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FROM THE EDITORS

In this edition of the Newsletter we continue the practice of printing a paper which will be of interest to all those who work in the area of Infant Mental Health. Beulah Warren describes in this paper the work of the Early Intervention Programme at the Benevolent Society of New South Wales, a programme which is now well established and which makes an important contribution in the field. We hope to continue this tradition, and again remind you that copy for the Newsletter is always welcome.

innovation is the first of section on Research in Progress. In this Berinda Larney reports on a research project she is about to undertake. We would like to make this a regular feature as it may allow researchers throughout Australia the opportunity to make contacts with others who are pursuing related lines of research. Again we invite contributors to this new section of the Newsletter.

AAIMHI is in the process of formulating a change in the Constitution which allows for the coordination of a number of State organisations, so that there will be a Federal Secretariat with branches in (at least) Victoria, New South Wales and South Australia. To make the Newsletter more accurately representative of this Federal activity, we need interstate contributions!

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Elected November 4, 1992

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FROM ANN ARBOR TO SYDNEY: INFANT MENTAL HEALTH DOWNUNDER - THE EARLY INTERVENTION PROGRAMME

From a paper presented by Beulah Warren, MA(Hons) MAPsS, Co-ordinator, Early Intervention Programme, Benevolent Society of New South Wales at the Fifth Annual Conference of the World Association of Infant Psychiatry and Allied Disciplines, Chicago, September 1992.

INTRODUCTION

In the introduction to her wonderful book, "Clinical Studies in Infant Mental Health", Selma Fraiberg outlined the early days of the Infant Mental Health Program, Ann Arbor, Michigan. The fact that the program received only referrals regarded as "severe" was attributed to the community's needs and the program's location in a clinic in a psychiatric department. It had been expected to serve a range of developmental disorders in infancy, including every day problems such as feeding and sleep disturbances.

Conversely, the protocol of the first Infant Mental Health Program in Sydney, Australia, identified its moderate to severe target population as premature infants, failure to thrive and misperceived infants.

Although a third of referrals are infants born prematurely or diagnosed as birth asphyxiated, only two infants have been referred for queried failure to thrive and none has been described as misperceived.

We see infants at risk of severe disorders, but because of our location within a large obstetric hospital, we get involved with families within days of the birth of their baby, that is before the initial difficulties have become pathologised, e.g. a feeding problem consolidated as a failure to thrive infant of six months.

In addition, two of the staff had worked together previously on an intervention project with premature infants and their families. The behavioural/motor self regulation model of development and intervention developed on that project, provided an ideal entree into families, as it addressed parents' concerns with its non-threatening explanation of infant needs.

As I describe our programme today, I feel we are a part fulfillment of Selma Fraiberg's prophecy,

when she said: "Our own conception of infant mental health would embrace a large number of models, each reflecting the unique problems of a particular infant population, each adapted to the setting in which the work is performed and the professional expertise represented in its staff." (Fraiberg, 1980).

THE EARLY INTERVENTION PROGRAMME

The Early Intervention Programme (EIP) is a preventive programme to reduce the incidence of child abuse and neglect in Sydney, Australia. The programme is funded by the Health Department of the NSW state government and administered by the oldest non-profit charity in Australia, the Benevolent Society of New South Wales.

The Benevolent Society has worked to relieve the suffering of the poor and disadvantaged of Australia, especially women and children, since 1813. The Society administered the Royal Hospital for Women (a large maternity hospital), and ran a Children's Home for neglected and abused children from 1917.

During the mid-80's, after a review of its services, the Society decided to link the above two services and introduce a preventive programme. The Society closed its Children's Home and commenced the Scarba Family Centre, with the emphasis on keeping families intact, rather than removing the children, when abuse and neglect have already occurred. At the same time, the EIP was established. The original protocol, written by Dr Gayle Shea-Everidge (1986) was based on the Child Development Project and the work of Dr Selma Fraiberg (1980) in Ann Arbor, Michigan, US, in the 1970's.

The goal of the programme was to reduce the incidence of child neglect and abuse by working proactively with families with identified difficulties, either antenatally or between parents and infants.

The underlying assumption is that child abuse and neglect is a consequence of the distortion of the parent-child relationship.

THE EARLY INTERVENTION PROGRAMME - HOW IT OPERATES

HOMEBASED

The Early Intervention Programme is a home based programme for families, either expecting an infant or with infants 0-3 years. However, most infants are less than 12 months at the time of referral.

The target population is families where there are problems identified as likely to distort the parent-infant relationship. The problem may relate to the needs of parents or child, e.g. parents who are depressed or anxious or have a psychiatric condition, or who are without supports; or a child who is difficult to manage, excessively irritable, born prematurely or has experienced birth asphyxia. The child is the client.

LOCATION

The programme is located within a large obstetric teaching hospital which delivers in excess of 4,000 births per year. The EIP services the Eastern area of Sydney. Although located within the hospital, the programme is community oriented, and works closely with other community agencies.

The EIP does not attempt to replace generic community services but to link families into those services, e.g. the Early Childhood Centres, or traditional Early Intervention Services. Thus, the programme acts for families as a bridge betw[een] hospital and community and, in the community, between health and welfare agencies.

The referral pattern is 50% from the obstetric hospital, and 50% from the community or the family.

