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

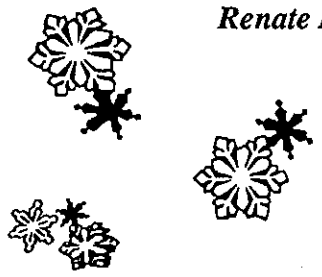
Number 3 **Newsletter** Summer 1989

From the Editor

This newsletter is widely recognised as an effective communication medium for those interested in infant mental health. It is a valuable forum where members of AAIMHI and other interested parties can exchange their views. Would you like to participate? We are compiling a list of people who are willing to write book reviews. If you are interested please contact us and include your areas of particular interests. Also, the column "Project News" needs some contributions. In this column we are not looking for data and results. Just give a brief outline of the project you are undertaking so that others will know what is happening in infant mental health in Australia. We are also looking for interesting articles! However, please be concise and edit your contributions to essential information so that more people can have a say. (Phone numbers and/or addresses will be included so readers can contact the authors for more details). Space in this newsletter is valuable since at present we can only afford twelve pages per issue.

So let me show the way and end this column now.

Renate Barth



From the President

In October AAIMHI had its first Annual General Meeting and the new General Committee was elected. My thanks to those outgoing members of the Committee namely Dr Denis Burnham and Dr Beth Kotze and welcome to the new members Marianne Nicholson (representing nurses), Dr Paul Tait (Paediatrician) and Dr Bryanne Barnett (Psychiatrist).

In my report to the AGM I listed what our objective had been for the preceeding year. The most important objective which we have tried to focus upon was to facilitate an awareness in professional communities that infant mental health is a significant area of expertise in its own right although it is often subsumed under general child and adolescent mental health. If we acknowledge this significance then it is a foremost task to develop a sense of a community among those disciplines particularly concerned with infants and their families.

AAIMHI has been trying to foster this sense of community through this newsletter and its seminars and will continue to do so in the coming year. It is crucial that this be our first step after which, with a solid sense of being an organised body of people, we can then go on to some of the other AAIMHI objectives. The second aim for this year is to develop a more sound financial footing. So far we have pushed ahead to live up to our original ideals of the quarterly newsletter and regular seminars despite the limited funds available. It is now necessary to plan carefully and the help and suggestions of all members as to how AAIMHI might fund itself are very welcome. There is now a Funding Sub-Committee which would like to hear from you through Sue Johnson, our Treasurer.

Since the AGM, AAIMHI has co-operated with the Australian and New Zealand Association of Psychotherapists (ANZAP) which hosted a conference featuring two international guests, Professor Michael Lewis and Dr Joseph Lichtenberg, as well as Dr Bryanne Barnett and Dr Judy Ungerer from Sydney. This was attended by a

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Report on the Fourth World Congress of the World Association for Infant Psychiatry and Allied Disciplines in Lugarno (September 20-24, 1989).

Lugarno was a very beautiful, relaxed and warm setting for the Conference. It is the one Italian Canton of twenty-five such self-governing republics in Switzerland. A cultural highlight for virtually all conference participants was seeing the Expressionism Exhibition, part of the Thyssen-Bornemisza Collection.

Prior to the formal opening of the Conference there were eleven separate Teach-in Sessions involving case studies. I attended a presentation on "Perinatal problems as they reflect in the family system: Issues and intervention" by E. Tutors, E. Muir and M. Huntley from Toronto. Joy Osofsky and Robert Emde were the clinical team. Throughout the conference working with all family members was not emphasised, so this team's attempts to integrate intrapsychic, interpersonal and intergenerational issues systemically was very important. In particular the priority given to fathers in theoretical and clinical intervention research was low at this conference.

However Kyle Pruett (United States) co-ordinated the establishment of an International Study Group on the changing role of fathers in infant development. If you are interested in being involved in this group, contact Dr Pruett at: Yale Child Study Center, PO Box 3333, New Haven, Connecticut 06510 USA.

Dr Hiram Fitzgerald, the Executive Director of the International Association for Infant Mental Health was the chairman of the programme committee. Programming goals emphasised interdisciplinary sessions and international sessions.

Subsequent days were organised around 1 or 2 Plenary Sessions, 2 Poster Sessions (running simultaneously with Media Theatre presentations) and concurrent symposiums and workshops. You can envisage the intricasies of defining your own program, somewhat helped and/or limited by linguistic ability as not all sessions offered translations.

Claire Bressa from UNICEF gave the opening presentation on "Infants' Rights" but widened the issue to consider all children. UNICEF was set up to help children who had lost parents during World War II. The children focused on now are:

1. Children in war – since 1945 there have been 150 wars and 80% of victims of war are non-military as against 20% in the first World War. Children are also enactors of violence: in Uganda in 1986 10-20% were less than 14 years old.
2. Working children – in the last 10 years the number has increased from 52 to 103 million.
3. Refugee children – approximately 6,5000,000.

