Australian Association for Infant Mental Health

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NEWSLETTER

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FROM THE EDITOR:

Still with you, it would appear, due to the overwhelming enthusiasm by the National Executive to continue my tenure in this capacity I am delighted to have the opportunity to grace your senses once again. To all those responsible for the recent conference in Adelaide, Congratulations on a stimulating and rich program! I would like to take a small liberty and thank, and I'm sure to have a resounding echo, the tireless efforts of our recently departed National President, Elizabeth Puddy. Elizabeth, your non-presence at the recent telephone conference was sadly missed. Thank you for your enthusiasm, encouragement, good humour, selflessness, exuberance and grace. Bon voyage. Congratulations to Michele Meehan (Victoria) for being brave enough to step into a very large pair of boots.

It is my pleasure to inform you that this will be the final Newsletter, in this form, that you will receive. From this edition the Newsletter will be available to you online via the web site at www.aaimhi.org. Please be sure to read the letter to members that you received with this Newsletter so you know the steps to accessing your Newsletter online. For those members who wish to receive their Newsletter in hard copy you will need to complete the section in the letter and return it to me at the given address. The process of creating the web site has taken a considerable effort and, on behalf of the National Executive I would like to express a vote of thanks to Pam Linke, without her tireless commitment this exciting step into cyber existence would not have been possible. I'd also like to acknowledge the support and work of David Lonie and Vladimir Tretyakov, thank you.

Welcome to yet another thought provoking edition. In this edition, for those of you who missed this year's conference in Adelaide, you will find the Winnicott Lecture given by DR Kent Hoffman as well as the presentation by DR Astrid Berg. Once again I have included our position on Controlled Crying to meet the demand for the growing interest in our position. There is a message in the Network News section from our newly appointed National President.

As a final word; please keep a look out for your invitation to the forthcoming World Congress in Melbourne this January, it's shaping up to be a knockout experience – not to be missed!

Best wishes,
Victor Evatt.

2003 CALENDAR OF EVENTS

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

9TH WORLD CONGRESS
January 14 – 17, 2004

Theme: The Baby's Place in the World

The University of Melbourne

Information:

WAIMH website: www.msu.edu/user/waimh/

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- AAIMH Position Paper

CONTROLLED CRYING

By: Australian Association for Infant Mental Health

Introduction

The Australian Association for Infant Mental Health aims (in part):

- **To improve professional and public recognition that infancy is a critical period in psycho-social development, and**
- **To work for the improvement of the mental health and development of all infants and families.**

Definition:

Controlled crying (also known as controlled comforting and sleep training) is a technique which is widely used as a way of managing infants and young children who do not settle alone or who wake at night. Controlled crying involves leaving the infant to cry for increasingly longer periods of time before providing comfort. The intention of controlled crying is to let babies put themselves to sleep and to stop them from crying or calling out during the night.

AAIMHI is concerned that the widely practiced technique of 'controlled crying'is not consistent with what infants need for their optimal emotional and psychological health, and may have unintended negative consequences.

Background to AAIMHI's concerns

- This statement is premised on an understanding of crying to mean crying that indicates distress, either psychological or physical, rather than the "fussing" that many babies do in settling or adjusting to different circumstances.
- Babies have to adapt to a totally new world and even small changes can be stressful for them. Leaving babies to cry without comfort, even for short periods of time, can be very distressing to the infants.
- Crying is a signal of distress or discomfort from an infant or young child. Although controlled crying can stop children from crying, it may teach children not to seek or expect support when distressed.
- Infants from about six months of age suffer from differing degrees of anxiety when separated from their carers. This continues until they can learn that their carers will return when they leave, and that they are safe. This learning may take up to three years.
- Almost all children grow out of the need to wake at night and be reassured by three or four years of age, many much earlier than this.
- Infants are more likely to develop secure attachments when their distress is responded to promptly, consistently and appropriately. Secure attachments in infancy are the foundation for good adult mental health.
- Infants whose parents respond and attend to their crying promptly, learn to settle more quickly in the long run, as they become secure in the knowledge that their needs for emotional comfort will be met.
- The demands of Western lifestyle and some "expert" advice has led to an expectation that all infants and young children should sleep through the night from the early months or even weeks. In fact infants have the potential to arouse more often in the night than older children or adults because their sleep cycles are much shorter. These short sleep cycles allow infants to experience more REM sleep, which is considered to be important for their brain development.
- Many parents become distressed and exhausted when their infants and young children cry at night, in part because of the physical strain of getting up and going to their babies to re-settle them, and sometimes in part because of the unrealistic expectation that babies "should" sleep through the night.
- Many infants and parents sleep best when they sleep together. There is no developmental reason why infants should sleep separately from their parents, and in most of the world infants do sleep with their parents or other family members, either in the same bed, or in a cot next to the parents' bed. Co-sleeping with infants should never occur when a parent is affected by drugs or alcohol, or where the bedding is overly soft. [All parents whether co-sleeping or not should check current information regarding safe sleeping for infants to avoid risk of SIDS eg http://www.sidsaustralia.org.au/]
- Many parents find controlled crying helpful and this is one of the reasons for its popularity. For other parents it does not work, or causes so much distress for the parent and the infant that it is discontinued.
- There have been no studies, to our knowledge, such as sleep laboratory studies, which assess the physiological stress levels of infants who undergo controlled crying, or its emotional or psychological impact on the developing child

Australian Association for Infant Mental Health - Controlled Crying Principles

It is normal and healthy for infants and young children not to sleep through the night and to need attention from parents. This should not be labelled a disorder except where it is clearly outside the usual patterns.

- Parents should be reassured that attending to their infant's needs/crying will not cause a lasting "habit".

- Waking in older infants and young children may be due to separation anxiety, and in these cases sleeping with or next to a parent is a valid option. This often enables all to get a good night's sleep.
- Any methods to assist parents to get a good night's sleep should not compromise the infant's developmental and emotional needs.
- If "controlled crying" is to be used it would be most appropriate after the child has an understanding of the meaning of the parent's words, to know that the parent will be coming back and to be able to feel safe without the parent's presence. Developmentally this takes about three years. This varies between children and observing children and responding to their cues is the best way to assess when a child feels safe sleeping alone.
- A full professional assessment of the child's health, and child and family relationships should be undertaken before initiating a controlled crying program. *This should include an assessment of whether in fact the infant's crying is outside normal levels.* All efforts should be made to link parents with community supports to minimise the isolation and frustration felt by many parents when caring for a young child. Other strategies, apart from controlled crying, should always be discussed with parents as preferable options.
- If an infant or child has already experienced separation from a parent due to sickness, parent absence or adoption, or if he or she becomes very distressed the method should not be used. This is because children who have already experienced traumatic separation are more vulnerable to negative effects from the kind of stress caused by controlled crying.
- Where parental stress due to infant crying may lead to risk of abuse it is essential that parents are linked with social supports and therapeutic intervention.
- Parents should be told that the method has not been assessed in terms of stress on the infant or the impact on the infant's emotional development.
- Where it is used recommendations should be for exercising caution and playing safe.
  For example,
  -paying attention to level of distress rather than number of minutes baby has to be left to cry
  -not continuing with any technique if it does not feel right.

