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Guidelines for contributors

AAIMHI aims to publish three editions per year in March, July and November. Contributions to the newsletter are invited on any matter of interest to the members of AAIMHI.

Referenced works should follow the guidelines provided by the APA Publication Manual 4th Edition.

All submissions are sub-edited to newsletter standards.

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Introductory remarks by Dr Julie Stone at the presentation and reading of the winning entry for the 2011 Ann Morgan Prize

It is a pleasure to welcome you to the presentation of the 2011 Ann Morgan Prize. This is the second year of this prize and it seems we still have much to learn about getting it right.

What the committee representing you our members believes we have got right is that there should be a prize to honour Ann Morgan and her invaluable contribution to our field of infant mental health. Many of you present today have been inspired by Ann's clinical experience and know-how, challenged by her incisive thinking and encouraged by her ever thoughtful warmth and generosity. Those of you who have not had the opportunity of being taught or supervised by Ann enjoy the legacy of her influence on the way we think about and work with infants.

Our hope for this prize is that it will come to be an award that is seen by all members of our Australian Association for Infant Mental Health, not only here in Victoria but Australia-wide, as a unique opportunity to reflect upon your professional and personal experiences and what they have revealed to you about the inner life and emotional world of the infant and young child; and that by writing about these reflections, you might:

- provoke your self and others into thinking in new and different ways
- inspire colleagues to think in deeper and more satisfying ways
- affirm infant mental health clinicians and encourage them to continue their work, and, or
- to explore or try new ways of relating to and being with infants and those who care for them.

Last year we used the word essay in our explanation about the prize. The notion of essay was confusing and challenging for some, as perhaps was awarding the prize to two pieces, one of them a poem. This year we hedged our bets a bit and used the phrase "a piece of writing" and that did not seem to be helpful either. Our plan is next year to spell out more fully some of the criteria the judges will be looking for in the hope that this may encourage more of you

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Introductory remarks - Anne Morgan prize (cont.)

to enter. The prize of $1,000 we believe is a handsome one and it would be wonderful to have a larger field to choose from.

It was my privilege to be the prize administrator for the second year. Ann Morgan, Campbell Paul and Joanna Murray-Smith [Melbourne based award-winning play write] again made up the judging panel. Their discussion about the entries was lively and wide ranging. I was again impressed by how carefully each of the judges had read the writings and how thoughtful they were in their considerations.

Several of this years entries addressed the experience of a starving baby, a baby or babies living within a war-torn nation far from Australia. The writing and the issues raised were confronting and took us into the territory of the political and philosophical baby, whilst striving also to keep us in touch with the subjective world of this baby, here, now, barely alive and needing help to become enlivened.

Ann said on first reading she found these entries "depressing." This sparked a thoughtful conversation about the place of hope in our work and the challenge to infant mental health clinicians working with starving children to continue to feel, to think, to hope and to inspire others to look beyond calories and weight gain and to acknowledge the importance of the inner world and emotional world of the infants, together with the life-giving nature of lively and engaging relationships between the infants and those who care for them.

Please write a reminder to your self now: must enter the Ann Morgan Prize for 2012. Put it in your diary and encourage your colleagues and associates to do the same. If you have any ideas on what else we might do to encourage submissions or to advertise the prize, then I, or indeed anyone on the committee, would love to hear from you.

The Anne Morgan prize 2011

Judy Coram

27 August 2011

I am delighted to be the winner this year of the Anne Morgan prize for my work with *The Free Baby*. I am sorry I am unable to be with you in person today but I am still working in Pakistan in a Maternal and Child Health program in a rural community for MSF. I am so pleased however that my daughter Georgie can represent my work today by reading my essay to you all. I want to take this opportunity of thanking my family Tom, Georgie and Pippa for being so understanding and patient with their nomadic mother since I started this work 5 years ago! Soon I will be there to plant vegies with you!

My journey into writing began late in my career when following my first mission with MSF in Thailand I met up with Frances Salo, my mentor, to discuss some of the more challenging aspects of the work. Typical of Frances she left me with the thought, "Judy, you really must get some of this clinical work down on paper!"

