THE AUSTRALIAN ASSOCIATION FOR INFANT MENTAL HEALTH

AFFILIATED WITH THE WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

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FROM THE EDITORS

Welcome to another edition! We are entering an exciting and busy time with our forth coming National Conference in Sydney on 4-6 September. Mary Sue Moore, Janet Dean and John Byng-Hall will all be visiting Australia for the Conference. David Lonie's Conference Update gives futher details.

There have been important changes for AAIMHI with the adoption of a national constitution at a Special General Meeting on 24 June. Isla Lonie writes to explain what these changes mean.

As well this newsletter contains some interesting reading. Hope to see as many of you as possible in Sydney.

Paul Robertson & Sarah Jones

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Towards better beginning: Using attachment theory and research in preventative intervention.

Report of Lecture by Dr Martha Erickson at the 1997 Australian Association of Infant Mental Health Conference in Adelaide October 1997

Prepared by Pam Linke and Sarah Jones

Dr Erickson presented a broad view of how attachment theory and research enable workers to work preventively with parents and children, particularly with families with new babies. Erickson drew on three bodies of work:

- her own longitudinal study conducted with Drs Alan Thrope and Byron Eglin (University of Minnesota).
- the work of the STEEP Program (Steps Towards Effective Enjoyable Parenting) developed with Dr. Eglin
- and an adaptation of the STEEP program for preventive intervention for families not necessarily wanting help but who have high risk circumstances in their lives.

Much of Dr. Erickson's work has focused on hard to reach, hard to engage families who are not particularly motivated about their parenting but eager, under the right conditions, for "someone to share their journey with them". Dr Erickson commented that there is a very large movement in USA as well as in Australia to using paraprofessionals or volunteers to do important work with new parents. Part of her work has been in communicating attachment theory and research to multiple audiences of professional and paraprofessionals.

Preventive Intervention

In thinking about preventive intervention Dr Erickson believes that we need to think about those risk factors and protective factors that characterise all our lives. There are common sorts of risk factors such as poverty, single parenthood, poor social

support, substance abuse or child abuse, and maternal postnatal depression. In addition, she commented, there are many two career families with parents lacking in the time and energy required to provide the emotional and physical care children need. Erickson believes that we ought to consider those kinds of families as also having risk factors. Her model identifies a need for workers to have a broad framework in terms of risk factors in socioeconomic groups, cultural traditions and styles of parent-child interaction.

Erickson stated we may not be able to change or eliminate some of the risk factors but we can certainly do something to bring in or build upon protective factors that will help improve the balance. There are some common factors identified in almost every study on resilience. Always at the top of the list as significantly influencing childhood resilience is the centrality of a child's relationship with a caring supportive adult. Resilience studies do not always refer to attachment theory however, but they always stress as paramount the availability of a caring supportive adult. A key role is given to the individual's relationship with his/her parent(s) who ought to be at the top of that list. It is not only parents but also the presence of other supportive people who aid a young person's healthy development. Dr Erickson believes that as a framework for preventive intervention the obvious starting point is to try to promote secure parent- infant attachment and to do that as early as possible.

In addition she asks what is it that an individual brings into their relationships not only with their child but also with other people in their lives? And then specifically what is it that the parents bring into their interactions with us as workers/service providers? One of the things that Dr Erickson has found in working with service providers in different settings is that it is very easy to be caught into patterns of playing out people's own personal history, without having an understanding about how their attachment history affects their interactions. She believes that it is very important to be consciously thinking about how we can we use ourselves in relationships and how can we help people discover a new way of being in a relationship. We need to use that knowledge to remind ourselves not to just run the other way if we find that someone's behaviour is pushing us away. In the STEEP program the workers set out to stay involved with the families even when some people behaved in ways that pushed the workers away. As long as the family said they were willing to be in the program the workers kept coming back. They found that ultimately workers did trigger a shift in the way the parents were thinking about themselves and their willingness to engage in the work. Workers could then focus on some of the more specific targets related to parents' capacity for sensitivity and attachment.

The Longitudinal Research

Dr Erickson's research team followed up a group of babies born in the mid 1970'ies to the present time. They found with the securely attached children, as they followed them into preschool and elementary school, these children had more confidence, were more connected with their peers and were more cooperative with adults than children who did not have that kind of secure foundation. This then meant that the teachers and others were more eager and willing to treat those children in the same sensitive way that they had been treated before. These children tended to elicit a better response, both from peers and other adults. So the long term impact of an early secure attachment is not that an early attachment at aged one causes great behaviour at aged 15, but it puts the children on a developmental trajectory by which they behave in ways that sets them up for more good interactions with others. There appears to be an additive effect for these children in that other people treat them more sensitively. These securely attached children find each other and form a nucleus of a positive peer network and again they are behaving in ways that reinforce their security. They have what is called in attachment theory a "working model of other and self".

