THE AUSTRALIAN ASSOCIATION FOR INFANT MENTAL HEALTH (Inc.)
AFFILIATED WITH THE INTERNATIONAL ASSOCIATION FOR INFANT MENTAL HEALTH

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FROM THE EDITOR

It has been a great honour and quite an experience to have edited the Newsletter during the past year. This issue marks the end of my brief apprenticeship as AAIMHI Editor. Family adventures now take me to New Zealand. I am hoping that many exciting opportunities with infants and families will arise. Perhaps it will be possible to find people interested in forming another antipodean chapter of the World Association for Infant Mental Health in the near future! I will look forward to suggestions and possible visits from Australian colleagues in that regard.

This issue features some of the work of AAIMHI members. Beulah Warren's research has taken her to Michigan in the U.S.A. on several occasions, and she shares with us the experience of a recent conference to which she was invited back to speak.

Judy Ungerer of Macquarie University kindly sent us a paper several months ago. It features some very exciting work in attachment that is the culmination of team research involving several AAIMHI members both at Prince of Wales Hospital and at several local universities.

The AAIMHI Committee would like to encourage all members to consider the sorts of roles that our new Association will play in future. As mentioned in the last issue, AAIMHI is pleased to be joining forces with WAIPAD as part of the new World Association for Infant Mental Health (WAIMH). We look forward to hearing your ideas, and in particular, what you perceive the needs of your region or organisation to be with respect to infants and families. Please forward your comments and suggestions to AAIMHI President Bryanne Barnett (02 827-8011).

- Kimberley Powell, Editor

AAIMHI ANNUAL GENERAL MEETING

The Annual General Meeting of the Australian Association for Infant Mental Health will be held on Wednesday November 4, 1992 in the Speech Pathology Clinic on the second floor of the Royal Alexandra Hospital for Children on Pyrmont Street in Camperdown. The meeting will begin at 7 p.m., and will be followed by a meeting of the new Committee.

All members of AAIMHI are urged to read the enclosed notification of Additional Rules that require your consideration in regards to the changes in the international Association which will be known as the World Association for Infant Mental Health. Please submit your responses to the Committee prior to November 4, 1992.

All members of AAIMHI are encouraged to attend the Annual General Meeting, and to meet with us afterwards for wine and cheese. We look forward to seeing you! Enquiries regarding the meeting can be directed to the President, Dr. Bryanne Barnett (02 827-8011), or to the Treasurer, Marianne Nicholson (02 361-6712).

Report on the 16th Annual Conference of the Michigan Association for Infant Mental Health

by Beulah Warren

It was my privilege to attend the 16th Annual Conference of the Michigan Association for Infant Mental Health (MAIMH) at the University of Michigan, Ann Arbor, Michigan during April of this year. I had been invited to present a workshop on the behaviour and development of premature infants, and to present a case study for the final Plenary Session which was to be responded to by Dr. Mary Sue Moore.

MAIMH describes itself as advocating an interdisciplinary approach to the optimal development of infants. The conference title was "Strengthening Families through the Power of Relationships". Traditionally, the conference is directed to front line workers of many disciplines through plenary sessions and workshops, focussing on the application of theory and research.

In the past the conference has usually been held on the first Monday and Tuesday in April. This year, however, the committee decided to have a pre-conference institute for one half-day entitled, "It Takes a Whole Community to Raise a Child". The keynote address and workshops focussed on cultural diversity and the particular problems of different groups within North American society.

A public lecture, "Insuring Goodness of Fit: Parents and Caregivers as Partners", was given by National Early Intervention Specialist, consultant and NCCIP Fellow Gina Barclay-McLaughlin to close the Sunday institute sessions. Ms. Barclay-McLaughlin presented statistics which showed the increasing demand for child care for children under six years as more mothers return to work outside the home. Families are often under-utilised for caregiving. Her strong message was the need to determine what interrupts and interferes with a family expressing its level of competence and then to help the family correct it.

The format for the conference was a combination of plenary sessions and workshops. On Monday, Dr. Judith Musick of Chicago spoke on "Helping Adolescent Mothers: What Works and Why." Dr. Musick's paper outlined some of the harsh realities of adolescent pregnancy in the United States. For example, Judith stated that the pregnant teen typically:

- grows up in a fatherless household,
- has a transient relationship with men,
- is extremely vulnerable to men,
- conceives the child in a relationship where the father of the baby is at least 50% likely to be an older man,
- has a mother who is likely to be in an abusive relationship with a man,
- does not feel that her body is her own responsibility.

Judith Musick also discussed many of the psychological issues associated with teenage pregnancy. For these girls, being a mother enhances their sense of identity, giving them a new and highly valued sense of self. A heavy burden is therefore placed on the child to reinforce that identity. Some teens are able to organise around having a baby, in which case they usually only have one child until their life is more organised.

