

The Signal



Vol. 12, No. 2

Newsletter of the World Association for Infant Mental Health

April - June 2004

RELATIONSHIP TREATMENT AT A BABY-PARENT UNIT

Opening the way for crucial meetings

By: Kay Karlsson

Psychologist, Psychotherapist

Anna Malmquist Saracino

Psychotherapist and group analyst

Eva Norling Bergdahl

Psychologist, Psychotherapist

The *Maskan* Baby-Parent Unit,
Stockholm, Sweden.

Illustrations: Birgitta Scholander

Introduction

Like many baby-parent units, the *Maskan* arose from the need for an intermediate form of care for intensive treatment directed at severe relationship problems in families with babies. The *Maskan* is a BUP (child and adolescent psychiatry) activity within Stockholm County Council's South Stockholm section, and has been in existence since 1989. The target group is those families with

babies who do not get sufficient help from outpatient meetings with child health center psychologists, and where neither institutional residence nor hospitalization provide adequate help.

With the group as structural framework, hindrances to relational development are treated. Mothers visit the unit group for three hours twice a week with their babies, with a further visit per week for individual psychotherapy sessions, for an average of six months. Fathers take part in the treatment and participate on a continuous basis in monthly family guidance meetings.

The objective of the unit is to use both psychotherapeutic and psycho-educational methods to treat relationship disturbances between mothers and their babies during their first year. The method has three main features: group get-togethers, individual psychotherapeutic sessions with mother and infant, and direct and tangible interaction treatment.

Plans for each individual couple are set up prior to commencement of the treatment process. Focus of the work, and objectives, are set up in consultation with each family. Any collaboration with colleagues in

adult psychiatry, social services, and/or the children's hospital is determined at the start of treatment. The work is followed up each month with the family, and if necessary with collaborating colleagues.

Intensive treatment at the baby-parent unit has been shown to be necessary in approximately 1% of all families with infants in major city regions. For the *Maskan*, this means around 60 families per year, which is beyond the capacity of the unit. In year 2001, 24 families were received for treatment. An assessment from 1997 showed that 9 out of 10 families with babies taking part in the treatment process received help in relationships with their infants. Infants had developed; interaction between mother and child had commenced. The positive effect remained three years after the end of treatment.

How does it feel, not being seen?

A baby seeks for eye contact with his mother. The mother appears to see straight through the infant, no changes are evident in her eyes, facial expressions or voice. The infant's eye ventures further round the room, stops a while at a bare wall, then on to the window from

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where traffic can be heard. The mother says nothing. The infant whimpers aimlessly, looks empty-eyed, whimpers again. The mother sighs: "Stop whining, what do you want now?"

How must it feel being the one to evoke sighs and displeasure? What happens to affects which are not given any meaning by the "other's" response. How can infants attach themselves to people who are unable to meet their needs?

Newborns are in the hands of their caregivers – their mothers and fathers. Attachment patterns are inherited transgenerationally. The inner lives of mother and father, and the relational patterns they carry from earlier generations, become the infant's emotional environment. Having had a good relationship with your own family of origin is the best start you can give your newborn infant. But not everyone has had that privilege.

How does this display itself?

Clear difficulties in taking care of an infant will most likely be noticed at the child health center or through tip-offs from friends and relatives. Less obvious difficulties may long remain concealed. Gradually, the infant can show symptoms expressed as eating problems, screaming, or sleeping difficulties. The mother might suddenly suffer from anxiety attacks or depression. Or else the day-to-day routine rolls on and a cheerless cloud descends over existence. What is then seen is absence and deficiency. No meeting of eyes, no soft body bending trustfully towards another, no exchange of smiles.

Child psychiatric treatment?

We cannot know in advance which infant will be a teenager who acts out, becomes anorexic or receives an

ADHD diagnosis. However, international infant research is united in pronouncing a good relationship between parent and infant to be the basis on which the infant's entire future development rests. Insecure attachment leads to uncertainty and greater stress, which in turn contributes to the development of bodily symptoms and a building up of destructive inner working models (Bowlby 1969). An infant with positive attachment can use its energy in the service of development. The energy does not become tied up in, for example, fear of aversive looks or insecurity spreading from an anxiety-filled mother. Infants exist within the inner environment of their parents.

Preventive?

Child psychiatry work with infants is often termed preventive work. The babies have no recognizable psychiatric symptoms. They live fully in the world of the body and express themselves via this. They do not know what a stomach cramp is, merely feel a discomfort and express this. People around the infant are those who interpret its sensations and provide help, or else become affected themselves and struck by helplessness instead of providing comfort.

Within a secure attachment, empathy and cognisance continuously deepens and strengthens the relationship. This can easily be witnessed in the tangible interaction between parent and infant. If a mutual and positive interaction is felt then the body registers this directly – we ourselves relax and the joy rubs off on us. When we experience non-functioning interaction, then tense headaches or other bodily feelings of unease arise.

It is from within the bodily world that an infant's symptoms must be understood. An infant who screams frequently or avoids eye contact shows in fact strong symptoms. In this respect, treatment is not preventive,

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The Signal is a quarterly publication of the World Association for Infant Mental Health. Address correspondence to Paul Barrows.

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but rather involves advanced child psychiatry treatment.

Creating primary relations

How does a baby form its own identity, become a person among many others? We achieve life in our meetings with others. Infants develop through relations with their primary caregivers. But dyad and triad are not everything. More recent infant observations and research have emphasised babies' competence and their innate ability to actively contribute to social interaction and relate flexibly to their surroundings from the start. Modern developmental psychology (Stern et al 1998, Trevarthen 1993) emphasises, as does group analytical theory (Foulkes 1975), communication, interaction and relations as the basic human driving forces. These theories have in common a view of humans as genuinely social beings.

We look for a meaning in life. A feeling of meaningfulness relates to the experience of existing in the present. Living in the present is a question of reaching others in our contact efforts. Our existence needs confirmation and we need a context in which to come into being, to be, to develop. These existential questions come to the fore particularly when a new life is born, when an infant seeks an attachment, and a mother bonds with her infant. When a mother "becomes" a mother, and "is" a mother for the rest of her life. Parenthood is a normal stage of development in life, and at the same time an upheaval. Parents and infant together are to develop a mutual relationship. This is a creative process providing both infant and parents with meaning in life.

Stern (1995) speaks of specific and central tasks relating to parenthood: maintaining life in the infant, being able to give the infant love, and creating a sustainable network around

both infant and parents. Am I capable of maintaining life in the infant, nourishing it so it grows and flourishes? Am I, as new parent, prepared to take on this great responsibility? Am I able to put myself and my own needs aside for a while and let the infant come first, both outwardly and also in fantasies and thoughts? How do I know I possess the ability to love? With the arrival of a baby, we are forced to look closely at sides of our personality which we previously could avoid. Another new task is creating a network around oneself and the baby in which to live and develop.

These tasks 'actualize' the parents' own basic reliance, formed during their first period of life. We have to change our identity and orient ourselves towards a new way of being. From primarily being the child of someone else, to being a parent to somebody.

Internal working models

We create internal working models of what we expect in meetings with others at an early age. Basic conditions for interaction with others are constructed early – during babyhood. The infant builds up internal working models for its way of relating to others dependent on the nature of the attachment he or she has to its own parents.

For example, a feeding situation can actualize many different kinds of internal working models. A slight sense of hunger gives expectations of soon having warm milk in mouth, warm arms round, pleased and watchful eyes, chatter and then sweet sleep. For another infant it might forebode much disquiet, tense stomach, screams of panic and vomiting. In the first case, satisfaction in motherhood is deepened, which facilitates being with the infant. A positive spiral is created, not only in the baby-parent relationship, but also in the infant's

relation to other people. In the second case, mother's stress and worry increase, which in turn increases worry in the infant. This disquiet can spread to its surroundings and become permanent.

We all have our internal working models, originally formed during our own period of babyhood, and successively changed and modified during our lives. But when faced with the task of developing a primary relationship with our newborn infant, it is from our inner, our own babyhood, that we retrieve knowledge. We have not forgotten. Some people take on the task with natural competence. Others merely face darkness, a deep hole into which they may fall headlong, back to a childhood of deficiency.

Mothers' own motivation

Treatment at baby-parent units is based on high motivation in parents. The mothers look for help not because they want psychotherapy for themselves, but because it is crucial for them to gain a good relationship with their infant.

Frequently, they do not know what they lack, merely that something is lacking. Perhaps they have met another mother and infant and noticed the reciprocity between them, compared to their own emptiness. Or they are aware of their own difficult babyhood and afraid they might repeat it. Some of the mothers have previously attended for their own psychotherapy and felt they have in part processed their childhood traumas, but that when holding their infant, body memories return.

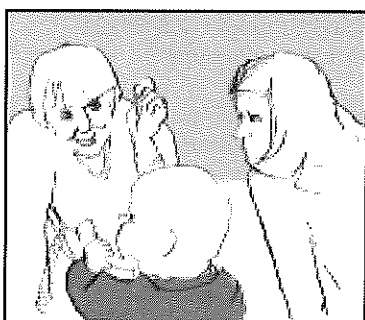
Treatment

At all times, treatment is directed at what is in-between mother and infant. It contains a whole series of paradoxes: time – timelessness; therapeutic framework – real life; psychotherapy – pedagogy; inner – outer;

mother and child have been inundated with, before a new potential space to meet can be created.

Psycho-educative approach

Once the mother is attached to the therapist and, via this sustainable relationship, has gained trust in the group and the treatment as a whole, the therapist can intervene on a more problem-focused and tangible pedagogic level.



