The Signal

Mindful Parenting:
Enhancing Reflective Capacities of Parents and Infants in a Therapeutic Group

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Introduction

At The Maple Counseling Center (TMCC), a large, non-profit, community mental health center serving greater Los Angeles, we have worked over the last two years to develop a therapeutic parent-infant group design that utilizes observation as a starting point for enhancing the reflective capacities of group members. Known as "Mindful Parenting," these experiential groups are part of a larger Infant Mental Health Service and Training Program currently in development at TMCC. The Mindful Parenting groups, which began in July of 2001, are an experimental work-in-progress that evolved out of interest in the clinical possibilities for interplay between contemporary psychoanalysis, infant observation, attachment theory and research, infant and brain research, affect regulation theory, and related areas of study, as well as the non-clinical parent-infant group format known as RIE.

Starting from the assumption that 1) a secure attachment bond is the foundation for adaptive infant mental health (Schore, 2001); 2) that the security of a child's attachment is strongly predicted by mother's capacity to reflect on her child's affective experience (Slade, et al, 2001); and 3) that the core of prevention in early childhood should be the enhancement of mentalizing (Fonagy, 1998); the Mindful Parenting groups aim first to create conditions that allow parents to experience, cultivate, and practice the art of wonder—wonder about what goes on in one's own affective mind-and-body experience as well as in that of the infant.

With this paper, I will make explicit the design of Mindful Parenting and offer preliminary thoughts on the utility of this therapeutic group in developing and supporting healthy parent-infant relations. The interdisciplinary underpinnings of our group work, including the application of infant observation and infant-led psychotherapies, will be followed by exposition of the structural components of Mindful Parenting. This will be complemented by descriptions of unadorned moments from our group experience, in an effort to make plain the ways that Mindful Parenting seeks to restore, enhance, and sustain the most basic affective contacts between parent and child, both verbal and nonverbal.

Reflective Capacity: An Interdisciplinary Lens

What mediates the link between the quality of a parent's earliest attachment relationships and the quality of an infant's attachment experience with that parent? Main's (1991) finding that a child's security of attachment is predicted by a mother's ability to articulate a coherent narrative about the quality of her own early relationships has led attachment research to finer and finer examination of the underlying mental mechanisms that might be able to produce such narrative clarity. Fonagy (1996) found that mentalization, or reflective functioning, the capacity to meaningfully reflect on states of mind in self and other, is correlated with narrative coherence and adult attachment classification, and is a strong predictor of child attachment security. Current research shows promise that maternal reflective functioning may serve as a mediating link between the mother's prenatal attachment organization and the infant's attachment security in the second year of life (Slade, et al, 2001).

Psychoanalysis has long considered the impact of the early relational environment, the introjected experience of that environment, and the power of these early experiences to shape life events. Bion's (1967) concepts of maternal reverie, alpha function, and containment, Klein's (1946) projective identification, and Winnicott's (1956)

Contents:

primary maternal preoccupation are all efforts to capture the same subtle, elusive, and mostly intuitive process by which one human being can meaningfully grasp what is inside another. More recently, concepts such as Stern's "ways of being with" (Stern, 1985) and Lyons-Ruth's "implicit relational knowing" (Lyons-Ruth, 1998) have further illuminated the underlying, non-conscious relational processes that mediate meaningful mother-infant and therapeutic relationships.

Infant and brain research likewise explore ways in which two individual brain-body systems move together, producing something resonantly larger than the sum of their parts. Schore (2002) calls attention to the synchronic interplay between mother and infant, where a rhythmic, affective dialogue unfolds, and where each matches the other's temporal and affective patterns, recreating in the other their own inner psychobiological states. Tronick's 'Dyadic Expansion of Consciousness Hypothesis' (Tronick et al 1998) proposes mother and infant as individually self-organizing systems, creating states of consciousness (or brain organization) capable of expansion into more coherent, complex states through collaboration with one another. Schore suggests that the center of psychic life has shifted from the verbal left to the highest levels of nonverbal and non-conscious right hemispheric function, and he notes that by incorporating interdisciplinary data with psychoanalysis, the :talking cure" expands into a more encompassing "communicating cure."

Chandra: An Inquisitive Coo, Answered

Chandra, a seven month old baby girl, spontaneously engages the facilitator with a simple coo during her fifth group meeting. The facilitator responds in kind and a prolonged 'conversation' builds from looks and gurgles, with mother and group looking on. This gives way later to group reflection about the nonverbal, nonlinear, musical nature of playful communications with infants, and the cycles of connection, failure and repair (Tronick, 1989) that define these early proto-conversations. Two meetings later, Chandra and her mother are the first to arrive for group. They settle quietly into the play area and Chandra is placed on her back, facing her mother. In previous meetings, there has been a sense of an as yet untapped connection between the two—Chandra, a pleasant, cooperative

baby, is in fulltime daycare while her single, divorced mother works. In group, Chandra generally seems content to gaze in long, sweeping movements at the silk canopy above, rarely interested in toys or motility and only occasionally participating in more contactful experiences with mother—and even then, in an undeveloped way. There is a sense that Chandra's easygoing temperament might actually put her at risk by giving the impression that all is right with her, always. She does not appear cut off at this point, but might she eventually lose touch with or miss opportunities altogether for more passionate contact? In this seventh group meeting, Chandra directs an inquisitive coo in the direction of her mother, and today, mother actively listens and responds in kind, with interest greater than previously seen. Chandra then purses her lips at mother, and mother purses hers back. Chandra hums, then mother hums. Chandra hums again and mother replies yet again. Ever so slowly, a delicate, improvisational melody of shared purrs, glances, smiles, hums, touches and coos unfolds. Minutes pass, with mother and infant fully engaged in their intimate dance. For those observing, the simple beauty of this moment is breathtaking.

The Utility of Active Observation of Infants for Parents and Clinicians

Infant observation as a training device has a rich history, including the Esther Bick (1964) method of formal observations of "normal" parent-infant dyads and families. Introduced at the Tavistock Clinic in the 1940s, this non-intervening observation of infants has been utilized at many clinical training institutions as a tool for developing the therapist's intuitive equipment and capacity for tolerating primitive anxieties (Hansen, 2002). In this method, an observer meets with a family for weekly one hour visits following the birth of their baby as a means of studying the development of the infant and mother-infant relations through the patterns of behavior that emerge and shift over time. Visits continue over a one to two year period, with the observer making richly detailed descriptive notes after each meeting. Visits are supplemented with weekly group seminars, where four to six observers gather with a more seasoned clinician-observer to reflect on the experiences of both the observer and the observed. While there is no intent to offer clinical intervention in this method, it may provide an essentially unseen

alpha function (Bion, 1967) for the parent-infant couple (McCaig, 2001, personal communication) through the reflective, containing activity of both the thinking observer as well as the larger seminar group.

Less formal versions of infant observation—shorter, more active, or without group processing of the observational experience - are incorporated into many child development curricula. Along these lines, the experiential, non-clinical parent training groups known as RIE, an acronym for Resources for Infant Educaters, utilize observation of infants in promoting respectful interactions between the caregiver and child. RIE was developed in 1978 by child development specialist Magda Gerber (Gerber, 1998) and colleague Tom Forrest, M.D. Working with small groups of ordinary parents and infants, Gerber created an experiential parent training format for learning respectful parenting practices. The RIE philosophy places primary emphasis on unhurried, sensitive observation of infants. RIE suggests that when a caregiver offers full, undivided attention to, respect for, and communication about the infant's unique needs, especially during caregiving routines, the groundwork is laid for the infant's trust in the caregiver. When this caregiver is patient and responsive enough to allow time for the infant to actively participate in caregiving routines as well as in their own discovery of the world, this makes room for the emergence of an authentic self and a sense of competence. RIE stresses natural gross motor development (e.g., allowing infants to reach motor milestones at their own pace, without interference) and emphasizes the respectful use of narrative communications prior to interacting with the infant (e.g., "I'm going to pick you up now,") and patience in waiting for the infant's response before proceeding. RIE has a devoted following through local and national groups facilitated by RIE associates and through applications in infant care centers and preschool settings.

In placing primary emphasis on the infant's inherent competence in navigating physical and social development, RIE gives the infant tremendous room to maneuver development in their own particular way.

Though limited in exploration of the internal worlds and affective exchanges of parent and infant, RIE's respectful parenting principles, unhurried observation of infants, and experiential group format have untapped potential in clinical use. Likewise, Esther Bick's observational method - in particular, the mindful attention to microscopic details of infant life and the unseen containing functions of infant observer and seminar group - continues to find new clinical applications.

Infant-Led and Parent-Led Therapeutic Facilitation

In recent years, the use of infant-led work with parent-infant dyads has grown. "Watch, Wait, and Wonder" (Cohen, et al, 1999), "Child-Centered Activity" (DeGangi, 2000), and "Floortime" (Greenspan, 1997) utilize similar observational components where parents follow the infant's lead. During observation, the parent is on the floor with the infant, observing the infant's self-directed activity, and interacting primarily at the infant's initiative. This may be followed by a parent-centered component, where parent and therapist reflect on the observations, focusing on developmental or relational themes in the infant's behavior, the parent's struggles in following the infant's lead, or links to the parent's early attachment relationships.

Other infant-led approaches are notable for active therapeutic work between therapists and infant-as-subject (Thomson-Salo & Paul, 2001; Norman, 2001). Emotional connections are made with the infant through verbal and non-verbal means, e.g. gaze, touch, talk, or play. The therapist commonly makes use of his or her inner experience of the infant as a link to the infant's internal world. While this work is primarily infant-centered, the therapist's efforts to make contact with the unknown in the infant have a corresponding action on the parent-infant attachment relationship, whether expressed overtly or not.

In contrast, psychodynamic infant-parent psychotherapy (Lieberman, et al, 2000) pays clinical attention to the infant, but focuses more on what transpires in the parent-infant couple. Subjective experiences of parent and infant are held more equally, though work is often more

parent-centered. The mental representations of the parent are a primary target of multi-modal intervention, accessed and modified through links to the parent's early and current relational experiences. Corrective attachment experiences provided by the therapeutic relationship also serve a primary role in this approach.

Only a few comparative studies examining the effectiveness of infant-parent psychotherapies have included infant-led work, but notably, these studies suggest that infant-led interventions where the parent is the facilitator have considerable impact on attachment status ("Watch, Wait, and Wonder;" Cohen, et al, 1999) and on inattention and irritability in infants ("Child-Centered Infant Psychotherapy;" cited in DeGangi, 2000). The effectiveness of infant-led work where the therapist serves as facilitator is an area for further study.

Following the infant's lead, by parent or therapist, holds continuing promise as a tool for intervention in the parent-infant relationship. More importantly, whether infant or parent is in the therapeutic foreground, the remaining other's contribution must be held in the background of the therapist's mind. To apprehend the full range and dimensionality of the attachment relationship and to have maximum impact, each member of the dyad must be held equally. This makes work with parents and infants tremendously challenging.

Creation of a Group Experience

In juxtaposing interdisciplinary ideas, I began to explore the creation of a therapeutic parent-infant group that would provide an experiential arena where parents and infants could play and learn and simply be together in body-and-mindfulness. This group experience would create a kind of a potential analytic space (Winnicott, 1951), where the emotional and spatial ebb and flow of attachment and exploration could be attended to with equal regard, where participants' affective experiences could be mindfully reflected upon, and where the parent-infant couple could explore and deepen how they know and feel about each other and the world. Facilitators would serve to create and support the conditions that allow this unfolding to occur and to offer both parent and infant direct experience with a reflective mind.

Onsite at TMCC over the past 20 months, we have served 17 adults and 13 children in two ongoing groups, composed of a culturally and economically diverse mix of primarily mothers with infants or toddlers, but occasionally also including fathers, grandparents, and extended family members. With recent implementation of a school-based Mindful Parenting group offsite, we have also served four teenage mothers, three fathers, and four infants in a time-limited group experience. As an alternative to traditional 'mommy and me' classes or support groups, Mindful Parenting provides a setting that enriches parent-child relationships, offers opportunities for motor development and social contact for infants, and occasions for adults to grow in parental competence and self-awareness—all in a framework of observational and experiential learning.

In onsite groups thus far, members have been primarily low to moderate risk, with some families intact, and others divorced. Some members have been stay-at-home mothers, with others working full or part-time, and also some struggling with anxiety or depression. Among children, we have seen issues of low weight gain, sensory integration difficulties, social anxiety, affect regulation problems, and aggression, alongside other developmental concerns. With our school-based group, we are now also reaching a higher risk population that includes un-wed teen mothers stressed with financial concerns, work, school, or little family support, and the demands of their premature or special needs infants. Regardless of the circumstances, many parents, consciously or unconsciously, are grappling with troubling psychic remnants from their own early attachment relationships—pockets of unmentalized affective experience—that make negotiating stressors particularly challenging. A starting point in this group work is the belief that there is profound bi-directional, relational and regulatory utility in strengthening a parent's capacity to come as close as possible to a child's subjective, affective experiences, and so our therapeutic work first of all attends to enhancement of reflective capacity and deep empathy—both verbally and nonverbally. This process is initiated through the parent developing an active observational stance, through the

accumulated practice of directing quieted, patient, curious, receptive attention to both child and self, and through learning to respect and follow the child's lead in contact-seeking and exploratory behaviors. The parent's activity of simply slowing down enough to notice serves as an empathic function. Thus, the infant's 'unadulterated' capacity to see, feel, venture into, experience, and eventually think about the textural, dimensional, or social properties of their world—hard/soft, close/far, in/out, fast/slow, etc.—is brought to the foreground of the parent's mind for reflection. What are the properties of this chair, that ball, this child, that mother? How might I make use of these objects? And, how does contact with them make me feel? These same questions may be applied to each new affective moment.

