

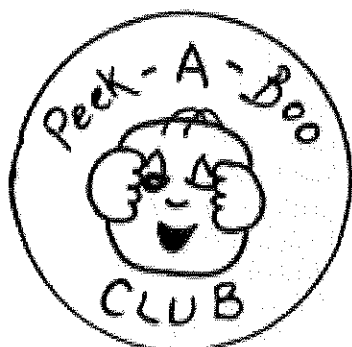


The Signal

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Melbourne, Australia,

INTRODUCTION (by Frances Thomson- Salo)

Wendy Bunston has developed an innovative group model for helping mothers and infants living in the shadow of violence - the Peek a Boo Club, in Melbourne, Australia. As far as we know it is a unique approach and although still in the early stages of development seems to offer hope to those families in terms of the gains they made, and

The Peek a Boo Club: Group Work for Infants and Mothers Affected by Family Violence

hope to other professionals working with them. Drawing on Wendy's experience of running groups for children who had been exposed to domestic violence, setting up a group for mothers and babies who had also experienced this seemed to open a new therapeutic possibility - and the idea of the Peek a Boo Club as a short term group was born. It was a privilege to hear in supervision about the sessions and how the group evolved, with the leaders coming to trust a synthesis of their expertise and intuition in knowing at what level to work - and play. Some sessions were videotaped, which provided compelling clinical evidence during the course of the group of its power to touch these families' lives, which was then supported by the results.

As a therapeutic factor, I would underline that the leaders actively engaging with the infants in the presence of their mothers contributed to their mothers feeling better about themselves and about their infants in a way that quickly brought results. Treating the infants as equal members of the group seemed to enable change at the level of the mothers' implicit memories - and their babies'. When the mothers saw their babies being engaged with, understood and above all enjoyed, they saw them differently.

As the mothers felt their own stories were *heard* while simultaneously,

early ways of being in a relationship in which they felt they deserved to be hurt were challenged (both verbally and through their experiences of pleasure in the activities provided as much as the infants), and their sense of self changed too. The staff-client ratio is high, but if these results in 8-9 sessions are sustained then much subsequent distress may be circumvented. Wendy Bunston has given a detailed account of the model in the spirit of offering it so that others can try it or adapt it.

THE PEEK A BOO CLUB

As the Community Group Program (CGP) of Melbourne's Royal Children's Hospital Mental Health Service (RCH MHS), we had, over many years, provided training to other professionals based on our knowledge and experience of working with children and young people affected by family violence. During this time it became glaringly apparent that something was missing from our work. Our assessment interviews with children and mothers indicated that the majority of our clients had been exposed to familial violence from birth, if not in the womb. For a smaller number, their conception was a result of violence. Neurological research indicated that very early emotional trauma can significantly impair the infant's developing brain (Schore, 2003a, 2003a, 2001, Wylie,

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2004, 2001, Teicher, 2002, Streeck-Fischer & van der Kolk, 2000, Perry et al., 1995), yet we commenced our intervention work with children in their mid primary school years.

While our Mental Health Service caters for children aged 0-15 years, the majority of our work centers on children aged 5-15 years. Our team had very successfully developed specialist and award-winning group work interventions specific to family violence under the banner of the RCH MHS Addressing Family Violence Programs (AFVP). We offered two programs, Parent's Accepting Responsibility- Kids Are Safe (PARKAS), Bunston, 2001; (Bunston & Crean with Thomson-Salo, 1999) and Just for Kids (JFK). These worked with the parent/child dyad and catered for children in their mid primary school years through to early secondary school.

It was time for us to go back in years, to start at the very beginning, in an effort to positively shift the developmental trajectory of these children's lives and intimate relationships. We had links with members of the RCH Infant Mental Health program who encouraged our proposal to run infant/mother groups within our AFVP. While confident we could bring a wealth of knowledge to addressing the impact of family violence within the mother/child relationship, as well as group work experience, we felt inept when it came to working therapeutically with babies.

Lindy Henry, a maternal and child health nurse who was completing the University of Melbourne's Master's degree in infant mental health, came highly recommended by infant mental health program members. She became our *infant expert* in the facilitation team. Bez Robertson, a worker from Community West also joined our team and was our local community expert, and a social worker with years of experience running women's domestic violence support groups. I made up the third member of this tri-collaborative facilitation team for the first group we

ran, and when we ran the second Peek a Boo Club, Naomi Audette, a dance and movement therapist on our AFVP team, took over my role. The AFVP provided additional support: Kate Enderby, a recent graduate psychologist assisted with the first group and Merrin Hollyman, a recent graduate social worker assisted with the second group.

THE FACILITATION TEAM

Each of us came with different though complementary approaches to therapeutic work. Naomi and I both use a psychotherapeutic approach; Naomi, however, privileges encouraging expression through movement and dance whereas I am more reliant on verbal and activity-based mediums. We also honor a philosophy within the AFVP that promotes work that is child-led. "Remaining true to a child-sensitive focus means remaining true to a process that is child led and not set by the compass of adult expectations. Children ... feel safe when their environment can meaningfully tolerate who they are and what they offer, and reflects back an affirming and respectful image of self" (Bunston 2001: p.9). Feeling safe is a critical therapeutic ingredient in working with clients who have little and in some instances no sense of what safety might feel, be or look like. This is not about diminishing the critical significance of the mother/child relationship, nor the integrity of the parent, but rather affords the child important consideration as a being who is complex, contributes to and expresses him or herself within relationships.

Our approach was well complemented by the analytically informed infant mental health masters degree Lindy completed. This saw "the infant not as the object of investigation but as the subject" and understood that 'infants use gaze and touch to explore their mother and the world around them' (Thomson Salo & Paul 2004: p.31). In addition Lindy brought an extensive knowledge of early childhood development and a confidence in working

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with babies and mothers that helped alleviate the rest of the facilitation team's anxiety about undertaking, what for us, was a new area of work.

Bez, a seasoned family violence prevention networker for the outer-western region of Melbourne, brought a more psycho-educational approach to the team. She had an array of resources used in her women's support groups and very good contacts with community support services that could provide practical assistance if needed. On more than one occasion Community West provided mothers with taxi vouchers and the occasional food voucher.

We forged strong bonds with one another as a team, motivated by our excitement about undertaking what for each of us was a new area of work, as well as the opportunity to work together, to learn from each other and learn from this client group. We spent considerable time together planning, practicing some of the songs we would use in the group (much to the amusement of other staff) and writing up a submission for funding.

THE PEEK A BOO CLUB

Originally we had in mind a *Rolls Royce* version of what would be the Peek a Boo Club, involving building extensive links with other services in the community, having guest speakers, inviting significant extended family members (i.e., grandparents, aunts, siblings) to certain sessions, writing up weekly comprehensive newsletters and undertaking a comprehensive evaluation and long term follow up. These plans were quickly thwarted by a failure to secure additional funding. Nevertheless we were determined. Our local *high risk* infant team in the Child Protection service agreed to pay for each client they referred, weekly supervision was provided by Frances Thomson-Salo through the RCH Mental Health Service, and the rest of the costs were borne by the RCH MHS and Community West. Our *Morris Minor* version was ready to go.

