

# The Signal



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## Mellow Parenting: An intensive intervention to change relationships

By:

*Christine Puckering*

Much effort has gone into supporting parenting in the United Kingdom over the last five years. The Sure Start initiatives have been of great value in offering a range of services for parents with young children. Many of these programs have relied on very well established and effective interventions like the Incredible Years programs devised by Carolyn Webster-Stratton (Webster-Stratton and Herbert, 1994) and the "Triple P" program devised by Matt Sanders and colleagues (Sanders and Dadds 1993). Promoting good child behavior and diminishing undesirable behavior has been a clear focus of many of the parenting programs. However,

managing behavior is only one part of parenting. The complexity and demands of the parenting role include scaffolding the emotional, cognitive, educational, social and physical well being of the child.

In addition, there is good evidence that, however effective when delivered fully, these programs may be failing to engage the most needy families. Those experiencing a constellation of social and interpersonal difficulties, including parental mental disorders, are the least likely to attend and use the interventions. The reasons for this may not be difficult to find. If the parenting relationship reflects general experiences of relationships, both in the family of origin and currently, then poor relationships with children may be an unsurprising corollary for those who find all relationships difficult. These are the families who find it hard to develop therapeutic relationships and do not use the opportunities offered. If they can be persuaded to use a mother and toddler group once, they never return, finding it "cliquey", being unskilled in making and responding easily to social contacts.

Rachel Steven and a team of health visitors in Wester Hailes, a socially

deprived area of Edinburgh, found that over 70% of the families they referred to the local child and adolescent psychiatry unit, which ran Incredible Years Parenting groups, simply never attended. Of those who did attend, none completed a full course of treatment. No matter how good the treatment, the service offered was not meeting the needs of this client group, because families simply did not engage with it. It was for this reason, and with the help of a primary care development grant, that they trained in and successfully ran Mellow Parenting to try to deliver an appropriate service to the families in their care.

The Mellow Parenting program was specifically developed for families with a pre-school child in which there were relationship problems. Relationship problems with the index child in an evaluation sample reached child protection thresholds approximately 25% of the time. Children and their mothers were also admitted to the program if the mother was experiencing domestic violence, had conflictual relationships with her family of origin, or had persistent psychological problems along with experiencing child behavior problems. The explicit aim was to

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give parents, at this stage largely mothers, the opportunity to explore and understand their own past and current relationships and how these impinged on their parenting. The group program lasted one full day a week, for fourteen weeks, with parents spending some of that time in a personal group, and parenting workshops while their children were in a children's group; some of the day with their children and staff, taking lunch and having fun in child-centred play activities. Mothers viewed a videotape, taken in their home during a normal family mealtime, with a group leader, with examples of incidents that went well and those that did not turn out the way they would have wished. Mothers were readily able to identify their failings, but found it very hard to give themselves credit for what they were doing well, and the group leader's role was often to draw their attention to their successes and skill. In the parenting workshop these successes were shared with other group members and their ideas sought to solve the problem areas. Mothers were reticent about being in the spotlight and sharing their own tapes but very much enjoyed seeing how others coped. Mutual learning and self-monitoring made the experience valuable, and most mothers agreed that they had gained extraordinary insight through the experience. When one mother, reflecting on her own interaction with her child, asked herself out loud "I wonder how that feels for him", it felt as though a significant process had begun towards the empathy that was previously conspicuously lacking in their relationship. Overall, the results of the intervention were positive. The program engaged hard-to-reach families (over 80% attendance) and demonstrated change in observed mother-child interaction, child behavior problems and children's intellectual development (Puckering et al 1999).

Recent developments of the Mellow Parenting Program have been directed to working more specifically with younger children and their mothers. In Gateshead, Jessica Brown has begun to develop a program for infants under the Sure Start umbrella, and in Coatbridge, Lanarkshire, a program for infants and mothers with post-natal depression has been piloted. The group was very well attended with every one of the eight mothers attending at least two thirds of the group sessions. Three mothers attended every session, and those who missed a session usually rang to give genuine apologies. The basic Mellow Parenting program was substantially unchanged, but more emphasis was placed on specific activities for mothers to help them manage depression and mother-baby sessions over lunch used age appropriate activities. Interaction coaching, baby massage, looking at picture books, nursery rhymes and lap-games were all used as a means of promoting close and attentive interaction. The pilot findings were positive. Mothers' depressed mood changed significantly, observed positive interaction went up and negative interaction went down. These are all important indicators. Simply targeting the mothers' depression may not have a direct effect on the mother-infant relationship, and long term impairment in the social, emotional and cognitive development of children has been demonstrated where the quality of the mother-infant interaction is reduced (Hay, 1997; Murray, Kempton, Woolgar, and Hooper, 1993). The Mellow Parenting program, while promising, needs more rigorous scrutiny in this context, using a research design incorporating a control condition and longer term follow up, before change can be unequivocally attributed to the effects of attending the group, and the results shown to have long-term effects on the mother and child, not least because the search for effective

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### *From the Red Cedar:*

Hiram E. Fitzgerald

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interventions has not yet come up with a convincing answer. Recent studies by Murray, Cooper, Wilson, and Romaniuk (2003) and Cooper, Murray, Wilson, and Romaniuk (2003) have shown a good response of mothers with post-natal depression to a variety of interventions. The treatments were non-directive counselling, cognitive behavioral therapy and psychodynamic therapy. The three treatments, offered in a randomized control trial, all gave mothers some respite from their depressed mood as measured by the Edinburgh Post-Natal Depression Scale (Cox Holden and Sagovsky, 1987) and were all superior to a "treatment as usual" control group. Only psychodynamic psychotherapy produced a significant improvement on a structured diagnostic instrument (Spitzer et al, 1989) but all the treatment effects had washed out by nine months post-partum, and none of the interventions reduced the risk of subsequent episodes of depression in the five year follow-up.

From the infants' perspective the results were even more limited. All three treatments reduced maternal reports of early difficulties in the mother-child relationship, and counselling produced better infant emotional and behavioral ratings at eighteen months and more sensitive observed mother-child interaction. However, none of the treatments had a significant impact on the security of the mother-child attachment relationship, mother or teacher reports of children's emotional or behavioral adjustment at age five or cognitive development.

Reflecting on the reasons for the effectiveness of Mellow Parenting, it became increasingly clear to the practitioners that the use of a group program conveyed immediate advantages in reducing isolation and the feeling of each mother that she was the only person who found

parenting difficult. While therapists in individual treatment settings may set out to convey that message and create a non-judgemental atmosphere, the supportive presence of other mothers conveyed that message directly. The groups were run on structured but non-directive principles. The therapists avoided suggesting a solution to problems, but supported sharing by other group members. Being the provider of a solution for another mother could prove very empowering. One mother remarked some years later on her experience in the group, "You believed in me and so I believed in myself." She has gone on to further her education, and to play an active part in community groups, and has avoided any further occurrence of the post-natal depression after a subsequent birth that blighted her early relationships with her first three children. Most of the women who took part in the controlled trial of Mellow Parenting had suffered very adverse childhoods. Twenty five percent reported a heavy-handed or frankly abusive relationship with a parent. Seventy three percent reported at least one hostile or indifferent parent figure. Of those who had a regular partner, fifty percent described their relationship as discordant and a shocking seventy percent could not name any friend or family member in whom they felt they could confide. In this context, it was perhaps no surprise that their relationships with their children replicated the adverse patterns with which the mothers were so familiar. It might reasonably be said that these women were familiar with how to conduct hostile relationships, but unskilled in the maintenance of mutually satisfying relationships. In the safe and non-judgemental atmosphere of the group, where the mother herself received nurturance and acceptance, one mother was able to say "I don't like the way I treat my children, but I don't know any other way to do it." The group was

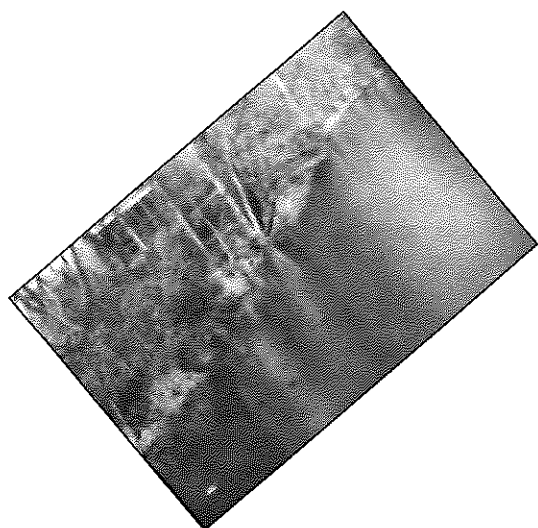
carefully structured to enable these mothers, with very little ability or experience of making trusting relationships, to sample good relationships for themselves and to start to develop mutually enjoyable activities with their children. In anonymous feedback some common themes emerged. Reflecting on what made the most difference to them the mothers often named "being listened to" and "not being judged" as the crucial factors.