Example: *The therapist observes a one-year-old boy playing with a toy telephone, putting the receiver close to his ear while talking loudly. His mother sits close by and looks at him, says nothing, fails to answer him. The therapist glances back and forth from child to mother, from toy to mother. After a while, the therapist directs herself to mother and shows how her boy puts the receiver near his ear and says: "It really does seem now like he's saying something...the phone's almost at his ear now...and he says "hurrr...urr...urr". The mother looks doubtful and questioning, she frowns and says: "Weeell...". The therapist looks at the child again, leans closer to mother, looks back towards child, moves closer to him asking the mother: "What do you think he is saying?" Now mother also focuses on the boy, moving closer to him. The three now form a close and tight triangle. Mother says to the therapist: "It's not quite at his ear, is*

it, the phone? But..." The therapist turns to mother, talking in an ordinary conversational voice, and imitates with her hand the actions of the boy with the receiver: "No not exactly, but getting there. Don't you think he is imitating you, how you talk on the phone at home, and he wants to do the same? Imitating you, you know, trying to copy you?" The mother knits her brow again and asks wondering: "You mean...he's...holding the phone to his ear?" Therapist to the mother: "Maybe not quite, but he's holding it like this..." Again she illustrates with greater clarity and intensity how the child attempts to hold the phone to his ear. The mother looks attentively at her child but is not really present with him.

The mother's empathy seems limited and, when she answers her boy, timing and attunement is often poor. She fails to answer her son since she cannot understand that he is trying to talk on the phone and imitate his parents' behaviour. It seems not to be about internal obstruction, but rather lack of experience.

The mother's difficulties in communicating can be seen not only in the relationship to her son, but also generally in the self-centred and monotone way she talks in the group. The episode above provides an example of how individual psychotherapy would not suffice or be adequate for the treatment goals of the baby-parent couple. The communication taking place at a non-verbal level is central to the treatment method.

How does the therapist work in the example above? She increases the intensity of her effort to reach the mother, to get her to understand the playing, to realize that the chance exists to enter the game and get in contact with her son. The therapist increases the intensity of all the therapeutic tools at her disposal. She names what she sees of the boy's behavior, interprets the content of what he is doing, and invites the mother to contemplate whether it is

possible that this is how it is. Her verbal interventions are reinforced by her use of body language - she precisely imitates what the boy is doing - while at the same time leaning closer to mother and showing her. Throughout the episode, the therapist glances backwards and forwards from mother to child, as if to link their relationship by spinning an invisible bonding thread between them with her eyes.

The "piving over and taking over" approach - the therapist recedes

When the mother gradually takes over the therapist's approach, it is important that the therapist is sensitive to the need to withdraw to a greater distance so as not to take vitality from the beginnings of contact between mother and child.

How can we detect when mother has started taking over the therapist's approach? We can see this through her becoming more present; seeing what the infant is doing, and sharing the experience with the child; talking to and with the child and not just about the child; gaining greater vitality, becoming more supple in her movements, more nuanced in her facial expressions; attuning to the child's affects, all of which are prerequisites for mutual, inter-subjective meetings.

Example: *The child draws himself up against the wall of a playhouse and looks in and out through its windows. The mother has followed the child's focus attentively all this time, her eyes searching him out. This develops into a peek-a-boo game between them. The mother breaks into a big wide smile. The child laughs heartily each time he makes eye contact with his mother and she says: "Peek-a-boo, peek-a-boo, peek-a-boo!" The mother, who previously sat stiff and passive in the group, can suddenly move her*

entire body and attune to the verbal expressions of the peek-a-boo game with sweeping and billowing movements back and forward.

Mother and child meet at last. There is a whole series of interactions. It is difficult to determine who takes the initiative. It is as though they both possess a readiness to enter into play. They both gain a new experience of being together with one another. One can surmise on good grounds that the feelings generated in this mutual experience increase the desire and opportunity of both infant and mother for further meetings. The therapist unobtrusively shares the pleasure of the meeting with mother, infant and others in the group. In this situation the therapist leaves mother and infant in peace. To paraphrase the words of Winnicott (1960), it is as if the mother needs to play with the child in the presence of the absent group. It may also be described in terms of mother and infant, in moments like these, widening their "inner landscape of implicit relationship experiences" (Stern, et al. 1998).

Therapist interventions

The therapist alternately directs verbal and non-verbal interventions towards infants, mothers, their interpersonal relations, and the group as a whole. Non-verbal interventions play an important part in the method. The therapist works purposefully via imitation, participation and affect-attuning interventions. These are aimed equally at both mother and infant with the objective of adding new experiences of inter-subjective relating. The presence of the baby gives the therapist a mandate to exaggerate affect expressions at a non-verbal level while also working with the adult problems of the mothers.

Thus the treatment method will include both the actual baby, mother's concept of her infant, her concept of herself as a mother, plus activated traces of memory from her own

babyhood. The therapist oscillates between going in as a subject, and being in full mutual dialogue, and making verbal interpretations and narrative descriptions. The Baby-Parent Unit's mother and infant group provides the opportunity for training in communicating and relating at the dyadic and triadic level etc in ever larger groups and social contexts.

What is therapeutically effective?

In the previously-mentioned assessment report, considerable consensus existed between therapists and mothers that a basic requirement for good treatment results was regular appearance at the group and being together with children along with other mother-infant couples.

How might we theoretically understand that as many as 9 out of 10 baby-parent couples are helped? When they start at the Maskan, many mothers have terror in their eyes. They face something completely new, full of responsibility. Only a successful outcome is allowed from them. Even if many of them have waited a long time before taking on parenthood, they have had to hear people say of course it will "work out well" – women have always had children.

What we see in the mother's eyes is terror, as if she has been left to pilot a jet plane without guidance – a task beyond her. The new mother is filled with the responsibility for taking care of the new baby; wishes for its utmost best, but feels unable to draw close to her child. This was to be the task of nature; instead the mother is caught unaware by difficult and painful memories, or rather states, since we are concerned with pre-verbal levels awakened by the new existential situation, and the mother can neither flee nor escape.

How might we understand the feelings and reactions of the mother and provide psychotherapeutic help? As

already mentioned, an interpretative psychotherapy making unconscious material conscious would not suffice. Through an embryonic theoretical paradigm developed by the Process of Change Study Group, we have gained relevant and fruitful ideas for considering further our clinical work with families with infants. In a 1998 article, Stern et al presented their thinking on the non-interpretative mechanisms active in psychotherapeutic processes: "the something more than interpretation" (p 903). This "something more" is made up of concentrated meetings between therapist and patient – "moments of meeting".

Research groups have formulated thoughts and theories on the inter-subjective processes which take place between therapist and patient in adult psychotherapies drawing on research results from infant research with, for example, observations of the interactions between mothers and infants, but also from other disciplines such as chaos theory and non-linear dynamic systems (Sander, 1998: 280). According to the views described here, the principle agent of change in psychotherapy consists of meetings characterized by enhanced emotional intensity reached between therapist and patient. Such meetings are characterized by a new quality revealing itself in the relationship.

Different systems of memory

The thinking about the importance of such concentrated meetings in relation to verbal interpretation is based on theories and research results related to memory function. At least two memory systems are taken account of: the declarative and the procedural.

Declarative memory stores, in symbolic or verbal form, whatever is explicit and conscious, or open to consciousness through, for example, psychotherapeutic interpretations. **Procedural memory** stores things

which are not symbolised, such as how certain tasks are done – cycling, swimming – and also how we are together with others, how we socialize.

Thus procedural memory stores various experiences of being together with others which become the basis of our implicit knowledge of relationships. For example, a child learns at an early age which form of emotional approach a parent will appreciate, and which will be rejected, and develops a way of being following from these experiences.

Implicit knowledge of relationships is active without us being conscious of it. This memory type is not language-based and is not automatically translated into semantic form.

Memories of this kind start being stored and represented within us long before language is accessible, and then continue acting implicitly throughout life. They can be reached and accessed for processing and developing *in interaction* – through transactions within the framework of a relation – rather than through interpretation where repressed, symbolized material is made conscious.

Within our scope of activities in the Baby-Parent Unit we are much involved in providing completely new experiences. Adding new experiences is as much a part of the work as encountering the pain linked with difficult procedural memories being awakened through a resurrection of the baby-parent constellation in the new mother. This time she is mother, not infant.

It is only within the framework of secure interaction that changes within the procedural domain are possible. Within the framework of a secure relationship, painful procedural memories become accessible for processing and can be looked at afresh. Through mother being seen and acknowledged by the therapist,

she can dare to meet the painful feelings brought to life by motherhood. Patterns can be revised and completely new experiences of being together with “the other” can be added. Eventually, the mother can open herself to, and make herself accessible to, the infant.

The therapeutic process

Within the ongoing relationship between therapist and patient, a shared knowledge of one another, and the specific and unique relationship they have, is developed. This knowledge is largely unconscious and implicit. Stern et al use the term “moving along” to describe the ongoing process between therapist and patient. This term finds its inspiration from the interaction which normally takes place between parent and child.

The unique, shared knowledge develops in a continuously ongoing process of mutual regulation of needs – acknowledgement of one another’s motives and wishes, both conscious and unconscious. Unforeseen events, misunderstandings, amending of mistakes, agreement, disagreement, negotiation, etc. may occur in the process. Within the framework of the relationship, this takes place between both mother and child and between therapist and patient. Even if parts of the relationship always remain unspoken and unconscious with both parties, both parent-child relationship and therapist-patient relationship are asymmetrical. In the therapist-patient relationship, it always lies with the therapist to remove obstacles and provide the conditions for a creative therapeutic process.

Occasionally, both parties in the process experience moments with a high degree of presence for both – “now moments”. These have an air of unfamiliarity and unexpectedness, putting the agreed framework to the test. Thrusts against the therapeutic framework occur at times during the

therapy. The framework sways, and a response from the therapist is required here which is specific and personal enough not to act as, and be seen as, a technical manoeuvre/evasive action. In these situations, the therapist faces a choice – stay within the usual framework and reach safe ground via, for example, interpretation, or tolerate the insecurity and openly meet the situation which has arisen, becoming accessible.