Through each infant's specific developmental trajectory, parents have the opportunity to wonder together about how it is that we come to know the landscape of human experience—the physical and psychic, temporal and spatial, sensory and emotional, subjective and co-constructed. The verbal and nonverbal facilitation of this interactive flow of affective experience from parent to child to parent and back, ad infinitum, forms the basis of our preventive intervention in Mindful Parenting.

Structural Components of the Group Experience

Mindful Parenting consists of weekly meetings of one and a half hours each. With ongoing onsite groups, parents make an initial eight-week commitment, after which they may continue for as long as they find the experience useful for them and their children. Offsite groups tend to be limited to pre-mobile babies and may last as few as 12 weeks. Infants are grouped developmentally, with rarely more than four months difference in age, and no more than four to six infants with parents per group. Alongside the lead facilitator, there are up to three interns or volunteer clinicians that observe and assist each group for the purposes of clinical training and education. Groups may begin with infant members as young as three months and continue through preschool age, depending upon the needs of the group served.
At our onsite location at TMCC, groups

take place in a 325 square foot gated area of a larger conference room. Décor is spare and toys are minimal with the youngest of infants, and increasingly challenging as the children develop. Pre-mobile infants meet with their mothers on a large blanket, and when settled and ready, babies are placed on their backs, facing mothers and facilitators, who form a circle on the floor around them. As infants grow older and begin to roll, crawl, sit, and cruise, the variety of toys and equipment increases, and the observing circle gradually widens and forms a semi-circle of chairs at one end of the room, allowing greater space for toddler exploration.

The play environment is aesthetically engaging and developmentally challenging, based upon the needs of attending babies. A silk canopy spans the center length of the room, protecting infant eyes from overhead lights and providing billows of pastel color for gazing. For the youngest, play materials may be as simple as a few wooden teethers and visually interesting cloth napkins propped as tents for study. Some are placed within reach of an infant's grasp and some invitingly just beyond reach. As the babies' interest, attention, and motor coordination expands, a varied assortment of simple toys is gradually introduced, thoughtfully placed about the room alongside low wooden platforms and step units to climb and explore.

The toys chosen are intentionally uncomplicated, have multiple uses and are mostly of natural materials. A toy's textural features provide the infant opportunities for contact with and expression of such experiences as hard and soft. The toys frequently take on emotional weight or serve as links to significant affective moments over time, or may be utilized as tools in making social contacts. Simple cloth dolls and animals; wooden teethers, blocks, and lacing beads; miniature wooden vehicles; balls made of felt, yarn, or rubber; woven baskets of all sizes and shapes; large and small pillows to rest or nurse on; text-free board books and wooden books; colorful silk or cotton scarves; and found objects such as gourd rattles or reflective stainless steel bowls comprise the majority of play materials.
The group time is organized around the

ebb and flow of observation, reflection, and live interaction. Following transition into the play environment, there is a formal period of quiet observation, usually lasting 20 to 30 minutes. With the infants in the perceptual foreground, the group work is more infant-centered, and parents and facilitators may sit back quietly, following the infants' lead with patient curiosity about what may be presented. Observations are usually silently noted, though facilitators may assist in developing parents' subtler observational skills by drawing special attention to micro-events that occur among the babies and adults. With teen mothers, we modify the observation period to include facilitators working more intimately for a time with each parent-infant couple. Offering immediate, live narration of micro-events assists the teens in growing their capacity to reflect on the minutiae of baby's experience. When parents are encouraged to slow down to the pace of infant life, they begin to notice finer details of their baby's experience—and gradually tease apart their own as well as the baby's emotional responses.

Adam: Walking with his Eyes

In a group comprised of teen mothers, 17-year-old Julie sits at the foot of her four month old infant son, Adam. Adam pleasurably mouths a teether in exploration, then after some minutes, shifts with what may be the early registration of hunger. Adam resorts to more intent pressing of teether-and-fist into mouth, followed by losing motor control of the teether, then by more urgent sucking on fists together with eyes now closed. He remains like this for some moments, all effort pressing fists into his mouth cavity, with eyes shut as if hunger and desire for the breast has transported him there in his mind. Adam begins to whimper and then fussing quickly mounts. A facilitator queries, 'What do you think is happening?' and mother responds, 'I think he's hungry,' and gently but swiftly pulls baby to her breast, where he settles in at once for a feed.

Later, Julie gazes with wonder at Adam, lying on the floor now before her, sated, arms and legs in perpetual but irregular motion, yet with eyes fixed on mother's gaze. From our first meeting, Adam has shown a preference for unusually

prolonged, uninterrupted gazing - into mother's eyes and the eyes of receptive group members and facilitators - an event described by one facilitator as 'walking with his eyes.' This opens a discussion of how desire precedes action, how a pre-mobile baby may 'travel' through senses or imagination or subtle motion to come close—long before gross motor achievements direct him physically to his destination. Several moments pass, then Julie quietly inquires, 'Do babies have thoughts?' The facilitator responds, 'What do you think?'

After the initial observation period, the group as a whole then has an opportunity to reflect on what was seen. The facilitator generally begins the reflecting period with a question such as "What are you noticing today?" or "What are your impressions?" or even "What are you feeling in this moment?" at which point participants have the opportunity to present what they noticed both in the babies and in themselves. Conversation will likely include references to how a particular sequence of activity felt—either for the infants involved or for the parents as active participants or witnesses. At this point, the parents' internal experiences move into the perceptual foreground of the group, and the group work is, for a time, more parent-centered. The infants' activity remains further back but still alive in the group's attention. A lively dialogue often occurs as parents and facilitators compare notes about what was seen and how it was experienced. Exploration of each group member's unique point of view creates opportunities to consider subtle events from various perceptual and affective angles, providing moment-to-moment microanalysis of the group experience.

The flow of observation, reflection and interactive experiencing continues throughout much of the balance of the group meeting, with parents and infants alternately brought to the foreground for mindful consideration. The group's focus is akin to how a sensitive mother might respond to her large family: moving as needed based on where the action is, with different family members shifting in and out of the foreground, while still others are tracked in the background of her mind. The reflective group mind that emerges creates a container for primitive anxieties associated with encountering the unknown in self and other. A similar, albeit separate, layer of containment occurs when facilitator and interns meet weekly outside group to further digest the experience in a reflective

supervision process, functioning not unlike an infant observation seminar. The possibility of multiple layers of reflection and containment—from parent to infant, facilitator to infant, parent to parent, facilitator to parent, and so on—make this intervention active, alive, creative, and flexible to the particular needs of each affective moment.

Finally, two structured activities are introduced during the last half hour with older toddlers. First, near the beginning of the child's second year (or when developmentally ready), the facilitator will offer snack time to the toddlers while parents relax and observe. This structured time provides opportunities for parents to observe: 1) how patient waiting for children to enter new experiences on their own allows for greater interest, autonomy, and cooperative interactions; 2) how food may be offered in ways that promote positive, respectful interactions between caregiver and child; and 3) how the use of comforting rituals may ease navigation of daily caregiving routines. This also provides one of the few opportunities in our relatively expectation-free group environment for children and parents to see and experience the joys and challenges of navigating structure and turn-taking in a social event (e.g., washing hands, putting on bibs, sitting down, eating while sitting, removing bibs, and washing hands again).

Second, when developmentally appropriate, an informal circle time is offered just prior to closure of the group time. The parents and facilitators form a circle and toddlers are invited to join in for two or three repeating short songs or finger plays or they may continue independent activities. Children often look forward to this musical and rhythmic group contact and are intently engaged throughout. Trevarthen (2000) notes the close attention paid by infants to the ordering of elements in simple melody or poetry, and cites research indicating how the musicality of mother's happy voice is important for supporting mutually satisfying communication with an infant. A closing song brings the group time to an end, and parents experience the power of ritual and song as tools for times of transition. In sum, Mindful

Parenting is an effort to create opportunities for wholesome "ways of being with" (Stern, 1995), and thinking about, parent and child and the complexity of experiences that the couple has when engaged together and exploring apart.

Dana and Lee: Making Contact Through Taking and Giving

Dana, a 13-month-old toddler girl who has been walking for less than a month, comes for her second meeting in a preexisting group. She stays mostly near mother and father, venturing only cautiously into the play area to tentatively explore some wooden teethers. She selects one colorful teether that resembles a bracelet and toddles somewhat shakily back toward the adults. Looking pleased with herself, Dana comes to a stop several feet from her parents, and peruses her prized wooden teether. At this point, Lee, a large 14-month-old toddler boy, suddenly approaches Dana. Lee, whose tremendous motor agility contributes to a tornado-like physical presence, has spent his group time today fearlessly bounding about the room and becoming increasingly aroused. Lee's father, who at times engages Lee in rough physical play, has on several occasions predicted with rankled certainty that his son will be "a bully." Dana is gazing at her chosen teether when, without hesitation, Lee plucks the teether out of her hands and walks in the facilitator's direction. Dana's mouth begins to quiver, her body to tremble, then a cry bursts from her lips and she toddles hurriedly to her mother's arms, where she collapses in tears. As Lee passes in front of the facilitator with a wild look in his eye, she announces, "I'm going to pull you close," and in an unusual gesture, gently but firmly scoops him onto her lap—in an effort to physically slow him and to contain his high arousal. He settles there, stilled for a moment. Calmly and without expectation, the facilitator says, "Dana had the bracelet…then you took the bracelet from Dana…now you have the bracelet…and Dana is crying." Lee looks at the wooden teether in his hands, pauses for a few moments, then rises, walks over to Dana, and extending his hand, offers it back to her. She looks up at him with a startled expression, then softens and after a moment, accepts the teether.
Some three months later, on the day of his last visit to group, Lee, now 17 months old, searches intently early in the meeting through a large basket filled with many wooden teethers. Lee pulls out each teether individually, considers it, and then discards each unwanted teether onto the floor. This sequence continues through several teethers

until he finally comes upon the one that resembles a bracelet. Lee stops his activity, pausing quietly, then immediately takes the teether over and presents it to Dana, who accepts his offering. Later that same meeting, while the group discusses the meaning of the exchange and links it to the empathic contact made three months before, Dana spontaneously gives Lee an affectionate embrace for the first time. At the end of group, after our final goodbyes to Lee, he gets up, walks over, and embraces Dana one last time.

Conclusion

While the effectiveness of Mindful Parenting has yet to be measured, anecdotal evidence seems to point to a positive impact on the thinking, affective relationship between parent and child. Over the coming year, we will be measuring reflective functioning in pre- and post-intervention interviews, and we hope to offer preliminary findings when available. Mindful Parenting represents the effort by this clinician to evolve a novel, hybrid group that enhances reflective capacities in parents and infants, promoting verbal and nonverbal communications. Utilizing elements from various disciplines, these groups strive to positively impact the parent-infant attachment relationship through allowing parents and infants to gain experience with and benefit from unhurried, focused, and bare attention to states of mind and body in self and other. This is the art of loving wonder.

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New Book

Pozzi, M.E. (2003) Psychic Hooks and Bolts: Psychoanalytic Work with Children Under Five and their Families. London: Karnac.

Soft cover / 217 pages / ISBN: 1855759071 / £19.99 Euros 31.98

'In this book it is made plain that complex and powerful understanding can take place in brief work. The baby's development is carried forward, the family re-groups differently, understanding brings a change in behavior.' Lisa Miller, author of Closely Observed Infants
'This book focuses on young children as old as five and the parents and siblings who live with them. It wants to explore deep, unconscious connections between children and parents, especially in those cases where symptomatic behaviours develop and turn a potentially pleasant and satisfying family life into hell.' -Maria Pozzi from the Introduction

Articles

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

Cooper, P.J., Murray, L., Wilson, A. & Romaniuk, H. (2003) 'Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression. 1. Impact on maternal mood.' British Journal of Psychiatry 182: 412-419.

Cooper, P.J., Murray, L., Wilson, A. & Romaniuk, H. (2003) 'Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression. 2. Impact on the mother‹child relationship and child outcome.' British Journal of Psychiatry 182: 420-427

Websites

The following website has been drawn to our attention:

www.tabs.org.nz

The hosts write: PTSD AND CHILDBIRTH, a new website, from TABS - Trauma And Birth Stress, NZ. We have had the pleasure and privilege of presenting at two Marce Conferences, Sept 2001 and Sydney last year and now are working with Prof Cheryl Beck (Connecticut University) on a study of mothers with PTSD after childbirth. Also includes material from Judy Crompton, Midwife and research from the UK.

Antipodean Activities:
Aspects of the Infant Mental Health Program, Royal Children's Hospital, Melbourne

By: Campbell Paul, Michele Meehan, Libby Ferguson, Susan Morse, Marell Lynch, Nicole Milburn, and Frances Thomson Salo

Introduction

A Toddler Withdrawn

Despite the apparent success of a liver transplant, 18-month-old Jacob appeared withdrawn, avoidant, wasted and he was refusing to eat. The medical and nursing staff responsible for his care were extremely concerned. There was no medical cause for his persisting lassitude and they referred him to the Infant Mental Health Service at the Royal Children's Hospital, Melbourne. In his short life, he had experienced a lot of pain and had been near death many times as result of the complications of his congenital liver disease. It seemed too cruel to contemplate that a person could inhabit so wretched a body and be so seemingly empty of soul as this young boy.