Many teenagers hope that the pregnancy will bring about *rapprochement* with their own mothers. However, often this does not happen and there is again a heavy burden placed on the young infant. Sometimes an adolescent mother has a succession of babies in order to get closer to her own mother. Some teens may have a baby so that someone will, they believe, love them. Many adolescent girls may already be caregivers of nieces and nephews, cousins, or even parents. Having their own child provides

at least a temporary escape from this other caregiving.

For teenagers as parents, there is the "role strain" of balancing the selfless work of motherhood with the egocentric process of adolescence. Teenage mothers may therefore value the role of mother, but not the function of that role. The program of which Judith Musick spoke seemed to provide a scaffold for the adolescent mother. It was successful when the mother developed a relationship with the program and personnel involved.

Dr. Louis Rosetti, Co-ordinator of the Communicative Disorders Program at the University of Wisconsin, spoke of enhancing interaction and attachment from hospital to home for premature infants and their families. The main thrust of his paper was that attachment between parents and infants needed to begin in the nursery. This was unlikely to happen without staff support. In Dr. Rosetti's view, any NICU which is not facilitating the development and enhancement of caregiver-infant interaction is out of step with mainstream NICU care in North America. He noted that for too long now in Neonatal Intensive Care Units many circumstances have disenfranchised caregivers from the process of caring for their infant.

Dr. Rosetti quoted research which indicated that nursery intervention programs continued over the first three months at home reduced the need for a wide variety of professional involvement during the first 12 months. Moreover, children at 5-7 years whose parents received intervention in the NICU gave more attention to their caregivers.

Over lunch on Monday, registrants were invited to meet and participate in a discussion about strengthening the Michigan Association for Infant Mental Health through the increase of the ethnic and cultural diversity of its membership and program.

A variety of posters was presented at the conference. I was particularly interested in INFANET, the brainchild of Dr. Marc Rains. INFANET is a computer networking system through which researchers can obtain resources and information from each other. I have brought information on INFANET back with me and hope to utilise the service. AAIMHI members will be kept informed about this new innovation.

During the conference, there were three brackets of eight workshops covering areas of early intervention, substance abusing families, cross-cultural consideration and issues of attachment. Some of the topics included:

* Is Early Intervention Effective? A Data-Based Answer to Empower Clinicians.
* Attachment and Separation Issues in Treatment of Substance-Using Women and their Children.
* Parent Consultants: Getting the Most for your Dollar.
* The Effect of Hearing Loss on Parent-Infant Attachment.
* Siblings of Children with Special Needs: Strengthening the Family by Strengthening the Sibling Bond.
* Acknowledging the Power of Multiple Attachment: A Clinical Approach to Intervention with Infants and Families Affected with HIV/ AIDS.

I chose to hear Dr. Mary Sue Moore discuss her latest work entitled "Not Safe to Sleep." (Mary Sue will be known to many AAIMHI people from her visits to Australia). Dr. Moore addressed the question of how the child responds to anxious attachment and drew our attention to the link between anxiety and physiological symptoms, particularly in sleep patterns. She outlined the different levels of sleep (1-2, light sleep; 3-4, quiet sleep) and the importance of each level in the sleep cycle. For example, in levels 3 and 4, the growth hormone is produced and the immune system strengthened. Thus, if infants are not able to get into deep sleep, there may be physiological

consequences for their growth. This work is relevant to the sleep patterns of premature infants and the research that has been carried out in that area.

On the second day, Dr. Patricia Crittenden of the Mailman Centre for Child Development at the University of Miami gave the Plenary Address entitled "Transdisciplinary Treatment: An Approach for the Nineties." Her paper was particularly relevant for those who work with high risk families.

The transdisciplinary approach means that one member of a multi-disciplinary team works with the family using the back-up of the other team members. The treatment occurs through the process of the relationship that is cultivated between the team member and the family. The treatment approach consists of the assessment of the level of family functioning, the writing of a Developmental Family Treatment Plan, and the delivery of the transdisciplinary service using a multidisciplinary consulting team.

The final session was the Panel Presentation and discussion where I presented a case that was responded to by Mary Sue Moore, a Child and Health consultant from Michigan, and the Director of the Michigan Department of Public Health.

Many questions were asked and a discussion followed about what services, whether different or fewer, would be available to families in Michigan. Of particular interest to the audience was how the difficulties of the infant as well as the concerns of the parent were addressed by one person, which is the trademark of the transdisciplinary approach. The transdisciplinary model was adopted by the Early Intervention Program here in Sydney at its inception.

Having attended the conference for two consecutive years, I can recommend it to anyone interested in Infant Mental Health work with infants and families. The 17th Annual Conference will take place April 25-27, 1993 in Ann Arbor, Michigan. See you there!

* Beulah Warren is Director of the Benevolent Society's Early Intervention Program at Paddington, N.S.W. If anyone is interested in the notes or papers from the Michigan conference, kindly contact Beulah at 339-4440.

