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WATCH, WAIT, AND WONDER: AN INFANT-LED APPROACH TO INFANT-PARENT PSYCHOTHERAPY

By

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From birth, infants are busy growing and developing in their capacity to show their feelings, to express themselves both verbally and through their gestures and feelings, to think, and to relate socially. We now know that early relationships affect how well infants develop. When problems develop in an infant's early relationships they are linked with later problems in social relationships, emotional health, thinking, and problem solving. Due to this, parents

who are worried about their infants and their relationships with them are increasingly seeking help. When infants are brought to mental health clinics, they obviously cannot use words to express their anxieties and distress. Symptoms typically appear as functional problems in the infant involving feeding, sleeping, and behaviors such as extreme tantrums or difficulty being soothed. While not apparently relational, these problems commonly reflect difficulties in the relationship between parent and infant. For example, sleeping problems may reflect the infant's separation anxiety resulting from an anxious attachment.

Case:

Mother: Joey has never slept through the night. He doesn't know the meaning of the word sleep. We haven't had a good night in the 11 months since he's been born. We can't get him to sleep during the day and we can't get him to sleep during the night. So during the day I was ready to call the orphanage and during the night my husband was dealing with him and ready to call the orphanage. I kind of reached a point where I said I can't go in there anymore because he's making me very angry. You give so much but he doesn't give anything back. A particular challenge in mental health interventions for infants is that although it is the infants who are of

greatest concern, the actual focus of treatment is on the parents or other caregivers (Lojkasek, Cohen, Muir, 1994). We have been refining an intervention called *Watch, Wait, and Wonder* over the past 12 years which is innovative because it shifts the focus of therapy to the infant, requiring the parent to follow the infant's spontaneous and undirected activity (Muir, Lojkasek, & Cohen, 1999). In this article we will describe the theoretical underpinnings and techniques of *Watch, Wait, and Wonder*, and findings from our research comparing the outcome of this form of treatment with a more traditional psychotherapy with the mother with the infant present.

Attachment Theory and its Association with Infant-Parent Therapy

John Bowlby (1988) suggested that attachment security develops through the experience that infants have with their mothers in relation to their mothers' emotional responsiveness and physical proximity. There is considerable evidence that for secure attachments to form, parents must perceive their infants' emotional signals accurately, respond to them sensitively, display affection, accept their infants' behavior and feelings, and be physically and psychologically available when their infants are distressed. Development appears to proceed more optimally

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for infants who are securely attached. These infants are able to regulate their emotions and have a sense of inner confidence and efficacy (Goldberg, 2000). Feeling safe, securely attached infants can express their curiosity and are eager to explore their environment. Securely attached infants enjoy more pleasure and harmony in their relationship with parents, which fosters infants' openness to other relational experiences. In contrast, infants who are not securely attached have mothers who are unpredictable and either provide minimal or inconsistent care or may even be frightening to their infants. An insecurely attached mother interprets her infant's normal bids to gain access to her and to explore and master the environment negatively, thus promoting insecurity in the infant. It is important to keep in mind that we recognize that in such situations the mothers themselves have had caregiving experiences that were not optimally responsive to their emotional needs. In the *Watch, Wait, and Wonder* psychotherapy, we help the parent and infant discover for themselves a new way of relating and aim to prevent a repetition of intergenerational transmission of insecure attachment patterns.

Following from attachment theory, an intervention consistent with attachment theory would need to meet a number of criteria:

- provide emotional and physical access to the parent,
 - focus directly on parent sensitive responsiveness to the infant's behavior and emotional signals,
 - place the parent in a non-intrusive stance, which allows for the provision of a space in which the infant can work through relational struggles through play and interaction with the mother,
 - provide a therapist who can function as a secure base for the dyad working through their relational difficulties.
- Watch, Wait, and Wonder* meets all of these criteria.

Watch, Wait, and Wonder Technique
Watch, Wait, and Wonder directly involves the infant in therapy. For half of the session, the parent is asked to:

- get down on the floor with the infant
- follow the infant's lead
- not initiate any activities him/herself
- be sure to respond when the infant initiates but not to take over the activities in any way
- allow the infant freedom to explore; whatever the infant wants to do is okay as long as it is safe
- remember to watch, wait, and wonder

We mark the *Watch, Wait, and Wonder* play space with a heavy duty plastic mat and always arrange the same toys in the same order. These are toys that the infant can manipulate and include both construction toys and representational toys. Typically, some of the toys are chosen to promote emotional and relational themes central to the infant's presenting symptoms. For instance, an infant with eating problems is often drawn to the feeding utensils such as bowls and spoons, and an infant with sleeping problems to the dolls and doll bed.

The therapist's role in *Watch, Wait, and Wonder* is less interactive than in other forms of psychotherapy. Just as the mother is asked to watch, wait, and wonder with her infant, the therapist sits slightly off to the side of the area defined by the mat and watches, waits, and wonders, reflecting on the interactions of parent and infant. The therapist shows interest and curiosity about the relationship and inner life of the parent-infant dyad, and supports and validates the parent's experience. This parallels the task of the parent since the parent is also placed in the position of being curious about and accepting of the infant.

