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EARLY INTERVENTION, PREVENTION, AND PERINATAL PSYCHIATRY

BY

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Preamble

One of the many reasons I enjoy reading *The Signal* is that it provides inspiration and encouragement to persevere. It is good to be reminded regularly that researchers, clinicians, thinkers whom I hold in high esteem, share my notions of what is important in the provision of services to parents and families. The excellent *Signal* article by Joan Raphael-Leff in the July-December, 2004 issue provides an introduction for the present

paper. Pregnancy and the early postnatal years potentially offer opportunities for intervention to improve the physical, psychological, and social well-being of children and their families – making the next generation healthier in the broadest sense.

Ideally, one would address the issues before conception occurred but including appropriate material in the school education curriculum and context has never been satisfactorily achieved as far as I am aware. It has been attempted, but the evidence for positive outcomes remains limited; short-term and often hypothetical (e.g., pre- and post attitudes were assessed but not actual behavior). In pregnancy and postpartum, most women receive some attention from health services, and we need to ensure that antenatal and postnatal care are offered to all, in a location and format that teenagers, culturally different communities, those with developmental disability, and so on, will also consider acceptable. We do know how to do this, but we rarely do it.

In the present article I will describe an attempt to enhance the routine care offered by the public health system in New South Wales to pregnant and postnatal women. The project, *Integrated Perinatal Care*, was set in train by Child Psychiatry, but would not be implemented within specialist mental health services; a successful outcome depended on

imbedding it in mainstream health care. Given that I want to concentrate on practicalities and that I am addressing the converted, who are already well aware of the relevant literature, this article will be informal, although some references are offered and copies of any locally published material may be obtained from the author. To avoid possible confusion, I shall limit discussion mainly to the antenatal part of the program.

Introduction

Health and welfare resources are limited even in the most affluent societies; all such situations imply overt or covert rationing. To use a local metaphor, no one thinks that bushfires should not receive attention, but there is a great deal of disagreement about what efforts should be made to limit the conditions that promote them. Medical and surgical emergencies receive full attention for obvious political as well as ethical reasons, but health promotion attracts a lower priority rating, for much the same reasons.

Over the past decade or so, parenting, pregnancy, and the early years of children's lives have been increasingly recognized, at state and federal levels in Australia, as key to optimal individual development. Visits from Fraser Mustard, Bruce Perry, Alan Schore, Peter Fonagy, and others have helped immeasurably. A focus (e.g., Commonwealth Department of Health

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and Aged Care 2000) on promotion, prevention, and early intervention was formalized in the National Mental Health Plan of the time.

The New South Wales Government established the concept of *Families First*, a health promotion and early intervention strategy to support parents in giving their children (from conception to 8 years) a good start in life. *Families First* is delivered by several different government departments: Area Health Services, Departments of Community Services, Education and Training, Housing, Disability, Aging and Home Care, in partnership with parents, community organizations, and local government. Different levels of support and linkage to services are provided according to level of need. Accurate assessment of the support required was essential and since the *Integrated Perinatal Care* (IPC) project was already being tested, it was accepted as a guide for early screening points.

Postnatal depression had already received considerable emphasis in the scientific and lay press, with the result that routine postnatal screening for depression using the Edinburgh Postnatal Depression Scale (EPDS: Cox et al., 1987) was in place in many early childhood clinics. The postnatal depression working groups recommended by the health department provided local structures for further exploration of early intervention potential, including formal support at senior and middle management levels. We aimed at a comprehensive array of inpatient, outpatient, community, and self-help provision. Specialized, inpatient mother-infant psychiatric beds have never been achieved in the public system in New South Wales (NSW), but we have done reasonably well over the rest of the spectrum – though the cover is thinly stretched. One achievement of note for our local area was the acquisition of funding to set up in the community a day unit (specialized staff but informal domestic setting) for women with moderate to severe “postnatal depression” (the term covers a wide

range of possibilities). This unit, Jade House, is important as a hub for many of our specialized teaching, clinical, and research services. It places a strong emphasis on relationships in assessment and therapy: mother-infant, mother-partner, other family members. As in most child psychiatry services, the family genogram is important, and we expect to have details of at least three generations to inform our thinking.

From local and international, clinical and research activities concerning postnatal anxiety and depression and their correlates, it became evident that the antenatal stage needed attention, and might even be more important from the point of view of the developing fetus. Jade House, like our other services, expanded to include a broad range of perinatal mood and related disorders. Screening and intervention on a broad basis seemed indicated, and particularly in a stressed population, the potential payoff promised to be considerable.

Raphael-Leff (op. cit.), among others, recommends screening and intervention during pregnancy and early postpartum. Relevant research projects have been reported. The next step is to put this into practice, and many of us in Australia and elsewhere are attempting to do so. I will describe one such program: *Integrated Perinatal Care* (cf. Barnett et al., in press, 2005).

IPC: Early Intervention and Prevention: Practical application in New South Wales

Basic tenets:

- Specialist mental health may need to initiate and support such programs, but most activities should be part of the mainstream, i.e., outside psychiatry.
- Additional funding and personnel are required in the early stages and should be sought from all possible sources within and outside health; pervasive and relentless opportunism.
- The notion of sustainability must also be addressed from the very commencement of the process.

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- “Screening” (or, if one prefers to avoid argument with the epidemiological purists, “comprehensive clinical assessment”) must be universal and routinely applied.
- All levels of risk, not simply high risk, must be identified.
- Processes and outcomes must be evaluated and results disseminated widely.

General requirements:

- Energetic, evidence-based advocacy.
- Patience and tenacity, since resistance is to be expected every step of the way, and the process will be both untidy and slow.
- Formal endorsement from staff at senior and middle management levels.
- Commitment from staff at the “coal-face”, who should be an intrinsic part of the process from the earliest planning stages onward.
- Regular feedback for all staff involved.

Specific requirements:

• *Factors to be identified*

Addressing: risk and protective (resilience) factors for current and future mental health or parenting problems. These problems include: chronic, current, or potential mental illness and psychosocial difficulties: anxiety, depression, psychosis, alcohol and other substance abuse, personality disorders, bereavement, lack of social support, domestic violence, chronic or acute physical ill-health, other recent adverse life events, and adverse childhood experiences, such as emotional, physical, or sexual abuse.

The list of factors (see Table 1) must be acceptable to all, and consensus must be reached about whose personal ‘favorites’ may have to be omitted, as time is limited. The list does not have to be exhaustive. The interview is for screening purposes and needs only to identify those currently in trouble or likely to be in the near future. A specific and detailed diagnosis is not necessary at

this stage. If distress is signalled, for example through the score on the Edinburgh Scale being greater than 9 (for English-speaking women), further exploration will be undertaken. The list is useless in itself; without staff training and support, nothing positive will happen and the data collected will not be comparable between individuals or sites.

• *Basic and advanced training packages*

Addressing: provision of information for managers; appropriate skill enhancement for all other relevant staff. Interviewing and interpersonal/counselling skills are required immediately; competence in running anxiety management, self-esteem, or depression groups may be acquired later if the staff wish.

Sensitive, competent interviewing or assessment is obviously key. These fields of inquiry may be “outside the comfort zone” of many midwives or early childhood nurses. The integrated consultation is going to be longer, and a more “counselling-oriented” stance is required for best results. The staff member is expected to engage with the woman and any other relatives or friends who may be present, engendering confidence in the service. Fortunately, nurses are usually enthusiastic about attachment matters and enjoy this aspect of training.

Training includes: why these selected items are considered significant; how to elicit the appropriate information; what to do with it (e.g., additional probes; managing anxious clients; managing personal anxiety; how to cope with the Pandora’s Box phenomenon; reminding oneself that almost nobody needs a psychiatrist, but it is important to recognize when that occasion does arise). The Edinburgh Depression Scale is the only self-report item (paper and pencil). Only where the client cannot read the scale for herself either in English or her own native language, should the interviewer or interpreter ask the ten questions directly. The scale is a very effective screen for current distress and depression but

does not provide a diagnosis. Question 10 of the Scale refers to thoughts of self-harm, and nurses definitely need additional training in managing this aspect.

Training must be tested, revised, standardized although allowing for flexibility, then made available, with trainers supplied if required. Some staff can be released for training for two days at a time, others only for a few hours or a half day, so defined modules and their sequence must be clearly identified.

• *Support for staff - thriving, rather than just surviving*

Addressing: formal and informal supervision; dealing with one’s own baggage/unfinished business (including acknowledgement that health professionals themselves may experience the problems and need help); attachment issues. Frontline interviewing staff antenatally and postnatally are usually nurses. In this country at least, it is only recently that this profession has accepted the idea of “reflective supervision” (again the words have had to be revised many times) and it needs to be provided by experienced supervisors external to the midwifery or early childhood nursing system (Fowler et al., 2001).

• *Identification of resources and gaps to be addressed*

Addressing: everything. Isolation; cultural and language issues; housing; welfare; family doctors; parenting support and training; parentcraft clinics; drug and alcohol services; play-groups; volunteer and professional home-visiting programs; child protection teams; specialist mental health services including suitable in-patient beds; abuse and domestic violence counselling and support services.

CONTEXT

The Child Psychiatry Department of the South Western Sydney Area Health Service, now called the Infant, Child and Adolescent Mental Health Service (ICAMHS), comprises three subspecialty interests: Child and Family; Adolescent; and Perinatal and

Infant (PIMHS). Since inception, we have maintained a focus on clinical and research work in the field of maternal mental health and its effects on her relationships with partner and children; specifically maternal anxiety, depressive and personality disorders, and attachment.

PIMHS is responsible for implementing IPC within our own health area (four major hospitals, about to expand to six) and facilitating uptake of the program in other health areas around the State of New South Wales. The State has an annual birth rate of 88,000. Annual births in our original area total 12,500, and around 30% of the families are of non-English speaking background while a small proportion are of Aboriginal or Torres Strait Islander origin. The South West includes dense urban and sparse rural communities spread over a wide geographical area. There are a few pockets of affluence scattered among situations of high unemployment, single parenthood, and deprivation. The health service struggles to attract staff of all disciplines as it is under-resourced and most professional workers live far from this region.