2nd Annual Symposium: Families in the 90's

The Infant Mental Health Working Party based at University of Western Sydney-Nepean is pleased to announce that its second annual one-day symposium, entitled "Families in the 90's", will be held November 14, 1992 at the Kingswood Campus of UWS-Nepean. The keynote address will be given by Dr. Frank Oberklaid, Director of Ambulatory Paediatrics at the Royal Children's Hospital in Melbourne and regular contributor to the ABC's Life Matters program. Dr. Oberklaid will highlight some of his recent research on children with behavioural difficulties and what the implications may be for families in the Western suburbs of Sydney.

Also speaking at the Symposium will be Beulah Warren of the EIP program, and Dr. Denise Guy of Redbank house--both AAIMHI members. The symposium will also feature several afternoon workshop sessions that will highlight key issues for workers in the Western suburbs currently involved in education, nursing and early intervention.

The Symposium will begin at 9:30 am. on the 14th of November at the Kingswood campus of UWS-Nepean. The registration fee (approximately $60) includes morning and afternoon tea, lunch and choice of afternoon seminars.

For more information, contact:

Alison Hine, Faculty of Education,
UWS-Nepean - 047-360-222

The Influence of Maternal Perceptions of Distress-related Attachment at 12 Months of Age

JUDY UNGERER, ROBYN DOLBY, BRENT WATERS
BRYANNE BARNETT, NORMAN KELK,
VIVIAN LEWIN, ALEX BLASZCZYNSKI *

One of the most interesting challenges confronting attachment researchers today is to specify the independent characteristics which mothers bring to the task of rearing their children and which influence the quality of their early attachment relationships. Research and theory on the cross-generational transmission of attachment quality suggests that such characteristics should be identifiable in mothers before the birth of their children, and that the impact of these characteristics should be evident in early mother-infant interactions. The purpose of this research was to explore the impact of one such maternal characteristic called negative affectivity. According to Watson and Clark (1984), negative affectivity refers to the tendency of individuals "to dwell on the negative side of themselves and their world" (p.465). It includes such affective states as "anger, scorn, revulsion, guilt, self-dissatisfaction, a sense of rejection, and, to some extent, sadness" (p. 465). Individuals high in negative affectivity may also experience positive emotions, but their dominant mood and perceptions are negative.

Research on maternal antecedents of attachment quality suggests that negative affectivity may indeed be a risk factor for mother-infant attachment relationships. For example, Belsky and Isabella (1988) and Spieker and Booth (1988) have reported that mothers whose perceptions of themselves, their partners, or their life situations were dominated by negative affectivity, particularly over the transition to parenthood and through the first year postpartum, were at heightened risk for developing insecure attachment relationships with their children. Furthermore, research by Egeland and Erickson (1990) with mothers who were themselves abused as children suggest that negative affectivity may be a dominant characteristic of this group who also are at high risk for developing insecure attachment relationships.

In our own research we were interested in trying to understand the processes which might link maternal negative affectivity to poor attachment outcomes. We thought that one domain that might prove interesting to explore would be the way in which mothers perceive negative affect or distress in their own infants. We chose this domain for the following reason. It is well established that a secure attachment relationship is characterized by a mother who responds sensitively to her infant's distress and by an infant who is able to express distress and be readily comforted by the mother. Mothers of secure infants interpret and respond appropriately to their infant's distress cues, while the infants themselves are able to express distress but not become so disorganized that they cannot easily settle and return to play.

We hypothesized that maternal negative affectivity might be particularly disruptive of this aspect of a secure attachment relationship. We thought that mothers high in negative affectivity would be less accurate in reading their infant's distress because their own negative affectivity would distort their perceptions. As a result, these mothers would be less responsive to their infant's distress, and less likely to provide the type of sensitive, contained handling that supports a distressed infant's own attempts to reorganize and return to a stable state. Infants who have experienced a history of such insensitive handling might be expected to show more disorganised responses to distress in early infancy because their own self-regulatory skills have not been optimally fostered. As one year-olds these infants should continue to experience difficulty in regulating negative affect and be more likely to demonstrate the avoidant and resistant coping strategies which characterize insecure attachment relationships.

Subjects:

In order to investigate these processes, we conducted a study of couples who were expecting their first child. Couples entered the study during the midtrimester of the pregnancy and were followed through their child's first birthday. 150 families are included in the sample, 45 of whom have completed the 12 month assessment, and are reported on here. The larger sample has been stratified to represent a range of personality functioning, although the first 45 subjects reported on here are a very typical Caucasian, middle class group. They are, however, a somewhat older group of primiparous mothers. Their mean age is 31.1 years, with a range of 23 to 41 years. The infants of these mothers are all full-term, and there are 26 males and 19 females in the group.

Method:

During the midtrimester of the pregnancy, the mothers completed a battery of questionnaires assessing personality, marital quality, and parenting history. The personality measures included the Beck Depression Inventory, and the marital quality measures included the Personal Relationship Questionnaire (from Braiker and Kelly (1979) and adapted to the Australian context), and the Intimate Bond Measure. Parenting history was assessed using the parental Bonding Instrument which measures perceived caring or warmth and overprotectiveness. The Intimate Bond Measure and the Parental Bonding Instrument were developed by Parker et al (1979) and have been validated on Australian samples. Mothers' perceptions of their infants and the infant's response to distress were assessed at 4 months using the Still-Face Procedure, and attachment security at 12 months was assessed using the Strange Situation.