Little did I know then what a lifeline this was to become for me in this work. During my work in Uganda I was able to do several Infant Mental Health interventions in the Nutrition ward of severely compromised infants, many of whom were unable to move forward with nutritional supplements alone. This was at times an overwhelming feeling when faced with such hopelessness, deprivation and despair. My writing became a way for me to find a clearer path often in a sea of chaos and was a way for me to debrief myself. More importantly it became an anchor and a lifeline as Frances so graciously provided long distance supervision to me and provided a 'secure base' for me to not feel so isolated in this work. It gave me the courage to continue and not despair in the face of so much adversity and deprivation. Her words that infants need to "drink in more than milk" resound clearly when I am working with malnourished infants but sadly this is not well understood by many in the field, and these interventions are often missing from the nutritional units. My work continues with MSF and I am now able to 'pass on' some of my experience and understanding of this to the staff. One of my counsellors who is studying psychology, following some Infant Mental Health interventions together, said that it has 'opened' up a new understanding for her. Of course as psychology is a relatively new field in Pakistan her university had not heard about Infant Mental Health at all! So from small beginnings at the Infant Mental Health Group in Melbourne this message is taken to the wider world so that infants do not have to remain invisible to the world. I am grateful to this group for enabling me to have the insights to work in this way and that this knowledge can be taken into the wider communities. How difficult it is though to keep the infant in mind when faced with such deprivation, poverty and despair? So many people affected by the impact of war and displacement from their lands, families and homes and living in such dire circumstances with no access to health care or education. There are so many Salida's across the world but it takes minimal interventions to sometimes make a difference in some of their lives.

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ANN Morgan prize-winner (cont.)

Finally, to discuss the dichotomy observed in Pakistan on the role of women and mothers. It is clear that culture strongly overrides religion on this subject. The following is a quote from the Quran:

> *Mother is the name of Paradise, paradise is in her feet. Mother is the name of love, love in her heart. Mother is the name of the knowledge, knowledge is in her lap. Mother is the name of friendship, friendship is in her act, mother is the name of life, life is in her child (Quran vs).*

Mothers are highly respected and revered in the Quran and there are many quotes expounding the virtues of mothers, but as the *The Free Baby* attests to in the following essay this is not the reality in much of this culture.

> *A man once asked the Prophet to whom he should show the most kindness. The Prophet replied: "Your mother, next your mother, next your mother, and then your father." (Sunan of Abu-Dawood) In other words, we must treat our mothers in a manner befitting their exalted position - and, again, revere the wombs that bore us.*
>
> *The Arabic word for womb is "rahem." Rahem is derived from the word for mercy. In Islamic tradition, one of God's 99 names is "Al-Raheem," or "the Most Merciful." There exists, therefore, a unique connection between God and the womb. Through the womb, we get a glimpse of the Almighty's qualities and attributes. It nurtures, feeds and shelters us in the early stages of life. The womb can be viewed as one manifestation of divinity in the world.*

Why then are women and children treated in the way they are here?

Thank you again for the honour of receiving this award and especially to Ann Morgan whose work with her bracelet came alive for me when working with malnourished infants!

Anne Morgan Essay – Judy Coram

The Free Baby

Mother is the name of Paradise, paradise is in her feet. Mother is the name of love, love in her heart. Mother is the name of the knowledge, knowledge is in her lap. Mother is the name of friendship, friendship is in her act, mother is the name of life, life is in her child (Quran vs).

Salida (meaning 'good deeds' in Pashtu) first came to my attention in the crowded Outpatient Department in a remote Rural Health Clinic in the area of Kille, Baluchistan Province, Pakistan. The room was congested with different ethnic women from the surrounding rural areas, including the Kuchi women with their sad and neglected children. The Kuchi are a nomadic tribe from Afghanistan, recognisable by their brightly coloured, beautifully beaded dresses. This is in such contrast to the Pashtu women, who appear hidden away under their black *burkas*. The *burkas* completely cover their head and body, which can have the effect of hiding them away from the world. At times, they seem invisible.

Kuchis (from the Persian word koch meaning 'migration'), are Afghan Pashtun nomads, primarily from the Ghilzai, Kakar, Lodi, Ahmadzai as well as some Durrani tribes, and occasionally there may also be some Baloch people among them. They live a traditional, nomadic life travelling between pastoral lands in Afghanistan and Pakistan. There are approximately three million Kuchis in Afghanistan, with at least 60 per cent remaining fully nomadic. Over 100,000 have been displaced in the past few years due to natural disasters such as floods and droughts.

The women in the clinic were jostling inside the clinic waiting to see the female doctors to get their medications. They rely on this medication in order to sustain them in their daily tough lives. Invariably they must provide the medication to their husbands as justification that they have been at the clinic. The clinic opened in 2006 and provides a welcome opportunity to leave the confines of their compounds for the freedom of the outside world. It also gives them the opportunity to gather together in groups and talk, as before this time they were unable to leave their compounds for any reason. Amongst the chaos of the clinic, the Health Educators were struggling to get everyone's attention to convey their health messages around hygiene and prevention of diarrhoea and diseases.

