



BABY TALK

The Official Newsletter of the Ohio Association for Infant Mental Health

Fall 2006

! **SPECIAL DOUBLE ISSUE** !

Volume 6: Issues 1&2

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BABY TALK RETURNS WITH DOUBLE ISSUE!!!

By John Kinsel

After approximately a year's absence from the computer screens and mailboxes of OAIMH members, BABY TALK has returned with a vengeance! This special double issue not only contains OAIMH news and related items (Volume 1), but also a special report from the WAIMH World Congress held in Paris this year and attended by/reported on by intrepid OAIMH members Michael Thomasgard and Elizabeth Finley Belgrade. The Editor apologizes for the break in publication. A comedy/tragedy of errors, technical difficulties and scheduling snafu's led to the unplanned moratorium. The OAIMH Board is taking steps to prevent such a mini-disaster re-occurring, including rotating editorship on a quarterly basis so more than one computer/network system is involved.

Enjoy this rebirth, double issue edition and watch your mailboxes (email and snailmail) for future episodes..er, editions of BABY TALK!

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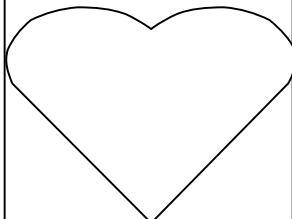
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*"Ohio's
Babies: The
Heart of Us
All!"*



Notes From The President

by Kate Merrilees

Recently I have been approached by several organizations asking for ideas on how to attract and sustain membership in the organization. Ironically those requests come at the same time that I have been asking myself about what does make OAIMH attractive to members as well as how to better meet the needs of our membership. While it is true that we all need to be a part of something, in these frantic times when helping professionals are scrambling to do more for vulnerable families with less funding, time is a precious commodity.

When I was new to the field and working in Michigan, there were no organizations that devoted their efforts to advocating for the needs of infants, toddlers and their families. It was satisfying professionally and personally to be active in both the state and local chapters of the Michigan Association of Infant Mental Health. These days there are multiple groups meeting on behalf of young children. Where do you begin to put your time and energy?

I will admit that I am biased. After all I am the President of OAIMH. However the credit card slogan, "Membership has its rewards" seems to apply. No, OAIMH is not offering a credit card, bonus coupons or sky miles for your membership. You will however have the opportunity to be affiliated with an outstanding and committed group of individuals who work diligently on behalf of young children. Your voice will be heard in local chapters and through your local chapter liaison to the Board and from the Board to the multiple state committees on which the Board is represented.

If it is true that we are judged by our friends, I would also suggest that it is then true that we are judged by our professional affiliations. When OAIMH

is asked to offer input on best practices for infant and toddler care or to discuss issues related to young children with political figures, it is a collective voice that replies. Those opinions are gathered and formed through the discussions and networking at local chapter meetings, state conferences and regional meetings.

Later this year when there is an opportunity to come together and reflect on our practice with families, it will be one more opportunity to solidify our values and beliefs about young children and their families. Membership in OAIMH takes you beyond city, county, state and country. OAIMH is part of the World Association of Infant Mental Health and so the ripples spread even further beyond our immediate environments.

Membership does indeed have its rewards!

AN OVERVIEW OF THE MARSCHAK INTERACTION METHOD (MIM)

By Janece Warfield, Psy.D.

The Marschak Interaction Method (MIM) is a diagnostic technique for the observation of adult/child interaction as they perform a series of structured tasks together. The method was developed in the 1960's by Marianne Marschak and expanded on by Ann Jernberg and colleagues of the Theraplay® Institute in Chicago to apply it to a broader age range. The MIM can be used with children who are oppositional, shy, autistic, and evidence short attention spans, as well as with adults who have reactive attachment disorder or need couples work. Theraplay® is a directive form of play therapy, is active and engaging, and focuses on five dimensions which are assessed through the MIM: structure, engagement, nurture, challenge, and playfulness.

Structure refers to how the adult situates the environment to have a clear beginning and ending, as well as appropriate limits and expectations, and provides a solid base for all other dimensions. The adult provides the appropriate boundaries between the child and their relationship which relays to the child that they are safe, the parent knows how to take charge, and provides a clear order of when things will begin and end. Structured tasks include: the adult builds a structure with their own blocks, then says to the child, "Can you build one like mine?"; the adult teaches the child something he/she doesn't know (Jernberg, Booth, Koller, & Allert, 1991).

The tasks show if: the adult can set structure; the adult takes a peer/pal relationship; the child is defiant and the adult relinquishes authority and submits to the child; there is no structure within the dyad and things are done in a haphazard fashion. In addition, you look to see who is in charge and how easy/difficult it is for the adult to set the structure and how well the child responds and accepts structure.

Engagement refers to how the adult interacts with the child in ways which lets the child know they are fun to be around and that the child and adult can connect, which, in turn, will let the child know they can connect with others. Sample tasks include: making up a tune together; engaging in thumb wrestling.