The premise underpinning our work in the Peek a Boo Club was that exposure to significant intimate relational violence and the sheer need to survive in such a context can often preclude a mother's ability to focus on her infant's attachment needs. Ultimately the focus of this group was to positively alter the developmental pathway of the infants and the infant/mother relationship, where there has been exposure to severe family violence. The psycho-educational component of this program was intended to explore issues of power and control, respectful expression of feelings, understanding cultures of violence and keeping safe.

Our identified goals were

- To create a safe place for mother and infant to interact, engage with other mothers and have fun in a non-judgmental setting
- To create a "holding space" for mother and infant, a therapeutic arena for them to form and consolidate healthy attachment patterns
- To increase the quality of infant/mother relationships through role-modeling, mirroring, attunement and play
- To positively influence the developmental pathways of the infants
- To increase the confidence of the women in their roles as mothers and as individuals
- To "get to know our infants", as well as "getting to know each other" and "our mutual stories"
- To explore "how things are for us and for our babies, and how we would like things to be"

The psycho-educational component of the program explored:

- How "we and others play out issues of power and control"
- Respectful expression of feelings
- Understanding cultures of violence and keeping safe
- The impact of family violence on children and the inter-generational transmission of violence
- How "we manage stress, its impact on us as mothers and its impact on our babies"
- 'What is violence – that of others and our own'

- Identifying "strengths and qualities in our babies and in ourselves"
- Building positive relationships

Apart from the assessment session, we had no set notions that activities or topics should be ordered in a particular way. We did what we felt progressed well from one session to the next and were led in part by where the group took us. When the babies were tired and wanted to sleep we left them sleeping, and would sing and do the movements of songs with these who were awake, or would use the quieter moments to move into discussions. It is interesting to note that initially some of the babies slept quite a lot but over the course of the group became increasingly alert and engaged not just with their mothers, but the other adults and infants as well.

ASSESSMENT

Influenced by the success of other infant interventions using home visiting (Puckering, 2004, Olds & Korfmacher 1998, 1997), we began our face-to-face contact with an initial (and sometimes two) home visit assessment sessions. We used the "working model of the child interview" (Zeanah & Benoit, 1995) to guide our questions, including ones we usually ask around the nature, length and perceived impact of the familial violence on the mother as well as the child. In this first meeting we also administered the Parent-Infant Attachment Scale (Condon & Corkindale, 1998).

The assessment session has always played a critical part in all the AFVP groups. Importantly, we believe it to be the arena for successful engagement as well as setting the emotional and therapeutic tone of our groups (Bunston, Pavlidis & Leyden, 2003). In our experience, being respectfully open and upfront about the violence that has occurred within families lays the groundwork for a future capacity (theirs and ours as therapists) to tolerate and hopefully transform the insidious legacy of relational violence. It also demonstrates our ability to *hold* them in a context that explores that which they fear to talk about. Simul-

taneously, we also engage through the use of appropriate humor, recognizing the importance of playfulness and fun, not just for the child but also for the parent.

WEEKLY SESSIONS

In total we provided a minimum of nine sessions (one/two individual assessment, six weekly, a reunion and a combined Christmas party) to the participating infants and their mothers. The weekly sessions (over six weeks) began as 2 hours in duration but from about week 3 onwards stretched closer to three hours. In the First Peek a Boo Club we had four babies and four mothers, two of the dyads having been referred by the Child Protection service and two through community agencies. The Second Peek a Boo club consisted of three mothers but five babies (including twins). The age range for infants in both groups was 3-12 months old.

We took over the Mental Health Service's conference room each Thursday, and the scent of our oil burner would waft through the building, subtly alerting everyone to the fact that the Peek a Boo Club was about to start. We purchased some large inexpensive cushions that were laid out in a circle in the middle of the room, further encircled by chairs, and played beautiful music in the background. We always ensured we had tea and coffee available and a delicious morning tea (often including something home baked). Maybe we were trying to create something akin to a cozy and nurturing nursery.

When all the participants arrived we discussed and created our group rules and spoke about the facilitation team's limited confidentiality, and that as professionals we are legally as well as morally committed to taking action if we believe a child is at risk. This is something we do in all our AFVP groups during the assessment and again in the first group session. "This highlights to parents the principles of honesty and transparency within which (our groups) operate, and also models accountable and truthful

behavior from the outset" (Bunston, 2000).

ACTIVITIES

During the first three weeks of the first Peek a Boo Club we used specific icebreaker name games soon after starting. In week 1, after revisiting the purpose of the group we did *rolling introductions* (Audette & Bunston, 2006). This activity uses a toilet roll, placed in the middle of the floor, much to the bemusement of participants, as its prop. The instructions were to take as many or little as each mother thought she needed, as well as a separate amount for her infant (without explaining what the toilet paper was to be used for). Each mother had to introduce herself and her baby and with each square of toilet paper taken, tell the group something about herself, for example, six pieces equal six pieces of information to tell the group.

The next week (and again the following by popular demand) we began with a "circle name and action game" (Audette & Bunston 2006). Each adult and the babies (with the help of their mothers) had to say their name accompanied by a particular movement. For example, I might say "I'm Wendy" and I would stick my thumb on my nose, wiggle the rest of my fingers and tilt my head to one side. The rest of the group would say "Hello, Wendy" and mirror back my movement. As each person did this we repeated their name and movement and then repeated all the preceding names and movements. This game, as you would imagine, took a bit of time but was an excellent social lubricant, largely because by the end we were unlikely to forget each other's name (and movement) and it evoked great hilarity.

Every week we sang nursery rhymes from our childhood (from our memories as well as the mothers), new songs we had discovered, and a few the mothers had made up. We actively involved the infants throughout (unless asleep). These songs were then collated in our weekly Peek a Boo Club newsletter that would arrive at

the participants' homes a day or two before the next session. The newsletter consisted of the words of the new songs sung that week, the recipe of the home-baked morning tea, a standing item outlining the group rules, and a brief overview of the topic discussed. It was colorful, with accompanying illustrations downloaded from the internet.

In week 2 we used soft scarves to cover and uncover the infants and played peek-a-boo, carefully watching the interactions between baby and mother to discern the comfort and trust levels with the activity. Prior to this we had marched around the room to music, the mothers holding their infants and swaying to music, the facilitators joining in and swaying scarves. This marching initially felt somewhat contrived and I remember feeling quite self conscious. As we continued, however, I became more aware of my awkwardness and gave myself over to a decision to just "have a go" and enjoy playing. As facilitators, we often experience having to make conscious our own feelings in order to transform them and then find our changes have created group changes. In this session we also used an activity we often use in our other AFVP groups. This involves placing a large collection of plastic animals (wild and domesticated) in the middle of the room. We ask parents to pick which animal best represents their child and to explain what qualities the animal possesses that best represents the child's personality. We then ask them which animal would they like them to be and, if different to their original choice, why? Lastly, we ask them to pick an animal that best represents themselves and then what they would like to be (if different to original). This activity reveals much (conscious and unconscious) material that can be worked with by the group.