THE TEAM

The EIP combines the elements of an infant mental health team and traditional early intervention service. The multi- disciplinary clinical team consists of psychologists, social worker, nurse with midwifery and neonatal training, together with a physiotherapist, with obstetric and paediatric training and occupational therapist, who is a trainee psychotherapist. Each worker has several years of clinical experience within her ow[n] discipline.

Each staff member is a primary worker, working in a transdisciplinary manner in relation to the family. In order to do this, team members are required to have a thorough knowledge about a wide range of areas, including:

- child development (related to emotional, motor and cognitive aspects)
- counselling/psychotherapy
- psycho-social aspects of family life
- complications in the neonatal period

The primary worker introduces herself as a team member. Thus the family is linked to a professional "family". The worker uses other members of the multidisciplinary team as both a professional and personal resource. On occasions, the primary worker may use another team member as a consultant, e.g. the physiotherapist on a developmental issue. The consultant is often the

worker who holds the family in the absence of the primary worker, e.g. when on holiday or sick leave.

In order for the team members to be available in this way, they also require support. In addition to their support of each other, all staff receive one hour individual supervision per week and one and a half hours of group consultation by a psychiatrist. In addition, paediatricians are available for consultation.

THE WORKER'S RELATIONSHIP WITH THE FAMILY

The emphasis is on developing trust between the family and primary worker. An ongoing, caring relationship with another person can provide the new parent with a sense of being held, or contained, and reinforces them as parents as they parent their infant.

The relationship established between the worker and the parent offers a prototype for the relationship between parents and their infants.

Parents are listened to in a non-judgemental way and every effort is made to understand the problem from the parents' perspective and reinforce their good parenting and observations of their infant.

The infant is observed in interaction with the parent and often a formal assessment of the infant's strengths and weaknesses is obtained, e.g. Neonatal Behavioural Assessment Scale (Brazelton, 1984).

Emphasis is on helping parents to:

i) recognise and name feelings, especially in relation to the baby, from the time of their infant's birth; and, ii) understand their infant's behaviour in a developmental framework and provide the necessary nurturance for their infant to meet his/her developmental challenge.

The worker attempts to contract with the family to work together to achieve certain goals. Involvement is concluded when parents and worker agree goals have been achieved. It is often found that withdrawing at this time, reinforcing the parents for goals achieved, empowers them to ask for assistance in the future if they feel the need arises.

CLINICAL ASSUMPTIONS OF THE PROGRAMME

The clinical assumptions of the programme are:

1. The infant (who is the client), is not conceptualised as alone, there being no such thing as a baby, only a parent (or parents) and a baby (Winnicott, 1964).

2. The relationship between parents and infants begins at birth and often much earlier.

3. The relationship is perceived as an ongoing, dynamic interactive process (Sameroff and Chandler, 1975) with both child and parents contributing.

4. The child's contribution is influenced by, for example: birth history, constitutional factors (Greenspan 1992), motor competence, sensory sensitivity, state control developmental level.

5. The parent's contribution is influenced by:

- personal factors including:
a) intra psychic factors, e.g.
i) their internal working model of how they were parented (Bowlby, 1982);
ii) ability to identify with baby, to re-experience being a baby (Pines, 1982)
iii) parents' current perception of the child
b) parents' physical and mental health

- interpersonal factors-whether or not there is a supportive spouse, immediate or extended family - Social environmental factors: housing, income, cultural background, e.g. in Australia 33% of adults were born outside Australia (Australian Bureau of Statistics)

- Current culture - in particular, accepted practices and attitudes towards child raising, influenced by, for example:
i) ethnic mix - in 1981 the Australian population was made up of people from 38 different countries
ii) cultural myths - e.g. the Australian male is "Crocodile Dundee"
iii) the level of violence which is acceptable to the community

6. Having a baby has a strong psychological developmental component. It is one of the most significant events in life span development and for some it is a time of crisis. New parents are challenged with the responsibility of another life. The realistic fragility of the baby and its vulnerability confront new parents with the imminence of death (Menzies 1975).

7. During pregnancy or immediately following the birth of the baby is critical for both engaging parents and protecting the infant:

- new parents have a heightened sensitivity to the needs of their infant and a strong desire to parent correctly (Brazelton and Cramer 1990) in the period around the birth.

- if parents can be helped to be available to their infant in the first months of life and the attachment

between the two is formed, later issues can be resolved. "Once the bond has been formed, nearly everything else could find solutions" (Fraiberg 1980, p 175). Secure attachment at 12 months of age is highly correlated with parents being available and in tune with their infant in the first six months of life (Ainsworth 1978) - infants are most vulnerable during the first 12 months. A recent examination of child abuse and neglect in NSW (Young & Brooks 1988) concluded that the highest incidence of reported abuse for both sexes occurred in infants under 12 months of age; However, if an infant can escape "emotional trauma until age five, the healthy core of personality will be well formed and future negative experiences need not cause permanent damage. Whereas a child who has been subjected to abuse during the first three years of life will always have a weak substructure of personality" (Bruno Bettelheim, 1964).

APPLICATION OF THE CLINICAL ASSUMPTIONS IN THE EIP

The essential component is a dual approach; to establish a working relationship with the parents in which it is safe to explore the meaning of the relationship between them and their infant (Fraiberg, 1980), while identifying the infant's unique contribution to that relationship. Every effort is made to reinforce the strengths of the relationship between parent and infant and minimise the negative aspects.