The success of the program was expressed in some of the feedback. On the theme of learning to trust, one mother said "I learned to open up and share my feelings" and another "The best thing was being able to sit relaxed, and cry, or say nothing or listen" and "The most important thing I learned was that I am worth it." The second theme of developing better and less damaging relationships with the infants was also touched upon: "The most important thing I learned was how to be more interactive with babies"; and, from a mother whose child was on the child protection register and had been exposed to worrying levels of maternal frustration and hostility: "I now put him somewhere safe when he is upset and I cannot stand it [his distress]."

Infant mental health is something of an orphan; adult mental health services do not regard the children of their patients as their concern, while child mental health services do not routinely see such young infants. Given the documented effects of the early parent-child relationship and the impact of post-natal depression on this relationship, the need to develop and evaluate effective interventions is pressing.

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*By the Red Cedar*  
Hiram E. Fitzgerald

On Feb. 12, 2004, Jack M. Stack, one of infant mental health's early advocates and sustained champions died. I first met Jack in early Autumn, 1979, when I attended my first meeting of the Michigan Association for Infant Mental Health Board of Directors. Jack and Michael Trout, Chairman of the MAIMH Board (1979-1980), proposed that the MAIMH Board of Trustees (as it was called then) officially create the International Association for Infant Mental Health (IAIMH), and the Infant Mental Health Journal and designate the IMHJ as the IAIMH's official journal. They even presented a design for the IAIMH logo, affixed it to the journal and prepared to publish the first volume in 1980 with Human Sciences Press as the publisher. I was extremely impressed at the time with the persuasive style of Jack's presentation and the forceful, though quiet passion that was always a part of the critical fiber of his logic. To understand the boldness of this proposal, keep in mind that MAIMH was itself only in its third year of existence and here was a proposal to establish an international organization! Where did this idea originate? It was the direct result of MAIMH's first truly open conference. The April 1979 meeting of the MAIMH brought together 1200 participants from around the United States, England and Canada. Hoping

## *In Memorium*

Jack M. Stack, M.D.

March 1, 1938 - Feb. 12, 2004

for just enough participants to break even on the budget, the conference organizers were shocked at the extraordinary response from outside of Michigan.

Michael Trout was elected as the first President of the IAIMH. Jack Stack was the Founding Editor of the IMHJ and served in that capacity through the first three volumes. He also edited *The Special Infant* (1982), a volume that contained papers from the 1979 conference, including chapters by Antal E. Solyom, Carolyn R. Aradine, Joan Lesser Firestone, Michael E. Lamb, B. Kay Campbell, Edna Adelson, Vivian Shapiro, Michael Trout, and James and Joyce Robertson, all well known infant mental health specialists with national and/or international stature. These were extraordinarily exciting times for those of us in Michigan as we attempted to push an idea that originated in Selma Fraiberg's theory, research, and training programs, the latter of which were funded by Betty Tableman, the consummate champion of infant mental health throughout her career in the Michigan Department of Mental Health. I remember well the meetings that we had in Ann Arbor restaurants plotting ways to develop the MAIMH and IAIMH into first rate professional societies that would have substantive impacts on state, federal, and national governments to increase funding for programs directed to the quality of life for families with infants and toddlers. Subsequent meetings often took place in Lansing and East Lansing because Jack served an 8-year term as a member of the Michigan State University Board of Trustees and was frequently in town. As a member of the Board of Trustees, he

played a key role in the establishment of the College of Nursing and he was a firm supporter of the College of Osteopathic Medicine, also located at Michigan State University.

After completing his undergraduate work at Michigan State University, Jack went on to earn his medical degree from the University of Michigan in 1963. In 1977 he completed a residency in psychiatry. During this time he published papers on topics related to pregnancy loss, infant mental health, and psychiatry. He was also the founding editor of the *Family Practice Research Journal*. Jack spent nearly all of his practicing years as a member of the Gratiot Community Hospital, including time as chief of staff and chairperson of the psychiatric unit. He played a key role in opening the first rural mental health center in Michigan and for more than 3 decades served the center in a wide variety of ways apart from his medical responsibilities. One of Michigan's Governor's, William Milliken, noted that Jack Stack had done "more than any other individual for the health of people of the State of Michigan." A passionate and unwavering supporter of women's rights, civil rights and human rights, Jack boldly advocated his positions, regardless of the impact his values and beliefs may have had in the public arena. For example, as a member of the MSU Board of Trustees he advocated openly for divestiture from apartheid South Africa, and supported policy changes that made the university's anti discrimination policy more inclusive.

Driving to Alma College on Feb. 21 to attend a memorial service to celebrate and remember Jack's contributions to

his family, community, patients, and the field of infant mental health, I had nearly 40 precious minutes of quiet time to reflect on my memories of Jack and his impact on the early history of infant mental health. The memorial service was an extraordinary demonstration of the love that a community can have for someone who selflessly worked to make the lives of others so much better. After illness caused him to retire from a fully active medical career, Jack began to write poetry that deeply expressed the love that he had for his family members. Many of these personal and loving poems were recited by members of his family as they celebrated his career. His long-time and close colleague Michael Trout, provided a particularly wonderful eulogy celebrating the individual with stories that gave everyone an opportunity to remember all facets of Jack, softening the fact of his loss, with warm remembrances of an individual who embraced life fully, and who gave enormous energy and time to serve others.

Jack is survived by his wife, Carol Ann, four children and fourteen grandchildren. The Michigan infant mental health community will miss him, but it will also celebrate him for the contributions he made on behalf of infants and their families. He had a profound impact on my life when he encouraged me to become administratively involved with the Michigan and International Associations for Infant Mental Health. Little did I know in 1979 that the next 25 years of my life would involve organizational management of infant mental health associations. I had not interacted with Jack for about 10 years, and so it was especially wonderful to be able to be with his family and friends, to briefly visit with Michael Trout, and to share their collective remembrances of Jack's contributions to their community and to society.

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## ***Further details about training in Mellow Parenting can be obtained from:***

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# Ending a Mother-Baby Group

By:

*Norma Tracey*

*Group Therapists:*

*Norma Tracey and Chris Barnes*

Ending is always hard! It is a long process of working through, internalizing and letting go. In this paper we will think about two elements presented by the mothers in working through the ending of their group – adoption and weaning. We will present and discuss their direct clinical material around these issues as related to their group coming to an end. Our group was within the structure of The Parent Infant Foundation of Australia and was one of five psychotherapy groups, each coordinated by two psychotherapists. It was a closed group with seven mothers and their babies, referred either from Maternity Hospitals, clinics or the Parish Community who began the Foundation. We met weekly for an hour and a half for almost a year, from the later stages of pregnancy or early after birth. The issue of the contracted year coming to an end was presented by the therapists some eight weeks before the ending date. The response from the group was to use every means possible to prolong the group, to deny the relevance of the end, or to act out by attending on and off. Two of the mothers went on a 500 kilometre car trip to another state to “go home and visit” the adopted mother of one of the mothers.

*The material of the sessions discussed here is from two of the last three sessions.*

## *Some Background Thinking*

Adoption occurs for all of us, perhaps not in the formal and/or legal sense, but in all aspects of our lives. From birth until death we are almost always in some state of being adopted or of adopting, be it a person in place of an absent “other,” our school, our faith, our university, our profession. It is a two- way agreement - we adopt and we are adopted. The Macquarie Dictionary (1988) defines adoption as “to choose for oneself or to take to oneself, to make one's own by selection or assent.” The Australian Concise Oxford Dictionary (1987) - “Take a person into a relationship he did not previously occupy, especially as one's child. To take voluntarily as one's own child, with the rights of one's own child, to take as one's own, in any relationship.”