However, clearly he was there, inhabiting his body. There was a need for some lively interaction for him to come out and to meet his world again. His mother was surprised that mental health might have something to offer her son. She had been immersed in so many medical crises that she said it had never crossed her mind that he might be "depressed." When staff from the Infant Mental Health Team were able to engage Jacob in a piece of playful behavior, his mother caught a glimpse of a child very different to the one she had so far experienced. She was startled by observing a moment of lively play that Jacob demonstrated in a simple ball game with Libby Ferguson and she was then able to pursue her own more lively play with him. After his mood had improved, she was able to say that it was as if she earlier thought he had already died; as if in her mind he had been psychologically dead.

Holding the child in therapy - holding him in our own minds and speaking directly with him- was of critical importance in his recovery. Our engaging him even in a brief moment of enlivened play, when witnessed by his mother, led to a transformation in the way she experienced him in her mind. She could see her son as alive and that there was a point in hope for his survival. It could also be demonstrated that her pain, grief, and tragic sense of loss …that these things too, could be contained for her sake and for her son's sake. Jacob went on to thrive and now visits the hospital for infrequent reviews as a very healthy and talkative boy.

This is but one of several illustrations of the approach to clinical work with infants and families that is at the foundation of the Infant Mental Health Programme at the Royal Children's Hospital in Melbourne. We believe that playful engagement and psychotherapy directly with the infant, in the context of work with the family and the broader system, is critical for the best outcome for the child.

In this series of four papers, we hope to illustrate something of the work of infant mental health in Melbourne. We hope it will be an appetizer to the richer tasting of the smorgasbord of infant mental health practiced in Australia. We look forward to our overseas colleagues joining us in Melbourne for the 9th World Congress where there will be a series of presentations by antipodean clinicians and researchers. Even more exciting for us will be to hear of the work of our colleagues overseas and to be able to share ideas and extend our horizons.

Our Program in Context

There are a network of services in Melbourne, which address the mental health needs of babies, toddlers and their families. There are several infant mental health programs integrated into child and adolescent mental health services and

these occur both in the public and private health setting. Australia has the unusual phenomenon of residential and home based Early Parenting Centres. These have developed out of a series of hospital type settings for mothers and babies who have had difficulties with feeding, sleeping and other routines in the early months of life. They are public institutions accessible to all families, and they have continued to develop and specialize. Recently, a more specific expertise has been built up to provide intensive assessment and assistance for the most high-risk families who might come before children's protective services. In Australia, there is also a comprehensive network of mother/baby psychiatric units and infant mental health clinicians play an important role within these adult psychiatric units. In the private health system, there are also inpatient mother/infant units with mental health, nursing and child health components to their programs. Interconnecting with each of these services is a range of private infant mental health practitioners drawn from the disciplines of social work, psychiatry, psychology, nursing and others. All this sits upon the extensive bedrock of the maternal and child health nurse (who has different titles in different States). These highly trained nurses have expertise in working with mothers, infants and families and constitute a universally available service with a very high level of access. Some 98% of families with a newborn child have contact with a maternal and child health nurse. Increasingly, these maternal and child health nurses have an additional training in Australia's university courses in infant and parent mental health. In her paper, 'Enough is Enough,' Michele Meehan shows us how in brief work with infants and their families the nurse can use insightful psychodynamic concepts and effect rapid interactional change.

There remain nonetheless areas of unmet needs for the families within our vast

rural and outback places. Families will travel long distances to access such help, but we are increasingly using teleconferencing and the telephone to reach such families. Training for workers in remote sites is crucial. There is an exciting collaboration amongst many disciplines to try to understand the world of the baby and family and what professionals, volunteers, and families can do to give the baby her best chance.

At the Royal Children's Hospital Mental Health Service, there is a long history of close collaboration between mental health, pediatrics and nursing. There is a strong emphasis on us taking the baby's point of view; we try to respect the baby's perspective. In her paper, Frances Salo tries to draw out some of the components of "Respect." The team at the Children's Hospital is multidisciplinary and draws on developmental psychology and child health, as well as psychodynamic theory. We have found the works of Winnicott, Lebovici and Stern, and many others to be helpful in our understanding of the baby and her family. We are lucky in Australia that we are a nation of travelers so that we are able to collaborate directly with colleagues in all other continents. We see the forthcoming Congress as a way to further extend these professional connections.

We are also a land of migrants, but have to come to terms with the traumas resulting from the Western occupation and dispossession of Australia from its indigenous peoples. We have an improving relationship with Australia's original inhabitants but the disruption of families' attachments caused by generations of dispossession of Aboriginal peoples has had a profound impact. Families may experience a crisis of confidence in parenting since many have lost contact with traditional baby care practices and supports.

Our work tries to reflect the multicultural nature of this country and this may be seen in the paper by Libby Ferguson and Sue Morse about the "Ooey Gooey Group." Being drawn from such a diverse range of peoples and cultures, we hope that we have the capacity to be imaginative and playful in our work as well as our play. Marell Lynch and Nicole Milburn in their paper about the Stargate Early Intervention Programme have found how important it is to have a

creative and informed basis to a clinical assessment, particularly for those infants in greatest need. In their work with children who have been placed out of home in the context of serious protective concerns, they demonstrate that building on interactional and psychodynamic understanding of the baby's world can provide real assistance to the infant's biological family and to those others who provide necessary care for him whilst he is at risk.

Overall, we hope that this series of brief papers will provide a keyhole perspective on the work of one infant mental health program within one city in our vast continent. We believe that if we work from the perspective of the baby within the family and draw on multidisciplinary teamwork and a broad range of theoretical foundations, we are able to provide something hopeful and useful for infants and their families.

The WAIMH Congress 2004

We look forward to sharing with you our interest and excitement about babies and their minds when you come to Melbourne in January 2004. We also look forward to being able to share the social and physical excitements of our continent. We hope you will be able to spend time at our beaches, galleries, concert halls, golf courses, sporting venues or in the bush meeting some of our unique fauna, as well as with our welcoming people. It may seem a long flight over the Pacific or Indian ocean, but it is a journey that Australians have made many, many times and clearly it is very possible. Accommodation is extremely comfortable and not expensive. We believe that Melbourne is justifiably described as one of the world's most liveable cities and we trust that you will be able to agree with us after you have joined us here during our next summer.

Campbell Paul
Infant Psychiatrist

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ENOUGH IS ENOUGH

By Michele Meehan,
Maternal and Child Health Nurse, RCH
Infant Mental Health Programme

As a Clinical Nurse Consultant in Maternal & Child Health, much of my day-to-day work is with infants with day-to-day problems. Sleeping, feeding, crying and behavior issues present in a variety of stories. Recently two cases had been referred to me with similar stories and an idea of 'overindulging' them seemed a way to help them shift.

Both babies were about 11-12 months and presented because of clingy and demanding behavior. Both would cry even as mum attempted to put them on the floor. As a result they were carried around most of the time, which by 12 months was well past acceptable to the family. Both were boys of married parents; Ben was a first child while Will had an older sister of six years old.

'Will' was striking in his aversion to strangers and his clinging to mother. I recorded that I found him wary and slow to engage. He stayed on mum's lap with his dummy (he was sleepy but had not slept in the car on the way down, a 70-minute trip). Mum showed me that if she made a move to put him down he grabbed hold of her - I told her to just wait while we talked for a bit. His sister had made herself at home with the food and tea service and was busy preparing lunch for us. As we talked of how draining this behavior was for her, especially with two children home on the school holidays, he slid down and stood at her knee. He sat down then pulled up on a chair I had near us and lay his head down, then turned away as though having a nap. I approached him, talked quietly, and stroked his back. He turned his head and looked at me. I then picked up a soft toy and a cloth cube with a bell inside. He looked at the lamb and I said it was sleepy too and laid it beside his head. I very gently banged the cube on the chair in a double rhythm. He smiled at the noise of the bell and I got more vigorous as he 'woke' up more. He let me pat his back in time to the bell and laughed. As this went on for a few minutes, I then picked him up and sat him between my knees as I knelt on the floor with him facing mum, away from me. He was looking around and I talked about what his sister was doing, and he

headed off to take her doll she had set at the table. He was interested in the food, so I sat him at the table with her and they remained playing there for the rest of the session. His mother said he would never do this and she had been surprised that he let me approach him as he had. It was obvious that he made no attempts to engage mum until he was happily playing and she responded warmly.

I told Mum that I thought the more demanding Will became, the more she felt pressured to 'get rid of him'; so the harder he clung to her, and so on. To expect him to suddenly change was a large request, especially as he felt that if he is upset this is where he needs to be because that is always what happens. While acknowledging that a main issue here for mum was her postnatal depression (mentioned by the referring nurse) I felt she needed a real strategy to help make a change rather than address any of her projections.

I suggested that, while it sounded horrifying, what she could try is to NOT put him down as soon as he is settled. When he grizzles or cries, to pick him up, but sit or turn him to 'take in the world' rather than cling to mum and 'see' only mum as the solution: to sit as I had done and show him the world waiting for him and let him be the one to say 'I want to go.' There was a similar strategy she could try by taking him out in his pusher (where he was happy) and when he got home (when he would immediately start crying) LEAVE him there until he wanted to get out. In a way you are saying "You can stay here as long as you like" – his thinking may be "I can get as much of mum as I want, so maybe I'll go off here for a while." He can carry in his mind the memory of getting her whenever he needs.

A week later mum reported that she had been able to do this, and that when he started grizzling she started by asking "what do you want?" instead of "what's the matter now?" and if she waited a few minutes many times Will would go off to play with something. The pram walks were very successful and she was getting out more and feeling better. He looked much more animated on arrival and greeted me with a grin behind his hand. He pointed to the stove and pots and demanded to get out of his pusher.

This idea of overindulging was also successful with 'Ben' whose mother said he was "an embarrassment" at playgroup or family outings, as he would ONLY stay in mum or dad's arms facing the wall or away from everyone. In contrast to Will, Ben had no idea about playing. While he was sitting on the floor (again with slow coaxing and pessimism from mum) I rolled a ball to him and he looked at it, then at me and did nothing. He made a similar response to any other toy offered. It seemed his parents themselves played with the toys and showed him what they did.

At no time in the session did the parents attempt to play or talk with him and both stayed on their chairs even though I was on the floor. I spent a fruitless hour trying to get him involved with little success. I discussed that I felt he needed to feel comfortable to play and not just cling. Parents said they could do this at home, but what about the playgroup and they had a big family get-together on Sunday! I talked about how Ben's separations were always at mother's instigation and he seemed to have no role in asking to leave, that just when he was 'settled' mum tried to put him down. Play group was the next day so I suggested she keep him with her firmly on her lap with an arm holding him tight while she talked about what the children were doing. If he looked interested in something to get it, and play WITH him on her lap - only if HE wanted to get down should she let him. I faced the next week with some trepidation, but as they came into the room he scrambled out of dad's arms, crawled over to the box, and brought out some balls. Mum immediately got onto the floor and sat there playing with him or just watching as we talked. He was busy, interactive, laughing and happy.

These two cases highlighted the dilemma parents find when they are trying harder and harder to remove a 'limpet': the more they push the harder the baby clings.

Working directly with the infant can make rapid shifts while the ongoing therapy for mother and baby can stabilize the relationship. As a nurse, parents come seeking 'intervention' for their baby and are often not ready to address their emotional issues or the relation-ship. Being able to bring in concepts of

the infant's mind and possible thought/emotion processes, that the baby has ideas about what is happening and not just being 'difficult, clingy or stubborn' is a good step to further exploration of the relationship being a duo and not just a list of 'good mothers should.' My membership in the Infant Mental Health group reinforces the dual role nurses can take in directly intervening with the infant, then being able to address the mother's emotional issues at the same time.

RESPECT: A MODEL OF INFANT-PARENT PSYCHOTHERAPY FROM THE ROYAL CHILDREN'S HOSPITAL, MELBOURNE

By Frances Thomson Salo

What I shall describe briefly are the guiding principles of the infant-parent psychotherapy that has been practiced at the Royal Children's Hospital in Melbourne for about 20 years, and this will be described in more detail at the 9th World Congress of the World Association for Infant Mental Health to be held in Melbourne in January 2004. This way of working has its historical roots in the need to find ways to help distressed infants who have been admitted to the hospital in some kind of medical crisis, as well as their parents. Ann Morgan, a pediatrician, who heard Winnicott speak in meetings as a medical student in the 1950s, set up the Infancy Group in the Royal Children's Hospital Child Psychiatry Department, in order to offer infants and their families a fuller service. The Group's present co-ordinator is Associate Professor Campbell Paul. The theoretical roots for this work can be traced to the work of the pioneers of infant mental health such as Selma Fraiberg, and to Esther Bick's infant observation work.
This in-patient model was then taken into outpatient work by a number of the Hospital infant mental health clinicians who were working outside the Hospital, as well as consulting to other disciplines in the community. It also underpins the teaching on the University of Melbourne Graduate Diploma /Masters in Infant Mental Health. We have previously

described it as 'direct work' with the infant (Thomson-Salo et al, 1999) although in retrospect this may not have been the best way to characterize work that we see as in the tradition of infant-parent psychotherapy but honoring the place of the infant in it. While much of what we describe below may be part of infant-parent psychotherapy as practiced elsewhere, the mnemonic R.E.S.P.E.C.T. highlights our view of the need to respect the infant within the therapeutic process, even from a few weeks old.