A frozen space

I first saw Salida from across the room wrapped very tightly with only her face showing. She had an expression that I have seen so many other times in this work; a lifeless, disconnected expression with the saddest eyes staring no where or at no one. She was held by a woman a little older than some of the very young child brides normally seen in the clinic. Her expression was one of being vacant and 'far away' in a frozen abyss, a psychic geode, unreachable and unobtainable. She showed no response and almost seemed buried, lost to connections and resigned to her fate. Salida had been brought to the clinic as she was

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ANN Morgan essay (cont.)

malnourished and failing to thrive. Her big eyes were lifeless and dull but they appeared out of proportion to the rest of her pale, emaciated face.

We asked them both to come into the counselling room, so we could talk a little more together. Salida was completely wrapped, as if she was in a straight jacket, her eyes were glazed and she took no interest in looking at anyone, so much so I thought she may have been blind. She reported to be about eight months old but she looked only about 3 months old. Once unwrapped she became distressed initially and looked uncomfortable with the new-found space to move around in. She was severely developmentally delayed, had very poor muscle tone and a scissoring of her legs. She was unable to sit, roll, or weight bear.

Following the initial distress, Salida began to bring her hands very slowly together as if enjoying the freedom of movement and the chance to move. She was a thin wasted infant who lay at the care-givers feet like a sealed abandoned parcel.

Loss of supporting matrix

Her caregiver Shireen was in fact her paternal grandmother who reported that her own mother Khadija had died four days following childbirth. They did not know why she had died, but blamed the Jinn (spirits) for her death. The Pashtu believe the Jinn are small male and female spirits which can be either good or bad spirits. *Pari*, *Parianan* and *Galgai* are some names for them. The Pashtuns are highly superstitious and protect their newborns by visiting the Mullahs and receiving *Tawiz* (holy prayers), which they hang around the babies' necks in small leather bound pouches. They also protect newborn babies by drawing dots on their ears, cheeks and between the eyes, and painting the eyes with kohl (black powder). This is also a way to protect them from *'The Evil Eye'*, which can be placed on them through jealousy from others. It was noticeable that Salida did not have a *Tawiz* around her neck to protect her. It occurred to me that in the family's mind perhaps she was the Jinn herself, taking the life of her newly bought, expensive bride and the future of the family.

Shireen began to tell us about her own family which consisted of 13 children, the youngest one being eight months old, the same age as Salida. She said they were very poor and she did not have enough breast milk to feed both of the infants, but her own baby was thriving. When I asked her how old she was, like so many of the women here, she did not know but said that she was married at 12 years of age, had her *menses* aged 13 years and then had one baby every year after that so could I tell her old she was! I thought she would be about 30 years, but she in fact looked much older than that. Her rugged features and tired eyes reflected the hard lifestyle for women here in the tribal areas, particularly due to the violence directed at them making them look much older than their years.

Displacement and loss

Shireen talked at length about their poor situation and poverty and about being forced to leave her homeland in Afghanistan to escape the war, leaving behind all their family, wealth and possessions. Living in Pakistan as a displaced person with no rights and living under very harsh conditions had caused her much grief and shame. She explained that her son had paid a large dowry (*Walwar*) for his wife who was only 14 years old when she married. She had become pregnant in the first year of their marriage but then had cruelly died four days following the birth of Salida. The family did not know how to keep another female baby alive.

Maternal mortality rates

Pakistan has one of the highest maternal mortality rates in the world particularly in the Baluchistan Province where it is reported that the rates are 760: 100.000 live births. It is reported that Pakistan, India and Bangladesh account for 46 percent of the world's total maternal deaths. In Pakistan, one of the major factors contributing to the high female mortality rate is a relatively poor educational and low socio-economic status that women hold in the country. Another relevant statistic is that over 89 per cent of deliveries are conducted by traditional birth attendants at home, who are unable to manage the complications that may arise.

Teenage pregnancies, due to early marriage, are yet another contributing cause of rising maternal mortality rates. As contraception is not permitted in the Islamic doctrine and husbands often force their wives to continue to produce children even if this is not their choice. These factors have all contributed to the high maternal mortality rates. Another cause of the high mortality rate is poverty and malnutrition, which affects 34 per cent of pregnant women. Around 48 per cent of lactating mothers have a calorie intake of 70 per cent less than the recommended level. This is insufficient for the good health of the mother as well as the baby. [MSF document 2010]

This year, 85 governments in a joint statement delivered to the UN Human Rights Council (UNHRC), reaffirmed commitment to addressing maternal mortality as a human rights issue and that the magnitude of the problem calling for the renewal of political will to address it. However, Pakistan was not one of the signatories to this document, because the government refuses to recognize the death of Pakistani mothers, as a result of medical negligence and lack of awareness, a basic human rights issue. There are some incongruities when Pakistan has one of the largest military armies and is a nuclear power but it has one of the highest maternal mortality rates, and lowest illiteracy rates amongst girls.