The worker is an ally of the parents and an advocate for the infant. The worker works with the parents to meet their stated concerns and facilitates their nurturing and protection of their child. The objective is parent/infant attachment and optimal social, emotional and cognitive development of the infant (Weatherston and Tableman, 1989).

SELF REGULATION MODEL OF DEVELOPMENT AND INTERVENTION[1]

Working with an individual family

When working with an individual family workers use the Self Regulation Model of Development and Intervention (Dolby et al, 1987) and (Warren et al, 1987). This model has proved useful in helping parents see their child as separate and having his/her own agenda. It enables parents to stand back, identify the efforts the child is putting in to achieve the developmental task and how they can help. The model suggests there are three developmental issues for infants over the first year. It outlines corresponding roles for parents, together with intervention principles and outcome for each developmental challenge, when the intervention principles are adopted.

1. This model provides a way of reframing parents' concerns to allow the worker to:

- identify the developmental issue for the infant in both behavioural and motor terms
- make the developmental issues, both motor and behavioural, relevant to parents, where parents have difficulty identifying what baby needs, particularly in the first few months of life

2. We have found this model helps keep our focus on the baby, not an easy task when the parents' problems are overwhelming.

3. In addition, it provides a common means of communicating
across disciplines, e.g. how the physiotherapist and psychologist can relate when acting as consultants to other team members.

4. The model has application across a breadth of clients:

* Developed originally for premature infants, it is very appropriate for the families with premature infants referred to our programme. Contact is made as the infant's discharge is approaching. Emotional support and developmental guidance are offered to parents over the next year or two. Intervention is offered at key change points.

* The model has also proved invaluable with what we call our "quick fixes". A family is referred because the infant is not in a routine, is demanding, waking half a dozen times a night and the parents are exhausted. After carefully listening to the parents, as to what they find difficult and what they want to change, the child's behaviour is explained in terms of his developmental issue. Once parents realise that getting into a regular pattern is high on the child's agenda, that he has to get himself to sleep, but they can help him in a systematic way, then they are willing to hear suggestions.

* There are families, of course, where the issues are not resolved quickly. In these cases, there has to be a lot of listening, reflecting and rephrasing as effort is made to address the internal pain and other needs of the parents, as well as their concerns for their infant.

* In situations where there is considerable disturbance, we become part of a supportive network for the family to help contain them and guarantee the protection of the child. For example, for families in which parents:
- are extremely isolated
- have severe psychological problems
- are mentally ill, ie schizophrenic

1. A paper outlining the Self Regulation Model of Development and Intervention has been submitted for publication and will not be expanded in this paper.

CASE HISTORY

I would like to present a case history which illustrates the effectiveness of this model in addressing parents' concerns.
Mrs Clarke was a 27 year old married woman. She was the first time mother of twins, and self referred to the EIP requesting help with her son, Joe. Joe's twin sister Poppy was born without difficulty and was an active, healthy infant. Joe had a traumatic breech delivery with forceps and had fitted. The family was told he had severe brain damage and was not expected to live. When the respirator was turned off, Joe survived. He was brought home after seven weeks in hospital, proved difficult to manage and could not feed. At the time of referral, Joe had been in foster care because his mother found it difficult to manage him. He was being fed by tube and a force feeding bottle.

Mrs Clarke wanted to bring Joe home, Mr Clarke wanted the infant to be adopted. However, they finally decided to bring him home for a trial period. The family lived out of the EIP area and were expected to become involved with local community support services. Both parents were Australian born and had adequate financial resources and good family support systems.

The worker who took the referral the physiotherapist discussed the case with me and the local community services which were to be involved. It was agreed the EIP should engage the family until links with local support services were established. The first visit to the family took place one week after Joe returned home, when he was 16 weeks of age. Mother and father were present, and sister Poppy was playing happily in a bouncinette. Joe was asleep. His cot was placed in the laundry, so his intense crying did not disturb Poppy at night. The parents were asked what their main concerns were. The father felt it would be best for everyone if Joe were adopted. His mother replied "I want to keep him, but cannot feel anything for him." The aim was to address the concerns of the parents. These were now clear: the issue of adoption for the father and the mother's lack of feeling for her son.

From experience, we know parents can be so concerned with caring for their infant's physical needs that it becomes very difficult to see their infant as a person. The goal of the visit was to help them get to know their son as an individual. An explanation was given that Joe's motor development would be looked at, but the emphasis would be on his emotional responses.

When Joe was brought out, he was dressed in a singlet, diaper and a wrap, which was more like a rag, but which they found helped him settle. He looked pale and had a worried, intense expression. On observation it was obvious Joe had difficulty with movement. However, no formal assessment score was given or discussed at that time. To help identify his strengths, a Meade Movement Checklist (Meade 1981) was carried out. Care was taken to conduct the assessment in a way which helped the infant in his attempts at movement, e.g. by asking the mother to support his head and shoulders in the midline. The room was very quiet as the parents watched J's responses. He looked intently at a face and, with difficulty, was able to turn his head to follow a toy. He attempted repeatedly to move his hands towards the toy. On pulling to sitting, his head lagged. But, when this was repeated slowly, he attempted to pull his head forward. When placed on the floor on his stomach, beside his sister, he tried several times to lift his head to look at her. The emphasis throughout was to focus on what he could do - his successes - rather than on what he could not perform. His attention was prolonged and at one stage there was a fleeting smile, which his parents saw. His father commented several times "I have never seen him do that before. We have not put the twins together or on the floor." It was difficult not to be impressed with Joe's prolonged attention and perseverance. His father saw that Joe was really trying and partially succeeding.