The tasks reflect the adult's ability to tap developmentally appropriate activities and pull the child into an interactive and engaging state. Do the child and adult demonstrate empathic awareness? Can the adult tell when the child is getting frustrated? Is the adult aware of the child's feelings and vice versa? Look for indications that the adult and child are not successfully engaging by the adult competing with the child and/or not letting them complete the task.

Nurture shows how well the adult and child demonstrate affection through touch, warmth, and care through activities which signal, "I will respond to your needs with love and affection." Sample tasks

include: giving each other a drink; applying lotion to one another; telling the child what he/she was like as a baby.

Challenge refers to how an adult sets up developmentally appropriate situations and helps the child become independent. Can the adult give the child their own space while realizing when the child can't handle the frustration? How does the child handle frustration? How is their ability to attend and concentrate? A sample task is asking the child to close their eyes and describe everything in the room.

Playfulness refers to how the adult and child engage in fun. Tasks are designed to elicit laughter and humor between the adult and child and show how they are able to give, receive, and sustain the playfulness.

HOW TO ADMINISTER THE MIM

Between eight to ten tasks are selected that will adequately assess at least one of each of the dimensions. The adult and child are seated next to each other at a table. The tasks are written on individual index cards which are numbered in sequential order and placed in manila envelopes (at least 8 x 11). The envelopes are numbered to match the index cards and contain the items needed to perform a task. For example, if card number one says, "Adult and child play with squeaky animals together", envelope number one would contain the two squeaky animals. The interaction takes between 15 to 30 minutes and should be videotaped, although a clinician can sit unobtrusively in a corner of the room and complete the scoring sheet of the interaction. After the tasks are completed the adult and child are asked a series of questions pertaining to the interactions. Feedback is provided on another day with the adult through watching clips of the interaction which reveal both strengths and areas that need improvement, and a Theraplay® treatment plan is developed.

For more information about Theraplay®, contact the Theraplay® Institute, 1137 Central Ave., Wilmette, IL, 60091, (847) 256-7334, or visit their web page, www.theraplay.org.

Jernberg, A.M., & Booth, P.B. (1999). *Theraplay: Helping parents and children build better relationships through attachment-based play* (2nd Ed.). San Francisco, CA: Jossey-Bass.

Jernberg, A., Booth, P., Koller, T., & Albert, A. (1991). *Manual for the administration and the clinical interpretation of the Marschak Interaction Method (MIM), preschool and school age*. Chicago, IL: Theraplay Institute.

Reflections on the 10th World Congress

By Elizabeth Finley-Belgrad

The World Association for Infant Mental Health Congress was held July 8-12, 2006 in Paris France. This wonderful city venue attracted over 1000 participants from 46 countries. A broad array of information was presented, ranging from theoretical discussions and dialogues to the specific application of successful intervention programs. France is a relatively traditional bastion of psychoanalysis. The field of Infant Mental Health is increasingly aware of the relevance, importance, and reliance on relationships. Some of the most interesting discussions were about how we as a field can begin to develop a more functional language to clarify some outdated assumptions and definitions that stem from different clinical approaches, particularly in light of more recent scientific evidence.

There are significant economic, political, and even differences in the application of Infant Mental Health principles between the United States and much of the world, especially the Western European countries. So many Scandinavian countries have well developed, universally applied systems for identifying early mental health problems and for providing appropriate early support to families. In contrast, many of these same difficult issues surface at a later point in our “pay as you go” system. In the United States our de-emphasis on relationships (e.g., splitting up of extended families to follow jobs across the country, working mothers allocating child care to others to increase family income, etc.), could be construed as being related to difficulties in other areas of individual and family functioning.

What is one to do with this disparity of data that will truly make a difference? In the United States there is no identifiable centralized place, person, or system that could act on the same information—not a big surprise, but the point was driven home to me. The true value of an international Congress is to exchange ideas and to compare how we as clinicians understand the meaning of nuanced social behavior, given our differing cultural and social backgrounds. The next World Congress in Japan should be a great opportunity for us to more fully understand this.

Institute IV (8, July), “Working with Young Children Following Disasters”

Presenters: Charles Zeanah (USA), Daniel Schechter (USA), Marie Rose Moro (France), and Neil Boris (USA)

By Mike Thomasgard

Charles Zeanah: Hurricane Katrina

A series of unfortunate events occurred, each with its own level of traumatic exposure. The initial wind damage knocked out all cell phone towers impairing further communication. Water breached key levees that led to fires that couldn't be extinguished—ironically due to a lack of water. Civil unrest followed; even those who escaped had to watch others being traumatized. Nearly 80% of homes were flooded and 60% of businesses were affected. We often forget that there's at least one natural disaster somewhere in the world each day.