INTEGRATED PERINATAL CARE – PATHWAY TO IMPLEMENTATION

In 1998, preliminary steps to implement Universal Perinatal Psychosocial Screening were taken. Like everything else concerning this project, the name was repeatedly changed until majority satisfaction was obtained, when it was finally referred to as IPC, although the health department translates this as Integrated Perinatal and infant Care – (one should readily concede points of dispute that do not affect the overall project). Universal assessment, to avoid both stigma and missed opportunities, was to be undertaken in early and late pregnancy, within three weeks of delivery, and opportunistically over the subsequent twelve months.

The federal emphasis at that time on health promotion and early intervention ensured financial support for four years from the Centre for Mental Health of the NSW Health

Department. This funding provided a Project Coordinator to oversee implementation locally and around the State; a midwife/nurse educator to work alongside the antenatal clinic staff at each hospital as they started to implement the assessment and triage process; a part-time research officer to collect, analyze and report on data, and three clinical staff to accept referrals and provide supervision. Funding limitations meant that other tasks, such as provision of the education programs, clinical consultation, oversight of the research aspects, and planning strategically for recurrent funding to ensure the project continued after June 2004, were undertaken by permanent staff of ICAMHS. The first assessment occasion is at the booking-in visit or whenever the woman first presents herself at the hospital. At many hospitals in New South Wales, the booking-in consultation involves a computerized interview, OBSTET, collecting general medical and obstetric history to provide a database for planning of subsequent obstetric care. In 1998 it already included questions on issues such as “sexual assault” and “mental illness”, but without indicating precisely what these meant and how the questions should be introduced or responses managed. No evaluation of the process had occurred, and little use seemed to be made of the valuable data collection as a whole.

New questions addressing a range of psychosocial issues suggested in the literature to affect parenting capacity (cf. Table 1) were formulated and tested in consultation with midwives, general practitioners, and Child and Family Health Nurses. The aim of the expanded clinical assessment is to identify a much broader range of problems (or their antecedents) than depression or anxiety per se, whether antenatal or postnatal. All the things that research and clinical practice suggest might make life difficult for families to develop and function satisfactorily. A further addition was the Edinburgh Scale, of which we now have many translations. Several of these appear in Cox and Holden

(2003). The EDS is a brief (10 items), simple, user-friendly, measure of distress, including anxiety, as well as a proven screening tool for current depression (validated for use antenatally as well as postnatally; Murray & Cox, 1990). Following extensive trial work, the local teaching hospital at Liverpool offered to be the primary site for formal implementation and evaluation (Matthey et al., 2004 a & b).

The semi-standardized assessment process is intended to ascertain whether vulnerability is present or possible - it is not intended to assess the details of the problem in depth; usually the interviewing health practitioner will not have sufficient time or training for the latter. There is no cut-off point – threshold is zero – in this assessment. Scores over nine in total on the EDS, or any score on the self-harm question thereof, mandate further assessment, usually, but not necessarily, by the midwife in the first instance.

It is important to remind anxious interviewers that women are not in any way compelled to divulge information - it is their choice whether they respond, lie, or refuse. Today there is a general consent to consultation that is signed by all patients attending the hospital. The obstetric unit has an additional consent and information form indicating that questions will be asked at the booking-in interview in order to offer the best possible help during the pregnancy and afterwards.

If the respondent answers any of the general questions in a “positive” fashion, or scores over nine on the Edinburgh Scale, or more than zero on question 10 of the EPDS, it is then incumbent on the interviewer to ask for more information, make decisions, and offer whatever help is deemed relevant. The clinical response to the overall consultation includes a spectrum of possibilities from “flag this for future consideration” to “arrange immediate appropriate consultation”. Prior identification of referral pathways and available resources is thus essential.

Unless issues are elicited that require an immediate response, the woman's permission is sought to discuss her situation at the weekly multidisciplinary intake meeting and to arrange any necessary follow-up. Many women are very pleased that someone has taken a personal interest in them and prefer simply to take away information regarding possible sources of help or to arrange telephone contact with one of the services. Most are happy for their family doctor or obstetrician to be informed of the results of the assessment and then take it from there. Domestic violence is sometimes acknowledged in this first interview, but often it is not conceded until later consultations, or the woman uses the material routinely made available to all to seek assistance outside the health system.

Following community consultation and specialized staff training, extending the program into our non-English speaking and indigenous communities is now underway. Education modules have been provided for interpreter services. User-friendly versions of the EDS are being tested in Australia for Aboriginal and Torres Strait Islander women.

EVALUATION

Publications listed in the reference section provide more details, but a brief summary of early results is offered below.

The questions have been piloted, evaluated, and refined. The original set of questions totalled 31. This has been drastically reduced (mainly because of time constraints) and the items (cf. Table 1), with suggested questions and a list of responses to check, are now integrated into the computer interview format (OBSTET and OBSTETRIX for PC use). Comparison of placing the set of questions en bloc or interspersing them throughout the interview indicates that the nurses prefer en bloc for most of the questions. Interestingly, they also reported that they do not receive adequate

supervision, even when repeated offers of supervision have not been taken up. This situation is gradually resolving as the nurses and their managers come to terms with what clinical supervision is all about and how essential it is.

Responses to the original 31 questions and the Edinburgh Scale from 562 women indicated that:

- 29% scored 10 or more on the EPDS, while 13% scored 13 or more (i.e., likely diagnosis of depression)
- 11.9% lacked emotional support from both partner and their own mother
- 26% tended to worry a lot or be perfectionist
- 28.3% had a history of anxiety or depression
- 8% hit their partner and 3% reported that their partner hit them
- 14.4% had six or more (out of a possible 10) psychosocial risks for parenting adjustment

Telephone interviews during the week following the antenatal consultation

with a sample (n=104) of the women indicated that:

- 80% considered the additional questions were reasonable and acceptable
- they did not mind the length of time spent on the interview and were pleased that someone was taking such a careful, personal interest in them
- objections to the lengthy consultation were often a result of the time the women had had to wait prior to the actual interview
- 7% considered the questions unacceptable. In some instances the objection was not to the new questions but to the questions already asked in the original computer interview and never evaluated. At other times the objections were due to puzzlement about why some questions would be asked e.g., concerning their own childhood, or to the questions (e.g., about losses) bringing back unhappy memories

TABLE 1

Possible variables for detection of a broad range of psychological and social risk factors (presaging parenting problems) in the perinatal period.

Final variables

- Expected availability of practical support (postnatally, ask about actual availability)
- Expected availability of emotional support (postnatally, ask about actual availability)
- Recent major stressors, changes or losses personal rating of self-esteem and self-confidence
- Personal rating of anxiety and obsessionality history of feeling anxious, miserable, worried or depressed for more than two weeks
- if yes, was that related to a previous pregnancy or birth
- Past or current personal or family history of emotional or mental health problems
- Past or current treatment for emotional or mental health problems
- Emotional, physical or sexual abuse in childhood
- Alcohol or drug (including cigarettes) use
- Domestic violence
- Earlier or current involvement with child protection agencies
- Edinburgh Scale: total score and response to question 10.

- no one suggested additional questions
- all were very pleased with the rapport created by the midwife

Telephone interviews at 5-8 weeks postpartum (n=65) indicated that:

- 75% of the women recalled the antenatal interview and questions
- 43% thought the consultation had been helpful
- a further 23% thought that asking the questions was a good idea although not directly helpful for them. The consultation had raised their awareness of relevant issues, offered an opportunity to express their feelings, and made them feel supported
- 9% had subsequently sought help for issues raised and had benefited
- the remaining 34% were neutral about the questions, considering them neither helpful nor unhelpful. Many suggested that the questions might have been less relevant to them since they were not first-time mothers

Interviews with a sample of the midwives (n=14) indicated that:

- the benefits of asking the additional questions were acknowledged, but some were concerned about the extra time required (between 10 and 40 minutes) and the addition to their workload. This led to the subsequent reduction of the questions

Following the introduction of the new set of questions:

- referrals for psychosocial intervention doubled
- approximately 37% of the women were deemed to merit referral
- about 50% of these declined the additional support offered (probably acceptable since they still attended the clinic regularly for the remainder of the pregnancy)
- of the 50% accepting referral, around 25% were seen for less than four sessions of counselling or other intervention and 17% for more than four sessions
- the other women were given information about other services (33%); referred to other services

(14%), or continued to have telephone contact with the IPC clinical team

- a further 13% of the women were "flagged" for postnatal follow-up e.g., because of anticipated lack of support, but not considered to require current referral
- workload for social work and mental health staff increased; estimated to be around 30% in the short term, declining as time passed, possibly as new resources were identified among other agencies, and the nurses became more skilled and confident about what they themselves could offer.

DISCUSSION

Antenatal clinics provide many opportunities for health promotion. I have described here one possible method offering a mode of enhancing job satisfaction for antenatal clinic staff as well as parents, but it is not a simple matter and there are many issues and consequences to be addressed, for example, increased workload upstream and elsewhere. Also, many physical and mental health questions are intrusive, so sensitivity as well as competence is required of the interviewer. Especially at the first antenatal interview, friends or other relatives may accompany the woman, so some questions, for example on previous obstetric history, the marital relationship or family violence, may need to be reserved for later consultations. In some clinics, a letter indicating the requirement for the woman to be alone for part of the consultation now accompanies the letter sent out with details of the first appointment. This may be a doubtful compromise as we need to ensure that this does not discourage partners from attending the antenatal clinic; after all we have spent much energy in the past ensuring fathers were included and felt welcome. Our current efforts include attending more to partners who do attend the clinic by offering information and discussion. As evidence supporting routine "screening" for domestic violence remains inadequate, further research on this important and politically vexed aspect is essential.

Several discrete paper and pencil self-report forms already exist for specific detection of problems such as postnatal depression, high risk of abusive parenting and so on. These have a different goal as well as a different process. Commitment to facilitating engagement and enhancing job skills and satisfaction for the professional, requires that assessment (screening) is carried out through personal interviewing. Before staff are expected to undertake this task, they need to feel confident that adequate and appropriate resources are available for the clients and themselves.