During the second half of the session, the parent is asked to talk about what he/she observed about the infant's activity and his/her experience during the session. The main idea of this is to

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put the parent in a position to become more knowledgeable about the infant and not feel it is necessary to intervene or to rely on the therapist for advice or insight. The infant, too, can use play and activity to master difficulties in relation to the parent. Although some parents talk about their early relationships with their own parents, this is not necessary for therapy to work. When used with infants, it is best to start *Watch, Wait, and Wonder* no earlier than the age of 4 to 6 months when infants can regulate emotional and behavioral states to some extent and are mobile to explore.

Case:

Mother: We were really expecting the therapist to say we looked at all the evidence and test results and I know that Joey is like this and because he's like this we can do this. It turned out that I did all the work! Once a week, for 1 hour, Joey and I would play on the floor with toys that were provided. The therapist would sit quietly to the side without any involvement. I was not to initiate any play. I was to follow Joe's lead and watch, wait, and wonder. Then for the second half hour the therapist and I would talk about what had happened during the play time. What did I see in Joey's behavior? What did I think he might be trying to do? How did I feel when he acted in this particular manner? She never told me to do things differently. Instead, she asked me questions and helped me figure out some of what mattered to Joey by helping me notice his actions and behavior that I may have overlooked. She gently urged me to think more about particular things he had done. After some time, things he had done many times before began to take on a new meaning and I was better able to understand his needs. For example, every week he went over to a bean bag chair and jumped or fell into it laughing. First, I thought he was saying Look see what I can do. Aren't you jealous of me? Then three weeks later it hit me. I understood he was repeating a game we play at

home. We have a new duvet and I throw him on the soft bed and he just loves it. I realized that he was inviting me to play.

The most important thing I learned was how sensitive Joey was to my moods and emotions. If I was angry or stressed, then he would be also. It was as though he could feel stress in my arms and hear it in my voice even when I was trying not to show it. He would cry and whine and couldn't relax. No wonder he couldn't fall asleep because he was being held by someone who wasn't relaxed. Now we are much happier and I have more understanding not only of Joey but of myself. I try to really listen to Joey even though he doesn't talk yet. I get down on the floor with him and try to allow myself to be led into his world. I guess in a way it's like having a totally new baby or maybe it's finding him like I never found him to begin with. I can honestly say I went through a stage where I regretted that he ever came into my life. We finally got our baby. He was missing. It feels more like a family now.

Research on Watch, Wait, and Wonder
We completed a study comparing *Watch, Wait, and Wonder* to a more traditional Psychodynamic Parent-Infant Psychotherapy often used in clinic settings (Cohen, Muir, Lojkasek et al., 1999; Cohen, Lojkasek, Muir, et al., in press). In Psychodynamic Parent-Infant Psychotherapy, it is assumed that in therapy the parent explores early relationships with his own parents and, through this process, gains insight into current relationships with the infant and family. The work in this approach is between the parent and the therapist. The presence of the infant in the therapy sessions provides the motivation for change.

This study involved mothers and their 10 to 30 month old infants who were primarily referred for problems manifested as functional symptoms in the infant or in behavioral or emotional

regulation. In some other cases, referral was triggered by factors that got in the way of the mother's capacity for infant care such as feelings of failure in the attachment process, maternal depression, and in a few cases risk or allegations of abuse. Problems were longstanding beginning in the infant's earliest months of life. Assessments were done before treatment began (pre-treatment), at the end of treatment (post-treatment), and six months after treatment ended (follow-up).

At the end of the relatively brief treatment (averaging 14 sessions over approximately 5 months), we found that both psychotherapeutic interventions had positive effects on infants and their mothers. Specifically, at the end of treatment both forms of psychotherapy resulted in reducing infants' presenting problems, increasing mothers' confidence that they could manage these problems, and decreasing stress associated with parenting. As well, at the end of treatment mothers were observed to be less intrusive and to engage in less conflict with their infants in infant-mother play interactions. This suggests that there are some common beneficial effects of treatment regardless of technique. At the same time, we found some differences in the outcomes of the two treatments. In particular, infants in the *Watch, Wait, and Wonder* group were more likely to shift toward a more organized or secure attachment relationship than infants in the group whose mothers had psychodynamic psychotherapy. The infants in the *Watch, Wait, and Wonder* group also showed greater improvements in cognitive development and increased capacity to become engaged in the cognitive tasks. Although we do not know whether improvement in cognitive functioning resulted from positive changes in attachment security or organization, attachment theory does suggest that improved cognitive developmental functioning should be an outcome of increased attachment security. Moreover, at the end of treatment, mothers of children in the

Watch, Wait, and Wonder group were significantly less depressed and reported more satisfaction and effectiveness in their parenting than mothers in the group receiving psychodynamic psychotherapy.