*Judy Ungerer is at Macquarie University, Bryanne Barnett is Director of the Southwest Regional Child and Adolescent Clinic at Liverpool, and the other members of the research team are associated with the Prince of Wales Children's Hospital. The paper was originally presented in Seattle in April, 1991.

At 4 months the Still-Face Procedure was used to assess the mother's perception of her child. The procedure has been previously used in research by Tronick (Tronick & Gianino, 1986) to simulate the interactions of depressed mothers and their infants. It begins with the infant seated in an infant seat opposite the mother. The mother is instructed to play with the infant for 2 minutes. She then leaves the baby alone in the room for 30 seconds, and then re-enters and sits opposite the baby but without interacting for 2 minutes. The mother is instructed to keep her face still and not to respond to the infant during this whole 2 minute segment. The mother then resumes interacting with the infant for 1.5 minutes. After completing this segment, we play a videotape of the interaction back to the mother and ask her to comment on the infant's behaviour and emotions during each phase of the procedure.

Although infants vary somewhat in their response to the procedure, there are some clear commonalities across infants. Typically, the infants notice immediately when their mothers go still. They may go quiet themselves and look very searchingly at their mother's face. Alternatively, they may reach out or vocalize or use coy facial expressions to try to get their mothers to resume normal play. When these attempts fail (because mothers are instructed to remain still), the infants look away. Some infants turn inward and begin to self-comfort by clasping their hands together or sucking on their fingers or clothing; others turn outward and focus their attention on something else, like pulling at their socks. All the infants seem to be affected by the experience. When mothers resume normal play, the infants do not. They initially are guarded in their response to the mother, and often do not look at the mother as much during play.

The behaviour of the infants during the Still-Face was scored for the frequency of seven different categories of behaviour including looking at or monitoring the mother, positive signalling to the mother (like smiling), negative signalling (like fussing), becoming engaged with an object (like pulling at socks), self-comforting behaviour (like thumb sucking), escape behaviour (like arching in the chair), and gaze avoidance. The total number of these behaviours exhibited during the 2-minute Still-Face segment served as a measure of the behavioural organization of the infant in response to distress, with a larger number of behaviours indicating a less well organized response.

Transcripts of the mother's descriptions of their infant's behaviour and feelings during the Still-Face were used to identify patterns of responding that appeared to be influenced by negative affectivity. In reviewing the transcripts, four different patterns of responding were identified. Two of these patterns were characterized by a focus on positive or relatively neutral affect, while the remaining two patterns were characterized by clear negative affectivity. The characteristics of these patterns are described below.

Pattern 1: (11% of mothers)

In the first response pattern, the affect of the baby is described in a neutral or only mildly negative way. The emphasis is on the confusion or uneasiness the infant feels when the mother's face becomes still. The infant is described by words like confused, puzzled, or unsettled, typically because this is an uncommon experience for the infant. The same theme is used to describe why the infants do not resume normal play when the mother do. They are described as not sure what to expect.

"I think he was perhaps apprehensive about it. He was a bit more tentative, he didn't know whether I was actually going to continue to play. I just think he was uncertain, he didn't know where he stood...he'd given all those cues to me earlier and had no response."

Pattern 2: (11% of mothers)

The emphasis in this pattern is on positive affect and on positive aspects of the mother-infant relationship. Negative affect when acknowledged tends to be downplayed and considered not to have a significant impact on the baby. For example, the infant is seen as only mildly or not at all distressed by the mother's lack of responsiveness.

"Well, he did notice I was different because I wasn't playing with him or anything, but it didn't seem to concern him."

The mothers describe themselves as having a positive influence on their infant, even when they are not responding during the Still-Face. This typically takes the form of the infant feeling reassured by the mother's presence, even when they are not interacting.

Q: "Why do you think your baby didn't look at you much?"
"I mean she must have been aware of my presence so she probably felt secure, but she was just playing on her own."

Finally, any positive greeting the infant gives the mother when they resume normal play is acknowledged, while any hesitancy on the infant's part to return to play is minimized or ignored.

"I think she was just really pleased that I was responding again."

Pattern 3: (36% of mothers)

This pattern is defined by themes of rejection and low self-esteem that are characteristic of negative affectivity. Mothers who fit this pattern convey a sense of feeling unimportant to their infants, and of failing to meet their infant's needs. Negative affect in the infant is perceived as rejection, and the reaffirming value of positive affect from the infant is often missed. For example, these mothers may fail to recognize their infant's attempts to try to get them to return to play. The

AAIMHI Professional Directory

Members of AAIMHI are invited to submit information about their professional interests so that a directory of professionals currently involved with infants and their families throughout Australia can be established on an ongoing basis.