Should the therapist dare to be accessible and open, then the moment may develop into a concentrated meeting, a “moment of meeting”, giving rise to a changed quality in the contact between patient and therapist. After a meeting of this kind, a new “open space” develops where the two “part” from one another following the intensive meeting or occurrence. A reorganization of defenses may then take place, leading to a new way of being. A deadlocked situation may be resolved for the patient and a new, somewhat different intersubjective field, be formed. Both therapist and patient know when this occurs, and the infant in the mother-baby couple is able to meet a more present and accessible parent.

The process then continues “moving along” – and yet in a somewhat different way than previously. Concentrated meetings of this kind open the way for continued exploration at a more complex level, for therapist and patient and for mother and child.

Crucial meetings

Absolutely most crucial for the infant’s mental as well as physical health is the interaction with the parents. If radical and permanent treatment results are to be achieved, then work must be started early on, and focus on, the intersubjective field. Infant ability for relating intersubjectively at ever deeper and more refined levels during the first year is natural, and particularly

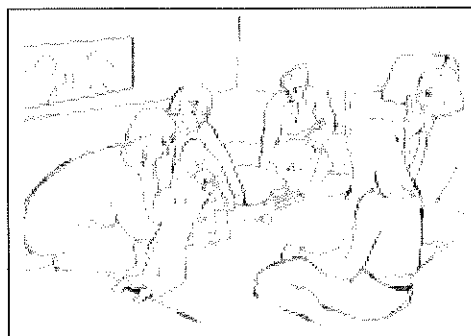
pronounced during the second six months. In order for this development to take place in an optimum manner, an available adult is needed to enter into mutual relations. The mothers coming to the Baby-Parent Unit have lacked preparedness for this, but during the treatment they have developed, sometimes in amazing fashion. At the end of treatment they say that they can be with their infant in a completely different way than previously. And this new way has also spread to any siblings. They also tell of being together with other people in ways previously beyond them or unknown to them.

The existence of the baby actualizes the mother's own babyhood. This fact, in combination with the multi-faceted treatment, provides space for processing the pre-verbal, bodily memories woken by parenthood. It offers the mothers the chance to achieve completely new experiences of being together with their children. Treatment results are good, the infants develop well and their initial symptoms disappear as the relationship with their mother develops.

The infants might have 70-80 years of life ahead – for them these meetings are crucial meetings.

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Strengthening infants and children: South African perspectives

By: Linda M Richter

"Is there anything useful to be said, in a post-modern context, about INFANTS, INFANCY and, perhaps least of all, CULTURE? We all seem to agree that there is no "universal" child to be studied and that children can only be understood in their social, temporal, and material localities. Further, as children have become constructed in the arena of identity politics as a minority group with rights, many of which are unfulfilled, we're bound to recognize that children, like other groups, are not uniform or homogenous. Rather, in the words of Allison James and her colleagues, children are "fractured and faceted in internal diversity" (James, Jenks & Prout, 1998).

But such relativism is less troublesome when we talk about children, than when we talk about infants. With regard to infants, it is very difficult not to adopt a variant of universalism in relation to at least some aspects of infancy. About infants, many of us find ourselves in sympathy with Robert LeVine's view that "child-rearing practices ... can vary culturally only within limits established in the distant evolutionary past without inflicting developmental damage on the child" (1977:16).

Culture is, of course, a highly problematical concept, and all social and human scientists struggle with the notion of culture whether they do so knowingly or not. Many of the important questions facing our disciplines have to do with universality and particularity among people, both individually and collectively. For one, these issues determine the validity and

generalizability of our knowledge, including our knowledge about infant mental health.

Twenty years ago John Ogbu (1981) introduced a cultural-ecological model to developmental psychology, in which he pointed out that child rearing is a future-oriented activity which consists of culturally organized formula to ensure children's survival and competence. However, he skirted round universal features of child rearing. Universal features of child rearing are those meta-aspects of child care which support the development of psychobiological functions; what Sameroff and Friesen (1990) call transactional regulation of human development. "Just as there is biological organization, the genotype", they say "that regulates the physical outcome of each individual, there is social organization that regulates the way human beings fit into society" (p. 124).

Because humans are complex organisms, regulation involves a variety of interconnected and overlapping processes. At any given time regulation of several component organic subsystems may occur simultaneously. In addition, a single caregiving action may service several regulatory purposes and many different caregiving actions may serve the same end state. Robert Bradley and Bettye Caldwell (1995) attempted to identify major components of caregiving regulation that they call near universals, that is, applicable to all known caregiving systems. They arrived at a classification of five regulatory caregiving tasks - sustenance, stimulation, support, structure and surveillance. This framework, which specifies purpose

(i.e. the regulatory function served), leaves unspecified the mechanisms through which the purpose can be achieved. Clearly people and settings in the proximal environments of children are strong determinants of these regulatory mechanisms. One need recall Whiting's (1980) observation that one of the most powerful ways culture influences development is through structuring the settings of daily life. In summarizing their conceptual framework, Bradley and Caldwell concluded that the central feature of optimal child care environments is responsiveness, regardless of how difficult the concept is to define (Martin, 1989). At the very least, responsiveness implies interpersonal sensitivity, empathic awareness, predictability, non-intrusiveness and emotional availability.

This is a useful approach to understanding cultural and parental practices to strengthen children; practices to increase children's capacity to withstand the setbacks and problems which we accept will be part of all children's lives, and more so of the lives of children growing up in seriously disadvantaged social circumstances. In summarizing a report on long-term determinants of competence in the 1970 British Birth Cohort Study, Osborne (1988) concluded that a critical element of childhood resilience could be attributed to an all-pervading parental attitude of interest in and devotion to the child. John Martin (1989) also draws attention to the importance of devotion in child care, as a transcendent concept that incorporates emotional availability and engagement.

Across all cultures is a perception of infants as being vulnerable to hazards that can endanger the infant's life and jeopardize his or her development. These hazards take many forms and there is no question that they are culturally, socially, and economically framed and expressed. Some caregivers fear their infant will succumb to Sudden Infant Death Syndrome, others that their child will fall onto a fire, be abducted by evil spirits, contract a life-threatening or disabling infection, or be socially polluted by human or animal detritus. Corresponding to the perception of vulnerability, and the pervasiveness of external, environmental or situational hazards, exist beliefs, practices and rituals which aim to protect and strengthen children so that they may survive and flourish. It is my view that it is not the precise forms of protection that ensure the safety and well-being of children, but the fact that caregivers engage in protective practices that are consistent with their culturally-informed goals of ensuring their child's survival and healthy development. Such beliefs and practices ground protective behavior and responsiveness on the part of caregivers regardless of their specific content.

I'd like to give you an example of this. Three years ago, together with a Master's student, I conducted a study amongst undergraduate students on cultural practices around infant sleeping. Each student in a large developmental psychology class conducted an interview with their mother or grandmother about where they, the student, had slept as a small child of four months old and four years old, and what reasons their primary caregivers gave for these sleeping arrangements. Recall over 18 or 20 years is not good, but the methodology was meant to elicit cultural idealization at least as much as practice; that is, what would have been the correct thing to do about the

sleeping arrangements of children of those ages and why? The findings were dramatic. With almost no exceptions, African students, about half the class, had slept with their mother in infancy and with sibs, aunts, grandparents, cousins, or parents when they were 4 years old. Almost all the White students had slept in a bed alone, and many of them slept alone in a separate bed in a separate room. These are quite different cultural practices, and each has presumed universal and specific behavioral and social implications.

What, of course, is the most interesting aspect of the study is that while the primary motivation for each of the sleeping arrangements was the same – that is, children were generally put to sleep with others, or slept alone, because parents believed it was “good for the child”, the subsidiary motivations varied dramatically. Subsidiary motivations were divided into child- or parent-centered concerns, and practical limitations. Even within a specific subsidiary motivation, concern for the child, African and White parents differed markedly in their explanations. African mothers tended to justify co-sleeping with 4-month-olds with statements such as: “When he woke up he would know he was not alone,” “I thought it would help the child feel at ease knowing her mamma was by her side,” “It would help the child recognise me as her mother.” White mothers explained independent sleeping by statements such as: “I believed children slept better in their own rooms,” “I did it to give the child a certain amount of independence, but also support,” and “I was afraid of crushing her.”

According to the point of view I have adopted in this paper, it is not the co-sleeping or independent sleeping which is of consequence for the child, but the motivational context of caregiver mindfulness, expressed as it is in activities intended to benefit the

child through, in this case, increased surveillance, support and structure achieved through preferred sleeping arrangements. Theodore Dix (1991) articulated a similar point of view in arguing that, for sensitive and responsive caregiving to occur, caregiver emotions must be empathically organized around concerns and outcomes related to children's well-being and development.

Many anthropological accounts of African childrearing stress the determining influence of cultural adaptations to high infant mortality rates, and the formative effects of material and economic ecologies. For example, on the basis of his work amongst the Gusii in Kenya, Robert LeVine (1977) argued that the predominant features of the care of African infants – closeness to the mother's body, responsiveness to crying, and frequent feeding, reflect the over-riding concern of parents for the physical survival and health of children, and they help to mould what he considered to be the kind of individual passivity and obedience that are necessary dispositions in an authoritarian society. In my view, such concrete and homogenizing simplifications have pervaded infancy studies in Africa, with some exceptions (Konner, 1977), and diminished our understanding of child care practices, as well as possible relationships between child care attitudes and practices and children's later competence and coping.

