



# BABY TALK

The Official Newsletter of the Ohio Association for Infant Mental Health

9<sup>th</sup> WAIMH World Congress Special Issue: Spring, 2004 Volume 4: Issue 2

## Notes From The President

*by Mike Thomasgard*

I had the honor of representing OAIMH at the 9<sup>th</sup> WAIMH World Congress, January 14-17, 2004 in Melbourne, Australia. The meeting was held at the University of Melbourne, established in 1853—fairly young compared to the aboriginal culture that dates back thousands of years! Clinicians from 29 countries attended the five day conference. Our 15 hour flight across the Pacific was delayed somewhat which meant that I missed the morning Institute on proposed modifications of the Diagnostic Classification: 0-3. I did learn, however that a Family Axis is likely to be added in a future revision—see “When Infants Grow Up in Multiperson Relationship Systems,” on page 4.

Australia truly is a land of many cultures represented by its indigenous peoples, the Aborigines and its more recent European and Asian immigrants. For me, one of most engaging sessions dealt with Aboriginal Infant Mental Health and Development (page 6).

Nearly everyone I met asked if I would be staying for a vacation—Can you guess that tourism is Australia’s #1 business? Congress planners remained true to their theme of “The Baby’s Place in the World.” Many of the clinically-oriented sessions targeted strategies to actively engage the baby—a refreshing change in emphasis, since much of my pediatric training emphasized work with the caregiver and/or the child/caregiver relationship, rather than directly with the child.

This special 9<sup>th</sup> World Congress Edition (Spring, 2004) was a pleasure to write. My hope is that each of you finds at least  
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## Notes (Continued)

one useful item in its pages—whether that’s a web site, an observation or a reference to an abstract.

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Audio tapes for all four plenary sessions may be borrowed from the OH Infant Mental Health Library Collection. To access: 1) [www.ohplibrary.org](http://www.ohplibrary.org) 2) Select the CAT database; 3) Select: Power Search; 4) Select: Subject, enter the term Infant Psychiatry; enter the word OR; 5) Select Subject, enter the term Early Childhood Education, Click on go. Tapes & Congress abstracts are item # 121 (p12).

What follows are selected comments and observations gleaned from the sessions I attended. MT

### Opening Plenary (14, January), “Healing the Child in Juvenile Court”

Presenters: Joy Osofsky and Cindy Lederman (USA).

- Traditionally, lawyers are taught not to trust science, yet there needs to be a common language between the legal system and the scientist/clinician who works with young children and their caregivers.
- Fifty percent of children in foster care have developmental delays primarily in speech/language, nearly 4-5 times higher than in the general population.
- Rarely is it the case that the maltreated infant has no symptoms. Correlates for different age groups include: Birth to 6 years (insecure attachment and poor self development); 6-12 years (aggression and rejection by peers), 13-18 years (school failure and delinquency).
- Web sites of interest:  
[www.miamisafestart.org](http://www.miamisafestart.org) and  
[www.futureunlimited.org](http://www.futureunlimited.org).

**Symposium 3 (14, January),  
“Supporting Baby & Family in the NICU  
and Beyond”**

Carolina Parjee (Australia) created a mother’s group—a safe environment where feelings and questions could be shared while also facilitating play between the infants. While there were many fears such as breaking down in front of the group, doing damage to the couple’s relationship and reliving the traumas of the NICU, these were not realized. Many mothers wished that others would know what they’d been through in the NICU. The biggest mismatch was the “idyllic image of having a baby,” versus the reality, even for a healthy infant. Fathers did express some curiosity about the group. However, there wasn’t sufficient interest to create a separate group. An audience member wondered “to what extent do parents need to see that the staff have feelings too?”

Glenna Boyce (USA) [www.in-reach.org](http://www.in-reach.org)  
“Why not use the inpatient experience to move the IFSP to the hospital?” This was facilitated by using desktop video conferencing about one week prior to discharge. Having visual recognition of the EI person you would be working with was very important to parents. This project reduced the time between leaving the hospital to a first home visit from 90 to 18 days in Utah.

BASICS (Baby Awareness and Support through Interactive Computer Systems), an interactive computer system designed to help parents cope with their baby’s stay in the NICU. Parent stories are accessed from a web site that utilizes touch screen

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**Symposium 1 (14, January), “The  
Compromises of Motherhood”**

Not enough attention is directed toward the infant. Assumption: “The baby has a mind.” This leads to important questions such as: 1) What do you think the baby is thinking about? 2) How do you think the baby feels now? 3) How did the baby deal with that? 4) How did this baby make you feel (countertransference)? The focus is on creating a listening space for the infant.