The aim of the directory is to facilitate increased awareness of infant mental health issues, and to foster communication amongst professionals around Australia. We look forward to hearing from you.

Please send responses to: AAIMHI
PO Box 39
Double Bay NSW 2028

Name: _____ Occupation: _____

Nature of involvement with infants: _____

Qualifications/Training: _____

_____

Address: _____

_____ Postcode: _____

Phone: (W) _____ (H) _____ Fax: _____

Areas of interest in Infancy: _____

_____

Special Skills/Expertise: _____

_____

Needs of infants & families in your region: _____

_____

Needs of Professionals in your region: _____

_____

Other Comments: _____

fragileness of the mother-infant relationship is clearly revealed in the mother's descriptions of their infant's feelings during the Still-Face. For example, in response to questions concerning whether the infant noticed the difference in the mother or why the infant did not look at her much during the Still-Face, these mothers say:

"It's about the same as him being on his own. There's not a great deal of difference between no-one being there and someone being there and not interacting. Maybe he didn't register that I was the same person. I could have just been a painting on the wall."

The infants are often described as not looking at the mother during the Still-Face because she is not interesting enough when she is still and not interacting. Similarly, infants who hesitate to return to normal play after the Still-Face are seen as not interested in playing with the mother because they have become involved in other things.

Q: "How did your baby respond when you resumed normal play"?
"She doesn't look at all happy...I think she was quite happy by herself you know. Perhaps it was all a bit of in intrusion, me coming and going to her. So perhaps she wasn't feeling she wanted that sort of play."

Pattern 4: (11% of all mothers)

This pattern is also clearly characterized by negative affectivity, but the dominant emotion in these interviews is anger. Themes of retaliation and hostile control are common in these mothers' descriptions of their infant's behaviour. During the Still-Face the infants are seen as experiencing negative emotions that have a hostile character. These mothers describe the baby as feeling "neglected, insulted, ignored, angry or annoyed." The infant's avoidance of eye contact with the mother during the Still-Face and when normal play is resumed is seen as retaliation for the mother's lack of interaction.

Q: "Why do you think your baby did not look at you much?"
"Maybe (this was) because I'd been sitting there ignoring her and she, I don't know what goes on in that mind of hers, maybe she thought, "Oh well, she doesn't want to play with me, I won't play with her".

Mothers in this group often view these infants as manipulative or controlling.

Q: "Why didn't she look at you much?"
"She was having a whinge but her eyes weren't closed, they were still seeing things. She's very tricky.

Q: "How did she respond when you resumed normal play?"
"Look, straight away, a big smile, grabs hold of me, no problem. The minute you get some attention, oooh, grab onto it. That's what she does, she absolutely grabs it first go."

Of the 45 transcripts reviewed, 31 transcripts or 69% of the interviews could be assigned to one of the four patterns just described. The remaining transcripts were a mixture of the four patterns, with most having both positive and negative themes. For the purposes of data analysis, it was decided to combine mothers emphasizing positive or neutral affect into one group (Patterns 1 and 2, n=11) which we will call the positive group, and mothers showing the two patterns characterized by negative affectivity into a second group (n=24), which we will call the negative group. Ten mothers showing a combination of positive and negative patterns were combined into a third mixed group.

Results:

The first analyses we conducted looked at whether negative affectivity in the mother's perceptions of themselves and others measured prior to the birth of their babies would be associated with the way they perceived their infant's distress at 4 months of age. If negative affectivity is a component of an individual's working model of attachment relationships, we would expect such continuity to exist. A comparison of the three maternal perception groups on their prebirth Beck Depression Inventory scores indicated no significant differences between the groups. The three groups did not differ in their depressive self-perceptions prior to the birth of their children.

However, when these data are interpreted within the context of Beck scores obtained concurrently with the mother's perceptions at 4 months, a different interpretation is suggested. By 4 months of age the maternal groups did differ in their self-reported depressive symptoms, with the mothers whose perceptions were characterized by negative affectivity having the highest Beck scores. Self-reported depressive symptoms did not change across the transition to parenthood for the negative affectivity group, while for the positive and mixed perception groups, reported depressive symptoms declined.

The difference between the negative and mixed perception groups was statistically significant, while the difference between the negative and positive perception groups approached significance. Thus, elevated levels of depressive symptomatology were a more stable characteristic in mothers with negative perceptions of their infants at 4 months of age. It should be noted, however, that these mothers were not clinically depressed. The mean Beck scores for all the maternal groups were well within the normal range. These findings are consistent with research by Belsky and Isabella (1988) showing that it is the change to more positive perceptions that is the better predictor of the quality of the mother-child relationship over the transition to parenthood.

Next we looked at whether the maternal perception groups differed in the way they perceived their relationships with others prior to the birth of their children. When the three maternal perception groups were compared in separate analyses on their ratings of their partner relationships and on their perceptions of their own experience of being parented, no

differences were found between the groups. However, a discriminant function analysis indicated that a subcluster of these measures might go some way in identifying mothers with predominantly positive perceptions of their infants. This subcluster included the Intimate Bond Measure - Care Scale, the Personal Relationship Measure - Love Scale, and the Parental Bonding Instrument - Mother and Father Protection Scales.

