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FROM THE EDITORS

This is our last Newsletter for 1994, and we are greatly privileged to be able to present in it the text of a paper given by Sula Wolff at the opening Meeting of the South Australian branch of AAIMHI. This meeting was a very successful event, and brought together professionals from many different backgrounds but who had a common interest in the welfare of infants. Dr Wolff's paper is a major contribution which summarises the problems facing infants and their families, and approaches which can contribute to reducing the impact of these problems.

AAIMHI can look back on 1994 with a sense of achievement. In addition to the establishment of the South Australian Branch, we have seen a major increase in the number of members of the organisation. Successful meetings have been held in Victoria, South Australia and New South Wales. Western Australia is also on the way to establishing a Branch and there are clearly a number of people there who work with infants and their families and who are looking for a professional group with which they can share their interests.

AAIMHI can anticipate 1996 with a sense of excitement. The Pacific Rim Meeting in April has attracted a large number of papers from as far away as Moscow, and the programme promises to be most exciting.

In the area of infant mental health services in general, several policy papers from both State and Federal Governments have indicated the importance of infancy as a developmental stage, and we may perhaps forecast the implementation of practical measures which will allow us to pursue our major goals as an organisation.

We wish all our members the very best for the New Year, and thank you for your support in 1994.

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THE SCOPE OF INFANT MENTAL HEALTH: POINTERS TO HELPFUL INTERVENTIONS

SULA WOLFF

INTRODUCTION

Infant mental health is usually concerned with children in their first three years. This is precisely when two most important human social attributes first arise: the capacity for affiliation and creating affectionate relationships with other people, and the capacity for moral behaviour and ethical standards. Both are essential for the survival and happiness of the individual and of the human group. The first three years are also a time of rapid development of language and intelligence.

There has been dramatic progress in our knowledge of early child development over the past 50 years. Bowlby's work and the researches into mother infant attachments that followed, have shed light on very early family relationships and on what the causes and consequences may be when things go wrong. More recently, studies of mothers and toddlers have vividly demonstrated how children acquire moral behaviour and their first notions about social rules, within a family context (eg Dunn, 1988; 1993). And all developmental studies make clear that intellectual development and social-emotional development go hand in hand, mutually influencing each other (see also Wolff, 1989).

Infant Mental Health came of age with the establishment of its own Journal some 15 years ago. Infant Psychiatry, once described as one of the "Hot Topics of the Future" (Tanguay, 1989), was launched at its First World Congress in 1980 (Call et al, 1983 and 1984) and the Minde's textbook was published in 1987.

In this lecture, to mark the inauguration of the South Australian Association for Infant Mental Health, I have chosen four themes: 1. Developmental gains in the first three years; 2. Preparations for parenthood; 3. Obstacles to healthy parent-infant relationships (within parents and within the child); and 4. Issues in early child care, related to current changes in family life. My talk will be sketchy, because the field of infant mental health is now wide. But I shall focus on what I think are some of the salient issues.

If I seem to be saying more about the psychiatry of infancy than about mental health, this is no coincidence. I believe that everyone concerned with infant mental health should know about the quite specific pathological processes and social adversities, often interacting with each other, which can interfere so profoundly with early parent/child relationships and with the intellectual and emotional development of young children. It is the more important

because, as I shall show, helpful interventions in infancy and early childhood can have lasting benefits.

Healthy child rearing takes many forms, as we know from cross cultural studies of how very differently mothers and fathers around the world, negotiate their children's early years. Different cultural values and beliefs dictate different methods of upbringing, but the compelling appeal of healthy young babies ensures that, when parents are well and not harassed by poverty or other overwhelming stresses, the care their infants get is good. So I shall not be concerned with the practical advice all parents need when they first embark on bringing up their children, and which many find in helpful baby care manuals, attuned as these are to the social milieu and culture of their readership. I shall be concerned rather with how we can make good the consequences of socioeconomic disadvantage, of family disorganisation, of major and minor psychiatric disorders and of some handicapping conditions of early childhood. And I shall end by briefly commenting on a few of the changes in family life we are now witnessing in the developed world.

1. DEVELOPMENTAL GAINS IN THE FIRST THREE YEARS.

Secure attachments of the baby to its mother and father are evident and measurable by the age of a year. They depend on the prior sensitive, emotional availability of parents, providing what has been called "intuitive parenting" (Papousek and Papousek, 1983), that is, the unselfconscious parent-child interactions in which the young baby is looked at, talked to, smiled at, and imitated in turn-taking sequences, geared to her own activities, her likes and dislikes. By the age of a year, a surprising number of infants are insecurely attached, and the nature of attachment at this time has consequences for the child's adjustment at nursery school in later years, securely attached infants tending to be less dependent on the teacher, more confident and more friendly towards other children (for a summary see Wolff, 1989). John Bowlby believed that on the basis of her earliest relationships the child creates inner working models of human relationships, modified in the light of later experiences, which determine her expectations of other people and her reactions towards them. Whether mothers and fathers can create secure attachments in their infant depends, as we shall see, on their mood state and on whether the stresses they have to cope with are manageable. But it depends also, as now know from the work of Mary Main (Main et al, 1985), on their own recollections and feelings about the care they themselves had from their parents as children. And recently Peter Fonagy (1994) was able to predict the security of an infant's relationship with his mother and father at 12 and 18 months, from ratings of interviews with parents during pregnancy, about their own childhood experiences. The parents' internal working models of relationships influenced the security of their child's attachment to themselves. Intergenerational transmission of the quality of parenting is no myth. But not all parents who had been deprived and had insecure attachments, themselves have insecure children. What seems to protect some deprived parents, is a capacity for self-reflection, that is self-awareness and psychological insightfulness and this finding may open the door to possible interventions.

The second gain, depending on a biological readiness to form inner standards and to appraise one's own competence in the second year, is the **beginning of moral judgement**. By the age of three, children have a sense of "we", of shared meanings, and of rules: "we do it this way" (Emde, 1989). How parents build on children's biological readiness in the second and third years, to help them develop morality, has so far been less thoroughly explored than how early attachments are fostered in the first year. But a start has been made, and we know that non-punitive teaching, based on the child's capacity for empathy, with explanations of how other people are likely to feel if they are hurt, is the most effective (see Wolff, 1995). The consequences for children's later development when parents instead, and for a variety of reasons usually beyond their control, use coercive methods of child rearing, are profound, with a real risk of an antisocial development.

The third developmental gain in the first three years is in **intelligence and language.** This too depends on the sensitive availability of parents and on their resources in terms of [illegible]e and knowledge about the intellectual needs of young children. Parents, themselves intelligent and educated, will have few problems unless they are preoccupied by illness, poverty or conflict with each other. Less well endowed parents and their children, as we shall see, have much to gain from intensive early intervention programmes.