**Symposium 2 (14, January), “Innovative Interventions”** An intervention model by Cooper, Hoffman and Powell (2000) was presented. Goal: “I want the children in my care to experience security.” In this model, children come to the child care staff (i.e., a secure base) rather than vice versa. The staff observes what the child is doing; in this way they become more physically available.

Related poster: Developing the community within a preschool setting: How strengthening the relationships between staff, children and families achieves positive outcomes from the children.”

The following is from a paper presented by Robyn Dolby at WAIMH 9<sup>th</sup> World Congress. Circle of Security: Parent [Caregiver] Attending to the Child’s Needs: Secure Base: Child says, “I need you to support my exploration, watch over me, help me, enjoy with me.” Safe Haven: Child says, “I need you to welcome my coming to you, protect me, comfort me, delight in me and organize my feelings” (Cooper, Hoffman, Marvin & Powell, 2000). The Path to Security: “I want the children in my care to experience security

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**Plenary Session 2 (15, January),  
“Attachment and Trauma,”** Presenter:  
Alicia Lieberman.

There are four sites in the US that form the “Early Trauma Network.” These include Louisiana State University—Joy Osofsky, Tulane University—Charles Zeanah, Boston University—Betsy Groves and University California San Francisco—Alicia Lieberman.

Definition of Trauma, “An exceptional experience in which powerful and dangerous stimuli overwhelm the child’s capacity to regulate emotions.”

Children who witness domestic violence have different reactions depending on their age. At 6 months, the infant may slap the mother’s face out of fear and anger. Between 1-2 years, the toddler may flee to the mother’s arms then bite or hit her. Reality is transformed such that the protector becomes the attacker. Basic questions such as who is safe and who is dangerous arise. The infant/toddler loses the capacity to sustain representations of the mother or father as a secure base. Intense emotions co-exist; there may be a longing for the father (i.e., my daddy can do all), yet there may also be fear that when the doorbell rings, he may return. When the child is most in need, the parent is most unavailable; “if she [the mother] can’t protect herself, who will protect me?”

By 3-4 years of age, the child may begin to identify with the aggressor so as not to be victimized. The child may begin to wonder, “Will I hurt you?” “Will you make me go away?” The mistake many therapists make is to respond only to the child’s aggression rather than also  
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### **Attachment and Trauma (Cont.)**

responding to the anxiety underneath. For example, the child may have outstretched arms, but the parent is thinking, “Don’t you hit me.” There is a misreading of such behavior as a sign of aggression.

Child-Parent psychotherapy integrates attachment theory, treatment for trauma, Fraiberg’s ghosts in the nursery, and psychoanalysis. This type of approach does not work well if the parent has severe depression and/or borderline personality disorder.

One needs to be vigilant such that once the child begins to move on (i.e., greater impulse control and better emotional regulation), we need to follow. It sometimes happens that the therapist sees the pain underneath the surface of the perpetrator and forgets about the terrible act that occurred. There may be a belief that “through love, I can heal everything.” This can lead to an erroneous assumption that the perpetrator is not dangerous.

There is a weakness in our treatment model since we start with the victim (often the mother-child dyad) and build a bridge toward the father. The court seldom examines whether there has been any change in the father, in part because no one has worked with him.

### **“Supporting Baby & Family in the NICU and Beyond” (Cont’d)**

technology. Physicians were worried that they would be replaced! Voice over is provided for those who can’t read; available in English and Spanish.  
<http://webdev.mccs.uky.edu/BASICS/>

**Plenary Session 3 (16, January), “When Infants Grow Up in Multi-Person Relationship Systems,”** Presenter: James McHale (University of South Florida).

*Historical Transitions in families:* 1) Being raised by a band of individuals in which gender differences were not apparent; older family members stayed with the children while those who were younger procured food; 2) As land was allocated to family homesteads, larger families were valued and families began to compete; 3) More recently, the individual within the family has gained notoriety.

Interestingly, “the triadic relationship is the most fragile of all.” The differences between relationships are important (e.g., the co-parental relationships are different than the marital relationship). The individual parent-child relationships do not predict what will happen when both parents are present.

*Implication:* Clinicians can’t predict what will occur in triadic relationship from the individual relationships that we may observe in the office or at home.

Rules: 1) “Assessments of the family must be of the family;” 2) “We must also do dyadic assessments;” 3) Hypotheses: a) Impressions must be understood within cultural contexts and the co-parenting alliance and b) Intervening within the dyad may not affect the baby, whereas strengthening the marital relationship may.

Emde’s comments: Relationships have two dimensions power/control of discipline and affiliation. There are hierarchies of responsibility to care for children. DC: 0-3 is considering adding a family axis.