In week 3 and again in week 5, Lindy brought in mirrors (30cm x 45cm) for each infant. The mothers were asked to hold the mirror up for their babies and encourage them to look at themselves in the mirror, and then

for the mother to look into the mirror and catch their baby's eye. This was a delightful activity that captured the moment of recognition and exchange through smiles between the two as the babies moved their gaze from themselves to their mothers. It also prompted a discussion about how comfortable we, the adults, felt about looking at our own images. The consensus was that we did not, and a discussion ensued about why this was so and what their children's experiences might be. Mirror work in the fifth session saw the babies much more curious about their own images, and more spontaneous and playful exchanges between the mothers, with the infants being placed together and encouraged to gaze at each other and their mothers.

Other activities (week 4) included laying out St. Luke's Strength Cards (a packet of large, beautifully illustrated cards identifying an array of strengths) and asking the mothers to pick 2 for themselves and 2 for their infants. A fruitful discussion ensued about why they had picked what they had and if there were any strengths they did not feel they had but would like. We also provided bubbles for the mothers to blow for the infants in this session, as a means of actively engaging the infants in play with their mothers. This was a session where one mother brought in an old video tape of herself singing at church a song she had written and performed for a puppet play. We joined in with the song, much to her and her infant's delight.

For the final activities in the last session (week 6) we provided face paints, used as a means of creating a fun and intimate activity for the infants and mothers, and then material paints to paint a T-Shirt for each participant. We (the facilitators) painted T-Shirts for the mothers while the mothers painted their infant's tops. This activity was intended as a symbolic and nurturing farewell gift (perhaps a transitional object) from ourselves to the mothers as well as their gift to their infants. The First group was very creative in their designs, with the "Peek a Boo Club" featuring on every single top.

The second group also used these two activities to end the group; however their T-Shirt painting was much more elaborate, and we kept the shirts to dry (and to give back at the reunion). The activities in this group were similar, with a slightly different order. They included a session where the mothers were shown how to massage their babies with oil while discussing the importance of nurturing touch and, in the context of their experience of the use of inappropriate (violent) touch, finding out how to give and receive appropriate touch. More movement and music activities were included such as an activity where the infants were placed in a hammock of strong material (each end held by an adult) and gently rocked back and forwards.

TOPICS

The topics we covered each week varied according to the mood of the group. We started out cautiously, wanting to create a sure and steady start for the emotional birth of this group. However, this may have reflected more about us enacting the fearful transference issues of the mothers during the initial life of the group. As a facilitation team, with this particular group, we were like new mothers, trying to find our rhythm and unsure of how to work with their experiences of violence in the presence of their babies. We spent week 1 getting to know one another and then in week 2 edged around the topic of 'how do we manage our stress' and 'how do our babies know when we are stressed'.

Going back to supervision (Frances having been able to view some video footage of week 2) we were able to acknowledge and process some of our countertransference issues. My anxiety, I believe, rested with the absolute vulnerability I felt for, and in relation to, these babies. As a childless woman I felt a little scared of these babies, and frightened that I may somehow unwittingly cause them harm if I led the group deeper. This hesitancy to tackle the tough topics contradicted my usual therapeutic style. Bez and Lindy were perhaps waiting for me to take the lead in facilitating these discussions and,

not unlike the mothers coming to the group with the 'experts' facilitating it, relinquished their authority at these times.

In week 3 we revisited the ways we manage stress using an activity sheet Bez routinely used in her women's groups. This is a page of illustrations with captions such as "cool as a cucumber" or "bottling it up". This led to a more intimate discussion about the backgrounds of the individual mothers and disclosures about their anger as well as areas where they felt they had not measured up to themselves or others. It revealed personal histories replete with their childhood experiences of being abused, neglected and abandoned. When it seemed timely we altered the tempo of the group and sang another song and ended this session with the song that had from week 1 become our signature finishing song, 'Twinkle, twinkle, little star'. What remained magical about this closing song was that we would place all the infants on the cushions and stand above them with a large, almost transparent scarf that had large golden stars printed on it. Held collectively by the adults and waved gently up and down above them, the infants seemed mesmerized. At different times over the six sessions, each adult would also end up lying with the infants under the scarf to experience what it was that never failed to enthrall the infants.

In the fourth session the mothers explored "our wishes for ourselves and for our babies". This evoked considerable discussion as themes emerged for these women around yearning for security and safety. Money featured in the discussion not so much as an end but as a way of ensuring their independence. The wishes they held for their babies were largely to be happy and healthy and not have a troubled life, as they all had. The issue of loss also emerged with one mother unable to attend the last two sessions due to a previously booked overseas trip. This was to be her last session, and as one of the other mothers had failed to show up, issues of us abandoning the

group and tolerating disappointment were reflected on.

The fifth session was perhaps the most emotionally intense. The topic discussed was 'what are the messages our parents have given us about ourselves and what are the messages we want our children to have about themselves?' Throughout the four previous sessions, the issue of violence experienced by them and by their babies had been disclosed. This session however revealed a depth of intimacy not previously shown, with revelations about the deep sense of shame and guilt they felt and some women suggested that they deserved some of what had happened to them. When we focused on whether they would ever feel that their children would deserve to have the same things happen to them, the mothers were adamant that they would not. This opened up the chance to reflect on the fact that maybe they deserved to both think better of themselves and to expect others to do so as well.

We also came to have more confidence in sharing our interpretations of what might be happening for the infants within the group, and as facilitators really "taking" them in, visually, emotionally and psychologically. We spoke to the infants about what we were doing and why, and we noticed that mothers in the group began to do this too.

PHOTOS AND VIDEOTAPING

We took digital photos with consent at different times throughout the session, printed them on photographic paper and gave them to participants at the end of the following session, or if someone missed a session, would send them out with the newsletter. We used the images we had compiled to create a photo collage to show back to the group at the reunion. We have also used this collage (with the faces of the mothers blurred) to professional groups when talking about the Peek a Boo Club. After much discussion and only after gaining consent from the mothers we videotaped parts of weeks 2, 3 and all of week 5.

We tussled with the rationale for taking photos and videotaping. This was a client group where stalking and harassment from spouses or partners was a common occurrence and ensuring the confidentiality and anonymity of their involvement in this group was critical for their sense of safety in attending. Some women were in hiding from their ex-partners. Others, while in new relationships with men who were not physically violent, had repartnered with men who appeared to exercise considerable control over their movements. The video camera was turned on when it seemed appropriate and video material, understood to be used only for professional training purposes, has not yet been shown publicly. Time prevented us from being able to edit and play back the video material, but it felt important to capture their journey through the group in photos and present this (much to their delight) to them.