LIST OF REFERENCES:

The references below are not specifically to studies on the impact of controlled crying on infants because there are no records of such studies. They are general background information related to sleep and to understanding children and stress.

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SUGGESTIONS FOR ALTERNATIVES TO CONTROLLED CRYING:

There are a number of suggestions on Dr William Sears Website:www.askdrsears.com. He also has a number of helpful books, including "The fussy baby" , "The Baby Book" and "Nighttime Parenting".

Fleiss, P. M. ,Hodges, F.M. Phil. D, 2000, Sweet Dreams: A Pediatrician's Secrets for Your Child's Good Night's Sleep, Los Angeles: Lowell House,

McKay, Pinky - "Parenting from the Heart" and "100 ways to stop crying".

Hope, M. (1996) For Crying Out Loud!: Understanding and Helping Crying Babies Randwick: Sydney Children's Hospital

The 'Natural Child' website has a wide range of articles for parents. www.naturalchild.com

Pantley, Elizabeth "The no-cry sleep solution" NY Contemporary Books, 2002

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Australian Association for Infant Mental Health
November 2002

- AAIMH Conference Publications

Building Bridges:

Parent-Infant Psychotherapy in a Community Clinic in Cape Town, South Africa

Astrid Berg, Adelaide, July 2003

Introduction

I want to thank Anne Sved Williams for having invited me to participate in this conference. Your theme of building better beginnings by placing work with infants in context is in the forefront of infant mental health.

Despite the many differences between Africa and Australasia, there is a universal common humanity which connects us all, so that I trust that what I have to say may also be applicable to your situation here.

I would like to acknowledge and pay tribute to the work done by Frances Thomson-Salo and Campbell Paul at the Royal Children's Hospital in Melbourne (Thomson-Salo et al). It is their work, together with that of Johan Norman (of whom I will talk later), which first made me conscious of one of the therapeutic factors in our own parent-infant work in South Africa. While Frances and Campbell work with infants from or at the Children's Hospital, the work I am presenting here this morning, is in the community. However, our approaches are very similar and it is gratifying to know that we have come to the same conclusions.

I will start this paper with some clinical aspects of parent-infant psychotherapy. I want to begin with what we know and are familiar with and then move on to the challenges that face any one who enter a community which is different to one's own.

Parent - Infant Psychotherapy

Parent-Infant Psychotherapy is a new category of psychotherapy, so much so that its actual naming is not fixed. Some authors refer to infant-parent psychotherapy, (Lieberman et al,2000 and Fraiberg, S.1987), others to parent-infant psychotherapy. (Stern,1995).

In my view the emphasis can fall on either side, so the name would change with each case. The point is that the two belong together – as Winnicott has stated in his reference to there being no baby without a mother. The main thrust of this paper will be on infant-parent psychotherapy, though I have another case which I could show you which is more parent-infant psychotherapy.

Definition:

The definition of this category of psychotherapy I have chosen to use comes from Lieberman et al (2000:472)
"Infant-parent psychotherapy aims at protecting the infant-toddler mental health by aligning the parents' perceptions and resulting caregiving behaviours more closely with the baby's developmental and individual needs within the cultural, socioeconomic, and interpersonal context of the family."

- It places the emphasis on the preventative aspect of this work – "protecting the infant-toddler mental health"
- The "aligning" of the parent with the baby is the crux of the therapy – it does not necessarily mean long term therapy where there is the hope of structural change in the person or the system.
- It underlines the context of the family – culturally, socio-economically and interpersonally.

Core Concepts:

The therapy of the parent-infant relationship is a relatively new terrain. Stern (1995:3) has named it a "new 'patient', never before encountered, [it] is not a person, but a relationship,..between a young baby and his parents." This relationship is the focus of the therapy. Selma Fraiberg who was the originator of infant-parent psychotherapy was guided by psychoanalytic principles (1987:139). The psychotherapy is aimed at uncovering childhood sources of unconscious conflicts in the parent so that the parent is freed from repeating her childhood tragedy with her baby. (ibid: 101)

As parent-infant psychotherapy evolved, it became evident that with this "new patient" the present exists in its own right (Liebermann, 2000: 474) and is not only a mirror of the past. The birth of a baby heralds a new era for the parent, one that he/she has never experienced before. Both infant and parents are in "the throes of the greatest and fastest human change process known: normal early development". (Stern, 1995:3) As the infant's brain is pre-programmed to grow and make connections, so the parents' are open to changes and input and thus more flexible than at other times in adult life.

Thus, this is a new beginning and although much of it is built on the parents' past, there is also a new-ness, a sense that we can start on a clean page and write the story differently.

One of the key concepts in this work is that there are different points of entry into the system.

Ports of Entry

The clinical situation of parent-infant work consists of different elements (Stern, 1995). Let us look at these more closely:

At the very centre is the interaction between the mother and her infant. This interaction can be observed by a third party. If we work from a purely behaviourist model, this is all we need – the actions between mother and her baby and simply altering these, for example, pick the baby up if she cries, with no question as to why the mother may be withholding comfort.

However, human beings are not computers, but have remembered histories, personal interpretations and feelings around actions. These are the internal representations. Thus mother's representations would consist of how she subjectively experiences and interprets the events of the interaction we are seeing. For example the crying baby may represent for her a part of herself which she denies and thus ignores.

Mother is not the only one who is forming representations – so is the baby, although its history is of course much shorter than mother's, there is less "baggage". As I am hoping to show you, the baby is avidly and actively involved in constructing representations of the interactions. For example, our crying baby may quickly learn that there is no point in crying, as it will be ignored, and thus she literally shuts up and shuts down. Her internal representation of her mother is thus built around not showing distress, the beginnings of the Winnicottian "false self".

The final addition to the clinical situation is the therapist, who also has representations and actions – more actions than in other forms of therapy. He or she may or may not pick up the baby (depending on the culture – as I will show), but the therapist will hopefully respond from a place that sees the baby's distress and realises that action is needed.

I am very aware that a crucial person has been left out of these schemes – namely the father. The role of the father has been neglected and it is receiving increasing attention. However, in the cases I see at the community clinic, the fathers are sadly strikingly absent – not only in the actual clinical situation, but also in the lives of the mothers and babies. The father however has a powerful presence in the mind of the mother and it is often this – the "father in the mind of the mother" – that is the prime determinant of the representation the mother has of her infant.

Now, where is the port of entry into this system? The focus has traditionally been on the parent as the port of entry into the system. That is, the representation in the mother's mind of her infant - how she views and experiences her baby - are taken up and worked with. If these can be transformed, she might be able to alter her actions. In our example, the therapist may ask the mother who this crying baby represents for her, why she is finding it so difficult to pick her up and soothe her.

Focusing on the infant's inner world, and focusing on the therapist's relationship with the infant, is a more recent development. Infant-led psychotherapies are receiving increasing attention. (Paul, 1997) This is in part a direct result of the research findings which show the capabilities which infants have to make links with the other. (Urwin, 2001, Trevarthen, 2001) I would like to add, from my own experience, that this universal ability of infants makes talking to the infant a meaningful port of entry in a transcultural setting.

The situation in Cape Town

I now want to take you to Cape Town.

