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FROM THE EDITORS

It would be a mistake to think that the Editors were so hard up for copy that they organised a Pacific Rim Meeting in order to help them sleep well at nights. However, we look forward to including in the Newsletter over the next two issues some of the highlights of this rich feast. In this edition we are including a report on the first three Plenary Sessions, the contributions from Charles Zeanah, Mary Sue Moore, Eric Rayner and Antoine Guedeney. In the next Newsletter we will present a report on the Plenary sessions from Hiram Fitzgerald, Hisako Watanabe and Dilys Daws. All the Plenary sessions were recorded, and the tapes from them are available - information about this is included later in the Newsletter.

The quality of the papers and their scope were a convincing indication of the interest there is in Australia in Infant Mental Health. It is to be hoped that for some of the presenters it was a dry run for the WAIMH Meeting in Finland next year; the comments which I heard from our overseas visitors certainly suggest that we have a very worthwhile contribution to make on the wider scene.

With increasing interest in infancy, and the contexts in which infants develop, there are a number of issues to which the papers presented at the meeting called attention. We would very much like to present some of this material in forthcoming Newsletters, and invite contributions.

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REPORT FROM THE THIRD PACIFIC RIM MEETING OF WAIMH

Disorders of Attachment - Dr Charles Zeanah

The first paper was given by Dr Charles Zeanah on Attachment Disorders in Infancy. He started by drawing attention to a confusion between insecure attachment as described in Attachment Theory which originated with John Bowlby and Attachment Disorders as they are described in DSM IV and ICD 10. While insecure attachment in infancy is associated with a greater risk for pathology in preschool, most insecurely attached children are not clinically disordered. The description of attachment disorder in DSM IV and ICD 10 is however of pathology, that is these children have insecure attachment patterns, but they do, in addition, have indications of clinical pathology.

He then outlined the DSM IV and ICD-10 description of Disordered Attachment, which both designate two major types of attachment disorder with persistent disturbance in the child's relatedness extending across social relationships and distinguished from Pervasive Developmental Disorder. One type is called inhibited, where there is ambivalent, inhibited or hypervigilant response to the caregiver, and the other disinhibited which includes indiscriminate oversociability and a failure to show selective attachments. In the DSM IV, this is further defined by the absence of Developmental Disorder, and a further requirement that there should be evidence of pathogenic care, such as maltreatment or institutional rearing.

He pointed out that these classifications were based on two major sources of observations, the social behaviour of maltreated children , and children who had been raised in institutions. However, with regard to children raised in institutional settings there are a number of confounding variables which relate to the conditions in which the children were raised - such factors as the lack of regular schedules, or of stable caregiving but that even in this group there are a number of children who, despite the adverse circumstances are still able to develop an attachment.

Dr Zeanah suggested that there were a number of problems with the conceptualisation of attachment disorders as defined in this way. A major problem is that what is described is a number of children *without* attachments and the focus is on social behaviour and relatedness rather than on attachment behaviour itself. Moreover, the description of a disorder extending *across a range of social situations*, does not take into account that children

can develop a differential attachment relationships with different caregivers. What is being described in fact is maltreatment disorders rather than attachment disorders, and there is an overemphasis on distinguishing these disorders from Pervasive Developmental Disorder and a lack of distinction between them and disruptive behaviour disorder. Although the aetiology is specified and the classification is based on a known aetiology, the differentiations are phenomenologically based. In practice, it is often difficult to get an accurate history, and the classification precludes the possibility of a biological contribution. Finally, the exclusion of children with Developmental Disorder does not make sense; it suggests that children with DD cannot have attachment disorders.

Although there hundreds of studies on attachment behaviours, there are no studies on the validity of the criteria used in DSM IV and ICD-10, so there is a need to integrate the studies which have been done on attachment behaviour.

Dr Zeanah now turned from considering the diagnostic classification of attachment disorders in this way to outline the contribution from attachment research. This work had shown that there was a biological propensity for children to become attached and that it was rare for an infant not to develop an attachment. Such a failure occurred only under extreme conditions. Attachment, he pointed out was a characteristic of the individual but differentially expressed (to different caregivers). There is controversy about the issue of temperament and its relation to the development of attachment patterns, but temperament by definition must have cross situational consistency whereas the attachment patterns of an infant may different in different situations (i.e. with different caregivers).

Attachment, he suggested, was a behavioural system with an external goal which was proximity to care giver, but that this external gaol was based on the real internal gaol which was **felt security**. In development as representational processes mature, the baby increasingly is able to know that some one is **there for them** without the need for actual contact for reassurance. Exploratory and attachment behaviour work in tandem and this is demonstrated in the Ainsworth Strange Situation - when the caregiver leaves exploratory behaviour diminishes. What we are looking at is a measure of the exploratory-attachment balance. Whenever either behaviour, exploratory or attachment, is extreme with the return of the caregiver, we classify the baby as insecurely attached. This phenomenon of a secure base or safe haven can observed out of the laboratory. The Strange Situation is not a procedure which diagnoses pathology - in the classification based on it, half the world is insecurely attached. If want to study Attachment Disorder we need to look in naturalistic situations. We are now talking of a subset of insecurely attached children and we need to decide where to draw the lines, that is - where does caseness begin?