The other UNICEF initiative is in drafting the Convention on Rights of Children proposed by the Polish Government in 1979.

An overview of the plenary sessions and the major themes of the conference as I perceived them would give some coherency albeit superficial to this brief review:

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Dear Fellow Member

AAIMHI is at a critical point in its development. With our first AGM behind us we, on the committee, are conscious of the tremendous burst of energy and enthusiasm, lead by our President Keryl Egan, which has gone in to ensure the success of the first year.

In order to maintain this level of activity we need to involve the wider membership and together address our financial situation.

From the financial statement given by the treasurer, Sue Johnson at the AGM, it was noted that several expenses have been incurred in the setting up of the association and in having the books audited. An ongoing expense is the production and distribution of the newsletter. One option discussed at the last committee meeting to reduce the expenditure was to lower the quality of the newsletter. Another option is to produce the newsletter less frequently. Both options were strongly rejected. It was felt that a high quality newsletter should be produced on a regular basis, as it is the means whereby members communicate with each other. In addition to providing the newsletter, AAIMHI plans to organise a regional conference in conjunction with WAIPAD in 1991, this also costs money.

Currently our main sources of income are membership fees and workshops. Do you have knowledge and skills which can be packaged as a workshop? We want to hear from you. Or perhaps you can help in some other way. You may be an accountant, or live with one, who would be willing to help with auditing the books. We believe that our membership represents tremendous knowledge, skills and talents and we are calling on that talent for the benefit of all members.

Please do not be hesitant. We are asking you to come forward with your ideas of how you can make a contribution to your association. Please write to AAIMHI or give us a phonecall on (02) 339 4440 (Beulah Warren and Sue Johnson) or (02) 328 6813 (Keryl Egan) to discuss your proposal.

With warm regards,

Beulah Warren
Vice President

AAIMHI Workshops

Bookings essential

Understanding Maternal Grief

February 16, 1990, 9.00 a.m. - 4.30 p.m.

Workshop Leader

Margaret Nicol

The main focus of this workshop will be on the development of grief counselling skills so that participants may:

- gain insight into the magnitude of the problem of maternal grief, which incorporates miscarriage, termination, stillbirth, neonatal death, cot death, the birth of a handicapped child and infertility;
- gain a psychological understanding of healthy and pathological grief reactions and those processes which hinder and support the bereaved;
- be better able to identify the needs of bereaved parents;
- explore the most effective ways of assisting the bereaved to a healthy resolution of grief within a counselling context.

Margaret Nicol is a clinical psychologist and author of the recently published book "Loss of a Baby: Understanding Maternal Grief".

Venue: 15 Cooper Street, Double Bay NSW 2028

Cost: $90.00

This workshop is limited to 30 participants. If there is a high enough demand, a second workshop will be conducted on February 17, 1990.

Enquiries: Keryl Egan on (02) 328 6813

Registration and cheque payable to:
AAIMHI, PO Box 39, Double Bay NSW 2028

Introduction to the Brazelton Neonatal Behavioural Assessment Scale

March 9, 1990, 9.00 a.m. - 1.00 p.m.

Workshop Leaders

Beulah Warren
Robyn Dolby

The workshop will involve a:

- life demonstration of the Brazelton Neonatal Behavioural Assessment Scale (NBAS);
- discussion about how the assessment can be used with parents to highlight the behavioural characteristics of their baby;
- presentation of research data.

Both workshop leaders are authorised trainers in the administration of the NBAS.

Beulah Warren is a psychologist and co-ordinator of the Early Intervention Programme, Benevolent Society of NSW, Sydney.

Robyn Dolby is a Postdoctoral Fellow in Psychology at Prince of Wales Hospital, Sydney.

Venue: 15 Cooper Street, Double Bay NSW 2028

Cost: $50.00

This workshop is limited to 12-15 participants. If there is a high enough demand, a second workshop will be conducted on March 10, 1990.

Enquiries: Beulah Warren on (02) 339 4440 or
Robyn Dolby on (02) 660 0003

Registration and cheque payable to:
AAIMHI, PO Box 39, Double Bay NSW 2028

Report on the Fourth World Congress of the World Association for Infant Psychiatry and Allied Disciplines in Lugarno (September 20-24, 1989).