EVALUATION

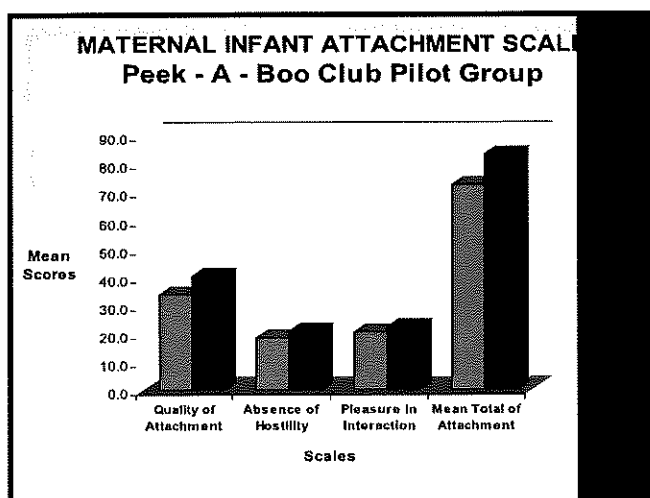
Small numbers (7 mothers and 8 babies) do not allow us to make any sound statistical analysis and conclusions. As noted, we administered the Parent-Infant Attachment Scale (Condon & Corkindale, 1998) pre and post group, and the graph below indicates the positive shifts made by the mothers in their attachment with their children post group. It is interesting to note that the mean attachment score of the seven mothers (acknowledging that at this stage these small numbers are statistically invalid) fell well below the mean score of "normal postnatal mothers" prior to the group. Post group, the mean attachment score of the

mothers fell within the "normal mean score".

We are in a position to re-contact the mothers from our two groups in the near future to see if these shifts have been sustained. As we run more programs our data base will grow, which should allow us to draw useful inferences for evaluation of the intervention.

We also asked the mothers to fill in qualitative questionnaires post group. These were extremely positive about the relational aspects of the group (forming relationships with others, the infants bonding with one another and learning new ways of relating to their infants) as well as the fun and relaxed environment provided. The most consistent difficulty they faced was getting to the venue, and on time.

Our observations of the participants were that the infants made quite rapid progress during the course of the group, particularly one infant with significant developmental delays. Additionally the infants became increasingly relaxed with their mothers and the other adults in the room. As would be expected, each week they began to explore their environment with more confidence, slept much less and became animated in their sounds, movements, eye contact and engagement with one another. The mothers formed bonds that lasted beyond the



group and six out of the seven mothers attended the Christmas party. The seventh mother was still in contact with the other mothers in her group and one offered to visit her to drop off presents and a hamper that had been donated to our service specifically for this group.

"WHERE TO" IN THE FUTURE

Our focus to date has been working with infants in the 3-12 months age group. We have already begun planning a third baby group as well as trialing our first toddler group for children aged about 12 – 24 months. Ultimately, should we generate and/or receive enough funding, we hope to develop specialist child-specific group work programs addressing family violence covering all ages within the 0-15 years age range.

The local community interest in the Peek a Boo club has been immense, with services both within and outside our catchment area contacting us to ask if they can refer clients to the program or to find out how we ran the program and asking for ideas about setting up their own intervention groups. A large component of AFVP (which helps us fund some programs) is to train others in the area of working with children/families affected by family violence, as well as produce professional manuals dealing with the areas mentioned above.

CONCLUDING COMMENTS

As with our other AFVP groups, our commitment to acknowledging the impact of the violence, as well as being able to hear and respond to the mother's own capacity to be violent has, we believe, led to successfully engaging the mothers, and keeping them engaged in these two groups. From the outset, speaking about what is sometimes unspeakable clears the way for quickly moving into a depth of sharing and connection that is therapeutically very powerful. We were initially cautious within the group setting about revisiting some of the material we had covered in their individual assessments, but when we

moved past this anxiety, so too did the group, with the gains noted in the Evaluation section. Most importantly we found that the infants had much to teach us, about themselves and about ourselves, should we take the time and care to listen.

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Further details about the Peek a Boo Club can be obtained from any of the following:

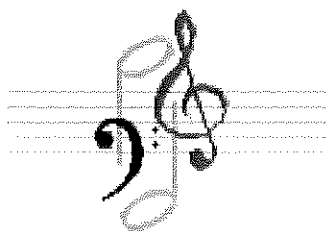
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About the Peek a Boo Club and/or any other of the RCH MHS Addressing Family Violence Programs, training or manuals:

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Visit our web page at www.rch.org.au/mhs/ services then click onto Community Group Program



“MOTHER MUSIC” – MUSIC THERAPY PILOT FOR A SURE START IN WEST LONDON

By Kate Binnie
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I am a newly qualified music therapist, fresh from the Bristol University post-graduate training that ended in December 2005. As part of the course we had to set up our own final placement in an area of particular interest, and I decided to approach my local Sure Start [a U.K. early intervention program] with an idea about integrating music therapy into their package of interventions for vulnerable mothers and their new babies. I wanted to set up a pilot project consisting of a weekly group for referred moms with, or at risk of, post natal depression. The broad aims of the group were to support mothers who felt they were not coping, by providing a safe, contained space where they could share their feelings; to provide the opportunity through music for creativity and growth of self confidence; to use music and the mother's voice to promote mother/baby bonding and to encourage positive, sensitive transactions between mother and baby. I was also keen to provide a space where isolated mothers (the majority of whom turned out to be relatively new immigrants from very different cultures) could meet, and form a self supporting mini-community of their own.

My own experience of post natal depression coupled with what I learned in my training led me to believe that with early intervention and support, mothers could grow through the essentially traumatic experience of having a baby and learn about themselves and their babies' feelings, leading both towards a mutually rewarding relationship. I felt that the route of anti-depressants and GP waiting lists for counseling was not the only or most effective way of dealing with PND, and that having a group available every week right from the beginning of a new baby's life might address problems almost before they had begun.

There is a wealth of research on how maternal depression affects a growing baby's brain and emotional development (including Murray, 1996; Balbernie, 2001; Mohan, 1998 and Gerhardt, 2004) particularly in terms of healthy attachment, and the subsequent effects on school performance, later mental health and parenting. I believed in setting up this group that music therapy could work quickly, positively and directly to counteract this. The vital ingredient would be our shared music which - as a non-verbal medium - would be accessible to all of the mothers, regardless of their culture, class or race, and which would of course be immediately attractive and engaging to the babies.

My aims for what became “Mother Music” fitted into the Sure Start program targets of early intervention and support, namely: “All Local Sure Start programs to have agreed and implemented, in a culturally sensitive way, ways of caring for and supporting mothers with post-natal depression” (Sure Start website) and in June I began a weekly hour long group at my local health center that ran until the end of November 2005.

WHAT IS MUSIC THERAPY?