Very little is known about the contemporary care of infants amongst Black South African cultural groups: either about those practices that may augment efforts to improve the health and development of children, or those which conflict with Western healthcare strategies. Health care recommendations are frequently imposed on people with little attempt at cultural justification, negotiation or accommodation. For example, for many

African mothers, the idea of placing a small infant, naked, on a weighing scale in a clinic, supposedly one of the monitoring mechanisms by which we attempt to secure the growth and health of small children, is a frightening exposure of her child to the traces of unknown and potentially dangerous other children who may unwittingly transmit ill-will of a variety of kinds. It would surely be of benefit to women to have their fears acknowledged and to accommodate clinic practices in simple ways that would reassure women of their children's safety.

Ideas and practices are part of a wider system of concepts that underlie and reflect perceptions of the world and of humanity's place in it. For this reason, ideas about children have close links with religious systems and worldview. From the point of view of African cosmology, infants are threatened by environmental factors (e.g. cold), natural events (e.g. the introduction of new foods), and what many people call "supernatural" factors, which refers to the relationship between people and their environment. Amongst this latter category, Hammond-Tooke (1974) distinguishes four broad causative factors – a supreme being, ancestors, witches and pollution beliefs. With respect to pollution, there is a generally held view that both humans and animals leave something of themselves behind when moving through the world and, at the same time, absorb traces of others. Children need to be protected against these umkhondo (in Zulu) or mohlala (in Sotho), and need to develop immunity to them as they grow older and develop (Ngubane, 1977).

According to the Zulu anthropologist, Harriet Ngubane (1977), the world is full of dangers. She says, "The environment is not only polluted by undesirable tracks or by what is discarded in healing. It is also made dangerous by sorcerers, who place

noxious substances on a particular person's pathway or scatter them along pathways to harm any passer-by" (p 26). Therefore, to survive these dangers, people have to be frequently strengthened to build up and maintain resistance. This is achieved by establishing and maintaining a form of balance, or moral order, with one's surroundings – one's relationships with other people, the environment, ancestors, and forces that produce pollution. Attempts to achieve this balance may give rise to new dangers. Ngubane says that "If a person uses very strong medicines to establish this balance, when he meets someone who is not properly strengthened, the latter is overpowered by his presence and may become ill. This is known as ukwekha ngesithunzi, to feel the weight or suffer the weight of someone's overpowering influence" (Ngubane, 1977: 26). And this is the danger to a child being weighed in a clinic on a scale used by many other children, some of whom may have recently been strengthened.

Some people are more vulnerable to dangers than others. The especially vulnerable include infants, strangers in the area, and people who have allowed too long a time to pass between strengthenings. "An infant," says Ngubane, "is not only a stranger to the environment. It also has a fragile bone structure, with wide joints, such as the fontanelle (ukhakhayi), which is considered a weak point against the hazards of the environment. In order to survive, the baby must be protected even before it is born. Its mother must observe a pattern of behavior that will minimize contacts with imikhondo (tracks or traces) ... (and) ... She should not allow long periods to elapse between strengthening treatments" (Ngubane, 1977:28).

Babies stay vulnerable for many months after birth. Diligent parents, especially the mother, need to take certain steps and perform particular

rituals to safeguard their child. These steps, which begin while a woman is pregnant, include the avoidance of potentially hazardous situations, the performance of rituals immediately after birth, and the maintenance of daily or weekly rituals. The important birthing rituals involve burial of the afterbirth, recognition of and response to the baby's first cry, treatment of the umbilical cord, meconium lavage, initiation into bathing and feeding, and the isolation of mother and child to protect them from external dangers, but also so they may get to know and adapt to one another (de Wet, 1998). All Black South African ethnic groups have rituals aimed at strengthening and protecting babies. For example, the Venda, Pedi and Zulu make many little cuts on different parts of the child's body and rub medicine into them. Amongst the Xhosa and Sotho the baby is held over the smoke of a fire in which special herbs are burnt (Van der Vliet, 1974). So important is the strengthening of a baby that the Tsonga have a saying that a child cannot grow from milk alone. Continual daily and weekly rituals include adding medicines to a child's food, burning protective substances near the baby, bathing the child in herbs, rubbing ointments on parts of the child's body, and performing enemas.

The study of medicine use undertaken by Thea de Wet in Soweto in 1998, is one of the few available contemporary South African ethnographies of infancy amongst Africans. According to her, rituals practiced in urban environments do not conform to those described in classical ethnographies, but continue to be practiced very widely in the form of variations and adaptations. One large category of variations involve the ingestion and the use as emollients of Dutch medicines: Rooilaventail, Stuijdruppels, Haarlemensis, Entressdruppels, Witdulsies, Doepe, Wonderkroon, Groen Amara, Duiwelsdrekruppels and

Behoedmiddel. In addition, a widely used medicine, Muti Wenyoni, is sold as an over-the-counter antispasmodic and medicine to ward off ill-will of various kinds, and to allay the baby's wind and digestive discomfort. African mothers mostly use these medicines as protection and prophylaxes against infant illnesses, to soothe restless babies and to promote growth and well-being. Frequently Dutch medicines are mixed together (for example at many pharmacies one can buy "Six Mix"), as well as with traditional herbs in a variety of combinations.

Haarlemensis is the substance used most often by Sowetan women. It is recommended because it is oily and sticks to the baby when rubbed on the skin, and is therefore presumed to have a longer-lasting effect with better protection for the child. Haarlemensis is packaged as a treatment for kidney and bladder complaints and a few drops are advised to be taken orally. It contains Balsam Sulphuris Base, Arachis Oil, Tar, Turpentine Oil and is classified pharmacologically as a laxative. Clearly many of these substances are not used in the ways recommended by the manufacturers, but new applications have been found for them within African belief systems. The psychological importance of strengthening rituals and the substances used in them, is illustrated by a mother, quoted by Thea de Wet, who says, "If you believe in all the things that you as a mother grow up with, then all this medication will help, but if you don't, they won't work and it will be useless to try them" (p 123). In order to achieve protection of children, strengthening activities become regular aspects of child care. To illustrate this, I quote the accounts of two women, reported by de Wet (1998: 134):

"I use Stuijdruppels, Haarlemensis and Wonderkroon. I wash the baby with water and soap two times a day and then I smear the child with

Vaseline which is mixed with druppels all over the body and then a drop of each bottle mixed with milk and give it to the baby".

"I use Groen Amara, Stuijdruppels and Haarlemensis once every day maybe until the child is one year old. I put one drop of each medicine in the baby's bath and if ever I am going out somewhere with the baby I will apply Haarlemensis under her feet, in earholes and on fontanelle with fingers and also on private parts."

Doepa also has very widespread use in South Africa. It is made from the resin of trees indigenous to Java and Borneo and its passage to South Africa via slaves and Dutch medicines can be traced to the East. Dhoop or Dhup is used amongst Hindus in incense that is burned to keep evil spirits away. Doepa has many meanings reaching far beyond that of a medicine or drug. It is variously described as a reukwerk (incense), a toomiddel (a charm), a liefdesdrank (a love potion), and toergoed (a magic object). In Soweto, Doepa and Imphepho (leaves from *Helichrysum* shrubs) are burnt either singly or in combination to soothe crying babies, especially when it is believed that the infant's fretfulness is a result of fear of things in the dark outside the house. One mother reported to de Wet that "I first see if the baby is not sick or hungry or try to find out what makes the baby to cry and then try to give her some Panado. If it does not help then I will burn Imphepho and Doepa – it will soothe the baby" (1998: 144).

In Thea de Wet's study, she found that 80% of women she interviewed reported using Dutch remedies to protect their infant from potentially harmful things around them (bad tracks, things in the air, and witches). "Parents can try to avoid dangers", she says, "but it is not always possible. Therefore they have to use protective medicines" (p.148). De Wet

strongly discounts arguments that women who engage in protective practices of these kinds are traditional, rural and uneducated. Instead, her sample of 169 women was generally young and unmarried; they had grown up in Soweto and most had a high school education. The majority of them did not think of themselves as particularly religious or influenced by so-called "tribal" traditions.

In drawing attention to these child care practices, I would like to avoid conveying any kind of condescension, by implying that such practices are superstitious or based on ignorance. On the contrary, ethnographies of White, Indian and Colored mothers' behaviors in South Africa would reveal as many seemingly esoteric practices when viewed from an outsider's perspective. The daily infant care practices of many White women in South Africa include widespread use of Chamberlains Gripe Water, Phillips Milk of Magnesia, and rooibos tea, together with rituals of rubbing and rocking, times and types of feed, diagnoses of infant state made on the color and quality of stools, and so on.

Nowhere in the world are parents able to completely protect children, especially small babies, from potential physical, psychological or spiritual harm. All parents attempt to "strengthen" their children to withstand the difficulties they will encounter along the way through rituals and other practices by which available knowledge is appropriated to gain control over an unpredictable situation. Regardless of culture, resilience applies at the individual level, as well as systemically. Protective factors are frequently personal characteristics, relating to the self, the family, the context.

Personal and cultural sense-making helps people order the past, guide behaviour in the present and generate decisions about the future. The

protective practices of African women, a few of which I have described here, have this quality of sense-making. As Christine Liddell (2002) notes, in her paper on Emic Perspectives on Risk in African Childhood, "... these personal narratives are one of the most continuous elements of experience, smoothing away many of the discontinuities of real events that occur across the life span" (p. 111). She goes on to urge that developmental psychology would benefit from a wider concern with cultural variations in the incidence, interpretation and management of risk (and I would add, protective) factors in children's development. "For the present", she concludes, "it remains true that we understand most about risk and its effects on human development for cultural contexts in which the risks are fewest and least extreme" (p. 112). Adapted to the points raised in this paper, we similarly know least about what parents try to do, mindful of risks, to protect their children through child-care practices which strengthen children's coping capacity and build resilience.