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Role of women in Pakistan

The majority of the girls who attend the clinic do not go to school. Pakistani girls and women, it appears, are dispensable commodities to be exchanged for honour killings. The practice of *Karo-Kari*, part of a cultural tradition in Pakistan, is a compound word literally meaning 'black male' (*Karo*) and 'black female' (*Kari*), metaphoric terms for adulterer and adulteress. Once a woman is labelled as a *Kari*, male family members, who include fathers and brothers, get the self-authorized justification to kill her and the co-accused *Karo* to restore family honour.

Child marriages

Child marriage usually refers to two separate social phenomena that are practised in some societies. The first and more widespread practice is that of marrying a young child (generally defined as below the age of fifteen) to an adult. Due to women's shorter reproductive life period (relative to men's), perhaps, the practice of child marriage tends to be of young girls to fully-grown men. This is common occurrence in the counselling rooms in Kutchlak.

The second practice is a form of arranged marriage in which the parents of two children from different families arrange a future marriage. In this practice, the individuals who become betrothed often do not meet one another until the wedding ceremony, which occurs when they are both considered to be of a marriageable age.

Swara is a child marriage custom in tribal area of Pakistan and Afghanistan. This custom is tied to blood feuds among the different tribes and clans where the young girls are forcibly married to the members of different clans in order to resolve the feuds. It is most common among Pashtuns.

Swara was originally meant to stop decades of old blood feuds between two clans, with the aim to resolve conflicts and to stop further killings. The *Jirga*, or village council, orders the family of the aggressor to send a bride to the aggrieved family. Sometimes girls, just a few months old, are given as 'blood money' and married once they reach a certain age. At times, girls are purchased from another family in cases when there are no women in the aggressor's family.

It is believed that the children of such unions could help keep peace between feuding families. Whether this happens or not, the girl taken in *Swara* bears the brunt of it all and is forced into a life of near slavery.

I have focused at length on this situation for girls in this area, as it was important to understand this before proceeding with the intervention with Salida. It also reflects the difficulties of keeping the infants and children in mind when there are so many other overriding issues.

First connections

During the first session at the clinic, Shireen spoke of the families' dilemma now that her son was destined not to have a second wife, as they was too poor to buy another one. What would the future hold for him and the family? As she was relating this story, Salida reached forward and held my finger in her hand, connecting for the first time. She was also able to gaze into my eyes which reflected an intense sadness and she held my gaze for some time. I was thinking about her experience of losing her young mother so early and the trauma of this loss. What would this mean to a newborn baby so reliant on the love of a mother to nurture and love her and keep her alive? Was it this that had put Salida into this stony frozen place disconnected from the world, people and her herself? As she held my finger in her hand, we spoke about how sad she must be to have lost her mother so young and how she wondered how she may survive without her. I was not sure if language and culture transgress understanding, however, she held my finger tightly and I am sure she gave an imperceptible squeeze at this moment. Perhaps she knew that I knew and understood.

I reflected on her experience of being raised under these circumstances and how she would make sense of this and her resignation almost explained this. I wondered how she competed for the time at the breast with her aunty of the same age. It is a usual practice in the village for anyone to feed a baby if they are left with them. I thought what an alien concept to the Western world this would be, dropping off your baby at a neighbour's house, and to have our baby breast fed by them, but this is adopted as a way of survival. Wet nursing of course has been around for centuries however even in the Western world.

I talked with Shireen about what was important for her to grow and develop and to be given the opportunities to have different experiences. But what did this mean for little Salida lying on the mat in this counselling room? Shireen appeared to be oblivious to her as she continued to talk about how poor they were and how can she feed this mouth as well. I have to say that I was not sure either how she was going to feed this baby except with the customary sweet Pakistani tea. Within the project, breast feeding is always the preferred method of feeding and very actively encouraged. According to the Quran, women are supposed to feed their infants for two years. Many of the women feel they have insufficient supply or the milk is not good for the baby and of course there are the situations when this is not possible for the women, especially when they become pregnant again so soon. There are few alternatives though as formula milk is never given to the families because of the risks of diarrhoeal diseases from unsafe hygiene practices which outweighs the advantages of this.