The visit lasted approximately two and a half hours. A second visit was made one week later. The door was open. There were two babies in bouncinettes on the floor. Joe was supported by pillows, as had been suggested. Both babies were dressed in pink and there was a photograph on the table of the twins together. Mrs Clarke looked slightly embarrassed and said "I only had pink clothes. I have not had time this week to buy blue ones. "Although he did not smile, Joe was a better colour, looked less worried and had gained weight.

Mrs Clarke reported her husband had begun nursing and playing with Joe and was now more accepting of him. On this visit Joe's difficulty in feeding was the focus. Suggestions for helping with feeding included positioning him to give him head support and changing to a cross flow teat (as suggested by the EIP nurse).

There was one more visit before local services took over. At the time of the last contact, Mrs Clarke said she felt better about Joe, although she still had difficulties when he cried. However, from the time of the first visit, there had been no more talk of adoption.

In this case, the primary goal was for Joe to be seen as an individual. Suggestions for handling were used as a vital part of facilitating Joe's responses. This helped the family identify his tenacity and determination and accept him as a member of the family. The issue of adoption was resolved and Joe's mother was beginning to feel

for her son; thus, the needs of the family were addressed and met.

CONCLUSION

The EIP has successfully blended the model of intervention outlined by Selma Fraiberg with the Self Regulation Model of Development and Intervention in its service to new families.

The Self Regulation Model of Development and Intervention allows workers to involve both parents within a broad framework of psychodynamic theory and child protection. It provides a multi-disciplinary team with a common approach to families and enables different therapists to work in a transdisciplinary manner.

In Sydney, Australia, the work of Selma Fraiberg and the Child Development Project has been adapted to meet geographic and time differences.

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CONFERENCE REPORTS

REPORT ON ATTACHMENT WORKSHOP

"A workshop to train individuals in the scoring of the Ainsworth "Strange Situation" procedure for assessing quality of attachment in 1-2 year old children".
Macquarie University Jan 27th - Feb 6th, 1993

This intensive ten day workshop was conducted by Dr Robert Marvin and was attended by 29 professionals from NSW and interstate working in academic, health and family counselling settings. It is worth noting from the start that the workshop ran smoothly with good technical (and nutritional) support due to the excellent organisation by Dr Judy Ungerer.

Dr Robert Marvin is a clinical psychologist at the Kluger Children's Rehabilitation Center and Research Institute, University of Virginia, Charlottesville. It was evident from day one that his depth of knowledge in the area of attachment and in the use of Mary Ainsworth's Strange Situation paradigm would provide us with a very sound base for learning. An atmosphere that encouraged questioning and lively discussion was quickly established; not an easy task with such a large "small group". Originally trained by Ainsworth in the procedure and scoring, he was able to draw on many years of experience of its use in research and clinical work and to comment on refinements and new developments in scoring, the extension of the measurement of attachment into other age groups (pre-school and school aged children and adults) and most recently with children who have cerebral palsy.

Ainsworth developed the paradigm to validate data gathered in the 1970's from a detailed home observation study of mothers and infants. The Strange Situation is a structured 'laboratory' room procedure that takes a mother and infant through a series of brief separations and re-unions. Through these episodes the 'attachment system' becomes activated (e.g. protesting as mother departs the room) and primarily through studying the infant's 'attachment behaviours' in the re-union episodes (seeking proximity, maintaining contact, avoiding, resisting) a classification of the relationship is made. Ainsworth labeled these as 'B' secure, or insecure 'A' avoidant, or 'C' ambivalent. One of Ainsworth's main premises was that a responsive mother/parent can provide a 'secure base' for the infant and this allows the young infant to explore and thus learn and develop. There is now a large body of research that has looked at the influence of various family and maternal factors on the early mother infant relationship using Ainsworth's method.

The workshop contained a mix of theory, direct instruction on the method and scoring and plenty of graded practice through working in small groups scoring video tapes of 'Strange Situations'. This however was only the beginning. In order to receive certification in the use of the procedure, participants must now go on to view thirty or more practise tapes and then score a series of 'test' tapes for reliability.

Many of us who attended the workshop are very keen to further our training in this area when Dr Marvin returns next year to conduct a workshop on the pre-school version.

Frances Gibson
Neonatal Follow up Programme
Royal North Shore Hospital.

CHILDREN'S EMOTIONS: FEELINGS AND RELATIONSHIPS.

This intensive and rewarding day conference held on February 13, 1993, was organised jointly by the Institute of Early Childhood and the School of Behavioural Sciences, Macquarie University. The organising themes were the emergence of early affectional relationships, emotional attachments and regulation of negative affect. It was particularly well attended, with a full lecture theatre at the Institute of Early Childhood Studies where Professor Toni Cross explained that a large number of prospective attenders had to be turned away for lack of room, so that possibly a similar event might be held again later in the year.