When followed six months later, effects of both psychotherapeutic interventions on presenting complaints and maternal and child functioning were maintained (Cohen et al., 2002). Moreover, in some respects, further gains were observed after treatment ended in that, at follow-up, there was continued improvement in infant symptoms and observational measures of maternal intrusiveness and dyadic reciprocity observed during mother-infant play. Although this general conclusion applied to both treatment groups, the pathway for change for the two treatments had a different timeline. As reported above, greater gains were made from the beginning to the end of treatment in the *Watch, Wait, and Wonder* than in the psychodynamic psychotherapy group on some measures. In the parent-infant dyads receiving psychodynamic psychotherapy, these gains were also observed but not until six months after treatment ended. At the same time, an advantage persisted in the *Watch, Wait, and Wonder* group from the end of treatment to six-month follow-up in that mothers in this group reported a further increase in comfort in dealing with the infant problems that brought them to treatment and a further decrease in their ratings of parenting stress.

What might account for the different timeline for changes to appear in the two treatments? In trying to understand this, we return to attachment theory. We think that *Watch, Wait, and Wonder* maximizes the requirements for forming a secure attachment relationship. The instructions to the mother to allow her infant to take the lead increases maternal sensitive responsiveness and makes the mother uniquely physically accessible to her infant, creating the potential for a

secure connection. Due to the need to find a way to establish a more secure relationship with the mother, when left to his own devices the infant will inevitably approach her. We have observed that at this point the infant will quickly bring forward the core issues in his relationship with his mother into the play; for example, the infant's desire for closeness when physical accessibility was previously restricted. *Watch, Wait, and Wonder* involved enhancing the mother's capacity to respond to her infant's activity with a reciprocal gesture, by placing her in a non-intrusive stance which allows for the evolution of the infant's potentialities or "true self" (Winnicott, 1976). We speculate that when the mother observes her child without being able to intrude, her assumptions about herself, her infant, and her relationship with the infant are challenged. More importantly, the interaction feels different and more pleasurable. Since as part of the process the mother begins to feel more competent in reading her infant's cues, she gains confidence to work things out with her infant on their own, resulting in enhanced confidence as a caregiver. Thus, it is the involving of the infant directly and the mother's non-intrusiveness that might account for the difference between *Watch, Wait, and Wonder* and the more traditional psychodynamic psychotherapy. Although the infant is involved in psychodynamic psychotherapy, the primary focus is on feelings and thoughts about relationships. This focus may delay changes as the mother needs to work through her earlier relationships before her new insights can influence the relationship with her own infant

The therapist in *Watch, Wait, and Wonder* engages in a parallel process of watching, waiting, and wondering; that is, the therapist does not intervene by modeling or directing for the mother or interpreting the infant's activity. Due to this, and to the expectation that the mother observes her infant's activity, she is enabled to

become more knowledgeable about her own infant and not feel the same need to rely on the knowledge of the therapeutic "expert". It also allows her to reflect on and deal with those anxieties that are aroused while trying to follow her infant's lead, which are often manifested in her difficulties in being sensitive and responsive to her infant's emotional cues.

Stern (1995) suggests that there are a number of "ports of entry" into helping parents' and helping other infants' relationship problems; for example, the overt infant-parent interactional behavior or parent representations. We recognize that both treatments that we studied aim to improve maternal sensitive responsiveness, but each approached this in a different way and that both were successful. Thus, "all roads lead to Rome" (Stern, 1995) but taking some roads takes less time than others.

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ATTENDING AND RESPONDING TO INFANT CUES AS AN ESSENTIAL FOCUS FOR EFFECTIVE EARLY PHYSIOTHERAPY INTERVENTION

By
Joyce Robertson

In this article, for clarity I refer to the caregiver as mother because it is more often the mother with whom I work, but I also work with fathers, grandparents and other caregivers. The baby's details have been altered so that he is not recognizable.

Winnicott (1988), quoting a colleague, John Davis, said, "[I]n the newborn physiology and psychology are one." This intertwining of psyche and soma indicates the necessity of considering the psyche in early physiotherapy intervention and this is the theme I would like to discuss further. I am a neurodevelopmental physiotherapist working with preterm infants from about 26 weeks gestation to nine months of age. I usually see babies first of all in NICU (Neonatal Intensive Care Unit) and then later at home and in baby clinics, thus providing continuity for families at this often stressful time.

Recent advances in neuroscience have shown the importance of early experience on brain development (Schor, 2001 a & b). It has also been shown that when a baby has an area of brain damage, there is a certain amount of neuroplasticity in the brain so that other cells can take over certain functions (Wigglesworth, 1989, Hadders-Algra, 2001). This neuroplasticity is greatest between 34 weeks gestational and eight months of age, hence the need for the physiotherapist to develop a rapid rapport with infant and mother. It is the specific handling from day to day by the family, facilitating and repeating good quality movement in the baby that creates the optimal synaptic connections.