The following elements are seen by the infant mental health clinicians as crucial in bringing those 'moments of change' in the therapeutic process, which have been explored by Daniel Stern and his colleagues in the Boston Process of Change Study Group (Tronick et al, 1998).

Relating with intentionality to the infant and parents

The clinician relates to the infant and his parents, as James Herzog (1999) described it, 'using their personality to find the pain', relating authentically as an alive other. This way of working was described very evocatively by Anne Alvarez (1992) in 'Live Company.'

The enigma of the child, his especial subjectivity, is recognized

Here we are thinking of the specificity of the intervention for that particular child at that moment of time. Bill Blomfield, a psychoanalyst who also worked at the Royal Children's Hospital, is quoted as saying that, "you look at an infant with already knowing eyes while knowing absolutely nothing about the infant in front of you" (cited in Thomson-Salo & Paul, 2001). Often those intervening may do so from a background of considerable experience with infants and therefore assume a knowing of the infant and miss the uniqueness of the infant they are with. The baby does not know the clinician either, so connecting with him is a two-way process allowing the infant to be active.

The infant as a subject

The infant is regarded as a subject in his own right, not to be objectified or measured. He therefore has an equal right with all other participants in the therapeutic process to be attended to fully. With the infant present, the work is focused more on the infant-parent relationship, rather than on the parent or the infant.

The clinician brings their playfulness to the infant and her parents

Here our debt to Winnicott is obvious. Play is the infant's language, and when the clinician relates to the infant with play that is thoughtfully about her, the infant has a sense of being 'met' and this conveys hope to her.

The enjoyment of the infant that the clinician brings

Trevarthen (personal communication) highlighted the importance of the infant's wish above all else to be enthusiastically enjoyed by her parents and significant others from birth onwards. This does not necessarily translate to an exuberance carried into the clinical encounter, but to an attunement to the infant's affects, underpinned by a quiet enjoyment of what infants bring. The sense of pride for the infant, coming from successfully entraining the other, is a very powerful organizer in the first year. I think if the infant's humor can be reached in a truthful way, this can also often kick-start some forward moves.

Creativity in the clinician's work and intuitions, and the infant's answering response

I think when the clinician is most truly himself or herself the infant recognizes the creativity in this. At times infant

mental health clinicians need to act creatively on intuitions about the infant, to come up with new ways to 'talk' to her (as well as interpretively with the parents). A 13-month-old infant, who had been seen with her mother by Brigid Jordan and Michele Meehan for feeding difficulties since she was 3-weeks old, was becoming resistant to giving up naso-gastric tube feeding. In a creative attempt to respect the little girl's defenses but help her find her pleasure, Brigid Jordan made an interpretation in play by taping a tube to a doll's face and offering the little girl the toy feeding bottle. The little girl instantly understood that her need to be in control was respected and with pleasure she began to take some developmental steps forward.

The clinician's integrative thinking

This is the kind of thinking that draws on psychoanalytic concepts, such as the ideas that Bion conveyed in his concept of containing confusion and distress, and making sense out of it. It is also exemplified by Dilys Daws (1989) when she describes how, when a story as an integrated narrative begins to take shape in her mind, there can be the possibility of it also taking shape in the parents' minds – and in that of the infant.

We think that these elements are present in every therapeutic contact or process when something in the infant and his family joins with what is offered by the clinician and a moment of change occurs. Being respectful of the individuality of the infant takes time but creates space for the infant to make his own contribution to the therapeutic process.

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R: Relating with intentionality to the infant and parents

E: The enigma of the child, her especial subjectivity, is recognised

S: The infant as a subject

P: Playfulness in the encounter with the infant and her parents

E: The enjoyment of the infant that the clinician brings

C: Creativity in the clinician's work and intuitions, evoking the infant's response

T: The clinician's integrative thinking

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OOEY GOOEY GROUP: A BEHAVIORAL INTERACTIVE GROUP FOR YOUNG CHILDREN WITH FEEDING PROBLEMS AND THEIR PARENTS

The Ooey Gooey Group is a group run within the Speech Pathology Department at the Royal Children's Hospital, for toddlers and young children with feeding problems. Most of the children come to the group with a history of complex medical conditions and often are reliant on tube feeding for most of their nutritional needs. All of the children have in common a reluctance to eat an appropriate amount or range of foods. Some have neurological difficulties and all have developed an unhelpful pattern of behaviors around food and mealtime. This might mean gagging on particular types of food or refusal to let anything in their mouth. They attend the group with a parent, usually their mother. The group meets weekly at lunchtime and comprises a play session followed by a meal.

The name of the group, Ooey Gooey Group, reflects its acceptance of messiness along with the development of comfortable familiarity with the sensory aspects of eating. Many of these children have learned to associate discomfort and unpleasantness with eating and drinking. Food intake has become "medicalized", measured and worried about. Neither parent nor child looks forward to mealtime with pleasurable anticipation. Rather, they anticipate struggle, anger, disappointment and a whole range of emotions and behaviors not conducive to pleasure and satiation of hunger.

Children attend the group at a developmental stage often vexed with fussy, changeable behavior. It is a time when they are still endeavoring to establish a sense of autonomy and separation from their primary attachment figure. Along with eating, the toddler is trying to become autonomous with toileting, dressing, bath time etc. It is also a time of curiosity and social exploration. The group capitalizes on this drive for independence and supports the parent in allowing their child to take risks and extend boundaries. An aim is to replace panic and alarm with curiosity and playful exploration.

The group provides a place for the children to experience food and eating at their own pace in an encouraging and often entertaining environment. The food is usually provided by the therapists and chosen to match the child's capabilities. It might be that the child is afraid to chew and swallow solid food because of a history of gagging or choking. Some children will have poorly developed oral motor skills and remain stuck at a level where they feel safe and past which the parent is frightened to go. The group aims to replace anxious anticipation with an expectation of pleasure. The child and parent's prior experience has often contributed to a classically conditioned link between food and unpleasantness.

The group is led by two speech pathologists with experience in the fields of oral motor behavior, medically complex children and infant mental health. The therapists model eating behaviors, often playfully, and encourage the child to follow. Explanations with the parents happen at the time rather than following the event. Having fun seems to enable the child to move on and to copy an adult in a safe environment. In this environment, parents also seem to feel able to try things and offer comments knowing they will be accepted. The group provides a place where risks can be taken. The children and parents try new things and the therapists risk looking inexpert and at times a bit silly. While the general routine of the group is set (i.e. moving from play to lunch to play), rather than prescribing the individual steps, the therapists enter into spontaneous and dynamic exchange, incorporating what

the children bring to the situation. Parents and children find themselves in predicaments, they manage to survive them and come to their own solutions, working out how to act together to learn from them.

Play experiences in the group are not specifically based on eating and mealtime. The children might at times play with feeding each other, the adults or dolls and teddies. They might also take up physical challenges with balls and cars. They practice negotiating for possession or dealing with dispossession of a toy. Parents join in the play or watch and reflect on the achievements of their own or another's child.

Parents often watch what another parent and child are doing and recognize their own situation. They develop an empathy with the other child and mother, and through that with their child. The intensity of parental expectation for their own child is reduced as they enjoy progress within the whole group. The children are also observant of each other and other patterns of eating. They experience the other children's coughs and gags as well as their enjoyment and emerging competence. They imitate and identify with the other children. Random events happen and are reacted to. Preliminary evaluation of the group has been encouraging. Measures of feeding resistance, range of food consistencies accepted and total food intake are done prior to and following attendance at the group. Preliminary results, on a small number of children, suggest that feeding resistance is decreased and an increased range of food consistencies is accepted. What we observe early in the group is that the children happily anticipate coming to the table to eat and show pride in their developing ability to manage food and mealtime. They develop social relationships with the other children, the parents and the therapists and within this safe environment feel more able to explore their environment and the messy, pleasurable environment of mealtime.

Libby Ferguson and Susan Morse
Speech Pathologists

UNDERSTANDING THE INFANT'S EXPERIENCE WITHOUT WORDS OR FAMILIAL HISTORY: A CASE STUDY FROM THE STARGATE EARLY INTERVENTION PROGRAM FOR CHILDREN AND YOUNG PEOPLE IN OUT-OF-HOME CARE.

By Marell Lynch & Nicole Milburn

The Stargate Early Intervention Program for children and young people in out-of-home care is a pilot service model designed by the Royal Children's Hospital Mental Health Service, Melbourne. The program provides a comprehensive therapeutic assessment to all infants, children and young people when they enter out-of-home care (foster care, residential care and kinship care) through having been found to be at risk of significant harm by Child Protection Services (CPS), in a major metropolitan region. The multidisciplinary therapeutic assessment aims to give parents, carers and workers within the system a clear understanding of the child's behavior to promote a more attuned and empathic response to the child's distress, better management of the child in care, and better planning for his or her future

The Stargate Program arose to address the barriers to accessing mental health services that had existed for children in out-of-home care. These barriers were predominantly centerd on systemic issues whereby children's placement in out-of-home care may not become clear and stable for some time. The result was children going into short-term or crisis-driven care while work was conducted with their parents in hope of reunification. The child remained in care and often needed to change to longer-term care when work with parents was not successful. Multiple placements often occurred and children became increasingly stressed and distressed. Overburdened foster care and child protection systems also became increasingly stressed and distressed.

The Stargate Program is based on the works of the key attachment theorists and recent findings from the trauma literature (e.g. Schore, 2002; Fonagy, 2001). Children seen by this program are between the ages of 0 and 17 years, with 30% under the age of three years. Results and discussion of the work with older children and adolescents will be reported elsewhere. As it pertains to infants, the program comprises a therapeutic assessment interview with the infant and his or her carer and parent, a pediatric screen and feedback to all stakeholders (parent, carer, foster care worker and CPS case manager). A comprehensive report is provided for each infant that includes assessment findings, formulation and recommendations. Referrals are made to ongoing infant health, including mental health, services if warranted.

One of the key roles built into the program is that of being an independent advocate for the parent, the child and the family between the three systems: Child Protection, Out-of-Home Care Agencies and Mental Health Services. Prior to Stargate, children in out-of-home care were 'parentless' in the sense that they no longer had someone to keep their needs in mind, communicate those needs and provide continuity across environments in terms of Winnicott's sense of 'going on being' (1960). The case presented below illustrates this position and the ramifications for the infant.
Working with infants who have entered the out-of-home care system presents particular challenges simply because the infants at that point in time are parentless. Information that is generally held in parents' minds is lost for many infants, or passed on to CPS in an ad hoc way. As clinicians who were accustomed to the traditional mental health model of taking a developmental and family history from a parent, and hearing from the parent what they have noted that warrants the child's attendance at the clinic, we have in the Stargate Program been forced to respond to the challenge of assessing the child with no developmental or family history. Sometimes the only information Stargate clinicians have is the date of birth, mother's name and the reason for going into care (e.g. 'mother in psychiatric inpatient unit with psychosis,' 'infant witnessed domestic violence and mother is uncontactable,' 'parents substance abuse rendered them unable to care for their baby.')

The challenge to the clinician's methods of understanding an infant case are a minor reflection of the challenge and difficulties the infant faces in being cared for by a stranger. The established patterns of healthy communication between mother and infant have been well documented (e.g. Trevarthen, 1984; Stern, 1985) and entry into out-of-home care can be extremely disruptive to infant communication. However, as the following case study illustrates, infants are able to clearly communicate their experience without words and without a consistent carer-translator.

Dee was a fourteen-month-old girl who came to the Stargate Clinic with her paternal grandmother, Angelina. When the referral was received six days prior, we automatically assumed that the grandmother would be able to provide the background history. When the child was being registered with the service we discovered that her grandmother spoke Spanish and that she had not been aware of Dee's existence until she was contacted by Child Protection two weeks earlier and asked to provide interim care for this infant. Shortly after the phone call, on the same day, Dee was duly delivered to her grandmother's care in just the clothes she was wearing.

Dee was brought to the clinic by Angelina and her paternal aunt. She sat quietly and watchfully in the pusher beside her grandmother and initially did not seek to engage with any toys, let alone people. Angelina described Dee's first two nights with her and how she had assumed that Dee would want to be cradled and comforted to sleep. Therefore Angelina had placed Dee in bed with her. Dee would not settle and pulled away. On the third night, when placed directly into bed, she went straight to sleep. Angelina described Dee as a restless sleeper. Feeding had also been an issue as Dee became extremely agitated and demanding around food, and refused any help. Angelina found it difficult to pace her feeding, as Dee would cram food into her mouth. She would not allow herself to be held when drinking, preferring to be left alone to bottle feed.

Dee was described as initially making few demands on adults and being sporadic in her engagement. She showed little interest in explorative play. Angelina described an incident where a pot plant had fallen and Dee, obviously fearful, had crawled away from the adults and it had been very difficult to settle her. Angelina also noted that she had to be careful as to how she touched

Dee because a slight movement or tap would leave Dee startled as if she had been hit. When Dee bumped or hurt herself, she did not cry or seek comfort. Dee was described as extremely engaging with adult males when out and as attempting to gain their attention. With adults in general, she showed no discrimination, and there was no variation in her response to separations from her carers or other adults.