Marie Rose Moro: The Banda Ache Tsunami Disaster

Trauma occurring to very young children is often missed. Many times the child's expression of decreased psychological functioning is manifested by functional somatic problems (e.g., headaches, stomach pains). Interventions took place on carpets—a place where children and their caregiver(s) could be safe. For many survivors, the main challenge was to separate the living babies from those that died—“the children of tears.”

Neil Boris: Rwanda

Rwanda was beset by a series of events staggered across time by 10 year intervals. HIV, commonly referred to as “dying from poisoning” to avoid the stigma of HIV, came first. This was followed by a shortage of food that hastened the genocide of nearly 85% of the Hutu population. The reality of the times was simple: “kill or be killed.” These events have led to an immense orphan crisis, with youth-headed households being the norm. Local autonomy was bolstered by heeding the advice of community leaders, who in turn, picked specific families in need of help as well as those who would be trained as family mentors.

Opening Plenary (8, July), “The Clinical Relevance of Infancy: A Progress Report”

Presenter: Daniel Stern (Switzerland)

By Elizabeth Finley-Belgrad (EFB) and Mike Thomasgard (MT)

Change is always hard. Daniel Stern continues to be a stimulating and inspiring leader for our field who seeks to encourage and instigate an active dialogue. So much of infant work strikes close to home and demands both self-analysis and integration to fully understand and be able to make full use of basic concepts in our professional work. Stern's book, *The Motherhood Constellation* (1995) addresses the fundamental notion that when a woman becomes a mother, it is much more than just a woman with a baby. She actually turns into a mother through a process that frequently results in major irreversible changes in her priorities and focus. This process has implications for approaching a mother in therapy; for one must recognize the primary importance and centrality of these issues to mothers. As an aside, this is a book that I read right about the time I (EFB) had my 1st baby. I had just entered my child psychiatry fellowship and it rang so true to my own experience that I have been a strong Stern devotee ever since. Clearly, this was one of his earlier forays into an approach that he is now advocating to rethink the words we use to talk about the developmental concept of a “two-person psychology,” as opposed to a more individually-based concept, as in psychoanalytic theory.

A shift is occurring from a one person psychology, where change is linear and predictable, to a two-person psychology where change is unpredictable, nonlinear, and nearly instantaneous. During the latter, there are very brief moments of opportunity for intervention. If one acts, it changes destiny; if one doesn't act, it also changes destiny! We often talk about sessions with children / families as if they were linear, though we are often lost during the course of the family narrative! In this new “nanopsychology,” (short, nearly instantaneous interactions), one moves from predictability to probabilities. We may have to rewrite Freud to include this new intersubjectivity—being able to sense or know of another's experience (a dialogue between minds). New research shows that what matters most with young children are the intentions of others, not their actions.

Other books by Daniel Stern include: *The First Relationship: Infant and Mother* (1977); *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology* (1985); *Diary of a Baby* (1990); *The Birth of a Mother* (1998); and *The Present Moment in Psychotherapy and Everyday Life* (2004).

Plenary II (9, July), “The Infant's Communication in ‘Two for One’ versus ‘Two Against One’ Family Triangles

Presenter: Elizabeth Fivaz-Depeursinge (Switzerland)

By Mike Thomasgard

“We felt that reconstructing the family from its dyadic components was not sufficient, so we developed the Lusanne Triadic Play (LTP). We needed to capture the family as a unit” [Fivaz-Depeursinge, E., & Corboz-Warnery, A. (1999), *The Primary Triangle: A Developmental Systems View of Mothers, Fathers, and Infants*, p. xiv]. The LTP bridged the two domains of child development and family process by exploring patterns of family alliances and studying the family as a unit, rather than the family as a set of dyads.

The *family alliance* is a system property that emerged from the interactions of the three partners (e.g., father-mother-child). Questions such as: “Does the family work together as a team?” and “Do the partners help each other?” emerge from such an analysis. The study of dyads is too simplistic with respect to human development. For example, “... a father-son relation develops a specific complicity that only emerges when they are alone together, whereas they may entertain a different relationship when they are with mother. Or the marital relationship may be in crisis, yet the parental alliance remains immune to this conflict when the parents are with the child. Hence the necessity to study the triad and its constituent dyads separately” (p. xxiv).

The core focus of this research is the *potential for development [emphasis added]*. Dr. Fivaz-Depeursinge’s underlying hypothesis is that “playfulness is the key to being a parent.” The LTP is semi-standardized; it is a problem-solving task that challenges the adaptation skills and creativity of the family members” (pp. xxvi-xxvii). Numerous patterns are possible, including: *role-reversal* (the parent is an intimate companion for the child); *triangulation* (the child is the go-between); *binding* (two individuals are bound together); *coalition* (Two against one); and *cohesive co-parenting* (all are included, in tune, and there is a shared joint focus). This shared perspective is well outlined in the preface to *The Primary Triangle*:

Imagine a mother and her baby daughter on a Sunday morning in the kitchen. The child has been fed and contentedly engages the mother in a round of dialogue play while the father watches. She looks at her father invitingly and it is now his turn. Deeply moved ..., the mother watches them in pure delight. Then the three of them join in the dialogue. There are moments of utter joy when they all laugh together and then tenderness and sympathy when the baby is tired and fussy. She eventually withdraws and the parents enthusiastically comment on her beauty and excellence. The baby becomes interested in watching the conversation [between her parents] (p. xiii).