This small window of opportunity to most effectively influence brain development means that I feel pressure to teach therapeutic handling as fast as possible. In the past I found that babies often got upset during treatment, especially when I focused primarily on how to change the way they moved, and I felt uncomfortable about their distress. I was also very torn between the emotional needs of the family, who had often just received the news that their baby may develop cerebral palsy, and getting started with physiotherapy for the infant. I felt that I wasn't really doing my job if I spent more time listening to both family and baby. When I heard a lecture by Mary Quinton, by then an elderly physiotherapist from Switzerland, this all started to change. Although not trained in psychology, she had a very intuitive approach. She would say "Follow the baby's lead!" "Listen carefully to what his body tells you through your hands" (Quinton, 2002). She taught that through our hands and bodies (as well as watching the baby's expression) we could feel how the baby accepted new movements and positions. In the same way that psychotherapists undergo personal therapy, Mary believed that physiotherapists should have a thorough understanding of movement in their own body to enable them to use the "inner eye" (Quinton, 2002) to understand the baby's movements. I have since read Allan Schore's work, where he writes about non-verbal "right hemisphere-to-right hemisphere affective transactions" that are beneath levels of awareness (Schor, 2003). Schore quotes neuroimaging studies showing areas of the right hemisphere that light up in the brains of mothers and infants during these transactions. I think that this unconscious, emotional intelligence is something that Mary

implicitly used in bodily communication with babies.

The outcome of the encounter with Mary was that I subsequently went to Innsbruck on one of her courses and then organized a similar course for her to teach in the UK. Then, because of my desire to understand and communicate better with families around the time of diagnosis, I completed a counseling degree. Some years later I completed an MA in psychoanalytic observational studies (Tavistock/UCL). It was from this point that I felt more confident to follow my intuition about how to work with babies and families. I no longer felt that it was "wrong" to approach the treatment on an emotional level, but that this approach is fundamental to the success of the whole treatment.

It is well recognized that the emotional state affects muscle tone. Tustin (1981) talked about the "second skin of muscular tension" that babies may use to "hold themselves together" when under psychological or physical stress. This is very evident on the NICU where babies go stiff when handled too much or too quickly, as if trying to protect themselves. We are familiar with toddler tantrums when the muscle tone increases, and the toddler goes stiff and cannot be placed in a push chair. But even more remarkable, the movements of babies differ according to what they are focusing attention on. Brazleton described how, just by observing one segment of a limb, the observer could tell whether the baby was looking at a person or a toy (lecture March 2004).

When a baby is born at 24 weeks gestation, the experience of being cared for in NICU is very different from the experience in utero. With the baby

that proceeds to full-term, as the fetus grows bigger there is firm even pressure all over the body and the fetus hears the mother's heart beat, breathing and tummy rumblings that Maiello (1996) called the "sound object" - the first object relation. However, for the preterm baby in NICU this is mainly missing, although later, if well enough, the baby may be nursed in skin to skin contact (known as kangaroo care) for periods of the day.

In utero, as the mother moves, the fetus experiences the motion, being gently buffered by the amniotic fluid. However, the preterm baby in an incubator is motionless apart from when being handled by nurses and doctors, often for extremely invasive (though life saving) procedures. Instead of being well flexed in a curled position, the baby in NICU is not supported by firm boundaries as in utero, although many NICUs now try to compensate by providing a nest. Even with the best NICU care, bright lights and loud noises are sometimes inevitable. These factors may all contribute to the lack of felt safety for the preterm or critically ill baby. Experience tells me that this can have an effect on the quality of movement.

Of course, all babies need to be well-supported and moved reasonably slowly. I sometimes work with full-term babies for teaching purposes, and if I put a baby down on a mat on the floor, the change of position and environment will sometimes feel frightening for the baby. However, if I maintain eye contact while keeping my hand on the baby's chest, the baby does not get upset and so I presume they feel safely "held". With some preterm babies, this is even more pronounced, perhaps because they have missed out on the natural, safe, in utero movement and have had the possibly more frightening experience of sudden and less supported movement in NICU. At around nine to twelve months I have found that some preterm babies are unable to

sequence movements in order to move fluently from one position to another. However, they sometimes will allow me to facilitate a movement, such as rolling, if I "hold" them with my eyes throughout the movement by moving with them and maintaining eye contact.

When trying to influence how babies move and improve motor patterns when cerebral palsy has been diagnosed, it is important to use activities that are functional and meaningful (Mayston 2000). The central nervous system is task-dependent in its organization (Flament et al., 1993) and so motivation for movement, with a positive emotional engagement, would seem to be desirable. Also, given that distress tends to cause increased muscle tone as mentioned above, it is important that babies enjoy therapy. Affect attunement (Stern, 1985), which provides a framework for affect regulation, is an important aspect of physiotherapist-infant communication and also provides a model for mothers who may be struggling to understand their babies' cues.