2. PREPARATIONS FOR PARENTHOOD

What do we know?

A common sense view holds that the best start for a baby is to be born to a healthy mother, mature enough to envisage her child becoming an independent person, a mother with a roof over her head, living in a loving relationship with the child's father, with sufficient material resources, and within a network of supportive relationships. This view is confirm[illegible] by researches into the fate of young children where such conditions do not apply.

Teenage pregnancies have increased over the past thirty years and teenage marriages are known to break down more often than later unions (Rutter and Madge, 1977). But teenage pregnancies carry other dangers too: there is a greater risk of premature delivery of low birth weight babies, largely because teenagers tend to miss out on regular antenatal care and their diet is often poor. Pregnant teenagers also tend to give up on education, and the risk of a later life of poverty as the head of a one parent family on welfare support, is great (Seitz and Provence, 1990).

Perhaps the commonest constellation of adversities is the following: A teenage mother, herself deprived of affectionate mothering in her early years - because of loss or incapacity of her own mother - and exposed to unsympathetic substitute care, becomes pregnant by chance or with some poorly articulated wish to have something for herself. She hardly knows the father, similarly deprived and perhaps delinquent.

Neither has a supportive family and neither has enough education to ensure employment and escape from poverty.

Quinton and Rutter (1988) showed that girls reared in institutions frequently had such a life course, that their marriages were stormy and brief, that they themselves often had personality problems, provided poor child care, and that some of their children in turn were taken into care in early life. These authors also showed that positive school experiences, leading to an inner sense of competence and potential achievement, could help such girls towards a very different life path: to choose well adjusted partners, to have their children later, live in harmonious marriages and provide good child care.

What effective remedies are to hand?

This study suggests that a **rewarding school life** can compensate some children for an otherwise barren childhood and contribute to the healthy development of their own children. Just as school success can prevent delinquency in predisposed boys, it can prevent unplanned teenage pregnancy and an unhappy marriage in girls. And we also know that good experiences at the very start of schooling, through high quality preschool education or a really food first teacher, can promote a happy and successful school life (Farrington, 1985: Horacek et al, 1987). So infant mental health promotion can be said to start in the classrooms of the parents.

But, school **instruction in parenthood**, while often enjoyable and clearly sensible, is not yet of proven value (Graham, 1994). Such instruction usually takes the form of classes in child development, in how to cope with the common problems of infants, and can even include the experience, for older girls and boys, of looking after young children in nursery groups.

More soundly based, as a result of many controlled studies, are **intervention programmes targeted at pregnant mothers at risk.** I shall mention just a few, to indicate the types of effective intervention and the outcome measures that can be improved.

The Rochester Nurse Home Visitation Programme (Olds et al, 1988) involved home visits to 400 pregnant low-income women living in New York State. Some were visited during pregnancy and the first two years of the child's life; some only during pregnancy; and some, the two control groups, not at all. All were screened for sensory and developmental problems; and all but one of the control groups were offered free transport to ante-natal and well baby clinics. The nurses gave information about foetal development, the effects of smoking and alcohol on the foetus, about early child development and how to cope with the common problems of infancy; and they strengthened the mothers' links with their families and friends, and with community support and social welfare agencies.

Among the most striking results were that babies of mothers under 17, who were visited, had significantly higher birth weights; and that pregnant mothers who had been smokers, cut down on their cigarettes and showed a 75% reduction of preterm deliveries compared with smokers who had not been visited. Both accidental and non-accidental injuries were reduced in the second year of infants whose mothers were visited postnatally compared with those who were not visited; and in the case of poor unmarried teenagers, there was a significant reduction of verified child abuse and neglect in the infants' first two years. Moreover, these young, disadvantaged mothers were observed to be less restrictive and punitive, and to provide more appropriate play material for their children (see also Seitz and Provence, 1990). Among the mothers who were visited postnatally as well as prenatally, teenagers more often continued their own education and had fewer repeat pregnancies; and older mothers more often started work.

Two other well controlled and evaluated programmes of intensive pre- and post-natal home visiting of poor families, one in Montreal and the other at the Yale Child Study Center, by psychologists and paediatric teams, had similar and very long lasting benefits (Larson, 1980: Seitz and Provence, 1990).

Children whose mothers had pre- and post-natal care, had the fewest injuries and the best objectively assessed home environment, including responsive mothering and suitable play material; they had fewer feeding problems and more participant fathers. In the Yale programme, children whose mothers were visited had better language skills at 30 months and by the time the children were ten years old, the mothers in the treated group had obtained more education and had better employment records than the controls. They had spaced their pregnancies more widely and had smaller families. Their children were more openly affectionate, had better school attendances, and the boys a much better school adjustment, and they had less need of special school services. Almost all families in the intervention group had become self-supporting and had saved the state a great deal of money in the form of welfare payments and special school services for the children (Seitz et al, 1985).

The positive results of such home visiting programmes (Pound, 1994) confirm the importance for families at risk, of services that can be based on those already provided in children's earliest weeks and years by Health Visitors in the UK, and I imagine in your country too but **not,** surprisingly in the USA.

Sally Provence, of the Yale group, suggest three principles for successful early intervention with parents: Competence; Continuity; and Partnership (Seitz and Provence, 1990). **Competence** on the part of service providers means knowledge and practical skills to match the needs of child and family. This is best acquired within a team setting and does not mean that only highly trained professionals can help. With training, supervision and access to a multiprofessional team, lay home visitors can play a vital role. **Continuity** of care is essential for building up helpful relationships of trust and dependability. **Partnership** means creating a working alliance with parents for the benefit of the children. Parents know their child better than anyone, and their child's well being is more important for them than for anyone else. A working partnership empowers parents, fostering their self-confidence in the upbringing of their children (Pugh and De'Ath, 1989).

Other successful interventions have had different aims. The Carolina Abecedarian Project (Horacek, 1987), for example showed that it is possible to identify children at risk of school failure even before they are born. Without special help, children of young, single, black mothers, themselves with little education, and living in extremes of poverty, had almost four times the rate of school failure than their average risk peers. When such children and their parents, identified by pre-natal screening, were given specific educational interventions in day care preschool, **and** later in the early school years, their rates of repeating school classes were dramatically reduced, and their attainments in reading and maths much improved. And we know that early school success has long lasting and wide ranging beneficial effects.

Preschool intervention in this project started when the children were three months old and continued until they entered kindergarten. It took the form of almost full time attendance at a special programme to help mothers foster their children's language and cognitive skills. Mothers were also given material help for their babies: food supplements and disposable diapers. the **school programme** during the first three school years, consisted of frequent home and school visits by special teachers, with two aims: helping parents to promote the child's learning at home: and forming a bridge between school and parents.