Angelina wondered whether Dee's behaviors were the result of an infancy where she had witnessed many frightening events and had not been readily comforted and made to feel safe. She also wondered whether her "independence" was a result of being left alone and having to grow up fast. Of most concern was Dee's indiscriminate behavior with adults

At the Stargate clinical meeting, where case discussion, formulation and recommendations are made, the clinicians were struck by how Dee had effectively told her story and how she had conveyed it through her relating style, self-regulatory tasks and protective behaviors to her grandmother, who not only knew nothing of her past, but did not speak her language. Dee's behavior met all the criteria for PTSD and indiscriminate attachment disorder. Her past experiences of witnessing domestic violence, experiencing care takers preoccupied and unresponsive due to substance abuse, and experiencing many carers like a 'pass the parcel,' were evident from her presentation. Dee's experiences were later confirmed in an interview with her mother.

One of the main underpinnings of the Stargate Program is that the recommendations provided are targeted to ensure that all the people involved with the child are consistent in their care. With Dee, the recommendations were very specific in order to target the way Dee interacted with the world. For example, recommendations included:
· That it was important to monitor Dee's displays of indiscriminate behaviour. There was a need for specific work on developing Dee's identification of, and with, the key figures in her world through the establishing of individualized rhythmical patterns of relating, sound/words usage, facial gestures and touch. This could later be developed using symbolic play of mother infant interactions.
· Monitoring for exaggerated startle response to sound and movement so that intervention could occur early and Dee be protected from further exposure to traumatic stimuli.
· Promoting of modulation and soothing activities/ games/ touch to assist Dee's self-regulation.
· Stimulative play on a one-one basis: peekaboo, rhythmical games, vestibular movement, singing etc

It can be seen from the above that the Stargate Program aims to provide recommendations for children that are targeted at the manifestations of the specific diagnoses of Post Traumatic Stress Disorder (PTSD) and Reactive Attachment Disorder. The diagnoses of PTSD and attachment disorder are often perceived to be simplistic categories that say little about the lived experience of the patient. What we seek to do at Stargate is to operationalize the concepts of trauma and disregulated attachment within the theory base itself. Stargate attempts to enact Fonagy's position that researchers (clinicians) should 'concern themselves with the mechanisms or psychic processes that may underlie such behavioural clusters' (Fonagy, 2001: p.187).

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WAIMH
Affiliate News

WAIMH Belgo-Luxembourgeoise

History of the group

At the beginning, three child psychiatrists went to the meetings of WAIMH-France. Six years ago, they decided to create a group of professionals (12 people) in Brussels working in the field of infancy; these professionals were mostly child psychiatrists and psychologists working in the infant mental health departments of different Universities in the French speaking part of Belgium. Two colleagues from Luxembourg were pleased to join the group. We thought it was important to meet and share the experience acquired from our clinical practice and to discuss our theoretical points of view. We have planned to meet twice a year concerning clinical cases and articles. Previous meetings have helped us get to know more about each other's practices. Some of the members presented a session at the WAIMH congress in Tempere, Finland (1996) and in Montreal (2000). It became obvious then that this group could apply for affiliation with the international WAIMH.

Belgium

In May 1998, we became the Belgo-Luxembourgeoise Affiliate of the international WAIMH group. Dr. Annette Watillon was the first president of the group and we are still very pleased to share her wonderful experience as a clinician working with the parent-infant relationship. Since our foundation, the members of the board remain the same. The current president is Dr. C. Devriendt-Goldman. From the beginning, Pr. D. Charlier-Mikolajczak has been responsible for international relationships. The initial group has generated a larger group open to other professionals in the field of infancy: child psychiatrists, psychologists, pediatricians, gynecologists, nurses, etc. At this time, the Belgo-Luxembourgeoise WAIMH has developed into a group containing over 100 members.

Future and Aims of the group

For the future, our aims and realizations will be :
- to continue the work inside the initial group.
- to organize one-day meetings: The first one was in 2001 : "A baby and his multiple origins"; the second in 2002: "First signs of autism" and in March 2003: "Sufferings of caregivers."
- to constitute groups with the aim of developing local networks relating to the perinatal period (the desire for children, pregnancy and age zero to three.) At the present time, we initiate small groups in different places around one of our members, who stimulates thoughts about different themes. There is, for example, a group around psychological issues in neonatal care (Dr. M.P. Durieux, Dr. C. Devriendt-Goldman). Other members have proposed at our WAIMH meetings the formation of two further groups: one around "Training in recognizing the first signs of autism" (Dr. A. Wintgens) and the second : "Signs and treatment of post-partum depression and psychosis" (Pr. D. Charlier-Mikolajczak.)
- to develop clinical research projects.
- to maintain tight relations with the French, European and the International WAIMH as referent groups.

By: Prof. Dominique Charlier-Mikolajczak

Luxembourg

Meeting of the European Affiliated WAIMH Groups, Paris January, 25-26, 2003

Report by Bernard GOLSE (Fr) and Robin BALBERNIE (UK)

The second meeting of the European affiliated WAIMH groups was organized in Paris, on the 25th and 26th January 2003, by Bernard GOLSE (France), Sam TYANO (Israel) and Massimo AMMANITI (Italy.) The first one was also held in Paris, in January 2000. Between these two meetings, for different reasons, it proved difficult to gather representatives from all the groups even though this was tried in Israel, Lisbon, Pisa and Amsterdam.

This time all the groups were represented, invited for two days in Paris by the French-speaking group, thanks to their ability to call upon a number of generous sponsors (European Aeronautic Defence and Space Company, Société Française du Radiotéléphone and the Fondation BETTENCOURT-SCHUELLER).

Here is the list of participants: Dominique CHARLIER and Annette WATILLON for the Belgian and Luxembourg group, Robin and Celia BALBERNIE for the English group (AIMH-UK), Tuula TAMMINEN and Merja-Maaria TURUNEN for the Finnish group, Fernanda PEDRINA from Switzerland, Marguerite DUNITZ-SCHEER and Peter SCHEER from Austria for the German-speaking group (GAIMH), Sotiris MANOLOPOULOS and Meropi MICHALELI for the Hellenic group, Miri KEREN and Sam TYANO for the Isareli group, Massimo AMMANITI and Filippo MURATORI

for the Italian group « AISMI », Grazziella FAVA-VIZZIELLO, Lenio RIZZO and Francesca SIMION for the Italian group named « GIOSUE group », Hanne MUNCK from Denmark and Pia RISHOLM-MOTHANDER from Sweden for the Nordic group (NFSU) and, finally, different members of the French-speaking group including Bertrand CRAMER from Switzerland, Bernard GOLSE, Antoine GUEDENEY and Valérie DESJARDINS from France.

The meeting took place at the Necker-Enfants Malades hospital where Bernard GOLSE is working, and was attended by Peter de CHATEAU (Sweden), the President of WAIMH.

Saturday morning session

Bernard Golse opened by emphasising the practical difficulties involved in getting this meeting organized on a regular basis. There was a move towards making the European Group more integrated. He talked about a wish to develop joint projects, with an emphasis on research. He reminded us that three years ago there had been talk of organizing a European Group initiative at EEC level with regards to infancy.

Then, Peter de CHATEAU explained to us that WAIMH has to consider three different levels: international, regional and then national, and how these interact. The WAIMH board has been trying to get rid of one of these levels - preferably the regional one – as they felt it made the administration too top heavy. But they found that this did not

work. There was some thought that there was a difference between Europe and America in the overall approach to WAIMH. In the debate it was noted how in Europe 'clinical discussion' is considered to be very important; and this was seen as perhaps favoring a slightly different emphasis from the more research-oriented, quantitative approach emanating from America.

The Melbourne Conference in 2004 was discussed, while recognizing that many potential delegates from Europe might not attend because of the distance involved. We learned that the bid for Paris to host the 2006 Congress seems to be the favored one. As soon as this location is officially confirmed, planning will begin on how to give it a more "European" slant. Members are invited to begin considering presentations now!

Bernard Golse went on to discuss the importance of the links that the European Group have with WAIMH, and (as was emphasized by everybody else throughout the meeting) went on to speak of the discrepancy in numbers between the National Affiliates and the Central Organization. A theme that threaded itself through the two days was: should more people be encouraged to join WAIMH, and how could this be brought about? In response, Peter de Chateau pointed out that there are five existing resources to encourage increased membership. These are: (1) The International Journal (2) The Signal (3) The Video Library (although the American system is not universally compatible with other countries) (4) The Membership Directory (5) The World Congress that members can access at a reduced fee.

It was thought that there was too big a distance in the relationship between the WAIMH Board and the members. This was one reason for trying to bring the Affiliates more onto the Board, as well as looking at other ways by which their influence could be increased. As a means of facilitating communication within the organization, Antoine GUEDENEY suggested that The Signal could develop into a world-wide "Zero to Three" with different language editions.

After that, each group gave a presentation of its functioning and activities. This was a rich and full session, and it is difficult to give a resume here that would do justice to the different and extremely stimulating content and issues that were covered. One especially interesting initiative was the course in infant mental health set up by the Finnish group as part of their commitment to supporting health visitors in Finland. They have trained over 2,500 health visitors, and this includes all of those practicing in Tampere and Helsinki. This training is recognized by the fact that it merits a higher salary. It consists of eight days spread over several months plus ongoing supervision for two years. The delegate from Finland spoke of how they had tried to "make differences interesting rather than threatening." They have been giving much thought to how they might promote infant mental health at all levels.

To close this session, Tuula TAMMINEN, the President elect of WAIMH, underlined the three main goals of WAIMH : a scientific goal, an educational goal and a charitable one. She did this in the light of the different levels of the infants' development, and drew a parallel between the ways to improve both the infant's development and WAIMH's functioning. Everybody noticed the importance accorded by Tuula TAMMINEN to the scientific goal of the association, especially the necessity for continuing the commitment to reflect upon infant psychopathology and how this might be addressed.

Saturday afternoon session

The Israeli group presented the new computerized chart for infants and toddlers that they have created for IMH work. This records all relevant details of assessment and treatment, and can even print out a closing letter that leaves out all the negative bits! It is called the PRINCE system and will soon be available for purchase. It perhaps has the potential to abolish paper files and, more importantly, provides a means of standardizing and organizing information to provide a basis for inter-country research.

There was then a presentation from Italy that included a video of clinical work. The work focused on a little boy named William, two years old, who was presenting as isolated and obsessive. In kindergarten he was shy and timid. All physical examinations were normal. His mother saw him as having regressed, especially in terms of social competence. This had been going on for the previous two months; and the first session was videotaped when William was just about two. His father had epilepsy, and his mother was thirty years old and was born in Russia. She had a previous child, born ten years before, who had died at two weeks from pneumonia, and this child had a different father. It was a normal pregnancy and the initial development was on track, with William developing language up until about twenty months. It was then that his development seemed to halt and he lost the language skills he had already developed.
We were struck by the group impulse to pathologize the child in the subsequent discussion, which was in danger of being dominated by a determination to give him a psychiatric label. Not everyone was happy with this, and the importance of the story was slightly lost. Some talked about how he might be showing some autistic features, and there appeared to be a risk that the audience was assuming that the problem resided within the child, perhaps unconsciously almost

colluding with the mother. The quality of the ongoing relationship with the mother or father was not really seen as central, nor were the other pressures on the family given any consideration.

As far as we could gather the clinical intervention consisted of some individual work with the child, although not on a regular basis, and a few sessions with mother. However, a second video clip when the child was nearly two years older showed that he had regained normal development, and with the therapist he was showing curiosity, playfulness and normal language. In the interim (and again family stresses were not considered) the mother had divorced and was looking far less strained.

At the end of the afternoon, there seemed to be agreement that we had reached a general sense of a European tradition that was more clinically, or case based, and that this should be seen as a strength that could be developed. This led to a long (and sometimes heated!) discussion about the two main backgrounds to WAIMH, research and clinical work. The main feeling of the meeting was that more case examples were needed in the literature, with a greater emphasis on in-depth clinical work. It was thought that every other Congress could be more on the theme of clinical work; or that each Congress should include a training element. Someone also suggested that after such a Congress, a selection of the training presentations could be sponsored to enable them to be taken around to the different Affiliates, benefiting a wider portion of the membership. Methods of promoting non-English clinical papers in the Journal was also discussed.

Sunday morning session

On Sunday morning, Bernard Golse and his group explained their project on the semantic and behavioral precursors of speech. This is a piece of research just at its beginning, and he was presenting it at this stage, while they were setting it up, in order to gain some immediate

feedback from the audience. He was also looking for some wider European cooperation from any other research groups that might have similar interests. What he received were some ideas and a lot of others' past projects.

This research project was based on the idea that the first communication between baby and caregiver is through the medium of gesture and the prosody of the adult's speech. They pointed out that it is the non-verbal aspect of adult speech that provides the channel of communication, and they called this "analogic" communication while also stressing its importance for conveying feelings and emotions. This was contrasted with the "digital," more precise, content of speech that mainly transmits concepts, thoughts and ideas. They were thinking along the lines of how there is a developmental changeover of emphasis here, and this is part of the normal process of inter-subjectivity, so that digital communication eventually becomes predominant. However, they stressed how analogic communication continues in all the non-verbal channels throughout life (e.g. tone, gesture, gaze, music, etc..)

The research project was looking at how arm and hand movements for the baby can be a sign that inter-subjectivity has been achieved. True communication implies that the baby and other are differentiated, there is a sense of inter-subjectivity, and signals can be exchanged. This sets up what they called "a loop of communication," which is a form of closed sequence. They also pointed out how, as an adult, it is almost impossible to speak without moving one's hands. They introduced the concept of motor representations, seen to have the function of filling the transitional space between parents and their infant. From this, they postulate that the roots of communication problems might be found in the arm and leg movements of the first and second years of life. If they can analyze these as they plan to, then it might eventually lead to a way of diagnosing future problems in communication from these early movements.