1995 was the year after the first democratic election in South Africa. The new country was in its beginnings and it was perhaps not by chance that the first conference on Infant Mental Health was held in Cape Town. This turned out to be a most stimulating and productive event and it was the start of many creative endeavours in Cape Town. It was the beginning of the Western Cape Association for Infant Mental Health, an active, multidisciplinary group that meets on a monthly basis and which organised the second conference in April of this year. Since 1995 there has also been a large research project done in conjunction with Reading University on intervention in post-partum depression was started and is ongoing. Then there is the University of Cape Town Parent-Infant Mental Health Service which I initiated and am responsible for. This clinical service is for children under 3 years old and is based in two places: one in Rondebosch, where the Children's Hospital is situated and which draws on a wide socio-economic spectrum of patients. The other is in Khayelitsha, the largest informal settlement outside of Cape Town. It is here where the real challenges lie.

The work in Rondebosch is much like I imagine work at any Child Psychiatry Unit in Europe. There is a reception area with staff, consulting rooms, playrooms, and a steady team that fills the building. The patients are seen as per appointment, the week is scheduled to the hour for every person working there. Regular team discussions are held where case material is presented in detail and where academic input is part of the course.

It is reliable, predictable, and known. It is embedded in the long history of similar units all over the western world.

Khayelitsha is a sprawling township, about 11km from Metropolitan Cape Town, adjacent to the International Airport. It lies in the so-called Cape Flats – an outstretched area between the mountains of the Peninsula and those of the lush winelands of the Cape. It has spectacular views onto both sets of mountain ranges, but on the ground the soil is poor and sandy, it is water logged because of winter rains, desert like and dusty because of summer winds.

Its inhabitants are Xhosa speaking people who have moved from their former "homeland", now the Eastern Cape, to the city in search for employment, better education and health care. Mostly the family, especially the elders, remain behind in the traditional homestead while the young people, young mothers flock to the urban areas. Housing is in make-shift shelters, which, as time passes may be turned into houses made of bricks. The ties to the homelands remain strong and funerals and holiday periods are usually spent in the Eastern Cape. Reverence for the ancestors is the basis of the traditional cultural cosmology.

When I went into Khayelitsha for the first time in my life in 1995, I realised how well the policy of Apartheid had worked in keeping us all apart. I was accompanied by Nosisana Nama, and later Nokwanda Mtoto – my two co-workers who have been with me ever since. They act as my guides, mentors and translators. The relationship is one of mutual respect and acknowledged dependence. I spend one morning a week in Khayelitsha at a well-baby clinic where immunization takes place. Obtaining this space took a long time and we as a team had to go through many disillusioning and frightening experiences in the community before we were able to find this safe base. We have called our Service the *Mdlezana Centre*. This is a Xhosa word depicting the early bond between mother and child, when they are still one unit – equivalent to the Winnicottian term of the state of primary maternal preoccupation.

The presenting problems in the infants that have been referred to our Service are:

failure to thrive, developmental delay, depression and more of late, HIV infection in both mother and child.

These clinical categories are of course limited, in that they fail to convey what I and my 2 co-workers feel with so many of the mother-infant dyads we come across. I would like to expand on my own inner responses by looking at my

Counter - transference

I am using the term here in its wider sense: "..to include everything in the analyst's personality liable to affect the treatment.." (Laplanche et al) It is particularly important to recognise these feelings in oneself when talking about intervention with patients who in many ways are so much "other". I also want to share these with you, as they may be a reason for why I am looking at this topic of "Talking to the Infant" in more depth.

1. The complex layers of guilt which many white South Africans experience needs to be acknowledged and confronted – the guilt is on personal and collective levels.
2. The feeling of being overwhelmed by the sheer numbers of children and infants one sees in the clinic as well as outside.
3. The sense of despair and hopelessness one encounters in the face of the extraordinary numbers of problems that so many mothers have to deal with.
4. Then there is the anger and frustration at the perceived passivity I often see, particularly in the teenage mothers – this is not depression, but more a sense of waiting for something, somebody from outside to come and provide help.

These internal responses are powerful and may make me want to give, in an acting-out manner. The unbearableness is often too great to hold and contain through thinking and reflection, and may precipitate me into doing something.

The guilt may lead to an impulse to reparation – but because the guilt can be so deep, the impulse can lead one into a correspondingly "high" omnipotent position, with the narcissistic gratification of "doing good".

Added to the above personal responses, is the underlying awareness of the cultural roots of my patients. I am mindful of not wanting to continue or to repeat the western colonisation – psychological occupation can be much more damaging than physical occupation (Kareem p.33)

Trans-cultural considerations

I do not consider the western methods of child rearing superior to those of Africa, nor do I know better as to how to deal with babies than the mothers I see, of whom many are doing what they are doing because of customs that go back to many generations.

At the same time I have to be aware of inverse racism (Ellis, p.66), which may inadvertently allow neglect and abuse of the infant, under the guise of being "cultural". Cultural difference should not be used as a defence and an excuse for doing nothing. (eg no depression in mothers)

The question I thus ask myself is the following:

What of the culture that I know can I convey to mothers and infants of a different culture, but who live in the same city and have aspirations for their children in much the same way that I have? What can I say to them that will not be an assumption of superiority of the western culture?

Another way of asking this would be
What about infants spans across cultures? I would like to suggest 3 notions:

1. The human capacity for making links, and for symbol formation, of which language development is one important manifestation. Stern describes how parents attribute their infants with intention right from the very beginning of life – and they do so mainly through language. (p.43)
2. The personhood of the infant. When an infant becomes a person varies from culture to culture and often this is punctuated by ceremonies. In the Xhosa culture, the infant is seen as a person from the beginning, though the baby and young child's independent rights are not generally recognised. The notion of personhood may be lost when the mother is burdened, as would be the case with a depressed mother in western culture. I would venture to say that if there is a good probability that the infant will survive physically, the infant should be regarded as a person from the beginning, no matter what the cultural context may be. After all, cultures are not static, but should be evolving as science evolves.
3. Thirdly, I want to turn to some of the current neurobiological research which all shows that the maturation of the brain is experience dependent. The interface of nature and nurture occurs in the psychobiological interaction between mother and infant. It is the mother-infant relationship that is the "first encounter between heredity and the psychological environment." (Shore, 2001) Early interpersonal events impact on the structural organisation of the brain - thus the interpersonal environment, and more specifically the attachment relationship, can be either growth facilitating or growth inhibiting. The growth of the baby's brain

literally requires brain-brain interaction. The regulators of both infant's and mother's brains are located specifically in the right limbic brain. These "conversations between limbic systems" constitutes a biological unit, an attachment that satisfies deeply emotional motives. Play and talking between mother and child may have direct trophic effects on neuronal and synaptic growth. The right hemisphere is developing maximally during the first 18 months of life – this is the part of the brain which is specialised for the processing of socio-emotional information and body states.

Thus, talking to the infant is validating at the very minimum the above three assumptions. That is, we are supposing that the infant is understanding, at some level, what is being said to him or her, that we are conferring personhood onto the infant by calling him/her by name and thinking about his/her situation and that we are literally stimulating neuronal and synaptic growth.