The general direction of the findings was for mothers with predominantly positive perceptions to rate their partner relationships as more loving and their own parents as lower on overprotectiveness. The discriminant function analysis correctly identified 64% of the mothers with positive perceptions, but only 46 - 50% of the mothers in the negative and mixed perception groups. The poorer classification results for the negative and mixed groups may be due to the fact that these groups are more likely to include mothers who are defensive and fail to report negative characteristics of their interpersonal relationships.

To summarize this point, there is some evidence to suggest that the presence or absence of negative affectivity in maternal perceptions of infant distress at 4 months is associated with related maternal perceptions of the self and significant others which can be identified in mothers prior to the birth of their children. Although the aim of our analysis was to demonstrate continuity in negative affectivity from the prebirth to the 4 month assessments, our data seem to indicate greater stability over time in mothers characterized by the absence of negative affectivity rather than by its presence, particularly when measures involving perceptions of partners or parents are considered. An alternative interpretation is that the questionnaire measures we have reported on are less reliable measures for mothers characterized by negative affectivity, and that other data, like the life history interviews we have collected, will be more reliable measures of negative affectivity in this group.

The second focus of the data analysis was to determine if negative affectivity in mothers' perceptions of their infants at 4 months would be associated with a higher incidence of insecure attachment relationships when the infants were 12 months of age. Chi-Square analysis indicated a clear relationship between maternal perceptions at 4 months and later attachment status. 91% of infants of mothers in the positive perception group were found to have secure attachments at 12 months of age, while only 50% of infants in the negative and mixed perception groups were securely attached. These data support our hypothesis that negative affectivity is a risk factor to the development of secure attachment relationships because it leads to distortions in the way in which mothers perceive and, we assume, also respond to distress in their infants. These results also support the notion that negative affectivity is an important component of an individual's working model of attachment relationships.

There are two qualifications that perhaps should be made in the interpretation of these data. First, although we have combined the two maternal groups showing negative affectivity in our analyses, it would be wrong at this time to conclude that all negative affectivity is the same in its impact on the developing child. This becomes clear when we look at the frequency of infants who are optimally secure in their attachment relationships in our different maternal perception groups. 80-100% of the infants in the two predominantly positive maternal perception groups were classified as optimally secure. In our two negative affectivity groups, 23% of infants with mothers emphasizing refection and low self-esteem were also rated as optimally secure at 12 months, while no infants with mothers whose negative affectivity took the form of anger achieved a classification of optimally secure. Thus, it appears that anger may have a more negative impact on attachment relationships than low self-esteem. Looking at the data in this way also suggests that not all babies rated as securely attached are the same, and that the optimally attached infants may be a unique group.

Finally, the data as we have presented them seem to be maternally driven, that is, it is the characteristics of the mother that have the greatest impact on the quality of the young child's attachment relationship. Although this orientation is consistent with most literature on attachment development, it is important to include the child in the equation as well. At the beginning we argued that the distorted perceptions of infant distress would lead to poorer regulation of distress by the infants themselves. We have evidence in our data to support this hypothesis from as early as 4 months of age. Infants of mothers whose perceptions were characterized by negative affectivity were less well regulated in their response to the distress of the Still-Face than infants from the positive perception groups. We believe that this poor self-regulatory response to interactive stress with the mother forms the foundation for the later non-optimal coping strategies observed in the interactions of insecurely attached infants and mothers at 12 months of age.

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AAIMHI REQUESTS MEMBERS' IDEAS FOR PROFESSIONAL DEVELOPMENT SEMINARS

During the past few years, AAIMHI has been involved in the development and implementation of several workshops that promote awareness of infant mental health and related issues amongst its members and other professionals. A list of these workshops has been compiled by Beulah Warren.

If you have any requests or ideas for future seminars, the Committee would be happy to hear from you. Please contact Bryanne Barnett, AAIMHI President or the Seminar Co-ordinator, Maria Radojevic.

1. Do Babies Have Feelings? The Emerging Self: Implications for Practice. Curtis Samuels, Russell Meares and Bruce Tonge. February 25, 1989.

2. Attachment Theory and Practical Implications. Bryanne Barnett, Maria Radojevic, Julie Campbell and Barbara Craven. September 2, 1989.