The LTP has four parts: 1) A two-plus-one configuration, mother and baby playing together, with father in the periphery; 2) A switch to the other two-plus-one: father and baby, with mother in the periphery; 3) The three together, father, mother, and baby playing; and 4) Two-plus-one, with the baby in the periphery and the father and mother talking together. These interactions are videotaped—one camera is focused on the baby’s face, while the other is on the parents. The baby is in an infant seat, set on a table facing the parents, so that the three of them make an equilateral triangle.

“Similar to other clinical research paradigms for observing families, the LTP challenges the family in constructing new interactions together. We consider the LTP frame of observation as a context of transformation in itself. Yet we know as therapists that these experiments require expert and customized handling if they are to be growth-enhancing for the families and meaningful for clinical research” (p. 131).

Merely going through the procedure is not sufficient framing in itself, at least not for the majority of families. Reviewing the video-recordings with the family and providing feedback is also desirable. First, ...watching the video-recordings from the perspective of the audience is different from and complementary to experiencing it as subjects. Second, ...in reviewing the interactions, the issues the parents might raise are discussed, key points are examined by asking about the parents’ subjective experience, and the baby’s competence as well as parental intuitive behavior are emphasized.

Third, this time window provides the parents with the opportunity to share their pride, pleasures, and concerns about their baby and their own parenting.... Finally, the feedback session is the time to put into practice and test the hypotheses on the working alliance formulated during the ...LTP (pp. 132-133).

Symposium I, (9, July), “Intersubjectivity and Neurobiology: Implications for the Mother-Infant Relationship

Presenter: Vittorio Gallese (Italy)

By Mike Thomasgard

Neurobiology is starting to help us understand the meanings of intersubjectivity, a word that has no coherent meaning! Dr. Gallese was part of the research group that identified “mirror neurons.” A quote from Daniel Siegel’s book, *Parenting from the Inside Out*, provides the basis of such neurons:

Mirror neurons are found in various parts of the brain and function to link motor action to perception. ...[A] particular neuron will fire if a subject watches an *intentional [emphasis added]* act of someone else, such as lifting of a cup, and will also fire if the subject herself lifts a cup. These neurons don’t merely fire in response to any action seen in another person. The behavior must have an intention behind it. Waving hands in a random way in front of the subject does not activate a mirror neuron.... Carrying out an action with an intended outcome does. In this way, mirror neurons reveal that the brain is able to detect the intention of another person. Here is evidence not merely for a possible early mechanism of imitation and learning, but also for the creation of mindsight, the ability to create an image of the internal state of another’s mind.

Mirror neurons may also link the perception of emotional expressions to the creation of those states inside the observer. In this way, when we perceive another’s emotions, automatically, unconsciously, the state is created inside us (p. 65).

As an aside, this is also the reason we chose the following quote for the collaborative peer groups section of our website, www.oaimh.org/peer/: “Everyone deserves the experience of existing in someone’s mind” (Jeree Pawl). There are a variety of different types of mirror neurons: motor (a goal related action) or audiovisual (activated when listening to sentences). Dr. Gallese’s research team is currently exploring differences in the sensation of being touched for two groups of children: typically developing and those with autism.

Commentary

Stern (Switzerland): There are probably other systems not yet discovered that help us communicate at this prerational level. Future areas to explore include the following: 1) What about the temporal features of such neurons (this may yield clues as to individual styles of communication)? 2) Where do the nuances lie? 3) What happens when you start an action and don’t finish it? 4) What happens when you talk to yourself? Stern’s summary: “We live in extraordinary communication with others.”

Massimo Ammaniti (Italy): Are mirror neurons the basis for projective identification (PI)? *DSM-IV* defines PI as follows: “The individual deals with emotional conflict or internal or external

stressors by falsely attributing to another his or her own unacceptable feelings, impulses, or thoughts. ...[t]he individual is aware of his or her own affects or impulses, but misattributes them as justifiable reactions to the other person. Not infrequently, *the individual induces the very feelings in others that were first mistakenly believed to be there, making it difficult to clarify who did what to whom first*" [emphasis added, p. 756].

Master Class, (9, July), "Parent-Infant Psychotherapy: How to do Brief Work Slowly—A Psychoanalytic Way of Being with Parents and Infants" Alternative Titles, "Reflections on Working with 'Under Fives': The Baby Clinic" or Psychoanalytic Quiet: "Taking the Problem Seriously" [Brief work is defined as 1 or 2 sessions].