Dr Zeanah then outlined the classification of Attachment Disorders which he and Alicia Lieberman have been working. They suggest the following categories:

1. Non Attachment Disorders

These are basically what is described in DSM IV and ICD 10 with the two patterns previously described, but with the requirement that the child should have a mental age of at least eight months. The reason for this qualifier is to ensure that the disorder of attachment is not the result of cognitive defect.

2. Disordered Attachment (or secure base distortions)

(a) with inhibition.

This is a secure base problem in which the child not able to move away to explore. What distinguishes this is relationship specificity, that is it is a - failure to explore in presence of caregiver. This is to distinguished from the children Kagan describes as inhibited. Those children are slow to warm up and that is a temperamental matter and does not alter in different relationships.

(b) with self endangerment

These are children who are accident prone. They show aggression directed at the self (such as head-banging, or self-biting) or at the attachment figure, particularly in situations when you might expect the child to seek comfort. Again the behaviour is more likely to be seen in the presence of the caregiver.

(c) with role reversal

There are many kinds, but in general the child assumes either a caregiving role to the parent or a sort of partnership with them. Behaviour which has been described as 'disorganised-disoriented ' in the Ainsworth Strange Situation may also be seen in these children.

(3) Disruptive Attachment Disorder

This is an attachment disorder in which the child has lost the primary attachment figure through separation or more frequently through death. The loss of a primary attachment figure in infancy is inherently pathogenic in infancy because the child does not have the cognitive and emotional resources to deal adaptively with this loss. Indeed, the child loses a giant part of the self.

Dr Zeanah commented they were now conducting a number of studies to validate this proposed classification of attachment disorder, and were developing a structured i/v of parent and child together, but that it was important to observe the infant and caregiver in a number of situations to fully assess the attachment patterns. The sorts of behaviour which need to be considered include the following:

How and when does the child show affect to caregivers; how does the child seek comfort; does

the child rely on caregiver, and what cooperation is there between the mother-infant couple; what exploratory behaviour does the infant show; and what controlling behaviour and finally what is the response on reunion. It is important however, not to rely too heavily on the reunion responses, as a number of studies have shown this these may lead one astray in making an assessment.

Finally, Dr Zeanah made some comments on interventions, suggesting that the major step was to prove an emotionally available attachment figure. He said that a number of studies have looked at supportive interventions, including a major study by Alicia Lieberman of home infant parent psychotherapy. However the picture is mixed in terms of being able to change attachment classifications.

The Complexity of Infant trauma: Representation and Transformation - Dr Mary Sue Moore

Dr Campbell Paul opened the session with Dr. Mary Sue Moore by regretting that Elvie Kelly had been unable to come to talk about the traumatic experiences of Koori children who had been taken from their parents as an aspect of white integration policy until only a few decades ago. In introducing Mary Sue, he noted that she had had a colourful career, commencing with her work as a teacher including with American Indian children and where she developed her special interest in children's drawings and how they represent their experience there. She then moved on to training as a psychologist and psychotherapist with periods in which she worked both with Bruno Bettleheim and John Bowlby. Her current activities around the world as a pollinator of numerous germinating clinical and research projects were well known to us in Australia and of the greatest value, reflecting as th did her immense skills as a facilitator and networker. Mary Sue's paper was titled 'The Complexity of Infant trauma: Representation and Transformation'[1]

Mary Sue responded by remarking that she was delighted to be back in Australia, where she seemed to be spending a lot of time lately. This was because she found that the work being done here in terms of the clinical work and research was very exciting for we were making important links leading to real advances in knowledge and understanding of all our patients. She explained that the topic of her talk was on the impact of trauma as reflected in a child's experience, and that she would be talking about the applications of this knowledge in terms of brain function and brain process. She was particularly interested in exploring how early experiences in infancy could be correlated with experience in later childhood, adolescence and adulthood, and what were the applications of this knowledge.

One new development of incredible value has been the introduction of PET and MRI scans which are now showing how different parts of the brain light up as people respond to events as they are happening. These new techniques are showing that individual differences have major effects and gender differences are profound. For instance, when men and women undergoing PET scans were asked the same question, different parts of the brain were activated, and for different lengths of time, but in the end the answer each gave was the same. The lesson to be learned from this is that it is not a question as to which approach is best, but that it is important to recognise that men and women can complement each other. Such research has informed us about infant brain development and the impact of trauma on this.[2]