Graham (1994) reports on yet another post-natal home visiting programme for a different at-risk group: parents of preterm babies. This enhanced their developmental level, improved mother/child interactions, and reduced later behaviour problems. an important point needs emphasis: interventions which help disadvantaged families or families whose infants are at risk, do not necessarily enhance the development of low-risk children. To be effective, interventions must be targeted at families in need (Seitz and Provence, 1990; Graham, 1994).

3. SOME OBSTACLES TO HEALTHY MOTHER-INFANT RELATIONSHIPS

(i) WITHIN THE MOTHER

What do we know

"Infants are biologically programmed with capacities ideally suited for a selective involvement with other human beings" and these capacities interact with those of the carer to create what has been called a 'transactional field" in which development then takes place (Minde and Benoit, 1991). This requires a responsive caregiver.

Maternal Depression: Major and Minor.

Let me start with an example of a **rare** condition which can seriously interfere with the mother-infant relationship and which it is absolutely essential to spot.

Susie and Anne, identical twins, were repeatedly admitted to hospital in their first six months with 'failure to thrive'. They were underweight, pale, apathetic and totally unresponsive. Physically they were healthy and, in hospital, they always ate well and gained weight. The ward staff suspected the mother of deliberately witholding food and care but, before alerting the social services department about a possible case of child neglect, they referred the family to the child psychiatry department.

Here, the mother, smiling and well cared for, at first denied all difficulties with her babies, but said she worried about their progress. It was only during a detailed enquiry about how she herself was feeling, that she told us of a complete change within herself. Ever since the twins were born, she had felt depressed, at times suicidal, and guilty about her total lack of feeling for the children. She ate and slept poorly, and wished she could, but could not cry. She had told nobody, not even her husband, about her feelings, unable to communicate with anyone. Apart from the arrival of the twins, there had been no precipitants for her change of mood. She had a somewhat demanding mother and a very reserved husband, but had not been exposed to any particular life stresses.

A diagnosis of a major depressive illness was made. the transformation in her and her babies brought about by antidepressant medication was astonishing. In addition to the pills, she was given very regular support in the form of home visits by a paediatric nurse and myself which she gratefully welcomed. The fear that her psychotic depression, suicidal urges, and almost total unresponsiveness to her children might return, remained with her for many years. The children's physical development was good, but their intellectual progress especially in language, was delayed during their first two years. By school entry, however, they functioned well and last Christmas the annual card from their mother, which I see as a sort of a talisman, shows them as very charming 13-year-olds.

This mother with a rare psychotic illness, had a stable marriage and the family had no financial worries.

Much more common are minor depressive illnesses: postnatal depression (Cox et al, 1989; Kumar and Hipwell, 1994) and later **prolonged or recurrent depressive illnesses**. These occur especially in working class mothers within a setting of other adversities: a past history of maternal loss and poor care in the mother's own childhood; current life stresses (arising for example, from poverty and poor housing); and lack of a supportive intimate relationship with a partner (Brown et al, 1986). Mothers with prolonged or recurrent depressive illnesses often have associated **personality difficulties**, sometimes involving alcohol or drug abuse, an outcome of their own early childhood privations.

George Brown, who has so marvellously clarified the complex origins of maternal depression, refers to the inner, experiential consequences of early lack of affectionate care, especially institutional care, as 'cognitive biases', equivalent to Bowlby's 'internal working models', which arise from the actual experiences of young children. When care is deficient, children are emotionally vulnerable and grow up with negative expectations, poor self-esteem and a sense of helplessness. Brown believes that girls with adverse early parenting can become ambivalent about dependency and intimacy: they long to be looked after and yet avoid intimate relationships. They are especially at risk of premarital pregnancy and of reacting with depression to later experiences of loss (Brown et al, 1986). They are also at risk

of making poor, often violent, marriages which end in separation (Downey and Coyne, 1990).

Effects of Maternal Depression on the mother-child relationship.

Depressed mothers are less sensitively responsive even to 3-4 month old infants. They fail to adapt their reactions to accord with those of the baby; are slower to respond and less likely to use the exaggerated intonations of **motherese**, which characterise early parent/child exchanges (Bettes, 1988).

In a careful, prospective, observational study of inner city depressed and non-depressed working class mothers and their three three-year old children, Tony Cox (Cox et al, 1987; Cox, 1994) describes two features of depressed mothers. They are inwardly preoccupied, or **"floating"**, emotionally unavailable to their children; and they fail to notice and respond to what their children do and say, and hence to **make appropriate links with and extensions to** the child's communications. The depressed mother's unavailability and psychological insensitivity in turn are strong predictors of an insecure attachment relationship in child (see also Stein et al, 1991; Murray, 1992).

The effects of maternal depression on the mother-child relationship are profound and may long outlast the depressive illness itself, because of associated personality difficulties of the mother; because of the frequent accompanying long term adversities; and because of mutually reinforcing negative interactions that are set up between mother and child (see also Rutter, 1990; Nicol et al, 1993).

When, in addition, the child is born with a difficult temperament, that is a predominantly negative mood, intense reactions, irregularity of behaviour and poor adaptability, this can make matters worse because the child's misery and apparent oppositional behaviour undermines the mother's sense of competence and self-efficacy (Cutrona and Troutman, 1986).

But the effects of maternal depression and personality difficulties go beyond the security of her infant's attachment tionship. Emotional unavailability and irritability affect the way mothers handle their toddlers' oppositional behaviour. Mothers who as children had been in institutional care, many of whom were also depressed, were observed to smack their toddlers more often, to use less effective methods of control and to have lower rates of reconciliation with their children after disputes (Dowdney et al, 1985). Maternal irritability and coercive child rearing can lead to an antisocial development in the child. In addition, depressed mothers often turn to their daughters as comforters (Radke-Yarrow et al, 1985). Both boys and girls are highly responsive to their mothers' miseries, and such children often miss out on play with other children because they are so preoccupied with their sick parents. A child's overinvolvement with the mother's distress at too early an age carries the risk of excessive guilt in later years and of distortions of the capacity for empathy and concern for others (Zahn-Waxler et al, 1990).

By 18 months, behaviour disorders, especially sleep and eating disorders and temper tantrums, occurred in 40% of children of mothers who had been depressed (Murray, 1992); and by middle and late childhood more children of depressed than of non-depressed mothers, had multiple behaviour problems (Radke-Yarrow et al, 1992).

And there is a **third**, important consequence of maternal depression for young children. Because they are less effectively stimulated intellectually, and are even read to less often than other children, their cognitive development and later reading proficiency tend to lag behind (Richman et al, 1982; Meadows and Mills, 1987, quoted by Minde, 1991).

What can we do about it?