Presenter: Dilly Daws (Great Britain)

By Mike Thomasgard

Framing

Freud: The unconscious is timeless; in the moment, timelessly

Reflective listening is used to find a solution

Visits include the health visitor, the young child, and their family

Clinical Tips

- It's helpful to notice who carries the baby and who sits where.
- The emotion in the first few moments of the visit (anxiety, anger) is often similar to what the baby experiences.
- If parents suddenly break off; wonder about mistiming with the baby
- Parents can convey information economically, if we let them. Our job is to create a place where jumbled and incoherent thoughts come together.
- When babies are not sleeping, parents lose time dreaming (necessary for the consolidation of memory).
- Observe the baby; this provides an opportunity for silence
- Is the baby in tune with emotions?
- Our goal is to persuade the parents to stay ...so they may share their thoughts (e.g., in the face of inconsolable crying). When thoughts are spoken out loud they are more bearable.
- You may find yourself bored at times. There may be empathy for both sides; why do I have to listen to this?
- Are misattunements deliberate or true? Is there too much attunement?
- Notice what is missing
- Who is the patient (baby, parent, relationship)?
- The infant has a separate mind
- The importance of disagreements: When a depressed parent is no longer working outside the home, they are removed from individuals that have the potential to disagree with them. What is often lost in the depressed parent is an enjoyment of the debate / the conflict. Different views are valuable (noticing the otherness of the baby).

Warnings

- This work can leave therapists very confused! However, if you've gotten it right, moving around from one subject to another feels connected to the parent.
- Who to attune to and when? For example, the baby may show his means of cheering up the parent by smiling. If the parent looks up at that point and sees the therapist smiling in response to the baby's actions, the parent's thought may be to wipe that smile off your face.

Final Thoughts

- If you send a letter prior to the visit, the decision as to who attends is more likely to be made by the mother. If a telephone call is made, one is more likely to get the father to come.
- Since there's often anxiety accompanying a first visit, allow the family to be 30 minutes late.
- Parents sometimes cause the baby to need attention.
- There is clinical utility in having another set of eyes to observe with you and to ask questions that one hasn't thought of.
- Let the parent(s) go home and decide if they would like to return.

Master Class, (11, July), "A Family Perspective in Interaction Guidance"

[Interaction Guidance is an evidence-based approach to working with very young children and their caregivers that involves family video replay of treatment sessions].

Presenter: Monica Hedenbro (Sweden)

By Mike Thomasgard

- The technique of interactive guidance is powerful, but also dangerous. Remember; what one chooses to show is what you wish to grow / foster and what will be remembered.
- Magic of video: The focus is on possibilities in the family narrative

Phases / levels to the filming

- Mother sits next to the baby and the father is off to the side
- Father sits next to the baby and the mother is off to the side
- Mother, father, and baby—the mother and father are *becoming parents; a family, a triad*)
- Husband and wife (This *system already exists*; this may be the video segment that is shown if there is intrusive parenting)

Technique / Process

- Unlike the LTP, described earlier in this issue, the camera is behind the parents with the focus on the infant's face. This allows one to focus on the infant's cues and signals more clearly.
- There are cultural differences: In the US the tempo of interaction with the child is much faster; when parents from the US watch Swedish family videotapes, everyone thinks the parents are depressed due to the slower tempo!

- What is the child doing?

- Week #1: First session with the parents
- Week #2: Video 10-15 minutes of daily situations (e.g., meal, play, diaper change)
- Between visits select a brief video moment to show parents; this is very hard work.
 - What is the child doing?
 - Is there turn taking? Count the number of back and forth interactions
 - Do the parents take turns? Is there good co-parenting that is based on the child's initiative?
 - Affirmations (verbal / nonverbal)?
 - Clarifications (repeat with a different voice; helps especially with low levels of activity)?
 - Is there a shared focus?
 - Use of *music as a metaphor* for interaction
 - Is the music soft or loud, happy or angry?
 - How well do the individuals play together?
 - Can people take solos?
 - Can others give space, play in the background and still be happy?
- Week #3: Review the clip with the parents, talk to them about what was cut; offer counseling; be respectful of strong feelings—stop the film. Remember, we tend to remember difficult and bad things, hence the difficult work of selecting what one chooses to grow. This is an iterative process—it's not a fixed video.
 - Child's emotions
 - Signaling
 - Sharing
 - Social referencing (e.g., when the child looks to the parent for reassurance re: safety)
 - Regulation
 - Parents' emotions
 - How do they think about feelings?
 - Mention emotions (e.g., parents may not notice the child's anger)
 - Is there affect attunement?
 - Are emotional moments shared? For example, the family of origin may never have argued, so this never occurred.