However as any child will discover there are people who are not going to respond in the ways in which they have come to expect. Everyone isn't going to treat them as well as that nurturing caregiver. They will run into adults who are insensitive; a teacher, for example, who is really unresponsive or harshly critical. The secure child can experience negative responses and yet not change her internal model to adapt to that new experience. The child will find ways to fit that new experience into what is known without changing its positive working models. This is a critical developmental concept to think about both with respect to the secure children and with respect to the anxiously attached children.

In the longitudinal research Dr Erickson looked at children who were securely attached in infancy, but developed significant behaviour problems later on and found somewhat predictable kinds of things that account for that change. If children come from a very

secure family environment and go out into a world that continually bombards them with messages that they are not worthy of good care and that they are not people of good value it is a lot to expect of any family to be able to hold the child together. This may occur with children of colour or from a different culture. Thus a positive early attachment is not a guarantee against later problems but it is a source of resilience on which we ought to be focusing.

Erickson went on to discuss anxious-resistant or insecure- resistant children whom she proposes have a degree of hesitancy in their attachment behaviour. This is often the product of inconsistent and unpredictable care, where children sometimes get a good response but very often they do not, so they keep working harder to try to get it. These children are observed in later situations to show common patterns. They show up looking visibly needy and dependent, requiring a lot of attention and a lot of help in ways that you wouldn't expect at their age. We find that the teachers in preschool or elementary school see that neediness, and in fact they often really start to try to correct the neediness in these children. They really try to be that significant adult who is going to tip the balance, but then after a couple of weeks when they look around and see 25 other children in the classroom they realise they cannot keep putting everything into the one child and they step back. How does the child experience that? It feels like rejection and inconsistency and so again the children behave in a way that make them vulnerable to the same kind of treatment. These children are also not popular with their peers and in fact sometimes their peers will connect with them quickly, superficially, but burn out on them quickly as well. Even five and six year old children can find the whiner and the clinger and the child who is so needy, and pull away from them. The challenge to us as we look at the longitudinal patterns is to really think about what it is going to help if this pattern has been in place for three, five or ten years. How can you, through a relationship, give a child a different kind of experience that contradicts their expectations. In short what is it that will begin to change their model of relating? That does not happen quickly and the longer those patterns have been in place the harder the task. We need to be conscious about not getting "sucked in" and then pulling back; this has been a salient issue for us when working with high risk multi-problem parents.

Interventions with high risk families

It is important to consider what are the multiple pre-conditions that create a context for sensitive attachment. It is not possible for workers to just go in and try to increase the parents' sensitivity, although that would certainly have value. It is also important to deal with those factors that either support or hinder ongoing sensitivity, mindful that one does not get you caught in the families' crises. This is one of the most enormous challenges in this kind of work and when the work is done by volunteers or paraprofessionals, who have too little support and consultation. The hazards are considerable. In the course of Dr Erickson's research they included teachers who were really conscious of contradicting these children's past expectations in relationships. There were two approaches identified

(i) one was for the teacher to be really predictable, promising only that which was possible to continue to deliver

(ii) the other was making some age appropriate maturity demands.

Many of these children had learnt from as young as six months olds that they were not "competent". They learnt that when they give a signal and cry for comfort or reach out their arms and smile and babble they are not effective in gaining positive response from attachment figures. Thus this start in life gave the infant not only a lack of trust in the reliability of their caregivers' responses to them, but also with a basic sense of powerlessness about their own ability to be a competent and successful initiator in "a good enough relationship". Thus it is important to give them some "competence opportunities". A child's capacity for competence behaviours are identified as having an important protective factors. When these earlier children are followed up into adolescence it seems they are vulnerable young people easy exploited. They are almost never those who are act out violently; they do not grow up to be perpetrators of violence but targets for other children's violence.

Children observed to have an anxious-avoidant attachment have very often started out with chronically unresponsive caregivers who never respond to their signals and cues in predictable ways. Rather than develop a heightened anxiety with intense efforts to engage caregivers, they are "shut down" early. In later settings they are most likely to be children showing significant behavioural problems. They show a striking lack of empathy. Teachers and others who work with them say things like "I was really pleased when she didn't show up at school, I hate to admit that but it's really a good day when she

doesn't come." Again these children have developed in ways understandably adaptive to their care giving environment. They have protected themselves from attempting intimate relationships with the inevitable concomitant disappointment. The avoidant behaviours become habitual patterns repeated in subsequent relationships. but as they take that into a new setting it makes them easy to have that played out again so that people pull away from them and their peers are not too keen on them either. Sometimes they are afraid of them, sometimes they just pull away from them.

