THE AUSTRALIAN ASSOCIATION FOR INFANT MENTAL HEALTH (Inc)

AFFILIATED WITH THE WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

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FROM THE EDITORS

It is with great pleasure that we end this volume of the Newsletter with a summary of the session on Future Directions of Infant Mental Health Services which was presented at the Pacific Rim Meeting of WAIMH in April, this year. One of the major reasons for organising such a regional meeting, is that it allows a number of workers in the field to come together and share their different perspectives. Only too often do clinicians bemoan the intransigence of the administrators in their inability to provide the important funds needed in running a clinical service, the administrators complain about the lack of reality testing of the clinicians and the academics mutter 'no statistical significance' in the background. Jeannette Milgrom was able to bring these three groups together at the Rim Meeting, presenting them with a common task, and enabling them to share an important experience. For no matter where the professional comes from, the unifying task is improving the infant's world. So we are very pleased to be able to end the Newsletter for 1995, with a summary of this Symposium.

Next year promises to be a busy one for AAIMHI and its members. We hope that a good number of us will meet up together in Tampere, Finland, at the WAIMH Congress. I know that there have been a number of papers submitted from Australia. And the Committee in Victoria are working towards plans for a two or three day meeting in November which will have a format similar to that of the 1994 Attachment Meeting. That is, we expect a number of overseas speakers to present around a specific topic, this time, Parent-Child Psychotherapy, which should allow the development of a theme throughout the meeting.

We are also looking forward to Dr Patricia Crittenden's visit earlier in the year, and, although her visit is not organised by AAIMHI, she will be visiting New South Wales, Victoria and South Australia, and this will provide a focus for meetings of each state organisation.

So with the thought of the riches to come in 1996, the Editors would like to take this opportunity of wishing all their readers the Compliment of the Season, and a stimulating New Year.

TABLE OF CONTENTS

	Page
Future Directions Of Infant Mental Health Services	1
Should the Mother Never Kiss the Baby?	8
AAIMHI President's Report	9
Meetings and Events	10

FUTURE DIRECTIONS OF INFANT MENTAL HEALTH SERVICES:

CAN CLINICIANS, ACADEMICS AND POLICY PLANNERS AGREE?

Report by Dr. Jeannette Milgrom and A/Professor Bryanne Barnett on a Panel held at the World Association for Infant Mental Health Pacific Rim Conference, Sydney, April 21, 1995. This Panel was coordinated and chaired by Dr Milgrom, who brought together three groups of professionals, Clinicians, Academics and Policy Makers, asking them to consider a number of questions. This Report summarises the papers presented by each member of the Panel.

Jeannette Milgrom[1], Co-ordinator and Chairperson

Can Clinicians, Academics and Policy Makers Agree?

I asked each panellist to present a brief position paper to cover the following issues:

1. **What is meant by infant mental health services? Who is the consumer? What parent-infant problems are we forgetting?**
   eg. The "worried well" versus parents who have psychiatric histories or extremely disturbed relationships.
2. **What exists and what doesn't?**
   What are service gaps?
3. **The players?**
   Infant mental health/parent-infant services
   - Who can do it?
   - Who can deal with the more complex cases?
   - What training do workers need?
   - How much support is needed?
   - What networking needs to occur?
4. **Building a future**
   What models of service delivery should be developed?
   How does this fit in with current health structures and services (eg. Child Protection, Child Psychiatry)?
   Who should be responsible for funding infant mental health work?

Panellists were also invited to discuss the issues above in the light of a case example. Professor Charles Zeanah, a key note

[1] **Dr. Jeannette Milgrom** is Director of Clinical Psychology at the Austin & Repatriation Medical Centre (A&RMC), Heidelberg, Melbourne. She established an innovative parent-infant clinic and has been involved in research studies of mother-infant interaction since 1980.

4449

speaker at the Rim Meeting, joined the panel in the final discussion.

Excerpts from the case example and papers presented by panellists are described below.

Lucy is a 4 month old baby. She cries constantly. Her mother, Joanna, feels "the baby hates me", and cannot bear to hear her baby cry.

She visits her general practitioner, certain that there is a physical problem, but nothing is detected. Joanna also finds it helpful to talk to her Maternal and Child Health Nurse. However, Lucy still cries, and controlled comforting does not work. Who does the Maternal and Child Health Nurse turn to for support?