Infant - Parent Psychotherapy

In her much quoted paper *Ghosts in the Nursery* Selma Fraiberg describes how the two therapists involved with Mary and her depressed mother struggled not to give in to their wish to "pick up the baby, and hold her, to murmur comforting things to her. If they should yield to their own wish, they would do the one thing they feel must not be done." They feared that the mother would feel even more threatened in her role as mother if the therapists could be seen to be doing it "better". (p.105) The main traditional view has thus been of observing the mother-infant relationship, and of talking to the mother about her fantasies. By making the infant him/herself the primary port of entry, we are adding a very significant dimension to the above.

A psychoanalytic case

Johan Norman's paper "To Talk with Infants – The relationship between baby and analyst as a port of entry into the Mother-and-Baby-relationship" is provocative in that he talks with 6 month old baby Lisa in much the same way as he would do with any analysand.

Lisa's mother had asked for help with her infant daughter who was refusing to meet her eye. The history revealed that, after a relatively good start, mother became severely depressed when Lisa was 2 months old. This required hospitalisation which lasted for 2 months. Lisa was looked after by her father and a nurse. When mother returned, she felt that Lisa did not know she was her mother and she felt very rejected by her daughter.

When Norman saw mother and child for the first time he was struck by Lisa's avoidance of her mother and mother's inability to hold Lisa on her lap. "I said to myself that I really had got into a situation where I didn't know what to do. It would certainly take a long time to help the mother to come out of her depression and meanwhile the child's relationship with her mother would have become internalised as a split and frightening relationship. The difference in the flow of time between mother's slow, depressed mind and baby-Lisa's rapid mental development was a crucial problem. Mother was absorbed in her mood and unresponsive and Lisa needed immediately a responsive relationship with her mother. It was a situation of emergency."

What follows is a poignant description of how Norman turned to Lisa and addressed her saying: "'Halloo Lisa, my name is Johan', and I said to her that her mother had asked me to see if we together could try to understand what it was that disturbed them both so much." While he initially felt strange in talking to an infant like this, he soon realised that this was actually working. Lisa looked attentively at him, looked him in the eye and his verbal comment to what he could see, hear and experience felt like subtitles to a drama. When Lisa began to whimper he felt pain and fear and his formulations were based on his emotional images of what was going on. "I said that I knew that Lisa's mother had been away from her, that her mother had been in hospital and in fact had disappeared from Lisa; that Lisa now rejected her mother; that Lisa was full of pain and fear when she saw her mother; that she tried to avoid her mother, as if her mother was ruined; that Lisa was afraid of her ruined mother." " I tried to find words to express my images and to describe what we were doing in the session. The session continued in this way and Lisa began to turn toward her mother's body, seeking her mother's shirt with her mouth, pulling and biting, and then began to cry. The situation was frightening as Lisa's mother looked very pained. She looked out of the window and her response to Lisa was rejection. She did make some efforts to comfort Lisa but they were superficial and without emotional presence. But Lisa continued her efforts to reach her mother.

When we came to the end of the session I had got the impression that Lisa and I had created a relationship in many ways similar to the usual analytical relationship, that she was able to work very hard, that the sessions involved a process, and that we ought to continue."

He saw Lisa with her mother for 3-4 sessions per week over the following 4 weeks.

Lisa's demands towards her mother intensified and at times seemed overwhelming, but slowly mother was able to respond. The analyst's emotional presence expressed through his verbal formulations and his non-verbal expressions, made it possible for all to stand the intensity of the pain. Gradually the storms of emotion and pain calmed down, and Lisa and mother were able to look at each other. And mother's depression lifted – Lisa's rejection of her was such a narcissistic blow, that it had delayed her recovery.

Norman makes several points in his comments on the process of this intensive therapy. I want to highlight 3 of these:

1. "Lisa made a distinction between the emotional link to her mother and to me."
2. "Lisa could accept paying attention to me when I was talking to her."

The ability of the baby to differentiate between two people, especially mother and another person, has been amply proven in infancy research. The ability to discriminate is seen in its defensive form with avoidance, as described by Fraiberg. The survival value of this defence is evident in Lisa's case and also in the case I will describe later.

3. Norman then discusses the importance of words when dealing with a pre-verbal patient. He distinguishes between the lexical and non-lexical meaning of words. By the latter is meant the gestures, the music of the voice and body language.

Well mothers are able to intuitively attune to their infant and can do so without actual words. Perhaps as therapists who are not the mother of the baby we need our analytical tools of words in order to connect affectively with the infant. Norman makes this point when he talks of the "analyst's sincerity" and "I myself need the verbal expression as the music of my voice and the dance of my gestures will be a more precise expression of what I mean when they are a part of my verbal expression." I would also like to refer to Rayner's paper *Matching, attunement and the psychoanalytic dialogue* in which he so lucidly describes the "affective duet" – the interplay between preverbal attunement and verbal communication.

The case of Lisa is of a particular nature in that we have a mother, who, despite her profound depression is able and willing to bring herself and her baby to daily sessions. She is also able to tolerate the intensity of the pain that is evoked in her child and herself. In addition we have an analyst who is available for this profound psychological work.

The community clinic situation

In returning to my situation in Khayelitsha there are of course stark differences, and the population is "hard to reach" from the western psychoanalytic perspective.
1. I can at best see mothers for half an hour once a week. I can never be sure whether they will return for their appointments – the reasons for this are varied, and are only sometimes due to resistance in the analytic sense.
2. There is the language barrier which is a major handicap for me. Although I am in the process of learning Xhosa and am able to understand bits, I am completely reliant on my co-workers to act as interpreters. We have to work together on many levels, because it is not just requesting certain information from the mother, but also for them to correct me when I am overstepping a cultural boundary. Even if I could speak Xhosa fluently, the language used in psychoanalysis, the assumptions we make about the origins of psychic conflict, are often far removed from the individual's outer experiences and inner life.
3. I also have to accept that there are physical gestures that are syntonic with the culture, but not with me personally. For example, Nosisana, my co-worker, would spontaneously take the baby from its mother and interact with it – doing exactly what the 2 therapists mentioned in Fraiberg's paper were restraining themselves from doing. I was initially taken aback, but did not stop her. I observed that the mothers did not seem to object at all and I have come to understand this. In traditional African culture (and I can generalise here) the sense of community outweighs the right of the individual – an older woman is seen as "a mother" to anyone younger than she is. (my personal experience)

If "umama" picks up a baby from the younger mother, she is in fact doing the correct thing and is showing her caring – she, as the older woman, should show the younger woman how to do it.

The most important leap to make as a therapist is awareness of the relativity of one's own culture, and the reality of another culture. If one can enter the situation with an open mind, learning from the experience becomes possible and from that principles of intervention can be formulated.

Despite the shortcomings which the irregular visits and my inability to speak Xhosa entail, my team and I have come to rely more and more on the power of talking to the infants as an important point of entry into the mother-infant dyad.

I would now like to show you two brief clips of video tape of two 3 month old infants. They were filmed during a research project where the mothers were given instructions to play and be with their babies for 20 min, but to try not to breastfeed. (I apologise for the simplicity of the technique of the tape)
The two mothers are completely different. The first mother says nothing to her baby, the second mother talks all the time – when translated, it read like an epic poem.