3. Infant Observation. Peter Blake. May 23, 1989.

4. Infants in Hospital. Nicholina Rotundo and Helen Hardy. July 25, 1989.

5. Maternal Grief Workshop. Margaret Nicol. February 16, 1990.

6. The Brazelton Neonatal Behavioural Assessment Scale: Workshop. Beulah Warren, Robyn Dolby. March 9, 1990.

7. Giving Birth to Feelings. Bob Gordon. June 2, 1990.

8. Therapeutic Skills for Nurses. Keryl Egan and Marianne Nicholson. July 28, 1990.

9. The Transition for Coupling to Parenting. Carolyn Quadrio. November 17, 1990.

10. UWS-Nepean/ Infant Mental Health Working Party Symposium. "High Risk Infants and Their Families." April 12, 1991.

11. Crying Babies. Margaret Hope. May 18, 1991.

12. Joint Conference. University of Sydney. AEIA and AAIMHI. October 17-18, 1991.

13. Infant Feeding Skills. University of Western Sydney-Macarthur and AAIMHI. Sarah Starr. May 13, 1992.

14. Seminar series with the Child and Family Health Nurses' Association of NSW (CAFHNA). June-August 1992.

AAIMHI STATEMENT OF OBJECTIVES

1. To improve professional and public recognition that infancy is an important period in psycho-social development.

2. To improve awareness of the interrelatedness of psychological and biological developmental processes.

3. To provide a forum for multi-disciplinary interaction and cooperation.

4. To establish and maintain discussion and exchange of information about infancy on both national and international levels.

5. To provide members with access to the latest research findings and observations concerning development in infancy.

6. To facilitate the integration of such findings into clinical practice and community life.

7. To work for the improvement of the mental health and development of all infants and families.

8. To provide where possible reports and submissions to governments, other authorities, organisations and individuals on matters relating to infant and family health and welfare.

9. Such other objectives as the Association shall approve by special resolution at an Annual General Meeting.

CONFERENCES, WORKSHOPS AND SEMINARS

Disruptive Youth in Today's Society: Second Annual Conference of the Australian Society for Adolescent Psychiatry.

Date: October 15-16, 1992
Venue: The John Lowenthal Auditorium, Westmead Hospital, Darcy Road, Westmead.
Enquiries: AUSAP Secretary (02) 633 6577.

An Evening with Dr. Frank Oberklaid: Recent Issues in Crying and Colic in Infancy.

Date: November 12, 1992 - 6:30 to 9 p.m.
Venue: Lecture Theatre Level 4, Health Services Building. Corner of Goulburn and Campbell Streets, Liverpool.
Enquiries: Child and Adolescent Clinic, .

Parenting, Communication and Sexuality: Tresillian Family Care Centres' Seminar for Health Professionals working with Children and Families.

Date: November 12, 1992 - 4:15 to 8.00 p.m.
Venue: Sydney Exhibition Centre - Hall 1, Darling Harbour

Families in the '90's: 2nd Annual Symposium of the UWS-Nepean/ Infant Mental Health Working Party.

Date: November 14, 1992.
Venue: Kingswood Campus, University of Western Sydney Nepean, Kingswood NSW.
Enquiries: Alison Hine (047) 360 222 or Sue Dockett (02) 772-9200.

Eliminating Boundaries: Challenges of the Nineties. International Early Childhood Conference on Children with Special Needs.

Date: December 2-6, 1992
Venue: Washington, D.C.
Enquiries: Council for Exceptional Children 703-620-3660.

Our Children...Our Future: 5th Annual Conference of the NSW Child and Family Health Association.

Date: January 27-29, 1992
Venue: Macquarie University, North Ryde NSW
Enquiries: Dr. David Lillystone (02) 476 4787.

AAIMHI PROFESSIONAL DIRECTORY - 1992

The following members of AAIMHI responded earlier in 1992 to a survey about the professional interests of our members.

Penny Cousens (B.A. Hons, Ph.D.) Psychologist, Oncology Unit, The Children's Hospital. P.O. Box 34, Camperdown NSW 2050.
w. (02) 692-6683, h. (02) 436-1946, fax (02) 519-4282.
Infancy Interests:
Attachment; regression associated with illness; long-term effects of illness on mother-child relationship.
Special Skills:
Assessment/ intervention of cognitive defic associated with treatment for childhood cancer and psychosocial effect on child and family.

Frances Gibson (B.Sc.App.Psych., M.A. Counselling) Psychologist, Neonatal Follow-up Program. 46 Hercules St. Chatswood NSW 2067.
w. (02) 413-4389, h. (02) 948-3526, fax (02) 415-1246.
Infancy Interests:
Development of premature infants from infancy to school age.

Denise Guy (MBChB-Otago, FRANZCP, Cert.Child Psychiatry) Child Psychiatrist, Redbank House, Westmead Hospital. Westmead NSW 2145.
w.(02) 633-6577, H. (02) 743-1059.
Infancy Interests:
Infant/ Toddler- Parent Psychotherapy; Group Programs; Failure to Thrive;

Ann De-Belin (Dip.App.Sc.Nursing, Mothercraft Cert., Midwifery) Karitane Mothercraft Society. 17 Avoca St. Randwick NSW 2031.
w (02) 399-7111, h (02) 543-8692, fax (02) 399-8510.
Infancy Interests:
Temperament scales; infant-maternal interaction scales.
Special skills:
Mothercraft issues; family dynamics; postnatal depression; toddler management.