CONCLUSION

IPC derives from child and family psychiatry and our service's foundation on attachment theory. It does not focus narrowly on (a) identifying or predicting antenatal or postnatal mental illness, such as depression, in the mother and then providing psychiatric treatment for that individual, or (b) high risk parents or children. It acknowledges all levels of risk and attempts to offer appropriate information, additional appointments, support, or referral. We regard this as simply provision of good clinical care. Such care tends to be provided by well-trained and supported staff who know that they are valued by management and clients.

Radical, sustained change in health practice is not easily achieved. To date, progress has been slow but steady. It remains to be seen whether the project described is ultimately successful – i.e., entrenched in the mainstream health system throughout the State. I know Signal readers will wish us well.

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President's Perspective

Tuula Tamminen

WAIMH is what its members are

Right now intensive preparations for the 10th WAIMH World Congress are in full swing. The Board of WAIMH, the Central Office, the international Program Committee and the Local Organizing Committee in France are all busy doing their best to create a top-quality congress for all who are interested in infant mental health. And, of course, many people around the world are busy preparing their abstracts for the congress. The infant's relational worlds will be viewed by clinicians and researchers from many perspectives. As every one can see from the **Call for Papers** (<http://www.waimh.org>) in addition to the traditional presentations we will also have two important new formats: clinical case plenary sessions and master classes. These exciting formats have been designed to enhance the focus on the clinical treatment and prevention aspects of infant mental health. The best experts in research and clinical fields will discuss important topics, and the whole spectrum of the newest scientific results and clinical innovations will be presented. I am convinced that the Paris WAIMH Congress in July 2006 will be one of the best congresses in this decade!

This is important nowadays when there is a continuously increasing number of both international and regional congresses all over the world. At least in North America and in Europe different congresses are already competing with each other for the best experts and participants. There is also a growing number of international scientific associations whose basic focus and main aims are overlapping. Young researchers and active clinicians may have difficulties

in finding the most suitable association or the most interesting congress for their own purposes. Going international is not always a simple task in a scientific field.

How is WAIMH doing in a situation like this? Many – perhaps most – world associations are so called umbrella organizations which have national associations as their members. So, they are associations of associations. WAIMH is different. WAIMH is a world association which has only individuals as its members. It is great that there are more and more WAIMH Affiliates in different parts of the world but there is no hierarchical structure between WAIMH and its Affiliates. The only existing rules are that each WAIMH Affiliate should have ten or more members who are also members of WAIMH international, and that their bylaws (purposes) are consistent with those of WAIMH.

This means that WAIMH is a group of individuals from different countries all devoted to infant mental health and interested in international activities. So, WAIMH is composed of people who are both motivated to support international WAIMH in its actions and to benefit from being a member. This ensures the unique atmosphere in our congresses and association and exceptionally close relationships between our members. WAIMH is an association where the members can become acculturated.

The number of WAIMH Affiliates and the number of members in the Affiliates have grown very rapidly in

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THE LESSONS FOR THE BABY AT THE CENTER OF THE UNIVERSE

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Most mothers have read about or at least heard about fairly strict approaches to parenting that warn them not to place their babies at the center of the families' universe. One such example is the series of books written by Gary Ezzo and Robert Bucknam called *On Becoming Babywise* (hereafter referred to as *Babywise*: 1995). Among other things these books encourage mothers and fathers to ignore the cries of their babies (see Chapter 8). Admittedly some of these books have a religious basis but even among fairly secular people such views can flourish as a type of wisdom concerning the right approach to babies.

There is often a premature focusing on obedience, which is presented as a kind of natural prelude to later mature functioning. Often when parents and professionals are sufficiently informed about attachment principles and research, it acts as an antidote to this kind of thinking. But the rhetoric is very seductive especially for earnest young parents who are keen to do the right thing. In the meantime, many babies are in for a pretty tough time despite the common notion that babies generally, "haven't got a care in the world".

Babies can be put through tremendous stress and anxiety by otherwise dutiful parents who are convinced of

the need to teach their babies certain "lessons". According to strict approaches to parenting, babies have to be taught various lessons and they have to be taught them before it is too late.

Infant mental health specialists worry that these "lessons" (which are very stressful and involve a type of rejection of babies' communications) are being taught to babies at the very time in their lives when they are least capable of dealing with stress and rejection. Indeed we would argue that the baby needs to be taught precisely the opposite to these "lessons".

But what are these "lessons"? Well, they seem to be put in various ways, but the gist of it is that we have to learn (as a baby) that we can't have all our needs met in life, and we certainly can't have them whenever we want. We have to learn that we can't have "everything". We can't have it "both ways". We have to learn to "wait our turn" and to not be "selfish" or "greedy". Bonus points if we can teach our babies to be polite and not to cry out for things.

To teach these lessons requires a combination of behaviors (and a fair amount of earnest effort and persistence and resolve), but as a minimum you have to be ready to ignore your baby's crying. In case you have any problems with that there are many books that are reassuring. Here is an example from *Babywise*:

The *Babywise* authors encourage a rather cavalier attitude to a baby's natural waking times referring to the baby's "internal clock" being "stuck". Of course the *Babywise* authors are not the only ones who reassure parents that "three nights" of crying,

and usually no more than "45 minutes" crying each night, is all that it usually takes to "reset" the supposedly stuck clock of the infant. And, as if anticipating the distress that this might cause parents they say that the baby "will not remember" these experiences. But memory is a complex phenomena and just because something "isn't remembered" doesn't mean that it hasn't had its effects.

The *Babywise* authors also seem confused about attachment theory saying that although a baby might be carried in a sling or sleep with its mother it isn't necessarily securely attached. That much is certainly true, but they cite an apparent proof of this which confuses the issue entirely. The authors say that the fact that the baby cries when removed from its mother (what they call the "stress of independence") shows that it can't have been "secure" in its "relational attachment".

Certainly in the Ainsworth Strange Situation Procedure, babies who are securely attached to their caregiver will often protest quite loudly when separated from their caregiver. Insecure-avoidantly attached babies usually protest minimally if at all. But what does this prove? The average person says, "ouch" when he stubs his toe on the ground and the person with diabetes or leprosy does not. Which one is the healthier?

Given time we all learn that we can't have everything we want. But do babies want everything anyway? Apart from food and comfort, a baby usually only wants one thing - to be held by his caregiver when he feels anxious. There is probably very little babies can do about this as they are

almost certainly pre-wired or pre-programmed to behave in this way.

When we think about babies it is often helpful if we can try to put ourselves into their shoes. I would never want to learn that I couldn't stand a reasonable chance of having most of my needs met in life. This is especially true in the emotional realm. I would never want to learn, as some sort of "fact", that I will be abandoned when I most want help.

It seems rather strange to me that modern parents in middle-class societies would want to set out to teach their baby that the world is not likely to respond to her needs when for most of us, in our life's experience, it is plainly not true. The world is actually not that bad a place for those of us who are fortunate enough to live in certain societies.

Of course, we are talking about the negative inner world that some parents bring to their relationship with their baby. They have an urge, perhaps unconsciously, to replicate it in the mind of their infant. Sadly, having been taught such a "lesson" about rejection in infancy, some people spend a lifetime trying to unlearn it, spending many years lost in hurtful relationships that seem to mirror the original rejecting relationship.

Despite what some authors might think, it is a fact that all babies experience themselves as being at the center of the universe, and, moreover, all parents are powerless to do anything about it. It doesn't matter what you think about it or even what you do about it. We may be determined to dissuade the baby of this notion, (presumably for its own good), but it will be of no use. As parents, our only influence upon this situation will be whether the baby experiences her universe as being a good one or a bad one. All babies are at the center of their universes but

each baby's universe is different. The parents construct the universe for the baby.

Of course babies are very far from being at the center of the real universe. This feeling of being at the center of the universe is a perceptual mistake that the baby makes based on its cognitive limitations. The average five-year-old has little grasp of just how big the world (and the universe) is, and how far he is from being at the center of it. Five-year-olds differ only in that some are at the centre of very poor universes.

In fact we rely on this type of healthy grandiosity that children naturally have, when we encourage them to believe that God cares intimately about them and their family. I would venture to say that all emotionally healthy children naturally take it for granted that they are in a relationship with God. That they have such a faith, which is really an innocent presumptuousness, is possibly why Jesus is reported to have said that, the kingdom of God belongs to them. Later in adolescence and adulthood we all have to rethink this whole question about our relationship with God when we catch up with just how insignificant we must be in the grand scheme of things.

I make the above point as something of an aside, but both Erikson and Winnicott noted that the tendency to believe in organized religion depends to a large extent on the development of a sense of trust (Erikson, 1965) and the availability of inner good objects onto which one can project the idea of a "good God" (Winnicott, 1965). Do religious parents who are following certain strict approaches to parenting understand this? If they did they might see that they are possibly thwarting their own efforts to inculcate religious beliefs into their children. Perhaps part of the problem with religious beliefs around the world

today is a growing belief in a God who is not good.

There are many who profess faith, yet in practice breathe mistrust both of life and man. (Erikson 1995).

According to Babywise, it is the parents' job, their duty, to make sure the infant does not experience herself as being at the center of the family or the universe. The baby must learn that she has to "fit in" with the rest of the family. But what does this ultimately mean?

Normally, when we think of a baby "fitting in" we might imagine this small baby in the middle of the couple or the family, happily snuggling in and fitting in. "Here you are." the parents might say, "Let us help you find a comfortable place to fit in. You belong here with us". But no, this is not the mindset being propounded. In what amounts to a kind of Orwellian double-speak, "fitting in," means actually the opposite; it means, "not fitting in". The parents are in effect saying, "Find a way to fit in with what is already going on around here."

In learning to "fit in" the baby really learns that it doesn't fit in. The baby has to twist or contort itself to the shape of the family or parental couple. The baby has to mold himself. Babies are quite capable of doing this, though to their own detriment. One of the sad and worrying things about babies is the extent to which they will distort and contort themselves in order to fit in with those that they love, those that they have attached to.