In a very deep sense we had adopted the mothers in this group and they had adopted us and the group as their own. Working with mothers and babies is different to any other kind of therapy. Real life is being lived in the clinical setting, emphasized by the presence of a real mother with a real baby and real concerns being presented around that baby. Babies are at the breast, are poohing, are being changed, and are crying. During that time the therapist or health worker becomes “real” in that the transference is more conscious and more defined, in a way that is slightly different to ordinary clinical psychotherapy. Many of our mothers had real adoption issues as well. One mother in our group had been adopted at birth; another mother had adopted a baby and immediately become pregnant at the age of 42 with her first infant after years of infertility; while a single mother was pressured to consider adoption for her baby, but had kept the infant.

We would like to write here about the way this group of mothers used their group therapy space and time with us to think about and share their experience of adoption and the fear of being “real” with adopted children.

## *3rd Last Group Session*

Present for this session were four mothers; one of the mothers was away on holiday and another had left the group with much ceremony the previous week to return to university.

After we had previously brought up the issue of the group ending, Jena, one of our mothers who was adopted from birth, said ending meant nothing to her, that perhaps it was the therapists who had a problem with ending, and she could not see what the fuss was about. She did not attend the next session, nor did one of the other mothers, Terri. They telephoned to say they had their babies with them and were on a 500-mile journey to visit Jena's adoptive parents. There Terri had felt so left out and unwelcome that she flew home. It had caused a stand up row and created enmity between the two who had been friends since the birth of their babies. After Jena came back home she did not attend the group. The other mothers reported that she had told them that for her the group had already ended and it made no sense to keep attending. One of the leaders rang her and Jena said that she would reluctantly come to the next group. She missed it, but without warning was here for this session.

We spoke of the meaning of the group coming to an end. Jena said,

"Oh you're not still on that subject! There's nothing to talk about." One on the leaders said, "Sometimes we deny painful events. People who have been adopted may sometimes have more problems with separating than others, and more reason than most to deny the meaning of loss." It was known by Jena that the therapist herself had been adopted and it made it possible for her to discuss issues with Jena that were harder for the rest of us. Jena responded, "Well I certainly don't have any problems with separating. The only reason that I didn't come back was because it's over. Over is over and my adoption has never been the problem for me." The other leader said, "But Jena did tell us before about having to live with the idea of a mother who wanted her and another mother who didn't want her every day of her life - maybe our going is putting all the group mothers in this state, facing that we both want you and don't want you." Jena said, "Yes! I remember talking about that." Jena picked her baby up from the floor holding her in her arms as the words poured out. "No one who ever held me was truly my mother, in the sense of being my own flesh and blood. Julianna is the first person of my own flesh and blood who I have ever touched or held and who I truly belong to in a real sense." Tears were flowing freely as she hugged her baby. The group seemed to absorb and share this with her. "You can see now why she is so precious to me. I always had the feeling my sister, who is also adopted, was more my mother's adopted child than I, because she was always ill and therefore always needed looking after in a physical sense." The group was sensitively responsive to this, and Rachelle, one of the other mothers, for the first time began to share how difficult it really was for her with her adopted son Amon.

Rachelle had tried unsuccessfully for nine years to have a baby of her own and finally had gone to Argentina in

order to adopt a child there. After the drama of going to Argentina and getting the baby, she had found out on the plane coming home that she was pregnant at the age of 42. For some time now she had not brought Amon to the group, coming only with Cecily, who was a year old. "No one can understand how terribly hard it is to have an adopted child and how hard it is to struggle in your mind with how you should live with him. I feel left alone with him and he is impossible. His jealousy towards Cecily is enormous, but worse than that is the continuous struggle with me. He says 'no' to absolutely everything, and has totally worn me down. I am going mad! I cannot cope with him!" She burst into tears and incoherent words flowed painfully. The group seemed totally absorbed in her pain and it seemed, in the therapists' minds, to come in closer and more protectively around her. "Last Tuesday I went to my parents and he was unbelievably awful there, showing me up continuously for not being able to handle him. We got home and it got worse. 'No' to those pajamas, 'no' to buttons being done up, crying about having to go to bed. Finally I broke down. 'You are killing me', I said. 'I am trying so hard with you and I can never please you. I am losing this battle. You are trying to destroy me and my love for you. I will not let you. My love is there for you so why won't you let me love you.' The group was stunned. One member of the group was holding Rachelle literally and the whole group seemed with her in her pain. The therapists began to talk about the meaning of being able to 'love' and 'hate' a baby, if the baby is your own or adopted, but it is harder if the baby is adopted. Terri (whose own mother committed suicide five years ago) talked about how fearful she was of any negative feelings between herself and her baby. If one was to be real with one's children, then hate and love went together. Both therapists said they

were aware of anger and hurt towards them as abandoning adoptive parents. Love and hate were on the same continuum. It was this remark that seemed to touch the group most and there were murmurs of, "You mean they won't die if they feel our hate!" They even ended up laughing about times they were angry with their infants, as though they were teasing Rachelle into laughing about it with them. It was Terri who rang one of the leaders the next day and said, "That was a really 'deeeep' session. I can't tell you how it opened my eyes to my fear of anything negative."

*Discussion:* With the issue of adoption comes the question of how real love and hate not only are, but also must be, if a real adoption is to take place. In our work with these mothers, the counter transference issue of being real or symbolic was always a fine line. For the mothers in the group, this was translated as "real" feelings about these adoptive parents (therapists) in the sense of feeling so powerfully negative, and hating and loving them in their leaving. Where symbolic begins and ends in the therapeutic encounter was central to our discussion together later, and at what point "real" is a necessary part of the therapy, really feeling love and really feeling hate. "Really" facing loss and "really" mourning the inevitable and the loss of power that goes with it.

#### *Last group session*

The mothers had very carefully planned this session beforehand. All six mothers arrived with morning tea and a giant orchid plant for each of the therapists. They set up the morning tea and put the plants at the back of the room. However, they were not to be deterred from their group purpose, saying, "We said last time that we want to talk about weaning today, because this is the thing that we are all having most trouble with." The significance of this was not lost

on the therapists, but when we tried to link it with weaning from us they rejected this saying, "No! It is about us and our babies!" Jena was the first one to speak, saying she might just breast feed forever. "You know how people mind getting up at night to feed their babies? I've never had that problem. Breast feeding is such a luxury I am glad to get up any time she wants it. Being up and playing with her in the night is a pleasure." The therapist said in response, "Weaning our babies is harder for those of us who have been adopted. If you've never had the breast yourself, somehow this is the intimacy that you feel you have missed." Jena looked sad and seemed for the first time to be near tears. Rachelle said, "I can understand what you're saying because my first son Amon is adopted and so I couldn't feed him, and letting go of breast feeding Cecily is really hard. My breasts are nearly empty but she still likes to get at them." Terri said, "I don't have a partner and I find it hard to wean too. It was so hard to connect in the first place and now I have connected it seems such a shame to have to give it up." Meg said, "Well I am someone who finds it extremely hard to let go. I still call my mother every day. Separating leaves an awful black hole and my aloneness takes away any relief in being free. I just think this is my last child. I will never do this again. When I look at other mothers and I am envious of them, I think, 'well I am still there, I am still breast feeding', but I know I can't go on forever. But how am I going to deal with it if I let go?" Rachelle said, "My breasts are really empty and there isn't anything there anymore. She blows raspberries and plays at the breast, and when it is over she says, 'good bye boob!' Somehow I don't want let go of the intimacy. I guess it's awful to say but for a long time now I haven't really had any intimacy with my husband and my daughter has filled that space." Meg said, "I know that part of my not weaning is

an obsession about keeping her healthy. I think I am still traumatized by the doctor telling me in the last stages of the pregnancy that she had only one kidney. In fact that is how I found this group. I rang Norma [one of the therapists] and I knew when I heard that caring voice on the other end of the phone, I knew I was going to be able to cope with this." She became teary and Norma said, "and now I am going." Meg replied, "I wanted more children and I know you never get what you want in life." Terri said, "Well one thing is for sure - it isn't happening for any of us like the books say!" Everyone laughed and exchanged chatter about what they thought of the books, laughing about how out of touch books were with the reality of what is going on for a mother. Then Rohanna, who had been in the group since she was six weeks pregnant and whose baby is six months old, said, "I seem to be doing what the books and the nurses say. I'm doing the right thing but it isn't working. I start by giving him solids instead of the breast at his midday meal and he is alright until halfway through and then he arches and starts to cry and go stiff and scream. I worry he has some terrible pain in his tummy, but then I give him the breast and he is perfectly all right." Rohanna then did exactly what she had described in front of us. Her baby took the solids quite happily until he got halfway through and then he started to arch and cry. Rohanna put him on the breast and he immediately settled and sucked happily. "See! And I don't want to lose the first feed in the morning and the last feed at night but I'm going back to work in six weeks so the weaning from this daytime feed is a 'have to'."