The conference had been scheduled to coincide with the visit of Dr Robert Marvin from the Department of Pediatrics in the Children's Medical Centre, at the University of Virginia. He spoke on his research based on Mary Ainsworth's four patterns of attachment, which he said were now known to have an 80% chance of being maintained at least up to the school years. Again there is an 80% chance that these patterns of interaction will be passed down the maternal line by the interaction of the mother with her offspring. One of the important questions, of course, is why the other 20% in each case come up with a different result, and especially what may cause a shift from forms of insecure attachment to secure attachment. This theme arose again later in the day in a panel discussion when he remarked that researchers were finding a shift from the figure of around 65% of securely attached children usually revealed in low-risk populations to lower figures found in a number of studies of around 50% where there had been day care of more than 20 hours per week. He did stress, however, that the figures for this research are just not in yet, and any conclusions would be premature. There was also comment from Associate Professor Bryanne Barnett concerning Bowlby's finding that his group of deprived girls who did well in adult life had had a secure base with someone. Dr Marvin recalled

Rutter's work on the outcome for institutionally reared girls which showed that there was a better outcome for those who developed a supportive relationship in later life with a caring, warm and concerned partner, and suggested that a psychotherapist might also fill this role.

Dr Marvin illustrated his lecture with videos of the different attachment patterns as shown by 2.5 - 3 year olds, developed as an extension of the original Ainsworth Strange Situation. By this stage, children have acquired motor and verbal skills, should know the rules of social behaviour, have an ability to regulate their own affect, and to take the mother's point of view and develop joint plans as in Bowlby's "goal-directed partnership". These children are also not so upset as the mother leaves, and can be happy with a friendly stranger where they are securely attached. One finding of his research has been that those children found to be disorganised (D group) at earlier stages, become controlling by the age of three or so, especially where the mother's difficulty remains unresolved so that she provides little structure. Others remain disorganised, showing signs of trance and fear-like behaviour, raising the question as to whether these children are suffering from some form of abuse. The group of disorganised children is of especial interest to clinicians because of the resemblance of their behaviour to conditions seen in adult life and usually diagnosed these days as borderline disorder.

Various measures were used to categorise the children in Dr Marvin's study, namely proximity/contact; body orientation (towards, away from, at 90° to the mother); speech; gaze (from good eye contact to stealing swift glances at the mother only when she is not looking); affect (e.g. smooth movement from one affective state to another, abrupt "switches" of affective state, inhibition of affect with emotional flatness, or the "over the top" responses found in the ambivalently attached child).

The following patterns of attachment were found for this age group of children:

SECURELY ATTACHED CHILDREN played best in pre-separation episodes; while younger children are upset when the mother leaves, older children will sit and wait for a while; on reunion, they will look at their mothers, then look away. Play will then be orientated towards their mothers, with elaborate conversations when each partner will tell the other what has been going on during the separation. Gaze becomes lingering, very close, intimate and reciprocal. There is lively affective response, which may include anger from the child, with smooth modulation of affect from one state to another.

AVOIDANTLY ATTACHED CHILDREN may be more friendly to the stranger than to the mother; their speech was notable for its brevity with a lot of cut-offs and monosyllables; they tended to look at their mothers with quick glances and to avoid eye contact. Often they ignored their mothers to a point just short of being insulting, and seemed adept at knowing how to avoid "pushing it".

AMBIVALENTLY ATTACHED CHILDREN showed "over the top" responses to separation with a striking feature being that the mother actively elicits distress from the child, suggesting that these children infantilise themselves.

CONTROLLING CHILDREN could be divided into two groups:
a) Those who attempt to control the caregiving, for instance greeting the mother with a bright "Hi!", and so offering to keep the mother happy.
b) A controlling-punitive group who control the interaction in an angry, insulting and punitive way.

The question as to whether secure attachment should be seen as the only desirable pattern of attachment was raised in later discussion, with Dr Marvin responding that securely attached children have a wider range of options and tactics at their disposal with greater flexibility of response. They do respond with avoidant tactics when this is adaptive.

A number of most important papers were presented at this conference, and your editors are hopeful that the various presenters will give their own account of their work and its implications in future editions of this newsletter.

WAIPAD Fifth World Congress

A Future for Babies: Opportunities and Obstacles
held in Chicago, September 9-13, 1992.

A further report.

The work of Jim McKenna, an anthropologist working at the Sleep Disorders Unit at the University of California at Irvine, aroused considerable comment at this conference and will be reported here.