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Plenary Session 1
"Outcome evaluation of brief psychotherapy in disturbed mother-infant relations". Chaired by Daniel Stern and Bertrand Cramer. This multidisciplinary study compared two types of brief interventions: a psychoanalytically oriented therapy (as previously described by B. Cramer) and Interaction Guidance, a technique aimed at improving parent/child interactions via coaching during parent/child play. (The latter approach has been previously described by S. McDonough). An evaluation consisting of: a symptom check list, mother's representation of her infant, the infant's affect states, an Ainsworth situation, the Crittenden Scale, mother's attunement, and the Beck depression inventory was given before treatment and repeated at the end of treatment and at 6 months and 12 months follow up.

The preliminary results were that both treatments were effective and there was no difference between types of intervention. The study design needs improvement. However part of the difficulty is that work in this field is still in its infancy.

Plenary Session 2
"Cultural variations of infant care practices: Health and development". Chaired by H. Stork (France) who gave the introductory presentation on the contribution of cross-cultural psychology to the study of interactions between family and infant. Participants from Algeria, Senegal, Brazil, France, India and Portugal contributed diversely although a major theme was on cultural representations.

Plenary Session 3
The Presidential Address "Lessons from infancy: New beginnings in a changing world and a morality for health" was delivered by R. Emde. His ideas about basic motives has been proposed in his earlier writings but he suggested that the infant's developmental thrust also contained a fifth fundamental mode, that of morality. Like the other modes this is exercised within the primary caregiver relationship, where concerns for self from the beginning are intertwined with concerns for the other.

Plenary Session 4
"Attachment within family systems: Implications for prevention". J. Stevenson-Hinde chaired and gave an introduction and overview of the area. J. Byng-Hall looked at attachment theory within family therapy using a case example; M. Sherman looked at family narratives and their encapsulation of internal representations of family relationships and affective themes; and I. Bretherton focused on intergenerational transmission of family relationships.

Plenary Session 5
"Symbolic communication and verbal communication in babies with early evolutive disharmony". Chaired by G. Levi (Italy) and involving predominantly Italian clinicians, the focus was on infants who "lost their possibilities" (M. Soule) as with chronic disease, mental retardation or autism.

This introduction to the last day also focused on psychosomatic issues and the important links between psychiatric and paediatric disciplines. Symposiums and workshops looked at: In-hospital intervention with preterm infants, sudden infant death syndrome, failure to thrive, handicapped infants, infants with AIDS and aspects of atypical development.

Information arising from the AGM of relevance to AAIMHI members was:

Joy Osofsky became the President Elect and Serge Lebovici the current President. The next World Congress is scheduled for Summer/Fall 1992 somewhere in the USA. The planned regional conferences: July 1990 in Kyoto, Japan; November 1990 in London linking the Anna Freud Centre and the Tavistock; and March/ April 1991 in Sydney, Australia.

Papers presented at the Congress will be primarily published in the Infant Mental Health Journal. Remember membership of AAIMHI entitles you to a reduction in the subscription rate to this journal. A special issue (Vol 10, 3, 1989) brought out at the time of the Congress, focused on internal representations and parent-infant relationships. It was edited by Charles Zeanah and Marianne Barton. This area was one of the dominating themes with the beginnings of more complex research going beyond understanding the interactive patterns of parent-infant relationships to "what is communicated and experienced within that pattern about the caregiving relationship, the self, and the other".

Dr Denise Guy
Director Child & Family Unit
Redbank House,
Westmead Hospital.

From the President

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number of AAIMHI members and was well worthwhile. It is hoped that ANZAP will continue to bring outstanding people to Australia in the future and that AAIMHI will consolidate its ties with ANZAP as well as with all other groups interested in infant development.

As part of this we are still interested in contributing to the WAIPA objectives of a regional conference in 1991 given further discussions this year and keeping the primacy of our domestic objectives in mind. The format for 1990 may differ from what you have seen so far in that there will be more workshops such as the ones by M. Nicol and B. Warren/ R.Dolby. Both workshops have been well received in the past and I would strongly encourage members to attend.

The rest of our 1990 programme will be announced in the March newsletter. In the meantime have a very happy Christmas and New Year after which I hope to see many of you at our workshops, seminars and social functions throughout the coming year.

Keryl Egan

Project News

The Sydney Family Development Project

Robyn Dolby and Judy Ungerer†*

"How is it that some children become sad, withdrawn, and lacking in self-esteem, whereas others become angry, unfocussed, and brittley self-assertive, whereas still others become happy, curious, affectionate, and self-confident?" [1] In an attempt to look at how these styles come about, the Sydney Family Development Project (SFDP) is studying emotional development in infancy and the kinds of emotional communications that take place between caregivers and infants.

SFDP is headed by Dr Judy Ungerer from Macquarie University and Professor Brent Waters, Dr Bryanne Barnett and Dr Norm Kelk at the University of NSW. Vivian Lewin co-ordinates the project which is based at Prince of Wales Hospital. Families are recruited from those attending the Royal Hospital for Women at Paddington (Sydney).