The mother's and baby's mind and body are continually interacting and influencing each other, so another area to consider is the mother's well-being and how the mother moves. This is not just an adjunct to treatment but is essential if the mother is to be free and available to "take in" (Bion 1962) the baby's feelings and process them, thus providing physical and emotional "containment" for the baby. This enables the baby to start to engage with the environment. As the baby takes an interest in the outside world, for example through eye contact or turning to a voice, the available mother can work to facilitate useful and good quality movement. It may be hard for the mother to do this if she has just been through the traumatic experience of a premature birth and subsequent life threatening illness of her baby followed by distress about a diagnosis of probable disability. Therefore it is

helpful for the physiotherapist to address, either directly or indirectly, the internal world of the mother.

Some babies with disabilities find it hard to give clear cues, making it more difficult for parents to respond appropriately. Babies with significant neurological disability may find moving or being moved extremely frightening as their own motor control during movement is unpredictable. Apart from the fact that we all have our own characteristic ways of moving, anxiety can cause some mothers to move too quickly for the baby to feel safe. Here, the mother's movement is an extension of the prosody of speech. It is not only the facial expression and the tone and pitch of the mother's voice, but also the speed and range of her movement and the firmness of touch that inform the infant's experience of her affect attunement. When working with a parent and baby facing these unknown and often terrifying experiences, I ask myself, "Where would be the best place to start?" Whereas, I used to be much more planned in my approach I now tend to go into the situation simply trying to feel and understand something of what is happening for mother, baby and anyone else involved and then respond to what I feel. Physiologically I think this involves using both my right and left brain and allowing right hemisphere-to-right hemisphere communication with the dyad (Schorer, 2003). Sometimes I start by listening to the mother and helping her to explore her feelings about the diagnosis and the difficulty of "not knowing" exactly what the future holds. Although I take longer before thinking about the baby, this helps the mother to feel more settled and so to be able to start thinking about the baby with me.

On the other hand, if the baby is screaming and unable to settle, or if the mother is particularly upset by the baby's apparent unresponsiveness, I may begin by reflecting with her about the baby - often thinking aloud or

"speaking for the baby". I may voice how it feels to be without the supportive walls of the uterus and how perhaps it is less frightening when I cup my arms around her on my lap. I talk slowly, looking at the baby with a gentle responsive gaze, and trying to respond to the subtle changes of muscle tone and facial expression.

Sometimes on NICU I can help parents to read their baby's cues or demonstrate a positive response; for instance, having the mother move from one side of her baby to the other and watching how the baby, even as young as 34 weeks, turns purposefully towards her voice when she talks to him. Holding the baby in a well-supported way facing mother may enable the baby to make eye contact. Helping parents to understand that behaviors such as yawning and looking away may indicate that a baby is overloaded and just needs some time out, will help parents respond appropriately. If these cues are overlooked, then the behavior may escalate and the baby go stiff and arch back in anger. This may develop into a habit of arching back which is unhelpful for motor development and is also likely to feel rejecting to the mother.

In the following brief extract from a session with a baby who I will call Bouzid, I decided to start the work by thinking with and about the baby. At this time Bouzid was 12 weeks old and his mother was isolated and depressed. Research by Murray (1997) about predictive factors for post-natal depression found that having an infant who was irritable or who had a poor motor ability significantly increased risk of depression in the mother. Bouzid's mother had come from Pakistan to marry, lived with her husband's family and spoke little English. I sensed that although the family were outwardly accepting of the diagnosis of disability, there was also a feeling of disappointment. As I spoke softly to Bouzid, who was grizzling in his mother's arms,

I thought I noticed a slight stilling in his grumbling. I said, touching him firmly, "I'm going to lift you up slowly and put you on my lap." I sat down on the floor with my knees bent and slowly took him from his mother, keeping him well supported in my arms and placed him on my lap. I kept his arms and legs gathered in, supporting his shoulder girdle slightly forwards, trying to provide a feeling of safety. I placed my hand on his chest. His eyes were moving around but not making contact with me. I talked softly to him and his sobs lessened. The containment of his body provided a point of fixation from which he could use his eyes. There were a few moments when he was just able to meet my eyes and I said, "Well done, you found me!" and eventually I saw the ghost of a smile. I stroked Bouzid's left hand and arm firmly and said, "Hello Bouzid, this is your arm." I stroked his right hand and arm and said, "And you have another arm here. Can you feel this one? Can you see it?" (bringing it within his line of vision).

I decided to start my intervention in this way because I wanted to reveal Bouzid's personality and help Mother to get to know him. I wanted her to see that Bouzid wanted to communicate, that he would still to my voice and that by making him feel secure he was able to take in more of his surroundings. This would be similar to Stern's aim to "change the parents' representations" (Stern, 1998). My expectation of a response from Bouzid, perhaps enabled him to respond, and myself to see the tiniest beginning of a smile. Kohut. (1977) describes how we respond to infants as if they had already formed a self. As often happens, I found myself talking to Bouzid as if he could understand. Norman (2001) describes infants' understanding of the emotions expressed in the non-lexical aspect of language and the value of talking to babies in infant psychotherapy.

