IMH component, and only after local initiative by committed individuals. Good examples are in Sunderland and Solihull. To date there has been no overall, central willingness to emphasize the importance of dedicated IMH services, although the importance of the quality of the relationship between parent and small child is specifically acknowledged as part of the primary objective of improving social and emotional development. AIMH (UK) has been active in promoting the importance of including an IMH service within Sure Start. In September 2002 a conference was organized on the theme of 'Bidding for IMH Services'; and members of the committee are on the advisory group for social and emotional development that meets regularly with the central office of Sure Start.

Another endeavour to influence government thinking was a paper sent by Paul Barrows, Chairman of AIMH (UK), to those working on the new National Service Framework for Children (NSF). This argued that the zero-to-three age group was not being well served by the current separate provision of mental health services for children and adults, and demonstrated how IMH fell between these two camps. This was argued to be a priority because of the potential offered by early intervention. Unfortunately this did not have the hoped-for impact, although a recent presentation by the chair of the relevant NSF sub-group did specifically refer to the needs of under-fives and one of the Development Workers charged with seeing through the implementation of the NSF has a specific remit for IMH. This worker has asked to meet with the committee of AIMH, so we will see what develops from this.

An alternative route into policy making that has developed is through forging a link with 'Young Minds', a well-established national organization campaigning for better mental health provision for young people. AIMH (UK) has been represented on their council for several years, with the result that babies are now specifically mentioned as a separate group in all their submissions to government. As a result of their new consideration of the mental health needs of babies, Young Minds has published a new booklet aimed at parents entitled 'Tuning into Your Baby.' They are currently planning to write a policy document on the need for dedicated IMH services, to stand alongside similar publications for the older age groups. This is an extremely important organization, with its own monthly magazine, that is frequently called upon for comment by the media and also is used by the government as a source of information that can inform policies and legislation. (Their website is: www.youngminds.org.uk)

Over the last year, AIMH Committee members have been heavily involved with the Child Psychotherapy Trust and their 'Early Days' project. This project gathered information on existing IMH provision within the UK, and they have recently published two relevant booklets. One ("Reducing risks: relationship-based services for babies

and parents") sets forth the arguments for establishing multi-disciplinary IMH teams within our public (or statutory) services, and this also includes a résumé of evidence-based practice in this field; while the other, "Positive beginnings: exploring UK provision for the social and emotional development of babies" does what its title says. Unfortunately, with a total change of personnel in the CPT, the plan to use these booklets to raise awareness of the importance of IMH among health service planners has not been put into action.

As for more internal matters, the theme for the year was violence. Joy Osofsky spoke on "The Effect of Violence on Infants" at the AGM in March. Later in the year Janet Dean and Mary Sue Moore presented their work on 'Violence Within the Family' in Bristol and in Newcastle. AIMH (UK) has also now set up its own website (www.aimh.org.uk) and its newsletter has begun carrying the President's Perspective section of The Signal to emphasize the link with WAIMH. Perhaps it will one day be possible to establish links with all the other European WAIMH affiliate websites.

And finally, there has been a major change as in the summer of last year Dilys Daws, the strength and inspiration behind the formation of AIMH (UK) retired from the post of Chair. However, and fortunately, she has not retired to a great distance away, and continues to be an advisor to the committee.

Robin Balbernie
AIMH Committee member

The Treatment of Antenatal Depression: A Systematic Review

By: Liz Boath, Eleanor Bradley, & Carol Henshaw

Contrary to popular belief, antenatal depression is common, affecting about 10–12% of pregnant women. Antenatal depression is a risk factor for postnatal depression, and around 50% of women who are depressed during pregnancy become depressed postnatally. Following the interest in our narrative systematic review of the treatment of postnatal depression (Boath & Henshaw, 2001), we are carrying out a systematic review of the treatment of antenatal depression. We have carried out a wide search of the literature, and have identified only a small number of papers so far (Spinelli, 1997; Swartz et al., 1997; Nahas et al., 1999; Parry et al., 2000; Oren et al., 2002; Spinelli & Endicott, 2003; Chiu et al., 2003). However, we are sure that there are others, so if you know of any other papers (published, in press, submitted, or currently being written) or any ongoing research in this area (no matter how preliminary) we would we delighted to hear from you.