Plenary IV (11, July), "Attachment Disorders in Family and Social Context"

Presenter: Charles Zeanah (USA)

By Mike Thomasgard (MT) and Elizabeth Finley Belgrad (EFB)

A basic challenge for attachment research has been the lack of specificity for psychiatric sequelae. For example, three studies have shown no relation between the Strange Situation Procedure (SSP)—a research paradigm that involves separation and reunion, and the clinical signs of Reactive Attachment Disorder (RAD). However, there is convergence between the disinhibited subtype of RAD and attachment behavior. RAD is now known as Deprivation / Maltreatment Disorder in the *Diagnostic Criteria 0-3 Revised* [2005 (DC: 0-3R)], as outlined below:

	Pages in DC: 0-3R ¹	Pages in DC: 0-3
150 Deprivation/Maltreatment Disorder Behavioral Patterns	17-19	29-30

1. Emotionally Withdrawn or Inhibited

Must include 3 of the following 4 behaviors

- Rarely/minimally seeks comfort
- Minimal response to comfort to decrease stress
- Limited positive affect, increased fear, irritability, sadness
- Reduced or absent social and emotional reciprocity

2. Indiscriminate or Disinhibited

Must include 2 of the following behaviors:

- Overly familiar behaviors
- Failure to check back, even in unfamiliar settings with adult caregivers
- Willingness to go off with an unfamiliar adult

3. Mixed Deprivation / Maltreatment Disorder

Must include two or more criteria from both Inhibited and Disinhibited

¹ From www.oaimh.org/peer/Background/Summary_ofDC03R.pdf, page 7 of 10 of the pdf

The challenge for researchers is to begin to account for 3 person attachment relationships (i.e., mother-father-child or caregiver-caregiver-child). *Dyadic interactions alone are no longer viewed as sufficient to describe in entirety the young child's caregiving environment [emphasis added].*

MT

I think the most important information from the work that Charley has done is to highlight the concept of a critical period for some of these symptoms. If intervention occurs prior to 22 months of age (i.e., early intervention), then both the inhibited and disinhibited symptoms improve. If the intervention occurs after that age, the disinhibited symptoms tend to persist.

The other potentially interesting thing to explore about children with these symptom profiles is whether or not there is a measurable and / or predictive physiologic item that could help us in some way with intervention. For example, are the disinhibited kids those with more sensory integration dysfunction? My best guess, given the common experience of sensory integration symptoms in people with borderline personality disorder, who are also exhibiting symptoms that are similar to the disinhibited profile, is that they represent the "grown up" versions of children with disinhibited RAD. EFB

Clinical Teach-In, (11, July), “Ultrasound Consultation During Pregnancy: Bringing IMH to Obstetric Practice”

Presenter: Zack Boukydis (USA)

By Mike Thomasgard

Ultrasound (US) is not new to medicine, yet viewing the screen can be a powerful experience for women and family members. Many women are provided with US photos or videos and these are often shared with important family / friends. They've also become part of the photo album such that children see their own “prenatal self.” Dr. Boukydis considered three questions: 1) How to expand routine US screenings to allow for psychological / developmental consultation? 2) How to bring a child development perspective to US during pregnancy? and 3) Can the US be used to initiate comprehensive prevention / intervention? Much of this work builds on Dr. Boukydis' extensive experience with the Neonatal Behavioral Assessment Scale (see: www.oaimh.org/inforesources/index.cfm, under the heading NBAS, and the Assessment of Preterm Infants' Behavior.

US technology continues to progress such that one can now see the fetus in three dimensions with extreme clarity. US during pregnancy may extend our understanding of fetal attachment and the fetus' response to the sensory environment, capacities for interaction, and self-organizing behavior. Finding the right words to explain what the obstetrician and ultrasound technologist see is critical. For example, maternal representations of the future baby could be clouded by drug exposure leading to thoughts of —“I'm damaged,” therefore “She's damaged.”

An US consultation has four phases: 1) Demonstrating the physical features of the fetus, 2) Exploring fetal posture and position within the womb, 3) Open ended, self-initiated exploration by the mother (e.g., fetal response to actions such as laughing or pressing on the abdomen), and 4) A post-consultation review. US during pregnancy has led to improved maternal-fetal attachment and decreased maternal state-trait anxiety scores for the US group versus controls. Mothers often want to do more to take care of their own health, in part because the fetus was made more 'real' to them.

Future research will utilize a video of the examiner's face with a split screen of the mother's face to further understand the impact of what's seen and said. Training tapes and a manual are in development, as are pilot studies regarding the health implications of US during high risk pregnancies (e.g., maternal diabetes, HIV, and drug exposure).

Master Class, (12, July), “Battling our Histories: Challenges in Reconceptualizing from Dyad to Family Collectives in IMH Practice”

Presenter: James McHale (USA)

By Mike Thomasgard

The predominant images we see for IMH are dyadic (e.g., Zero to Three's logo is a set of hands holding the infant). The *DC: 0-3R* is dyadic in nature [e.g., Axis II: Relationship Disorders and

the Parent-Infant Relationship Global Assessment Scale (PIR-GAS)]. However, one could include on Axis IV, co-parenting stress as a source of anxiety. At present, there is no Axis VI. The initial plan was to include only a family history of mental health. "We need to start thinking across caregivers to evaluate the family." Dr. McHale recommended the book: *Pathways to Competence for Young Children: A Parenting Program*, by Sarah Landy, Lynn Kern, & Elizabeth Thompson (2006), as a useful guide to such a perspective. As an aside, you may have noticed that our own logo is triadic (two caregivers and a baby)!