His approach begins with the concept that human beings are adapted to group living from the time when gathering together at night in a safe place such as a cave was a real protection against such dangers as the sabre-toothed tiger, and that frequent arousal during the night to keep the protective fire alight would have been the norm. At the conference he showed particular interest in a comment that for colonies of Europeans living as missionaries in far-off locations earlier this century the institution of the "happy hour" when everyone gathered for drinks at nightfall might fulfil a similar function. McKenna has applied his

anthropological vision to the current Western practice of placing babies in their own beds at night, believing that this is in violation of the physiological programming of the human infant. His thesis is that this practice may be an aetiological factor in SIDS (Sudden Infant Death Syndrome) or in other forms of sleep disturbance which could therefore be avoided by encouraging mothers to sleep with their babies. This idea developed originally after years of observing baby monkeys clinging to their mothers day and night, and from observations of parents in other cultures where sleeping with their babies is the usual practice. He also made the point that putting babies to sleep in separate rooms is a relatively recent practice in our own culture, often bolstered by warnings about overlaying which are probably no more than old wives tales. In fact their origin may be traced to prohibitions issued by the Roman Catholic Church against sleeping with babies dating from the middle ages when famine was rife, and many babies were said to die from this cause, although more possibly desperate parents were instituting a form of birth control. He notes that most books on infant care discourage the practice of co-sleeping, giving reasons such as the child's fidgeting, the parents' need for time together, and the unsubstantiated claim that it will establish a dependency that will make it difficult later for the child to fall asleep when alone. In Western industrialised society, he claims, child-rearing practices have focused on early independence and autonomy with the minimum disruption of the parents' lives, with emphasis on the needs of the parents rather than the baby.

I might note at this point that the methods advocated by Truby King were widely adopted by our society throughout much of this century and experience as a psychotherapist points to the frequent occurrence of a history of being a "Truby King baby" as a common factor in later disturbances in a sense of a personal existence and "core self". He recommended that infants should be fed according to a strict four-hourly schedule, except for eight hours at night when it was important, he said "to let the stomach acids clean out the intestine". From the viewpoint of a psychotherapist, these precepts have been responsible for untold lifelong misery for those who were his infant victims in this part of the world. Since a young infant has no means of obtaining food if someone does not provide it, the result is unthinkable anxiety, with the experience of complete isolation and abandonment, and bouts of uncontained crying which lead eventually to an exhausted sleep. The infant copes with this situation by a precocious intellectual development (sometimes called premature ego development), and the complaint in adult life is of a sense of futility and lack of a sense of being "real". Such individuals experience themselves, whenever their False Self fails to "keep them on the run" as falling into a state of empty depression which they may characterise as a "'black hole", a "void", or some similar phrase: or they will speak of "going to pieces" in times of personal stress: a state of fragmentation representing massively disorganised ego function. We should also be asking ourselves whether the present-day practice of "controlled crying" is not also a variant of this desire that infants should control themselves prematurely, and what effect this may be having on their subsequent self development.

McKenna observed first that his own child could be readily soothed to sleep if he lay beside him and breathed as if he were asleep, noting that the infant was especially receptive to breathing cues, and linking this with his observations from primate and anthropological research. He became interested in SIDS which affects one in 500 babies in the United States, and is a condition where apparently normal and healthy babies, usually aged between two and four months of age, suddenly and unaccountably die. While recent research suggests that abnormalities in foetal development may predispose some infants to this condition, and a vast array of factors such as smoking in pregnancy, prematurity, being a second or later child, having a young mother, nursing on the stomach, elevated body temperature from over-dressing or a stuffy room, and wintertime have all been implicated by different researchers, McKenna believes that the absence of cues from a co-sleeping partner may also play a role. In infant monkeys, he says, where the baby always sleeps clinging to the mother's belly, separation from the mother, even for a few hours, has been shown to cause physiological effects such as changes in heart rate and body temperature, sleep disturbance, increases in cardiac arrhythmias, and signs of clinical depression.

In his lecture, McKenna noted that at between the ages of two to four months, the human respiratory system is especially vulnerable, since this is the period where respiratory control changes from involuntary to voluntary which is needed in order to become able to speak. Involuntary respiration continues in the human when deeply asleep, or immersed in reading this newsletter, for instance. Recently, it has been thought that in SIDS something is wrong with the way in which vulnerable babies rouse themselves during sleep. When they should wake if they stop breathing for an undue length of time, for some reason, these babies do not do so. A study done by Harper et al at UCLA checked the heartbeats and respirations of 7,000 babies, 16 of whom later died of SIDS, and discovered that this group had gone through far fewer short respiratory pauses while sleeping than those who were still alive. Again, Kinney et al at the Children's' Hospital in Boston showed that the brains of 61 infants who died of SIDS showed significantly less myelination when compared with another 87 who died of other causes. Laitman, an anatomist at the New York Mt

Sinai Hospital has researched the development of the throat and larynx in infants, and has found that in newborns the larynx locks into the back of the nasal cavity, enabling the infant to breathe and swallow at roughly the same time. During the first few months of life, however, it drops down into the throat - a metamorphosis unknown in other mammals, and offering increased possibilities of miscuing. McKenna notes that human babies begin switching back and forth between voluntary and involuntary respiration between two and four months of age, at the stage when the neocortex (the higher brain) becomes myelinated and so connected more reliably with the brain stem where automatic functions are coordinated. Babies become able to manipulate their breathing by changing airflow rates, air pressure and lung volume, and of course, to cry in a number of different ways, so their mothers can now say: "He's hungry", or "She's just tired". SIDS babies, perhaps, may not be able to manage the flip-flop between these two modes of respiration.