Liz Boath Centre for Health Policy & Practice, Staffordshire University, School of Health, Blackheath Lane, Stafford, ST18 OAD Tel: 01785 353708, E-mail: e.boath@staffs.ac.uk

Carol Henshaw, Keele University Academic Psychiatry Unit, Harplands Hospital, Hilton Road, Stoke-on-Trent, ST4 6TH ,Tel: 01270 752110, E-mail:chenshaw@bankhouse.u-net.com

References:

Boath, E.H. & Henshaw, C. (2001) The treatment of postnatal depression: a comprehensive review. Journal of Reproductive and Infant Psychology, 19(3), 215-248

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Chiu, C.C. Huang, S.Y., Shen, W.W.; Su,K.P (2003). Omega-3 fatty acids for depression in pregnancy. American-Journal-of-Psychiatry, 160(2), 385

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Swartz,H.A. Markowitz, J.C. & Spinelli,M.G. (1997) Interpersonal psychotherapy of a depressed, pregnant, HIV-positive woman. Journal-of-Psychotherapy-Practice-and-Research, 1 6(2),166-178

Announcement

International Infant Observation Conference
Florence, Italy
April 16-18th 2004

Dear Colleagues:

We are pleased to inform you that the joint organizing Florentine Associations for the VII International I.O. Conference ("Paths of Growth: From Eyes to Mind") have drawn up and settled the following points:

1. We have installed a specific site (website: www.bick2004.info; e-mail: info@bick2004.info) where more detailed information can be found. A brochure is being prepared for the First Announcement/Call for papers. We are also planning to arrange a number of social events that we hope will be to your liking.

Before March 1, 2004 Standard fee Euro 350 / for members of Supporting Associations Euro 300/ for students Euro 150

After March 1, 2004 Standard fee Euro 400/ for members of S.As. Euro 350/ for students Euro 150

Only the speakers and the discussants of the plenary morning sessions will not be required to pay the registration fee. However we greatly appreciate any kind of contribution or sponsorship that you would like to offer. We can accept a maximum of 600 participants.

Scientific topics:

A. The methodology of Infant Observation in relation to its
   1. Formative functions
   2. Effects of "mental transformation" (for the observer, the group, the baby and the mother/father) as distinguished from the "therapeutic effects"

B. The extension of the I.O. methodology in different contexts (for example, pregnancy and the prenatal period) and in different fields (linguistic, pediatric, educational, etc.)

C. I.O. as a research tool for understanding child development. The comparison among observational methods.

In addition, predictive and preventive aspects related to the above mentioned scientific topics will be discussed.

A poster session is available.

A meeting for the teachers of I.O. will be arranged to compare orientations and experiences and to promote the next International Conference.

International Scientific Committee

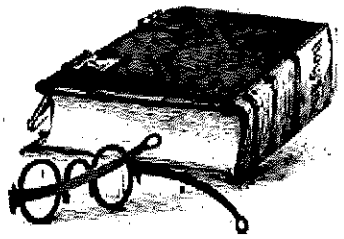
President: Gina Ferrara Mori
Argentina: L.Berta, M. Cardenal
Belgium: R.Sandri, A.Watillon
Brazil: N.Caron, M. Pelella Melega
Canada: A.Lebel
France: AFFOBEB (Secretaire R.Prat)
Germany-Austria: R.Lazar
Greece: E.Lignos
England: G.Williams, J.Magagna
Italy: L. Cresti Scacciati, S. Nissim, S.Maiello
Mexico: E.Pérez de Plá, N. Reyes de Polanco
Poland: A.Gardziel
Spain: J.Tizon
Sweden (Scandinavian Countries): B.Blomberg