We often explore the Mother-Infant Relationship; what about the Father-Infant Relationship, and the Mother-Father-Infant Relationship? The co-parental alliance—a triadic model that accounts for intercaregiver dynamics, is absent. *It's important to remember that "co-parenting does not equal attachment warmed over" [emphasis added].*

Presidential Address, (12, July), "Infant Mental Health in Cultural and Multicultural Contexts"

Presenter: Tuula Tamminen

By Mike Thomasgard

The *DC: 0-3R* should have a culture-specific axis of developmental pathways and culture-sensitive parenting. We have a bias toward the western world that emphasizes the individual over the universal. There is great potential for cross-cultural research in the areas of moral evaluation, emotional arousal, and child-rearing.

WAIMH Business Meeting (12, July)

By Mike Thomasgard

- The 11th World Congress will be held in Yokohama, Japan (August 1-5, 2008).
- The central office for WAIMH will move from Michigan to Tampere University in Tampere, Finland. This transition is already in process and will be complete by the next World Congress. At that time, Hiram Fitzgerald will step down as Executive Director of WAIMH. The current Associate Executive Director (Palvi Kaukonen of Finland) will then become the Executive Director. Future associate executive directors will serve 4 years prior to taking on the top post.
- The WAIMH executive board is considering development of a research training seminar for young investigators.
- There may be changes to the WAIMH by-laws regarding the board (e.g., meeting every 2nd year, one board member from each country, and a smaller executive committee that would only meet yearly)
- A new Affiliate representative, Mark Tomlinson, of South Africa was elected to the Executive Board
- WAIMH is exploring collaborations with various Humanitarian Organizations located throughout the world.
- To correct for a shortfall in money, cost savings are planned. Dues may increase for 2007 by \$15 per person / year and *The Signal* (the WAIMH newsletter) may be sent out electronically, reserving the option to continue receiving it by mail. *The Signal* has grown in size from 6-8 pages per issue to 23 pages. While not yet a peer-reviewed journal, it is moving in that direction. Finally, the search is on for a new editor.
- Two new affiliates have been approved: New Zealand and Portugal. Latvia and Nebraska are now provisional affiliates.

Access to cultural competence videos on the web

By Mike Thomasgard

The Southern Consortium for Children in conjunction with Edenmarketing.com and Ohio University College of Osteopathic Medicine has created a web site containing five useful videos on cultural competence. The videos and their accompanying PowerPoint presentations are available free of charge at www.cbhed.com/catalog.html. Click on the cultural competency section for access. If you wish to obtain continuing education credit, a nominal fee is required. Viewing the videos does require free software that may be downloaded to your computer (i.e., Real Player for Windows or Mac and Adobe Acrobat Reader). The five videos cover the Latino, Asian, African American, Appalachian, and Gay / Lesbian / Bisexual and Transgender cultures. All videos were recorded in 2005 and range in length from 43 to 67 minutes.

The same web site contains three additional sections that may also be of interest including: Child Psychiatric Disorders (11 videos), Outcome and Evaluation (1 video) and Systems of Care (2 videos). The psychiatric disorders videos focus on when and how to use psychotropic medications in preschool children, substance abuse in teens, ADHD, psychotropic medications, depression, obsessive compulsive disorder, bipolar disorder, conduct disorder, psychotherapy, posttraumatic stress disorder and autistic spectrum disorder.

A special thank you is extended to fellow OAIMH member John Borchard, who alerted us to these videos.

Collaborative peer supervision groups: New on-line video

By Michael Thomasgard

Our web site www.oaimh.org now features a one hour video of a typical collaborative peer supervision group meeting. The on-line video was made possible by a 3-year grant from the Maternal and Child Health Bureau to Michael Thomasgard (Columbus) and Janeece Warfield (Dayton), project co-directors. Our goal in creating the video was to bring to life the steps taken before, during and after a typical meeting. The video is an important addition to our centralized start-up, maintenance and evaluation resources that eliminate much of the need to "reinvent the wheel," as new groups are formed in IL, IN, MI and OH.

Background: Collaborative peer groups typically have 8 to 12 members drawn from diverse disciplines (e.g., nursing, physicians, psychology, and social work). The primary focus of the monthly meetings is to provide a safe, structured and regularly occurring opportunity for clinicians to experience empathic supervision in the process of discussing what are often challenging infants / young children and their caregivers. Continuing education credits and / or hours of peer supervision for Help Me Grow, Part C service coordinators are provided. The *purpose* of the project is to improve the clinician's ability to assess, treat or appropriately refer children with developmental variations, problems, and disorders of mental health. Evaluation includes qualitative and quantitative methods to assess the clinical utility of CPS groups and their potential for continued professional development.