McKenna's most recent study has involved the exploration of sleep patterns of mother-infant pairs in a sleep lab where continuous electro-encephalographic, eye-movement, heart rate, and breathing recordings together with an infra-red film of the nights' events can be made. Tests such as these show that in a normal individual several cycles through the various stages of sleep are to be expected. These are classified as stages 1, 2, 3, and 4 from light to deep sleep, and are characterised by changes in the electroencephalographic pattern of "brain waves", with a progressive shift from alpha waves of 4 - 6 cycles per second to delta waves of high-voltage activity of 0.5 - 2.5 cycles per second in deep sleep. In the course of a night there are usually 4 - 5 periods of emergence from stages 2, 3 and 4 sleep to stage 1, where there are also found rapid conjugate eye movements, irregularity of pulse rate, respiration, and blood pressure, and dreaming (a state known as REM or D sleep). While young adults spend about 7-8 hours asleep each day with about 1 and a half hours in REM sleep, newborn infants sleep from 16-18 hours daily and spend at least half of this time in REM sleep.

McKenna's data, scored at 30 second intervals, showed that where mothers and babies sleep together, a remarkable interaction is found, for the movements and breathing of each partner affect the other. As one rouses from deep sleep into REM sleep, so does the other, and vice versa. For the first two nights of this study the mothers and babies slept in separate but adjacent rooms so that the mothers could get up to feed their babies, and here the recordings did not show this physiological entwinement. When the mothers and infants were put to sleep together however, the infra-red film and 12-channel polygraph recordings showed frequent arousal - a virtual nocturnal dance. In the morning, however, these same mothers claimed that they had had their best night's sleep since the baby was born. McKenna proposes that the transient arousals he observed with the co-sleeping pairs are especially important since they give the infant practice in waking up. All babies experience apnoeas or pauses in breathing several times a night. While a healthy baby will wake up, it may be that those who will die of SIDS have some inhibition of arousal. Since his research shows that arousal of the mother leads immediately to arousal of the baby if it is sleeping next to her, he reasons that the baby's capacity to arouse and so to "flip" from automatic to voluntary breathing will be enhanced by co-sleeping. He found that in this situation, babies wakened on an average 24% more often during the night, and sees this as valuable practice in shifting from involuntary to voluntary respiratory patterns.

Finally, I might add that I have recently heard from a colleague who now lives in Germany where, she tells me, co-sleeping is a popul concept. It is now being recommended that the children should occupy the "master bedroom" with the parents, while the "extra" bedroom in their generally restricted living space becomes the "private room" for the parents when they wish to be intimate. When we look at the tiny cottages which most of our forefathers in Australia would have occupied, it would seem that some such similar arrangement must have been the rule!

Isla Lonie

NEW FACILITY OPENED

Karitane Family Care Cottage at Liverpool was officially opened on 24 March, 1993.

The Cottage provides a supportive non threatening environment where parents with children 0 - 5 years of age can obtain advice on a variety of parenting issues. Common presenting problems include feeding and settling difficulties with young babies, general management issues in relation to toddlers and older children and women experiencing post-natal depression.

Families are able to self refer to the centre. Individual counselling and group activities are available. The centre is staffed by three Nurses - Stephanie, Kim and Kerry, two Social Workers - Michelle and Pauline and an Administrative Assistant - Sue.

The Cottage operates on an appointment basis Monday to Friday 8.30 a.m. to 5 p.m.

Further information about the service can be obtained by ringing the Cottage on 821 4555.

RESEARCH

MATERNAL REPRESENTATIONS BEFORE AND AFTER THE BIRTH OF A FIRST CHILD

Berinda Larney, Post-Graduate Student in Women's Studies, University of Sydney is starting work on a project which has the aim of assessing maternal representations in 100 first time mothers between the 28th and 32nd week of pregnancy, and four months postpartum. The sample population will come from ante-natal clinics in the King George V Hospital for Mothers and Babies, and the measures used include a semi-structured Interview of Maternal Representations During Pregnancy (I.R.M.A.G.), and a battery of questionnaires administered during the seventh month of pregnancy and then four months post-natally. The theoretical background on which this research is based includes the work of Klein, Sandler, Bowlby, Winnicott, Lebovici, Raphael-Leff and others. Berinda will be exploring the hypothesis that there is a change in the mother's representation of self and baby from before the baby is born to when it is four months of age, and that the direction of this change is influenced by the perception of the birth experience as positive or negative.

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

Following discussions between members of AAIMHI and the Victorian organisation, WAIMH (Vic), we are slowly progressing towards the re-organisation of our current structure. We have also had input from Hiram Fitzgerald, the Executive Director of WAIMH, and this was facilitated by the visit of Beulah Warren to the Michigan Association for Infant Mental Health Annual Conference, where she was able to discuss with Hiram the structure of our organisations in Australia.

We are therefore moving towards a Federal organisation which will retain the name of AAIMHI, but with State organisations which will be branches of the Federal organisation. Branches will be responsible for the activities in their own States, and the federal organisation will be responsible for the Newsletter, the liaison with our parent body to which we are affiliated, WAIMH, and, as an immediate task, the organisation of the next Pacific Rim Conference of WAIMH in Sydney in 1995.

The finer details of this will need further negotiation, but it has been suggested that the Federal Secretariat will collect membership fees and redirect them to the State organisations, retaining what is needed to support the administrative structure and the Newsletter. It is hoped that the newsletter will become in turn the responsibility of each State to produce which will ensure that we get copy from each State!

In practical terms this will mean that at the Annual Meeting of AAIMHI which will be held in October or November, the Committee elected will hopefully include representatives from all States which have members. It will be difficult to have face-to-face meetings of the Federal Executive, but similar organisations manage with telephone conferences.