One of the leaders suggested that perhaps the big issue in weaning was the timing and the dosage so that it wasn't too sudden. Mothers and babies seemed to be telling us that both struggled and both mourned the

loss of the intimacy. Today there was a sharing of that loss of the intimacy, and it is the mourning together that gives meaning to the mourning. Rohanna said, "I have something very important to say. This group has meant so much to me that nothing will ever take its place." She cried as she described how the group had shared her pregnancy, the birth of her baby and all the hard times after the birth. With great affection she acknowledged the role of the leaders being centrally there for all of them. "Nothing will ever replace this group for me or you people."

Rachelle said, "This group has been everything I imagined a mother's group would be - a unique experience where I could say and think things I never dared even know about before." Jena said, "Those secrets in one's heart that one would never share with another I have been able to share here and I know I will never find it again. It doesn't mean I will ever forget you," she said turning to the leaders, "but it won't and can't be the same without you." Carol (a single mother) said, "Well I have something important to say. I would not have survived without this group." There had been a group joke that every time Carol came to the group she cried. "I'm not going to cry today," she said. "It is too serious. It was that I had a place where I could come and cry, especially with no partner to cry with or to cry to. This group helped me find my mum and my dad again and to go home with my baby. I'll always be grateful for that." Terri said, "This is the most support I have ever received in my life. This group has given me confidence in life and living and particularly given me the courage to go to therapy. [Terri is in psychoanalysis.] Both Norma and Chris have been of such value to us. I will never forget you and the unique place you will always hold in my life." Then Meg spoke, "I've been crying all morning just because I am so glad I



have met you all. I have never fitted in a group and all my life I have seen myself as the crazy loser. This is one group I belonged to and I am still a crazy loser but you all accept me and it is ok. I've met some horrible bitchy women in my life but you have given me an experience of women who care. Norma's caring voice talks inside me now. You and Chris have been there for us."

All the mothers were crying. Some were holding each other and some were holding their babies. We shared with them what an enriching experience it had been for us as well. "Will you do another group? Will you do it here in our room? In our time?" they asked. "Will we go on as a group without you?" "Let's meet at my place next week," Jena said. Then provocatively, "You could both come and visit my place." They all said to the therapists, "You could come. The group is finished so you can come." "No, today is our last day with you." "Well you could just come after the group is over." "No, today is the last day." "Could we just see you at Christmas time for our Christmas party?" "Of course " we answered, "but it wont ever be the same." "When our children get older we can move from each others houses and go to the park with the children and they could all play there." The therapists said, "Maybe you are telling us the weaning would be over and you will be free to play without us. There is a celebration, not just the sense of loss with separating. There are both feelings, just like in any weaning." People were laughing and crying at this point in time. Chris, one of the leaders, sealed off the end of the session by thanking the mothers for all they had given us. We all cleaned up together, then stood at the door and said an emotional "good bye" to each one as they left.

*Discussion:* There was in both of us a tremendous sense of gratification and

a sense of mourning. There was a sense of being privileged to create a parallel process in the group to what was going on for each of them in relation to their baby. It became important that we documented and shared it with our colleagues, which we did at the next peer supervision session. This paper is also part of our mourning and of our celebration. From this enriching experience came an understanding of the meaning of weaning in a way no book could describe it for us. From the experience came an understanding of the reality of adoption, and of how therapists work in an adopting-and-being-adopted environment all the time.

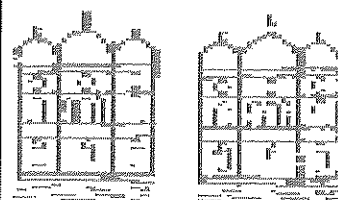
It emphasized the meaning of holding in groups and of having boundaries, of being not only in the area of the symbolic but sometimes in the "actual", the area of the real. It was the timing that was important, and the dosage and the careful weighing of the movement between both that was relevant. The orchids each of us received were symbolic of continuing growth. One of the issues in separating out is the acceptance of non-ownership and the surrender of ownership on both sides. In the situation of the adopted child there is particular relevance as each time it brings up the issue of belonging and not belonging, as expressed by both Jena and Rohanna. The questions, "Who are you? Who have you been for me?" take on a new relevance.

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# WAIMH *Affiliate News*

## Finnish Association for Infant Mental Health Pirpana

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Since the Second World War, Finland has had a special free public health service for both maternity and child health. The service is well accepted and it is considered a part of being a good parent to use the well-baby clinics. Traditionally, the biggest emphasis has been on physical health, on checking up on developmental milestones and providing vaccinations. As awareness of the psychological needs of children has increased, psychological well being and the promotion of mental health has become a national key target in well-baby clinics.

This has meant a great need for further training in parent guidance and counselling and supporting the early relationship between the child and the parents. The national project, VAVU, has trained about 3,000 health visitors and people working with children in day care during the last 4 years. The training includes 2 years of supervision in groups of 2 to 4. The developmental part of this national program was directed by Dr. Merja-Maaria Turunen and the scientific evaluation of this international multi-centre project is undertaken by the University of Tampere under the direction of Prof. Tuula Tamminen with Kaija Puura as main researcher. The

project is part of the European Early Promotion Project.

The special funding provided by the government for the development of mental health services for children helped the basic services to integrate the new ideas of infant mental health, the importance of good attachment relationships and also the importance of fathers, into their normal way of working. It is now a quality indicator that well-baby clinics use this kind of working model.

As the knowledge of infant psychiatry and the importance of attachment relationships has increased, there has been a steady growth in more intensive, systematic parent-infant group therapies and these are now provided in all central hospitals and elsewhere in bigger cities. The need is greater than the service provided. University clinics offer inpatient family units and day units for infants and their parents. This consistent service system, arranged on a local basis, has brought new families and parents into mental health services and also made the word mental health more acceptable.

Another crucial basic service is public day care. About 64 % of children

under school age (in Finland 7 years) participate in public day care. Every child has a right to day care, but there is a progressive fee depending on the income level of the parents. Day care is heavily subsidized by the municipalities and represents the largest cost within social services' budgets. But if parents want to use public day care the municipality must provide it. Most of the day care is in groups in day care centres, but there is also public family day care available, which is often wanted for children less than three years of age.

If a child has developmental or psychological problems that need extra support in day care, the child may "use a place for two children" in the group, may be in a smaller integrated special group or be in a special group for language delayed children or in a special group for children with special needs. Some children have personal assistants in the group if there is a need for close supervision or the child has great difficulties in making contact in an age appropriate way with other children or adults. Special support in day care is provided for 5 to 15 % of the child population in day care, depending on the area and the municipalities' resources. In areas with a large

immigrant population, there is more need for special support in the early years.

As a result of all this there are many professionals working with children and their families. Initially a group of interested professionals started to meet to share experiences and knowledge in a voluntary and non-structured way. This included many activists from the big child organizations in the country. As a result, within a year there were about hundred names on the mailing list and a more structured way of organizing the exchange of ideas was needed. From the few who had attended the World Conference in Stockholm, a large and active interest group had emerged.

Organizing the World Congress of WAIMH in Tampere was both a major task and a chance for remarkable activity on the infant psychiatry front in Finland. Professor Tuula Tamminen had already for some time been making great efforts, both to enhance the visibility and importance of infant mental health in Finland and to be an active member in WAIMH. The Finnish affiliated group formed an official association in 1998. The first President was Dr. Päivi Kaukonen (1998 to 2002) and she still continues as Vice President ([kaukonen@sci.fi](mailto:kaukonen@sci.fi)).