Please send your answers and proposals to one of the following addresses:

Luigia Cresti:
E-mail: florence2004.cresti@tiscali.it;
Mobile +39 335 75 61 167;
Phone: (answering machine) +39 055 66 71 21/ fax +39 055 26 54 044

Simona Nissim:
E-mail: simonan@tin.it;
Phone: +39 050 543252;
Fax +39 050 540150

Luigia Cresti Scacciati
(On behalf of the Organizing-Scientific Committee)
A.F.P.P – Centro Studi M. Harris – A.M.H.P.P.I.A



LITERATURE MONITOR

BOOKS

Guidelines for Infant Development in the Newborn Nursery is a comprehensive manual written for neonatal nursing and medical staff initially. It covers all aspects of developmental care, including topics such as week-by-week pre-term development, tips on bathing, changing, and caring for a fragile infant and much more.
Available from Inga Warren, Winnicott Baby Unit, St. Mary's Hospital, London W2 1NY, UK.

Parents of Premature Infants: Their Emotional World Norma Tracy Whurr 2000

Norma Tracy is a psychotherapist who specializes in work with families. Originally, she worked at the Institute of Child Health and is now living and working in Sydney. This is a refreshing look at the way the whole family reacts to the crisis of being in a neonatal intensive care unit; it also explains the baby's situation, and the effects on the staff.

ARTICLES

Archives of Women's Mental Health Vol 6, Supplementum 2 (2003) Guest edited by N. M.-C. Glangeaud-Freudenthal & P. Boyce. "Special Topic: Postpartum Depression – Risk factors and Treatments." In memory of Prof. Channi Kumar. Contact: Silvia Schilgerius, Journals, Editorial and Marketing Department, Springer-Verlag KG, Sachsenplatz 4-6, A-1201 Vienna, Austria.

Bakermans-Kranenburg, M.J., van Ijzendoorn, M.H. & Juffer, F. (2003) 'Less is more: Meta-analyses of sensitivity and attachment interventions in early childhood.'
Psychological Bulletin 129 (2): 195-215

Abstract:
Is early preventive intervention effective in enhancing parental sensitivity and infant attachment security?If so, what type of intervention is most successful? Seventy studies were traced, producing 88 intervention effects on sensitivity (n = 7,636) and/or attachment (n = 1,503). Randomized interventions appeared rather effective in changing insensitive parenting (d = 0.33) and infant attachment insecurity (d = 0.20). The most effective interventions used a moderate number of sessions and a clear-cut behavioral focus in families with, as well as without, multiple problems. Interventions that were more effective in enhancing parental sensitivity were also more effective in enhancing attachment security, which supports the notion of a causal role of sensitivity in shaping attachment.

Barlow, J. et al (2003) 'Working in partnership: the development of a home visiting service for vulnerable families'. *Child Abuse Review* Vol. 12 (3) 172-189. Published online in Wiley Interscience (www.interscience.wiley.com)

Boath, E.H., Major, K. & Cox, J.L. (2003) 'When the cradle falls II: the cost-effectiveness of treating postnatal depression in a psychiatric day hospital compared with routine primary care.' *Journal of Affective Disorder*, 74 (2): 159-66.

Clarke, C.L. Gibb, C., Hart, J. & Davidson, A. (2002) 'Infant massage: developing an evidence base for health visiting practice.' *Clinical Effectiveness in Nursing*, 6: 121-128.

Mouradian, L.E., Als, H. & Coster, W.J. (2000) 'Neurobehavioural functioning of healthy preterm infants of varying gestational ages'. *Journal of Developmental and Behavioural Paediatrics* December 21 (6): 408-16

This study is important as it shows that babies who are born early, even though they may be a reasonable weight, feed fairly well, and look like a 'normal' term baby, actually are very different.