This "fitting in" is an important component of the "no loss" attitude to parenting which seems to have a wide following. Things must continue as they were before. For example, the marital couple must continue with the same relationship and enjoy the same behaviors that they did previously. For some this takes on a moral connotation. They must entertain and

"fellowship" as they did before. They must read the Bible with the same diligence, despite having a new baby. There is a type of denial that is encouraged, certainly to the detriment of the baby, but I would argue that the mother and father suffer as well. Perhaps, I am being overly dramatic but in a sense the baby has been stolen from them.

For those parents with busy work lives the desire to continue things as before is much more understandable on a practical level. Mortgages need to be paid and work place promotions don't wait around for everyone.

So often, one hears in psychotherapy clients' complaints of "not fitting in". They desire to feel that they belong and that they are acceptable in relationships. But not surprisingly, even when they are in a relationship, problems persist or even become magnified. Participation in an intimate relationship brings a sense of disbelief. For some, it is as if they are being tricked. They suspect their partner of being unfaithful. Or perhaps, they feel their partners looks down their nose at them. This happens repeatedly. Whatever the problem, the relationship inevitably goes downhill and ends.

Adult clients with substance abuse also seem especially to feel that they don't fit in. When intoxicated, however, they begin to feel at last that they do "fit in", that a gap has somehow been bridged.

Sometimes an exaggerated ability to "fit in" becomes a problem in later life. Patients with Borderline Personality Disorder suffer from a chronic sense of identity disturbance. They don't really know who they are, but they take their cues from the people that they are mixing with. As one psychoanalyst stated, for these people, "Who I am is where I am." They have what has been termed an "as if" personality. They are always acting a part. Though it is by

no means agreed as to the exact cause of this difficulty, one possible early determinant is this requirement that babies "fit in" and the chronic trauma that is an inevitable part of such a process.

But if we think about what it is that we are trying to teach babies in the first few months of life, we have to understand that we are quite restricted in what a baby can actually learn. A scientific or contemporary understanding of infant development would hold that a baby can only learn what its developmental stage will allow. This is where the tendency of books like *Babywise* to ignore developmental stages (and particularly the work of Erikson, Bowlby and Winnicott) causes them to come unstuck.

If we are thinking about "lessons", in the first twelve months a baby can only "learn" either that its world is a safe place or an unsafe and unpredictable place. It can only develop a certain ratio of trust in its caregivers versus mistrust. The baby is learning to develop a sense of attachment or its opposite, detachment, (or more precisely some form of disturbed attachment). Every experience that the baby has is filtered through that particular lens. The baby cannot learn that he is not at the center of the universe. The baby can only learn that the universe (which he is at the center of) is not a safe and secure one. He cannot learn that his parents are lovingly trying to teach him a lesson for his own good; the baby can only learn that his parents are unresponsive, apparently unloving, and unreliable.

When a caregiver does not respond to a baby's cries, a baby can only learn that her caregivers are unable to perceive what she would have thought were blatantly obvious communications. The baby can only learn that these obvious and sometimes frantic communications are

patently not up to scratch. Eventually, the baby must feel that her communications are pointless and are best forgotten. The baby must begin to think that her initial thoughts and feelings regarding relationships and the pleasure one can take in them are misguided. A sense of mistrust, inferiority, and impotence must be the outcome.

If we briefly imagined that a baby could cognitively comprehend concepts as abstract as putting others first, not being greedy, waiting ones turn and being self sacrificing, etc., how would we know that the baby was actually learning these things? Surely it is entirely up to the baby as to how they interpret their caregiver's behavior. Parents would have to keep their fingers crossed for good luck lest the baby misconstrue their intentions.

If the caregiver ignored her baby's crying and made no empathic response, one might infer that the baby is learning that when I am in pain, my caregiver will not be there to comfort me and attend to my needs. At minimum the baby is learning to distrust critical relationships early in life.

Psychoanalysts interested in theories of development have proposed that when babies are distraught they experience a type of loss and collapse which becomes structuralized or embedded into the emerging personality. Some theorists who have written about Borderline Personality Disorder note how patients commonly report a feeling of "falling in space" and "fragmenting" and "coming apart". It is not unreasonable to propose that such feelings represent a recurrence of early experiences stored or imprinted as a bodily memory. The emerging research into the effects of stress hormones on an infant's brain function and structure is of critical relevance here. The baby's developing limbic (emotional) system

is likely to be altered in an adverse and, some have postulated, permanent way.

Too often parents are urged into misguided attempts to "get in early" and "teach" some laudable concept. If we take parents who are perhaps not sensitive to begin with and then we exhort them to lack empathy, we are asking for trouble. Instead we should be trying to inculcate in parents attitudes such as those contained in the "watch wait and wonder" program. Encouraging them to "watch" and truly observe their baby. Not to see what they think they see but to watch afresh, as it were, without any bias or preconceived notions. Not to see what others have told them they will see but, perhaps for the first time in a long time, to stand back and see their baby, and even the world, in a new light. Without knowing it, some parents' actions towards their baby can translate into the creation of a dark, nightmarish universe where the baby is subjected to repeated experiences of loss, deprivation, separation, not being heard, fears of not existing (annihilation), and confusion. In such situations hope and faith is erased and it is difficult for it to be instilled in later life.

When do we learn that we can't have everything we want? When do we learn that we are not at the center of the universe? I don't think the average healthy person ever really learns it fully, but one comes close to it in the experience of parenthood. So here is another irony for books like *Babywise*. The very virtue the book is trying to help parents inculcate in their infants would be better learned at this particular point in time by the parents themselves.

How do we learn to put someone else at the center of attention? Well it is not very easy and some people simply can't do it at all. It helps though if we have at one time in the past (and indeed many times) been at the center of attention ourselves. Such an

experience, particularly in early infancy, creates a sense of belonging, a sense of fitting in, a sense of being able to cope with life's inevitable disappointments. A secure sense of attachment leads eventually, at an appropriate point in development, to the ability to be able to wait for good things to come (i.e., a sense of hope), and a sense of being able to give to others.

To conclude, parents who are determined not to put their baby at the center of attention risk damaging their infant's normal, and possibly God given, template for development. It wouldn't matter if, as many think, it were all forgotten later in life anyway. What we now increasingly understand is that, far from being forgotten, our earliest infant experiences form the foundation for later emotional wellbeing, cognitive functioning, work/creativity, social responsibility, and intimate relationships.

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President's Perspective Continued

different parts of the world. The interest and excitement in infant Tomental health has been enormous. The number of members in WAIMH international has not increased as much as it could have done. This fact sets challenges for all of us. How can an association with individual members grow bigger and bigger and act world wide and yet offer possibilities for its members to be active? How can we promote good interaction between WAIMH members and between WAIMH and its Affiliates? More members of WAIMH than ever have been involved in preparing the last WAIMH congresses and this will be the case for the Paris Congress as well. An increasing number of members have also been supporting the Signal, yet, we still need to increase the proportion of members who are actively involved in WAIMH. WAIMH should also find good ways to motivate new members and to stimulate more members from Affiliates to become interested in global infant mental health.

There are two basic questions. What benefits are associated with membership in WAIMH? How can members of affiliates benefit from also holding membership in WAIMH? These kinds of questions are on the agenda of WAIMH's Board of Directors right now.

In any case, one of the best advantages that a WAIMH member has is the possibility of participating in our top-quality congresses at a reduced fee. Welcome to the 10th WAIMH Congress in 2006 and, of course, welcome to WAIMH!

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THERE IS NO SUCH THING AS A FATHER

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Fathers I have met in family consultations have been, like most parents, keen to help their children, *but always with an eye on the mother*. Relationships, except the most infantile, are essentially triangular. Though he is not immediately aware of it,¹ the infant's entrance is what sets the scene. The eternal triangle - of love, jealousy, and betrayal - is older than any psychological theory, but Sigmund Freud was the first to state that the child's desire for each parent is at least as strong as, or even stronger than, their desire for each other. He noted how the father's presence prevents Oedipus' fate: "The little boy notices that his father stands in his way with his mother" (Freud, 1920).

From the infant boy's point of view, a father is at first a less immediate figure. The mother is all around him while he is inside her but, once he is born, this experience is gradually diluted by the entrances of other people, adults, and older children, who take over from time to time. The speed of this process varies greatly, but the direction does not. The luckiest children get to know their father intimately early on. Most cultures tell us that the sexes are opposite so it comes as a surprise for new parents to discover that the infant requires more or less the same kind of care from both. Males experience hormonal changes when their partners have babies. A fall in testosterone makes them more maternal. Yet the differences, however small, are

significant. The father never had his child inside his body and he does not have to give much, in terms of volume of genetic material and of time, to produce him. He does not even have to survive until the child is born.

Babies have little concept of gender at birth but usually develop an identification with the mother, since she is the primary caregiver. To the others around him gender is of enormous importance and the little boy soon discovers that he is male, which is not the same sex as his mother. "Disidentification" a term coined by Greenspan (1968), is the painful process of becoming "not female", a repudiation of femininity which is a familiar feature of most boys. "I am not like her," he thinks, but then, "Who am I like?" What follows is an identification with masculinity (Frosh et al., 2001). This is an uneven journey for most boys, who will make exaggerated efforts at being superman at one moment and become helpless infants the next.²

Traditionally, fathers came into their own when the child was older. For sons this was also the shift from mother's apron strings to an apprenticeship with father and his craft. In the modern world the presence in a small boy's daily life of real men, as opposed to stereotypical heroes in cartoons and stories, will help him to find a more balanced sense of gender (Pruett, 1993). The term "role model" is often applied here but is inadequate. Identification is much more than imitation. A famous football player may be a role model, but real identification can only be acquired through personal contact. The boy needs a rounded character, not a cardboard cut-out.

In non-human primates there is relatively little connection between

male parents and their offspring, but as humans evolved, the sharing of food and pairing³ led to the possibility of father-child attachments, even in infancy. But, except in the rare case when the mother is absent, the male partner does not get far as a parent unless he is trusted by the infant's mother. He may not be the father at all, and even if he is, the mother may not want him. His role is optional, whatever anyone may wish or feel. Yet in spite of the contingent place of fathers, they are of immense importance because we make so much of the reproductive process. It matters profoundly to a child, as to his parents, who made him. Human imagination makes tasks into things, but a father is nothing without a mother and a child, and the same applies at each point in the triangle.⁴ He is both participant and witness, both player and audience.