The Association has grown rapidly and now has 254 members. It has a Board of seven members coming from different professions and regions of the country. The Board meets on a regular basis. The current President is child and adolescent psychiatrist Merja-Maaria Turunen ([merja-maaria.turunen@hel.fi](mailto:merja-maaria.turunen@hel.fi)) and the secretary is psychologist Mirja Sarkkinen ([mirja.sarkkinen@hus.fi](mailto:mirja.sarkkinen@hus.fi)).

The association is multi-professional, including researchers, clinicians, policymakers and people working with small children in different settings.

### *The Association has had several main functions:*

#### *1. Training*

Training has consisted of two annual events in the form of seminars. One has traditionally been smaller and more interactive using national specialists. The other one has been for a larger audience using international experts such as Stella Acquarone and Paul Barrows from the UK and Joan Robinson from the USA.

The National seminar in 2002 focused on collaboration between day care and well-baby clinics.

#### *2. Policymaking activities and political activities in the field of infant mental health.*

The Association has joined forces with the Finnish Psychological Association in order to try to get the National Health Insurance to cover private psychotherapeutic and interactional treatments for under five year olds. Unfortunately, the National Health Insurance is at the moment having great difficulty in deciding what forms of therapy, and for whom, they would fund. Suddenly, at the end of 2003, they announced that they would no longer fund individual therapies for those under 16, but family therapy would be funded. There is at the moment great confusion in the field. Wisely enough our President, Tarja Halonen, in her New Year's speech, besides addressing some major political issues, took up the necessity of supporting child

psychiatric evaluation, research and treatment and insisted that the resources must be found. So there has been support from a very high level, which will hopefully turn into concrete resources.

The Association is currently working on the first draft of a document on the quality of day care for those under three. This document, once it is ready and accepted, will be presented to politicians for further action. The Association is well aware of the delicate balance of responsibility and feelings of guilt that can so easily make parents feel defensive and can lead to denial. Day care as a service is undoubtedly needed but much needs to be done to ensure the quality of relationships in this area. There is unfortunately also a very worrying trend, with more mothers tending to use day care even when they are at home themselves, often with the new baby. More flexibility in day care arrangements are needed and parents need to recognise that they are always the most important and best support and stimulant for their child's development.

#### *3. International activities*

Professor Tuula Tamminen, being now the President of WAIMH and a member of our Association, is the most important link with WAIMH. The large Finnish interest and input to the WAIMH Amsterdam Congress showed that infant mental health, whether in relation to research, clinical work or policy making, is an interesting and growing field in Finland just now.

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# Mothers as Managers

By:  
*Penelope Leach*

The phrase “controlled crying” epitomises an increasingly popular approach to parents’ (especially mothers’) management of their infants. The approach owes much to the concept of “sleep training” first formulated by Ferber<sup>1</sup> a generation ago. If parents are asked to pinpoint the very worst part of raising a baby through the first year, more of them pick lack of sleep than anything else. The delayed-response method, which is often referred to among parents as “Ferberizing” aims to train babies from four to six months of age to go to sleep without adult soothing and to go through the night without attention.

Ferber’s approach has always been counterbalanced by authorities, such as Sears<sup>2</sup>, who argue for “attachment parenting” with attention available to infants by night as well as by day, and, often, for co-sleeping or “family beds”. When parents experience “sleeping problems” extreme versions of each of these opposite approaches attract some as passionate advocates. (See Appendix 1 “Approaches to infant sleep” on page 15)

Now, though, Ferberesque arguments and techniques are being generalised from problem solving to ordinary practice and from the middle of an infant’s first year to the whole of it. This of course means that they are being generalised from sleeping patterns to all behaviours. In the newborn period “there is no such

thing as a baby” (as Winnicott told us) and there is no such thing as a “sleeping problem” either – at least not one that belongs to the infant. Sleep and wakefulness, feeding and other physical functions, play and neuro-muscular and brain development are all interlinked and moderated by the relationship between infant and mothering person.

So instead of being part of a temporary approach to entrenched sleeping difficulties, “controlled crying” is being presented as central to an overall strategy for mothers’ avoidance and/or management of all the difficulties and conflicts that may arise in caring for babies. The phrase “controlled crying” has slipped into child care advice, both in print and on the Net, and with it the notion that mothers can control every aspect of their babies’ lives and should strive to do so as both they themselves and the infants will be happier if they do. Astonishingly detailed and prescriptive plans for the exercise of such maternal control, manipulation and management are reaching a wide public. A typical example of the routine advised for a baby of three to four months usually starts like this:

7.00am Baby should be awake, fed and nappy changed  
7.30am Wash and dress baby  
9.00am Settle baby to sleep *for no longer than 45 minutes*, loosely wrapped and in the dark with the door shut

These routines are prescriptive. Parent’s queries about how to ensure

that the baby’s longest sleep period is by night rather than in the day often includes instructions not to talk *or make eye contact with the baby* after the last feed at 10pm until the next feed at 7am. Advice also often includes total blackout on all windows and limiting protein foods, vegetables and fruit after lunchtime so as to lessen the likelihood of an early morning bowel movement, as well as ‘controlled crying’ for those who wake all the same.

*Why do many mothers, including older and better-educated women, welcome this Truby King-like advice?*

Successive surveys, culminating in the recently reported results of the Lever Faberge Family Report 2003<sup>3</sup>, suggest that as well as finding the transition to motherhood demanding and difficult, many women are finding the ongoing actuality of mothering disappointing. There are increasing numbers of women deciding not to have children and increasing numbers striving to overcome involuntary childlessness, but among those who do have a child or children there are increasing numbers who are ready to acknowledge that being a mother has unexpectedly distressing and lasting effects on previous adult-only lifestyles and careers.

In this social context any set of strategies that empowers women to control infants’ behaviour and limit their demands will be attractive to

many, especially if they are convinced that the system is good for their babies: that using it makes them better mothers. The message "You are in charge; you know best what is good for your baby" may be especially appealing to those women who are least sure that they know anything about babies, and least able to allow themselves to be guided by what they feel. Authoritarianism is especially attractive to people who are at their most vulnerable. Many new mothers, bombarded with differing explanations and advice about babies have been heard to say "I wish someone would just tell me what to do". These instruction books do just that and their appeal is increased by the offered level of daily – hourly – detail.

Once a woman has decided to adopt such a scheme, no judgment or decisions are required. Following each day's routine is mindless, (though far from effortless) and assures her of the rightness of doing things she might otherwise have been uncertain about and had to work out for herself. The idea of closing the door on a baby and leaving him to cry, for example, can be both tempting and shameful. Good enough mothers can be tempted and may or may not find themselves ashamed. But if leaving the baby is part of "settling him" in a prescribed way at a scheduled time in a day whose every moment is programmed to do what is right for him, a woman can feel like a good mother even whilst he cries, ignoring rather than hearing him. Constantly assuring mothers that this (and only this) is the right way to manage a baby ("follow my routines..."), such a programme insulates mothers from feeling neglectful or guilty and from finding their own ways.

*Among many swings and fashions in childcare advice, why is this one important enough to merit a response from infant mental health professionals?*

It is not so much the content of these very specific recommendations that uniquely merit a professional response, more their implications for the relationships between mothers and babies. Routines, even very detailed ones, are not in themselves bad for babies. Most infants flourish with at least some predictability in their daily lives and if more makes a mother feel better able to cope, her baby may also benefit, as long as routines are not so rigid that his daily experiences are always the same and he has no chance to learn about the difference between sleeping with the door open or closed, or eating less or more than usual for lunch.

Controlled crying is not necessarily undesirable either, although the name has unpleasant connotations. Indeed leaving a baby to grumble in her cot for a few minutes when she is known to be tired and is clearly fighting sleep may be the very best way to help her let go and drop off. Even "leaving a baby to cry" is not always as harsh as it sounds. Holding back from the early-waker instead of hurrying to him at the first murmur, for example, may actually increase his sense of security (as well as his ability to stay awake for a pleasant morning) by showing him that his parents are confident that he can manage on his own for a little while and that it is safe for him to do so. But there is a crucial difference between these examples of normally sensitive parenting and the alternative, highly routinised and externalised style of infant care. While the former is based on parents knowing their baby, noticing and

striving to understand his or her cues, often putting themselves in those non-existent shoes and bearing the baby and the baby's feelings in mind even when they refuse to meet his or her immediate demands, the latter is based on parents "knowing best".