In general not a lot is known about how to improve children's' capacity to relate other than the generalisation of offering a relationship to give them a different model. Notions of improving competence and skills focus is very important with these children. The relationship as a potential for change is very powerful. However we need to understand how terribly confusing it is for those infants with disorganised attachment patterns where their caregiver who is supposed to offer protection is also a source of threat.

Dr Erickson's conducted research with Dr Megan Gunnar on cortisol levels in children's saliva. They found that those children who showed high states of anxiety during the strange situation procedure also measured with high cortisol levels in their saliva. Studies, such as this, looking not only psychologically measurement but also physiological measurement should deepen our understanding of the sensitivity of parent infant-interaction. They highlight how important it is to intervene preventively and early.

Context for attachment and sensitive parenting

(i) parents' expectations and knowledge of child development

If we can aim our interventions at parents prior to the birth of the first child we may be able to assist with not only the soon to be born child, but on subsequent children. Here is an extraordinary window of opportunity for improvement. One of those simple messages revealed in the research has to do with the influence on parents of their expectations about becoming a parent. Parents need to have realistic expectations about child behaviour. There is a need for promoting parents' knowledge of child development - basic sorts of information may be missing. This is important at all ages but it emerges as being very important in the second year of life when parents get into discipline and guidance issues. Problems arise when parents think that children as young as six months, for example, are capable of sitting down in front of the TV and entertaining themselves for hours.

(ii) providing meaning for key developmental behaviours

Some parents regard their children's behaviour as having a specific kind of intent - ie. attributing the motives of an older child to an infant. For example the parent who thinks that an infant is being wilful when she has trouble settling. What seems to be important is helping parents' understanding the meaning of certain key developmental behaviours; one of these is the significance of the "separation protest". So that, for example, understanding what the separation protest means and its place in the course of development becomes a really critical focus for preventive intervention. Autonomy of the infant is another major issue that comes up again and again. Before the second year it becomes important to look at children's self directed behaviour and to respect their emerging autonomy. For parents if this takes the form of negativism and punishment for a child's non-compliance it can be a time when an anger cycle develops.

(iii) gaining an understanding of the infants' perspective

One of the things that parents need to be introduced to is seeing life through the eyes of their child - what Erickson calls "perspective taking". Dr Erickson believes that the baby only wants one thing in the first year of life - to know that she is able to have her needs met and that she has a way of broadcasting those needs in order to do so. In the STEEP program Dr Erickson's team have found that writing letters to parents in the voice of the baby has been very effective in achieving this. The use of video recording is an adjunct to this process.

(iv) Social Support

One of the other major variables that create the context for sensitive or insensitive handling by parents is whether these parents feel part of a socially supportive network. Service providers are major sources of support. However it is critical to take a long term view of who and what is going to sustain families as the child(ren) get older. We need to help families develop lasting supportive networks that are more natural; informal and formal. Many multi-problem families are in social and familial

networks which work against the best interest of the parent-child relationship. Some young families are isolated; connecting them is critical. Others are very connected and say they are supported but exist in a dense network of transitory people moving their lives. If those people are undermining the messages the parents need, they maybe re-enforcing an insensitive style of relating to their children, for example those parents who are substance abusers or in abusive relationships. These are some of the most challenging issues in preventative intervention. Parents need to learn how to identify positive sources of support, to reframe the way they think about support and develop the skills and confidence to access that support effectively. When thinking about aspects of preventative intervention we need to think about parallel processes; ie. looking at who reassures the workers as they try to reassure the parents as they try to reassure the children. In each step of the intervention those layers and parallel processes need consideration.

In Dr Erickson's longitudinal study 47 women were identified who had been abused in their childhood. Forty per cent of those women were abusive or neglectful to their own first born children. Another 30% were not identified by Child Protection Services but were not providing the kind of optimal care for their children or even "good enough" care. There were poor inter-generational familial patterns bought out in their parenting. The other 30% were women who cared well for their children. The three factors that characterised those parents able to care well were:

(i) they themselves had a caring adult available to them in childhood.

'How can we make sure that children get that care somewhere if they are not getting it in their own families?)

(ii) they had a supportive partner when they became parents

(iii)they had come to some resolution in regard to their own childhood experience (often through at least six months of therapy).

Thus in addressing these issues in preventive intervention is important for parents first to face the pain and acknowledge the ongoing influence of past deprivations. Understanding why caregivers behaved as they did is controversial in clinical circles because it raises issues of whether the task for the child-victims of abuse is to forgive their perpetrators. Erickson concludes it is important to step back and take a look at the factors that affected those people who cared for us well and not so well. She feels that is useful in helping people move on. It is important to help people to think that you can choose things you want to carry forward and choose things you want to leave behind. Then the task is mustering all the available resources to help people live out those choices.