Music therapy is based on the understanding that the ability to respond and to experience oneself through music is an inborn quality that usually remains unimpaired by disability, injury or mental illness, and is not dependant on musical training. An established discipline allied to health and education services, music therapy has traditionally been used with clients who have psychological, behavioral, learning or physical difficulties, and where expressive speech may be impaired for physical or psychological reasons. Music therapists are trained musicians, and during the music therapy training we learn to use our instruments and voices in order to match, tune into,

reflect, support, contain, challenge, and essentially to be with our clients in order to build a therapeutic relationship without the need for words. The aim is to work towards “health” in its broadest sense (physical, mental, emotional and spiritual), developing individuality, self awareness, motivation, confidence, creativity and choice. In some contexts the work may be in a more physical model (for example in neuro-disability or stroke rehabilitation) where the aims may be to frame and encourage motor skills and speech in conjunction with a multi-disciplinary team, or in a more psychotherapeutic model (for example in mental health work). Often work with the physiological will go alongside a corresponding emotional and supportive role as the relationship between client and therapist develops. Music therapy is used in various contexts throughout the lifespan, from work with babies (and some new work in the ante-natal period), through childhood and adolescence, especially with children with special needs and autism, to adult mental health work, in palliative care and in dementia care. Work can be one to one, or in groups, in institutions and schools, and increasingly (as with Sure Start) with families and in the community.

WHY MUSIC THERAPY FOR MOTHERS AND BABIES?

Music therapy training begins with looking at healthy mother/baby interaction as a model of the therapeutic relationship in clinical work. Therapists look at the work of Daniel Stern and his concept of vitality affects. These feeling states are the shapes, contours, rhythm and length of how we think, act, vocalize and feel from moment to moment. A healthy mother/baby relationship develops through a mutual sensitivity to this flow of “now moments” so that the baby, without understanding the meaning of mother's words, feels what she means across sensory modes in a direct and

immediate way. Music therapists use this concept in building a therapeutic relationship with all client groups. By attending to a client and his/her music, vocalizations or movements (for example, from a disturbed child's screaming, right through to a severely disabled client's breathing or tiny head movements) and by responding with improvised music sensitively in the moment, we aim to build a relationship whereby the client feels heard, held (in the Winnicottian sense), understood and connected with. Music therapists are therefore ideally placed to work with mother/infant interaction. We can use our thinking about "being with" our clients to work directly with the mother/baby dyad; modeling ways of playing and singing, using music to encourage and motivate mothers who have lost a positive connection with their baby, stimulating moments of shared pleasure and joy, modeling praise and helping mothers to recognise and enjoy the good moments, and to build on these. The essentially arousing and emotional qualities in music are used to encourage a process of positive, sensitive transaction between mother and baby.

Mothers with PND may not be able to tune in to their baby's affects in a sensitive way. A mother may be so low that she cannot respond appropriately to her "social baby" who – as a *work in progress* both physically and emotionally – needs this interaction in order to build his brain and emotional and social world. Or, a depressed mother may be anxious/angry and not respond sensitively to her baby's need for regulation. As Sue Gerhardt described (at the AIMH (UK) Annual Lecture April, 2005) a baby cannot manage his own feelings yet – he learns to do this from his mother. This may be very hard for a new mother if she has not had a good experience of being mothered herself. She may not be able to regulate her own feelings, or conversely may be overly pre-occupied by them.

In the Sure Start group, I gently encourage mothers to notice their feelings about their own babyhood, often stimulated by music and lullaby. This sense of looking at the new mother's own mothering has been a big part of the work and is I believe key to many depressed mothers' sense of

inadequacy, anger, and disintegration. Many of the women at the group also have no mother accessible for support and advice – either because they are dead or because they are far away, and may never be seen again. A common theme therefore is grief and loss, and I have sensed this has needed to be shared and acknowledged as part of the new mothers' process towards being able to deal with their own relationship to their baby.

SET UP AND CONTEXT

Before I began running the group in June, I spent around 8 weeks getting to know the Sure Start health team, health visitors and midwives – those "on the ground" who would be making referrals to the group. I organized several experiential workshops for staff, and open workshops for new moms at the local health center, in order to get across the concept of music therapy and how it could be useful in this context. When meeting the moms, I felt it was important to be careful how I presented the idea. Music as "therapy" seemed too threatening, and so I came up with the name of "Mother Music" and explained that the group was for sharing, talking, music, singing, and would be non-judgemental, free and reliably there each week for anyone who needed it.

Staff at Sure Start were initially a little circumspect. Music therapy is still quite a small, specialist profession and it is quite hard to get across the way it "works". However, I have found that promotion and communication are key, and have persistently produced fliers, leaflets, and attended team meetings in order to give continual feedback to staff throughout the 6 month placement. The more I have worked to build an open relationship with staff, the more referrals and support I have received in turn. I have also carried out an evaluation process for each group (there have been two, an 8 and a 10 week group, with a break during the summer) and have presented the results in feedback meetings to Sure Start staff and health visitors. I have also learned to be reflexive in my approach. My initial model of a closed group for women with PND has grown into an open group for any vulnerable mother, with a baby of almost any age. Many of the immigrant women at the group would not recognize the

word "depression" (which is essentially a western concept) and express their emotional distress in somatic terms e.g.; "I have too much pain" or "my head hurts all the time". I have learned (with the help of extensive supervision) to extend my therapeutic antennae, to be culturally aware of differences in how mothers play with and respond musically to their babies, to watch for all the non-verbal clues that things are not going well, as I cannot rely on language. Almost all of the mothers have limited English, and some none at all. It has been an incredible experience that re-affirms my belief in the extraordinary and universal power of music.

A TYPICAL GROUP

Usually between 5-7 mothers arrive for the group, all with a baby aged between 3 weeks to about 12 months. We have had as few as one mother, and as many as 10, plus 10 babies and several toddlers. This size of group is hard to manage. However, I am lucky enough to have had a wonderful assistant, a Sure Start nursery nurse, whose experience and knowledge of many of the moms, and of the system in which I am working has been invaluable. The group starts at 10 a.m., but people are always late, and there is a time for getting settled, changing a diaper, feeding, and so on. We sit on the floor on cushions and mats, with a wide selection of instruments scattered around the area. There are drums, shakers, whistles, maracas, recorders, bells, an ocean drum, a xylophone, South American pipes, a Tibetan singing bowl, a guitar, my violin, and, of course, we all bring our voices.

I begin by singing a "hello" with guitar, grounding the session in music, and acknowledging each mother and baby, noticing how they are in my song, picking up on a pretty new dress, or that they did well to get here on such a rainy day. Without stopping the music, I then encourage the mothers to take their focus away from me and onto their babies, putting them on their lap, or on a cushion for face to face contact. I encourage them to sing their own hellos to their babies, noticing how he/she is today, and what effects the music has on him/her. I encourage mothers to notice babies movements and vocalisations, tuning

into them, and responding to them unselfconsciously. I carry on playing, and perhaps humming or singing positive comments as mothers gradually begin to sing, and to connect with their babies. A Polish mother, whose own mother recently died and who has been very depressed and withdrawn, recently began to sing to her child at this stage, leaning over him and singing "I love you K!" and delighting in his smiles and gurgles. This felt like a real breakthrough for them.

This introductory music has often spontaneously developed into a group improvisation, as mothers use the instruments to play, drum, and keep on singing. The Afghani moms in particular are fantastic drummers. On one occasion as the "hello song" ended, a persistent yet shy rhythm from a young Afghani mother who speaks no English at all drew the group back into music – her rhythm was irresistible. It grew into a strong, dancing piece of music, and I joined in with my violin, as did other mothers from Poland, Somalia and Mexico in a truly international expression of what felt like mutual support, openness and joy.