Post-natal depressions occur after 10% of all births and are usually self limiting. But, in half the affected mothers they become persistent or recurrent. A half of such illnesses are never detected at all and almost all the rest are managed exclusively by family doctors. It has been suggested (Kumar and Hipwell, 1994) that the detection and treatment if these common non-psychotic illnesses by health visitors and family doctors should be a priority.

John Cox and Jenny Holden (Holden et al, 1989) devised a simple self-administered screening questionnaire, the Edinburgh postnatal depression scale. They also evaluated a programme of home visits by health visitors specially trained in non-directive counselling, for mothers identified as depressed on this scale when their infants were six weeks old. Over two thirds of mothers who had had an average of nine weekly counselling visits, had fully recovered three months after the end of treatment, compared with just over one third of the untreated controls.

In Britain several special services for vulnerable mothers with young children have been evaluated. Their aim was to improve early mother-child relationships and prevent child abuse and later difficulties in the children. In the Leicester project (Nicol et al, 1993), families with toddlers were included if there were family or social difficulties; developmental failure in the children; or disability of the mothers. Three types of intervention were evaluated: mother and toddler groups; regular visits from specially trained health visitors; and family therapy. The first two were very popular, but family therapy was **not**, and was perceived as making things worse. On the whole, the treatments were effective **only** for families with severe problems, confirming that interventions need to be targeted at people who actually need them, and not at every one who seems to be at risk. Well trained health visitors and mother and toddler groups can then improve matters.

Two befriending schemes, involving unpaid volunteer mothers who themselves have problems: **Home Start** (Van Der Eyken, 1982) and **Newpin**, are currently flourishing in the UK (Cox et al, 1991; Cox, 1993). I believe you too have a successful parent aide programme to prevent child abuse, involving mothers as befrienders, but without specific problems themselves (Lines, 1987). Although health visitors and infant welfare clinics are regularly available in the UK, the most depressed mothers with the biggest problems often feel too threatened to use statutory services. For this reason, a partnership approach was tried, in which self-help groups were set up with professional backing, to enable mothers themselves to provide services for others in a similar plight. The essence of befriender schemes is that the befriender is not limited by professional rules; that the befriended person is

seen to be like the befriender; that opportunities for real sharing of emotions and experiences exist; and that no statutory threat (eg that the child may be taken away) is perceived in the relationship. Both UK schemes involve intensive training of the volunteer mothers by means of lectures and self-development groups. Home Start, in addition, has strong links with statutory agencies and supplies material resources such as play swaps and toy libraries. Both schemes have mobilised great commitment on the part of the mothers. Newpin has been evaluated over the years, with detailed comparisons between mothers and children in the scheme and control groups not yet involved. What has emerged is that Newpin was able to recruit, train and sustain work with mothers who themselves had had greatly troubled childhoods and were currently experiencing major stresses. The mothers most fully involved, especially in training, experienced the greatest improvements in their self-esteem and sense of control over their lives, and their mental state improved. Disappointingly, changes in the mother-child relationship were less clear, perhaps because adverse mother-child interactions had already become established before ever the programmes started and perhaps because the focus of intervention was not sufficiently child centred.

(ii) ARISING FROM WITHIN THE INFANT

What do we know

It will be clear that infant mental health is concerned with a network of relationships and that to talk of parental insensitivity and unresponsiveness, or of the infant's difficult temperament, introduces a degree of artificiality into our view of early child development. Yet, as I have shown, there are environmental adversities and maternal psychiatric disorders which so impair the care parents can give their children that they need attention in their own right.

In just the same way, there are difficulties infants bring with them into the world which have to be identified (see Anders, 1989). Perhaps the commonest are **extremes of temperament**, that is, genetically based individual differences in the organisation of emotional sensitivity and responsiveness (Emde, 1989). Excessive sensitivity, for example, poor adaptability to changing circumstances, a predominantly negative mood, and intense reactivity, can be demoralising especially for inexperienced parents with other stresses in their lives. **Pre-term babies** too are often less responsive and more irritable, and their mothers have to work harder at mutual interactions and may suffer 'parent burn out' (Barnard and Kelly, 1990).

The commonest reactive behaviour disorders of early childhood: **sleep and feeding problems**, tend to occur in infants predisposed by physical ill health, a difficult temperament, minor motor developmental difficulties in the case of feeding problems, or a depressed mother. Sleep disorders are eminently treatable (Minde et al, 1993); feeding disorders more difficult to remedy (see also Skuse, 1994). Both can be frustrating for parents and impair parent-child relationships.

Inborn abnormalities of the baby can be powerful obstacles to parent-child relationships. Impairments of vision and hearing; general developmental delays; pervasive developmental delays such as early childhood autism; and specific developmental delays, for example of language skills, fall into this group.

What can we do about it?

A golden rule is to listen to parents and to take their worries seriously. Occasionally parents convey **hidden messages:** their manifest concern about an abnormality in the child, may reflect their own depressed mood and their fear that they may actually harm their child.

So an accurate diagnosis is essential. To hear their child has a difficult temperament and that his or her adjustment problems are not the parent's fault, can be guilt relieving, and open the door to a less coercive and more patiently supportive approach.

A number of effective treatment programmes for sleep disordered infants have been described, some relying on specially trained Health Visitors (Douglas and Richman, 1984), some on specially trained social workers (Minde et al, 1993). The treatment of eating problems has been less systematically studied (Skuse, 1994).

Impairment of vision and hearing as well as developmental delays require expert assessment. Affected families need to know where to turn. The right specialist team will not only make and helpfully convey an accurate diagnosis; but provide supportive and remedial help and education; put families in touch with the relevant parent organisations; and act as long-term advocates for the child with education authorities and, later, employment and care organisations. Even with relatively minor handicaps, many affected children and their parents benefit from long-term, if infrequent, contact with a specialist they know, so that in a crisis, help is at hand.

4. ISSUES IN EARLY CHILD CARE

Substitute Child Care.

Let me start the final part of my talk with an optimistic note: in most developed countries, except for some in the Islamic world and in eastern Europe, institutional care for young children who cannot be looked after at home, is a thing of past. The work of John Bowlby and his followers has seen to that. Substitute family care is the preferred option and the developmental benefits should be considerable.

Poverty

But we have reason to be seriously concerned about a more widespread obstacle to healthy child development: the rising proportions of families who live in poverty within the wealthiest countries of the world, and the declining welfare provisions for such families.

The difference between coping and not coping, for parents as well as for children, depends on the magnitude of stresses and adversities in their lives. So even if one hazard can be reduced, there is a chance of a better survival. From what I have said, it will be clear that poverty, deficient housing (Fox et al, 1990) and poor schooling, indirectly contribute to poor child care, over and above parental personality problems.