I ask you to note the following ways in which this mother contains her baby:

- The rhythmicity in the mother's verbal and non-verbal communications: her repeated phrases, the clicking sounds, the bodily movements.
- The manner in which she confers personhood onto her infant: she situates him in his greater family context by reciting his clan names.
- Her identification with his hunger – how she gives words to his frustrations and feelings of anger.

I would now like to come to my cases which, in conjunction with the above, made me conscious of the effectiveness of talking to the infant.

Case 1

Xolani Mkize,3 months old, came to us with his 17year old mother, also in February.

Mother was part of the Iron-deficiency study and concern was expressed re mother's disconnected interaction with her infant on the video.

Xolani is this young mother's first child. She ran away from her home with a friend to come to Cape Town. The friend got married and she had to leave the home they were sharing in Khayeltisha. In the meantime she fell pregnant, but the boyfriend is not supportive. She is now staying with another friend and her husband. She has made contact with MGM and is hoping to return home at the end of this month.

Xolani is an attractive baby who was initially serious and did not make eye-contact readily. When he was picked up by Nosisana he responded to her talking to him. Mother was told that he needs to be spoken to – "to praise him in his own clan" (which is Kabozile) His name, Xolani, means that mother was hoping for peace with her family.

Mother was shy or embarrassed about our interaction with her baby – but when she was seen outside, she had him lying in front of her and she was talking to him in an animated way.

We were concerned about mother's intellectual abilities, and supported her going back to MGM who has apparently forgiven her daughter.

DIAGNOSIS:

Maternal Depression in a young mother, separated from her family of origin

We saw them again 2 months later, in April. Mother seemed less depressed and was smiling when Nosisana picked up her baby. She took delight in him, and he was well-fed. "She is not embarrased by us praising him." Her depression also had lifted and Xolani was more responsive. At not even 5 months he was sitting steadily on the floor, unaided. When he was picked up by Nosisana, he was jumping up and down on her lap, and the conclusion was that "someone is doing this with him". Mother also imitated Nosisana who was helping Xolani hold a little doll.

We discharged mother and child and told them of our weekly availability.

Case 2

Kwanga Ngcaba was 5 months old when he was referred to us in February of this year. His mother is 21 years old.

He was referred because of a drop in weight about 2 months ago. Kwanga had gastro-enteritis and had not picked up his weight since then, although the symptoms had ceased.
He is mother's first child. The maternal grandmother is living in Eastern Cape. This young mother was "drifting from aunt to aunt", as she had no fixed abode here in Khayelitsha. Her boy friend, that is the father of the child, was also not really present and she was entirely dependent on the aunts.

She stopped breast-feeding when he was 1 month old, because the baby "did not want to". It seems that the bottle feeding and the gastro-enteritis contributed to the drop in weight. Mother denied any other problems, said she loves her baby and that she herself is eating and sleeping well. These few facts we elicited with some difficulty.

Observations:

This young mother was well-dressed, as was her baby. She would give him a pacifier when he cried. (this is a very rare habit, as usually the breast is given for comfort) Kwanga was quite a thin child. Mother was cut-off from him, and avoided eye-contact with the interviewers and with her baby. I felt that her eyes were "drifting" like she was with her life. My team and I had a sense of hopelessness when we heard this story and when we saw the non-interaction and wondered what we could do. Because mother denied any negative feelings, it seemed pointless to be empathetic.

After a while Nosisana took Kwanga, put him on her lap and talked to him. He needed to be coaxed to respond, but eventually did so with a smile and physical movements. Mother did not take any delight in this, and looked away. However when her problems were addressed, she did look at Nosisana more steadily. I asked Nosisana to turn Kwanga to look at his mother, but he avoided her – he rather looked at me and Nokwanda, my other co-worker. He was returned to mother, and she now, for the first time held him facing her and smiled at him, and it appeared that he met her gaze (I could only see his back). Mother was given our pamphlet which explains the importance of interacting with the baby.

I made the diagnosis of depression and deprivation in mother and baby who presents with failure to thrive. We hypothesised that the early weaning occurred because there was no-one to help this young mother.

We asked mother to return in a fortnight. At the second visit Kwanga's weight had increased and when Nosisana approached him, he cried. He was more responsive to his mother, and more alive. His mother had a "lighter" feel about her and she was interacting with him face to face. She is still living with the one aunt, but the relationship with the boyfriend seems to have stabilised. She said that Kwanga looks like his father.

Comments on this case

On an outer, social and family level we have a situation which is common in our communities.

- The migration of young people from the rural to the urban areas results in disruption of family ties. Most importantly the absence of the maternal grandmother leaves the young women without the guidance and support they would receive were she present. The result of this is frequently seen in the early weaning of the infants. Formula feeding poses many problems and is often the start of the failure to thrive.
- The instability of the relationship with the father of the baby impacts very negatively on the mother's mental state. Her anger towards him may be displaced on to the infant.

On the inner and interpersonal level we have

- The often encountered denial as regards negative feelings. This may be based on shame, as it is not really culturally accepted to speak about ones problems outside of the family.
- Then there is the avoidance of each other, mother and baby – this was very clearly portrayed with Kwanga and his mother. But we could also see that he was able to distinguish between her and Nosisana and was able to respond in a differentiated way to each of them.

Taking Kwanga and talking to him was the only thing we could do at that moment, and it unlocked a hopeless situation. Mother was able to take in what she saw and heard, Kwanga was able to respond to her. The proof of this was in his weight gain and in his preferred response to his mother during his second visit.

It also demonstrates well how the mother-infant-therapist system is a dynamically inter-dependent one (Stern, p.16)

and that by addressing one part, one is inevitably affecting all the other parts.

IN CONCLUSION:

With increasing experience in the direct talking to infants we have come to realise that this is indeed a powerful intervention and we have many examples of this. We have to hold in mind, that we may feel propelled to do instead of to think for the reasons I mentioned earlier. However, it is my sense that talking to the infant, and even holding the infant, should not always be reduced to an acting-out because of unbearable feelings of despair on the part of the therapist.

Talking to the infant has its effects in several ways:

- It communicates to the mother that we regard her infant as an important, thinking and feeling person, separate from her. This in turn would influence her handling of him and her perception of herself as a person. In our experience it does not disempower the mother.
- It communicates directly to the infant that we see and respect his/her individual presence and acknowledge his/her difficulties in the way that Norman did so eloquently with Lisa. A small seed may have been planted which contributes to a positive development in the self-experience of the infant.
- Because it is doing something that is in my view universally human, it is not didactic or prescriptive. It opens the door to self-other communication that can take the shape of the culture in which the mother-infant dyad is embedded.

When Ayanda's mother praised her son in his clan she did something powerful and profound for him. As therapists we cannot do this, but we can help the mother along the way by showing her that her baby is a person that can be talked to.

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- Winnicott Lecture

Holding Environment, Inpingement, and Potential Space.

Winnicott Lecture, University of Adelaide, July 23, 2003

by: Kent T. Hoffman

Donald Winnicott has been for me, since I was first introduced to him early in my psychoanalytic training, the North Star concerning understanding the central needs of the self within personality development. Aside from being an astonishingly original thinker (even though he never seemed to have seen himself in such a light), Winnicott has also been – within the world of psychoanalytic – the poet of the relational matrix. As in all good poetry, his writing has an elusive quality, bordering on the noetic. Which is to say to say that his thinking touches upon domains of human experience that are often beyond words. Concepts such as the true self, the false self, a holding environment, and potential space are immediately intuited by those who hear them as accurate representations of our deep inner life. But, as in all poetry, the exact meaning can never be known.