Long before reproductive knowledge and gender identity are issues for the child, attachments to caregivers are being formed. Attachments to each parent are independent and develop at different rates (Steele et al., 1996). Recent studies seem to support the traditional sequence in which father becomes more important after 10 or 11 years (Lamb & Lewis 2004; Steele & Steele, 2004) but this turns out to be dependent on early intimate contact between father and child, such as bathing the baby. The Steeles found that fathers who have not understood their own life stories, and who have not mourned their losses, are less engaged as parents. These men are more passive in their thinking and their children become less confident and less sociable. Grossman and her colleagues (2002) show how fathers in conventional families, where mothers spend much more time with the children, have a unique role in helping them to explore the wider world from

mother's secure base. A specific connection between fathers and baby boys is highlighted by Feldman. She notes sex differences in the rhythms of intimate contact so that fathers are more in tune with sons, and mothers with daughters. "The coregulation formed between father and son during the first months may be essential environmental inputs that facilitate the formation of self-regulatory capacities" (Feldman, 2003). Father's attentive care of his baby son seems helpful in its own right, not just as an adjunct to mother's.

When mothers are depressed following the birth it is their male children that suffer the most lasting effects, particularly in self-regulation (Morrell & Murray, 2002). Some of these boys become dreamy or hyperactive, even at primary school age, long after the mother's depression has lifted. Here, an involved father can minimize, or even prevent, developmental harm. Similarly if the mother is physically ill after the birth, for example a premature delivery or an emergency caesarean section, a father might come into his own as a primary parent. There is nothing, apart from social prejudices and the lack of functioning breasts, to stop men from caring for babies effectively (Pruett, 1993). But in the absence of early intimacy he becomes more like a teacher, or coach. Studies on modern fathers show that they are most useful for the child's social and mental development when they are engaged in parallel with the mother, rather than "taking over" when the child is older.

In recent decades in western and western-influenced societies, equal parenting has for the first time been considered possible. It is unusual in historical terms, but it is not "unnatural". In some hunter-gatherer societies men take an equal and active role in parenting,⁵ and this arrangement may have been more prevalent for the hundreds of thousands of years that hunting and gathering was our only way of life. It

is now socially acceptable for a man to be closely involved in the care of his infant, occasionally more so than the mother. But familiar distinctions between parents still prevail, so that when a child is ill at school, for example, the default response is to call the mother. Segregation of roles – "father's money for mother's domestic service" – was the norm in many mid-twentieth century societies, but this is now in competition with a more complex notion: "fair shares for adult parents". The spectrum of parental roles is now greater, with some men as primary caregivers at one end, and traditional breadwinners who stay away from the nursery at the other. In the middle, both parents may be earning money *and* caring for their children each day. All this offers richer variety and choice for families and more opportunities for parental arguments.

When development goes well enough the players will negotiate their triangular life in small steps. Toddlers will have tantrums and both parents respond more or less effectively. Alongside the quality of their teamwork the capacity to do this comes from their own experiences of care in infancy. When our own rages have been calmed by bigger and more patient adults, we carry within us a belief that loss of control can be managed. It is easier for two to deal with an explosive child than one alone, but it can also lead to conflict. One familiar sequence is an exhausted mother saying to the father "You deal with him now!"

When things go wrong

Children with behavioral and emotional disorders almost invariably have a history in which this kind of containment has not happened. Even if the primary problem is mainly biological, the formation of a secure attachment between child and parents, and other caregivers, is the most important ingredient of mental resilience. Security does not depend on having his own two parents caring

for him, but it does depend on having one or more faithful caregivers who can manage powerful feelings of love and hate between themselves and the growing child. It may not be fair that the mother carries a greater burden of responsibility for promoting secure attachment, but she usually does.

Many cases of postnatal depression occur when a lone mother has no confiding relationship with another adult. If she has to care for a child on her own, she is deprived of adult company and emotional support. Neither has a break from the other. Whether this is idyllic or maddening it cannot be good for either. The same applies where a man has to do the task alone, which is increasingly common. Babies thrive when they have a small number of familiar and loyal caregivers so that the child does not have to have an exclusive relationship with only one. Some of the pioneering family therapists would teasingly refer to this state as a cross-generational "marriage" (Whitaker, 1977; Palazzoli, et al., 1978). Jay Haley was the first to describe the "secret coalition" (1976), whose mischief has continued to preoccupy family therapists.⁶ Families in therapy usually contain more than two people, but enmeshment⁷ between one parent and a symptomatic child is a common theme. The props on the family stage include a bedroom door which may, or may not, shut out the child at night when he reaches a certain age.

Paternal function; making up the numbers

In the triangular drama exclusion and inclusion are not fixed positions. Each player is at the same time a partner in a couple, and also alone on the outside looking in, occupying a third position, or metaposition.⁸ It is a paternal function to make such experiences and reflections possible. It provides "an alternative point of view" as one 16-year-old boy who never knew his father elegantly put it.

There are of course many lone parents who can support a healthy independence in their children, but this is likely to depend on the parent having both internal and external supports. In her mind there are parents who can work together, and in her life she will have secure adult friendships (who can also do some babysitting). Both maternal and paternal functions will from time to time be performed by the same person, by parents of the opposite sex, or by people who are not parents at all. The Oedipal challenge is, after all, more about generation than about gender. Babies can't make babies.

Absent fathers

In his own mind no child is "without a father". In the absence of a given story he will make up his own. Today fatherlessness is no longer regarded as an automatic disadvantage, nor is it rare. Some women choose to have children without involving the father after conception. Others find single parenthood preferable after trying to collaborate with the father or with another adult male. The findings of social science and developmental psychology show associations between variables, such as single parenthood and social difficulties, but these can be misused to make prescriptive statements about how families should be,⁹ or to criticize parents who do things differently, for example raising a child with no word or sight of father. During the last decades of the twentieth century single mothers in Britain and USA became political targets, as if all social problems were their fault. Yet there is statistical evidence to show the benefit of having two involved parents¹⁰ (Cabrera et al., 2000), even if they are not together.

Cooperation between parents is more difficult, but probably more important, if they are separated. Although parental separation is usually painful for children, most harm occurs when there is unresolved and relentless conflict between them, together or

apart (Kelly, 2000; Booth & Amato, 2001). Although they may think that he does not notice it, the quality of the parents' relationship is always a matter of fundamental significance for the child. Careful agreement over contact, education, and money is enormously hard work, especially when there are new partnerships, but it is a priceless gift to children when they do not have to feel responsible - like in-house marital therapists - for the way their parents get along with each other.

When the father is rarely or never seen, the child depends on his mother or other relatives to inform him. If a boy with no contact with his father hears from his mother only that he is a bad man (perhaps along with all other men), he will feel that he is descended from someone who not only could not stay at home to care for him, but also would not, and therefore, does not love him. This, though not necessarily true, is painful and disturbing to the child's self esteem (as much for a girl as for a boy). If the mother says good things about the absent father, that when they were together there were some good times, and that father loved his baby or his partner, or both, then the child has the chance of a good father in his mind.¹¹ This requires brave and active mental work on the mother's part. She may despise him, or feel nothing for him, but it is possible for a mother to make sense of her broken relationship with the father, much as parents can make sense of their own parents' deficits. A bad father can still be understood, and not just rejected out of hand. The same applies to missing mothers. These are therapeutic tasks (Dowling and Gorell Barnes, 2000). Some fathers are more helpful out of the picture (Jaffee et al., 2003) and sometimes there is very little good to tell.

Father waits in the wings for his entrance between mother and son

Though some modern young couples without children may hope to discard traditional roles, once the baby is born

an unsymmetrical triangle is created. Biological realities do make a difference, and cultural prejudices about men and women do not simply disappear when we want them to. With few exceptions the mother is still the primary parent, while the father follows. This sequence is in many families much quicker than it was even twenty years ago, but in others it is still traditional, with father seeing little of his children in the early months or years, and always deferring to mother when he does. Whatever the sex of the child, the mother tends to be the gatekeeper for his relationship with that child¹² (Allen & Hawkins, 1999; White, 1999). She introduces the father and child to each other, or fails to do so. For boys there is the potential for comparisons, even rivalry, between son and father, while she is the referee.

The triangular predicament for boys is not unique, but there are developmental differences between the sexes that make boys more vulnerable to both biological and emotional stress in the early years. Because of this fragility (Kraemer, 2000) boys take up most of the time of child mental health services, while girls predominate in adolescent clinics. Whatever the underlying problem - such as an inborn tendency towards anxiety, restlessness, inattentiveness, clumsiness, learning difficulties, social aloofness, or depression - the quality of triangular relationships has a powerful influence on the outcome. Clinically a case can be made for the familiar hypothesis: *that many younger boys with emotional and behavioral difficulties have powerfully enmeshed relationships with their mothers from which the father is to some extent excluded.*

Adapted from:

Sebastian Kraemer (2005) Narratives of Fathers and Sons: There is no such thing as a father. In: Arlene Vetere & Emilia Dowling, (Eds.). *Narrative therapies with children and their families: A practitioners guide to concepts and approaches*. Brunner Routledge.

Footnotes

1 as early as four months children can manage triangular relationships (Von Klitzing et al 1999)

2 Girls' identifications, if smoother, are more complex because they have to distinguish themselves from mother's person but not from her gender. Paternal functions are just as important for girls, but that is another topic.

3 "if a male cannot tell when a female ovulates, he must tend her more or less continuously to be sure he sires her offspring" (Hinde 1982)

4 "There is no such thing as a baby" said Donald Winnicott in 1940, perhaps the first to note the essentially systemic nature of the baby and mother couple. "The infant and the maternal care together form a unit" (Winnicott, 1960, p39). A father's function is equally dependent on the existence of the other two (Etchegoyen, 2002, p34)

5 The Aka pygmies of Central Africa share parental care of infants, more than any other human group studied. There are no external enemies, so men are not needed as boundary keepers and protectors. "Husband-wife reciprocity is most likely the prime factor that leads to increased paternal involvement" (Hewlett, 1992, p171) Paternal investment is lower when the male has higher status, suggesting a link with non-human primate patterns in which males are more likely to care for children when they want to impress the female.