It was important, she said, to define what she was meant by the word trauma, and here she quoted her colleague, Dr Susan Coates: *Trauma is what we might call the experience of the individual when there is perceived a threat to the existence of the self.* That is, any experience, whether from the inside or outside in which there is perceived a threat to their life - that is, to continued existence. Added into this definition is the idea that a disruption to a child's primary attachment will be perceived as a traumatic attack on the self as well as a disruption of the attachment, because attachment is biologically innate. As a species we are helpless as infants, without any claws or fangs, but we can find someone to protect ourselves. The securing of an attachment is crucial to the survival of the self as an individual. This may be related, too, to the Koori experience because many of those who are parents now were involved in the removal process. A major difficulty for aboriginals working in the welfare area is that their parents of they themselves may have suffered removal, and so where they may need to identify abuse and become even the agent of removal they will experience enormous guilt. For each of us, our own history intergenerationally will influence the feelings we have. When working with families where abuse is taking place, we need to take into account the impact on ourselves, our families, and on our internal world.[3]

Mary Sue then went on to say that she is unhappy with the use of the term *disorganised attachment* where there is trauma or risk of trauma.[4] She was referring to those children who were initially difficult to classify on the Ainsworth Strange Situation and

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[1] Paper written with Dr Susan Coates, to be published in *Psychoanalytic Enquiry*, September, 1995.

[2] Gaensbauer, T. Reference to paper in Journal of American Journal Child and Adolescent Psych. 1995 concerning a 12 month old infant present in a room when a letter bomb went off, killing her mother.

[3] Monica Leniardo from London has written on this subject.

[4] The concept has come out of the work of Mary Main and Pat Crittenden and others.

who were later reclassified as *disorganised or disoriented* because they tried multiple approaches in their attachment behaviour. While this may look disorganised we now know from careful work (including Beatrice Beeby, Joe Jaffe, Sidney Feltzheim), that children and parents who are interacting in disorganised attachments are the most rigidly aware and attentive to attachment patterns. These are children who are hypervigilant to the other's state, and so acutely sensitive to changes in the other. What we see from the outside as disorganised, is in fact highly organised. What may look like a fugue state may also be to do with hypervigilance. Even the slightest change in our tone of voice or facial expression may produce this effect. We may understand this in terms of the response of the human brain to trauma. Mary Sue would prefer to speak of disorganised attachment relationships as *traumatic attachments*. There is also the need to be very careful in stating that what is crucial to insecure or anxious attachments is not the equivalent of psychopathology. Bowlby's theory always discussed attachment behaviour as *adaptive* to the behaviour of the other. We might think of an anxious child responding to a parent's cues - which could be read as 'I don't want close behaviour' and so producing avoidant responses. If we try to look at pathological groups, we are always working retrospectively, and we do need to be extremely careful not to start to believe that one sort of attachment will always lead to some sort of pathology. We need to remember that children may show different attachment behaviour to different parents, so if we only see the mother and child together we might run the risk of calling this an avoidant child. Insecure or anxious attachments then are not equivalent to psychopathology, but are adaptive to the behaviour of the other. They are responses to very specific behaviours in the parent, and there is always the potential for another form of attachment with another attachment figure.

Mary Sue then moved on to the infant brain response to trauma, citing the work of Bruce Perry, Basel Van der Kolk and Judith Hermann. Perry has studied children who have had an early traumatic history and has found that they function along an *alarm/fear/terror* continuum - all responses which are innate. Perry has brought into this the concept of a *freeze response*. All are associated with similar parts of the brain which have to do with affect arousal responses and other physiological responses such as outpouring of adrenaline and cortisol. An infant who is threatened has then available to it a hardwired fight and flight response, but also, when trauma is extreme, a freeze response. This is a sort of paralysis or dissociative response, and is to be distinguished from the fight or flight response, where there is a sense of agency. The freeze response is the most extreme response to terror because it cuts off sensations coming from the outside, and so cuts off the ability of the individual to protect the self. 'I cannot defend myself if I am not an agent,' she said. 'If I act, the trauma might get worse.' This is the situation where a child who cries might get battered, where a child who is pinched or poked when the nappy is put on will not respond, since a response might lead to more danger. These are potential responses to trauma in the early life of child, and involve parts of the brain stem, midbrain, limbic system and parts of the cerebral cortex which are in rapid development in the early months. If a child is repeatedly traumatised or abused, then we see overuse of these developing parts of the brain, and so, hypersensitisation without the development of other types of defences and organisation. This has a very pronounced effect on the later behaviour of the child, because this means that these are going to be hyper-reactive parts of the brain. The normal barrier that all of us have in terms of tolerating levels of pain or trauma is going to be reduced, due to overactivation and hyper-reactivity, so that a very small stimulus in the environment can produce an extremely traumatic response in the child. Once a person is hypersensitized, it is very hard to get rid of those reactions. One of things that is important here is that those parts of the brain that are developing in our hypersensitized children include those parts that modulate hypervigilence, startle response, anxiety and mood dysregulation, so that we are already thinking about what happens in dyads - in mothers with depression for instance, and in behavioural impulsivity and hyper-reactivity.