Certainly, Winnicott's arguments tend to be more, in T.S. Eliot's words, "hints and guesses" than exacting and fully reasoned treatises upon the nature of the developing human personality. I, for one, like this approach. It somehow seems closer to the reality of what we are approaching as we dare to look into the murky recesses of what we all have most in common – which is to say our core needs, longings, our most hidden terrors, and our deep-rooted potential. Elusive, glimpsed from the side – rather than directly, with the headlights shining upon the subject at hand – this is Donald Winnicott as he explores how we are most human.

I am going to suggest in this lecture that Winnicott's central theme regarding personality development is one that each of us know well, from the inside out – that is, within the context of the places that we each struggle daily. Because Donald Winnicott outlined again and again, through each of his writings, the perilous, ever challenging difficulty of the innate and vulnerable true self in its search for differentiation and autonomy while simultaneously establishing the much-needed connection that we all require. Is it possible to be both authentically individuated and genuinely intimate? Can we have needs for both self and relationship – and more importantly, can we have these needs at the same time?

Winnicott is the master of paradox – of that place within human experience that is always more question than answer, that requires of us aliveness and refuses to be answered with a simple yes or no. For example, Winnicott says very early in his classic writing titled: *The Capacity To Be Alone* that "the capacity to be alone is a paradox – it is the experience of being alone while someone else is present. . . This is the place that I have set out to examine, the separation that is not a separation but a form of union." Now, that gets the head to spinning. Which is to say, it gets the left brain – the rational, pin the answers down to a clear formula brain – to momentarily give up it's grip on reality. Quite suddenly we

find ourselves in that remarkable place of Winnicottian enticement and provocation, considering how through the journey into increased separation and individuation – we are actually not made more separate, but rather are provided a new capacity for complexity and uniqueness – a complexity that actually enhances and carries within it the safe joining involved within intimacy. In true Winnicottian form, we are here invited to consider an infant who is somehow able to say to herself: "My caregiver and I are one and at the same moment my caregiver and I are two." This is the richness of the paradoxical matrix that Donald Winnicott provides: a separate self that isn't a self unless it is in relationship and a relationship that isn't a relationship unless it includes a separate sense of self. And, under no circumstances would it be in the infant's best interest to have to settle into claiming only one half of this intricately enfolded equation.

But how is this multifaceted sense of identity accomplished? And – more importantly – how does the experience of 100 billion neurons becoming 1000 trillion neural pathways in the first three years of life – allow this capacity for authentic autonomy within genuine relatedness for the self-in-the-making? How does the developing self of the child come to know her uniqueness while simultaneously allowing herself to be available to the caregiver? How can the child differentiate himself and yet retain the resources of the caregiver? How does the developing self of the child negotiate the precarious territory between lack of contact with the needed other and too much accessibility? More directly, in terms that get to the heart of Winnicott's central concern within personality development, how does the infant experience his need for what Winnicott describes as simply "being" while remaining in the presence of the caregiver without experiencing the other as an intrusion – or in Winnicott's terminology, an impingement? It is here, in the domain of "Being with, without impingement" that, for those of us functioning through a Winnicottian worldview, becomes a central concern of all parent/infant psychotherapy.

This is the work of the *Circle of Security Project* through The Center for Clinical Intervention at Marycliff Institute in Spokane, Washington (where I work alongside my colleagues Glen Cooper and Bert Powell) and the University of Virginia in Charlottesville, Virginia (where our colleague Robert Marvin works).

- Can I go out into the world and explore what I need to explore, according to my own needs and my own timing?

- Can I, upon my own initiative, request and be granted full access to your comfort and protection, your delight and your willingness to be with me in a wide variety of feeling states – both positive and negative, both intense and subtle?

- Simply stated can I go out from you and return to you – with either need being fully acceptable on your part? Even more to the point, can I exist within the domain of my own truest self while having access to your ongoing interest, concern, and care – no matter where I am on the Circle? And, can you let me be <u>with myself</u> and <u>with you</u> simultaneously, without forcing me to focus upon you and your needs? Again, to quote Winnicott: "The alternative to being is reacting, and reacting interrupts being and annihilates." Annihilation throughout all of Winnicott's writing is the death knell of the true self.

Our learning over the past 30 years mirrors the conclusions of Donald Winnicott: The responsibility for initiating and facilitating the dance of differentiation and intimacy – of supporting being without impingement - belongs with the caregiver. Winnicott, predicting the Circle of Security as we have now come to know it, said over 50 years ago: "The child lives within the circle of the parent's personality . . ." This dance of differentiation and intimacy is, quite simply, too much for the child to negotiate on his/her own. Interestingly, as we like to say to the parents we work with, "Babies come with a set of instructions: just pay close attention and they'll tell you everything you need to know." Which is to say that infants from the earliest moments of life are more than willing to respond to this dance and respond favorably to attunement – a non-intrusive, resonating holding environment – on the part of the caregiver. Just as importantly, children will respond with very clear signals – from distress to avoidance to a failure to thrive – should the caregiver misattune to these key needs inserting her or his self into the internal world of the infant – through either too much involvement or not enough. (As we will soon see, misattunement on the part of the caregiver will be an impingement on the world of the infant and can take place both by doing too much or not enough. Both register as an assault, making their mark on the fragile self of the developing personality. Inaction – and the powerful "lack" that is registered may well be at the heart of what is most destructive for an infant. This "lack" is, within the Winicottian paradoxical worldview, both a nothing and a something. It is a loss on the part of the infant of a regulating presence when one is most needed and the insertion of a non-regulating presence – an unresolved, disorganized, impingement where one is not needed. More on this in a few minutes.)

Here is how we summarize our understanding of Donald Winnicott:

1. Babies require a "holding environment" in order for the "potential space" of this mutual dance of self and other to actually take place. This concept of a holding environment that gives rise to potential space is among the most beautiful in all of psychoanalytic literature.

2. The caregiver is the source and resource (the "facilitating environment") for the development of the true self. The infant's organization of an internal capacity for emotion regulation requires the caregiver's organized perception of him/her.

3. For an integrated sense of self to emerge within a child, that child must have a caregiver, according to Winnicott, "willing <u>to offer herself</u> as an <u>attentive medium</u> for the baby's growth." This, as we all know, is no simple task. Indeed, it is the lack of the caregiver's capacity to both offer her/his self and to be a fully attentive medium that is at the source of so much that goes wrong in the lives of infants and young children.

4. At the heart of the problem facing both parent and infant is the issue of "capacity" on the part of the caregiver. Said in

Winnicottian language: Is the caregiver capable of "empathic anticipation" of the babies needs? That is, is the caregiver capable of:

a. Recognizing a need as a need (especially if we are focusing upon a parent who must seek to provide care through the dense haze of her own history of growing up in a severely limited context of holding), and

b. Is the caregiver capable of empathy? As we are now confirming in the world of psychoneurobiology, empathy given is a product of empathy received. Empathy is a form of resonance and resonance is the byproduct of shared affective states. The baby has a feeling and, ideally, the caregiver joins the baby in that exact feeling state. Such a caregiver has the capacity to "be with" (again, join, resonate, share) the particular feeling that is emerging in the child.