6 "the term coalition means a process of joint action *against* a third person...the problem is more severe when the coalition across generations is denied or concealed...when this act becomes a way of life the family is in trouble" (Haley, 1976, p 109.) Haley, one of the great pioneers of early family systems therapy, did not acknowledge the Freudian origins of the pathological triangle.

7 'enmeshment' here describes a harmful misconnection between parent and child which has been a focus of developmental psychology for at least 50 years; the double bind (Bateson et al, 1956), maternal impingement (Winnicott, 1960), anxious attachment (Bowlby, 1973), invisible loyalty and parentification (Boszormenyi-

Nagy & Spark, 1973), enmeshment (Minuchin, 1974), Expressed Emotion (Leff & Vaughn, 1985), disorganised (Main & Hesse, 1990) or unresolved/preoccupied attachment (Patrick et al, 1994), and failure of reflective function (Fonagy & Target, 1997) or of attunement (Trevarthen & Aitken, 2001)

8 "If the link between the parents perceived in love and hate can be tolerated in the child's mind it provides him with a prototype for an object relationship of a third kind in which he is a witness and not a participant. A third position then comes into existence from which object relationships can be observed. Given this, we can also envisage being observed. This provides us with a capacity for seeing ourselves in interaction with others and for entertaining another point of view whilst retaining our own, for reflecting on ourselves whilst being ourselves" (Britton, 1989, p87).

9 We might encourage fathers to bathe their babies, but any *obligation* to do so will not necessarily help, and may backfire. Associations between parental behaviours and child outcomes can only show what happens when people make their own choices.

10 The more the task is shared the more the children will see that gender roles are not fixed. This is regarded as an advantage by most therapists but not by all families. Some have very traditional views which have to be respected and explored in every case.

11 "A father who is dead may be carried within the child's mind as a very alive figure depending on the mother's way of talking about the father". "... a father who is physically present might nevertheless be lived as symbolically lost, absent or dead in the child's inner world" (McDougall, 1989, p 209). "The physical availability of the father may be neither sufficient nor necessary for triangulation to evolve. What does seem critical is a situation within which the child can envisage a relationship between the two other, emotionally significant figures." (Target & Fonagy, 2002, p57)

12 or with a stranger: Hobson et al (2004) show how maternal sensitivity is correlated

with the one year old child's capacity to engage more freely with other people. When father is non resident, mother's relationship with him retains a strong influence on the quality of the child's relationship with him (Dunn et al, 2004).

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CONFERENCE REPORTS

ENRICHING EARLY PARENT-INFANT RELATIONSHIPS

London, March 2004

A conference took place in March 2004 to honor American pediatrician Dr. Berry Brazelton and to showcase his pioneering method of aiding mother-infant interaction: the Neonatal Behavioural Assessment Scale (NBAS).

During March 4-5, 2004, nearly 400 delegates gathered at Church House, London SW1. Academics and health professionals came together to share research and practical experience and to meet Harvard University's Dr. Berry Brazelton who developed the first interactive assessment of newborn behavior 30 years ago, and Dr. Kevin Nugent, Director of the Brazelton Institute, Boston.

This was the first conference of its kind organized by the Brazelton Centre in Great Britain, with help from American sponsors, the Johnson & Johnson Pediatric Institute.

Studies have now established that babies can recognize the voice and smell of their mother at birth. At four days old, they can distinguish between their mother's face and other faces and they can even recognize emotional expressions. Infants are primed from birth (and earlier) to interact with their caregivers.

Now brain imaging has confirmed what was previously suspected: "The prime task of brain development in the first few weeks of life is the forming and then reinforcing into permanence of necessary connections. The baby must interact with a loving and responsive environment in order to ensure normal brain growth." (Balbernie, 2001)

The NBAS was originally designed as a tool for clinical research but is now increasingly being used as a way of facilitating this first and most crucial relationship. During an Assessment, which lasts about 30 minutes, parents are encouraged to observe their baby's many abilities, such as the ability to self-soothe, to block out disturbances during sleep such as noise or harsh light, to distinguish the sound of their parent's voice from all other voices, to let their parents know when they want stimulation and when they want sleep.

Studies have shown that the NBAS increases maternal self confidence, (Rauh, et al., 1988) improves paternal attitudes and involvement in caretaking, (Myers, 1982) influences reciprocity in mother-infant interaction (Gomez-Padro, 1995) and influences a baby's developmental outcome (Das Eiden, 1996).

Early intervention

Eminent speakers at the March conference included not only Dr. Brazelton himself (enthralled the audience at the age of 85 as he spoke about his work for almost an hour), but also Dr. Kevin Nugent, his long-time colleague.

Dr. Nugent introduced delegates to the Clinical Neonatal Behavioural Assessment Scale (CLNBAS), a shortened version of the NBAS (now renamed Neonatal Behavioral Observations). This has been developed specifically for clinicians caring for newborn infants in hospitals, clinics, or home settings. It presents "a significant clinical window into the parent-infant relationship, offering a unique opportunity to enter into a supportive partnership at a time when parents may feel vulnerable and in need of support."

To those who felt that clinical interference could disrupt natural bonding, Dr. Nugent put the opposing, evidence-based, view that *relationship-based* interventions can have a positive effect on families and development. He said the intervention comes as "a unique opportunity to show parents that their baby is not just competent; he or she can organize behavior in a selective way and make choices: what to attend to and what to avoid."

From the Jacobs Foundation in Zurich, Scientific Director, Dieter Wolke discussed his work with the NBAS as a measure in the GAIN study of babies with intra-uterine growth retardation and Dr. Joao Gomes-Pedro, Chair of the Paediatrics Department of the Medical School of Lisbon at the University of Lisbon, brought the "Portuguese message" that in his country the NBAS is used with success as an intervention, particularly with families at risk.

Early intervention is now accepted as a health protection principle, and it has recently been recognized that "the preservation of the mental health of infants is the key to the prevention of mental disorder throughout the lifespan" (Fonagy, 1998).

Maternal Depression

Infants are "pre-programmed" for relationships. A newborn's "orbitofrontal cortex contains neural networks that are particularly sensitive to the stuff of relationships and emotions - body language, face-to-face communication, voice tone, and especially eye-contact" (Balbernie, 2001). This playful exchange is most at risk when a mother's postnatal illness prevents her from responding appropriately to her baby.

"Getting the first, prototypical, important relationship of anyone's life more or less right is a necessity, not a luxury" (An Infant Mental Health Service). The NBAS can be particularly effective in this context. Professors Lynne Murray and Peter Cooper from the Winnicott Research Unit at the University of Reading, spoke about their research work with depressed mothers in the UK and in South Africa. There are indications that maternal sensitivity may be increased when using the NBAS in a treatment package.

Clinical Psychologist Per Svanberg showed videos and presented the work he is doing in the northeast of England to screen for, and intervene in, attachment-related difficulties.

At Bethlem Royal Hospital, developmental psychologist Susan Pawlby from the Institute of Psychiatry, uses the NBAS as both a clinical tool in her mental health work, forming part of the assessment and treatment of patients in the mother and baby unit, and as a research tool, to tell us more about the implications of severe maternal mental illness for the developing child. "We know that the children of mothers who suffer from postnatal depression are at increased risk of impairment in their cognitive, behavioral, emotional, and social development. We know very little however, about the infants of mothers who suffer from severe postnatal illness."

As Kevin Nugent said, "the NBAS is the key to unlocking the baby's communication. It reveals a portrait of the baby, tells us who this baby is, and how to care for him or her."

In the Community

As well as academic presentations, there were also talks by health care professionals about the work they do every day to help parents and babies.

Health visitor Anne Girling in Cambridge has found that the NBAS can help parents "gain a new understanding of their infants". Midwife Mabel Simms, senior lecturer at the School of Women's Health Studies at the University of Central England, confirmed that "The midwives who have been exposed to the NBAS in the clinical area have been very positive about it...the NBAS is particularly helpful to women who have had a traumatic birthing experience."

Rachel Chittick, who is working in Neonatal Intensive Care at Liverpool Women's Hospital, presented her plans to assess premature babies who have reached 36 weeks in her NBAS research study on the effects of general anaesthesia on babies born by caesarean section.

Paul Barrows, principal child psychotherapist with the United Bristol Healthcare (NHS) Trust, dealt with the often overlooked subject of fathers and babies. He explained that even where the baby has no father, there will always be a father in the mother's mind – a combination of the baby's father and her own father. This internal representation will be conveyed to the infant who will acquire an internal picture of the couple. The nature of this parental couple will be central to the baby's emotional development.

Betty Hutchon and Annette Mendelsohn talked about their use of the NBAS as a supportive intervention with a baby with chromosomal abnormalities. Joanna Hawthorne presented her survey of 22 families in the neonatal unit at the Rosie Hospital, using the NBAS with premature babies who had reached term. This intervention helped mothers notice more about their baby's behavior, and most mothers reported that they felt more confident and supported. All the mothers said they would recommend this intervention to others.

Babies come into the world ready for relationships, utterly dependent on the loving care of their families. Yet they also arrive at a time when many parents have never even seen, let alone held, a new baby. For absolute beginners, the first few weeks of parenthood can be a steep learning curve: its 24-hour demands can threaten to overwhelm some couples, many of whom have little family support today. "The time of greatest influence, for good or ill, is when the brain is new. If we want to help the next generation, we should be working with their parents while they are babies" (Balbernie, 2001).

Now that the birth rate is decreasing, and fewer and fewer new parents have ever encountered a baby before, the NBAS is arriving at just the right time.