It is hoped some 200 families who are having their first baby will participate in the project. To date about 100 families have been recruited. The sample is selected to represent a wide range of maturity of personality functioning as measured by the Defence Styles Questionnaire.[2]

Families are initially contacted during the second trimester of the pregnancy and are followed for three years using interviews, questionnaires and parent-infant observations. The question of interest is how parents' maturity of personality functioning translates into different ways of perceiving and responding to an infant's emotional capacities.

Infants' emotions and emotional communications are far more organized than previously thought. We are using the still-face observation procedure when infants are 4 months old, particularly to look at their emotional capabilities. In this procedure mothers at first play normally with their infants then are asked to look at their child but keep their face completely expressionless and still. They remain still like this for two minutes, then resume normal play.

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 on their socks. All the infants seem to be affected by their experience. When mothers resume normal play, the infants do not. They remain guarded and continue to look less at their mothers for the next minute or two.

We are interested in mothers' explanations for their babies' behaviour. Each mother watches a video-replay of the still-face procedure and comments on what her infant is doing and how she thinks her child is feeling.

Mothers have very different perceptions of their infants' feelings during the still-face procedure and when the infants hesitate to resume normal play. Some mothers describe their infants in a way that seems most reasonable to us. They see their infants as confused by their lack of responsiveness and as hesitant to resume play because they are not quite sure what their mothers will do. A second group of mothers describe their infants in ways that seem to reflect more their own negative experiences in relationships instead of what their infants are likely feeling. They describe their infants as feeling angry and rejected and the infant's unwillingness to resume play is viewed as retaliation for the mother's unresponsiveness. A third group of mothers see their infants as unaffected by their lack of responding in the still-face procedures. These mothers appear generally to feel unimportant to their infants and so lack confidence as parents.

These groups of mothers see themselves very differently and we expect provide very different emotional environments for their children. We believe these differences will have an influence on how children come to understand their own emotions and how confident and competent they will feel in themselves and how easily they will be able to establish warm and satisfying relationships with others. We will be pursuing these themes in our later assessments of the infants and parents.

1. Tronick, E. Emotions and Emotional Communication in Infants. American Psychologist, February 1989, 112-119.

2. Andrews, G., Pollock, C. & Stewart G. The Determination of Defensive Style by Questionnaire. Archives of General Psychiatry (in press).

*Postdoctoral Fellow in Psychology, Sydney Family Development Project, Avoca Clinic, Prince of Wales Hospital, Randwick, NSW 2031.

†Senior Lecturer in Child Psychology, School of Behavioural Sciences, Macquarie University, Sydney, NSW, 2109.

A Group Program for the Treatment of Postnatal Depression

Susan Williams* and Rosemary Seale*

Introduction

This paper describes the development and results of a group treatment program for women suffering postnatal depression.

Postnatal depression is increasingly documented as a clinical condition variously affecting some 10-40% of mothers in the first year after childbirth. Symptoms of postnatal depression include anxiety, tearfulness, exhaustion, sleep and appetite disturbance, memory and concentration difficulties, suicidal and/or obsessional thoughts, fear of social contact, loss of sexual drive, feelings of guilt, inadequacy or worthlessness (Barnett, 1989).

In 1987 Tresillian Family Care Centres received funding from the Women's Health Unit, Department of Health, NSW, to develop, implement and research a group program for women with postnatal depression on a pilot basis over a period of 18 months.

Intervention

The postnatal depression groups met for a 2-hour seesion each week over 10 weeks. One follow up session was offered three months after completion of the programmes.

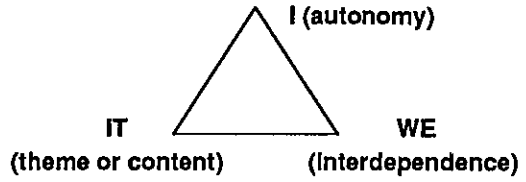
Babies were not included in the group and 82% of the mothers required organised childcare which had the therapeutic advantage of women giving themselves some 'time out' without feeling they were abandoning their children.

The main objectives of the program were to:

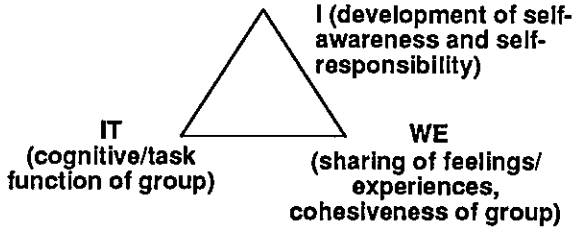
* reduce the level of depression and anxiety
* facilitate personal growth
* enable participants to use mainstream community groups more effectively.