As I have indicated, a major task is the organisation of the Pacific Rim Conference in 1995. I would like to hear from anyone who would like to be included in the organising committee for this Meeting. At our Melbourne Conference we had a Committee which included members from both Melbourne and Sydney. The Melbourne members did a marvellous job in organising the venue and social arrangements, and the Sydney group did the same for the Programme. a similar division of work will probably be necessary for the Sydney meeting.

The actual date for the meeting has not been decided, but we are looking at April or May, 1995. The Royal Australian and New Zealand College of Psychiatrists Annual Congress is in May, 1995. The theme for this will be on psychotherapy, and there may be some visitors to that Congress who have interest in infant research. We are hoping if this is so to have the two events close enough in time to be able to invite some of the College's overseas visitors to our meeting. At this stage we have from the profits of the Melbourne Meeting enough money to ensure that we can invite some overseas guests as key-note speakers. Suggestions of who would be appropriate would be welcome.

David Lonie, Regional Vice President.

MEMBERSHIP FEES

The annual subscription to AAIMHI is now due. Because of the merger between AIMH (our original overseas parent) and WAIPAD, and the formation of WAIMH, it has become possible to reduce the subscription to AAIMHI to $40-00. Please send your completed Membership Form to PO Box 39, Double Bay, NSW 2028. To avoid mutilation of the Newsletter, we have enclosed the Membership Form as a separate insert with the Newsletter.
We are also updating our Directory of Members, and plan to circulate with a future Newsletter. The information requested is on the back of the Membership Form, so if you wish to be included in the Directory, please complete it and send it in with your 1993-94 Subscription.

Deadline for next AAIMHI Newsletter
15th March, 1993

Please send letters to the Editors, newsletters, announcements, short articles etc to

The Editors,
AAIMHI,
PO Box B7,
BORONIA PARK NSW 2111

THOUGHTS FROM THE PAST

It is salutary to realise just how far we have come in terms of infant care. The editors were fortunate enough recently to have had access to one of the early manuals on infancy written by Truby King, and published in the 1920's. Truby King was an important figure in the infant welfare movement in the immediate post World War I period. He was the superintendent of a large psychiatric hospital just north of Dunedin, New Zealand, and as was common in those days such hospitals prided themselves on their farms. Legend has it that Truby King used the lessons learnt from animal husbandry to set up a home for foundling children in a nearby homestead, at a place called Karitane, just north of Seacliff. He followed his success with the foundling children by being instrumental in starting the Royal Society for the Health of Women and Children in New Zealand, and a Hospital in London known as the Babies of the Empire Hospital.

In his book, **The Expectant Mother and Baby's First Month**, he quotes the conclusions of a Conference in London in 1919 as follows:-

That at present overfeeding the baby, especially in the first month of life, is one of the commonest and most serious mistakes of nursing mothers, often upsetting the child and leading to the early abandonment of suckling.
That, with very few exceptions, nursing only every four hours from birth is best for mother and child, though in a few cases more frequent feeding may be desirable.
That in general there should be an interval of seven or eight hours between the last feeding in the evening and the first feeding next morning.

He goes on: *'Were the secretion of milk and the feeding of the baby functions of men and not women, **no man - inside or outside the medical profession - would nurse his baby more often than five times in the twenty-four hours** [his bold type not ours!] if he knew that the child would do as well or better with only five feedings. Why should it be otherwise with women? Mothers have too much to do in any case: why should they throw away time and leisure by useless frequency of nursing?'*

He includes a useful illustration (reproduced below) to demonstrate the daily timetable.

CLOCK-FACE.
FOR FOUR-HOURLY FEEDING.

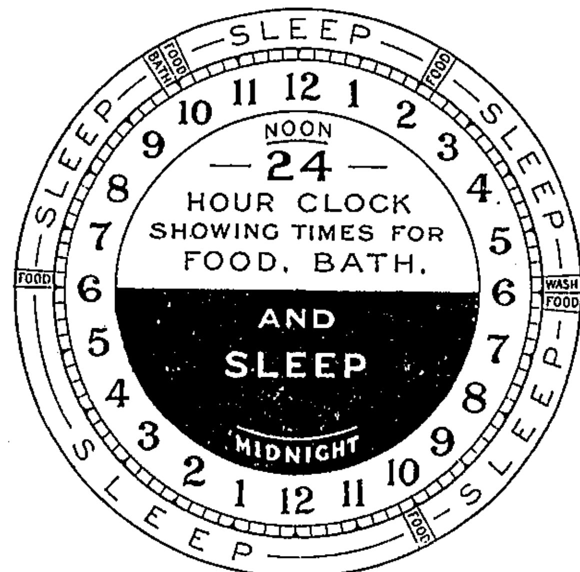

Fig. 3.
If more convenient, the bath may be given in the evening—the baby being merely "sponged" or washed in the morning.

And to demonstrate the effects of this regime we include a delightful photograph from the book.

Fig. 4.
A doctor's children. Healthy, hardy, happy little girls, ages two and nearly four years. Good jaws and sound teeth.
Nursed four-hourly from birth—never more than five times in twenty-four hours; plenty of fresh air and exercise—never any coddling.