As a physiotherapist I wanted to feel Bouzid's muscle tone and facilitate his integration of the sensation of the various parts of his body. I wanted "to paint in" (Quinton, 2002) this symmetrical position of his body lying in midline, by pressure with my hands on his buttocks pressing up through his spine. I also wanted to provide a contained and stable position from which he could make eye contact with others and communicate by facial expression. I gave tactile input to his arms to draw his attention to them and drew his shoulder girdle forward so that he had the possibility of seeing his arms and hoped that he might also associate these two perceptions. He had the possibility of bringing his hands to his mouth.

This position on my lap felt to me like a "gathering together" of Bouzid, providing a "background of safety" (Sandler, 1960) before Bouzid himself was able to achieve sensory integration. Haag. (2000) describes the importance of the sensory contact of the spine combined with visual contact in her work with autistic children, saying that it provides a "background place," an experience of a "background with a floor." Her description gives the sense of a support that moulds itself to the body so that there is less fear of falling through. I think of the position in which I held Bouzid as providing "a secure base" (Bowlby, 1973) in a physical and emotional sense, from which the infant can move out and then return to.

I find this way of working very demanding because of the intense involvement with the experience of baby and mother. However, I also find that it is more effective and rewarding than the way I used to work and it would now be impossible to go back. In addition to helping develop better motor patterns it is very satisfying to facilitate better communication between infant and mother, which is crucial to their relationship and to the baby's longer term development.

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Editor Needed: The Signal

After six years of superb service, Paul Barrows is ending his tenure as editor of The Signal. Continuing the tradition started by past editor Charley Zeanah, Paul expanded The Signal's scope beyond that of an ordinary newsletter, including citation quality articles with special emphasis on clinical issues/interventions and prevention programs, international perspectives, as well as WAIMH news, presidential columns, and windows to published literature. Now, we need to have a successor to continue this tradition. Individuals interested in serving a three to five-year term as editor of The Signal should contact the WAIMH Central Office for more information.



By the Red Cedar

*Executive Director's
Annual Report*

Hiram E. Fitzgerald

Historically, WAIMH has not issued an annual report to its membership. This has been a mistake and since the mistake is mine, I aim to correct it in this column.

WAIMH Mission Statement and Organizational Goals.

During the past year, President Tuula Tamminen asked the Board of Directors to look anew at WAIMH's mission statement and its organizational goals. This examination resulted in an affirmation of the mission statement contained in the by-laws, but presented in a more succinct form:

The World Association for Infant Mental Health (WAIMH) is a not-for-profit professional organization that exists for scientific and educational purposes. A central aim is to promote the mental well being and healthy development of infants throughout the world, taking into account cultural, regional and environmental variations, and to generate and disseminate scientific knowledge.

Within the context of its mission statement, WAIMH seeks to facilitate increased knowledge about mental development and disorder in children from conception to three years of age; the application of knowledge about scientifically based services for care, intervention and prevention of mental disorder and impairment in infancy; the application of knowledge about evidence-based ways to support the developmental transition to parenthood, as well as the healthy aspects of parenting and caregiving environments; the international cooperation

of those concerned with promoting the optimal development of infants, as well as the prevention and treatment of mental disorders in the early years; aspects of research, education, and interventions in the above area

WAIMH pursues its goals by engaging in a number of activities, the most visible of which are:

World congresses and regional meetings

Regional Meeting: July 2007, Riga, Latvia; World Congress: August, 2008, Yokohama, Japan

Publication of *The Signal*, its quarterly newsletter

Beginning in 2007, *The Signal* will be published on-line, with copies available as a PDF via the WAIMH listserv and through the WAIMH web page,

Sponsorship of the *Infant Mental Health Journal* in partnership with its Michigan Affiliate

Heading into its 28th year of publication with over 1000 subscribers, the IMHJ is the leading international and interdisciplinary scientific journal focused on social-emotional development, prevention, and clinical interventions during infancy and early childhood,

Supports existing and new regional and/or national affiliates

During 2006 WAIMH welcomed four new Affiliates, one located in the United States (Nebraska), and two in Europe (Portugal and Latvia) and one in New Zealand. Affiliates now represent 20 countries as WAIMH's influence continues to grow and adapt to increasingly diverse cultures.

Maintains an information repository WEB page

The site for accessing World Congress programs and IMHJ Special Issues of Congress abstracts, obtaining an index

to all articles published in the IMHJ, addresses for all Affiliates, copies of *The Signal*, copies of WAIMH minutes, WAIMH financial reports, and access to member information.

Collaborations with other organizations; establishing task forces

Building relationships with other organizations to strengthen international and interdisciplinary collaborations,

Study groups and committees; and carrying out special projects.

Among the special projects currently under development are those concerning training programs, WAIMH organizational structure, WAIMH publications, Affiliate participation in WAIMH governance, and policy issues. We will report committee recommendations in *The Signal* so that all members are informed and Affiliate organizations can have active discussions prior to voting on any changes.