As the postnatal depression group program developed, the leaders became aware of elements in the group work intervention that could be described by the Theme-Centred Interaction Model as put forward by Shaffer and colleagues (Shaffer & Galinsky, 1974). The important initial idea was to have a 'clear cut' theme for the targeted women to identify which would enable them to come to the group in a voluntary and motivated way. The main theme chosen for the program "How to manage my postnatal depression better" openly addressed the reality of depression for the women but was positively framed to offer them the hope of sharing and learning new and alternative ways of dealing with their personal distress and anxiety. The development of sub-themes was very much the on-going work of the leaders and group members together. Some examples of these were: "What I want to do better/differently", "No wonder I'm depressed", "I've survived before" and "I need to look after myself" (Seale and Williams, 1989).

Another key concept in the model is the "I-We-It Triangle" (Seale & Williams, ibid).



The "I" refers to the "self" part of each person, the "We" to the relationships between group members and the "It" to the theme or content of the group. The following application of the "I-We-It Triangle" was developed for clinical practice.



The careful balance of the three elements described above is crucial for this group of women where:

- a feeling of helplessness and passive dependence has blotted out a sense of autonomy (I);
- isolation and denial of feelings has prevented any sharing and normalising of these feelings (We);
- some participants are so overcome by their emotions that they are no longer able to think clearly or rationally (It).

Recruitment and Profile of Women Participants

61 women, mainly suffering moderate to severe postnatal depression, participated in the study and were allocated to one of eight groups. One third of the women were taking antidepressive medication at the commencement of the programmes. A significant finding was that women suffering postnatal depression represented a very normal distribution of the population of women having babies with regard to age, marital status and occupational background. For instance, 84% were married and 44% were 26-30 years of age (Seccombe, 1988).

The women were recruited via media coverage, flyers exhibited at Baby Health Centres and Community Health Centres and via other health professionals. 16% of the women were self-referred and had in general not been recognised by the traditional health services as considerably depressed women. That a significant proportion of women go undiagnosed is supported by Tonge (cited in Pennicott, 1988) and Dennerstein, Varnavides and Burrows (1986).

* Socialworkers, Postnatal Depression Program, Tresillian Family Care Centres, 2 Shaw Street, Petersham NSW 2049

Measurements

A pre-group, post-group and 3-month follow-up group questionnaire was administered which incorporated the Edinburgh Postnatal Depression Scale (Cox, Holden & Sagovsky, 1987) and evaluative feedback by the women as to the usefulness of the program for them.

The questionnaires achieved a 90% response rate and the results were independently evaluated (Reynolds, Seale & Williams, 1988).

Some Results and Discussion

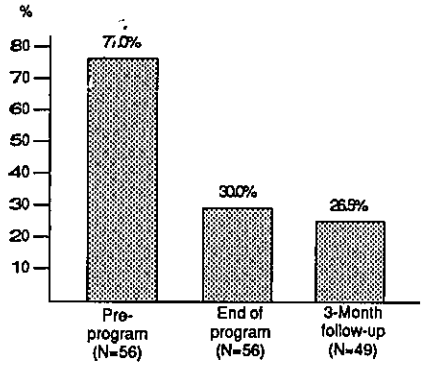


Figure 1: Total Score on Edinburgh Postnatal Depression Scale

Figure 1 shows that 77% of participants registered a score indicating presence of a depressive illness pre-programme (i.e. a score of 12+ on the Edinburgh Postnatal Depression Scale). The other 23% of participants joined the programme for preventative reasons (e.g. previous episodes of postnatal depression). Of the 30.0% of group members still depressed at the end of the program, some had finally accepted they were ill and were in the process of seeking longer term psychiatric follow-up. We regard this as successful in the sense that these women had strenuously resisted intervention other than the group, but through group support they became less denying of their real distress and sought continued care.

Three months after completion of the programme the depression rate was still declining.

The group helped the women significantly with: understanding postnatal depression; not feeling so alone; building self-esteem; gaining skills to accept feelings and manage depression better (i.e. be more in control); being more objective about the nature of interactions with important others, especially partners; and knowing how to be less dependent and more assertive. The women reported their increasing enjoyment of their baby and family life (Reynolds, Seale & Williams 1988).

98% of participants said they felt the programme was helpful and relevant to their needs. These were listened to and not trivialised. 93% said they would recommend the programme to other women. The high rating of leadership skills (85%) and low level of stress experienced by the women in the group (35%) suggests that the group climate was very safe, trusting and contained. This is vital for a group program in order to ensure ongoing involvement of this fragile group of participants.

Conclusion

This is a short summary of our pilot project. The issue of postnatal depression and its treatment is complex.

We suggest that a group treatment programme is a cost-effective, relevant service for women with postnatal depression. It promotes self-responsibility, use of existing mainstream resources and has proved a valuable tool for networking. It is complementary to and reinforcing of other forms of intervention, e.g. psychiatric/early childhood nurse intervention.