Joanna becomes more depressed, crying and sleeping all the time. Her husband Gary, has a demanding job and works long hours. Her mother-in-law tries to help but Joanna feels she is taking over, Joanna is very houseproud and likes Lucy to be clean and well dressed and her house spotless. She makes multiple visits to the Accident and Emergency Department of the Royal Children's Hospital. The tension mounts, the crying is endless. Gary is ready to leave: "Joanna might be better off without me or maybe we are not cut out to be parents." They consider asking for foster placement and referring to Community Services Victoria. Lucy is now 6 months old.

What might be going on? Who could have helped? Would brief early intervention have made a difference?

A referral is made to a specialist parent-infant centre and the following picture emerges:

The mother is crying throughout the first two interviews as she reveals the following issues that are troubling her;

She feels that she is the world's worst mother and should never have had a child. She remembers how capable and competent she felt as a chief receptionist when working before having a child. Her life was ordered and predictable. She discusses her disappointment in her husband who doesn't understand her emotionally and what she is going through. She had a wonderful pregnancy, felt cared for by everyone but remembers the shock she received when the real baby was nothing like her imagined baby: the baby was very fretful, cried a lot, had colic. She felt rejected when her baby would not calm and took this to mean she was not a good mother. Post-Partum depression seemed to have been missed by professionals, as Joanna always put on a brave front, was carefully dressed and focussed her concerns on Lucy.

Joanna's early history included memories of her mother who had been unable to cope with the demands of her own babies and employed a nanny,

In addition, at the age of 10, her older sister (who had been a parental figure) died. The family had never adequately grieved this loss.

Observation of the infant showed her to be very sensitive to her mother's mood, sensing her high anxiety. Lucy now seemed to experience crying episodes as terrifying as she was often left to cry alone. Joanna seemed uncomfortable when she held Lucy. She talks about the terrible despair she feels when Lucy cries. As the interview progresses and Joanna tells her story, she feels calmer. She is surprised when it is pointed out to her, that Lucy is reaching and smiling at her. She looks down and says 'Maybe she does like me'.

What sort of intervention is appropriate?

Do we need to just help the mother or treat the infant in the relationship?

A CLINICAL PERSPECTIVE

Carol Richards [2]

Future Direction of Infant Mental Health Services

In Lewis Carroll's Alice in Wonderland, Alice speaking to the Cheshire cat asks "Would you tell me please, which way I ought to go from here?" "That depends, a good deal, on where you want to get to" said the cat.

In any service providing help for infants and mothers we must ask ourselves are we providing the service meeting the needs of the clients or a service we want to provide, which may be too traditional or too limited in its approach?

Our consumers are infants and mothers, for in those days, weeks, months up to the age of two the infant and mother are a unit who through a natural process separate together in their own time. There is another player present whilst this phenomenon is taking place - the father, whilst sometimes forgotten is also a consumer. Infant Mental Health Services are those which attend to, or take notice of, the emotional and mental health of the infant, particularly within the mother-infant unit.

What exists for this unit in the community? The Maternal and Child Health Nurse, the General Practitioner and the Paediatrician. These generic services are there but only physical problems may be addressed and time constraints may negate the opportunity to ask further questions. What is needed is a specialist service which provides a highly skilled team of professionals who can both work with the client and support each other in this demanding work. A team who can look at what the needs of the client are and act as an advocate for the infant. There are many experienced and well qualified staff who have no interest in and do not recognise the importance of infant mental health.

Non-traditional ways of intervention need to be considered. The client should not have to be pigeonholed into existing treatment programs. There should be a flexibility of Service, flexibility for the individual and a flexibility of ideology. Services should have the ability to respond quickly to the need, as a day or week in the life of an infant is a very long time, and long waiting lists can be expensive both in terms of mother-infant "wellness" and dollar costs to the community.

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[2] **Ms. Carol Richards** is currently working in the Infant Clinic, Department of Clinical Psychology at the Austin & Repatriation Medical Centre. Carol's nursing career has spanned 35 years, 28 of which have been working with mothers and babies and has included the position of founding Director of Canterbury Family Centre.

At this point I'm sorry we are not in Wonderland. Who should fund such a service? Just as the service I propose encompasses a wide range of interventions and its cost effectiveness lies in its diversity, I believe funding needs to come from both Primary Care and Psychiatric Services.

Alice awoke to discover 'Wonderland' was a dream. I would like to propose that the discussion that ensues from this panel will provoke us to launch into a new innovative and multi dimensional approach to the Infant Mental Health service of the future.

Desiree Saddik[3]

Who is the Consumer? What Parent-infant problems are we forgetting?