While I was working with Salida in trying to reach some

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part of her and unlock the trauma she had experienced, I was reminded of Daniel Stern's *Motherhood Constellation and Supporting Matrix*, where he writes it is a fundamental anxiety for all mothers to ask the question, "Can I keep my baby alive?" In *The Motherhood Constellation*, Stern describes it as "a mother's instinctual focus on and devotion to her infant", as being critical to the child's development. What is the outcome in the case of Salida when this was missing? Stern writes that psychoanalytic support could take the form of 'the good grandmother transference' appropriate to the motherhood constellation. With all the other contributing factors in Salida's life and the factors of strong cultural beliefs, would this be possible?

In 1995, Stern also introduced the term *proto-narrative envelope*. This 'envelope' contains experience organized with the structure of a narrative, a story without words or symbols, a plot visible only through the perceptual, affective, and motoric strategies to which it gives rise". Stern stresses how early experiences of mother-child interaction "have a beginning, a middle, and an end and a line of dramatic tension; they are tiny narratives, proto-narrative envelopes". Salida however, appeared to have been wrapped in a sealed envelope with no opportunity for the narrative to be opened and told.

Following the session, Salida and her grandmother were referred to the Nutrition Unit for assessment and inclusion into the program. After they both left the room the counsellor turned to me and said, "She is a free baby". I of course immediately thought she was meaning that she had some opportunity away from her tight wrapping with freedom to move and some release from her dark abyss. She explained to me however, that she will be available for marriage to one of the family members without having to pay 'the bride price'.

Her destiny was already prearranged, born into this Pashtu culture where women are commodities to be bought and sold, abused and raped. This is not what is written in the Quran, but it is clear that centuries-old traditions outweigh the religious philosophies for many in Pakistan and in Afghanistan. The veil of secrecy about these practices and the collusion of these abuses and fear of retribution from family members offer no protection to the girls and women. The violence is so extreme that it of course keeps the power and control firmly in the hands of men, all in the name of religion and culture.

A 1987 study conducted by the Women's Division and another study by the Human Rights Commission of Pakistan in 1996 suggested that domestic violence takes place in approximately 80 per cent of the households in the country. In Pakistan, domestic violence occurs in forms of beatings, sexual violence or torture, mutilation, acid attacks and burning the victim alive (bride burning). Just two days ago in a rural village a woman was stoned to death by her husband and friends for some indiscretion.

This is the world that Salida has been born into.

Unsealing the envelope

In follow up visits the counsellor and I continued to try to retrieve Salida from her dark inner world. Slowly she began to emerge from her envelope and even managed a smile. She enjoyed the opportunities to find a central position with the freedom to explore and make connections. There was little change in the grandmother's ability to 'see' and 'be with' her but improvements were seen in Salida's ability to connect with others and her enjoyment of the new space she found herself in. She was able to 'catch' the faces across the room and appeared to relax more and smile. She appeared to improve in her functioning although she remained very delayed in her development. Sadly she was lost to follow up which leaves one always wondering whether the sealed envelope was opened enough and the therapy sufficient to provide the 'good grandmother transference'; enough for her to survive sufficiently to become another child bride to a Pashtu family member.

Does what we call 'engaging with the infant' matter?

Frances Thomson Salo

These thoughts arise from attending a very interesting Anna Freud Centre Parent-Infant Psychotherapy International Study Day **'How to begin ... creating engagement between infant, parent and** therapist', discussing video clips of the work of a number of experienced therapists.

Three very different ways of engaging with the infant were presented. First, a clip of a 7-week-old whose mother had had a traumatic pregnancy and birth, a low birth weight baby and she felt too anxious to bond**. The style of the therapist in the clips in encouraging the mother's bonding with her infant whose needs the therapist initially scaffolded, had at times a more directive quality. S**econd, a mother and her 14-month-old daughter who had had difficulty in maintaining a steady weight gain after being placed in a crèche at 3 months were seen by 2 co-therapists, one therapist working more with for the mother, the second more available for the girl. The third clip was almost entirely of a therapist in focussed interaction for about 15 minutes with a 14-week-old boy.

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These different styles of interaction raise the question what do we mean when we talk of engaging with the infant? Where do they fit on a spectrum?

Spectrum of ways of engaging with an infant

Less 'direct' ways

For example, modelling interaction for the parent, coaching and 'Speaking for the baby' (Carter et al, 1997). Another response is when the therapists make a gesture like stroking the infant's arm, which may look maternal, perhaps to facilitate the interpretive work or draw them back into a positive alliance with the parents. I'll leave aside the more physical movement therapies (Tortora, 2011).