References

Barnett, B. Maternity Services in New South Wales. Appendices to the Final Report of the Ministerial Taskforce on Obstetric Services in New South Wales, Sydney, Department of Health, Appendix 5.8, 1989, 104.

Cox, J .L., Holden, J. M. & Sagovsky, R. Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry, 1987, 150, 782-86.

Dennerstein, L., Varnavides, K. & Burrows, G. Postpartum depression: a review of recent literature. Australian Family Physician, 1986, 15,11, 1470-72.

Pennicott, P. Postnatal depression often unrecognised. University of Sydney News, 21 June, 1988, 99.

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Seale, R. & Williams, S. Theme-centred group work model for the treatment of postnatal depression. Proceedings of 21st National Conference, Australian Association of Social Workers, Townsville, 2-7 July 1989 (in publication).

Seccombe, M. Birthrate falls to a new low point. Sydney Morning Herald, 3 September 1988, 2.

Shaffer, J. B. P. & Galinsky, M. D. Models of Group Therapy and Sensitivity Training. New Jersey, Prentice-Hall Inc, 1974, 242-64.

Other Seminars, Conferences and Activities

April 6-7, 1990.
Inaugural Crown Street Commemorative Conference entitled "With Courage and Devotion – King George V Honours Crown Street".

Enquiries:
Joy Vickerstaff on (02) 516 8417 or Catherine Maxwell on (02) 516 6084 or Maureen Ryan on (02) 516 6450.

April 17-20, 1990.
Australian Child Protection Conference under the auspices of NSW Child Protection Council.

Venue: Macquarie University, Sydney.

Enquiries:
Australian Child Protection Conference
NSW Child Protection Council
PO Box 228, Parramatta NSW 2150

April 26-27, 1990.
Fourth Annual Conference of the Drug and Alcohol Nurses Association entitled "The Client, the Family and the Counsellor".

Venue: Concord Hospital, Concord, Sydney.

Enquiries:
Meredith Adams
Drug and Alcohol Services
Concord Hospital, Hospital Road, Concord 2137
Phone: (02) 736 7911

August 19-25, 1990.
National Child Protection Week

August 26-27, 1990.
NAPCAN Victoria is organising the NAPCAN conference entitled "Parenting Towards 2000".

Venue: Monash University, Melbourne

October 22-26, 1990
Sixth Congress of the Federation of the Asia-Oceania Perinatal Societies. The Congress theme will be "Perinatal Medicine – Facing the 21st Century".

Venue: Hyatt Regency, Perth.

Enquiries:
Wyeth Clinical Meetings Service
PO Box 148, Parramatta NSW 2124
Telephone: +61-2-635 7144

Resources

Video

"Following the Birth of a Handicapped Child"

This video explores the thoughts and feelings of family members following the birth of a handicapped child. Topics include: the shock of finding out; effects on the marriage; reactions of friends and extended families; reactions of siblings.

The video can be ordered from:
William K. Frankenburg M.D., University of Colorado Health Sciences Centre, 4200 East Ninth Avenue, Denver, C.O. USA.

Books

"Infant Mental Health Services : Supporting Competencies / Reducing Risks" by Deborah Weatherstone and Betty Tableman.

The manual provides a framework for infant mental health services, covering: referral and enrolment; arrangement for service; assessment process; intervention strategies; termination issues; special circumstances; and program organisation issues.

The manual is available for US$25.00 from:
Michigan Department of Mental Health, DMH, Lewis Cass Building, Walnut Street, Lansing, MI 48913, USA.

"Young Unwed Fathers: Research Review, Policy Dilemmas and Options" by Jacqueline Smollar and Theodora Ooms.

This summary report (of a project undertaken by the Family Impact Seminar, Catholic University of America) is available for US$5.00 from: Shared Resource Centre PO Box 2309, Rockville, MD 20852, USA.

"Music is for Young Chidrenn Too!"
(0-5 years) by Deidre Russell-Bowie.

This book can be purchased for $6.95 (plus $2.50 postage) from:
Deidre Russell-Bowie,
Macarthur Institute of Higher Education
PO Box 555, Camperdown NSW 2560

Response to article "Infants in the Children's Court" by Toni Single (AAIMHI Newletter Nº 2, Spring 1989)

The scene described by Toni is all too familiar, of infants appearing before the court shortly after birth, where there is the likely risk of abuse. In a number of instances we have been involved in case conferences even before the birth of the infant. The mothers have been psychotic or drug abusers, often teenagers themselves. The area of emotional abuse is still fraught with considerable dissent. It is an emotive area, one in which more interdisciplinary discussion is needed. It is heartening to read that the author has had a 'good experience' with the children's court. I agree with her that this is not a popular branch of child psychiatry and that many practitioners baulk at having to be involved in court matters.