The music always opens up the talking and sharing. The group can spend some time talking about whatever is around that day, from maternal guilt, to breast feeding and sleeping issues. Often women talk about how isolated and lonely they feel. My job at this stage is to sit back and perhaps gently to facilitate and support the discussion where necessary. I am delighted to see how the group has become more self-directing as time has gone on and as I have gained in confidence to just "go with the flow".

We then move into interactive songs for the mothers and babies to share. We may use well known favorites, e.g.; Twinkle Twinkle or songs I have composed like the "kissing song" where mothers choose which bit of their baby's body is most kissable! A favorite is the well known "Finger song" which involves finger and toe massage, together with face to face contact and singing – a powerful sensory experience for both mother and baby. By the end of this section of the group the whole atmosphere in

the room is invariably calmer, more open, relaxed and reflective. Mothers have had a space to talk, opened up by the initial music. Mothers and babies have shared fun and creative games and songs and it never matters if a baby screams, throws up, or goes to sleep – there is no pressure to perform.

Finally, there is a space for closeness and quiet as I ask mothers to get comfortable with their babies for the final section of the group. This has evolved into a time where mothers breathe deeply, hold their babies close (often they are feeding by now) and find a moment of peace and stillness before going back out into the busy world. I play my violin – a simple improvisation on what I feel is right at that moment. The music is usually lulling, often rocking, often in a minor key, and very reflective. Mothers have told me after this that they have experienced a sense of closeness and connection to their babies that they have never had before. After a moment of silence, everyone gradually gets themselves together, chatting and finishing feeds and changing diapers before going home. I find a moment for each mother and baby to say goodbye and check in to how they are, especially if during the session any particular music or issue has seemed to uncover a sadness or need.

EVALUATION

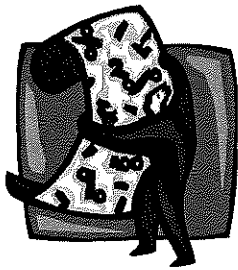
The mothers who have attended the group filled in a simple questionnaire, anonymously. Comments have included: "I enjoyed discussing feeding problems, and coping with raising children in a different country away from my family". "I learn how to play with and enjoy my baby". "The last relaxing bit with violin she enjoyed very much". "I felt open (sic) by the music, and feel closer to my baby than before". "I feel accepted and like the group because I am not alone". "...it has helped me to sing and play with him more at home". Every mother who attended the pilot requested the continuation of the group, and this has led to Sure Start employing me to continue the group starting January 2006, which I am delighted about!

There is so much scope for Music Therapy within Sure Start. I am hoping to extend this group so that there is

one for new babies and one for older babies as my initial group matures. I have also been asked to work one to one with clients who are in urgent need of more focused therapy, but who have little or no English. I would also like to extend the work to the Children's Center to do a group with the pre-school children. There is also scope for work with mother/toddler interaction on a one-to-one basis. Sure Start have also asked me to run a group for staff. Music really does help people to connect and communicate, on every level, and in every system right from micro to macro....

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CONFERENCE REPORT

ZERO TO THREE

National Training Institute
November 4-6, 2005
Washington DC

By
Robin Balbernie

They certainly go for it in America. Two and a half days of conference at the Washington Hilton, with plenary sessions beginning at eight and then the whole day continuing until after seven. A far cry from the slightly panicked look that seems to come over people in the U.K. when they start to look for coffee and chocolate biscuits after the first hour and then expect to be home by five! The conference was set up so that there was always a plenary session in the morning and afternoon, attended by all, followed by smaller group presentations on a number of different subjects. This gives an incredibly wide span of topics, but the downside is there is always that slight sense of anxiety that something else might be more interesting. However, Zero to Three has an incredibly efficient high-tech system whereby the entire proceedings are recorded and made available on a CD Rom afterwards, so that one gets to see every single presentation and receive a copy of all the Power Points and handouts. This package of information makes it about the best value conference around.

The first plenary presentation was really slanted towards the demographic characteristics of pre-kindergarten provision in America, looking at the comparatively high rate of expulsion and examining the reasons behind this. Delinquents in diapers presumably! The rather obvious point was

that difficult behavior in any child will almost always have had its genesis in prior events and family environment. A piece of research has turned up the unsurprising information that low rates of expulsion in pre-kindergarten provision go with the amount of training that teachers have had and also are influenced by whether or not they have access to a mental health consultant. The presenter, Dr Walter Gilliam from Yale University, underscored how important it was to provide quality early educational experiences for very young children in order to promote their social and emotional development in ways suitable to get them ready for school, especially by helping them learn to regulate their emotions in a way that is appropriate to the situation. (A copy of the study that this presentation was based upon is available on: www.fcd-us.org "Pre-Kindergarteners Left Behind: Expulsion Rates in State Pre-Kindergarten Systems")

I took myself to a presentation on Evidence Based Practice, thinking I would pick up some more hot-off-the-press examples of clinical work that had been researched and followed up. In the event it was more a presentation around the philosophy of the Evidence-Based Practice Movement and how it could be applied to Infant Mental Health. The presenters made the point that academic research knowledge does not easily translate to either clinical work or professional wisdom, and these are often the best sources for evidence-based practice. They stressed the importance of what should be considered legitimate evidence when wishing to influence policy, or even make a decision about whether or not to provide a service. Each case has to really be considered on an individual basis and, in a way, even interven-

tions tailored to one particular family's needs can be regarded as a pilot study and then evaluated by the family itself. It is important to use the best available research as a guide but not see it as a limitation. They advocated the setting up in each locality of a "Community of Practice" group, which could use its collective expertise to scrutinize and improve clinical practice, policy and research in the context of what was already in place and the specific demands and characteristics of the local community. (Nothing really startling here.) These are some of the websites recommended: www.researchtopractice.info www.promisingpractices.net www.pathwaystooutcomes.org/index.cfm

After a slightly hard to eat lunch which could only be accessed after a major struggle with a definitely non bio-degradable plastic box, we had a presentation on how the health of young children is being affected by environmental hazards in America. This was fairly depressing, and it almost sounds as if it will be a race as to whether or not the pollution that America pumps out will either destroy the world through global warming or poison their own children first. Small children have a far greater exposure to environmental toxins than adults, or even older children, because of their diet, metabolism, and the way that their small size and "mouthing" behavior puts them in the direct path of a lot of very nasty pollution. Often the effect of early toxins may take many years to express themselves, especially as they may be linked to certain developmental phases (such as the ability to reproduce) that are many years in the future. Children generally ingest more of anything than adults in terms of volume per body weight. They play closer to the ground where many pol-

lutants concentrate, and their normal hand to mouth activities will expose them to considerably more risks than adults who may not be at risk at all from the same substances (for example lead paint). The speakers talked about how some substances can trigger an epigenetic change, and such an alteration in gene expression will affect other genes in turn and these may be passed on from parent to offspring. This exposure to dangerous substances begins during pregnancy, and here the length of gestation is an important factor to consider when looking at pre-birth exposure to toxins. They went into some fairly gruesome data, too detailed and off-putting to make close notes on, but which would be available on the CD Rom of the proceedings. One piece of information which did remain with me, something I had not realized before, was how contaminants in general become concentrated in fatty substances (in red meat, fish, and milk) so that a diet of fast food not only is a risk for obesity but also for accumulating some quite seriously poisonous substances at the same time.