Interestingly, according to recent research in Great Britain by Peter Fonagy and our own study with Beatrice Beebe in the United States, we are talking about a very specific kind of resonance. Infants and young children need to know two things:

1. Someone is here, in this emotion with me (i.e. sharing in this increasingly complex affective experience) and,

2. that same someone needs to be willing to let me find my way around inside this feeling. That is, the one who is joining me here needs to be both at ease with this feeling and willing to allow my own innate capacity (true self) to organize a response to this particular feeling state, thus building my own sense of competence with all feeling states; a facilitation that is fully present without drawing attention to itself. This might be considered a kind of emotional scaffolding, in which emotional regulation is learned by sharing an emotional state with someone who is capable of accepting and thus organizing what, for the young child, is – until just this moment – beyond their capacity. Little by little an infant and young child is being sponsored in a new capacity to more fully experience and manage increasingly complex emotional states.

This is the stuff of the Winnicottian relational dance: i.e. presence on the part of the caregiver; a willingness – in Winnicott's words to be "used" by the evolving mind of the infant . . . which is to say, the parent is assimilated by the child without the parent's interference. Like the proverbial image of a fish swimming in water without necessarily even recognizing that the water is there.

So, we are talking about what we might call "shared affective resonance without interference." Now, that's a mouthful. But in my decades of studying Donald Winnicott this appears to be at the heart of what he is speaking about when it comes to the art of healthy parenting. Let me say it again: shared affective resonance without interference (or to use Winnicott) without "impingement." It is this experience of a caregiver's availability for moments of paradoxical presence, simultaneously supporting both separation and closeness – and all of the emotions that accompany this dance – without impinging upon the emerging true self, that the infant and young child most requires. From the perspective of the infant, Winnicott describes this as the state of "going-on-being," and "continuity of existence," that is – the all-important experience of having a feeling that can be shared without being controlled. Winnicott says it directly in his essay titled "Parent-Infant Relationship:" "The holding environment therefore has as its main function the reduction to a minimum of impingements to which the infant must react with resultant annihilation of personal being."

Here we are at the heart of what I want to be talking with you about today: resonance without impingement; being joined without being controlled. Put in words from the perspective of the infant: "I need to be known and allowed to be as I am while the other who I most need willingly remains." When this is not available, we are suddenly at the source of human longing. And when non-availability graduates into full on interference and impingement, we are at the source of Winnicott's "annihilation anxiety" and significant psychopathology.

What I want to focus upon today is how our work in the Circle of Security Project is aimed precisely at this issue of sponsoring and supporting safe, shared, non-impinging emotional resonance with the families we seek to serve.

The question before us as clinicians has to do with:

1. How do we strengthen resonance on the part of the caregiver that already exists, and

2. How do we bring awareness on the part of the parent to the impingement that is – sadly – already taking place?

Over the years we have developed a protocol that, as you know, will be the source of discussion in sessions outside of this particular presentation. In that protocol we have devised a rather effective methodology for introducing, within the context of video review, both strengths and struggles that the parent and infant are living within.

Showing strengths is already relatively well known in video review work as practiced by a number of clinicians throughout the world. The uniqueness that we find in our Circle of Security work has to do with how we openly and sensitively invite the parent to explore their areas of struggle, their clear misattunement to the needs and cues of the child. More directly, in the context of the thinking of Donald Winnicott, we seek to pin point and then share with the caregiver exactly how it is that she or he is impinging – by doing too much or too little – upon the fragile, developing self of their child.

Now, to summarize what I have already been discussing, it is important to clarify that we see impingement in two significant ways: first, in the graphic interference on the part of the caregiver *into* the subtle rhythm and emotional state of the child. To operationalize this style of impingement in the moment-to-moment world of parent and infant, let's now look at several pre-intervention vignettes from our lab where we work with parents and infants. As we look at these interactions, I want you to ask the following questions:

- What does the caregiver do at exactly those moments when the infant is not making bids for connection or showing what are typically seen as "needs" to the caregiver?

- What does the parent do with a "point of repose" and self-generated rest away from direct contact, i.e. that

hidden place where to the untrained or unattuned eye there appears to be "nothing happening?"

Key themes observed:

1. Child being asked to meet the parent's need

2. Child being forced to disregard or neglect his own hidden/true self

3. Sense of impingement and resulting fragmentation on the part of the infant

Please know that treatment of the kinds of issues you have just seen will be the focus of the workshops that follow. My concern in this lecture is outline, with as much clarity as possible, where the central/core problems lie – from a Winnicottian perspective – within parent/infant relationships.

Thus we need to move on to a second, less obvious way of defining impingement. And that has to do with how the caregiver's intrapsychic world – especially the aspects of her history of unregulated affect – impacts and impinges upon the intrapsychic world of the infant. Again, Winnicott said it with remarkable clarity: "The child lives within the circle of the parent's personality . . ." The Swiss psychiatrist Carl Jung said it similarly when he inferred that children grow up in the unconscious of their parents. What is being implied here is that children know – because of what their parents do and don't do; support and refuse to support; resonate with and go blank or pull away from – their caregiver's unregulated, unresolved state of mind. And it is this specific state of mind that is sadly shared and inserted into the evolving state of mind of the child. Our work is designed to specifically address how this state of mind on the part of the parent impacts the child and to give the parent access to an understanding of the impact this is having upon her/his child. We do not see it as our place to ask the parent to change her behavior, but rather to give her the respect of believing that she can come to know what she is doing that is currently harmful to her child and then through her own reflection and choice to consider new options for herself and her child. This is done in true Winnicottian fashion by first offering her a holding environment in which to explore who she is and precisely how her state of mind (via her behavior) is impacting her child.

In the following case vignette, we will be looking at a mother and a child who struggle on both sides of the Circle. This two-year-old child has grown up with a caregiver that, due to her own history, has a hard time allowing her child any experience of autonomy while simultaneously having great difficulty providing any of the nurturance that he so deeply craves. As we listen to this mother describe her struggle, what we will be hearing is how her own history *impinges* upon every moment of interaction. And quite specifically, we will be looking at how this parent is genuinely trying desperately to protect her child from the very pain that lives in her history – a history that is clearly fully alive in each moment. Again, pay close attention to how this history is always present and continually interfering/impinging upon her own state of mind regarding relationship and thus upon the fragile and developing self of her child. And, as she increasingly reflects upon how and why she has chosen to relate to her child in this particular way, let yourself begin to imagine the new possibilities opening up – the potential space that might be increasingly available within her relationship with her child due to this decision she is now making to openly risk; to stand back and examine unconscious choices that have – until this moment – dictated profoundly limited options for both her child and herself.

In conclusion, impingement comes in a variety of forms – all of them dangerous to the growing true self of the infant and young child. With a deep sense of indebtedness to Donald Winnicott (as well, of course, to John Bowlby and Mary Ainsworth) a small group of clinicians in the United States are attempting to find ways to bring reflective awareness to parents so that they can recognize their deep desire to be good parents, their real capacities and strengths as caregivers and – painfully – the very place where they seem to most struggle – especially with this very impingement of both behavior and state of mind (not that they are separate). Our experience is that parents welcome this opportunity and bring hidden capacity to the process of positive parenting that they so deeply want to provide for their children. Holding environments-in-the-making are what we are seeking to provide. And, in many cases, holding environments-in-the-making are precisely what we are seeing result. This allows for a sense of potential space – the possibility of a new possibility for parent and child alike. And that, dear colleagues, is what I know each of us in this room most seek to provide for those we work with.