Child, Youth and Family Development
Human Sciences Research Council
Private Bag X07
DALBRIDGE 4014
richter@hsr.ac.za

Note

This article originally appeared in the *Journal of Child & Adolescent Mental Health* (2002) 14 (2), and is reproduced by kind permission of the author and publishers.

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School of Infant Mental Health

Reflections on the 9th WAIMH Conference

Melbourne, January 14-17, 2004

"The Baby's Place in the World"

About the general atmosphere

As Tuula Tamminen, our new President of WAIMH, said at the Congress dinner, "We had to find a place to think and to talk about the "Baby's Place in the World" and we could not find better than Melbourne."

Melbourne is indeed a wonderful place in the world, but in itself, this would have not been enough, if it had not become a "shared environment" during the four days of the Congress, plus the day of Pre-Conference Institutes. Affects, concepts, and meanings were exchanged in an atmosphere of recognition of each one's place in its own right. As Jessica Benjamin formulated it, mutual recognition is possible only when the partners are secure enough in their own position...If this is so, we may announce that WAIMH members' attachment classification is secure!

A concrete example of fruitful mutual recognition was the joint power point presentation at the first plenary session: Joy Osofsky, a psychologist (whom you all know) and Cindy Lederman, a judge for Juvenile Court, stood together in front of the computer and clicked the mouse alternately, illustrating 'live' both their different foci and the complementary nature of their conception of the role of the court in the young child's healing process.

"We are in many ways like a family," said Peter de Chateau, the out-going President of WAIMH (who showed

us in his Presidential address, how excellent research could be done without video cameras or computers...already 30 years ago!).



Well, talking about families, we heard the pros and cons of going back and forth from dyads to triads, both during Alicia Lieberman's and James McHale's plenaries and from their respective discussants...along with the incredible performance at the Congress dinner

given by the psychiatrist-comedian Dr. Liam O'Connor.

Last but not least, a few lines about the extraordinary food we were served during the whole conference. As we all know, feeding interactions have a special role in interpersonal relationships – for young ones as well as for grownups. Being well-aware of this, the Local Organizing Committee made Mary and Steve, the caterers, come back from their summer vacation! Every day opened new opportunities, not only to learn new things in Infant Mental Health but also to taste new food! Have you ever heard of, if not tasted, a "Caramelized grape, walnut and blue cheese tart," or a "Chicken Santa Fe stuffed with green olives, coriander and green chili," or even a "Chicken on sesame rice cake"??? If only we could be just as creative in finding new concepts and treatments for infants and families as these caterers were

About the content

Obviously, we, the authors, can reflect only on those presentations we

attended, so please forgive us all our colleagues who have worked hard at presenting their work and won't be mentioned here.

What is new about the DC:0-3 Classification system?

A tremendous amount of work has been achieved in the last two years by the Zero to Three Task force with the aim of integrating the experience of clinicians who routinely use the classification, thus increasing the validity and reliability of the diagnostic categories. Emily Fenichel and Bob Emde reported the results of their web-based survey, showing those categories that are the most used, those that are problematic and also mentioning the problematic finding that only 43% of the participants in the survey had had a formal training in the DC O-3. Antoine Guedeney presented a review of the few clinical studies that have been done on the classification in different countries (France, Brazil, Israel). Those of you who are interested can find it in the last special issue of the Infant Mental Health Journal. A developmental trend emerged: Feeding and Sleeping disorders in the first year shifted to Relational disorders in the second year. Also, it was shown that the relative frequency of the different diagnoses is setting-dependent.

The most common reported problem was the difficulty in deciding between Axis I and Axis II diagnoses. Brian Wise and Bob Emde pointed out the main changes that will appear in the DC: 0-3R version scheduled for Spring 2004. Just to cite some of them, the criteria for Feeding Disorders will

include I. Chatoor's subcategories (Disorder of homeostasis, Disorder of reciprocity, Disorder of somatopsychological differentiation, Post-traumatic feeding disorder). Mood disorder will be divided into 2 subtypes: Major Depression and Depressive Dysphoric Disturbance.

The audience debated the validity of the diagnosis of major depression under the age of 18 months, and whether depression can be inherent to the infant regardless of the quality of the parent-infant relationship. One specific instance of inherent depression that was raised by the audience was that of infants at a hospital for severe and enduring illness. The diagnosis of Mixed Disorder of Emotional Expressiveness has been clarified by adding the criterion of a pervasive difficulty in expressing various affects, instead of anxiety or sadness only. The Axis V term of "levels" has been changed into "skills". Regulatory disorders are further specified.

Related ongoing issues are whether there is a need for operational criteria, for an upper-age limit and for adding the dimension of emotion regulation. The diagnosis of MSDD will be used for children under the age of two with significant impairment in communication, sensory and motor processing, together with some potential for intimacy and closeness. Finally, we had quite a lively discussion about the diagnosis of PTSD, in which several points emerged: there is a need to be more specific about the nature of the traumatic experience, to pay more attention to developmental level in the symptomatology (for instance, no play can be expected at the age of one year!), and to re-examine the former decision of "priority" of diagnoses (such as PTSD over Reactive Attachment Disorder), while the use of co-morbid diagnoses has been raised as an alternative.

For those interested in ongoing information about the development of the revised DC, the Web site is the Zero-to-Three Web site: www.zerotothree.org/imh and the e-mail is mhenry@zerotothreee.org

About Sick Babies in Hospitals

Ronnie and Marguerite Dunitz-Sheer from Austria (Graz) gave a well-attuned duet about their approach to weaning from tube-feeding.

Then Miri Keren, together with Australian colleagues, Campbell Paul, Michelle Meehan, Sue Morse and Rosalie Birkin illustrated different aspects of the infant mental health professional's role in mediating fears of pain and death in the infant and the parents, making use of their respective disciplines. They identified those situations where parental devotion becomes intrusion, and how a "healthy body conception" can be promoted in the chronically sick baby. All of us tried to put words to the often overwhelming counter-transference reactions we experience to a baby in chronic pain and/or doomed to death, and to parents who often have pre-existing psychological and relationship problems. We also sought to understand the nature of the psychic and physiological withdrawal defenses often seen in these sick babies.

About Clinical Teach-Ins

Seventeen clinical teach-ins took place. We attended the one entitled "Play is Self-Initiated Learning: But What If My Baby Isn't Motivated to Play"? presented by M. Papousek (Germany). She showed us the link between the baby's initiation of play and the quality of the parent-infant relationship. She emphasized how play is a biologically-driven activity for the infant, meant to meet several needs, such as curiosity, self-efficacy,

exploration, competency and mastery. Videotaped interactions showed us how infants don't initiate play with mothers when the playful elements in intuitive parenting are absent. These elements include a modulated tone of voice, a playful variation of repetitive themes, cycles of build-up and release of affective arousal and tension in interactional games, support and help with problem solving, and provision of a stimulating environment and ideas attuned to the infant's developmental level. Sometimes, the infant has difficulty in enjoying play, due to a regulation problem of his/her own.

This describes the intellectual content of this clinical teach-in; the affective part of it became somewhat "playful" under Mechthild's "intuitive facilitating" stance when the participants started to talk about their own experience and research on play in young infants, as if talking about play made us playful, i.e. spontaneously associative and thus, often creative.

About the Plenary Lectures and Discussions

"Healing the Child in Juvenile Court"

"Juvenile court is the last place where children are #1... we see some 30% of transgenerational transmission of abuse...our aim of intervention is to lower this rate," opened Judge Cindy Lederman. Joy Osofsky described the profile of young American children in foster care: it turns out that one in five children is an infant, and infants are paradoxically those who remain in care twice as long as their older peers. More than 50% suffer from severe physical health problems, including dental decay, and 50% show developmental delay, 4 to 5 times the rate of delay found in the population. Add a very poor language level and scarce play capacities, and we have the gloomy end-result: very young kids with aggressive behaviors as

their main mode of interpersonal communication. Though all these findings painfully show how the developing brain is affected by deprivation, trauma and violence, neural plasticity, or the brain's ability to compensate for early deprivation, is the rationale for the goal of healing that juvenile courts can and should have. Facilitation of healing is through understanding and speaking up for the needs of the babies who have been maltreated. Joy and Cindy suggest we should "encourage engagement, to allow exploration and initiation, instead of directing and teaching, and to focus on mother's strengths." They reported on their pre- and post-therapy assessments, including both parent and child items: parental behavioral responsiveness and intrusiveness, child's responsiveness at reunion, enthusiasm and affect.

"Attachment and Trauma: The Convergence of External Reality and Inner Experience in Infancy and Early Childhood"

Alicia Lieberman started with an extensive review of the symptomatology and the principles of assessing the impact of trauma on exposed infants. Then she illustrated the major principle of having both parent and infant attend the treatment sessions with a poignant clinical case of a little boy who had witnessed his mother threatening his father with a kitchen knife, and who became terrified of his mother, who was also his main caregiver. One of the turning points in the dyadic therapy was when Mother was able, through the support she received from the therapist, to tell her little boy that she was very sorry about what she did, but that he does not have to be afraid of her, that she will never threaten him because she loves him.

Miri Keren mentioned, using a short vignette, that young infants exposed to severe trauma do not always

develop PTSD, especially when they stay in close proximity to their attachment figure. Then, a clinical case showed the need for adding the dimension of the father's presence in therapy, so that the clinician could deal with both the aggressor parent and the victim parent in the presence of the child. The clinician's capacity to tolerate and to hold the aggression inside the room becomes therapeutic in itself for both parents and infant.

"When Infants Grow-up in Multi-Person Relationship Systems"

James McHale started with an extensive survey of the concept of "co-parenting." It is defined as the degree of collaboration and support between adults who raise children together, and therefore requires the existence of solidarity and consistent rules and standards. Video-clips illustrated different patterns of co-parenting, based on features such as competitiveness, mutual engagement, warmth and parent-centeredness (as opposed to child-centeredness). Five patterns emerged from McHale's studies: Child at center, Competitive co-parents, Cohesive-Child centered, Cohesive-Parents in charge, and Excluding families.