David Lonie, Psychiatrist.
P.O.Box B7 Boronia Park NSW 2111
w (02) 817-5223, h.(02) 817-5223, fax (02) 879-7305
Infancy Interests: Interested in most aspects of infancy.

Elsie Mobbs (M.A., M.Stud.Psych., B.Sc., Dip.Ed., R.N., R.M.) Psychologist, NSW Perinatal Network Services. Royal Prince Alfred Hospital. P.O. Box 36 Westmead NSW 2145.
Infancy Interests:
Oral-tactile; one-sucking-object imprinting; Griffiths Assessment.
Special Skills/ expertise:
Mammalian maternal deprivation effects.

Dr. Leonard Israel Siegel (FRANZCP, Fellow Academy of Child & Adolescent Psychiatry) Child, Adolescent and Family Psychiatrist, 14 Ashley Centre. Westmead NSW 2145.
w. (02) 893-7100, h. (047) 396-000, fax (045) 711-552.
Special Skills:
Family therapy; psychoanalytic psychotherapy.

Paul Tait (MBBS, FRACP) Paediatrician, Department of Paediatrics, Westmead Hospital. Westmead NSW 2145.
w. (02) 633-6810, h.(02) 428-1258.
Infancy Interests:
Failure to thrive; emotional deprivation; sleeping disturbance; Sudden Infant Death Syndrome.

Angela Todd (B.A. hons, Ph.D. in progress) Psychologist, Department of Psychiatry, Clinical Sciences Building, Nepean Hospital, Penrith NSW 2750.
w. (047) 320-585, fax (047) 320-567.
Infancy Interests:
Developmental follow-up of high risk infants; mother-infant relationships in women with postnatal depression.
Special Skills:
Developmental assessment; statistics, computers, report writing.

Marija Radojevic, (B.App.Sc.(O.T.), B.A.(hons), M.Clin.Psych.)Lecturer, Institute of Early Childhood at Macquarie University.
p. (02) 369-8200, fax (02) 387-7175
Research Interests:
Attachment, mental representations of relationships, fathering, family context of infant development.
Special Skills:
Assessment of attachment in infancy and adults, clinical early intervention for 'at-risk' parent-infant relationships.

Desiree Saddik (Bachelor of Psychotherapy, M.Psych., Post Masters Clinical Child Psychology Specialty) Clinical Child Psychologist and Director, Early Parenting Outreach Program. Canterbury Family Centre, 19 Canterbury Road, Camberwell 3124.
w.(03) 882-8336, h.(03) 510-1110, fax (03) 813-3927.
Infancy interests:
Failure to thrive; application of psychoanalytic principles in working with infants and mothers; infant observation; developmental research.
Special skills:
Infant and child psychological assessment and psychotherapy; supervision and consultation; multidisciplinary team work.

Norma Tracey, Social Worker/ Psychotherapist-Neonatal Project Royal Alexandra Hospital for Children and King George V Hospital. 11 Mons Road, Lane Cove NSW 2066.
w. (02) 427-2028, h.(02) 427-2028.
Infancy Interests:
Primary Maternal Preoccupation first 3-5 weeks of life.
Special Skills:
Specialising in the psychoanalytic inner world of mothers and fathers during the first few weeks of the baby's life.

PROFESSIONAL DIRECTORY

Current members of AAIMHI are invited to submit information about their professional interests so that communication amongst infant mental health workers can be better facilitated. Please complete the form attached to the membership insert, and mail to:

AAIMHI
P.O. Box 39
Double Bay NSW 2028

We look forward to hearing from you!

P.S. Our thanks to all our members who launched the directory by taking the time to respond.

CALL FOR MEMBERS

AAIMHI wishes to thank all its members for their support over the past year, and we look forward to your continued interest in 1992-93. Because of the generous support of our members, AAIMHI has been able to expand its activities. In 1992, workshops were held in the Southwest region of Sydney, and specialised workshops were held in conjunction with the Child and Family Health Nursing Association (CAFHNA). Future plans include a Pacific Rim regional conference in the next two years, and several workshops that will highlight overseas visitors. We look forward to your participation at these events, and to your involvement in the future of AAIMHI as part of the World Association for Infant Mental Health.

International members of WAIPAD or IAMHI will be informed in the near future of the new rates for international membership. Enquiries about the Journal of Infant Mental Health should be made directly to The Editor, Infant Mental Health Journal, 4 Conant Square, Brandon, Vermont U.S.A. 05733. The rate for personal subscription per year is approximately $48 U.S.

MEMBERSHIP FORM

NAME: _____

ADDRESS: _____

_____ PHONE: _____

WORK ADDRESS: _____

_____ PHONE: _____

OCCUPATION: _____

- ☐ I enclose $55.00 for annual subscription of the Australian Association for Infant Mental Health.
  or
- ☐ I enclose $30.00 for an annual subscription to AAIMH, and I enclose proof of my full-time student status.

Please post this form with your remittance to:

AAIMHI, PO Box 39,
Double Bay NSW 2028
Australia.