Any increase in the popularity of rigid, instruction-manual child care is unwelcome to infant mental health professionals because it runs counter to the vast international literature concerning the unarguable importance of secure attachment; to the rapidly growing associated body of research demonstrating the importance of maternal sensitivity and responsivity, and to findings currently emerging from the fast-moving field of research into infant brain development. The security of an infant's attachment to mother and the sensitivity of her care go together. Stress, including the stresses that lead to insecure attachment, damages an infant's capacity to learn and may, in extreme instances, damage it forever. Whatever specific infant outcomes are studied – from language development to resilience to sociable play – the sensitivity and responsivity of their mothers explains more of the variance in most studies than any other variable.

Nobody can be sensitive to another person all the time; nobody can always be responsive. But the more responsive, loving experience a baby gets the more he will flourish today and the more resources he will have to cope with difficulties tomorrow. It is through this first love relationship that babies learn about themselves, other people and the world; experience emotions and learn to recognise and cope with them. And it is through this baby-love that they become capable of more grown-up kinds; capable, one far-distant day, of giving children of

their own what they now need for themselves. As Alison Gopnik<sup>4</sup> puts it "... for babies and young children care and teaching are inseparable. The very same actions that nurture babies give them the kinds of information they need... The scientific research says that we should do just what we do when we are with our babies – talk, play, make funny faces, and pay attention." Paying attention means a mother thinking with and for and through her baby, as well as about her cooling supper or beckoning bed; thinking about him and herself and how the two of them can turn the next challenge into pleasure, rather than about a set of instructions or the time.

Bearing a baby in mind in this way is not at all the same as total indulgence. Indeed parents who are having problems with babies past the newborn stage demanding to be fed every hour or to be held constantly, often need to be firmer without being less loving. However most of the parents who are adopting these external-control methods are not doing so to deal with real problems in the here-and-now but with feared problems in a fraught future. Anxious lest babies take over their lives and control them, they gladly adopt programmes that allow them to manage and control the babies' lives. Sadly they may thereby delay, even perhaps distort, the relationship of mutual regard that enjoyable parenting relies on now and forever.

Newborn babies have a built-in drive to develop and practise every aspect of being human, yet each aspect of their growing up depends on their partnership with adults. If a parent holds herself aloof from her baby as a person, and from revelling in the physical pleasure in each other's bodies, and in nursing at the breast or bottle, that underpins their

adjustment to each other, seeing him instead as a programme and a project, she will not do all she can to keep him happy and busy and communicating with her. And of course the less busy and happy the baby is and the less he 'talks' to her, the less of a pleasure he will be.

The instruction manual approach gives parents a sense of adult control and separateness and supports their use of authority over the baby when what they most need is personal support while they risk submerging themselves in a relationship with him. It is misleading to parents to suggest that by rationing and routinising their attention to the baby they can conserve their adult autonomy because, however much they may resent the fact, their happiness and the baby's are inextricably entangled. A mother may resent her baby's crying; resent, even reject, the fact that he needs her - again. But ignoring (controlling) the crying does not only condemn the baby to cry unanswered but also condemns the mother to listen to him crying. So being sensitive to a baby's needs, tuning in to him, treating him as he seems to ask to be treated, is not only better for the baby but also better for the mother and for their relationship. Being responsive to a baby soon grows into mutual responsiveness between child and parent.

Infants are not out to "get at" parents. Watching and listening to babies and responding positively to them whenever possible does not turn babies into bullies or parents into victims. On the contrary, it leads, naturally and without prior planning or particular rules, to negotiation between adults and infants and thence to the reciprocity on which all intimate

relationships eventually depend. It is by negotiation (rather than by rules) that a parent arrives at the appropriate period of grace between this particular baby waking up and an adult arriving at the cot side. It is by negotiation that a mother can gradually stretch the time between feeds, or persuade her baby to accept her face and voice for reassurance when something startles him, instead of instant breast. It is through months of these reiterated mini-negotiations that a baby learns that mother is not him but someone separate. Someone who thinks about his needs and can be trusted, but who also has needs of her own. These lessons are the foundations of mutual regard. Laid in the first six months, they will support the mother-child relationship not only through infancy and as an alternative to rigidly programmed parental control, but through the toddler's confused and confusing developmental drive for autonomy and the child's increasing passion for peers, and into adolescence. And by then mutual regard is the only hope because power-tactics no longer work at all.

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## Appendix 1: Approaches to infant sleep

*Controlled crying* - (also known as sleep training) involves putting a baby in his cot and leaving him for a predetermined number of minutes, however hard he cries, before returning to check on, or comfort him. When a parent does return s/he does not pick the baby up or stay with him but gives a brief verbal reassurance and a pat and then leaves again. This pattern is repeated until the baby finally goes to sleep.

In some schemes the parent stays away for the same length of time between visits on the first night (say 5 minutes) and then increases the interval to say, 7 minutes on the second night and 10 on the third. In other schemes, aimed at faster results, the time between visits increases from the beginning, rising by x minutes between each visit on the first night and starting the second night at the interval reached the night before.

**Ferber** has published various versions of his approach. A moderate one goes like this:

From the age of four months a baby should have a regular bedtime and bedtime ritual that ends with him being put into his cot awake, and left. *If he cries, he is left for 5 minutes by the clock before a parent checks to be sure he is all right, gives him a pat and a kiss, and then leaves again. If the baby is still crying after another 5 minutes (and another and*

*another...) the checking and reassuring routine is repeated.*

*The next night, the process is repeated but with 10 minutes between checks. On each subsequent night the response to any crying is delayed by a further 5 minutes so that on night 4, for example, the baby might cry for 20 minutes between visits – and for an hour or much more altogether:*

*Ferber warns “If you cave in, all your efforts will be for naught”*

*The shared-sleep approach – or the “family bed” – of which Sears is the best-known advocate, sees it as normal for an infant to wake in the night. It does not expect (or especially encourage) a baby to learn to put herself to sleep (or*

*back to sleep) until she is ready. Instead its aim is to make sure she feels secure about going to sleep and confident of a parent’s availability if she wakes.*

*The child is fed, cuddled, rocked, or massaged until she falls asleep. She then shares her parents’ bed so she is parented as fully by night as she is by day. Comparing Ferber’s approach with Sears is something like comparing oranges and apples as they are not both attempting the same feat. Ferber’s programs are aimed at training babies to sleep through the night so they don’t disturb parents. A family bed accepts babies’ nightwaking and aims to minimise the*

*disturbance it causes to them or their parents.*

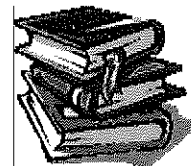
Parents’ passionate but contradictory reactions to these two “strategies” clearly demonstrate that neither is right or wrong for everyone. But the strength of those reactions also suggests that searching for the “right” sleep strategy, or justifying the one they use is painfully important to many parents. Feeling like a zombie because of disrupted sleep patterns is not all that is at issue here: there is also feeling like a bad parent.