It is not just a question of extremely disturbed families with chronic difficulties, but those families who are having difficulties specifically related to having a new infant. If these problems are not addressed major escalations can occur over a matter of months (see case study). Difficulties mothers and infants are having may be minimised because there is a sociocultural and familial fantasy that having a baby is an enchanting and magical experience, kept in place by the media, and by generations of mothers themselves who out of guilt or a sense of failure keep secret any struggles they may have had. Clinicians, policy makers and academics may share this expectation and this may strongly impact what difficulties they see or will accept in parents and infants and what they will not accept. That the baby could die at the hand of the mother or that the mother go mad, is quite unpalatable. PND is minimised, the mother isn't coping, the baby is too demanding etc.

In addition, difficulties experienced by parents and infants may appear in many forms. The infant and sometimes the parent cannot speak and may need the professional to verbalise their distress for them, distress which not otherwise picked up can lead to abuse or somatisation eg. sleep difficulty. The parent and infant, or the family may be seen together, reflecting the need to keep more than one member of the family in mind when thinking about the infant's mental health.

What Exists for the Consumer and what Doesn't?

Infant mental health services are few and far between. Pre-natal detection of families who may need special services is poor. Post-natally, services are hard pressed. In addition, long waiting lists, and poor links between services result in poor referral processes and possibly poor service utilisation.

The Players

All workers who have contact with families with infants should play a role in the detection of risk. Treatment is then usually best given by infant mental health workers who may have a background training in a number of disciplines but will need at least three years specialist training for this task.

Dr. Janet Dean states that the risk is that workers may replicate something of the family's prior difficulties in the intervention.

Building a Future

Models of service delivery should favour an emphasis on multidisciplinary professionals, early identification, strong networking between pre-natal and postnatal services and a range of specialist services on top of the universal services post-birth.

AN ACADEMIC PERSPECTIVE

Bryanne Barnett[4]

An extensive body of literature exists about infant mental health and the services it requires, but the question of future directions of infant mental health services is actually academic, ie. hypothetical, in the areas where many of us work, infant mental health does not exist.

Moving some of the relevant service planners and providers beyond infant physical health is going to have to be an early goal.

Who is a forgotten consumer?

This depends where you work: geographically, politically and professionally. Sometimes the mother is forgotten, sometimes the father, sometimes the infant or other children, sometimes the grandparents. It is very hard for any one service to think of, to remember, everyone who has or should have, a stake in infant mental health.

To begin with, the mental health of the foetus and infant depends on the caregivers. Those who monitor the health of the mother during pregnancy, especially if they are medical, often do so in order to produce a physically healthy baby, they are not interested in the mother beyond that. They will tell her to stop smoking and drinking and not to let her husband keep beating her, but they will not help her to achieve this. They are certainly not interested in the parents' psychological or social well-being, and they will avoid at any price asking questions related to this - like aspects of personal or family psychiatric history, the relationship with the partner or with the grandparents. Yet these are precisely the items which tell you whether there is or will be a significant mental health problem for the mother - and mental health problems are the commonest adverse outcome of pregnancy. The mental health of the foetus depends on the mental health of the mother while she is pregnant.

Postnatally we are improving a little - many services are now beginning to recognise the parents' psychological state and the importance of this to the infant's physical welfare at least.

It took years to concede that children might not all be experiencing the happiest years of their lives and that some

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[3] **Ms. Desiree Saddik** is Program Manager of the Early Parenting Outreach Program, Canterbury Family Centre, Victoria, She recently won a Creswick Fellowship which enabled her to study infant service delivery and specific services in London, Paris and Geneva in 1993.

[4] **A/Prof. Bryanne Barnett** is Associate Professor in the School of Psychiatry at the University of New South Wales, and Area Director of Paediatric Mental Health Service for the South Western Sydney Health Area. A major focus of research and clinical interest is the mental health of mothers.

might even be depressed, Similarly, there has been reluctance to acknowledge that mothers, as Simone de Beauvoir emphasised, are also not contented, satisfied or happy all the time. Trying to persuade people that infants and toddlers become depressed and even suicidal is going to take some time.

What I would like to see is improvement of services in general to all parents antenatally - to achieve the healthiest possible infant and parents; psychologically and physically. When you mention this, people say "What a good idea, but of course we can't afford it". My point is, can we afford *not* to provide it - to fail to invest in our future?

Similarly, at the time of delivery and subsequently all mothers and their partners should have more attention paid to their psychological needs. Postnatal parenting classes should be routinely provided and attended. There are people who do not attend antenatal classes - often those in most need, Similarly, they would not attend postnatal classes but the worried unwell *would* be catered for and there are a lot of those. For those families recognised as at risk antenatally or postnatally, special services are needed, for example, home visitation schemes, One day all neonatal intensive care units will spend as much time, money and effort on the psychological survival. Perhaps those who are heavily invested in ensuring physical survival of the infant at all costs cannot and should not be expected to include mental health aspects to the same degree. Training will make a difference but this sort of inclusive approach requires a team.