Looking Within to Expand Without: Study of WAIMH's Organizational Structure

When WAIMH was formed in 1992, it merged the organizational structures of two parent organizations. From the International Association of Infant Mental Health, WAIMH acquired its Affiliate structure, and from the World Association of Infant Psychiatry and Allied Disciplines it acquired a management structure. Fourteen years have passed by and the WAIMH Board of Directors decided that it was time to review WAIMH's organizational structure to see whether it best represented the growth that has taken place in WAIMH since 1992. Many more Affiliate organizations have been developed, world congresses have moved to biennial offerings, the journal has moved from four to six issues annually, and overall WAIMH has grown. So, during the next several months the WAIMH Board will review its structure with the goal of finding a

way to involve greater participation in WAIMH's activities. More about this will appear in *The Signal* in the coming months.

PARIS BIENNIAL CONGRESS

The 2006 Congress was one of the most successful in WAIMH's history. Over 1100 people assembled at the City of Science museum and convention center to enjoy over 800 presentations embedded within symposia, workshops, poster workshops, a record number of posters (400), plenary sessions, clinical teach-ins and video sessions. Innovations for 2006 included master lectures and plenary interfaces. These innovations were so successful they will be incorporated into the standard offerings at future congresses. We learned two important lessons in Paris. First, video sessions need to be scheduled in theater style rooms with greater seating capacity. Second, poster workshops need to be restricted to 8 posters and scheduled in separate rooms, not in hallways. These lessons learned will be evident in our programming for 2008 in Yokohama. Our on-line submission worked without error and enabled posting of the program and abstracts on the WAIMH web page without difficulty. However, the CD version of the program and abstracts used in Melbourne was missed in Paris. We will return to this practice in Yokohama. The BCA professional company was superb: an exceptionally competent professional company with efficient and extremely pleasant and cooperative staff. The local organizing committee selected splendid social events. Although all evaluation forms have not been analyzed to date, the results will be shared in this column in future issues. The WAIMH board also established a variety of work groups and I will report on their progress in future issues.

WAIMH OFFICE

Effective August 2008, the WAIMH offices will move from Michigan State University to the University of Tampere, Finland. The transition team, consisting of folks from each respective office, has been meeting electronically and face-to-face in Paris. All is moving along well and we anticipate a smooth transition in 2008. More about this move will be included in future issues of *The Signal*.



President's Perspective

Tuula Tamminen

The World Association for Infant Mental Health had the most wonderful and successful congress in Paris in July. The scientific program was very rich indeed, and there were 1200 participants from 39 countries from different parts of the world. The Local Committee, chaired by professors Antoine Guedeney and Bernard Golse, worked efficiently and skillfully to produce an event rich with cultural experiences and strong support for the congress. The Program Committee, chaired by Elisabeth Fivaz-Depeursinge, worked in a creative way and introduced a new program format, called Interfaces, which were remarkably well received. In these interfaces an authentic video-material of a clinical case was first presented and after watching the video-tape, two persons representing different views in the field of infant mental health described their understanding of the case. Interfaces were clinically very rich and the discussions offered interesting learning possibilities for all of us. The new format was well accepted by the audience, and WAIMH will certainly continue to develop these! Also keynote lectures, workshops and posters were top-level "gold-pieces" of state-of-the-art clinical knowledge and research findings.

Once again, I want to thank all those who invested so much energy and time for this excellent congress. In addition, I wish to express my gratitude to all participants for the exceptionally open, friendly and warm atmosphere people created together. The Paris Congress was a real WAIMH meeting!

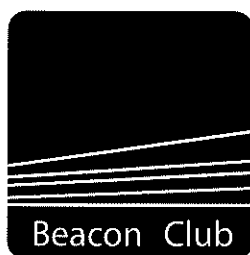
In Paris the Executive Committee of WAIMH also held its annual meeting and we took the most important steps in developing our association towards a true world-wide organization. The most profound decision was that WAIMH will change its organizational structure so that Affiliates will

have increasingly clear involvement in WAIMH's structure and activities. The EC set up a working committee to prepare a new plan of the organizational structure and to identify all needed changes in our by-laws. We aim to be ready by the next WAIMH Congress in 2008 in Yokohama, Japan.

This evolution, this maturation process of WAIMH is, in my opinion, extremely important so that WAIMH will be able to face all new challenges in promoting infant mental health throughout the world.

There are also other important changes going on in WAIMH. So far, our Central Office has always been at Michigan State University and our Executive Director, professor Hiram Fitzgerald, has taken care of the responsibilities of running the office. This has meant a huge amount of work, skill, local investments, and extreme motivation. WAIMH is deeply grateful for all this! Dr. Fitzgerald has informed the EC that he will step down after the Yokohama Congress and the EC has decided that the Central Office will move to the University of Tampere, Finland. The Finnish Ministry of Education has provided funding to set up and to start running such an office and the complicated process of moving the office has already started. But until the 2008 Yokohama Congress, the Central Office will stay in Michigan and Hiram Fitzgerald will continue as the Executive Director, assisted in Finland by associate Executive Director, Palvi Kaukonen. This new arrangement will help with the transition process.