In my experience of working in a mother-infant distress unit, in developmental paediatrics and as a member of a 'child-at-risk' team in a grossly under privileged area, and then in Psychiatry, I have found myself in the position of 'advocacy' on behalf of the infant and on behalf of the mother. It is certainly a position not to be envied.

The Family Law Act, 1975 seeks to ensure the right of children to grow up in those circumstances which best assure material and emotional security, and allow optimal development of body, intellect and personality. As early as 1973 Justice Selby of the Supreme Court of New South Wales recommended the appointment of a panel of psychiatrists to assist the court in custody disputes. We are no closer to having such a panel. Child psychiatrists continue to present information to the court through the adversarial system. (1) This is certainly undesirable.

The Child Care Protection Act of New South Wales 1987 theoretically provides preventive intervention for children 'likely to be abused'. In practice it leaves much to be desired. If infants and children are to be protected from 'emotional, physical or sexual abuse' in families that are 'at risk' there has to be improved dialogue between the court system and the professions. There is a serious shortage of child psychiatrists in New South Wales, and more so of those with an interest in Forensic Psychiatry. It takes time and development of skill and expertise before a psychiatrist is prepared for forensic matters. Besides, doctors quite often feel that they 'have to testify with absolute certainty'. Requests for assessment and reports are quite often made at the eleventh hour, creating even more difficulty thus.

The professions are as much to blame for the lack of awareness and failure to educate the System. The author has highlighted the major difficulties which still exist.

The interim removal of infants to a 'place of safety' and the time taken to arrive at a final decision on behalf of the baby and the shortage of skilled professionals able or willing to assess could be resolved by the Department of Family and Community Services establishing a panel of professional people who can be called upon, and who would educate other professionals. There is a widely held belief that court referred families are poorly motivated and lack insight. This is so only as long as the health professional is seen as an adversary. Once a level of trust is established (this takes some amount of work) better results can be achieved.

In my opinion the reasons given for the frequent use of short-term foster carers by the Department are the most deplorable. It is time that these issues are taken congnizance of. The shortage of long term foster parents is in part due to the frequent trauma inflicted on these people as a result of either improper assessment in the first place or bureaucratic bungling which we have seen in some cases. A proper assessment of prospective foster parents in my opinion is rarely carried out. I have seen some very disturbed people who have been on the 'list' of foster parents.

Assessment of 'At Risk' babies and their families entails immediacy, hours of interaction and observation, writing of reports, conferences and representation in court – a professional must be willing to give of this time in order to produce a successful outcome. Yes, as psychotherapists we are spending hundreds of hours attempting to provide a 'corrective emotional experience' for those who have been deprived at some earlier stage of their lives. There is an increasing incidence of disorders of 'Self'(2) the reasons for which are too numerous to discuss, and inappropriate here. But the failure of children to achieve cohesion is often the result of faulty self object experiences, amongst others – the situation of multiple inappropriate carers must not be allowed to exist.

An increasing interest and awareness in infant development will hopefully lead to improved advocacy for infants, and as Winnicott puts it to 'stand in the baby's shoes'.(3) More emphasis needs to be placed on the education of parents, and professionals need to be empathically tuned into the infant-parent relationship. Parents give of themselves from their own experiences of being parented. The acquisition of a sense of Self is derived from the Self, Self-Object Experience in those critical first two years. Our paediatric colleagues are in a most unique position to address this area of need, along with those of us in the mental health field.

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2. Wolf, E.S. Treating the Self. The Guilford Press, London, 1988.
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Joan Haliburn FRANZCP,
Child Adolescent and
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Report on the Conference: Caring for Children and Adolescents with HIV/AIDS

Prince of Wales Children's Hospital
University of N.S.W.
November 2-3, 1989.

Papers presented at the conference related to the illness as well as to the social and behavioural aspects of the condition.

Dr Ron Penny spoke of the different classifications of the disease. The clinical expression is in the lung, the gut and the central nervous system. Some of the presenting symptoms are: failure to thrive, fever, chronic diarrhoea, or some central nervous system involvement. Obviously, an important factor is the need to discriminate from other types of infection.

The highest paediatric risk factor is an HIV infected mother. The cause of infection in 75% of paediatric cases to date has been vertical transmission. If an HIV infected woman has a baby there is a 30% chance the infant will be infected. Infection can occur during the pregnancy, however it is not known whether it is transmitted at a particular point in time or whether the foetus is vulnerable throughout the pregnancy. It is not known for approximately 18 months whether or not the baby has AIDS as up until that time the baby may be carrying the mother's antibodies.