Description of the Neonatal Behavioural Assessment Scale (NBAS)

Unable to speak, the newborn baby communicates by doing things: looking wide awake and interested, turning away, yawning, sneezing, screwing up his or her face and, of course, crying. The NBAS is a way of sharing and understanding this behavior for new parents. If parents can observe the newborn's reflexes and understand their ability to habituate (shut out disturbing stimuli when asleep), regulate their sleep and wake states, and self-soothe, it can help the parents respond appropriately.

The NBAS demonstrates an infant's strengths, helping parents and professionals to develop caretaking strategies. It is based on a positive model of parenting and child development – rather than a medical model, searching for deficits.

With the parents present, the Assessment is carried out on an infant halfway between feedings by an NBAS trained professional

experienced with newborns. It takes approximately half an hour to carry out at any point from birth until the baby is two months old. Ideally, the exercise is repeated three times in the first month, which gives both parents and professionals a chance to identify the baby's strengths and areas of difficulty. Caregiving strategies are shared with parents. The intervention is also used to assess the effect of inter-uterine deprivation or maternal substance misuse on the baby, and is used to support parents of babies born prematurely, or with congenital abnormalities, or Down's syndrome.

The NBAS is used in research studies and as a supportive intervention. There are 17 centers worldwide where health professionals can be trained. In the UK, the Brazelton Centre in Great Britain aims to encourage health professionals working with babies to train in the NBAS and therefore adopt a powerful way of working with parents.

Further Information

A CD collection of talks given at the March 2004 Conference with Dr. Brazelton and Dr. Nugent and other speakers, and a DVD about the NBAS: *More Than Word Can Say* will soon be available to buy from the Brazelton Centre in Great Britain.
www.brazelton.co.uk

Dates for study days and conferences will also be found on the site. Workshops and training in the NBAS are arranged at a mutually convenient time.

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Other useful links:

www.brazelton-institute.com
www.zerotothree.org
www.talktoyourbaby.com

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MARCE CONFERENCE, OXFORD, SEPTEMBER 2004

At this major biennial conference, Paul Barrows (Chair, AIMH UK) organized a joint AIMH/WAIMH symposium to look at the issue of how to try to develop services for perinatal care, seeking to integrate child and adult mental health services. As part of the symposium, Professor Tuula Tamminen, President of WAIMH, presented an overview of developments in Europe while Professor Bernard Golse gave an outline of the situation in France. Professor Golse's presentation is reprinted below.

The conference was also the occasion for a very fruitful meeting between

Professor Tamminen and Professor Lynne Murray (retiring President of the UK Marcé Society) which it is hoped will lead to a creative collaboration between WAIMH and the Marcé Society in the future.

Models of Perinatal Mental Health Care - How to Improve the Treatment of Mental Illness Related to Childbearing : The Situation in France

WAIMH /AIMH UK Symposium, Oxford, September 26, 2004

By Prof. Bernard Golse (Child Psychiatrist and Psychoanalyst: Chief of the Child Psychiatry Unit at the Necker-Enfants Malades Hospital, Paris; Professor of Child & Adolescent Psychiatry at René Descartes University, Paris 5)

Introduction

I am very pleased and honored to have been invited to participate in this symposium, but I have to say that I don't speak very good English, so I have to speak relatively slowly, and I apologize for that.

Each country has a specific history of perinatal (that is to say perinatal psychiatry, perinatal psychology, perinatal psychopathology, or perinatal mental health), and it is clear that the state of perinatal mental health care closely depends on this history. I will try to explain the French situation in the light of this.

As a matter of fact, I have not prepared either a "psychodrama", or an accurate clinical or technical paper. Rather, I have chosen to make only a sort of short, basic and honest presentation of the French system relating to the organization of the field of perinatal psychiatry, in order to point out some real difficulties we have still to face in our country.

Before that, let me say that I am the head of the French-speaking WAIMH group, a group which was created by Serge Lebovici and me in 1994, with the aim of enhancing the French and European position in the international setting of WAIMH. We organized two meetings in Paris of the different European affiliate WAIMH groups, first in 2000 and then again in 2003.

Tuula Tamminen was present each time, and it was very interesting to compare the different situation of each group from a political, social, clinical, theoretical, technical, and ethical viewpoint. For the time being, and before the next world congress of WAIMH which will take place in Paris in July 2006 (a congress organized by Antoine Guedeney and me, with the help of many others), I believe it is extremely important to enhance and to increase the collaboration among the different European affiliate WAIMH groups in order to better define, if there is one, an European way of thinking in the field of perinatal mental health.

A last word of introduction to underline the fact that the French-speaking WAIMH group and the French-speaking Marcé Society are closely related and collaborate in the same field, but the WAIMH group more from the infant's perspective, and the Marcé group more from the parents', a difference which, in the end, proves to be very fruitful.

French means and measures in the field of perinatality

During pregnancy, the law imposes a medical follow-up for each woman with the requirement of a monthly consultation from the third month and the recommendation of three ultrasound examinations.

The delivery takes place either in a hospital or in a clinic; it is a medical delivery and delivery at home is implicitly forbidden. The teams in the maternity units are always

multidisciplinary (midwives, obstetricians, pediatricians, social workers, and so on), but psychologists or psychiatrists are only present in the public centers and not in the private ones.

After the birth, the medical supervision of the baby and his mother is provided by public centers, called Protection for Mothers and Infants (PMI), and each family is informed about the existence and the role of these centers which are devoted to children from birth until they are six years old.

Each birth is strictly notified to these PMI centers where pediatricians and pediatric nurses are working. In some cases, the team of the PMI centers may be in contact with the families before the birth if some difficulties are reported by the maternity units. Home visits are possible, often suggested by the maternity units and delivered by the pediatric nurses and/or the family helpers of the PMI centers, especially in the case of small birth weight, twin or multiple pregnancies, or psychosocial difficulties.

Here there is a great need for meetings between the team of the maternity unit and the team of the PMI center, but we don't have, in France, a specific system of "health visitors" as in UK or other Nordic countries. However, a link can be established between the PMI centers and the day-care centers, if the baby needs a special and accurate follow-up.

Regarding the financial and social situation, all the medical care during the pregnancy is totally refunded for every family if the pregnancy is correctly declared, and there is statutory maternity leave for the mother (beginning six weeks before the birth until ten weeks after); whereas, the father has only three days free after the birth.

To conclude this first part of my presentation, I will just note that professionals involved in the field of perinatal psychiatry may have to work in close connection with the judicial services and also with the adult or child and adolescent psychiatry public districts which have been created in France, in the seventies, in order to offer the same psychiatric provision for all the population.

The connection with the judicial services makes possible the involvement of those services in some special and difficult psychosocial cases needing different forms of assistance. This particularly concerns the problem of families where child abuse and its prevention and treatment are an issue. The link with the psychiatric districts makes possible the provision of help and care to parents in great psychiatric difficulties, that is to say, severe maternal depression or puerperal psychoses.

Various forms of help are available for parents as out-patients or as in-patients and, in the latter case, mothers and babies may be admitted to units named "mother-infant centres" where mother's medical and psychiatric treatment, baby's care, and help with attachment processes may be jointly provided.

The Impact of History

As I said before, each country has its own specific history regarding perinatal psychiatry.

In France, I believe it is useful to highlight four points:

- First, in France, the development of perinatal psychiatry is chiefly due to child psychologists and psychiatrists and not to adult psychiatrists, so the place of psychoanalysis is probably more important than in other countries (via the works of S. Lebovici, M. Soule, and many others).
- Second, we are very protective of private life, and that is probably why

the role of the "health visitor" is not officially defined and set up.

- Third, until now, we have focused much more on the mother's difficulties rather than the father's.
- Fourth, despite the work of the clinical group involving Sylvain Missonnier and Michel Soule in the French-speaking WAIMH affiliate, much greater attention has been devoted to the mother's difficulties *after* delivery rather than to the parents' difficulties during pregnancy.

In relation to these four points, it is clear that, in France, perinatal mental health care mainly concentrates on the post-natal period and mainly focuses on the question of the mother-baby relationship.

We have now to increase our attention to the prenatal period and to the father's difficulties, which are so frequent and so important to take into account.

Obstacles and Main Requirements

1) Perinatal psychiatry has undoubtedly been expanding over the last fifteen or twenty years, but it is still difficult to organize a really efficient system for care and prevention. Beyond the impact of history that I have just referred to, a number of other factors are also involved:

- First, individual and social reaction-formations remain very powerful and prevent the awareness of a mother's difficulties from being really effective. Pregnancy and the delivery and birth of a baby seem to be most often assumed to be happy events, so that it is very hard to fully take account of maternal depression (before or after the birth), puerperal psychoses, and even the post-partum baby blues.

- Second, and perhaps for the same type of reasons, it is often also very difficult to clearly recognize the baby's difficulties: the younger the baby, the more it is almost

unbelievable to accept the idea of his suffering or of his madness.

Accepting this idea requires a real kind of "working-through" to take place in everyone's mind. This point is crucial to the organization of the training of the different professionals involved in the field of early infancy: the professionals who meet the babies and who, most of the time, are not child psychiatrists themselves, but pediatricians, pediatric nurses, social workers, etc. Without this effort of working-through, mere knowledge of the early signs of a baby's difficulties is not useful, and the risk then exists of collusion with the parents' denial of their baby's difficulties.

- Third, in the field of perinatal psychiatry, the need for a multidisciplinary team around the parents and the babies is absolutely critical, but often – if not always – really difficult to be brought into play in a lively way. There is always a risk of splitting between the different professionals who sometimes use the same words to speak about different processes, and other times use different words to speak about the same things. Here is really a trap that we have to carefully escape in order to avoid conflicts and misunderstandings.

- Finally, even if perinatal psychiatry manages to take hold of many problems in the field of public mental health, even if the frequency of maternal depression is very high (10 or 15%) with the danger that babies are at-risk for a long time, even if we now have greater knowledge of what it would be useful to do than in the past, despite all this, the politics of early mental health care are still not at all satisfactory.