Early and Single Motherhood

Mother -child attachments are, as Bowlby showed us. mainly biologically determined and culturally stable, even in higher

animal species. Father-mother attachments are much less stable, largely culturally determined and, in animal species, fathers play a very variable role. So there is a disjunction. Yet human infants need stable attachments to both parents so that they have effective role models. If mothers increasingly act as sole parents for their sons **and** daughters, I believe a shift is needed in their view of men, if boys are to grow up well socialised and happy.

We have seen that teenage pregnancy and single parenthood can, for a variety of reasons, impair infant development and that there are intergenerational links between patterns of family life and patterns of child rearing.

High quality preschool and school education, especially for socioeconomically disadvantaged children and for children from emotionally deprived backgrounds, can help such children postpose parenthood, form more stable partnerships and, in turn, provide better care for their children.

Whether better **employment opportunities** for disadvantaged young men could enable these to maintain their place within the families they have created, has as far as I know not yet been explored. The focus of most intervention programmes has been on young mothers, and the employment prospects of women these days are better than those of men.

Child Abuse and Neglect are also commoner when there is poverty, marital stress, parental depression and personality disorder. And here too there is considerable intergenerational continuity. But a supportive marital relationship, or therapy can be prophylactic (Egeland et al, 1988). And we have seen, from the many evaluated intervention programmes beginning during pregnancy, that personal counselling, in addition to practical help, can be effective.

Day Care.

An important current issue affecting parents from many walks of life is day care. Increasing numbers of single mothers who want to escape from poverty depend on this service. And more married mothers are going into full time work, not as previously, when their child starts nursery school, but during their child's first year. This is often not from choice to maintain a career, but from necessity and against their inclinations, because the father's earnings alone cannot support the family.

While there has been some criticisms of Belsky's (1988) conclusions that day care for more than 20 hours a week in the first year is a risk factor for insecure attachments and for later aggressive and non compliant behaviour, especially for children in disadvantaged families, his concerns have to be taken seriously. In a recent survey in the UK, Melhuish (1994) (but see also Hennessy et al, 1992) found that many day care settings offered poor quality care, with young children unattended to and understimulated. Children in good day care settings (as universally in Scandinavian countries), or with minders or home carers, do well, but children who spend long hours for many months and years in poorly resourced child care settings (with low staff morale, a high staff turn-over, low staff/child rations and limited staff/child interactions) are delayed in language development and educational attainments well into middle childhood. And this applied to middle class as well as to disadvantaged children.

SUMMARY

1. The first three years are crucial for three developmental achievements: (1) secure attachments and positive inner working models of human relationships; (ii) the basis for moral behaviour; and (iii) the foundations of language and intelligence. All depend on secure parent-child relationships.

2. Obstacles to positive early relationships stem from pathological processes in parents or children, often magnified by socioeconomic and educational disadvantages.

3. Several effective interventions for families at risk have been discovered: special home visiting and counselling programmes starting before the bay's birth; special day care, and home/school liaison teaching; health visitor counselling for mothers with postnatal depressions; mother-to-mother volunteer services for deprived and depressed young women.

4. Family life in developed countries is changing and there are many issues to which I imagine your new society will address itself: the increase in one-parent families; increasing numbers of young children living in poverty; increasing unemployment of young men; and problems I have not even mentioned, arising for example from the newer treatments for infertility.

But I suggest that one vital issue your movement can address is how to guarantee high quality day care for the many very young children whose parents now depend on such a service.

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ATTACHMENT CONFERENCE - ERRATA

Our reporting of the AAIMHI Attachment Conference contained some minor inaccuracies. We sent a copy to Lynne Murray and Peter Cooper, and Peter very kindly corrected the report and rewrote the report on his presentation. This result is a very clear summary of the findings of the Cambridge Study, and so we have included it in this Newsletter.

The first paper on Saturday morning was given by Dr Peter Cooper and was entitled *Postnatal Depression and its Management: The Cambridge Study.* Dr Cooper first discussed the evidence for the concept of PND as a special disorder and pointed out that although much of the earlier epidemiological evidence for it being a special condition had been discredited, there was some indication that it was, in that the expected incidence of depression after birth was not evenly distributed but was concentrated in the first six months; those whose depressions postnatally constituted a first onset had shorter episodes; and postnatal depression, especially those of first onset was associated with impairments of the mother-infant relationship.

Time after Birth	**0-3 month**	**3-6 month**	**6-12 month**
Expected	3.8%	3.8%	7.6%
Found	7.7%	5.2%	2.2%

Incidence of Depression after Childbirth

Two questions asked in the Cambridge Study were:

1. Would early remission of PND have an impact on the infant, *and*

2. Do different forms of treatment have specific effects on infant outcomes?

To answer these question the study examined 8 week brief therapy with hourly sessions in the home with the baby present. The group of mothers with PND was selected as follows:

Time after Birth	**Procedure**
6 Weeks	Case Identification - EPDS and SCID
7 weeks	Assessed and allocated (blind) into groups
8 - 18 weeks	Therapy
18 weeks	Assessed - EPDS and SCID
9 months	Assessed - as above
18 months	Assessed - as above

207 mothers met the study's entry criterion of suffering a major depressive disorder (according to DSM-III-R). 194 of these women agreed to participate in the study. They were allocated to the following groups:

Group	**n**	**Focus**	**Method**
Routine Primary Care	48	No additional care	Control Group
Non-directive	42	Maternal mood	non-directive counselling
Cognitive Behaviour (CBT)	41	Mother-infant relationship	Cognitive Behavioural Therapy
Brief Dynamic Therapy	40	Mother-infant relationship	Interpretation in terms of mother's history

Very few of the mothers refused to participate, moved, or dropped out of the study. 171 women ended up participating throughout the study. The low droputs for the study (5%), much better than the standard 20% droput rate, spoke to the subjects' need, considering that they had not sought treatment, but had been approached by the team. Very few had asked for help, and they often had not identified themselves as depressed.

The study used generalist and specialist therapists to control for experise effects; and some therapists conducted two forms of treatment to control for therapist effects. No therapist or expertise effects were found.

The CBT group focused on handling difficulties with the baby and skills training because previous studies (see below) had found problems with sleep, crying, and separation problems when the child was left alone while the mother did chores:

Problem	Depressed	Control
Sleep:		
Difficulties settling	43%	18%
Distressed on waking	40%	15%
Crying:		
A problem	73%	35%
Prolonged crying	83%	50%
Relationship problems	58%	13%

To ensure that the form of therapy actually given was that which was described the women's perceptions of therapy were measured with the Silove Perceived Therapy Quality Questionnaire, which measures cognitive focus, behavioural task-orientation, organisation, transference, relationships and inner conflict foci. The results demonstrated that the therapeutic orientations differed in the expected ways.