To achieve this we shall need much education of relevant professionals and of the general public. Maybe we should start by defining what an infant mental health professional is and explaining our work to our professional colleagues and the public. I think the initiative to improve infant mental health services must be taken by infant mental health professionals and by concerned parents; both groups together could have tremendous lobbying power.

Gay Edgecombe[5]

Who is the consumer?

The consumers are families, with children 0-3 years and the agencies providing services to these families. Families include those with a few minor problems such as crying/unsettled infant/child, disturbed sleep patterns, which can be dealt with by appropriately prepared primary health care providers and those families with infants who have diagnosed mental health problems requiring ongoing specialist services.

What services don't exist?

Those parent-infant problems that do not receive the services they require may be due to the following:

- lack of accessible parent information;
- local primary health care providers lacking appropriate skills and information;
- lack of local specialised infant mental health services; a health care system that is not integrated;
- gaps in referral systems between primary care providers and specialised services;
- limited or no access to specialist support services in rural and remote areas;
- lack of recognition for the need or under resourced services to provide ongoing support in the. home for families and their infant(s) with complex health needs;
- inability of state wide health care systems to redistribute funds to ensure that the mental health needs of infants and their families are met.

What parent-infant problems are we forgetting?

We can prevent and/or minimise mental health problems by providing health promotive and health education services. Early recognition of parent-infant difficulties can be maximised by easy to access to day stay or overnight services provided by parenting centres.

The players

Families (including extended families for some cultural groups), health care providers, government and non-government agencies (eg. religious groups, self help groups).

Who can deal with the more complex cases?

Specialised teams with time to spend with families, including time for team debriefing sessions. Specialised teams must clearly identify their role and specify how their role is linked to the family's community based primary health care provider(s). In many instances families have developed trusting relationships with their local primary health care providers) and rely on them for information about their specialist care.

Building a future

What models of service delivery should be developed?

Enhance the effectiveness of established services such as the Maternal and Child Health Service in Victoria by identifying linkages to specialist infant/family mental health services.

POLICY PLANNING PERSPECTIVE

Karen Cleave[6]

Primary Care Policy Planning Perspective

The Family is the key primary care service provider.

Primary Care Services support the family to maintain the health of their children through health promotion, early identification and intervention strategies.

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[5] **A/Professor Gay Edgecombe** is Associate Professor/Chair of Community Child Health Nursing in the Faculty of Nursing at RMIT. She is actively involved in a number of committees including the Primary Care Positive Parenting Strategy Advisory Group of Health and Community Services Victoria.

[6] **Ms. Karen Cleave** is Director of Primary Care Division within the Department of Health and Community Services, Victoria, and services include: Women's Health; Specialist Children's Services; Maternal and Child Health School; and Parent Support Program.

The Primary Care Service System provides opportunities for families to maintain or resume normal developmental pathways and reduce the need for more complex long term services.

Primary Care Division provides a range of universal and specialist programs. Education and training initiatives, research and evaluation are important in developing a responsive and effective service system.

Existing gaps can be identified in the service system. There must be movement towards the development of an integrated service system so that families can move smoothly from one service to another in response to their identified health needs.

Peter Birleson[7]

Context: Child and Adolescent Mental Health Services in Victoria.

- Victoria has been undergoing significant reforms to its human service delivery systems.
- In March 1994 Psychiatric Services released a major policy document, *"Victoria's Mental Health Services; The Framework for Service Delivery". It* described the regional basis for service delivery, a community focus, mainstreaming of mental health into general health services, and a new output-based funding system.
- In February 1995 a draft policy document was released called *"Victoria's Child and Adolescent Mental Health Services (CAMHS): Future Directions" for* consultation and comment. This document is the basis of my talk.
- Policy is about setting the frameworks which will determine the actions of systems. Who will be responsible, for doing what things, to whom, at which times, paid for in what ways, to what total amount? It is politically determined, ie. it is influenced by public perceptions; and it is about finding a balance between potentially opposing forces.

Target Clients

- Victorian CAMHS will develop specific sub-programs or Infant-Clinics on a regional basis. They will develop referral networks and provide a basis for training other staff in the identification of infant disorders.
- Specialist services are a limited resource. They will therefore focus on clients whose psychiatric problems are more severe or disabling, and more complex. However, since early intervention can prevent problems becoming more severe there is encouragement for indicative and selective prevention for populations at known risk.
- Milder problems or psychosocial adjustment difficulties are not the domain or specialist services, and will be managed by primary health, welfare and education services. Here, specialist services have a support and consultative role.