For instance, in France, we have far too small a number of mother and baby units (pre and postpartum) which are very expensive to set up and to manage (only 40 beds for the

whole country!); we are not always able to keep babies and their mentally ill parents together; we do not have, as yet, good arrangements in the field of child protection (i.e., in relation to physical, emotional, and sexual abuse) and we are not really efficient about the organization of so-called "perinatology", the goal of which would be to set up a focused, prenatal preventative service, respectful of the family's freedom and confidentiality.

Conclusions

These, then, are the different remarks I would like to make. I hope I have been only realistic, and not too pessimistic.

We have still a lot of work to do, but the situation is very interesting because the ideas are moving and many teams are now involved all over the country in the field of perinatal psychiatry.

We hope that politicians will be responsive to this new field of knowledge, so crucial for early development, both in respect of care and prevention.

Many thanks for your attention.

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MYRIAM DAVID *THE DISCREET PIONEER*

Myriam David, a psychiatrist with a psychoanalytical mind, was a pioneer in several domains: infant mental health, training of infant mental health professionals, the theory and practice of foster care, home-based psychological treatments for infant and families, clinical research on maternal deprivation, and clinical research on mother-child interaction. She collaborated with John Bowlby, and played a major role in the transformation of French institutions for infants. She died in Paris, peacefully as it seems, on December 28, 2004, just before the celebration of the freedom of Auschwitz.

In our clinic for infants, children and adolescents, in the Paris Hôpital Bichat-Claude Bernard, in one of the poorest districts of Paris, residents in child psychiatry did not know her name, though many professionals in the field would. Myriam David certainly did not belong among the very well-known stars of infant psychology and psychopathology. She wrote relatively few papers and books, never was on TV, made only a few professional films (among which *Infants in Institutions* is the most famous), and gave only one interview about herself and her professional and personal background. Our residents should know that she worked in this very same place, at the Bichat Claude Bernard Hospital, where Jenny Aubry was her boss, and Françoise Dolto and Daniel Widlocher her colleagues.

Now that she has left us, it is certainly important to recall how important her role was for the development of infant mental health, and how this role was not acknowledged. This situation was shared by a small group of women, medical doctors, or psychologists, having both a pediatric and a psychoanalytical background. These women were open to British influences, and all of them, after the war, worked on maternal deprivation and on early parent infant relationships. They were: Jenny

Aubry, the head of the team, professor of pediatrics; Dr. Marcelle Geber, who worked on Kwashiorkor in Uganda, and helped Ainsworth with testing her children in her first attachment study; and Geneviève Appell, friend and colleague.

Myriam David was also a member of the French resistance. She was deeply influenced, in her professional career, by her experience of being deported and being a doctor in Auschwitz-Birkenau. This experience was to give her particular sensibility to the extent to which institutions may be prison-like and dehumanizing to infants. What Bruno Bettelheim applied to autism, Myriam David was to apply to nurseries, and to the care that mentally ill parents need in order to be able to keep their infants with them while avoiding deprivation and abuse. Myriam David had lost her mother early in life, which of course may have contributed to her being so accurate about attachment, loneliness, and depression in childhood.

Born in 1917, she became a medical student in 1940 in Paris, in the Bichat Claude Bernard Hospital. Interns and male senior doctors were on the front line. She stayed in Paris, while her family went south to the free zone. She remained on duty in the railway stations, greeting and taking care of refugees. After the armistice she too went south and joined the Combat Resistance network. She wrote her thesis about acute nephritis in children, just before the rounding-up of Jews in the Vel'd'hiv in 1943 and just before Jews were forbidden to practice medicine. In the interview she gave to *Devenir*, which it took her four years to decide to allow into print, she told me about how she was arrested almost immediately. As a matter of fact, this 23-year-old young woman was responsible for two major resistance networks, one in the North one in the South, with the task of making up false identities that could resist Gestapo inquiry. And she did so

for more than a year and a half, with her constant ability to work with precision, and to be able to bring people into a task, sometimes much farther than where they had intended to go, without pressing guilt on them, but just by reminding people of what had to be done. The Compagnon de la Libération, Jean de Bénouville describes her: "straight haired, with no make up, slick faced, she looked like a Russian anarchist, but with the ability not to attract attention". Even so, she was arrested and was tortured. "Words cannot tell what is the feeling of awe and terror to be cornered, to be in a state of such helplessness, to be just a bowl of anxiety" (Devenir, 1994). Myriam and her sister were sent to Auschwitz-Birkenau. Myriam found it always very hard to express herself about the camp experience. Just before she passed away, with a heart both strong and weak, she began to write about this experience, along with Rosine Crémieux, another colleague and also a member of the resistance who was deported to Auschwitz. Oddly enough, the two women had worked in the same building for years without sharing the experience. But in an unexpected manner, Myriam began to talk openly about the camp and the links with her professional experience at the Loczy Institute, in Budapest, a place she was very supportive of, and everyone present remembers this as a very special and deeply moving moment.

When she returned to France, along with her sister, she felt free. Nobody wanted to hear about her experience, which sounded incredible. She seized the occasion to go to the United States, with a grant given to the members of the Allied Resistance Forces. She went first to Leo Kanner's institution, then to the Judge Baker Guidance Clinic in Boston. She went into psychoanalysis, and had supervision with Beata Rank, who was the only one able to give her the feeling of understanding what she went through. She stayed in Boston for three years and became very enthusiastic about working with infants, children and families, and about the mixture of direct intensive psychoanalytically-oriented work with children, and individual and group

help for parents, casework and supervision. She would draw on this model to design her home-based family therapy unit, financed by the Rothschild Foundation.

In 1950, Jenny Aubry, who she had met in the United States, asked her to take the lead on a research project on maternal deprivation in a Parisian nursery for infants, Parent de Rosan. This research took place with the help of John Bowlby, after 1955, and the whole Jenny Aubry research team (Aubry-Roudineco, Geneviève Appel and Myriam David) went each month to the Tavistock Clinic to discuss what would be the first French evidence-based research on the subject, and the only French one mentioned by Bowlby in his famous Maternal Deprivation paper. Thanks to Bowlby, the research got support from the World Health Organization (WHO), so that it could be pursued until 1962. Myriam David and Geneviève Appell conducted a follow-up of the infants, with a control group of normal infants, all of them being seen and observed at home, a method very seldom used at that time in France. This would be the basis of some first-hand observation of the development of mother-child interaction.

But getting into the Parent de Rosan nursery, at the beginning of the fifties, she received a great shock seeing these deprived infants, with wide eyes, rocking themselves, being emotionally taken care of by no one; she was reminded of the helplessness and the pain she suffered in the camp. "I do not accept that someone pretends not to know... it was incredible to discover the resistance of professionals of all kinds to acknowledging the reality and severity of institutional deprivation, and the effects of harsh ways of making separations between parents and infants." This led David to work with social services, implementing the casework technique she brought back from the States, within the Protection Maternelle et Infantile, which was responsible, after 1945, for maternal and child health and protection. She then went on to open a new unit for young children, *L'Unité de Soins à*

Domicile des Jeunes Enfants (Home based unit for the care of infants), under the auspices of the Rothschild Foundation, and with the help of Serge Lebovici. The center was hosted in the Alfred Binet center, in the XIIIth district of Paris. In this unit, she implemented the techniques of care, training, and help that she brought from Boston; she also developed a therapeutic foster family agency, since not all separation can be avoided but, she believed, had to be prepared for and worked through with the family and foster family. She wrote a book on the subject of foster care that remains the main reference work in France, describing the clinical aspects of these situations, among children, parents and institutions.

Few child psychiatrists in France in the sixties and seventies, and an even fewer number of psychoanalysts, took an interest in deprivation, separation in infancy, and the effects of institutionalization. Very few worked with the child protection services and very few were interested in training these professionals in child development, in parental disorders, in the development of the first relationships. Almost nobody read the English professional literature, and except for psychoanalysts, nobody knew about Bowlby and attachment theory; almost no psychiatrist, with some few exceptions like Cyril Koupernik and some others, tried to implement some methodologically sound clinical research. In their follow up of institutionalized babies and their control group, David and Appell discovered the richness of observing the baby in its natural setting, from the perspective of what was not yet called mother – infant interaction. David also drew attention to the negative effects of psychotic mothers on their babies. As Fraiberg would have put it, she says early on that the baby can't wait for the mother to feel better, and that the baby should not be considered as a therapy for the mother. Before the onset of the use of video, David and Appell were the true pioneers who discovered the richness and specificity of the mother-child relationship. Myriam David is therefore to be considered the pioneer of infant mental health in France, and

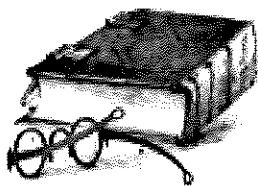
the real initiator of clinical research in the field, followed by Serge Lebovici, Michel Soulé, and Léon Kreisler among others.

One can estimate the importance of the role played by David in effecting change in French nurseries- and the extent of its lack of recognition – when one considers the research she conducted in the Denfert-Rochereau emergency nursery. Here she filmed, as Bowlby did in hospitals, the impact of parent-infant separations, assessing the number and duration of contacts of the children with the staff, training the staff in new ways of interaction with the infants, assessing changes in withdrawal behaviour and in the development of the infants as the staff became more emotionally involved with them. What was then pioneering, evidence-based, action research has become the daily task of the child psychiatrist, but Myriam David was the first, and the one who helped mobilize institutions away from being indifferent to the needs of their infant clients. Myriam David was impressed by the Loczy Institute, founded by the pediatrician Emmy Pickler in Budapest. She considered this little orphanage to be a neglect-free institution because it is a small one, paying attention to the needs of the abandoned baby, and emphasizing its own initiative.

Myriam David's huge clinical and theoretical contribution was scarcely recognized as such when she was alive, except by the wide family of professionals she was in contact with. WAIMH was able to pay her respect in giving her a much deserved award at the Amsterdam 2000 Congress. She was very touched by this recognition, albeit a late one, of her accomplishments. The ceremony was very moving, with the presence of Berry Brazelton who Myriam had known for a very long time, a vibrant homage read by Bernard Golse, and the presence of a large French group including many close collaborators and friends.

Antoine Guedeney

Entretien avec Myriam David,
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These listings are for
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Inclusion does not imply
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recommendation.

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