Marital distress was found to be significantly linked with poor co-parenting, but still, triadic dynamics are more complex than marital dynamics. Other influencing factors include prenatal family representations, individual parental traits, such as flexibility and restraint capacity (especially in fathers), and the child's own characteristics. Co-parental antagonism has been correlated with significant symptomatology and impaired adjustment in toddlers. McHale emphasized the need to include triadic interaction observation while evaluating a toddler with problems: often, the parent-child dyad looks okay, while the triadic interaction reveals high antagonism and poor co-

parenting. He concluded on a humorous note: "Assessment of the family needs to involve assessment of the family"!

Elisabeth Fivaz-Depeursinge, in her discussion, focused on the relative independence of sub-system functioning, while showing a clinical case of a family with a bipolar parent. The dyadic mother-infant interaction was less cooperative than the triadic/co-parenting one at 9 months, as reflected in the Lausanne Trilogue Play situation. In spite of the clinical improvement, the Strange Situation at 17 months revealed an avoidant attachment pattern. Bob Emde, the second discussant, raised the developmental aspect of co-parenting, showing how it may change according to the child's developmental transitions. Readers interested in knowing more about the family level may read the last issue of *The Signal*.

"Depression and Withdrawal Behavior in Infants: Theory, Research and Clinical Applications"

Antoine Guedeney shared with us fundamental questions related to the very existence of depression in infancy in the first two years of life. He argued that it is only from 18 months of age that the concept of "gone" can be grasped by the infant, as this is a major developmental intersection, where several core processes take place (joint attention, language, attachment pattern). Antoine argued that what we do see in clinical practice in the first two years are sad babies as part of PTSD and/or Reactive Attachment Disorder and not "intrinsic" major depression. (This part of his lecture evoked a lively discussion where many of the audience did not share his view). Then he proceeded to describe the significance of Withdrawal Behavior (measured by the Alarm Distress Baby Scale, clinical cut off of 5 and above), and showed how it is a significant red

flag of pathology, either physical or psychological. He stated that it is not synonymous with depression, nor with psychological problems: it can be an early and subtle sign of organic disease, as he showed in a video-clip. Ann Morgan, his discussant from the Melbourne Royal Hospital for Children, described the "too quiet child" in the hospital, in danger of being overlooked and left to his depression. She emphasized the need to touch, to speak, to sing and to move with the infant, as the first vital step, well before the parent-infant relationship is changed.

About a few symposia and workshops

"The Compromises of Motherhood"

Joan Raphael-Leff showed how the increasing relevance of perinatal therapy in the panoply of preventive interventions is a "second chance" for psychoanalysis. Ann Morgan emphasized how the transition to parenthood, or to "being three" necessarily evokes fear of mutual exclusion, and therefore brings ambivalence into the relationship towards the newborn. Pathological situations arising from extreme ambivalence include domestic violence and total lack of fantasies during pregnancy. She described how working through the issue of ambivalence in the setting of a group therapy for infertile women brought a decrease in infertility and IVF failures rate.

"The use of the Alarm Distress Baby Scale (ADBS)"

Teams from Australia, Finland, and Israel shared with Antoine Guedeney their respective experiences with the scale he has developed to detect early withdrawal behavior in infants. The symposium started with Antoine's description of the scale. The scale include 8 items: Facial expression, Eye contact, General level of activity, Self-

stimulating gestures, Vocalizations, Responses to stimulation, Relationship, Attraction. It is based on the here and now, needs no note taking, should not be interrupted and can be used in various settings, especially in pediatric routine check-ups. Normal score is 0, and the range is from 1 to 4. The clinical cut-off score is 5 and above. Kaija Puura from Finland, and Daphna Dolberg and Miri Keren from Israel, made independent comparative studies of the ADBS with other scales of parent-infant interaction and found significant correlations. Clara Bookless from Australia made an interesting longitudinal study from pregnancy to 13 months. She found that infant's withdrawal behavior was linked to maternal depression in the third trimester of pregnancy and sexual abuse before the age of 13 years, and it disappeared with the improvement of the mother's mood. Stephen Matthey from Australia also found a significant correlation between the infant's withdrawal and the mother's mood.

"Ports of entry for the treatment of early relationship problems"

This symposium, organized by Arnold Sameroff, provided a model for understanding and treating relationship problems, taking into account the different ports of entry that therapists can use to reduce relationship distress. After reviewing Sameroff's transactional model, Susan McDonough presented the principles of Interaction Guidance, where observable interactions also serve as the therapeutic port of entry. The same port of entry is used in the method of brief therapeutic assessment of family interactions developed by E. Fivaz and the Lausanne group, and Miri Keren and her group, but it is specifically grounded in semi-standardized interactive situations, such as the Lausanne Trilogue Play. Direct interventions and video-feedback are

used to elaborate with the family the resources and problems in their interactive patterns. Robert Emde and his colleagues developed the concept of leverage, consisting in identifying the best opportunities for engaging therapeutic change in a relationship that is embedded in a network of other relationships. Finally, Byron Egeland presented the lessons drawn from his long experience with STEEP. All of these, and other methods of relationship-based therapeutic interventions, are described extensively in a recent book edited by Sameroff et al (2004), entitled: *Treating Parent-Infant Relationship Problems*.

"Family affective process between baby, father and mother: Functional and problematic patterns over infancy"

This workshop was conducted by Elisabeth Fivaz-Depeursinge and James McHale. Many attended and took an active part. They basically showed how the extent of the disturbed affective context between all three members is a potent predictor of problems, beyond the extent of marital conflict between the parents. In particular, they showed that the young infant's capacity to interact in a triangular way with his/her parents is put to the service of socio-emotional development when the parents cooperate; whereas, in contrast, it is put to the service of regulating the parents' relationship, when conflict is not directly negotiated between them.

"Origins of risk: Paternal antisocial behavior and violent neighborhood"

This important symposium on fathers, initiated and conducted by Hiram Fitzgerald, showed how paternal negative behaviors, exposure to neighborhood violence and family type were linked to the child's

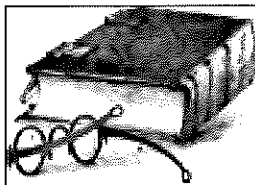
capacity for emotion regulation and cognitive level, both independently and in interaction. The strength of these findings comes from the large size of the sample: 680 families. Also, it was innovative in the sense that most of the studies on fathers (not numerous anyway) have focused more on the impact of fathers' absence than on fathers' negative characteristics.

"Aboriginal Infant Mental Health and Development"

In my personal view (M.K.), this symposium was special not only in its content, but also in the very fact of its inclusion in the program. Indeed, speaking up for the traumatic experiences of the aboriginal parents and their infants was courageous because, unfortunately, these are still happening in some parts of Australia. As it was so well-said, this symposium was about the non-Aboriginal children as well as about the Aboriginal ones; it was about Australian society and its hidden aspects. Living myself in a complicated socio-political situation that has severe psychosocial implications, I felt implicated - and therefore moved - in this symposium.

To conclude, beyond the quality of the plenaries and the numerous symposia and workshops, this conference in Melbourne was one more window into each other's work. We may say that each conference, by gathering professionals from different schools and places, fills up gaps in the puzzle that is Infant Mental Health. Next time in Paris!

*Written by Miri Keren, M.D. (Israel),
and Elisabeth Fivaz-Depeursinge,
Ph.D. (Switzerland), April 2004.*



LITERATURE MONITOR

Please note that these are listings for information and do not imply recommendations.

Articles

Gale, C.R., Walton, S. and Martyn, C.N. (2003) "Foetal and postnatal head growth and risk of cognitive decline in old age" *Brain* 126: 2273-8. cnm@mrc.soton.ac.uk

Results suggest that brain development during infancy and early childhood is important in determining how well cognitive abilities are preserved in old age.

Bouwstra, H., Boersma, E.R., Boehm, G., Dijck-Brouwer, D.A.J., Muskiet, F.A.J. and Hadders-Algra, M (2003) "Exclusive Breastfeeding of Healthy Term Infants for at Least 6 Weeks Improves Neurological Condition" *Journal of Nutrition* 133: 4243-5. m.hadders-algra@med.rug.nl.

"To investigate the minimal duration of exclusive breastfeeding for optimal neurological outcome, we assessed the quality of general movements (GM) at 3 mo of 147 breastfed healthy term infants that were followed from birth.... Exclusive breastfeeding for >6 wk was therefore associated with markedly less abnormal and more normal-optimal GM. Thus, we conclude that breastfeeding for > 6 wk might improve the neurological condition in infants."

Ohgi, S.; Akiyama, T.; Arisawa, K. & Shiemori, K. (2004) 'Randomised controlled trial of swaddling versus massage in the management of excessive crying in infants with cerebral injuries'. *Archives of Disease in Childhood* 89: 212-216.

'Results indicate that swaddling may be more effective than massage intervention in reducing crying in infants with cerebral injuries'

Rampono et al (2004) "A pilot study of newer antidepressant concentrations in cord and maternal serum and possible effects in the neonate" *Int J Neuropsychopharmacol* 2004 Sep;1-6.[Epub ahead of print].

Based on their results, Dr. Rampono and colleagues hypothesise that low clearance of antidepressants may predispose neonates to 'neonatal serotonin toxicity,' and recommend further study in a larger population.