*“My year old son not only does not sleep through the night, he fights bedtime and naptime every step of the way complete with screaming, thrashing, ranting and sobbing. When he finally exhausts himself and falls asleep he only stays sleeping for 2 hours max. He was like that during his first 3 months in a co-sleeper in our room. It’s worse in the cot.” (H.G. Warwick NY)*

*“My older daughter slept through the night without our reading any books. The second didn’t sleep through until she was 4 years old. We tried the Ferber method at 6 months and one year and have burned the charts we kept so she will never find out how long we let her cry.” (M.C. Leeds)*

*“If you cave in, all your efforts will be for naught”*

# BOOK REVIEWS



*PSYCHIC HOOKS AND BOLTS. Psychoanalytic work with children under five and their families.*

BY  
MARIA POZZI

London: Karnac, 2003  
217 pp., £19.99

This fascinating book introduces, with many clinical highlights, the innovative psychoanalytic work with toddlers and their families which started at the Tavistock Clinic in the early 1980s, known as the 'Under Fives' Counselling Service.' Lisa Miller, a pioneer and very experienced child psychotherapist in this kind of brief work, describes in her foreword how 'the families arrive in pain and anxiety, pushed to enact internal states, taken over by forces they feel they cannot control either in the child or parents' reactions to it. They don't know why they are behaving as they would not wish to behave. It is plain that powerful and complex understanding can take place in this brief work. Simply by coming the family announces its readiness to seek help and it is of the utmost importance that the families are seen without delay.' This book is one of the contributions of child psychotherapists from the Tavistock Clinic in London to parent-infant psychotherapy. One can trace in it the theoretical influences of the work of Klein, Bion, Winnicott, brief psychodynamic psychotherapy, parent-infant psychotherapy, attachment theory, the family therapy work of Byng-Hall, and recent

developments in the neurosciences. This book is a very welcome and important addition to the forum of infant-parent work, although its main focus is on work with toddlers and their families.

The first part of Pozzi's book covers theoretical ideas and technical aspects of short term and focused psychoanalytic counselling where young children are seen together with their parents and siblings in whatever combination they wish to be seen. The Tavistock model of infant observation is dealt with in a separate chapter, emphasizing its ever increasing importance. The second part of the book consists of rich case histories.

The book covers the most common complaints and symptoms met in under fives' counselling. These are dealt with in different chapters, including: eating problems, sleeping problems, separation problems and how these get entangled with parental difficulties, soiling, bereavement and loss, learning disabilities, borderline children, hyperactivity and - not so often written about- gender identity. Postnatal depression, so common but often undetected, and mental illness in the family are important chapters. These topics are dealt with very vividly and make for exciting reading.

The therapist describes the impact of the family on herself and how her mind is working - not excluding the difficult moments. Her impressionistic picture of the family in the waiting room is often very telling. The cases do not include referrals of work with babies - an aspect of the work that develops rapidly once links with ante- and post-natal services have been made. Her

work shows a great respect for the uniqueness of the families and their members and for the multileveled work with them.

The difficulties of the children described may stem simultaneously from a number of different sources. The problems may be internal to the child, there may be unresolved problems from the parent's childhood, stresses in the parental relationship, or arising from external events. Some of the difficulties are chronic and multi-determined in their complexity. The initial point of contact can also vary, from referral of the child, or of another member of the family. Similarly, the focus of the work may be the relationship between the parent and the child, or between the two parents.

The intensity, quality, and/or duration of the troubles will often have had a strong emotional impact on the parents; making them feel confused, helpless, exhausted, and inadequate in coping with what should be ordinary life situations. The aim of the therapist is to help the parents turn their lonely and meaningless suffering into a more tolerable and understandable human pain. This brief and intensive work requires from the therapist great observational skills, a psychoanalytic eye and ear and flexibility to be open in the-here-and-now to the conscious and unconscious communications: being alert to all these different communications enables the therapist to reach some understanding of the emotional needs and disposition of each family member separately and together. Pozzi lays great stress on



the setting of the work, on the parents' mental disposition, and especially on the mindset of the therapist in reaching a successful outcome. This work requires emotional receptiveness to transference and countertransference feelings, a frame of mind of not knowing, linked with the interest and curiosity to find out by observing and exploring together with the family. Furthermore, the work requires the capacity for multiple, almost simultaneous, identifications which is made possible by contact with the different parts of one's personality. This creates the conditions for exploring the complexities of the external and internal situation of each family member, understanding what they are contributing to the troubles, and finally for creating a coherent and meaningful narrative.

The author, a very experienced child psychotherapist, has a deep understanding of the young child's emotional life, early conflicts and the need for containment of these, as well as the need for psychic transformation and the regulation of feeling states. She knows the serious consequences of the lack of containment and protective parenting. The writer gives a thoughtful and thorough presentation of her successful and sensitive work in the clinical setting and examines how the changes have come about, what has worked and what is required. Although she shares the experience and amazement of many infant-parent psychotherapists at the incredible changes that can be achieved, against all odds, she also describes more difficult cases, where the results have been only partially beneficial. According to her, the help offered by services such as this can resolve parenting difficulties, unblock complex situations, prevent things getting worse, and open up the possibility of other therapeutic interventions. Sometimes the work can function as a

prolonged assessment. It is an advantage that this kind of counselling work with infants and their parents can be carried out in busy public mental health services. Counselling can be offered as parental guidance with severely developmentally delayed children, as a form of assessment, or as consultation to a nursery school. When the waiting list is too long, Pozzi has seen the importance of containment and consultation via the telephone for parents who would otherwise be left by themselves in too lonely a situation. She has also developed a telephone helpline for parents, so that the needs of families can be responded to quickly. In her own words 'the target of this brief work is to reach vulnerable young children early when they are still flexible in their personality structures and defence formation, and to alleviate the pain and suffering in the child's and parents' life.'

This book is highly recommended for psychotherapists, and for all those working with young children and their families.

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### *Mother Nature*

BY:  
SARAH BLAFFER HRDY

London: Vintage  
(Random House), 2000  
697 pp, £12.50

Hrdy's 700 page book is organized into three parts: (1) Look to the animals (2) Mothers and allomothers and (3) An infant's eye-view. The first part, slim and fit at 120 pages, includes much of the non-primate evidence,

including patterns of procreation and parenting in birds and bees, other insects, fish and mammals. References to the history of literature, art, and politics set the scene for what is a comprehensive account of the evolutionary and social meaning of motherhood. This is delivered in the context of a literate and entertaining account of the scientific origins of maternal behavior from Darwin's day forward. The second part of the book is the largest at 260 pages, and this is where the author hits her stride covering all the range of ethological evidence (mainly from primates) concerning various forms of family life. There is a dizzying amount of information here. This includes pithy summaries of ethological work and informal comments of evolutionary theorists, as well as revealing personal reflections that easily bring the reader to a state of admiration for the author's breadth of scientific knowledge concerning evolution, and her integrity as a liberal-minded wife and mother. The final section of the book, covering 150 pages, includes what is a most vivid and original summary of attachment theory, concentrating upon the social impact of John Bowlby's theory and the central place of his writings in the history, and applications, of evolutionary thought.

Impressively, there are some 50 pages of notes supporting the 24 chapters and a bibliography running to nearly 70 pages, with well over 2000 references cited. The reader is left with a feeling of having encountered an accomplished author (she has three earlier books to her credit) at the height of her powers, addressing a subject central to her life's, indeed her gender's, concerns. And, no less for the male reader, there is much to ponder. Below I select from Hrdy's extensive range of topics covered either because I found them central or simply most interesting or provocative. I present summaries of

Hrdy's comments on infanticide and male-male competition over mating, marriage, grandmothers (the prototypical allomother), abortion and maternal hostility, before making a final recommendation very much in favor of engaging with this text.

### *Infanticide and male-male competition over mating*

Hrdy chooses as the epigraph to place at the beginning of her book the words of George Eliot (1848) who said of Mother Nature "(she is) by the bye ... an old lady with some bad habits...". Hrdy's doctoral research put in the spotlight one of the nastiest habits on record of a primate mother from a species of monkey, the langur, where males had been observed to grab infants from their mothers and bite them to death. Hrdy's own observations confirmed this to be the case, and showed in addition that male langurs did not always face opposition from the mother who occasionally colluded. The bereaved mother langur would not only *not* hold a grudge, but after the male had killed her infant she would mate with him. Her ethological study revealed that it was infanticide by unrelated males, and female collusion because the marauding male (laying claim to females of the existing senior male) "*might take over her troop one day.*" (p.35) Hrdy claims that this example of sexual selection, involving same-sex competition, and deliberate acquiescence by the other sex, over matings has now been reported for 35 different species of primates, and human behavior is not immune to this pressure. Hrdy reviews the low-grade expression of this pressure in the macho showing-off antics of humans, and not just in the adolescent period when the capacity for reproduction is first realized.