A child who has had traumatic experiences is likely to respond to new events with extreme terror. Perry has talked about the continuum from alarm to fear to terror. Here the barriers are broken down. In normal development we would expect first an alarm response, with a sequence of responses that a child can use to defend against this. There is then an increase in fear if things remain unpredictable, and finally a move into terror. Traumatised children slide straight through into terror. What happens to us on the outside is that we see irrational or illogical responses. What has happened seems to us not to be such a big thing - a child or a toddler took a toy away from the other - and the child who had the toy taken away fell on the floor screaming in a tantrum. This is another very important pathognomonic sign for post-traumatic stress. These children do not have the barriers that we would expect to help them tolerate mild disturbance, and so they find themselves in extreme states very rapidly. Mary Sue stressed that she said 'find themselves' very purposively, because the response is not volitional, but is behaviour that happens to the child willy-nilly in response to triggers in the environment. She said that she gets very concerned about the fact that some behavioural methods of working with these children talk about the 'manipulative child': the child who throws a fit to make somebody else miserable or to get their way. While she conceded that there are children like this, they are not these children, who are terrified and find themselves in a tantrum and are frightened by it themselves. We can sense that difference clinically. These are children for whom there are hidden triggers in the environment -

triggers which are hidden from us but not from the child. Just as with individuals who have suffered experiences of abuse or torture, such things as the colours of room, a scene from a movie, may create this response. A small piece of the history of a traumatic event may reproduce the traumatic state. *These children are not manipulative, but are being manipulated by the trigger in the environment, and any component of it can reproduce the traumatic effect.* There are implications here for the DSM IV classifications in terms of Attention Deficit Disorder, Oppositional Defiant Disorder, Conduct Disorder and Post-Traumatic Stress Disorder. Mary Sue takes particular offence at the pejorative sound of 'oppositional defiant' in that it implies that the children have volition when in fact they do not. We must understand, she said, that a child who appears oppositional or defiant may be responding to each new request with a mini freeze response. This is important in treatment and management of these children, for there is a need to give control back to them to allow time for their arousal level to come down. Similarly, in Conduct Disorder, the impulsivity is best understood as acting out against the self as for instance in eating disorders and self-mutilation. The impulsivity is not planned, nor enacted in order for someone else to feel bad. It just happens. We need to understand that the counter transference responses to such behaviours are powerful, and that they are easier to manage where we can remember that the destructive impulses are not directed against the other.

Our brains are capable of recording memory in other ways. There is a quality of memory which is called *non-declarative* or *procedural*. This is present in all of us and recorded in different parts of the brain from declarative memory where there are words to explain things. Non-declarative memory is a memory for procedures and interactions with different people and with the environment. Here there are no words to be declared. A good example is riding a bicycle - you can't really tell a person how to do it, but once you have experienced it, your body has a sense of the procedure of it - the feeling of balance and moving the pedals. This non-declarative memory is very likely to be activated in situations where there is danger in the interaction. The reason for this is that we are organised as human beings as a species to remember things that are dangerous so that we do not walk into them again. If we have had interactive experiences which involved danger, we are likely to remember minutely what the interaction was about. That includes even, if someone was approaching us and there was later a traumatic experience, the way their eyes were glancing and the exact look on their face. We record all of that in a procedural memory. With traumatised children we do not see free play but what Lenore Terr calls re-enactments. We see the procedural memory acted out without fantasy, without elaboration - simply the procedure followed again. Where there is trauma in infancy there will be traumatic memories which are recorded, but which may not be verbalisable or capable of recalling the process which was traumatising. Many times when we work with adults who have histories of abuse what comes up in the therapy are fragments of memories including pressure on the body in certain places, or a frightening experience when the quality of light changes for instance, if it reminds the individual of an earlier traumatic experience which has been encoded in procedural memory.

Mary Sue then showed some drawings done by a child who was just a year old when her mother was killed in the same room when a letter bomb went off. The child at 6 years would only draw blotches, which when compared with a police video taken of the scene immediately afterward were an exact representation of the blotches on the wall left from her mother's shattered body - a procedural memory imprint.

Dr Ann Morgan, a paediatrician from Melbourne, then discussed Mary Sue's paper, as a masterpiece, which had taken us through the questions of really trying to distance us from the pain of the trauma and to think of it in physiological terms of what the infant and we are experiencing. It prepares us for understanding what is happening when there is trauma to the infant, starting with the freezing response before the infant has a sense of agency, and then taking us through our understanding of a very really important issue of the fragments of the body memories - the fragments of experience and how important it is for us to be able to listen to them.

Unfortunately, this issue of trauma to the infant is with us all the time. We don't always listen to the aboriginal infant and what has happened - it is something each one of us must remember because it is what infants are experiencing in Rwanda and Sarajevo. Unless we listen we can't learn and modify our response. The important thing about the infant is that this is where it all begins. Ann said that she thought it was important to think of how to translate Mary Sue's work into thinking about loving and hating. She made a plea for a measure of hate - 'for me it is part of love', she said. If there is a passion about the infant whether it be in love or hate, it is an experience that we have with the infant. The absence of love is indifference, and she felt that because sometimes we cannot bring ourselves to think about hate, we fall into a pattern of indifference. We need to experience what it means to hate as a part of our loving of the infant. It is important to understand that the hate as well as the love belongs to all of us. What we need to be able to do, not only to understand and put words to the experience of these young children and our own experience, is also to think what it means for us to be part of that experience. If we do not participate in our thinking about hate, then we become indifferent to the infants that are traumatised and hated everywhere.