Group	Cognitive	Behaviou-ral Focus	Inner Tasks	Relation-ship conflict
Counsell-ing	2.2	1.6	2.6	2.2
CBT	3.1	3.1	2.8	1.7
Psycho-dynamic	2.4	1.4	2.9	3.4

Focus of therapy (higher number indicates more the focus)

Women's Perceptions of Therapy.

Was the therapy reported by the women to be helpful? Satisfaction levels were high for all treatment groups, cognitive behaviour therapy being perceived as the most helpful:

	Moderately Helpful	Very Helpful
Counselling	19%	74%
CBT	10%	90%
Psychodynamic	28%	65%

Effect of Therapy on Depression

		EPDS Scores	
	n	Before	After
Counselling	42	13.9	10.0
CBT	41	13.5	9.0
Psycho-dynamic	40	12.7	8.8
Control	48	12.4	11.3

Therapy results led to substantial mood improvement in all groups. There were no differences between the treated groups in percentage reductions in EPDS scores or in remis rates.

Treatment speeds recovery. Whereas natural recovery occurs in 3-6 months and the control group caught up by 9 months, the treatment groups got significantly better earlier. Those with no previous depressive history do especially well with CBT; those with previous depressive history do especially well with psychodynamic treatment. The counselling group did not show this interaction effect. Mothers of boys do worse in all conditions except psychodynamic, where they generally did better. Having a boy and no treatment led to no remission of symptoms by 4-5 months postpartum

Maternal Reports of Infant Problems

Results for infant behaviour problems (feeding, sleeping, crying) found a significant natural improvement caused by the passage of time in the control group, and treatment added nothing to this effect: all improved with or without treatme Both rapid remission and treatment had significant effect on maternal reports of relationship problems. There were no differences between treatments; but treatment led to significantly fewer relationship problems than was apparent among the controls. Both early remission and treatment improve the relationship. Treatment benefits the relationship even in women who remain depressed. The finding is maintained at 18 months with a significant treatment effect persisting. All treatments were equally good.

Videotaped Interactions There were no effects of remission or treatment on the quality of the mother-infant interactions. Thus, ratings of any dimension of marked disturbance before treatment showed a great improvement after treatment but globally the infants didn't look improved and they performed nowhere near as well as Murray's original well control group in her earlier study. The results are pretty disappointing. Change is small and there doesn't seem to be an effect for treatment or remission per se on ithe quality of the mother-infant interaction..

Cognitive Outcome. Cognitive outcomes measured by Object Concept tasks and Bayley Scales found little result, and there was a major effect of gender with boys of depressed mothers coming out worse than girls on the Bayley Mental Index. It wasn't affected by early remission of depression. There's hardly any room to improve the antidepressant effect of treatment, but there is no impact on cognitive outcomes.

Attachment. Measures of attachment at 18 months came out worse than normals from the Cambridge non-depressed group. Treatment had no impact and boys (40% secure) did much worse than girls, who were up to normal scores (70% secure). However, only ABC attachment types have been studied so far.

Summary

Treatment improved maternal mood rapidly for all groups. The mothers' account of the relationships with their babies showed positive benefits of both treatment and remission which persisted till 18 months postpartum. There was no evidence of treatment effects on cognitive outcomes or attachments. Improving mothers' depression did not help attachment. There were no therapist effects or expertise effects.

AUSTRALIAN ASSOCIATION OF INFANT MENTAL HEALTH INC.

PRESIDENT'S REPORT

In this Year of the Family the Association had two significant initiatives - our first conference in July and the launch of the South Australian Chapter in October.

The conference, "Principles of Attachment Theory: relevance to intervention with infants and caregivers" drew 280 registrants which was no surprise given the quality of the international speakers who participated:- Drs. Lynne Murray and Peter Cooper, Cambridge, England, Robert Marvin, Charlottesville, and Mary Sue Moore, Boulder, USA. It was a most stimulating two days which included a visit by Dr. Carmel Lawrence, the Federal Minister for Health, to launch Commonwealth Government's study - "Postnatal depression: toward a research agenda for human services and health" edited by Dr. Jan Carter.

Although the associated entourage of press was disruptive to our process most registrants were sympathetic and Mary Sue Moore did a brilliant job of refocussing our minds to the issues of attachment.

I would like to thank all the committee members who played a part in the success of the conference in particular Dr. David Lonie who spent many hours communicating by fax with the speakers and Dr Marija Radojevic who was responsible for the negotiations with Westmead Hospital. We were very grateful to Dr. Judith Ungerer of Macquarie University who was responsible for organising Dr Robert Marvin's itinerary, for the time she gave to the initial planning committee.

Following the AGM 1993, a committee was established with Dr David Lonie as chairperson and representatives from both Victoria and South Australia, to explore how to structure the National organisation to co-exist with State organisations. The subcommittee teleconferenced on several occasions. Our thanks and congratulations are due to Dr. Elizabeth Puddy and Ms. Pamela Link of Adelaide for the many hours and efficient manner in which they set about the business of establishing the South Australian Branch. Although some of the technical details are still to be finalised the local committee held a conference and launch on October, 10th. Dr. Sula Wolff was the plenary speaker and thrilled us all with her presentation, "The scope of Infant Mental Health: Pointers to Helpful Interventions". Congratulations to the South Australian Committee.

Dr. Campbell Paul, the Victorian representative on the committee, has been very active in promoting the Victorian Branch activities, and discussion has revolved around finding a solution that accommodates the particular characteristics and expectations of the Victorian membership. We are grateful for the time both Campbell and David have given and anticipate a satisfactory solution in the near future.

Once again Drs Isla and David Lonie have edited the quarterly newsletter at the excellent standard we have come to expect from them. Not only have they been responsible for editing but they have contributed at least two excellent articles themselves. Isla gave an exciting expose on Chaos Theory, "Is the baby's gaze a strange attractor? .Chaos theory: a new paradigm in biological research", in the June issue. In the September Newsletter, David summarised the papers and discussions of the Attachment Conference. So many requests for this Newsletter have been received we will have to do another print. Many thanks to Isla and David.

As last year, I point out that the editors are always looking for good copy so why not write and tell us of your work, activities or research and what you would like the Association to be doing. The Newsletter is the means by which we can keep each other informed and is crucial to the effectiveness of our organisation.

AAIMHI is the affiliate in Australia of the World Association of Infant Mental Health (WAIMH) and Dr. David Lonie is the Australasian representative on the WAIMH executive. The international body has agreed to a Pacific Rim Conference in Sydney April 21-23, 1996, title: " The Baby, Family and Culture: Challenges of Infancy Research and Clinical Work".