In conclusion, I think that WAIMH is going through a very active developmental phase and at the same time a general professional interest in the field of infant mental health is rapidly increasing and widening. This means that WAIMH is building towards a successful future!



The Beacon Club

Endowment for International Development

Reaching out to fulfill WAIMH's mission

A beacon is a signal that gives notice, summons, and encourages. The WAIMH Beacon Club Endowment Fund was started in July 1993 as a result of frequent requests from scientists and clinicians from developing countries asking for complimentary memberships and subscriptions to the Infant Mental Health Journal. Outreach is an important part of WAIMH's mission; the Beacon Club Endowment Fund was formed to honor as many of these requests as possible.

Past Beacon Scholarship recipients include:

Armenia Bangladesh Burkina Faso Estonia
Kazakhstan Romania Russia Yugoslavia

The Beacon Club Endowment Fund

*Contribution is tax deductible for US members.
WAIMH is a tax exempt 501 (c) (3) educational organization.*

Help us extend information about infant mental health to our colleagues throughout the world who temporarily lack the resources necessary to maintain memberships in professional societies.

As developing countries gradually make the transition to vibrant economies, such investments on behalf of infants and families will be repaid three-fold.

As a member you can:

- Sponsor WAIMH memberships and Infant Mental Health Journal subscriptions for individuals from developing countries
- Designate the recipient of this membership or allow WAIMH to designate the recipient
- Extend the influence of infant mental health research to countries now developing new approaches to issues of infancy
- Make it possible to build capacity for promoting the well-being of infants and their families
- Apply to WAIMH's Central Office to receive a Beacon Club scholarship

Cut Here —————



Yes! I want to support the Beacon Club

I'm sponsoring a Beacon Club Scholarship for (choose one):

- ☐ \$150 USD 1-year membership for one person
☐ \$250 USD 2-year membership for one person
☐ \$350 USD 3-year membership for one person

Your Information

Name of Donor _____

Donor's E-mail _____

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Payment: Check (US affiliate bank) _____

Visa/MC/AmEx _____

Expiration Date _____ Amount _____

Signature _____

☐ I want WAIMH to designate the recipient

☐ I want to designate the recipient myself (Please provide the recipient's information below)

Name of Recipient _____

Mailing Address _____

Country _____

E-mail Address _____

Phone _____ Fax _____

Send applications and requests for scholarships to:

World Association for Infant Mental Health (WAIMH), Kellogg Center, Garden Level, East Lansing, MI 48824-1022, USA
Phone: 517-432-3793 Fax: 517-432-3694 E-mail: waimh@msu.edu Web: www.waimh.org



LITERATURE MONITOR

Articles

Akker, Olga van den & Redshaw, M. (2006) Editorial: Depression in the perinatal and postnatal period continues to challenge researchers and practitioners worldwide. *Journal of Reproductive and Infant Psychology*, 24 (2): 83-85

Akman, I. et al., (2006) Mothers-postpartum psychological adjustment and infantile colic. *Archive of Disease in Childhood* 91: 417-419. Postpartum maternal depressive symptoms and insecure attachment style are associated with infantile colic. Screening and early intervention of postpartum depression might promote the health of both the mother and infant.

Eluvathingal, T.J. et al (2006) Abnormal Brain Connectivity in Children After Early Severe Socioemotional Deprivation: A Diffusion Tensor Imaging Study. *PEDIATRICS*, Vol. 117 (6), pp. 2093-2100. Conclusion: Our study demonstrates in children who experienced socioemotional deprivation a structural change in the left uncinate fasciculus that partly may underlie the cognitive, socioemotional, and behavioral difficulties that commonly are observed in these children.

Senior, R. et al., (2005) Early experiences and their relationship to maternal eating disorder symptoms, both lifetime and during pregnancy. *British Journal of Psychiatry*, 187, 268-273.

Chambers, C.D. et al., (2006) Selective Serotonin-Reuptake Inhibitors and

Risk of Persistent Pulmonary Hypertension of the Newborn *The New England Journal of Medicine* Volume 354:579-587 February 9 Number 6 Maternal use of a selective serotonin-reuptake inhibitor (SSRI) after the 20th week of pregnancy increases the risk of persistent pulmonary hypertension of the newborn (PPHN) by a factor of six. In a case-control study* performed in four North American cities during 1998-2003 an SSRI had been used at this stage of pregnancy by 14 of 377 mothers whose infants developed PPHN (3.7%) and six of 836 matched control mothers (0.7%), (adjusted odds ratio 6.1). Neither SSRI use before 20 weeks nor use of other antidepressants at any time was associated with increased risk of PPHN. (*Archives of Disease in Childhood* July 2006, pp.626)

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