In subsequent discussion, the question of how to intervene in such cases came up. Both speakers talked about the need to hear what is there and to stay with the child. Ann added that hopefully we

and young child needs to experience a warm intimate and continuous relationship with mother or permanent substitute which both enjoy, varied in countless ways by father, siblings and others. His style is quite unlike Winnicott's with no empathic personal intuitions, no anecdotes: the work of a passionate scientific overviewing Darwinian naturalist.

In the 1950's Bowlby was involved with administrative and public tasks. He began to realise that he found intimate emotionality difficult and so engrossed himself with his researches. By the late 1950's he had come to the start of his theory of attachment with his paper 'The nature of the child's tie to his mother.' While his earlier work had focused on physical separation from the mother, he was moving to a theory whose language was unashamedly biological and evolutionary. Increasingly using a systems theory approach, this new discipline of ethology brought the study of animal behaviour in its natural environment to a new maturity with the help of two famous primate biologists, Hinde and Harlow, to aid in understanding human mothers and infants together. Bowlby's papers on attachment theory came under concerted critical fire from a strong section of the British Psychoanalytic Society, and Winnicott who was then the President appeared to agree with them. It was said that Bowlby's point of view grossly ignored the unconscious, together with fantasy and internal psychic structures. It must here be said that though he believed in, and personally continued with, analytic therapeutic work, he saw himself as not strong on intuition and had given up doing five times a week psychoanalysis. Bowlby vigorously argued back saying that his attachment theory was one and only one approach to the study of meanings. Surely psychoanalysis must be concerned with this too, and cannot afford to ignore information that is relevant to its work, even if it is not collected from behind the couch. He was profoundly moral, even moralistic, in his condemnation of such a view as then held by many analysts. For their side they were even more moralistic in their defence of keeping all data away from psychoanalytic theory except that from behind the couch. While this view did help to preserve the clarity of psychoanalytic thinking, it was at a terrible price in losing his active involvement with the Analytic Society, although he continued to be a member. It is in his approach to the parent-child relationship as an observing biologist that he must stand or fall. He was dissatisfied with much psychoanalytic theory because it wasn't using modern scientific method. The question is not whether Bowlby left the current clinical analytic mode of thinking - he certainly did over a large region of his ideas. The question is rather whether psychoanalysts and therapists ought to have some place in their minds for receiving the findings of biological and other observational studies. From the mid 60's Bowlby was at work on his great trilogy *Attachment, Separation and Loss,* which took until 1980 to complete. Bowlby poses the psychoanalytically minded clinician with a question: if attachment is instinctive, then surely it would often be active in any unconscious thoughts. Also would not the repetition of primary attachment relations be dynamic in the analytic transference relationship? How can we best conceive of and deal with this in our daily work? Separation theory has gone far, as we have seen from many papers in the conference. And again, in his book on grief Bowlby exposes the cruel fiction that children do not mourn.

Bowlby once said 'Donald and I really had the same task bringing home the importance for the child of the experience of the real external environment. Only our approaches were different. He was the poet of the two, I was the scientist. '

A Baby Alone Does Exist: Infant Depression, Recognition and Evaluation - Antoine Guedeney

Dr Guedeney began this most moving paper by recommending Charles Zeanah's review of the book edited by Arnold Sameroff from Emde 'Relationship Disturbances in Early Childhood' as a good introduction to the issue of infant depression.

He then referred to the special project group of distinguished investigators, led by Robert Emde and Arnold Sameroff, who spent a year together at the Centre for Advanced Studies in Behavioural Sciences at Stamford University in 1984. They had the task of rethinking the conceptualisation of behavioural deviance in young children under three years of age, and came up with ideas which were important and innovative. Beginning with the premise that the standard psychiatric nosology such as the DSM and ICD systems is not satisfactory for young children, the group was concerned not so much with the lack of data on specific disorders, as with the lack of descriptive information to enable understanding of clinical problems in this age grd It was thought that the lack of satisfactory nosology might be the result of a tendency to deny problems which ran counter to the idea of infancy as a trouble-free period. The group came to reject this explanation as inadequate, and instead developed a more radical hypothesis that with a few memorable exceptions, disorders exist less in the infant than in the vital relationships that function as the infant's care-giving context. This represents a true revolution in terms of the representation of psychopathology, turning former notions upside down. Possibly this movement may now have gone too far in denying the infant any role in its own pathology, for while the relationship disorder may be the cause of the depression, the depressive syndrome or withdrawal reaction clearly belongs to the child and needs to be taken into account.