Addressing an interpretation, intended for the parent, to the infant to soften its effect for the parent (Norman, 2001).

Interpreting in an adult way to an infant, however young (Dolto, 1994).

Respectful engagement with the infant in the parents' presence to understand the meaning of the infant's experience (Paul, 2011).

Less direct ways

For the Study Day, clips over 2 weeks of the first case showed some interaction by the therapist, **Judith Whitehead**, with a 7-week-old infant, for example initially holding and comforting him when he was crying, down-regulating, modelling care and interaction with him to settle him. The main feature, however, that emerged was the therapy with his parents. His mother who was anxiously avoidant was encouraged by some directive communication requesting that she bend her face down to the infant's, or nuzzle his cheek and say what she felt about her relationship to him, and to notice the change in his expectancy for interaction. After two weeks he was much livelier and his mother seemed more connected.

Addressing an interpretation intended for the parent to the infant to soften the effect for the parent

Johan Norman (1999) described assessing in a first session that the severity of a mother's depression meant that it would take too long to help her become available to her 6-month-old gaze-avoidant daughter, and he therefore interpreted to the infant so that her mother could hear it. He interpreted that the infant was afraid of, and avoided, her ruined mother. The infant immediately returned his gaze and began to reconnect with her mother. Norman had interpreted to the infant because he thought it would be too hard for her mother to hear.

Interpreting in an adult way to an infant, however young

Bjorn Salomonsson (2007) has previously described interpreting to an infant when he offered mother-infant psychoanalysis to 2-week-old Nicholas and his mother. Salomonsson believes it is feasible to approach the infant directly, because the infant is able to affectively understand aspects of the therapist's interventions. In this sense the therapist 'talks' with the infant in his own right. Salomonsson says, after Nicholas cautiously pays some attention to him and then frets, "Nicholas, I wonder what disturbs you. You have many feelings. Hunger hurts. You sense the wonderful milk. Then you recall that you didn't like Mom's breast and her "ouch" when it hurt her. Your feelings clash. You didn't want the breast and throw your head back. Then you get hungry and want it anyway. And Mom gets stressed." Salomonsson states that Nicholas does not understand the words but understands "my sincere intonation, and the rhythm and tempo following my understanding of what goes on within him when he is at his mother's breast" (Salomonsson, 2007). The distressed infant is assumed to seek containment from the analyst and the infant-analyst dialogue becomes a major vehicle of change.

Amanda Jones' BBC films, *Help me love my baby* (2008) suggest that at that time, while she seemed to interpret to the infant, she gave more primacy to the mother's therapy. To 5-month-old Izzy, Jones said, picking up a comment her mother had made, "When your mother looked at you I don't know who she saw, she didn't see a baby – I think she thought she'd given birth to something – alien-like – so she didn't see you for a little baby – she saw a little monster there". Jones was talking to the infant about some of the mother's perhaps not metabolised-enough projections. Subsequently, when Izzy is irritable Jones says, "What am I going to do with you because mummy and I really have to talk this one through", as if the mother's need came first.

For the Study Day, in Amanda Jones' clip can be seen a move to direct engagement with the infant. The therapist had previously, as a support for the isolated teenage mother of a 14-week-old baby (conceived in traumatic circumstances), filmed clips of him. On this occasion Jones gave the mother the camera to film the therapist interacting with the boy, to help the mother stay in a non-psychotic state after she had decompensated, to empower her when feeling threatened, which had been frightening for mother, therapist and infant. In Jones' interaction with the infant she hoped to draw attention to his needs, to re-present him as a little baby needing and connected to his mother and to make a link with his loving protectiveness in the future. Jones told the boy she would make a video for them to watch later and that he would always remember how much he loved his mother's milk as the first best meal and would trust and love his mummy forever; and Jones and he would take a gun to the man who hurt his mother. Jones scaffolded him to manage sleepiness and other discomfort, and stroked his chest in gentle circular movements, offering

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Engaging with the infant (cont.)

her fingers for him to chew, talking all the while; there are occasional mirroring episodes with her responding to his responding. Jones' intervention of talking to the infant seemed to incorporate some aspects of an interpretation for the mother as well as giving him an experience of being related to with something similar to embodied parental mentalizing (Shai & Belsky, 2011).