What psychoanalysts know as the exhibitionistic impulse is, at least in part, deeply rooted in our evolutionary

origins. Hrdy does not propose an equation between child abuse (by a boyfriend or stepfather) and infanticide by unrelated male primates. The latter, she argues, is carefully planned, deliberate and goal-related while the former often erupts out of a sudden lack of control over emotions and behavior. The extent to which human aggression and immorality stems from fearful disorganized early attachment experiences, which are likely to compromise and restrict crucial aspects of forebrain development, is covered well in the final part of the book. This is where Hrdy reviews John Bowlby's extensions to Darwin's theory of the emotions, locating them in the equipment the baby brings into the world, part of an evolutionarily determined bio-behavioral system. Initially, of course, this system functions to elicit care from the environment, and increasingly (over the first year) is extremely sensitive to fears of separation, loss, and abandonment.

### *Marriage: 'Monogamy as a compromise that children win' (p. 230)*

Mother Nature is stretched by the demand to maintain a consistently sensitive and responsive environment. She can't easily do it on her own. Therefore, much attention is given in Hrdy's narrative to the choices she makes regarding the father, and others she may recruit to help provide care for her infants. She confesses her personal bias in favour of monogamous unions, which she sees as especially appropriate to contemporary human circumstances. "Long-term trust permits unparalleled efficiency and emotional satisfaction. I place a high priority on the benefits that two cooperating parents offer children." (p. 232) Whatever the marital choice made by a woman, she is likely to need many others (not simply father) to help achieve her

personal professional aims as well as her wishes to practice Mother Nature's better habits.

### *Grandmothers*

No one may be more helpful than the mother's own mother. Examining this role involves a key feature of the human story, i.e. the certainty that not only one's offspring will go through a period of unrivalled long dependence on caregiving in order to survive, but the human mother is likely to live long enough to become a grandmother. And, like every family role and circumstance Hrdy considers, the probable evolutionary determinants of post-menopausal life are thoroughly explored. The force of the argument is that in stopping procreation in one generation (at menopause), support for the 2<sup>nd</sup> and 3<sup>rd</sup> generations may then become the focus. She argues, for example, that we should not be alarmed at the high prevalence of teenage motherhood among lower social classes, and the corresponding tendency for these young girls to have their mothers (the grandmother) raise their children. This is, Hrdy points out, just why women have evolved to live 70-80 years, i.e. so that they can contribute to the caregiving needs of their grandchildren. Teenage pregnancies, the source of so much understandable social and political alarm, are another aspect of motherhood that is hardly new in evolutionary or historical terms. The contemporary expression may be caused in part by the young impoverished (and often poorly loved) girl's wish to conceive and give birth whilst one's body is relatively free of sexually transmitted diseases and the ill-effects of drug abuse. To wait may be to risk the chance of not conceiving successfully at all.

### *Abortion and maternal hostility*

On the other hand, what about conceiving too early or in circumstances that are certain to lead

to an unwanted or seriously unwell baby, and the corresponding risks to the well being of the pregnant mother? Is not abortion the woman's right to consider and decide? Laws still protect this right, but they are under serious threat in America. While embracing and defending this achievement of the last 30 years in America and the western world more widely, Hrdy does not shy away from pointing out that parallels exist between abortion today and infanticide in the past. Babies are not always, and have never always, been born to mothers consistently able to display the 'maternal instincts' claimed for them in so many idealized religious, literary and scientific accounts of motherhood. Maternal instincts include the wish to protect the survival of the mother herself, and her related position in the social-political hierarchy to which she belongs. Thus it is and always has been, Hrdy tells us, with the consequence that women rid themselves of babies in the past as frequently as women opt for abortion today. Though, in the past, infanticide represented less risk to the woman's health and survival than abortion, and thus was the more common strategy for resolving the dilemma posed by an unwanted pregnancy. Hrdy, of course, deplores infanticide and maintains that being pro-choice is being pro-life.

Beyond abortion, there is the reality - long-recognized in the psychoanalytic literature - concerning inner conflict of the pregnant woman, and mother, tinged by deeply felt (unconscious) hostility toward the baby. This theme is not as fully developed in Hrdy's text as it might be. She is more likely to feel at home with the views of Daniel Stern who maintains that unconscious hostility is relevant but less important, in the mother's mind, than her urgent (evolutionarily determined) wish to safeguard the survival of her baby.

### *Summary/ Recommendation*

To sum up, one's understanding of pregnancy, motherhood, evolution, history, anthropology, literature, art - as well as attachment theory and research - can only be enriched by engaging with her narrative. Blaffer Hrdy does justice to the contemporary dilemmas facing a mother who juggles concerns over career, child(ren), spouse, extended family and friends. This is achieved by showing that the trade-offs and bargaining a mother engages in with herself and others, in order to ward off danger and maintain security for herself and her family, is not all unique to the modern or post-modern world. Rather, it is a continuation of the profound struggles for survival faced by women ever since the hominid form we recognize as our own evolved in the Pleistocene era, some 10,000 to 1.6 million years ago. Thus, deeply felt ambivalence toward pregnancy and motherhood, stemming from all range of life-threatening conflicts, are the rule and not the exception across species and across evolutionary epochs. In every era women have sought to improve their inclusive fitness, i.e. the chances that they will successfully reproduce and raise offspring who might, in turn, survive to reproduce themselves. Yet, whether or not this latter success is realized depends greatly on the care provided by the mother and the caregiving input she elicits from others, e.g. father, grandmother, older child(ren). As John Bowlby never hesitated to say, 'a society which values its children must cherish their parents.' Blaffer Hrdy's book may help empower individuals, as well as social and political forces, to respond afresh to Bowlby's injunction.

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## Editorial

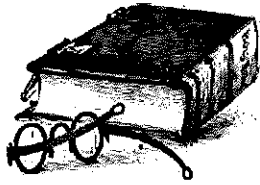
When this Editorial appears the Melbourne Congress will be concluded, but hopefully readers will feel inspired to submit contributions to *The Signal* to help those who could not attend to savor something of the experience.

Meanwhile, this edition contains two papers that continue the theme of group work with parents and infants, and more would always be welcome. Likewise, I would greatly appreciate contributions for the Literature Monitor and Conference Report sections. There is in fact no Conference Report this time as I have received no contributions - I do depend on readers for these.

We also have a very interesting piece on "controlled crying" from Penelope Leach. (Incidentally, you can also find a position statement on this matter on the website of the Australian AIMH).

With all best wishes for the New Year

Paul Barrows



## LITERATURE MONITOR

### Articles

Squire, S. & Stein, A. (2003)  
'Functional MRI and parental  
responsiveness: a new avenue into  
parental psychopathology and early  
parent-child interactions?'  
British Journal of Psychiatry  
183:481-483  
Contact: [sarah.squire@psych.ox.ac.uk](mailto:sarah.squire@psych.ox.ac.uk)

"Correspondence: 'Treating maternal  
depression?'" P. J. McGrath, F. J.  
Elgar, C. Johnston, D. J. A. Dozois &  
S. Reyno with Authors' reply: P. J.  
Cooper and L. Murray The British  
Journal of Psychiatry (2003)  
183:461-462

Klass, P.E., Needlman, R. and  
Zuckerman, B. (2003) 'The  
developing brain and early learning'  
Archives of Disease in Childhood  
88:651-654  
Contact: [perri.klass@bmc.org](mailto:perri.klass@bmc.org)

Anand, K.J. & Scalzo, F.M. (2000)  
'Can adverse neonatal experiences  
alter brain development and subse-  
quent behavior?' Biology Of The  
Neonate, 77(2): 69-82.

Morrell, J. & Steele, H. (2003) 'The  
role of attachment security,  
temperament, maternal perception, and  
care-giving behaviour in persistent  
infant sleeping problems.' Infant  
Mental Health Journal, 24(5): 447-468.

### Journals

The December number of the Journal  
of Child Psychotherapy 29(3) is a  
Special Edition devoted to Under-  
Fives Work. Includes papers by  
Barrows, 'Change in parent-infant  
psychotherapy'; Likiernan, 'Post  
natal depression, the mother's conflict  
and parent-infant psychotherapy';  
von Klitzing, 'From interactions to  
mental representations'; Reynolds,  
'Mindful parenting, a group approach  
to enhancing reflective capacity in  
parents and infants.' See:  
[www.tandf.co.uk/journals](http://www.tandf.co.uk/journals)

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