Dr Alex Wodak and Dr John Ziegler drew the strong link between poverty, poor education, intravenous drug use, prostitution and AIDS in the United States. They stressed the point that one needed to address the issue of poverty and education if one was really going to tackle the AIDS problem.

One of the very interesting papers was from Dr Ann Bye, Neurologist. She talked about HIV in child development and explained that there is CNS involvement in 50-90% of the cases. The most common involvement was progressive encephalopathy, although there are some instances of static encephalopathy. With progressive encephalopathy there is a loss of development of milestones and impaired brain growth. In children there is the initial exposure to the virus, the incubation period of 2 months to 5 years, then the neurological deterioration which parallels that of the immune system. Outcome can be fatal within 3-4 months.

Many statistics were quoted over the 2 days. The most challenging statistics were given by Vince Lovegrove whose 4 year old boy has AIDS. When they were told their child had AIDS in 1985 there were 4 known cases of children with AIDS. In 1989 there are 140 known cases throughout Australia, which represents an increase of 3500%. It is estimated that the hidden number of paediatric cases would be in the vicinity of 2940. I found that quite a shattering statistic and it really represents an enormous problem in terms of caring for these children. AIDS in children is increasing at 3 times the rate of increase in other groups.

The overriding message from the conference for me was that AIDS is a fact of our society. It is not something that "they are going to find a cure for" in the immediate future so we have to learn to deal with it. It is also something we have to deal with without being judgemental. There is a need to recognise that the disease can affect any one of us, or it can affect someone we love. In fact the prediction is that by the end of the century most of us will have somebody very close to us who has the disease. The real test for professionals is in terms of dealing with their own feelings about the disease, their own death and dying. In coming to terms with those feelings we will be able to better care for our clients.

Beulah Warren, Psychologist
Co-ordinator
Early Intervention Programme
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Book Review

First Feelings: Milestones in the Emotional Development of your Baby and Child by Stanley Greenspan and Nancy Greenspan. Penguin 1985, 304 pp.

As indicated by the title, this book looks at the early development of emotions, starting immediately after birth and continuing up to the age of four years.

As with other current American clinicians and theorists such as Brazelton, the authors give the infant full status as an individual, a small person who has his/her own developmental and emotional tasks that must be worked at from the moment of birth onwards. The first of these is the attainment of self-regulation, the ability to stay calm (or to return to a calm state) in the midst of the overwhelming excitement provided by the outside world. The Greenspans list six such developmental tasks and describe the processes involved.

The infant is seen always in the context of the interpersonal environment and the most important part of this environment is the parents. So the parents' feelings, their parenting styles and parenting problems are also examined. Common parental fears are discussed and suggestions made as to how parents can deal with their difficulties and facilitate the emergence of the infant's developing skills. These sections in particular, make this book of use to health professionals working with infants or young children and their families.

The book is actually written for parents. In the preface the Greenspans state that this book was written for parents who want to take up the "challenge of understanding their child's first feelings as well as their own" (viii). It is thus written for the general public and the material is set out in a structured format, each chapter being broken down into subsections and summaries provided. The language is clear and without

Book Review

continued form previous page

jargon. There are no research findings provided which could be a disadvantage. However, the authors provide a comprehensive bibliography and offer to make available an even fuller list on application. There is also an index.

Although there are no research findings quoted, the primary author, Stanley Greenspan (according to the description on the inside cover) has been awarded the American Psychiatric Association's highest honour for child psychiatric research. Given that he occupies several senior and prestigious positions in the American psychiatric establishment, and also from the contents of the bibliography, it can be assumed that the book is based not only on highly skilled observation, but also on a knowledge of the relevant research. His co-author and wife Nancy Greenspan is a health economist also highly regarded in her field.

The authors define emotion in terms of observed behaviour. The Greenspan baby is an "observed baby" rather than a "clinical baby" to use Stern's (1985) terms. Stern defines the clinical baby as one which in reconstructed from the memories of adult psychotherapy patients. The Greenspans do not deal with memories or with constructs that cannot be observed. Their orientation is behavioural. However, this is not a book about behaviour modification, or a list of ways in which to manage the rebellious toddler. The emphasis throughout is on understanding, both of the infant and the parent, and of the interaction between the two. The mood is one of optimism. The authors do not doubt that it is possible for parents to understand their children (with a little help when necessary) and so to optimise their development.

In summary, this is a most readable book, written by people highly regarded in the field and of use to both parents and professionals.

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Early Intervention Programme,
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Correction

The article "Infants in the Children's Court", in the previous newsletter should be amended to read " . . . *due to the shortage of Special Magistrates and the shortage of skilled professionals* . . . " (on page 5 – point 1)

This was inadvertently omitted. Our apologies to the author.

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