Video: The meeting focused on a 4-year-old boy for whom a diagnosis of Asperger's Disorder was being considered. For this particular child, having an anxious parent further exacerbated his difficulties with understanding and coping with the social world. Diagnostic criteria for this disorder, as well as commonly co-occurring behavioral conditions (e.g., attention problems, perseverations, aggression and anxiety / affect regulation problems) were considered. Attention was paid to how the *DSM-Primary Care* reference could be useful to the clinician, starting with the presenting complaints for Aggressive / Oppositional Behaviors (p. 199) and Social Interaction Behaviors (p. 277). Supplementary text is provided on the web site that highlights the necessary steps to obtain educational credit. A brief summary of the meeting led to the following two conclusions: 1) A diagnosis of Asperger's Disorder is often made prematurely or extremely late and 2) Ideally, the clinician can provide helpful information early on in a manner that doesn't frighten families and that encourages them to put energy into intervention versus a quest for a diagnosis.

For further information about collaborative peer supervision groups, please contact Janeece Warfield at janeece.warfield@wright.edu or me at thomasgardm@pediatrics.ohio-state.edu.

Update on infant mental health providers

By Michael Thomasgard

Oaimh was fortunate to have Ms. Blair Loftspring update our web-based, find an infant mental health (IMH) provider listings during the summer (2005). Blair was an intern working with Holly Schlaack a current board member. While this significantly reduced the number of active IMH providers, an update was long overdue. In February, my wife Julie and I sent out hard copies of individual provider profiles for review along with an oaimh membership application. We also used this opportunity to correct a problem in the web site database. Up to that point, individuals who were both an oaimh member and an IMH provider did not have the option to list their home and work addresses, respectively. We also moved the update / addition form to a more prominent location on the main page of the *find a provider* section. This form may be used by existing providers to update their profile and / or by others, to suggest the name of a potential IMH provider for our web-based listing.

Greenspan: Web radio transcripts available

By Michael Thomasgard

Last fall, I discovered a wonderful resource that focuses on children with autism spectrum and other developmental and learning disorders: www.floor-time.org. While Dr. Greenspan's live weekly web broadcast is available every Thursday at 10:30 AM EST, I found the transcript archives to be a great clinical resource that I could read at my own leisure. For the more adventurous, you may call in live with questions at 1-877-907-8889. You may also send your questions via email in advance of the program to: webradio@floor-time.org. A variety of guest speakers and topics are featured, as is practical advice for parents, professionals and policymakers. Topics include early recognition and treatment of developmental difficulties, the misdiagnosis of autism spectrum disorders, learning to regulate moods and impulses and pathways to empathy and thinking.

The mission of the Floortime Foundation is: "...to redefine the potential of children with developmental and communication challenges by making the DIR model more broadly available." 'D' stands for functional emotional developmental levels, 'I' for individual differences in sensory processing (e.g., auditory, visual / spatial) and 'R' for relationships that are tailored to the child's individual differences and that move them up the developmental ladder. The **September 2, 2004**: [Floortime - What it Really is and What it Isn't](#), provides an excellent summary of the overall DIR model.

Here's a brief sampling from the transcript archives:

May 5, 2005: [How Parents Can Help Their Children to Better Attend and Engage, and Also How to Deal with Tantrums and Meltdowns](#)

December 2, 2004: [Working With Family Dynamics: Turning Challenges Into Constructive Opportunities](#)

July 1, 2004: [Helping Kids Become Great Communicators](#)

March 25, 2004: [How to Help Children Control Their Moods, Aggression, and Regulate Their Behavior](#)

If you visit this web site, you will soon discover many other helpful resources including a number of useful publications from the "Interdisciplinary Council on Developmental and Learning Disorders."

!!!! DAN SIEGEL, MD COMING TO OHIO IN FALL, 2007 !!!!

Exciting news! The Southwest Ohio Chapter of OAIMH has engaged Daniel Siegel, MD to come to Cincinnati to present at their Fall Conference! What a coup! Much sought after to present on Infant Mental Health, Dr. Siegel is famous for his capacity to communicate the intricate relationship between early brain development and the development of attachment in ways even I can understand. Author of the book, Parenting From The Inside Out, Dr. Siegel is an engaging and extremely knowledgeable Infant Psychiatrist. This editor of BABY TALK heard him at a ZTT Institute a number of years ago in Pasadena and has been a fan ever since.

To add to the excitement, the Southwest Ohio Chapter has agreed to allow the rest of OAIMH to join them by converting their Fall Conference to the Bi-Annual OAIMH State Conference, so we are all invited. Keep your eyes peeled for more information about this upcoming treat. Thanks, Southwest Ohio! (Ed.)