Respectful engagement with the infant to understand the meaning of the infant's experience

Also at the Study Day, Astrid Berg presented a first session with her co-therapist, with a mother and an inhibited girl, an older infant than the other two. She was offered a biscuit and felt held in Berg's containing gaze, for as long as it took to resolve her dilemma about taking the biscuit. She then revelled in the gaze. Berg made relatively few comments and interventions but they underlined the child's developmental trajectory in the session and her inhibition in reaching out and taking in. The mirroring seemed appropriately contingent and the girl seemed to change the interaction in quite a major way: as Berg 'read' the embodied communication that she wanted to eat the biscuit, the child initiated a peek-a-boo game; after Berg interpreted, "She's cautious", the child seemed to invite Berg into play with some abandonment. I think the child felt 'read' and that her mother could be 'held'. Berg watched with a warm, permission-giving, communicating and empathic gaze, probably with a dance of invitation, which would convey the sense of a therapist's mind on hers and the child seemed to feel delighted to be enjoyed and have someone 'be' with her.

Campbell Paul (and members of the Royal Children's Hospital Infant group) has described the approach of trying to understand and communicate with the baby as a person in their own right. When things go well, parents respond to their baby's cues with appropriately contingent mirroring, when "the sensitive, infant-attuned caregiver intuitively mirrors the baby's momentary expressions of affect with emphatic emotional displays" (Paul, 2012). Two-month-old Stuart was referred for severe failure to thrive and cried as his mother and grandmother said he had not been feeding. When Paul commented, "Another anxious week", Stuart looked at him wide-eyed. Paul, noticing Stuart had calmed after crying, said, "He's looking about in a thoughtful way". Stuart turned to Paul and stared intently for 15 seconds, smiled, then stared almost unblinking for 30 seconds. Paul commented, "A big stare", smiled and asked, "Do you think I could say hello?" Paul held Stuart so he could see his mother. He commented as Stuart smiled at his mother for the first time, "That's your mother. That's a big smile". Stuart wriggled, and Paul commented, "You're a bit of a wriggler", and Stuart gave a shiver, then vocalized vigorously, his mother smiled and talked tenderly, and he sat up straight. Paul talked about how sometimes it is hard for babies to say what they are worried about. Stuart's eyes moved back to him. When his mother took him back Stuart turned his head round to look directly at Paul. He immediately began to thrive (Thomson Salo 2007).

The three interventions described at the Study Day were effective in that all the infants improved. However, the first three ways on the spectrum above would not be described as appropriately **attuned mirroring. Does** it matter that the quality of engagement with which a therapist interacts with an infant is not always contingent?

Currently some therapists describe moving from the notion of 'technique' towards conceptualizing 'ways of doing', acknowledging that the therapist's ways of intervening, while subscribing to the following cornerstones of a psychodynamic approach, are almost entirely due to their 'personality and experience'.

Cornerstones of what unites psychodynamic therapists

1. Striving to establish a well-thought through setting

2. Striving to take the infant's point of view and to find the port of entry from the first session

3. Willingness to reflect afterwards about transference-countertransference and the unconscious

4. Recognising the presence of hate (and within it development, strength, and passion)

The four therapists demonstrated the following styles of engaging in the clips shown - suggesting interventions to the parents that at times come over as directive, while supporting their infant; secondly, relating verbally and physically to the infant in an intimate assured way, and thirdly, a respectful, collaborative approach holding back appropriately.

A conference attendee suggested that the infants improved despite the therapists' mirroring perhaps not always being contingent, as babies develop well when parents respond to only 50% of their overtures**.**

Does it matter if the reasons why we initiate engagement with an infant make the interaction less inauthentic, eg to hold a therapist (who may be internally frightened), or to hold a mother, or to repair the therapeutic alliance with her?

An authentic response I see as interacting and talking about the present moment, about the experiences and affects that the infant has in the therapist's presence. In authentic relating, the therapist is talking to the infant about being that infant, with embodied mentalising communication. Being authentic is partially surrendering to the process, not knowing where it will go. Sandra

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Engaging with the infant (cont.)

Buechler (2008) in *Making a Difference in Patient's Lives: Emotional Experience in the Therapeutic Setting* asked, "What do we have to do to matter enough to be watched?" And I think her answer is what a therapist aims for with an infant. She wrote, "I think one way is to be emotionally open,transparent and readable so that patients become interested in what they learn from how we tick (36)."

The infant senses if the therapist really wants to understand. To answer my question, perhaps the infant 'gets it' that the therapist is authentically trying to be helpful even if their style of engaging with the infant may not be quite authentic.

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Baby Strengths cards: a brilliant new resource for working with infants and their parents

Rarely do I come across something which immediately shouts at me: "Use me and I will enhance the work you do with grace and ease!" A series of 25 cards, beautifully illustrated by Jan Player and produced by St Luke's Innovative Resources, did just that, and I think will do that for you too.