Key Service Linkages

- *New service systems will not be established for infants and mothers, Therefore existing service systems need to be re-engineered.*
- It is recommended that Adult Psychiatric Services Mother & Baby Units, who focus on mothers with severe psychiatric disorder, form consultative links with CAMHS staff involved in the Infant Clinics.
- CAMHS Infant Clinics also need to link with H&CS Primary Care Maternal & Child Health Nurses who work with other parent/infants. Liaison and consultation can assist education, early identification and referral to specialist services. Early Parenting Centres in the metropolitan regions may have a role in coordinating case management.

Roles in Service Network

- Joint Programs may be desirable for certain populations with multiple needs such as youngsters in short-term foster care.
- Primary Care is developing a community education strategy for positive parenting. There are possibilities for focusing on parents whose children are at high risk.
- Here education for children and adults about emotions, human development, difference between individuals, relationships, communication, problem-solving, etc. may be important.

Estimated Need and Resource Allocation

- *Resources are finite* and must be deployed wisely.
- The longer-term goal is "outcome-based" funding. Appropriate outcome measures will be required for all areas.
- What resources are required?
- Community Services target is 20 clinical staff (equivalent full time) per 100,000 children under 18 years of age.
- Research into outcome effectiveness is being encouraged as it is sorely needed.

Model of Service Delivery

- What is an appropriate general model for service delivery in the 1990s? Consumer/service partnerships to enhance services.
- To be accessible services need to be open to change. To avoid being overwhelmed they need to orient and educate referring agents to what are appropriate referrals - produce written referral guidelines.
- All cases need an accurate diagnosis, formulation and written case plan. Short-term treatments are first choice,
- Use least intrusive treatments in hierarchy of care

  - Community Out-patients
  - Outreach Out-patients
  - Day Programs
  - Inpatient Care

[7] **Dr. Peter Birleson** was seconded from the Royal Children's Hospital to Health and Community Services Psychiatric Services to manage the Child and Adolescent Mental Health Services Redevelopment Project. He worked in Paediatrics before training as a Child and Adolescent Psychiatrist.

- Secure Care

Infant Psychiatry Issues

- The development of a new field creates challenges and opportunities for its early practitioners, A critical one is resources.
- The argument of claiming 1/18th of total CAMHS community resources for clients in the first year of life may not be sustainable but could be a start.
- To operate as part of a more comprehensive service system requires the establishment of informal and formalised linkages, and agreement on respective roles. *Who will play the lead role in this?*

Veena Macarty[8]

Postnatal Depression Services Review NSW 1994

Postnatal depression has been recognised as a major public health issue in NSW. This was first highlighted in a report into midwifery services in this state and this has been further developed by identifying postnatal depression as a national health target for the year 2000.

The NSW Minister for Health in 1993 commissioned a report into services for postnatal depression in the state. A Steering Committee was appointed comprising members of relevant royal colleges and service providers to oversee the project and a project officer to co-ordinate the review.

A process of extensive consultation with grass roots workers and sufferers was undertaken to identify what services were available and how services could be best provided. Proposals from the Steering Committee were debated by the local working parties, and their responses were used to modify any proposals.

From this process of consultation coupled with evaluation of the relevant literature, a series of recommendations were formulated for postnatal depression services in NSW in collaboration with P. Boyce, E. Murphy & V. Macarty. Important recommendations include: provision of adequate training and identification of staff to manage women with postnatal depression; development of protocols for routinely screening the postpartum period; outlining management protocols; establishment of appropriate facilities for women with puerperal psychosis. Specific problem areas were identified in relationship to identification and management of postnatal depression among Aboriginal women and women from non-English speaking backgrounds.

[8] **Ms. Veena Macarty** is Special Projects Officer of the Family and Child Health Unit Policy and Planning Branch of New South Wales Health Department. She has had 13 years experience working with families in extreme difficulty adjusting to parenthood and recently reviewed post-natal depression services.

SUMMARY

Who are the consumers?

Clinicians	Academics	Policy-Makers
Extended Family	Depends on Service	Families who need to resume or maintain normal development.
Mother-Infant-Father 'Worried well'		
Babies who may present with physical difficulties	Include pre-natal population	Special needs infants
Problems we may want to forget	Caregivers and families of children 0-3	Parents with extremely serious mental illness or populations at risk CAMHS clients (0 - 18 years) Women with PND

WAS JOANNA A 'WORRIED WELL' CLIENT?