I then went to listen to a case presentation on how a very emotionally mixed up and damaged teenage mother was helped within a school-based setting to not only improve her relationship with her baby but also to stick with her own schooling and actually succeed in finishing her year. A tremendous amount of work had gone into this, and it was fascinating to hear how the school and individual therapist together, as well as the other workers in the program, nurtured this unhappy young lady so that she could begin to take pride in herself and in her child as well.

The next full conference presentation was given by Mary Dozier who described the program that she and her team have initiated for helping the foster parents of maltreated and traumatized small children. (She has described this intervention in the *Bulletin of Zero to Three* (April/May 2002) "Attachment and Biobehavioral Catch-Up"). Her talk was extremely clear, and wove clinical intervention and theory together as she described this very tight model of practical,

attachment-based, help. (She also has a paper in the recently published volume "Enhancing Early Attachments" which gives more detail than the Zero to Three article.) The focus of the intervention is helping foster parents understand the often puzzling and rejecting behaviors of the children they are committed to care for, so that they can re-interpret the young child's signals in a counter-intuitive manner. Babies who have experienced adversity will push any new caregivers away, thus inadvertently denying themselves the loving care that they need. This is tied in with a consideration of the foster parents' "state of mind" with respect to attachment, since research shows that parents with an autonomous state of mind tend to be responsive to children's distress and that the children in their care typically, and quite quickly, develop secure attachments. The intervention does not attempt to change the foster parents' representations of relationships, but it does set out to help them override their own natural tendencies so that they actually begin to respond to their children's behavior in a manner that helps the latter to develop greater self-regulatory abilities.

The foster parents who have been helped to "see through" the way in which the children in their care tend to push them away, so that they become more genuinely convinced that these children still really need them, are then in a better position to interrupt this self-perpetuating cycle of insecurity. It is important to get foster parents to behave in a more thought-out way towards the children in their care, something that needs a lot of individualized support, otherwise the children may often be left with no strategy for dealing with their own distress. Many children placed in foster care will have disorganized attachment, stemming from past maltreatment, and research shows that unless they are placed with caregivers who have an autonomous state of mind with respect to their own attachment, then 70% of them will remain disorganised. What children who have been accommodated need is a foster parent who is committed to them; but some research that

they have done shows, as one would expect, that the more children a foster mother has had based with her then the lower is the commitment to the current child. They have also found that the younger the child is when taken into care then the easier it is for foster parents to become committed. Relationships where there is little commitment almost always end in disruption.

I then went to a joint presentation by Arnold Sameroff and Susan McDonough where the transactional model was applied both to development and to intervention. (Again, the gist of these presentations is available in a recent book, "Treating Parent-Infant Relationship Problems".) Susan McDonough gave a brief overview of her therapeutic strategy of Interaction Guidance, illustrated with some of the videos of mothers and babies which are central to this way of intervening. This therapeutic use of video replay enables the clinician to slowly build up a picture of how the parent they are working with sees, experiences and interprets their relationship with their baby and the setting in which they find themselves. This was one of those sessions that seemed to end almost as soon as it had begun; in stark contrast to the next one I went to on Pregnancy and Mental Illness which I found fairly inconsequential from beginning to end. So much so that I am not going to describe it. However, the speaker did give out some websites that I had not heard of which seemed to be useful for issues around pregnancy, parenting and mental illness. They are: www.bcrmh.com and www.nmha.org

In the evening there was a special session on supporting children and families affected by trauma. This was an especially apposite presentation, preceded by a lunchtime presentation by Joy Osofsky on the work that she and her team are doing, against all odds, in the aftermath of the New Orleans disaster. The two presenters, Kathleen Rice and Betsy Groves looked at trauma specifically in the context of how it affects very young children and how

their subsequent capacity to recover from trauma is dependent on their capacity to find reliable relationships in their environment. For very young children, both the impact and outcome of trauma will depend upon the physical and emotional availability of their primary caregivers. This was a moving presentation threaded through with the hopeful message that we all have an innate capacity for resilience because of our adaptive abilities to make and maintain relationships, use communication to solve problems, and to regulate both internal, emotional states and behavior. They presented clear, tried and tested, strategies for intervention that ranged from individual work to how children can be supported and moved forward in the day care or school situation. Zero to Three has just published their work as "Hope and Healing: A Caregivers Guide to Helping Young Children Affected By Trauma" (from www.zerotothree.org only) – highly recommended by me. As well as looking at how children and their families can be helped, their presentation also addressed and stressed the painful impact of this sort of work upon the professional.

The final full session was on how mental health consultation can help in child care settings. The speaker, Kadja Johnston, gave a sensitive overview of this that emphasised the importance of gaining an understanding both of the whole culture of the organization and of the subjective experience of those working within it. She illustrated how important it was to avoid being "the expert" and to approach understanding as a process and not a quick fix; so consultation becomes more a matter of broadening perspectives than producing answers out of a hat. There was nothing that was very new here, although it did end with a nice quote from Jung: "If there is anything we wish to change in the child, we should first examine it and see whether it is not something that could be better changed in ourselves." I am still trying to make my mind up as to whether or not I have the nerve to try it out on the next parent who moans about their child's behavior.



LITERATURE MONITOR

ARTICLES

Bartels, A. & Zeki, S. (2004). The neural correlates of maternal and romantic love. *Neuroimage*. 21(3), 1155-66.

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Romantic and maternal love are highly rewarding experiences. Both are linked to the perpetuation of the species and therefore have a closely linked biological function of crucial evolutionary importance. Yet almost nothing is known about their neural correlates in the human. We therefore used fMRI to measure brain activity in mothers while they viewed pictures of their own and of acquainted children, and of their best friend and of acquainted adults as additional controls. The activity specific to maternal attachment was compared to that associated to romantic love described in our earlier study and to the distribution of attachment-mediating neurohormones established by other studies. Both types of attachment activated regions specific to each, as well as overlapping regions in the brain's reward system that coincide with areas rich in oxytocin and vasopressin receptors. Both deactivated a common set of regions associated with negative emotions, social judgment and 'mentalizing', that is, the assessment of other people's intentions and emotions. We conclude that human attachment

employs a push-pull mechanism that overcomes social distance by deactivating networks used for critical social assessment and negative emotions, while it bonds individuals through the involvement of the reward circuitry, explaining the power of love to motivate and exhilarate.

Stress in pregnancy: Effects persist even 10 years later

O'Connor, T., Ben-Shlomo, Y., Heron, J., Golding, J., Adams, D., & Glover, V. (2005). Prenatal anxiety predicts individual differences in cortisol in pre-adolescent children. *Biological Psychiatry* 58, 211-217.

Children whose mothers experienced significant stress or anxiety during pregnancy have a greater vulnerability to psychological problems, even 10 years later.