This will be another wonderful conference for as well as the excellent plenary speakers and WAIMH executive members attending, over 70 papers have been submitted to the scientific committee in Melbourne. Margaret Ettridge has agreed to assist with organising the Conference which will be held at Sydney University.

The Association has had a dramatic increase in membership this year. Perhaps it was due to the fact that the Committee decided to drop the membership fee, or perhaps it was a consequence of the Attachment Conference. I think it is a reflection of the growing interest in infants and their caregivers by a wide range of professionals. The Association, which is very committed to the goal of improving the mental health of the infants of Australia offers an ideal forum for such like-minded people.

My thanks to the hard working committee for their commitment to the Association and to all members for their commitment to infants and their caregivers.

Beulah Warren MA(Hons)MAPsS

President- AAIMHI, 17th November, 1994.

TREASURER'S REPORT

This Financial Year I have acquired some office and computer skills I never thought to have until AAIMHI had a Conference and grew four fold in membership and turnover.

In 1993-1994, AAIMHI had a turnover of $5, 851 of which $2,090 was membership comprising 38 financial members and $3,675 was from seminars. This financial year we had a turnover of $20,133 of which membership was $4,068 at the greatly reduced cost of $40. There were 146 financial members at 10 November, 1994. Membership is growing Australia wide, particularly in South Australia where there are 31 members. We have 9 Victorian members, 7 in Western Australia, 4 in ACT, 3 in QLD and 2 in NZ.

I would particularly like to thank the members of WAIMH who loaned us the money to float the Attachment Conference and the NSW Branch of the Faculty of Child Psychiatry who generously supported the preliminary printing. Also my accountant, Jon McEwan who got it all to balance. It has been a very stimulating year and this year promises to be just as exciting.

Marianne Nicholson, Treasurer.

AAIMHI (South Australia)

The Inaugural Conference and Launch of the South Australian Branch of AAIMHI was held on Monday, 10th October, 1994 at the Barr Smith Theatre, Scotch College, Mitcham, South Australia.

It was a one day Conference, with over 100 people attending, and included an Keynote Address from Dr Sula Wolff, from Edinburgh, papers from Dr Brian Stofell, Senior Lecturer in the School of Medicine, Flinders University, Dr Campbell Paul, Royal Children's Hospital, Melbourne, and workshops run by Associate Professor Alan Russell, Department of Education, Flinders University, Beulah Warren, Benevolent Society of NSW, and David and Isla Lonie, from NSW.

The Conference was a great success, held in a beautiful setting, and was a major contribution in bringing together professionals from differing backgrounds but all with an interest in, and concern for, the welfare of young children and their parents.

The Conference was organised by Dr Elizabeth Puddy and Pamela Linke whose indefatigable work has established the South Australian Branch as an important contribution to the work with infants and their parents in that State.

The Conference was held immediately after the Annual meeting of the Faculty of Child Psychiatrists, RANZCP which had also been held in Adelaide. This allowed those who had attended that meeting to stay on for the Infant Mental Health Meeting, and this may be a model for what is envisaged will become an annual event for an emerging federal organisation of the parent body.

BOOK REVIEWS

Becoming Attached: Unfolding the Mysteries of the Infant-Mother Bond and Its Impact on Later Life by Robert Karen. Warner Books, New York. 1994. Available from Gleebooks, Glebe, Sydney. $50-00.

If the study of infancy is one of the most rapidly growing areas of research in child development, Attachment Theory must be considered as one of the major contributions to this field. This year is the 50th anniversary of the publication of John Bowlby's paper on the Forty-four Thieves, a paper which it is reasonable to consider as a starting point for what has happened subsequently. So we now have the task of considering the history of an idea which is unfolding and continuing to develop.

Given that there are fifty years of books and papers to absorb, and to place in context, this is a most timely summary of what has happened and is happening. The most recent reference cited is 1993; but the wealth of the book lies in part with the accounts of interviews with a number of the major figures writing at the moment, so that we are there, as it were, as the papers which we will read in our Journals ( ) the next year are being written.

It is an extremely readable book - it makes sense of the confusing to-and -fro dialogue between researchers and polemicists. It takes up the historical point and counterpoint as Bowlby and the analysts, Ainsworth and Chess, Main and Kagan, Belsky and Scarr fight out what the research findings mean and what their implications are for what we do with our children and what needs to be said or unsaid. But one needs to be careful about its readableness. A friend of mine pouncing on it and turning to a particular page which, I had to confess I had already read, said "But what do you think about the gender differences?" and quoted 'Secure boys.....were no more assertive, controlling or angrily aggressive than secure girls'. I had to confess I had missed this interesting point. She did, however, have the excellent index in the book at her disposal. And although I find the reference format difficult - endnotes organised by chapters which refer to a Bibliography, so there is a double shuffle ( ) find the appropriate reference, the references are excellent, and alone would justify the purchase of this book for anyone who wants to keep abreast of a very rapidly burgeoning literature.

It is always humbling to realise that what we hold dearly now and believe to be a piece of the Truth, may in twenty years have to be discarded. But a reading of this book suggests that there is a thread which reaches back fifty years, and which, if we continue to follow it, will provide us with a clearer idea of what makes a person a person.

Reviewed by David LONIE

You and Your Baby in Neonatal Intensive Care: Conceived and compiled by Norma Tracey. Published by Care of Parents in NICU Trust Fund. Available from Wellcome representatives in all major hospitals.

Norma Tracey tells me that Dilys Dawes has written to her to say that there is only one word for this booklet, namely

superb! I find it totally wonderful, and believe that it must have already become essential reading for the parents of pre-term infants. Norma's flair for finding the right words shines through in her introduction to the strange world of the intensive care nursery: *The sight of your very small infant, lost in space-age equipment, may have you feeling like a stranger in a foreign country.*

Lisa Aske, clinical nurse educator, John Spence Nursery, contributes an excellent chapter on the subject of "What can I expect from my communication with the Ward Team?" where she stresses the accessibility of staff to parents and their desire that parents should know that they may visit as often and for as long as they wish. Norma takes up the theme of parents' contact again with a sensitive recognition of the normal emotional responses of parents in this situation, beautifully illustrated by numerous comments from the parents themselves. Helen Hardy, occupational therapist at the intensive care nursery, The Children's Hospital, Camperdown, provides an extremely helpful chapter on the ways in which parents may involve themselves with their baby: *However competent and gentle the hospital care your premature baby receives, he or she needs the parenting which is uniquely yours to give.*

Stephen Matthey, clinical psychologist and research coordinator, then offers a special word for fathers, including recognition of the father's need to express his feelings, to find support from friends and family, and the extra burdens which he must bear in caring for other children and coping with his usual work. Kim Suttor, neonatal intensive care nurse, has written the section on the various pieces of equipment and monitoring devices which are in use in the nursery, so helping greatly in demystifying what is going on. The important question of baby feeding is taken up by Bronwyn Mascord, parenting and lactation specialist, NICU, KGV, who gives full recognition to the difficulties experienced by the mothers of premature babies and reassuring advice. Norma then returns to the topic of the parents' emotional responses with gentle reminders of the possibility of various reactions to the stress of the situation and a special acknowledgment for those whose baby dies. Beulah Warren and the staff of the Early Intervention Programme, Benevolent Society of NSW, contribute a chapter on "Taking Your Premature Baby Home" in which they answer many questions facing the parents, recognise the parents' mixed feeling about a baby who started life with such difficulty, and offer suggestions as to how to help him or her to sleep.