The cards highlight various aspects essential to understanding and appreciating infants' development and individuality. Some are aimed at understanding infant needs, and relate directly to statements on the Circle of Security. For instance, "I need you to watch over me" will be a very familiar statement to people who work with the Circle. Others highlight infant behaviours, and it is many of these cards which show Jan's genius at its best. Whilst the words on the card are a straightforward statement of normal infant development, the delightful drawing often portrays a behaviour which may NOT delight the parent. A good example is the card entitled "I can be curious": the curiosity is portrayed by one infant pulling the hair ribbon of another small and rather unhappy child. Thus the card ensures that the infant behaviour which may upset the parent is very quickly reframed not just as "normal" but also in terms which imply that good may come of curiosity – perhaps directed somewhat differently! The "I can learn" (depicted next page) and "I can be clever" – dissecting a packet of flour – are more examples of the reframe which Jan uses with such a light touch.

How and where could these cards be used? The workers' creativity will provide many ways, and will be relevant to almost everyone who works with infants, particularly when working with their families. Parents themselves may find them useful as a simple and clear guide to watching their children and better understanding their play and their emotional needs. For those who want guidance about the use of the cards, this is provided in the small booklet which accompanies the cards. The booklet also has sections describing the author's inspirations, and some well-written pages on infant attachment, strengths and normal development, as well as parental reflection.

The cards use a combination of bright and pastel colours which give them a distinctive but gentle sense.

Jan works as a Family Support Worker for Anglicare in South Australia, in a service called Staying Attached which supports women with severe mental illness and their

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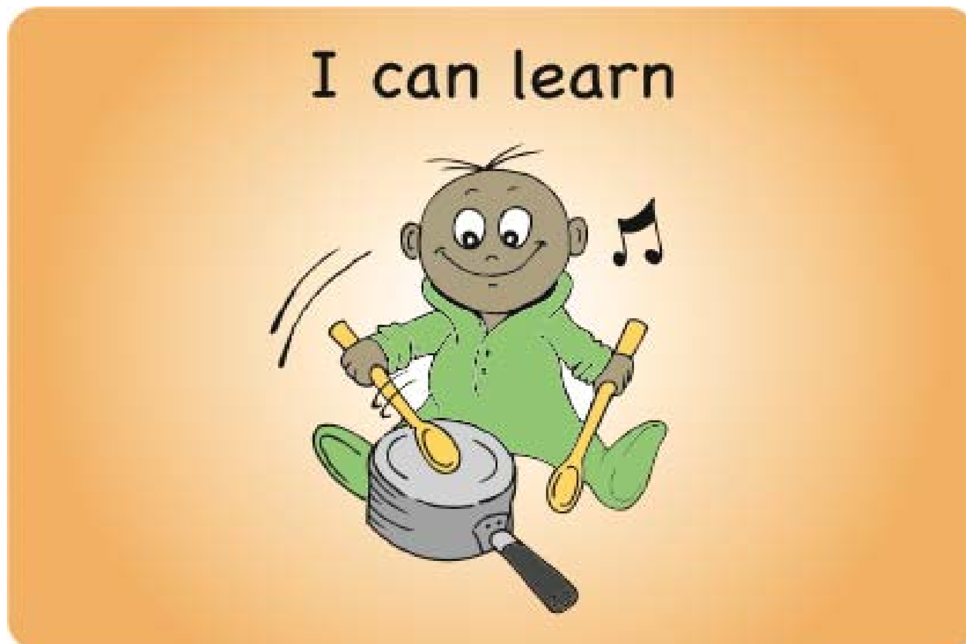
infants. In her work, in using other Strength cards produced by St Luke's, Jan became aware that whilst those cards worked well for the women and their own issues, it did not help her to assist them in focusing on their infants. Often, women saw infant behaviours in negative terms" "he's doing that to get at me". Jan began to sketch some ideas for showing the behaviours in different ways, using the knowledge she has gained from working with the Circle of Security and her creative but untrained artistic skills. She showed her ideas to Russell Deal from the St Luke's team, and it was clear how well this new resource would not just fit with the Strength cards already available but add an important new dimension. The cards were then developed in collaboration with St Lukes, with permission from the Circle of Security personnel as well.

The cards are available from St Luke's Innovative Resources online at http://www.innovativeresources.org/ for $39.95

How better to finish than with the "I can be fun" – the joy of infants it is so good to share with families!

Anne Sved Williams

Two examples of the Baby Strengths cards



Baby Strengths card designs and artwork by Jan Player. © St Lukes Innovative Resources.