Depression in infancy, or the phenomenon of withdrawal and psychomotor retardation, is a disease - a *dis*-ease - much closer to the adult forms of depression than was thought before. It also has

probably an earlier onset, maybe from the very beginning of life, in the form of withdrawal. As early as 2½ years of age it may be found as a purely depressive disease. So Dr. Guedeney would consider depression as one of the remarkable exceptions which the Stamford group has referred to, as a trouble that lies within the infant as much as it arises from the interpersonal relationship. He also considers infant depression a disease which has still to fight for recognition, for until recently it has been left out of diagnostic categorisations. In DSM IV, for instance, there is no place for a diagnosis of major depressive episode in infancy, although there are categories for pica and trichotillomania. There is a category of Reactive Attachment Syndrome where there has been significant deprivation, and Adjustment Disorder Syndrome where the disorder is not so severe, but in both these cases reactive and transient infant behavioural over-reaction is not assessed separately from the cause of depression.

In considering what is needed to make the diagnosis, Dr Guedeney then referred to the American National [illegible]ndards for Infant Clinical Programmes (NCCIP group) who suggested five axes for consideration of a diagnosis of depression occurring between 0 and 36 months: namely dysphoric mood (which must be present), expressionless facies, gaze aversion, blank staring, bland affect, and irritability, all present for at least two weeks. The child is rigid and silent, withdrawn and refusing contact. Alternative diagnoses may lead to a risk of confusing causes and consequences.

No further description of anaclitic depression and hospitalism has been made since that given to us by Réné Spitz (1946), and this is often relegated to an historical anecdote, so that we may fail to inform our students of its continuing relevance in the world today. It continues to be evident as failure to thrive in multi-risk, hard to reach multi problem families, especially among single mothers and infants living in [illegible]erty in our own communities; in hospitalism; in disasters such as wars, starvation and migration; and in the fourth world with kwashiorkor and marasmus. Selma Fraiberg has described freezing as one of the earliest defenses of the infant - as the only way left to the infant to cope with the unbearable. This brings us close to what is a withdrawal reaction in infancy.

Dr Guedeney then raised the question as to what was the age when the earliest indications of depression can be found. Certainly major depression is possible at school age, but he then presented a vignette of a child aged 2½ placed in foster care for 6 months by the juvenile court because of her 19 year old mother's neglect. This child could hardly walk by herself having grossly retarded psychomotor development nearer to a 16 months developmental level, ate very little, had a sleep disorder with difficulty settling and waking in the night, showed extreme separation anxiety with clinging to her foster mother, and banged her head each time she was refused anything, and even more when she met with her mother. She was not clean either by day or night, and showed severe speech delay. Each time she met with her mother, her foster mother took her home deeply withdrawn, grave and mute. She was seen each week in consultation, attended a psychology and speech group twice a week, and was in exceptional foster care. It took her more than six months for her depressive symptoms to disappear which they did in the following order: first her sleep disorders, then her eating; then her speech delay, the toilet training was achieved, then a smile appeared, with a slow disappearance of separation anxiety with the beginning of an open reaction to the acknowledgment of other people. This improvement was very fragile, with regression occurring easily, especially when her mother had a new baby and forgot to come to see her. Her head banging which had almost disappeared, returned and learning again became very difficult. Individual therapy three times a week was then commenced to help this child to build a sufficiently strong relationship to herself and her parents to manage the set-backs her mother often confronts her with. She still has a very long way to go before she can feel safe and rely on people. This child received no treatment for six months after foster home placement since her depression had not been recognised. Dr Guedeney made a strong plea for earlier recognition and treatment of infant depression before irreparable damage was done.

Dr Guedeney then made some further remarks about infant depression in developing countries. He said that he agreed with Reginald Lurie who linked anaclitic depression, kwashiorkor, marasmus, and failure to thrive. All could be considered to be expressions of infant depression. While kwashiorkor is often described as a purely nutritional problem, it should be remembered that the word means 'first - second', referring to the jealousy and depression of the first born which occurs when the child is suddenly weaned when the mother gets pregnant again. Psychological changes may be demonstrated in children with kwashiorkor, such as an extremely strong reaction when confronted with their image in a mirror with a refusal to look at themselves. In the example he showed, the mother was clearly depressed and looking away, and he suggested that maybe the infant could not stand to see himself without the mother looking at him, as explicated by Winnicott. There is a quite violent rejection of any kind of stimulation, which is not only related to an insufficient level of nutrition. Kwashiorkor is not only related to an insufficient level of nutritional education but is much more linked with deculturation and emigration from countryside to suburbs. In fact, severe forms of malnutrition are very rare in the countryside, even though the food offered to children there may be the same. Comparison of children hospitalised for kwashiorkor, sickle cell anaemia and for surgery has shown that malnutrition is linked with psychopathology within the family much more than with family income.

In France, the most common picture of infant depression is non-organic failure to thrive which is linked with poverty and neglect. This is recognised as a psychological emergency. There have been a great number of studies which aim to separate organic from non-organic failure to thrive, and here the most significant items identifying the non-organic form are the interpersonal ones. Possibly what is needed is a depression scale for hospitalised infants. The depression may not be recognised because the physician thinks of only physical responses. This failure to recognise infant depression may be the effect of denial of the underlying infant depression - a feeling of helplessness in the face of the depression, leading to a search for an organic cause.