What are Service Gaps?

Clinician	Academics	Policy makers
Specialist infant mental health services (pre and postnatal) Links between services Generic services may not focus on the mother' s emotional needs or relationship difficulties with infants	Focus on maternal mental health Current services need to be reorganised/enhanced to develop integrated specialist services Antenatal classes Lack of skills of health care providers Parent information Home support	Integrated service system Gaps can be identified: • Under 6 years • Link between acute and primary **Identification** : Screening for PND and at-risk families

ARE THE SAFETY NETS PROVIDED BY EXISTING SERVICES SUFFICIENT? IF NOT, IS IT JUST A MATTER OF LINKING OR MODIFYING EXISTING SERVICES OR DOES SOMETHING NEW NEED TO HAPPEN? DID JOANNA NEED A SPECIALIST PARENT-INFANT SERVICE?

Who can do it?

Clinicians	Academics	Policy-Makers
Infant workers with a variety of background and further specialist training and experience Multidisciplinary team interested in infant and maternal mental health	Infant mental health workers People already in the workforce Parents working with professionals Specialised teams must be linked with primary health care providers	-The family -Multidisciplinary team **Who is Case Manager?** • Primary Care Service. • Link up existing services between Adult and Child Psych services, Infant Clinics, Maternal & Child Health Nurses • Training and identification of staff

IS EXTRA SPECIALIST TRAINING OR EXPERIENCE NECESSARY? WAS THIS THE PROBLEM IN JOANNA'S CASE?

What models are needed?

Who should fund it?

Clinician	Academics	Policy-Makers
Specialist services networking with Universal services Shared funding between psychiatric services and primary care Needs based services	Funding from every possible source Need to integrate services Further education of professional colleagues and the public on infant mental health Early recognition and access to day stay services	Infant clinics as subprograms of CAMHS and training other staff Links with Mother-Baby Units Education, training, research and evaluation Health promotion, early identification, intervention **Re-engineer existing services for funding** Hierarchy of care • Money exists, justification needed

CONCLUSION: INFANT MENTAL HEALTH SERVICES

WHAT GOVERNMENT DEPARTMENTS SHOULD BE RESPONSIBLE?

CAN WE STRETCH THE SAFETY NET OR WILL THE HOLES GET BIGGER AND MORE PEOPLE LIKE JOANNA SLIP THROUGH?

WILL FUNDING FALL BETWEEN THE NETS OF FUNDING BODIES?

In summary, we need to work together to extend the safety nets, with smaller holes and extra sections. The gaps will not easily be fixed; understanding and goodwill is not enough. We need to share the wisdom of the three groups here today to create a solution and then take responsibility to implement it.

SHOULD THE MOTHER NEVER KISS THE BABY

From a book by J.B. Watson, (the founder of behaviourism): Psychological Care of Infant and Child, published in 1928. Will our views seem as odd in seventy years?

There is a sensible way if treating children. Treat them as though they were young adults. Dress them, bathe then with care and circumspection. Let your behaviour always be objective and kindly firm. Never hug and kiss them, never let them sit in your lap. If you must, kiss them once on the forehead when they say good night. Shake hands with them in the morning. Give them a pat on the head if they have made an extraordinarily good job of a difficult task. Try it out. In a week's time you will find how easy it is to be perfectly objective with your child and at the same time kindly. You will be utterly ashamed if the mawkish, sentimental way you have been handling it.

If you expected a dog to grow up and be useful as a watch-dog, a bird-dog, a foxhound, useful for anything except a lapdog, you wouldn't dare treat it in the way you treat your child. When I hear a mother say: "Bless its little heart", when it falls down, or stubs its toe, or suffers from some other ill, I usually have to go for a little walk to let off steam. Can't the mother train herself when something happens to the child to look at its hurt without saying anything, and if there is a wound to dress it in a matter-of-fact way? And then as the child grows older, can she not train it to go and find the boracic acid and the bandages and treat its own wounds? Can't she train herself to substitute a kindly word, a smile, in all of her dealings with the child, for the kiss and the hug, the pickup and coddling? Above all, can't she learn to keep away from the child a large part of the day, since love conditioning must grow up anyway, even when scrupulously guarded against, through feeding and bathing? I sometimes wish that we could live in a community of homes where each home is supplied by a well trained nurse, so that we could have the babies fed and bathed each week by a different nurse. Not long ago I had opportunity to observe a child who had had an over-sympathetic and tender nurse for a year and a half. This nurse had to leave. When a new nurse came, the infant cried for three hours, letting up now and then only long enough to get its breath. This nurse had to leave at the end of a month and a new nurse came. This time the infant cried only half an hour when the new nurse took charge of it. Again, as often happens in well-regulated homes, the second nurse stayed only two weeks. When the third nurse came, the child went to her without a murmur. Somehow I can't help wishing that it were possible to rotate the mothers occasionally too! Unless they are very sensible indeed.