**Symposium 15 (15, January), “The Baby as Subject”** Moderator Frances Thomson-Salo (Australia).

By giving time to the baby it allows the parent to step back. It opens up a gap, an expectancy regarding what’s to come.

Campbell Paul: “To hold a baby is to identify with the baby as another person—to paraphrase Winnicott.” The baby becomes the therapist; once progress occurs it can be self-perpetuating.

The advantage of our work is that we can build on the developmental thrust of the infant and can be esteem building for parents. The play is the work; it’s “ok” to not initially involve the parent in play with their infant.

While some might worry that this would leave the parent feeling guilty that they couldn’t relate to their infant, it’s often more true that the parent can then see the infant’s potential to interact. This can open up new possibilities for future interaction.

**“Innovative Interventions” (Cont.)**

with me. First, I need a map, a way to clearly identify and understand the children’s emotional needs. I must then learn to stand back and observe what the children are doing and what I am doing.

Next I need to talk with someone about what I am doing (and not yet doing) to meet the children’s needs” (Cooper, Hoffman & Powell, 2003).

For copies of the paper please contact:  
[Mailto:r.dolby@unsw.edu.au](mailto:r.dolby@unsw.edu.au)

**Symposium 18 (16, January), “Fathers and Infants”** Jorge Tizon & Peitat Fuster (Spain),

Fathership as Psychosocial Transition,” reported that 27% of men experienced some form of post-partum blues.

Svend Aage Madsen & Dennis Lind (Denmark), reported their findings using the Father Bonding Instrument administered 3 months prior to the child’s birth as well as 2 weeks and 5 months thereafter. The father’s ability to reflect on the infant’s state of mind was linked to his relationship with his own mother. There was no significant contribution from his own father.

Hiram Fitzgerald et al., (USA), in “Origins of Risk: Paternal and Neighborhood Influences on Child and Family Functioning” examined families in which the fathers were antisocial and alcohol using. Conclusion: Negative paternal behavior (antisocial), exposure to neighborhood violence and alcoholic family type independently and in interaction negatively influence child cognitive function, degree of conflict and emotional/behavioral regulation.

**Plenary Session 4 (17, Saturday), “Early Withdrawal and Depression in Infancy”**  
Presenter: Antoine Guedeney (France).

Historical Perspective: 1946 (Spitz) Women in prison who were rapidly separated from their infant (Bowlby) “When hope disappears,” depression does not arise directly from separation or loss.

1982 (Herzog and Rathburn) After DSM-III, proposed constellation of sad, gaze  
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**“Early Withdrawal and Depression in Infancy”** *(Continued)*

aversion, staring, irritability, dysphoric mood, plus four more criteria.

1983, Infant depression as a part of Attachment disorder.

1983 (Tronick) Still face, while studying infant maternal depression, found that such infants show depressive behavior even with non-depressed adults.

1994 (DC: 0-3) No definite criteria.

2000 (? Name) Loss and the role of oneself. At 18 months; “gone” is used when waiting for something to appear. Why 18 months? The toddler has the ability to play with affect; a goal-corrected partnership is present along with joint attention. Relationships can be modified and Piaget’s object permanence starts. 2002/2003 (Luby) Proposes new criteria for those between 3 and 5 \_ years. 2003 (DC: 0-3 Survey), only 20% used Mood Disorder: Depression.

Where are the boundaries? Withdrawal is more common with Autism, Major Depressive Disorder, Reactive Attachment Disorder, Severe and Enduring Pain, Failure to Thrive—Kwashiokor and Post Traumatic Stress Disorder.

Dr. Guedeney has been working on a measure of Infant Withdrawal, entitled the “Alarm Distress Baby Scale.” It has 8 items (scored from 0-4) that reflect facial expression, eye contact, general level of activity, self-stimulation, vocalizations, response to stimuli, relationship and attachment. The scale is administered during the physical examination and is akin to Winnicott’s “Set Situation” (1941).

Bottom Line: Babies cannot wait for help; we must develop a standardized way to  
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**Symposium 21 (17, January),  
“Aboriginal Infant Mental Health and  
Development,”** Presenter: Helen Milroy  
(Australia)

This was one of the most interesting presentations and was a great opportunity to briefly understand infant development in another culture. The basic belief of the aboriginal people is that time is circular. Everything is connected; rocks, the sky, plants and animals are all equally valuable and each has feelings. Aboriginal children grow up in a world of stories. These are represented in song, dance and painting, each of which has multiple layers that are repeated with more detail each time they are told.

Each person has a true and proper story: the world we see is only the surface representation. Stories begin in the middle or at the end and then move in a circle to the beginning. The implication is that old people are both ahead of and behind us; there is no future! The grandparents are the holders of knowledge; they tell the stories. Babies are born into a story and are conceived in spirit prior to being physically conceived, thus, problems may arise much earlier than conception. The infant is picked up as a spirit baby and is born from the country. The country knows where the children are; Australia is a black country with a black history—like the black swan that has white skin underneath.