Turning to the question of the origins of infant depression, Dr Guedeney then posed the question as to whether it was closer to a so called basic depressive response than is adult depression. Withdrawal and retardation could be seen as a biologically based basic response, but there is probably a more complicated continuity between the withdrawal reaction (as described by Engel and Smale) occurring in infancy, and depression in the full sense of the term. This is supported by the work of Seligman on learned helplessness, and Menahem's work in Australia describing a withdrawal reaction in infants in different clinical settings. We may then consider that a withdrawal reaction or a psychomotor retardation could exist from the very beginning of life. Spitz said in his paper that anaclitic depression had striking resemblances to familiar symptoms of depression in the same situations as in adult depression, namely the loss of the loved object, but still concluded that it must be different from adult depression because of the absence of any discernible precursors of the ego. We now know a lot more about these kinds of precursors, and might consider on the contrary that anaclitic depression is the prototype of adult depression based on separation anxiety and the rupture of attachment bonds. Psychomotor retardation may be thought of as the target of antidepressant drugs. Paul Déni, a French psychoanalyst, insists on the idea that infant depression, however it begins, is always the result of psychic work, leading to the maintenance of a depressive object. There is then no such thing as a simple basic or biological depressive reaction in infancy. We can then follow a line from early withdrawal reaction in infancy to depression in the full sense of the term. This withdrawal reaction in infancy may occur each time the infant is faced with something which cannot be coped with, such as extreme pain, or an extreme psychological situation. Later in life, the withdrawal reaction could give way to a more complex form of depression, closer to the adult form, going along with the development of the ego and the growth of verbal skills.

Asking why infant depression seems to be so hard to recognise and to see, Dr Guedeney then suggested that there is something about infant depression hampers which its recognition. In the history of the concept each time a step is taken forward, research seems to take a slower pace. Infant depression is in fact in the centre of our clinical practice. We also use the term quite often while meaning very different things, from the affect of sadness which is part of normal psychic life, to severe withdrawal reactions, psychomotor retardation and severe flattening of affect. This may be linked with description of the depressive phase by Melanie Klein as the crucial psychic space which allows a relationship with a complete object. Infant depression is like a sort of black hole, something which induces confusion and evokes in everyone deep and black memories. In fact, infant depression is unbearable, like what is called 'the real' in Lacanian theory. For this reason, it tends to lead to very strongly opposed points of view, sometimes to negation of the infant's individuality, as in the totally organic explanations, where causes are sought exclusively outside the psychic world of the child, be it in experience or in obvious environmental cau[illegible] thus denying any influence from the child himself [illegible] his condition. This problem of recognition of infant depression comes from the depressed child himself. By this, Dr Guedeney does not mean that the child is responsible for his condition, but rather that the depressed withdrawn child is a scandal to everyone. The child is persecuted by the relationship with the caregiver, or rather, by the loss of it, and exposes this by massive projective identification. We see this in failure to thrive or kwashiorkor children as they arch against all contact, crying with intense pain, evidencing psychic pain whenever someone approaches them. We also may think of those infants who lie inert and absolutely indifferent to anyone. They seem to be in active rejection of any kind of relationship: to withdraw into themselves in a purely autocentric and mechanical activity. It may remind us of experiences with patients with extreme depression or melancholia, where no real contact possible since they are centred only on themselves, and we feel rejected from their world of guilt. They reject all contact, and cleave to their suffering, their delusion, to their hate, no matter what we may say. Such patients ate very difficult to stay with: we want to get away from them, or to fight against what they say. In the same way, the needs of depressed infants tend to be forgotten, and the infant may be avoided or even badly treated. To an unreasonable degree, the responsibility for the infant depression may be attributed solely to the parents or organic causes.

Infant depression is something like a black sun, full of the narcissistic energy that the child needs to keep psychic function organised around a depressed object. In fact, for the infant, it seems that this depressed object is the only one left. This black sun or black hole is like the Medusa's head, which is impossible to look at without being transformed oneself into a statue of salt. To look at the Gorgon's head, like Perseus, you need a shield. You need some protection to look right into the heart of

psychosis. Perseus used his shield to see the reflection of the Medusa's face, rather than look at her directly. In the case of infant depression, maybe the process of infant observation can be a protection against the projective identification coming from the depressed child which attacks every kind of relationship which the child might have. The presence of a third party thus enables the recognition of initiatives coming from the infant. An observer can be less taken into the infant's projective activity, and so can preserve an observational task without acting out.

This concept is at the heart of a withdrawal scale for infants - the 'Baby Alone Distress Baby Scale' - for use by professionals in well baby clinic settings which is being tested in Dr Guedeney's unit. It involves a medical examination by a paediatrician, which is observed by a nurse, who then spends five minutes in recalling the details of the examination using the scale which notes such details as the way the baby is held and put on the table, the child's response to the examiner, whether the child looks at itself in a carefully placed mirror, whether he takes the toys or rejects them, how he responds to vaccination and pain, whether he can use regression, and how he can let himself be soothed by himself or a toy or by the voice or by the mother. The observer, who can recall these details without having been exposed to the intimate interaction with the infant is thus able to make a much more objective assessment. In this way, it may be possible to achieve a depression rating for infants.