Certainly a mother, when necessary, ought to leave her child for a long enough period for over-conditioning to die down. If you haven't a nurse and cannot leave the child, put it out in the back-yard so that you are sure no harm can come to it. Do this from the time it is born. When the child can crawl, give it a sand-pile and be sure to dig some small holes in the yard, so it has to crawl in and out of them. Let it learn to overcome difficulties almost from the moment of birth. The child should learn to conquer difficulties away from your watchful eye. No child should get commendation and notice and petting every time it does something it ought to be doing anyway. If your heart is too tender and you must watch the child, make yourself a peep-hole so that you can see it without being seen, or use a periscope. But, above all, when anything does happen don't let your child see your own trepidation, handle the situation as a trained nurse or a doctor would,, and, finally, learn not to talk in endearing and coddling terms.

Nest habits, which come from coddling, are really pernicious evils. The boys or girls who have nest habits deeply imbedded suffer torture when they have to leave home to go into business, to enter school, to get married - in general, whenever they have to break away from parents to start life on their

own. Inability to break nest habits is probably our most prolific source of divorce and marital disagreements. "Mother's boy' has to talk his married life over with his mother and father, has constantly to bring them into the picture. The bride coddled in her infancy runs home to mother or father, taking her trunk, every time a disagreement occurs. We have hundreds of pathological cases on record where the mother or father attachment has become so strong that a marital adjustment, even after marriage has taken place , becomes impossible. To escape the intolerable marriage the individual becomes insane or else suicidal. In the milder cases, though, the struggle between young married people coddled in infancy shows itself in whines and complaints and the endless recounting of ills. Not enjoying the activities that come with marriage, they escape them by tiredness and headaches. If his wife does not give mother's boy the coddling, the commendation, and the petting the mother gave him, she doesn't understand him, she is cold, unwifely, unsympathetic. If the young wife does not constantly receive the gentle coddling and admiration her father gave her, then the husband is a [illegible]e, unsympathetic, un-understanding. Young married couples who do not swear a solemn oath to fight out their own battles between themselves without lugging in the parents soon come upon rocks.

In conclusion, won't you then, remember when you are tempted to pet your child that mother love is a dangerous instrument? An instrument which may inflict a never healing wound, a wound which may make infancy unhappy. adolescence a nightmare, an instrument which may wreck your adult son or daughter's vocational future and their chances for marital happiness.

AUSTRALIAN ASSOCIATION OF INFANT MENTAL HEALTH INC.

PRESIDENT'S REPORT

[illegible]is past year will be remembered as the year of the Pacific Rim Regional Conference of WAIMH. of which AAIMHI is an affiliate, and the dramatic increase in membership. At the end of the financial year we had 191 members, and 100 have already renewed their membership for 1995-6, -55 from New South Wales, 20 from Victoria, 10 from South Australia, 7 from Western Australia, 4 from Queensland, 1 from ACT, 2 from New Zealand and 1 from Germany.

As it was at the end of July, 1994 that we held the two day attachment conference, we had only just finalised the last accounts and expenses when we began the early planning for the WAIMH Conference.

The Pacific Rim Regional Conference, "The Baby, Family and Culture: Challenges of Infancy Research and Clinical Work" was held at the University of Sydney, April, 21-23. Dr. David Lonie, the Australian representative on the WAIMH Executive, took responsibility for the organisation of the Conference and was assisted by committee members, in particular our Treasurer, Marianne Nicholson. Margaret Ettridge was engaged to take responsibility for the day to day administration and to ensure the success of the event. Dr. Campbell Paul chaired a scientific committee in Melbourne, with the task of selecting the papers and arranging the three day programme. Over 70 papers and workshops were presented

David and Isla Lonie went to extraordinary lengths to provide for the social requirements of the overseas visitors. David and Isla, together with Marianne and Campbell, deserve our thanks for the hours of time and tremendous effort they put in to guarantee a wonderful conference Total number of registrations for the conference was 223.