Journal

The 2004 (vol. 22 no. 1) issue of the *Journal of Reproductive and Infant Psychology* is entitled:

'The importance of the postnatal period for mothers, fathers and infant behaviour'

and includes the following papers:

Continued on Page 24

The Interdisciplinary Council on Developmental and Learning Disorders

4938 Hampden Lane Suite 229 Bethesda, Maryland 20814
301-656-2667 www.icdl.com

March 23, 2004

This is to let you know that Stanley I. Greenspan, M.D. is a recipient of the 2004 Mary S. Sigourney Award for distinguished contributions to psychoanalysis. The Sigourney Award is the highest international honor for contributions to depth psychology. Among Dr. Greenspan's contributions cited at the award ceremony, recently in New York, is his work on understanding the developmental pathways leading to the formation of mind, including the capacity for relationships; affect signaling; social problem-solving; defenses and coping strategies; internal symbols and representations; creative, logical and reflective thinking; and processing information and experiences. Also cited was his pioneering contribution to understanding the developmental roots of different types of developmental disorders and psychopathology, including autism, mood disorders, and attentional and impulse control problems, as well as his developmental models of intervention and the psychotherapeutic process.

Dr. Greenspan's acceptance comments focused on a new responsibility for depth psychology. He called on psychoanalysis to focus not only on its treatment modalities, but on its growing insights into the deepest levels of the mind. The importance of exploring what makes us human, our relationships, and the deepest levels of our feelings and wishes, he cautioned, is especially vital in light of a growing acceptance of overly simplified notions of human functioning. Dr. Greenspan's acceptance comments are attached.

Dr. Greenspan is also the recipient of the American Psychiatric Association's Ittleson award, its highest honor for child psychiatry research, and the American Orthopsychiatry Association's Ittleson award (he is the only individual to receive both Ittleson awards). He is also a recipient of the Strecker award for outstanding contributions to American mental health, and, together with Senator Edward Kennedy, the Healthy Mothers, Healthy Babies Coalition Special Impact Award for improving the health of America's infants and children. His latest book is *The First Idea: How Symbols, Language and Intelligence Evolved from Our Primate Ancestors to Modern Humans* (with Stuart Shanker—due out August, 2004). He has recently begun a new weekly web-based radio show on children with developmental, learning, and emotional challenges at www.floorstime.org.

A New Responsibility for Psychoanalysis - Stanley I. Greenspan, M.D.

Thank you for this wonderful honor. Receiving the Sigourney Award invokes many warm and appreciative feelings, as well as a sense of responsibility and a commitment to work harder in the future to live up to it.

The Sigourney Award, in highlighting specific contributions and programs, has supported a far more important, larger goal—understanding the deepest levels of the human mind. In this context, psychoanalysis

confronts a challenge of unprecedented opportunity and responsibility. In the middle of the past century, when psychoanalysis and psychoanalysts were leading most academic departments of psychiatry and were having a much-appreciated influence on all aspects of society, it was easy for psychoanalysis to exert constructive leadership. Its view of the human mind conveyed the emotional depth and complexity of mental functioning.

Now, however, psychoanalysis and its view of the mind have come under significant challenges. These challenges have taken the form of asking for more outcome studies on its treatment methods, more proof of its theories and more empirical support for its mode of inquiry. These challenges, however, are all solvable with further research and insight into the workings of the mind. In fact, they have already resulted in an impressive array of studies and findings and are welcome motivations for the growth of the field.

Then, what is the issue behind recent critiques? The real issue may be a broad societal movement towards reductionistic and, unfortunately, anti-humanistic ways of conceptualizing human and mental functioning. Rather than biological insights providing a welcome addition to a fuller psychology of human functioning, that is, how different biological phenomena become experienced at different psychological levels, instead we are seeing more and more attempts to describe human functioning solely in terms of biological systems or surface behaviors or combinations of both. For example, we all know that

treatment outcome studies often only look at surface symptoms with little focus on the subtlety of relationship patterns, the internal state of the individual or even such basic capacities as the ability to experience a sense of self and others as full human beings.

What's missing from current approaches is a consensus regarding basic assumptions of what constitutes a human mind. Is it simply symptoms, behaviors, biochemical and physiologic patterns, or is it also fundamental relationships, affective experiences, wishes, and various levels of feelings and conflicts, etc.? From our developmental studies there is enormous empirical support, now, for a number of capacities that comprise the human mind. For example, these include the capacities to: (1) form relationships and engage in sustained intimacy; (2) experience and express a wide range of deeply felt affects; (3) construct a sense of self that integrates different emotional polarities; and (4) form, elaborate, and differentiate internal representations as a basis for a sense of reality, sense of self and others, and a range of higher-level self-observing and reflective capacities.

If we allow the focus to shift from these capacities that constitute the depth of the mind only to its surface features or biological foundations, we are compromising far more than treatment. We are compromising a view of who we are as human beings. In general medicine, it would be akin to eliminating cardiac or kidney functioning from our definition of human physical functioning because they were complex and hard to measure. In mental health, however, we have a history, harking back to ancient times, of simply denying or disavowing the existence of certain human phenomena and compromising our very humanity.

The battle for the definition of our humanity needs to be fought at a number of levels, including scientific and political ones. For example, at present, funding priorities of the federal government strongly favor looking at easy-to-measure surface behaviors or biological systems. In education, these priorities are emphasizing teaching and measuring facts to the nation's children rather than "understanding." These priorities are not based on science, but on basic assumptions about what constitutes

human functioning, as well as what constitutes "science."

As the world confronts greater interdependency, not just of shared communications and economies, but of shared dangers, understanding the deepest experienced components of our mind is more important than ever before. Psychoanalysis must come together and represent the deepest levels of the human mind in all areas of human endeavor, from individual psychopathology and treatment to understanding complex social phenomena. Current research is showing that psychoanalytic explorations are most helpful for individuals with complex psychological and interpersonal problems. As a perspective on the human mind and a method of inquiry, psychoanalysis also needs to understand the complex social patterns that are denying human depth and complexity. It must look at its own defensive reactions to the mounting challenges it has been facing. Ultimately, it must embrace nothing short of the responsibility of guiding the world back to an appreciation of the qualities of human beings that have contributed to its creation and may determine its future.

Please Save the Date
October 21-22, 2004

FLORIDA ASSOCIATION
for

INFANT MENTAL HEALTH
ANNUAL CONFERENCE

Colonnade Hotel • Coral Gables, Florida

Plenary Keynote Speakers
Megan Gerson, Ph.D.
University of Minnesota Institute of Child Development
Researcher for international attachment research on cultural and stress in young children

Joy Goldberg, Ph.D.
Professor of the State Center for Infant Mental Health in LIAI Health Services Center
*Author of *Young Children and Family Transformation and Disruption* (July 2004)*



WAIMH *Affiliate News*

The Italian Association for Infant Mental Health

The AISMI (Italian Association for Infant Mental Health) was founded in October 1998. The Association is constituted according to Civic Code articles 36-42. Its legal office is in Via di S. Costanza 35, 00198, Rome. Massimo Ammanniti, from the University of Rome, was the first President and the current President is Filippo Muratori from the University of Pisa and the Stella Maris Scientific Institute (f.muratori@inpe.unipi.it).

The Association provides a valuable working experience for professionals from a variety of backgrounds: child psychiatrists, psychologists, psychotherapists, pediatricians and rehabilitation therapists, who belong to both the academic and the clinical sector (private and public) from across Italy. This experience has progressively increased interest both in improving collaboration between different professionals with a range of perspectives and has deepened interest in infancy issues across Italy.

With these general aims in mind, the Association has decided to retain an empirically focused working orientation, including three distinct study groups: (a) Infant-Parent Program (b) Diagnosis in the first three years of life (c) Assessment Instruments and Methodology.

We have particularly taken as one of our primary tasks, the discussion of clinical cases, presented through videotapes, with the ultimate aim of developing a suitable diagnostic assessment, along the lines of DC-Zero-to-Three, which we have found very helpful.

The Pisa Group organised two European meetings. Both took place in Pisa, one in January 1999 on "Diagnostic Evaluation in Infant Psychiatry," and the second in September 2001 on "Regulatory, Multi-

system and Pervasive Disorders." These two meetings, with more than 200 delegates, involved the participation of speakers from many European countries. We can now say that the DC-0-3 is a well-known and widespread instrument all over Italy. One outcome of these meetings is represented by a recent number of the *Infant Mental Health Journal* prepared by Antoine Guedeney (France) and Sandra Maestro (Italy).

As a whole, the Association's aims reflect those of the World Association for Infant Mental Health (1980), but with particular regard to the specifics of the Italian context, in which team working and cooperation between public and private services, as well as between clinical workers and academic researchers, is a rather unusual, if non existent, experience.

To help realize these aims, the AISMI also organised two International Conferences, both of which took place in Rome, one in May 1998 on "New Frontiers in Mother-Infant Psychotherapy," and one in November 1999, on "Traumatic Stress and Infant Psychopathology." They were attended by many specialists from both the private and the public sector, as well as from the academic world, and from many parts of Italy. Among many, we would particularly like to name our special guests, Daniel Stern and Joy D. Osofsky. Following such enriching experiences, the AISMI promoted a day seminar on "Attachment and Infant Psychopathology," held in May 2000 in Rome, conducted by Mary Target and Peter Fonagy, presenting papers on attachment and the development of psychic reality and on the infantile roots of borderline personality organization respectively.

More recently, the AISMI promoted two other International Conferences with the

aim of considering the many new developments arising from the neurosciences for the understanding of infant and toddler development. The first, on "Biological Regulation and Relationships at Risk in Infancy," took place in May 2002 in Lerici, a very picturesque village on the Ligure sea. Dan Siegel from California gave the main lecture at the conference. The second, on "Psychopathology Between Gene and Generation," took place in May 2004 in Matera, a very old and mysterious town in the south of Italy. The distinguished presenters were Robert Plomin, Judy Dunn and Dan Stern.