Appendix: Circle of Security Graphic: Page 15

Dr Kent Hoffman

Center for Clinical Intervention
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July 23, 2003

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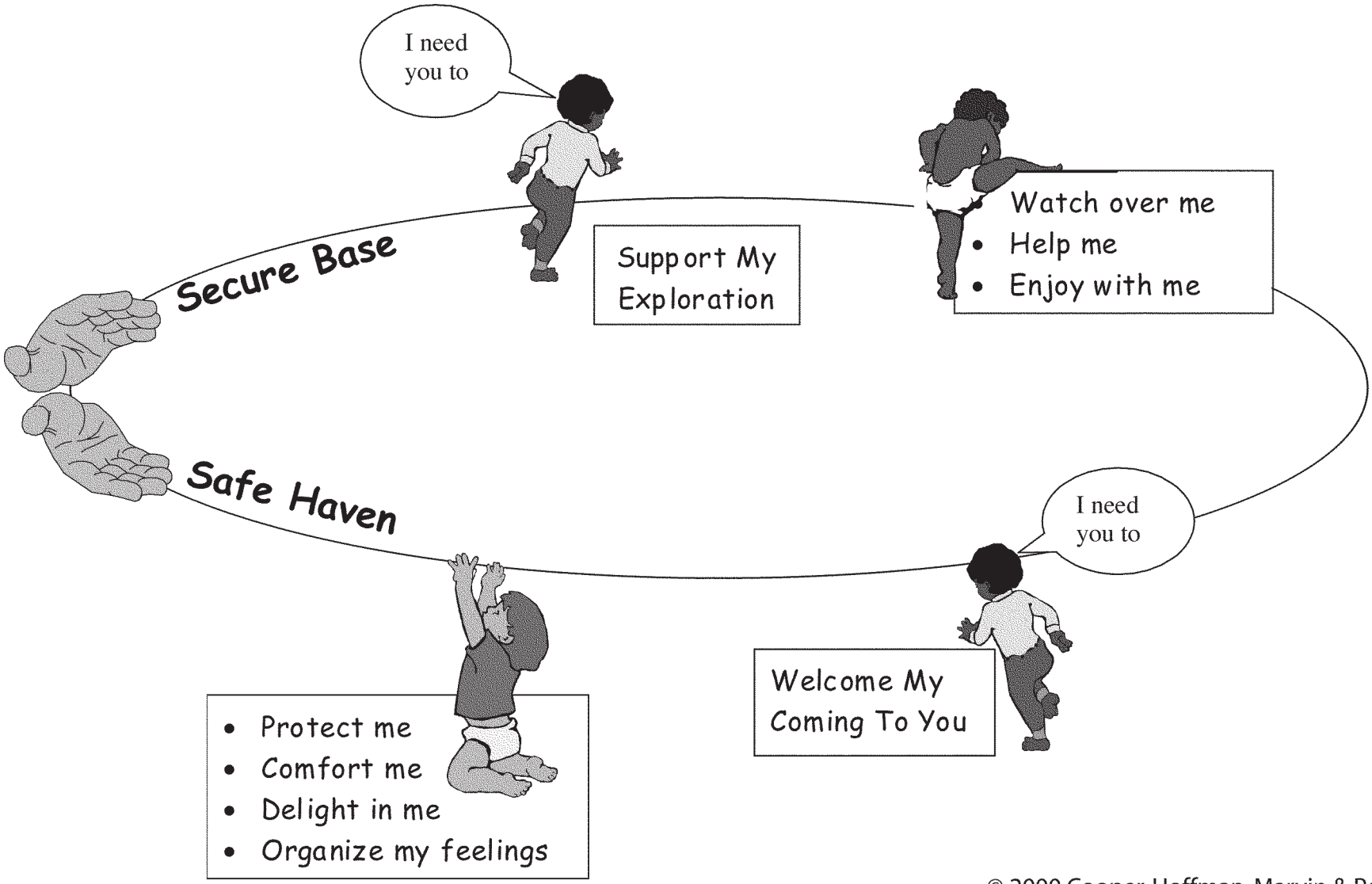
CIRCLE OF SECURITY

PARENT ATTENDING TO THE CHILD'S NEEDS



NATIONAL NETWORK NEWS

by Michele Meehan

A Message from our new National President

Thank you for your support of my nomination to the position on the National Committee. I see our main work is to support each of our branch associations in their efforts to gain members, as well as to provide forums for discussion and education on issues of Infant Mental Health.

We need to ensure that our areas of communication are used to the maximum, namely the Web site and the Newsletter. We will have a public image via the Internet and should become vocal on any issues relating to infants. How to co-ordinate this is something we need to think hard about, and become a reference point for opinions and comment on the affairs of infants. While the World Congress will be an opportunity to promote our field of work, we need to be ready to have thought out our view on issues: we can't respond if we don't know what we think about something.
While the organising committee is in Victoria it is the national Association that is the host, and all States need to push attendance at the World Congress, and be ready to present the face of the Australian organization at the event.

Michele Meehan
Email: michele.meehan@rch.org.au

Vic NETWORK NEWS

Vic BRANCH REPORT **by Michele Meehan**

Our first meeting last week is focused on preparation for the January Congress. New President is Rosalie Birkin, who previously coordinated our scientific program. We have had 12 new members since the Adelaide Conference, and are talking about plans to promote membership during the January Conference. The benefit of having a National brochure, running a membership table with information about each State's scientific program was suggested. We are also planning to get any speakers at the scientific meetings to prepare a one-page summary of their presentation to go to the newsletter.

Michele Meehan
President

NSW NETWORK NEWS

NSW BRANCH REPORT **by Marianne Nicholson**

All is well for the NSW committee. Our membership continues to grow with some 14 new members over the past two months. We have given away two semi-scholarships to assist students of the Infant Mental Health Course at the NSW Institute of Psychiatry. A successful workshop evening was recently held titled 'Focus on Fathers' presented by myself with an overwhelming turnout of 8 lucky people. There will be a case discussion evening to be held at Learning Links by Mary Morgan and Elke Andres. Trish Glossop will present an evening on Brain Development on November 6th. We are organising a 'Settle for Sleep' symposium in Hobart around late October/ early November to be facilitated by Beulah Warren, Lorraine Rose and Marianne Nicholson.

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Qld NETWORK NEWS

Qld BRANCH REPORT **by Debra Sorensen**

We have a new committee, with a hand over meeting a month ago. Hopefully there will be a great deal of energy to be put towards the 2005 conference, the first organizing meeting being scheduled for the 16th September. The scientific program for 2003 will hopefully include a presentation by Brigid Jordan, although I haven't personally heard this confirmed. Sue Wilson is following.

Also the Mater Hospital runs an antenatal program for women abusing substances and the project officer has been approached to present a session. Thoughts for 2003 so far include approaching Robyn Dolby to present material on attachment.

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