Analysis of stress hormone levels in 10-year-old children has provided the strongest evidence yet that prenatal anxiety may affect the baby in the womb in a way that carries long-term implications for well-being.

The study suggests that fetal exposure to prenatal maternal stress or anxiety affects a key part of their babies' developing nervous system – leaving them more vulnerable to psychological and perhaps medical illness in later life.

The research, involving families taking part in the Children of the 90s project at the University of Bristol, is published in the journal *Biological Psychiatry*.

Previous studies of animals had shown how stress in pregnancy affects the hypothalamic-pituitary-adrenal axis, the body's stress response system. But until now scientists have been unable to show that it also affects humans in the same way.

Seventy-four children were asked to take part in the pilot study, which involved taking saliva samples first thing in the morning and three times during the day on three consecutive school days. Scientists then tested the samples for levels of the stress hormone cortisol.

Psychologist Dr Thomas O'Connor from the University of Rochester in New York compared those results with psychological tests completed by their mothers during the last stages of pregnancy, ten years earlier.

He says: "We found that anxiety in late pregnancy was associated with higher levels of cortisol in children many years later.

"These results provide the strongest evidence to date that prenatal stress is associated with longer term impact on the HPA axis in children, a finding repeatedly demonstrated in animal investigations."

One theory suggests that anxiety or stress in pregnancy increases the mother's own levels of cortisol, which crosses to the fetus and influences the baby's brain devel-

opment, notably its stress response system. These changes to the stress response system may make children more susceptible to a range of psychological and medical problems.

Dr. O'Connor says: "Findings from several human studies of children and adults suggest that elevated basal levels of cortisol are associated with psychological risk or psychological disturbance, notably depression and anxiety. Our findings point to a possible mechanism by which prenatal stress or anxiety may predict these disturbances into early adolescence, and possibly into adulthood.

"More work is needed now to consider why cortisol should be associated with particular forms of psychiatric disturbance, and what factors accentuate or mollify the links."

NOTES

□ The hypothalamic-pituitary-adrenal axis (HPA axis) is a major part of the neuroendocrine system which controls certain activities of the body, including reactions to stress, by means of both nerves and circulating hormones

□ ALSPAC The Avon Longitudinal Study of Parents and Children (also known as Children of the 90s) is a unique ongoing research project based in the University of Bristol. It enrolled 14,000 mothers during pregnancy in 1991-2 and has followed most of the children and parents in minute detail ever since.

□ The ALSPAC study could not have been undertaken without the continuing financial support of the

Medical Research Council, the Wellcome Trust, and the University of Bristol among many others.

See www.alspac.bristol.ac.uk

Weissman, M.M. et. al., (2006) Remissions in maternal depression and child psychopathology STAR*D-child report. *Journal of the American Medical Association* 295 (12), pp.1389-1398.

Results: Remission of maternal depression after 3 months of medication treatment was significantly associated with reductions in the children's diagnoses and symptoms.



THE BRISTOL UK ALSPAC STUDY \$2 MILLION TO INVESTIGATE HOW STRESS AFFECTS THE UNBORN BABY

This report coincides with the announcement of a large follow-up project with the Children of the 90s study funded by the National Institutes of Health in the US.

Eight thousand children will take part in the study to examine the mechanisms by which anxiety and stress in pregnancy may have long-term effects on psychological development in adolescence.

Families will be asked to collect saliva samples from children at the age of 14 so that scientists can examine cortisol levels and look at the longer term effects of stress on the mothers.

Dr. O'Connor says that the size of the grant – more than \$2 million – reflects how importantly the issue of stress during pregnancy is now seen by medical researchers.

He says: "Some scientists have suggested that prenatal stress should be viewed alongside smoking and alcohol intake in pregnancy in terms of its potential adverse effects on the fetus."

"Data from a previous study in the United States indicate that 20.9 per cent of the population of 9-17 year-olds are affected with a debilitating mental illness. 13 per cent are diagnosed with anxiety disorder, 6.2 per cent with a mood disorder, and 10.3 per cent with a disruptive behavior disorder."

"Early adolescence is characterized by a marked increase in the levels of serious and persistent mental disorder, notably depression, anxiety, and substance use."

"If we can identify why this happens, the mechanisms whereby early risks lead to later psychological disturbance in the child, it will have substantial application for doctors and the health services."

"If it is the case that stress/anxiety in pregnancy has a long-term direct effect on adjustment in adolescence, then that would suggest that we might be able to intervene during pregnancy to prevent some of this."

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MI-AIMH ENDORSEMENT RECEIVES NATIONAL AWARD

MI-AIMH has received a national award from The Annapolis Coalition on Behavioral Health Workforce Education for innovative

educational practice in the area of Child and Adolescent workforce education. The Annapolis Coalition is a collective endeavor of diverse organizations and individuals committed to improving workforce recruitment, retention, training, and education. This initiative spans the treatment and prevention of mental health problems and illnesses, substance use disorders, and co-occurring mental and addictive disorders. In recognizing the Michigan Association for Infant Mental Health (MI-AIMH) Endorsement for Culturally Sensitive, Relationship-Based Practice Promoting Infant Mental Health as a promising strategy for improving workforce development, the Coalition is promoting systems change and workforce reform at the national level.

As reported in *From Neurons to Neighborhoods* (Shonkoff & Phillips, 2000), there is a critical shortage of well-trained professionals who have the knowledge, skills and supervised work experiences to promote healthy social and emotional development, intervene and treat serious early childhood mental health problems. This award recognizes that the MI-AIMH Endorsement is one of the first and most comprehensive efforts to identify best practice competencies at multiple levels and across disciplines and to offer a pathway for professional development in the infant and family field.

Scores of MI-AIMH members and committees supported the work of competency-based endorsement promoting infant mental health practice for over 10 years. Many sayings come to mind as I announce this... "it takes a village

(Marion Wright Edelman)” or “we are all connected – even the trees (Arthur Miller)” or “What about the baby? (Selma Fraiberg)”. At times, the work seemed overwhelming. How could we get this finished? Sheryl Goldberg chaired the MI-AIMH Endorsement Committee, shepherding this ambitious project through most of the 10 years. Valerie Brown brought her excellent organizational skills to the process at all 4 levels. Melissa Kaplan-Estrin and Bill Schafer co-chaired the Endorsement Test Development Committee. Members

at all levels put themselves “on the line” and field tested the test questions. Generous support from the W.K. Kellogg Foundation enabled MI-AIMH to complete some of the most important tasks. The offices of Dykema, Gossett Inc. provided “pro bono” legal counsel for copyright of all materials and a “license to use”. Over 70 members stepped up to the plate and have earned Endorsement to date. Three state affiliates have joined MI-AIMH through a “license to use”. ZERO TO THREE has recognized the importance of the competencies for workforce development at the

national level. It has been an amazing process and an honor to work with you around this important MI-AIMH project.

Celebrate what MI-AIMH has done and our colleagues who have helped us to do it!

With sincere appreciation,
Deborah Weatherston, Executive Director, MI-AIMH

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