Keryl Egan the founding President of AAIMHI in 1988 gave the opening address of the Conference and the plenary speakers were,

Dr. Hiram Fitzgerald from Lansing, USA, Executive Director of WAIMH

Di- Hisako Watanabe from Yokohama, Japan-

Dr, Antoine Guedeney from Paris

Dr. Charles Zeanah from New Orleans, USA

Mrs. Dilys Daws from London, United Kingdom.

Dr. Mary Sue Moore from Colorado, USA.

Dr. Eric Rayner from London, United Kingdom.

Dr. Ann Morgan from Melbourne, Victoria.

The Victorian branch collaborated with the Melbourne Institute for Psychoanalysis to present a one day Colloquium on Infancy and Psychoanalysis, immediately following the Sydney Conference. From all accounts it was a very successful day, a summary of which was published in the last newsletter

It is appropriate at this point that I thank our editors of the Newsletter for another excellent four editions. Two editions covered the Plenary sessions of the Pacific Rim Conference and the Melbourne Colloquium, while earlier editions gave us the opportunity to read papers by Dr Sula Wolff and Norma Tracey. Thank you, David & Isla.

The opportunity must also be taken to ask for articles from you, our members. We know that many of you are doing interesting work that others would enjoy and benefit from reading about. Alternatively, you may have some concerns you would like to sit and get a response to, or a book you have found helpful and you are prepared to review. We would love to hear from you. I'm sure we could play a part in making the Newsletter a more effective vehicles for the dissemination of information.

Discussions re establishing independent state branches while maintaining a national organisation have continued through the year, The Victorian branch are proposing a small National secretariat with separate State committees who will collect their own membership monies and send a proportion to the National body. This proposal is currently being reviewed by our solicitors. The matter will be kept on the agenda until resolved. At the last committee meeting it was resolved to send to the State branches a proportion of the annual subscription to help in the setting up of the branches. Perhaps each of the state branches or groups could send a brief statement of their scenario to put us all in the picture.

Putting on two conferences in 9 months has taken a lot of the committee's time and energy over the past two years, I feel it would be of value to us all to re-establish smaller specific topic seminars and workshops appropriate to particular needs. Of course, many members may be conducting such events already wearing other hats. If so please let us know so we can determine if the need is there and if it is something which should be addressed by AAIMHI.

We have written into our constitution a two year limit on occupancy of the position of President so I will vacate the chair this evening. I have enjoyed the past two years, in particular getting to know the various committee members better as we worked closely to achieve particular goals. It is a great committee to be part of and we are always looking for new enthusiastic members.

Increased understanding of the needs of infants and their carers of Australia is a worthwhile commitment.

Thank you.

Beulah Warren MA(Hons) MAPsS
President AAIMHI 1994-1995.
25th October, 1995.

VISIT OF DR PATRICIA CRITTENDEN

March 11-22, 1996

Dr. Patricia Crittenden of the Family Relations Institute, Miami, Florida, will be visiting Australia in March, 1996.

Dr Crittenden is well known for her research in Attachment Theory and particularly with maltreated infants. She will be conducting a 10-day training course in Adult Attachment Assessment and a two-day workshop on attachment and psychopathology in Sydney. Places for both will be limited so early expression of interest is advisable.

Enquiries: Associate Professor Bryanne Barnett
Dr Louise Newman
Tel: (02) 827 8011

AAIMHI Committee

Elected 25 October, 1995

PRESIDENT	Marianne Nicholson, S.R.N., S.R.M. (London), M.C.
VICE PRESIDENT	Beulah Warren, M.A. (Hons).,M.A.Ps..S
SECRETARY	Marija Radojevic, B.App. Sci.(O.T.), B.A. (Hons), M. Clin. Psych., Ph.
TREASURER	Penelope Cousens B.A. (Hons), Ph.D
MEMBERSHIP SECRETARY	Mary Morgan B. App. Sc (O.T.)
COMMITTEE MEMBERS	
A/Prof. Bryanne Barnett	M.D., F.R.A.N.Z.C.P.
Julie Campbell	M.A.
Kerry Lockhart	R.G.N.,C.M.,C&FHN (Cert),G.D.P.S.M. (Health)
David Lonie	F.R.A.N.Z.C.P.
Isla Lonie	F.R.A.N.Z.C.P.
Louise Newman	B.A. (Hons), F.R.A.N.Z.C.P.
Deborah Perkins	M.B., B.S., B.Sc., Dip. Paed.
CORRESPONDING MEMBER	
Elizabeth Puddy	M.B., B.S., Grad. Dip. Parent Education and Counselling. Cert. Fam. Therapy

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH.

SIXTH WORLD CONGRESS

Tampere Finland, July 25-28, 1996

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