They are trying to answer the question "where does the baby look when the adult speaks to him?" They felt there was a natural evolution of the baby's movements of arms and hands when the adult speaks, and also when the adult stops speaking. They want to investigate links between the baby's gaze and representation, and the prosody of the parent's speech. They will begin by studying the trajectories of the baby's hands and arms and linking this to the baby's direction of gaze. This will involve filming from different angles with digital cameras, co-ordinating these and then analyzing the data with the aid of a dedicated computer program they are developing. The whole project began from the observation of how the baby responds to music. They are looking for concordances between movement, parent's speech and eye contact. The methodology will involve conducting multiple analyses simultaneously (e.g. hand movement and gaze) on the way joint attention is being focused on the space between baby and parent, and how each is filling it. They were keen to gather up any ideas that other researchers or clinicians might have on this (contact Bernard Golse at the following email address bernard.golse@wanadoo.fr.)

The second part of the session was devoted to the business meeting, which opened (again) with a discussion about membership fees and how WAIMH is financed. People stressed how a wider membership might mean reduced fees, so how could this be made attractive?

Nominations of new members of the WAIMH board are due shortly, and Peter de Chateau invited proposals from Europe. As part of the discussion people spoke about the risk of a potential split with the United States on the horizon, and how this could be avoided. He also reiterated the idea of using the WAIMH home page and The Signal to disseminate more information; but since this is currently limited to full members, it will not affect Affiliates. The general idea seemed to be that WAIMH should take on more of a role in integrating the different Affiliates, especially since the

importance of infant mental health is best promoted at local level. This is one reason, all delegates stressed, why an over-centralized system will not work. It was felt that the different continents should each have a representative on the Board or Executive Committee. However, it was also acknowledged that a Board with too many members simply does not work. There was a balance to be struck between costs and creating a group that can work effectively.

Bernard Golse proposed setting up a European Group as a separate entity. It was generally agreed that this would be a good idea and would provide a forum for an exchange of knowledge and ideas. It was discussed whether or not this could lead to a single European Group meeting with a representative from each country, but it was recognized that this would first need to be discussed at a local level. There are practical issues here, such as how is this to be financed. People also brought up the need to bear in mind how many countries are now joining Europe, and certainly infant mental health needs to be promoted there as well.

Each country's Affiliate needs to generate a mandate to proceed with this idea, moving towards setting up some form of European network. Somebody suggested that there may be EEC funds that could be accessed, but practical details were a bit vague. Several countries said that they did not feel it was appropriate for them to appoint the President of their group to such a meeting, as this post changed so rapidly that there would be no continuity within the European Group, and thus no group would ever actually form.

Bernard Golse wanted the European Affiliates to start thinking about the place of the European Groups in planning the Congress in Paris for 2006. The meeting ended with this idea, one that will have to be developed when Paris is officially confirmed as the site for the 2006 Congress.

Conference Reports

A major part of the remit of *The Signal* is to keep WAIMH members abreast of recent developments in the field. It is hoped that this new section of *The Signal*, together with the "Literature Monitor," will be helpful to readers in this respect by updating them on the latest conference presentations from across the globe and the most current literature of note. The success of both these sections, however, will very much depend on members' contributions, so please email me with details of any interesting articles/books/videos that you come across and write-ups of any conferences you may have attended. Send to: *paul@pbarrows.freeserve.co.uk*   Thanks.

All three of the following reports originally appeared in the AIMH (UK) Newsletter and are reproduced with the Editor's kind permission.

The Tavistock Clinic Annual Infancy Study Day: What is a Healthy Baby?

A Multi-disciplinary Perspective

London, Friday 8 November 2002

This day brought together speakers from different countries and different professional bases, all working with parents and infants in a variety of settings. The audience shared this diversity as well, and the list of participants revealed people had travelled from around the country to attend.

The day began with Mary Sue Moore (Consultant Clinical Psychologist, Colorado, U.S.A.) asking "Healthy Babies and Parents: Are They Conflict Free or Skilled at Repair?" She posed the questions: What is ordinary, healthy functioning? How can repair and recovery occur? Does healthy equal happy? She stated that there is no such thing as trouble-free infancy or parenthood, nor can they can be free of conflict. She saw struggling in a healthy way to become a parent as leading to resilience and feelings of internal stability in the infant. She spoke about the development of attunement and affect regulation in healthy babies and how events which cause anxiety in the infant or toddler may cause regression, when certain newly-acquired skills may be lost. The context, i.e. the disrupted environment, causes the changed behavior, which in itself need not be viewed as unhealthy.

Mary Sue Moore based her thinking on attachment theory, on developments in neuroscience and on evidence from research. With the brain achieving 80% of its development in the first two years of life, the right hemisphere intact, and functional, at birth, and the left hemisphere fully functional by four months, the infant is highly receptive to environmental influences. The process of attachment develops through the infant's experiences with others and also by observing how others interact (which she termed procedural memories.) Such learning is stored and its memory triggered by later experiences. Thus she gave an example of how the experience of witnessing domestic violence in infancy could lead to being bullied at school. The experience would have initially triggered a freeze-response, as the infant is unable to flee or change the situation; the further experience in school might subsequently trigger a similar response.

Mary Sue Moore spoke about the effect of high arousal on neonates: their self-regulation becomes disorganized and they may turn away or shut their eyes to avoid over-arousal. She showed a diagram, which was new and innovative, describing the correlations she had found between high and low flexibility/inflexibility and high and low vigilance, combining to form the various states of attachment. This new work will be published shortly and we can look forward to studying her analysis and schema more closely and in more detail.

The second presentation was a film made and presented by Effie Lignos (Child Psychotherapist, Athens, Greece) of three singletons and a pair of twins.

She produced it for teaching purposes. The babies were observed in the usual way, weekly, for two years. Each baby was filmed over a brief period to show a certain stage of development, within their family settings: with fathers, siblings, an au pair and a grandmother present. We saw a baby being bathed, both parents in attendance; a baby at the breast and trying to get to sleep, appearing to try to brush away her mother's stroking hand; an older baby whose sister "loved" her so much, almost smothering her with her jealousy, and affecting the mother's ability to develop a direct relationship with the baby; and twin boys of whose different needs mother was well aware, yet we saw how giving her attention to one appeared to make her feel she was depriving the other and so neither got her undivided attention.

The richness of the film's content showed, among other things, ways in which babies develop security, the capacity to be alone, to tolerate separation, parents' abilities to identify with their babies, babies' abilities to both express their wishes in a variety of ways as well as to protest against unwanted experiences. We saw parental reverie in action in the way they talked to their babies about their thoughts. Fathers were shown as involved, joining the mothers in caring for their babies (and eliciting their own maternal aspects) and a grandmother was shown in her helpful role. The twins showed us that each one experiences mother being in relation to the other, which related to what Mary Sue Moore had said regarding procedural memories (i.e. learning from observation of others interacting.) We were able to see how observations of infants can lead

to noticing how infants react, how each in his or her own way has his or her own alive response. The use of video can show these things to students, and, in use with parents, highlight what is hard to notice or when it can seem that nothing is happening. The vignettes were able to show us moments at different levels of complexity, so that parental failure could be noticed by the way in which the infants struggled with it, but also survived.

The discussion gave rise to some very interesting considerations of cultural factors involved in assessing what one is observing, and to the danger of applying too harshly some conceptions that can easily become misconceptions or even stereotypes.

Small group discussions followed to allow participants to think about the topic of the day. One important aspect of the discussion in my group reflected what was becoming a common theme for the day; that is, both the struggle with difficulties and the struggle to become an individual were seen as healthy aspects of developing the ability to manage conflict (i.e. conflict in the inner world.)

Annette Mendelsohn, Child Psychotherapist, and Betty Hutchon, Paediatric Occupational Therapist (London, U.K.) presented work with parents in a neonatal care unit of a hospital. Their interest is in moving away from a deficit model and promoting psychological health. They presented their use of Brazelton's Neonatal Behavioral Assessment Scale, explained its use and showed a video of this work. The emphasis was to show the potential for development with vulnerable, hospitalized infants such as those born prematurely with complications, and to help parents recognize that potential.

Annette Mendelsohn spoke about the contribution of a psychoanalytically informed child psychotherapist in the neonatal unit with the focus of

attention on thinking about the uniqueness of the infant, and on seeing how the infant's behavior describes his or her state of mind. This method is rooted in the subjectivity of the observer's emotional experience and her receptivity to the emotional content of communications. This subjectivity of experience is akin to countertransference in psychotherapy. We heard that the maternal capacity for reverie (empathy with, and thoughtfulness about, the infant's emotional experience, as described by Bion) can remain frozen when an infant is born prematurely. Also, the mother's (and father's) receptive/interactive capacity for repair and recovery can be absent.

During pregnancy, representations of the baby develop in the mother's mind and peak at seven months gestation, subsequently diminishing. In the description of "Thomas," born at 30 weeks, we heard that he was not the baby the mother expected to have. At 30 weeks reality came as a blow and mother froze (she perceived Thomas as rejecting her.) Traumatized by the actual baby, this mother was prevented from having meaningful, and therefore empathic, contact with him. Annette Mendelsohn's intervention helped her to think of him as someone who needed her to help him, thereby bringing her into contact with a maternal part of herself that had been lost in the traumatic experience of the birth and the reality, which she could not face.

When Betty Hutchon assessed Thomas, initially mother was unenthusiastic and on the video one could see her turning away, not wanting to be involved. At the fourth meeting she was shown an excerpt of the video and things began to improve. A follow-up after discharge showed Thomas and mother's relationship progressing well. Mother's angry rejection, as a result of her disappointment, had been heard and contained. It is interesting to think about an infantile part of herself having been too highly aroused by the reality she faced, i.e. not the baby she had fantasized she would have, and self-regulating by turning away, in the way that Mary Sue

Moore had described earlier. Mother was helped to turn back toward Thomas, to see him as he was and to see herself needed by him.

The day brought us into the realm of early infancy, with its delicate and intricate web of influences on development. With the emphasis on healthy development, this was a different perspective from the more common focus on pathology at such events. The vicissitudes of early development are unpredictable but we were led into thinking about resilience and how beneficial experiences can promote healthy development despite them.

Gabriella Klein
Child and Adolescent Psychotherapist

EXPLORING RECIPROCITY: A CORNERSTONE OF THE SOLIHULL APPROACH

The 4th Annual Solihull Conference

21st October 2002

This conference was led by Dr Mary-Sue Moore and Janet Dean, visitors from the United States, already known to many present because of their extensive expertise in the field of infant mental health. In their presentation they developed ideas about the enduring consequences of early trauma and neglect and examples of the kind of multidisciplinary/cross agency working necessary to provide effective interventions with infants and their parents. Janet and Mary-Sue's focus for the conference was 'reciprocity' which was richly exemplified in their mutually affectionate and respectful relationship, which provided many of the day's most enjoyable moments.

Mary-Sue Moore and Janet Dean both work in Boulder, Colorado: Mary-Sue as a Research Psychologist and Child Psychotherapist, and Janet Dean as Clinical Director of the Community

Infant Program. This is a home-visiting preventive-intervention service for infants at high risk and their parents, staffed by infant mental health specialists, nurses and para-professionals. Mary-Sue Moore is also a visiting teacher at the Tavistock Clinic in London.

Reciprocity is a cornerstone of the Solihull Approach. As some readers may be aware, the Approach is a psychotherapeutic and behavioral intervention based on theories of containment, reciprocity and behavior management. It is devised for all care professionals working with young children and focuses on children's sleeping, feeding, toileting and behavioral difficulties as a way of thinking about mind/body relationships. It has been shown to enhance health-visiting practice by enabling more effective working and leading to improved job satisfaction (Douglas & Ginty, 2001). Work is currently in progress to develop a similar resource to support the work of school nurses, and in the future for midwives, social workers, Sure Start projects and others involved with infant and child mental health services.

Reciprocity is concerned with attunement, and is contingent upon the mutual regulation of affect between mother and baby. Building upon ideas from Stern (1985) and Murray and Cooper (1997), the Solihull Approach describes how from the moment of birth, the baby and its primary caretaker, usually the mother, have effects on each other:

"The baby communicates with his mother with every means at his disposal, through crying, shrieking, stretching, flexing, cooing, grimacing, gurgling, smiling, looking and so on. It is of enormous significance to the baby that he can influence the mother's response to him, rather than being a passive object to whom things are done, as he then has the experience of being in an active, dynamic relationship."

Early in the day Janet Dean emphasized that the motivation to be reciprocal in our relationships is a prerequisite if our interactions with others are to be meaningful. She highlighted how reciprocity is concerned with the ability to sustain pleasurable, rhythmic interactions with another, and also importantly, to be able to regain this rhythm when synchronicity is temporarily lost. This was reminiscent of the work of Allan Schore (1994) who argues that the capacity of a mother (or primary carer) to re-engage her infant, shortly after an emotional connection has been broken, is key to promoting secure attachments and resilience to emotional distress throughout our lives.

Janet Dean suggested that when assessing infants, a critical question relates to the child's ability to self-soothe, and to develop an internal process of self-regulation. This ability has important implications for impulse control, mood, and self-esteem not only for growing infants but also for us as practitioners. Janet argued that as workers, we need to prioritize making space, through reflective or clinical supervision, to put ourselves back into synchrony; to face the emotional impact of our work and to address our own insecurities – our life-long struggles with helplessness, being overwhelmed and autonomy.