(Conference Reports by the Editors)

WAIMH THIRD PACIFIC RIM MEETING

AUDIOTAPES

The Plenary Sessions of this Meeting were audiotaped and are available from GEM. The tapes are of excellent quality. Each Session is available on one tape as follows:

(1) Friday 21st April, 9 - 10.30

Attachment disorders in Infancy - Charles Zeanah

(2) Friday 21st April, 4 - 5.30

The Impact of Trauma in Infancy - Representations and Transformations - Mary Sue Moore

(3) Saturday 22nd April, 9 - 10.30

Some Beginnings: Bowlby and Winnicott - Eric Rayner

A Baby Alone Does Exist - Infant depression, Recognition and Evaluation - Antoine Guedeney

(4) Saturday 22nd April - 4 - 5.30

Pathways to Behavioural Disregulation: Infancy, Alcoholism and Context - Hiram Fitzgerald.

(5) Sunday 9 - 10.30

Aspects of Infant-Parent Psychotherapy - Hisako Watanabe

Parent-Infant Psychotherapy - Remembering the Oedipus Complex - Dilys Daws

(6) Where does Infancy Research and Clinical work Now Lead Us - Panel Discussion

Each Session is on one tape, which are available at a cost of $7-00 and Postage $1-00 per tape, from GEM, PO Box 127 LAWSON NSW 2783, Phone 047 591655, Fax 047 59 2778

AUSTRALIAN ASSOCIATION FOR INFANT MENTAL HEALTH (INC)

Membership Fees for AAIMHI are due at the end of June. Enclosed in this Newsletter is a Membership Form. The Annual Sub is $40-00. It is hoped that at the Annual meeting, we will be able to modify the Memorandum and Articles of Association to allow for State Branches. Part of the discussion in progress to introduce this change involves the financial arrangements under which the organisation will operate. As an interim arrangement, the State Branches will be refunded a portion of the subscription; the actual amount being based on the cost of financing the Newsletter which is the main 'federal' element of the current subscription. Based on the current costs of the Newsletter, of each $40-00 collected $20 per State Member should be refunded to the State Organisation. A number of members have joined in the last three months (April - June) - their membership fee will carry over to June, 1996.

FORTHCOMING BOOK

The Motherhood Constellation by Daniel Stern, Basic Books 1995.

A new book by Daniel Stern is likely to raise considerable interest. The Motherhood Constellation does not disappoint us. It builds on his papers published over the last few years mainly in the Infant Mental Health Journal on internal representations. With his focus on the emerging field of Parent-infant psychotherapy, Stern bases his theoretical approach to this area on his understanding of the development and significance of internal representations. Although primarily centred on Parent-infant psychotherapy, The Motherhood Constellation is a rich summary of his views on how the infant develops internal representations and is, in my opinion, a clearer exposition of his views and the expansion of his work on this area makes for easier reading tan his papers which by virtue of the fact that they are papers are more condensed and

'dense'. The book also makes it clearer how the elements of his recent work fit together.

Although perhaps this book may appeal most to those working in the area of Parent-infant psychotherapy, psychotherapists in general and other professionals who find the study of infant development enriching in their own fields will discover much in this book. Stern says, when discussing the differences in various clinical approaches to infant psychotherapy

> 'There is one final question concerning the equal effectiveness of the various treatment approaches. What consequences should these findings have on public policy? A shortsighted political and economic answer would be to conduct only the therapeutic approach the costs the least to perform and have it done by professionals who are the most cost-effective to train. A more farsighted scientific answer would be that different therapeutic approaches, even if they do not differ in treatment outcome, can, as the subject of clinical research, teach very different things about the psychopathologies being treated and the therapeutic process of change.

The Motherhood Constellation is a major addition to the current literature and is highly recommended. It will be available in Australia in July, through Gleebooks, Glebe Point Rd, Glebe, price $65-00.

Reviewed by David Lonie.

AAIMHI - Western Australia

As we go to press, we hear that a Branch of AAIMHI is being started in Western Australia. We are looking forward to more news of this event, and perhaps an item about it in the next Newsletter.

ROTARY FUNDING RESEARCH INTO FAMILY HEALTH

(a reminder)

The Australian Rotary Health Research Fund has announced that at least for the next three years they will support research focussed on promoting **Family Health.**

About $500,000 will be available for grants. Advertisements calling for applications will appear in The Weekend Australian, the 1st Saturday in June 1995 and MJA 1st issue in June 1995. Applications will close with the Fund on the 15th August 1995.

Enquiries to Secretary Joy Gillett on (02) 633 4888.

Deadline for next AAIMHI Newsletter
15th August, 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

NEWS FROM EACH STATE WOULD BE PARTICULARLY WELCOME!