Finally, Norma gives a philosophical view of the importance for parents of knowing that they have suffered greatly and that this experience may be of value: *An infant born before his or her time, removed from the mother's womb to a machine somewhere between the womb and birth, challenges everything we can now achieve in medicine and science. It also challenges the human spirit to rise above this and be enriched by the experience, whatever the outcome. We hope that this booklet goes a little way in helping this process that touches most deeply the very font of human life.*

Reviewed by Isla LONIE.

MOTHER-BABY UNITS IN NSW

NORTHSIDE CLINIC MOTHER-BABY UNIT

In 1991 the Northside Clinic set up the first dedicated mother-baby unit in the Sydney area. The Unit provides an experienced and dedicated team to treat mothers experiencing Postpartum Depression and/or Psychosis. The Mother-Baby Unit is set up to treat the more severely ill mothers whose illnesses occur in the 12 months after the birth of the baby. As such, these are women who require hospitalisation, commonly medication as well as intensive treatment and support. Babies are routinely admitted with their mothers.

The programme run is based on cognitive behavioural principles. There are some structured groups which incorporate the principles of Dr Jeanette Milgrom's HUGS programme. There is also attention paid to mothercraft and general mother-baby interaction. Fathers are involved as much as is practical and formal couples therapy is commenced if necessary following the inpatient treatment period.

The average length of stay is between two to four weeks and on discharge appropriate follow-up and support is arranged. This commonly involves referral to the appropriate early childhood centre and mothers group or playgroup. It may also involve referral to a consultant psychiatrist.

The Director of the Unit is Dr Paul Friend, consultant psychiatrist at Northside Clinic. Referrals can be made through the Hospital Liaison Officer on 439 6866.

For further information contact: Mrs Carmel Lynch, ph: 449 7580 (home or Mr Bernard McNair, Northside Clinic, ph: 439 6866.

ST JOHN OF GOD HOSPITAL, BURWOOD

A postnatal depression and anxiety unit and nursery has opened at St John of God Hospital, Burwood. Accommodating up to six mothers and eight babies in a discrete and fully separate area of the hospital, the unit acknowledges the special role of fathers in the recovery process by providing accommodation for them to stay with their partners during treatment. With the programme focusing on the needs of the mother and her family, provision has been made for infants under one year who need to remain with their mothers.

Educational and insight-oriented groups are integral parts of the multidisciplinary programme. Individual support and counselling are available to both mothers and their partners to empower them to meet their personal needs and those of their infants. Issues dealt with during the open-ended programme include: Parent crafting; women's expectations, self esteem and confidence; dealing with personal problems, such as conflict resolution, improving communication skills, panic attacks or frightening, intrusive thoughts; infant sleeping and feeding problems; interaction with baby; learning to correctly identify the signals babies send; and coping with unsettled babies.

As the PND recovery process usually takes between two to four months, an Open Support Group has also been formed for ex-patients and community members. Operating once a week from our Day Hospital, Steven Richmond House, the

group provides a framework of trust and support to assist the recovery process and enable networking amongst mothers to take place. Topics under open discussion include self esteem, rational versus irrational thoughts, dealing with conflict, assertive behaviour, time management and parent craft issues. A fathers' support group is also planned for early 1995.

Mrs Kerry Lockhart, Nursing Unit Manager of the Mother & Baby Unit was previously Deputy Director of Nursing, Karitane Mothercraft Society. For further information, please contact her at St John of God Hospital, Burwood, ph: 747 5611.

FORTHCOMING MEETINGS

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

Third Pacific Rim Meeting

The Baby, Family and Culture -

The Challenges of Infancy Research and Clinical Work

Overseas Speakers are expected to include Hiram Fitzgerald. Hisako Watanabe, Antoine Guedeney, Charles Zeanah, Mary Sue Moore, Dilys Daws and Eric Rayner.

Where: Holme Building, The University of Sydney.

When: **April 21-23, 1995**

Enquiries: Margaret Ettridge - (03) 380 1429

MARCÉ SOCIETY

Pacific Rim Conference

Childbearing and Mental Health - Risk and Remedies.

Guest Speakers include Professor John Cox, University of Keele.

Where: Holme Building University of Sydney

When: **April 19-20, 1995.**

Enquiries: Phone (03) 380 1429

NOTE: This Meeting immediately precedes the WAIMH Meeting, and it is likely that Infant Mental Health Professionals will be interested in attending both meetings.

COURSE ON INFANT RESEARCH AND DEVELOPMENT

The NSW Institute of Psychotherapy is offering a ten week course on infant research and development to be held in the Evan Jones Theatre, Rozelle Hospital, commencing on January 19, 1995. It is hoped that this will provide a suitable introduction to the Marce Conference on April 20, and the WAIMH conference from April 21-23. The course is open to interested professionals for a cost of $175.00. Individual lectures may be attended for a cost of $25.00 per session. Enquiries may be made to Mrs Monica Fritchley (Phone/fax) 804 6889.

AAIMHI AND WAIMH.

The Australian Association for Infant Mental Health is an affiliate of the World Association for Infant Mental Health. Membership of AAIMHI does not include membership of WAIMH. The advantages of being a member of WAIMH is that it entitles you to a reduced fee for the four yearly Congress which in 1996 will be held in Tampere, Finland, regular postings of Signal, the WAIMH Newsletter and a reduced subscription to Infant Mental Health, a quarterly Journal.

AAIMHI's membership runs from July to June, each year, and the Annual Fee is $40-00.

Membership of WAIMH runs from January to December. The 1995 Dues are $US50-00 without the Infant Mental Health Journal, and $US98-00 with the Journal payable by VISA and Mastercard.

If you would like Membership Forms for either or both organisations please write to AAIMHI, PO Box 39, Double Bay, NSW 2028; or leave a message on (02) 817 - 5223.

Deadline for next AAIMHI Newsletter
15th February, 1995
Please send news, letters, announcements, articles etc, whatever you would like to see in YOUR Newsletter to:
The Editors, AAIMHI,
PO Box B7,
BORONIA PARK, NSW 2111