Mary-Sue spoke of how 'holding a memory with another individual is made up of micro physical and affect cues' which provide crucial information about the other person. For healthy full-term infants the capacity to read others' cues and to produce cues for others is neurologically hard-wired into our brains and is in play from birth. The infant initially needs a soothing adult to regulate arousal levels for him, and through experience an understanding of self-soothing and sensory-down-regulation is built up. This process is very finely tuned across the first months of life, so that if there is no helpful adult intervention, the ability to regulate one's own breathing and be in a calm, regulated state, will be thwarted. Babies cannot do this for themselves, and if it is not processed for them as infants they will be less able to do it for themselves in later life. The close link with Bion's (1959) concept of maternal containment of infantile anxiety and distress so the baby can experience it in a more manageable way was evident in the material presented by Mary-Sue and Janet Dean. However, this basic tenet of British psychoanalytic thinking has apparently not had the same impact across the Atlantic.

Reciprocity, or contingent responsiveness, can go awry when there are non-contingent responses made to an infant's cues i.e. parental actions are not responsive to the child but responsive to needs of the adult. For example, an infant may be feeling overwhelmed by face to face contact and turns away but the parent experiences this as rejection and looms, becoming overly intrusive and leaving the child feeling powerless either to avoid interaction or to regulate their emotional state. In such a way, reciprocity may be 'de-railed' in early infant-parent dyads and consequently in families as a whole. Experiences that are accompanied with strong emotions build up faster pathways in the brain and the responses evoked up to two years of age will therefore become 'hard-wired' into the brain and show itself as the infant's 'attitude towards and expectations of' others.

Equally, although babies are wired from the beginning to respond to seek emotional contact with others, the responsiveness of individual babies can vary. The impact of disability, premature birth, drugs in utero, and the genetic contribution, can all influence the child's level of ability to read and give out cues. The 'goodness of fit' between the parent and child, and their adaptability to each other's style of relating, is critical for a positive attachment relationship.

Mary-Sue provided a new and interesting framework that we are unable to reproduce here as she has recently submitted it for publication in a journal. The diagram represented her thinking about the link between patterns of regulation and attachment. The various

insecure attachment categories: 'avoidant,' 'ambivalent,' and 'traumatized' were positioned in an ascending scale of how far they reflected a greater or lesser focus on either 'self' or 'other.' This relates to the child/parent dyad's capacity for movement back and forth between awareness of self and awareness of others. The bottom axis referred to the scale of vigilance towards incoming sensory data. It is worth noting that these axes shifted from low – high – low rather than increasing in a straightforward linear way. Mary Sue also wished to emphasize that 'an attachment label cannot be applied to just one person, it is always a dyad you are describing when discussing infants and parents' (personal communication).

Children with a secure attachment have a sense of expectation and are able to predict that their caregiver will recognize and meet their different cues for feeding, stimulation, sleep etc. They do not need to be especially vigilant of their environment or parental mood and can be open in the expression of their own cues as well as their awareness of those of others (low vigilance/high capacity to move between an awareness of self and other.) This group will develop mutual affect regulation whereby both mother and infant each have an impact on the regulation of the emotional state of the other; the process is two-way and, therefore, positively reciprocal in nature.

Those dyads that fall within an avoidant or anxious attachment category are those that are preoccupied with their own emotional state (high vigilance/low awareness of other) understandably finding difficulty with empathy and/or are resistant to interpersonal contact. The origins of such a state of mind may be biological, genetic or environmental. This group can also include those on the autistic spectrum, or who have required intrusive medical intervention but may also reflect those who suffered emotional or physical neglect, including neglect from maternal mental illness or depression.

A key feature of attachment is the ability to predict what will happen in our early relationships; if we cannot do this we become highly anxious. When we have multiple unpredictable experiences, it can lead to rigid defences against future emotional contact and, unfortunately, may block even potentially positive interactions. Mary-Sue stressed that individuals with such rigid defences do not evolve them arbitrarily; they will have developed them innocently as a way of stabilizing their world in the face of uncertainty. This should alert us to the underlying reasons when we come across some of the same features in our work with parents and other adults.

The dyads in the top right hand section (high vigilance/high awareness of 'other' at the expense of self) included those infants who have highly unpredictable and traumatic early experiences at the hands of their parents, which may include physical abuse. They are hyper vigilant and are only secure when able to monitor closely the emotional state of the primary carer. They block self-expression having learnt that asserting their own needs may have negative consequences and avoid interaction when they sense the parent is in a negative state.

A child who experiences trauma does not usually have a sense of its own agency in the world. He becomes passive or freezes as a last-ditch survival mechanism. Mary-Sue argues that this early freeze response, as a way of getting through painful experience, is associated with dissociation in later life.

It was interesting to hear Janet Dean describe how, over the past decade, she and her colleagues have begun to assess for dissociation with their adult clients. She suggests being alert to the kind of language that reflects dissociation, such as: 'I'm out of it,' 'not in the room,' 'zoned out.' Some clients cannot be in the room long with a worker or attend and take in information and process it. She emphasizes that our presence as

workers inevitably creates ambivalence because it demands a relationship with our clients. We should not underestimate how anxiety-provoking our contact can be for parents as it re-arouses old fears of rejection. She also stressed the need for us, as workers, to identify our own anxiety and levels of arousal, which may trigger our own dissociation from a difficult situation. These are the moments when we go somewhere else in our mind rather than remaining emotionally available and present in the room to attend and listen to clients. Janet's style, directly observable on video, is one of patience and 'wondering with' parents, not approaching issues confrontationally or head-on, allowing a relationship to develop where possible but taking definitive action where she deems necessary. It was a privilege to be able to watch her at work.

The gap in professional understanding of and response to child protection issues, often apparent between health services and social services, was given some thought during the day. Janet shared some of the dilemmas her own service had in the beginning and how difficult it can be to persuade social service colleagues that certain infants are at risk from emotional and/or physical trauma without physical evidence linked to a perpetrator. Again, the freeze framing of the micro moments of facial expressions of a mother with her child, captured on video, but almost unidentifiable in real time, provided strong evidence for the power of this medium.

Janet argued that health professionals could have a key role in helping social workers identify some of the aspects that point to problematic interactions between parents and their infants. We need to be alert to parental capacity for empathy, whether they respond contingently to their infant's cues, the level of dissociation in parents and how this impacts on ourselves as workers. How parents talk about their baby can offer insight into what the infant represents for them in their inner world, i.e. is the child a threat in some way? Or

how a parent physically handles a child may offer further clues, i.e. is there a real emotional connection when bathing or dressing the child? The value of understanding the micro-nuances of reciprocal interaction and also when it is absent was apparent. Where there are observable triggers for risky behavior from a parent toward their child, whilst very worrying, this may mean treatment might be more possible. Janet's position, which made clear sense, is that the situation is more dangerous for both the mother and infant when triggers are not observable and originate outside the dyad.

Many thoughts and images have remained firmly in mind since the day in October. However, one central theme in Janet Dean's work with parents and infants at risk has held particular sway. Janet emphasized the necessity of offering validation of the expressed feelings or experiences of the adult, especially those thoughts elicited from inquiries about whether they wanted to raise their children in a similar way to their own upbringing. Often these responses reflect the mental representation of the baby in the parent's mind. By validation, Janet means not collusion or simple reassurance, but some positive acknowledgement that you have taken the parent's words seriously, at the same time attempting to avoid evoking further anxiety or resistance.

Diana Fallowes and Clare Hadley
Child Psychotherapists

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Mental Health in Infants and Parents: A Study Afternoon

St Clements Hospital, Mile End.
East London and the City Mental Health Trust

The Mental Health in Infants and Parents study afternoon was jointly organized by the Child and Adolescent, Adult Mental Health and Adult Psychotherapy Department in Tower Hamlets. It followed the successful day that was held in September 2001, which looked at the psychodynamics of parenting infants and young children (Dawson, 2001). This year two speakers were invited, who were able to help us to consider the trans-generational effects of childhood experiences upon mental health and well-being. Dr Neil Morgan, Locum Consultant Psychiatrist in Adult Psychotherapy, and Dr Cathy Urwin, Consultant Child Psychotherapist, both of whom work in Tower Hamlets, chaired the afternoon.

Dr Neil Morgan began by remarking upon an apparent growing convergence in thinking by different approaches to adult psychotherapy in accounting for adult distress as being influenced by childhood experiences. More specifically, he referred to models that focus upon the interpersonal experience between the child and their care-givers, conceived as schema development within the cognitive tradition, and the process of building up an internal representation of the child's outer world in the psychodynamic tradition. Referring to Bowlby, he suggested that an appreciation of inter-generational transmission could help us as professionals work towards inoculating against mental ill health in the way that general medicine has been able to develop inoculations against physical ill health.

Dr Urwin introduced the speakers. She began by commenting on the impact that a new baby can have upon the family, suggesting that it is a time of considerable turbulence. She also reminded us that the processes involved affect both the parent and the child.

The first speaker, Paul Barrows, (Lead Clinician for Child and Adolescent Mental Health Services in south Bristol, Course Organizer of the MA in Infant Mental Health, and Chair of The Association for Infant Mental Health UK) asked us to consider a vital, but often neglected, issue within multidisciplinary teams, which is: who should be seeing a particular family, and why? He linked this to a consideration of how the role of fathers has often been neglected in the formulation of cases, particularly within the psychodynamic tradition. This was illustrated by a case study, involving an 18-month-old boy whose parents were considerably distressed by his chronic night waking. He commented on how affectionate the parents were towards the child and, after a relatively short time, he was able to formulate the case as being an example of how the strategies employed by parents to soothe their children at night can prevent the children from developing autonomous self-soothing strategies, which results in disrupted sleep for the whole family. The result, as many of us will know, is a child who demands the presence of his parents intermittently throughout the night whenever he happens to wake.

He was aware that this family had received generous portions of multidisciplinary time already, none of which seemed to have had much impact. In keeping with his normal approach, he invited the whole family to attend. In gaining a greater appreciation of the father's understanding of the problem, there was significant progress. It became clear that it was the father who was least able to tolerate his son's crying. He always attended to him when he woke, regardless of advice that he had been given by professionals. An investigation

of the intergenerational family history revealed that the boy had come to represent for his father his paternal grandmother, who had died shortly before the baby was born. Unresolved grief and personal guilt had contributed to a belief by the father that being allowed to cry would damage the boy. The 'ghost' of the paternal grandmother, in this case, had come to 'haunt' the nursery of the child in the present. Discussions around this theme led to the family – particularly the father - returning home with a remarkable new sense of freedom. This enabled them to empower the child to develop his own resources for self-soothing at night. This case showed how important the information of the father's history had proved in its resolution.

Paul Barrows suggested that the implications of this case hinted at how the neglect of the role of fathers in the development and maintenance of childhood difficulties within the psychodynamic tradition has been a marked and missed opportunity, and stated that this imbalance should be redressed. Rather than merely existing within a dyadic relationship at birth, infants are actually exposed to a complex matrix of social relationships, each of which has an impact upon their development, mental health and well-being. At the heart of this is the parental couple. How does the child envisage the relationship between these two important significant others? How does the child allow it's parents to come together, identify with this, and go on to develop their own mental map of parenthood? The parental relationship, whether it is healthy and adaptive or not, exists as a vital early model of social relatedness.

The second case study presented by Paul Barrows, continued the 'ghost in the nursery' theme (Fraiberg, Adelson & Shapiro, 1975), demonstrating how the parents' own experiences of childhood (in this case violence on the mother's side, and humiliation on the father's) influenced the way they perceived their child's behavior (in this case their two year old son's violent temper tantrums.) Their different childhood experiences gave them very different perspectives on how to respond to their son, and he represented different things to both of them. As this case developed it became apparent that the parents' own memories of childhood were being projected onto the child in the present, and that the father's ghosts were just as influential as the mother's. Again, to neglect the impact of the father, and his own personal history would have been an important oversight.

In his concluding remarks, Paul Barrows drew two implications. The first was that as professionals we should be aware of how tempting it might be to step into an absent father's shoes and replace him, rather than working hard to find out exactly what his influence is upon the family. Secondly, we were reminded of how an understanding of the way relationships are observed and internalized as representations of the world can in itself be used therapeutically. The modelling of self-reflection as a healthy and adaptive way of thinking about childhood problems can be a useful tool for families to take away with them both during and after therapeutic contact.

The second speaker, Dr Alia Parvin, a Clinical Psychologist in the community team in Tower Hamlets presented her research thesis, which explored Bangladeshi mothers' explanations of postnatal distress.

She began with a consideration of why cultural variation is important, particularly when thinking about the subjective experience of distress. More specifically, in preparing for her study, she noticed that there was a lack of research into how other cultures understand postnatal distress, or any consideration of how these ideas might map onto Western notions of postnatal depression as a diagnosis. Her starting point was the apparent lack of postnatally depressed non-English speaking Bangladeshi mothers in Tower Hamlets. She was interested in finding out why this was. Did postnatal distress not occur in this population, or was it that they simply remained undetected?

Alia Parvin's research has thrown some very interesting light upon the different ways that this phenomenon is thought about. She completed a qualitative study, interviewing non-English speaking Bangladeshi mothers referred for PND, and GPs with a specific interest in the condition. More specifically, she was interested in finding out how the accounts of these two groups of people compared/contrasted to one another in relation to their understanding and conceptualization of maternal distress.