Australia under European rule is a land of opposites and contradictions. “Aboriginal mothers were ‘OK’ for white children, but they were also viewed as unfit mothers for their own children.” Recent aboriginal history has been a story of stolen children taken into the welfare system and of  
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**“Early Withdrawal and Depression in  
Infancy”** *(Continued)*

assess infant withdrawal. In three different cultures, the measure has been robust using a cutoff score of >5 (sensitivity and specificity of 0.8).

**Discussant: Ann Morgan** (Australia). Ms. Morgan told a story in which 3 children knew of an infant and her mother who had died in a car crash. Their responses succinctly described each child’s understanding of loss. The 3-year-old remarked, “the baby lost her mother;” the 8-year-old, “that baby won’t learn to play, and the 11-year-old, “that mother lost her baby.” If the infant loses the connection to the world, it’s a loss to the past, the present and the future.

**“Aboriginal Infant Mental Health and  
Development,”** *(Continued)*

stolen mothers—who raised the European children. “The six year old child could be both competent in the bush, but also lost in the bush.” The Olympics portrayed the black tracker as taking the white child home, yet left out the image of who watches the black child at home.

While Australia prides itself on caring for its children, there are many Aboriginal communities without children and without mothers. “The story the aboriginal child learns is the wrong story: the true story is everyone’s story—the country can raise both Australian and non-Australian children in the right story.” Australians are being nurtured by a black mother who has black milk.

For more on this unique story go to:  
<http://www.austlii.edu.au/au/special/rsproject/rsjlibrary/hreoc/stolen/>

### Presidents of Affiliates Meeting (17, Jan)

The World Association is struggling with guidelines for Infant Mental Health and with standards of competence just as the local affiliates are. Given the European community, there is increased flexibility for graduate students to cross borders and learn from other universities. Perhaps there could be exchange families that would make this easier. It's a struggle for students to be able to attend the World Congress given the expense of travel. There are many countries (e.g., China, India), regions (The Middle East) and in some cases, entire continents (e.g., Africa, South America) that are not yet represented within WAIMH. There will be a special issue of the *Journal of Infant Mental Health* dedicated to this idea. In a sense, this represents not only "keeping the baby in one's mind," but "having the rest of the world in mind." WAIMH plans to update its web site soon.

### WAIMH Business Meeting (17, January)

WAIMH is back in "the black." Officers: President—Tuula Tamminen (Finland), Vice President, Antoine Guedeney (France) Secretary—Elizabeth Tutters (Canada), Treasurer—David Oppenheim (Israel). While many board members are from the discipline of child psychiatry, there is now greater diversity with respect to Pediatrics, Nursing and Social Work.

### OAIMH PRESENTATIONS

**Poster (15, January)** "9/11: The Effects of Terrorism on Children Less than Age Six Years," John Kinsel & Michael Thomasgard.

### Conversation Hour (16, January)

"Development of an Infant Mental Health Web site: Potential Applications for WAIMH Affiliates." Michael Thomasgard and Jeff Rosenbaum.

### Training In Infant Mental Health

1. *The New South Wales Institute of Psychiatry*, Master of IMH (2 years); Graduate Diploma in IMH (3 years) [Mailto:institute@nswiop.nsw.edu.au](mailto:institute@nswiop.nsw.edu.au) or write to: NSWIOP, Master/Graduate Diploma IMH, Locked Bag 71118, Parramatta BC NSW 2150 Australia.

2. *The University of Melbourne*, Infant and Parent Mental Health, Graduate Diploma of Mental Health Sciences (1 year); Master of Health Sciences (2 years). [Mailto:campbell.paul@rch.org.au](mailto:campbell.paul@rch.org.au) or write to: Assoc Prof Campbell Paul or Dr. Brigid Jordan, Royal Children's Hospital MH Service, Flemington Road, Parkville, Vic 3052, Australia.

### Web Sites of Potential Interest to OAIMH Members

1. *Children of Parents Affected by a Mental Illness* [COPMI (Australia)] <http://www.aicafmha.net.au/copmi/national/programs/index.htm>

2. *Fathers (Australian web site)* <http://www.newcastle.edu.au/engagingfathers>

3. *Minnesota Infant Mental Health Project (Infant mental health, attachment, early brain research, creating peaceful classrooms, stress and trauma in young children and supporting the mental health of young children.* <http://www.education.umn.edu/ceed/trainings/default.html>

**By The Numbers:** The 9<sup>th</sup> Congress was attended by 670 people representing 29 countries.