Murray, L. & Cooper, P. (2003) 'Intergenerational transmission of affective and cognitive processes associated with depression: infancy and the preschool years.' In I.M. Goodyer (ed.) *Unipolar Depression: A Lifespan Perspective.* Oxford University Press.

Nota Bene

From a new website from the Royal College of Psychiatrists (UK): www.focusproject.org.uk
Research Project on Attachment

Since the early work of John Bowlby and Mary Ainsworth some forty years ago, attachment theory has generated a rich and extensive literature incorporating a considerable body of research. This project comprises a review of the attachment literature, specifically using an evidence-based approach. The findings of the review will be published in the form of a report or book. The publication is intended to serve as a resource for child mental health and primary health care professionals in understanding and dealing with attachment issues in their practice.

Major themes in attachment will be addressed and within each theme salient questions will be posed and answered on the basis of the evidence available. The review begins with an outline of attachment theory, laying out the components of the theory and the specificity of attachment behavior, as originally conceived by Bowlby. The second theme focuses on the measurement of attachment. The various methods used to measure attachment are described and the reliability, validity and clinical and research usefulness of specific measures are appraised. Other themes include the relationship between parental attachment organization and representations of parenting, the consequences of attachment organization for the child's functioning/ mental health, and the ways in which life events or experiences, including treatment, may alter attachment organization.

Suggestions for themes you are interested in would be welcomed. Vivien Prior has joined the team, and is conducting the project work, and you can email Vivien Prior at v.prior@ich.ucl.ac.uk

Web Addresses

The French speaking Marce society site with details of meetings, working groups etc.: www.marce-francophone.asso.fr

President's Perspective

Peter de Chateau

This column is written in November 2003 and is my last one for the Signal,as I will step down as President of WAIMH in January 2004 during our Ninth World Congress in Melbourne,Australia.Tuula Tamminen,Finland,will take over our presidency then and I do wish her and the new Board of Directors a very successful and prosperous period of time in office.

Over the last few years we have in several european countries seen a substantial cut-back in the finances of the social-welfare system.Many proposals have been made by governments,politicians and other official bodies to raise taxes and to increase individual contributions for sevices and treatment provided for by medical,psychological and social services.No doubt if these numerous proposals are implemented many families with young children in need of these services will suffer.This is a dangerous and troublesome development.

Recently an interesting article was published in one of our daily newspapers.In the therapy of a mother-infant couple the use of psycho-analytical theory and practice was presented.The article was well-written,included interesting information to the general public and was positive about infant mental health issues,including the need for therapy and treatment,in its presentation.

However a few days later in an editorial in the same newspaper a mockery was made of the use of psychotherapy for young children.Moreover it was stated that money and other resources could be better used for the treatment of other and more serious diseases.This illustrates a dangerous notion that prevention and early treatment and therapy of mental disorder at a young age is something that can wait or is something even not to be done at all.Our experiences over the years have however convinced us that the opposite is true.

The World Association for Infant Mental Health is an association that among other things is organised to promote the development of scientifically based programs of care,intervention,and prevention of mental impairment in infancy.

The theme of our World Congress in Melbourne is "The Baby's Place in the World" and very timely chosen as can be seen from developments due to a declining world economy.We should continue to develop our expertise in the field of infant mental health as we have done so successfully in the past.However in times of global recession we might also consider being more active in influencing the general public and our society.We could increase our cooperation with other organisations with goals similar to ours.Perhaps we could promote our case better in the political field.Babies and their families most certainly deserve a very prominent place in the world.

WORLD ASSOCIATION
FOR INFANT MENTAL HEALTH
University Outreach & Engagement
Kellogg Center, Garden Level
Michigan State University
East Lansing, MI 48824-1022

Tel: (517) 432-3793
Fax: (517) 432-3694
Email: waimh@msu.edu

Website: WAIMH.ORG

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