In relation to childbirth, the mothers seemed to draw upon a cultural discourse that described the experience in terms of pain, illness and the importance of having plenty of time to recover from the trauma of having had a baby. This conceptualization of childbirth extended to the way they understood postnatal psychological distress – that it was caused directly by the trauma of the birth. This was placed within two explanatory frameworks:

1. Religious/Spiritual Framework:
This discourse presents postnatal distress as being the result of an individual having to endure a trial set by Allah, to test her faith (Fara). Alternatively, it may be the result of the 'weak and vulnerable' body being more susceptible to possession and spiritual exploitation (the Bai.)

2. Embodied Framework:
This discourse states that the mind is affected by the weakness of the body, and this is seen as an inevitable and understandable result of the 'physical trauma' of birth.
Alia Parvin suggests that one function of these frameworks is to distance the phenomenon from individual responsibility, and any resulting stigma associated with being unable to cope. Psychological distress is located as either

having been inserted spiritually, or caused by and expressed through the physical phenomenon of pain. She stressed that the 'embodied' concept is less like western notions of 'somatisation' and more like the concept of 'reactive depression.'

This group of mothers seemed to have very different expectations of what treatment was available to them, and often did not know that a diagnosis of PND had been given, what it meant, or even how they were being treated for it. They often referred to their medication as 'vitamins,' or asked for vitamins instead to help them. They saw psychological distress as a result of physical trauma, and did not consider that 'depression' could be why they felt unmotivated, tired, and lethargic. The idea of depression filled many of them with fear because they saw it to be a dangerous and terminal condition (this is in contrast to UK white mothers with PND who are often relieved to receive the diagnosis.) The mothers also had very different ideas about what constitutes a successful recovery – agreeing that to be better meant being more able to function physically, not necessarily feeling less psychological distress. They often attributed recovery itself as being the result of changes in social context (i.e., the baby became less difficult as it got older) or the result of prayer to Allah.

Alia Parvin's account was illustrated with some fascinating excerpts from the interview transcripts. She placed the research within a discussion that emphasized how wide the mismatch was between the understandings and meanings held by GPs and those held by the Bangladeshi women, specifically around what is meant by 'recovery.' She also stressed the importance of social context in understanding distress, particularly an appreciation of the extent and quality of the family support that might be available to a mother who has just given birth. Finally, we were asked to think about whether enough is being done to clarify the expectations and understandings held by our clients when they seek our support, and also whether enough is being done to consider how patients from ethnic minority communities might understand and think about the diagnoses and treatment strategies that are often taken for granted by health care professionals.

The two presentations were followed by a plenary session, consisting of the speakers, the two chairs and Allie Nolan (Sure start Coordinator in Tower Hamlets), Rosemary Loshak (Coordinator of services for children whose parents have mental health problems, a brand new Tower Hamlets initiative) and Dr Eleni Pilazidou (Adult Psychiatrist with an interest in affective disorders and intergenerational transmission.)

The plenary session began with a discussion about the themes generated by Alia Parvin's talk, specifically in relation to whether second- and third-generation Bangladeshi mothers have similar understandings of PND to non-English speaking mothers. Consideration was given to whether the increasingly stretched resources of the NHS contribute to an increasingly negative social context of childbirth for this group of women, and it was suggested that this might contribute to a higher incidence of postnatal depression in this community than is acceptable.

Attention was then given to Paul Barrows' statement about the neglect of the role of fathers in approaches to child mental health. It was agreed that whilst the psychodynamic model may have neglected this important aspect, other models such as Systemic Family Therapy, had not. Distinctions were drawn between models that base their understanding of child mental health upon the internal representations that the infant is developing during its formative experiences, and those that do not. Cathy Urwin commented that this understanding allows us to consider how the infant can trigger the 'infantile' experiences of the parents, making them think and behave in certain ways. Dr Julian Stern, Consultant Psychotherapist, also reminded us that some of the earliest work in the psychodynamic tradition did not neglect the role of fathers, and he cited Freud's 'Little Hans' case as an example.

In summing up, Neil Morgan invited us to think about whether Tower Hamlets is doing enough to address the needs of whole family systems within the context of inter-generational transmission. Comments from the floor included questioning whether enough is done to avoid increasing the numbers of children who are taken out of their families and 'looked after' by the local authority. It was noted that the new initiatives, such as the Looked After Children Team, and the new team being coordinated by Rosemary Loshak are both addressing these issues directly. Julian Stern also reminded us that specialist teams also serve to mask more profound defences within services, which ring-fence their admission criteria in order to avoid working inter-generationally. Allie Nolan noted that initiatives such as Sure Start promote preventative, community-based, non-pathologising approaches to mental health care of the whole family and it was agreed that this would seem to be a clear step in the right direction.

Dr Jonathan Wells
Clinical Psychologist

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President's Perspective

Peter de Chateau

In our bylaws the purposes of WAIMH are laid down in the following opening statement: "The Association has been organized to operate exclusively for scientific, charitable, and educational purposes", followed by a more detailed description. As we are now approaching our 25th anniversary and soon will be celebrating this happy occasion it perhaps is appropriate to discuss some of the issues connected with these purposes.I will address a few of the issues currently of great importance for our organization's development and the choices to be made for our future direction and growth. In particular it is useful and necessary to especially look into organizational matters: global representation within WAIMH at all levels,voting procedures for different committees and task-forces, the organization of our congresses and finally our cooperation with other international organisations and other bodies in our field.

During the last years there has been a lively discussion on the internal, organizational structure of WAIMH. The bylaws with their amendments, the business meetings and the meetings of the board of executives have been the vehicles for decisions influencing the changes in organization and membership representation. Especially the position and the role of the affiliates have been the subject of changes. (see also Brigid Jordan's, Bernard Golse's and my own contributions in earlier issues of the Signal.) The result of which has been a new and more influential platform for the affiliates, a new organization and place for their cooperation and their contributions to the Executive Committee and the Signal as well as a more distinct input in the program of our world congresses and in

the Journal. It is also wonderful to see the growing number of affiliates and we should work hard to achieve that this positive trend is continued and new members and new affiliates, especially in regions with underrepresentation, can find their way to join the globalization of WAIMH.

Voting procedures are characterised by a low degree of participation in our association. This seems also to be the case in many associations comparable to ours. However as we only have individual members, unlike many other international organizations with country members, and are a multidisciplenary organization not much can be expected to be changed in this respect. As our members unfortunately only in 10% use their democratic rights in different election procedures over time,we here do acknowledge a rather substantial problem. I therefore strongly would like to ask the membership to vote whenever invited to by WAIMH, to attend business meetings during our congresses, to actively participate in discussions and decisions within their own affiliate, and also to react and to write to members of the Executive Committee and other officials. As we are preparing the agendas for many Executive Committee Meetings, meetings with the Local Organizing Committee, the Program Committee, and the business meeting in Melbourne we would like to ask the members to let us know their proposals, ideas, and wishes so membership participation and democracy can increase.

Athough we are in the midst of preparations for Melbourne, we also have to look at the 10th World Congress to be held in Paris in 2006. The membership most certainly has a great

opportunity to influence what will happen and what it will be like there and then, organizing an international and multidisciplinary meeting with a low-budget has obviously over the years since 1980 become a more difficult, complicated, and financial risk. Pharmaceutical industries and other commercial and also public institutions are not very eager to sponsor meetings on very young infants' and children's mental health, since not much money can be made by doing so. Also our own attitude has over time been not to become dependent on commercial interests influencing perhaps the program and other activities of our congresses.In order to keep our association financially sound and independent our income is from the membership fees,the Infant Mental Health Journal and our world congresses. This last activity is by far the most dominant in terms of generating funds and therefore absolutely of vital importance. In order to ensure a high quality of congress presentations the work of the different Program Committees has been much appreciated by our members. Different wishes and expectations do however live in our membership due to its international and multidiciplinary composition.Here again our members do have a marvellous opportunity to make their wishes and expectations come true: make your voice heard at different opportunities and do not hesitate to contact our officers at a local or central level. Also ideas on how to improve and guarantee our financial health and future will be especially appreciated by us all.

Last but not least much work has to be done in terms of international exposure of our knowledge and ideas. Cooperation with other international associations in our field is an ongoing process that has resulted in informal meetings with representatives of those organizations, the presentation of official symposia at each others congresses and collaborative actions and points af view
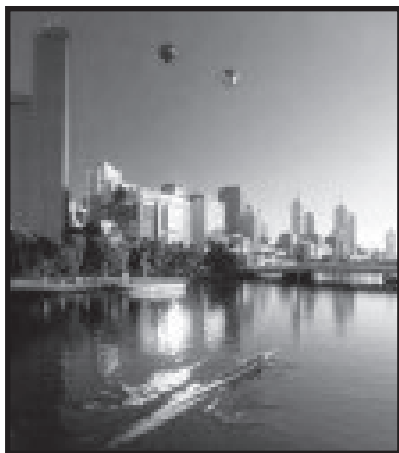
By the Yarra River
MELBOURNE 2004!

By Hiram Fitgerald,
Executive Director WAIMH

In just a few months, WAIMH will be deeply involved with its 9th World Congress in Melbourne, Australia. The program committee has crafted an exciting program that promises to keep all participants actively centered on infant mental health issues delivered by way of pre-congress institutes, clinical teach ins, plenary speakers, symposia, workshops, poster sessions, poster workshop, and video sessions, conversation hours, and mentor luncheons. Plenary speakers are James McHale, Joy D. Osofsky and Cindy Lederman, Antoine Guedeney, Alicia Lieberman, Kaija Puura, and Peter de Chateau. Program activities provide vivid evidence that the field of infant mental health is both vigorous and diverse. And when the intellectual feast draws to an end, there are countless opportunities for all family members to relax and refuel.

Yarra Valley
Go north east to visit Healesville Sanctuary and view koalas, kangaroos, wombats, platypus, dingoes, emus, and Tasmanian Devils. Enjoy on-site tastings at 38 wineries, stay at any one of 71 hotels, and enjoy the valley's many parks, crafts and antique shops.

Macedon Ranges
Go northwest to the Great Dividing Range, to take in one the most beautiful wine regions in Australia, featuring chardonna, semilion, pinot noir, shiraz, and cabernet wines.

Werribee Park
Interested in tranquil beauty, visit one of Victoria's largest private residences, with over 4,500 roses forming a center piece of one of Victoria's finest gardens.

Phillip Island
Go 90 minutes southeast and visit with Koalas from treetop boardwalks at the Koala Conservation Centre, get close to seals at the Seal Rocks Sea Life Centre at Nobbies, and in the evening join the Penguin Parade and watch little Penguins cross the beach on their way to their burrows in the sand dunes.

Great Ocean Road
Beginning at Torquay, enjoy 300 kilometers of spectacular coastline, and at Port Campbell National Park view the Twelve Apostles and the Loch Ard shipwreck.

Murry River
Go 50 kilometers east and ride the Murray River Paddlesteamer while viewing majestic river red gums, Cockatoos, and Galahs. Train buffs can hop on the Puffing Billy steam train for a 13 kilometer ride from Belgrave to Emerald Lake through the beautiful Blue Dandenong Ranges National Park.

In Melbourne
Visit the Queen Victoria Market, a century (1878) old center of trade and commerce that spans 7 hectars and hosts fabulous foods and wines as well as clothing, fabrics, flowers, jewelery, handicrafts, and artefacts. Find aboriginal art at the Aboriginal Gallery of Dreamings, walk through the extraordinary Royal Botanic Gardens, established by Charles La Trobe in 1945, or try the Fitzroy Gardens and Captain Cook's Cottage. Children will especially be awed by the Melbourne Acquarium. Melbourne was founded on a site historically occupied by Aboriginal Koorie tribes. The Yarra river, named from the Aboriginal words "Yarra Yarra" (running water), is a focal point for much of Melbourne's cultural life.

Combining the clinical and scientific program with Australia's unique history will make this World Congress one to truly remember. Located in the South Pacific, Australia is equally accessible from nearly any part of the world. Melbourne's 2000 restaurants and 70 different national cuisines provide justification for its reputation as Australia's culinary capital, just as its glorious parks justify it as the garden capital. January is summer with average temperatures ranging from 26C (79F) to 14C (54F), and with more hours of sunshine than many other countries in the world. Congress attendees will need to have a valid passport and a visa.

All members of the WAIMH Board of Directors, the Scientific Program Committee, and the Local Arrangements Committee look forward to greeting you in Melbourne and working with you as we collectively examine "The Baby's Place in the World."

in situations of mutual interest. Still much work has to be done to improve these possibilities in which the membership can be very helpful. This holds true also for collaboration at a global level. Our knowledge of improving mental health conditions for infants, young children, and their families is unique. Oue voice is however very seldom heard at a worldwide level. WAIMH should make a priority of changing this state of affairs and see to it that channels can be found to diffuse our solid knowledge to a high level of international organizations in order to promote our view on the conditions under which many of the youngest and their families live worldwide today.

In closing, I would once again like to ask you all kindly to react to my ideas, which you are very welcome to do at WAIMH's central office or directly to me at peterdechateau@yahoo.se.

WAIMH 9th World Congress
January 14-17, 2004
Melbourne, Australia

REGISTRATION:
For your convenience, program information together with on-line registration and accommodation forms are posted on the Congress website **http://waimh.org/ Information_2004.htm**

HOTEL: http://waimh.org/Information_2004.htm
On-line accommodation bookings will not be accepted without an accompanying credit card payment. Payment of fees must accompany all registration forms, and confirmation will not be forwarded until receipt of payment.

WAIMH MEMBERSHIP:
Please visit our website at **http://waimh.org/Information_2004.htm**

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