AISMI have already sought to promote collaboration between various Italian regions, and we hope with this latter meeting to increase memberships in the south of Italy, which is not well represented at present. Both these meetings have reserved half a day for presentations and communications by the delegates. This active participation demonstrates the impact of our association, not only on our members, but also on Italian professionals and culture more generally. Some of us, indeed, are members of the Health Ministry and some Social Affairs Ministry Committees, looking at intervention and prevention programs for infants, children and adolescents.

The AISMI actively participated in the meeting organized by Bernard Golse in Paris, January 2003 (which was very successful in promoting cooperation among all the European WAIMH affiliate groups), preparing a clinical case which prompted a very interesting discussion during the meeting with the participation of T. Tamminen, B. Cramer, P de Chateau, A. Guedeney and many others.

Prof. Filippo Muratori, MD

Announcements

CALL FOR PAPERS

Special issue of *Infant Mental Health Journal*

Editors: Mark Tomlinson
Leslie Swartz
Hiram E. Fitzgerald

International Collaboration in Infant Mental Health: Pitfalls, Challenges and a Way Forward

Every year, approximately 135 million infants are born throughout the world. Of these, over 90% live in low-income or 'developing' countries. The 'typical' infant, therefore, lives in an environment which is very different from that inhabited by the typical infant mental health researcher. A recent study of selected journals since 1996 shows that 95% of contributions dealing specifically with infancy have come from researchers based in North America, Europe and Australia and New Zealand and have almost invariably focused on infants in these countries. With this imbalance between where knowledge about infant development is being produced and where the majority of the world's infants are being born, it becomes crucial to expand our knowledge base about infants and infancy in developing countries.

There are encouraging signs that international collaboration between richer and poorer countries on infant mental health issues may be increasing, but there are many challenges for this work. Collaboration across countries and cultures can be a political minefield, with problems on all sides. Researchers from wealthier countries may underestimate or, on the other hand, romanticise the skills of those in developing countries. Similarly, developing country researchers may idealise or angrily denigrate colleagues from other contexts. All of

these responses are understandable reactions to power and resource imbalances which are real. There are strong incentives not to collaborate. Nobody wishes to be accused of colonialism, racism, or, on the other hand of 'selling out' to more powerful colleagues. Just because collaboration may be difficult and challenging, however, is not a reason to avoid collaborating. With open and frank discussions of the issues as they arise and recur, many issues can be dealt with.

There are many experiences of collaboration, both productive and painful, and for this special issue of *Infant Mental Health Journal* we are interested in receiving contributions which do not shy away from the difficulties but which also record ways to overcome these and to make a success of collaboration. We welcome especially submissions co-authored by researchers from different parts of the world who have collaborated or are collaborating on projects. In addition, we welcome both qualitative (ethnographic) and quantitative research articles as well as those that address critical clinical issues related to early development. All submissions will be peer reviewed for the journal in the usual way, and all submissions must conform to the publication style of the journal.

Electronic submissions:
waimh@msu.edu

Mail 4 copies: WAIMH; Kellogg Center, Garden Level; Michigan State University, East Lansing, MI 48824-1106, USA. Deadline for submission to the special issue is **November 1,**

International and interdisciplinary Conference on the occasion of awarding the Arnold-Lucius-Gesell-Price 2004 Award to Professor Sir Michael Rutter

Without Attachment Deprivation, Adoption and Psychotherapy

Symposium Date:

Friday, October 29th, 2004
2:00 - 5.30 pm
Saturday, October 30th, 2004
9:00 - 4.30 pm

Symposium Venue: Lecture hall of the Kinderklinik und Poliklinik im Dr. von Haunerschen Kinderspital, Lindwurmstr. 4, 80337 Munich, Germany

Scientific Organization:

Dr. Karl-Heinz Brisch, Ludwig-Maximilians-Universität, Kinderklinik und Poliklinik im Dr. von Haunerschen Kinderspital, Pediatric Psychosomatics and Psychotherapy, Pettenkoferstr. 8 a, D-80336 Munich; Phone: ++49 89-5160-3954, Fax: ++49 89-5160 4730; e-mail: Karl-Heinz.Brisch@med.uni-muenchen.de; Prof. Dr. Dr. h. c. Th. Hellbrügge, Internationale Akademie für Entwicklungs-Rehabilitation, Theodor-Hellbrügge-Stiftung, Heiglhofstraße 63/II, D-81377 Munich, Germany.

Symposium language: English and German

Information and registration:

Internationale Akademie für Entwicklungs-Rehabilitation und Theodor-Hellbrügge-Stiftung, Heiglhofstraße 63/II, D-81377 München
Phone: +49 89 / 72 46 90 40, Fax +49 89 / 719 3610, www.theodor-hellbruegge-stiftung.de

Reply/Information by phone: ++49 89-72 46 90 41 or Fax: ++49- 89-7193610
An die Internationale Akademie für Entwicklungs-Rehabilitation und Theodor-Hellbrügge-Stiftung Heiglhofstraße 63/II D-81377 München

President's Perspective

Tuula Tamminen

From WAIMH's history to its future

WAIMH has its history, and we as members of WAIMH have our individual and joint, shared memories. WAIMH also has its future, and we all might have ideas and hopes of what WAIMH should do and how it could operate. Perhaps we even have some dreams about WAIMH's successful future. At least I have!

WAIMH's history includes many wonderful occasions, inspiring congresses in different parts of the world and huge amounts of thoughtful and creative voluntary work done by several active infant mental health specialists and researchers in so many countries. Quite soon the most important aspects of WAIMH's history will be published as a Silver Edition of the *Infant Mental Health Journal*. It is important for all of us to know and respect the roots we have.

But what about WAIMH's future? Since we are so deeply involved in developmental and relational issues, we all know that we are right now together building up WAIMH's future. Tomorrow's success is created today and it is our shared responsibility to shape WAIMH's future. Each member of our Association is important in this job. So, I am inviting each of you to join in dreaming the best possible future for WAIMH!

In my vision WAIMH will be a truly international, world-wide organization for people devoted to infant mental health. This means many things and requires that all of us will be active. There are still countries which have good infant mental health services and persons doing high quality research but who don't yet belong to

the WAIMH family or even have any networking with us. Another kind of effort is needed to reach those countries; e.g., in Africa and some parts of Asia, where one wishes to increase general consciousness of infants' needs and broaden understanding about infant mental health issues among decision makers, so that available services are created and specific research problems are identified and investigated. Yet an additional task for us is to run our Association in a way that respects cultural diversity and creates world-wide understanding. In my dreams WAIMH is no longer so strongly an American or European style organization most active in the parts of the world where the birthrate is the lowest. This is a vital issue for WAIMH's future. All human behavior and activity is based also on cultural issues and we cannot continue our operations ignoring those parts of the world that contain 70% of the world's population. We need a global view that will increasingly bind us to one another around the world.

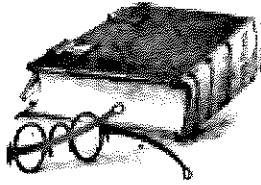
My vision of WAIMH means also that our Association will become more and more interdisciplinary. Infants, parenthood, care-giving, healthy development and mental health are all comprehensive and holistic issues. Promoting optimal human development at the beginning of life is everybody's concern. To achieve the goals of WAIMH printed in our by-laws we really need all kinds of experts, specialists and front-line workers, therapists, researchers and educators in WAIMH. And at the same time WAIMH has to keep its core identity stable and clear: it is a therapeutically oriented scientific

association aiming to promote infant mental health.

All this is much – but not enough, I still have even wilder dreams! We have during our life-time had the privilege to see incredible technical development and the globalization it has produced. We have also been eye-witnesses of how this unbelievably fast globalization has happened according to the hard laws of economics and power politics. We cannot just stand and watch. Humankind deserves something better than this. All global actors should realize what kind of opportunities they might have. In my dreams global scientific associations, especially ones like WAIMH, have perhaps the best possibilities to create and promote a new kind of globalization: world-wide, joint understanding based on research and evidence based clinical knowledge. Science has huge power and similar to money, it is valid everywhere. Scientific associations that are specialized in human development have lifesaving messages and meaning to everyone and infancy, the earliest human development, is the best window to the future of the world.

Today, we know how important joint visions are for any organization. And infant specialists have an additional knowledge of how strong developmental power is stored in dreams shared by several persons. So, I invite every member to join in the process of building up vision for WAIMH. I am looking forward to hearing about your dreams!

Tuula Tamminen
tuula.tamminen@pp.fi



LITERATURE MONITOR

CONTINUED...

'Acceptability of psychotherapy and antidepressants for postnatal depression among newly delivered mothers'

Chabrol, H.; Teissedre, F.; Armitage, J.; Danel, M. & Walburg, V.

'Users' views of two alternative approaches to the treatment of postnatal depression' Boath, E.; Bradley, E. & Anthony, P.

'Searching for antenatal predictors of postnatal depressive symptomatology: unexpected findings from a study of obsessive-compulsive personality traits' George, L. & Elliott, S.A.

'Relation between Edinburgh Postnatal Depression Scale scores at 2-3 days and 4-6 weeks postpartum' Chabrol, H. & Teissedre, F.

'Using the Working Model of the Child Interview to assess postnatally depressed mothers' internal representations of their infants: a brief report' Wood, B.L.; Hargreaves, E. & Marks, M.N.

'The experience of first-time fatherhood: a brief report' Bradley, E.; Boath, E. & Mackenzie, M.

Books

Ayers, M. (2003) *Mother-Infant Attachment and Psychoanalysis: The Eyes of Shame*. Hove & New York: Brunner Routledge.

Osofsky, J. (ed.) (2004) *Young Children and Trauma: Intervention and Treatment* New York & London: Guilford.

Sameroff, A. et al (2004) *Treating Parent-Infant Relationship Problems*. New York & London: Guilford.

**WORLDASSOCIATION
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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