STEEP evaluation.

STEEP combined home visits and group interventions for very high risk first time parents from the second trimester of pregnancy to the child's first birthday. Independent evaluation showed that parents had a more positive regard for their child, more delight in play with the child, better understanding of the child developmental needs and more appropriate home environment. But they found no effect on the quality of attachment when those children were 12 months of age. There were a high number of disorganised attachments in the early intervention group. This was of concern because above all they wanted to do no harm. They found however that by 18 months more of those families who received the intervention were moving towards more secure attachment. Whereas in the control group they were moving towards more anxious attachment. Dr Erickson believes that part of the problem was that they ended the intervention just as the parents were dealing with the fact that the babies were becoming toddlers, and at a time when the workers were just making a connection with the parents who had had low trust in them in the first place. Parents may have perceived the workers as pulling away support just at the time when the hardest stage of parenting was beginning. The interventions have, therefore, continued into the second year of life and evidence from some evaluation shows positive changes in that second year. The parents' high level of commitment to the facilitator seemed to be the factor that really counted for progress. A finding which again highlights the importance of the relationship in the process of change.

they could do to increase their chances of their child being like what they conceptualised. In addition to this parents were asked to recall who was influential in their lives and what memories, good and bad, stayed from this person.

Determinants of parental sensitivity and insensitivity

Martha Erikson outlined the important points for assessing parental sensitivity\insensitivity. Key determinants of **parental sensitivity** are the parent's ability to recognise the child's capacity to signal needs. Assessing whether parents accurately interpret cues and signals, respond contingently to the infant
(infant lead) and are consistent and predictable over time is the clinicians task. She noted that it was important to put consistency in a realistic framework for parents; consistency does not mean hyper-vigilance.

Key determinants of **parental insensitivity** are parental detachment, being unavailable, misinterpretation of cues and signals, and parental intrusiveness. Parental insensitivity may stem from a variety of sources, including erroneous beliefs (eg. the "spoiling" myth), lack of knowledge, unwillingness to respond, and/or inability to respond because of personal stress or depression.

When looking at a maltreated sample of children whose parents were observed to be psychologically unavailable and detached Martha Erikson found that those children experiencing this in first 2 years of life did very poorly in comparison to other children. Misinterpreting cues and signals often occurs with playful activity. These parents often lack an understanding about what play behaviours meant. Intrusiveness occurred sometimes out of a lack of knowing what to do, driven by the parents own needs for comfort and contact. Thus, parents often resent needing to respond to the infant.

In order to address such parental insensitivity, it is important to help parents understand an infant's goal directed behaviour, that is that infants are purposeful. A danger with this is that parents can over assume intentionality. Workers need to focus on how the infant's competence emerges from a very early age. A useful way of demonstrating this is through **therapeutic video taping.** This can be used to tape record basic childcare tasks eg. bathing, changing nappies, feeding, new accomplishments of infants, favourite activities of the infant, and staff initiated experimentation with appropriate toys. It is important to make the video recording non-intimidating. Many parents in the STEEP program enjoyed the video taping. Parents receive a copy of the tapes at the end of the program.

From her experience of video recording Martha Erikson highlighted a number of advantages of using video recording. It is found to:

- promote self-evaluation and self-affirmation,
- validated the parent as expert on their own child,
- focussed on strengths of both parent and child,
- provided a permanent record for monitoring change,
- personified the infant,
- enabled parents to gain a different perspective,
- affirmed individuality of the child,
- conveyed notion of reciprocity and mutual influence,
- engaged extended family and friends,
- and is useful for supervision of other workers.

During the workshop participants were asked to view a video of a mother and an infant interacting. She asked participants to highlight the strengths in the mother and infant. Then she asked what the participants would like to see done differently and how they could give feedback to the mother to build on her strengths.

Another aspect of the STEEP program was providing parents with a knowledge of child development. This included parents having realistic behavioural expectations of the child, an understanding of key developmental behaviours, and the ability to see through the eyes of the child. Parents required a deeper understanding of the meaning of certain critical behaviours. Some parents don't understand the meaning of their child's reaction. Martha Erikson proposed the clinician often need to enable to promote parent capacity to see things from their child's point of view. Martha Erikson identified a number of useful strategies for re-framing infant behaviour with parents. These included getting the parents to experience, through exercises, what it is like to be an infant and speaking 'through the voice' of the infant.

Martha Erikson highlighted the importance of social support for 'at risk' families. Parents need to have access to both formal and informal resources, and the skills and confidence to be able to access these

resources. It is important to identify what resources parents do have and the barriers that may be preventing parents from gaining access to resources.

The afternoon session finished with Martha Erikson providing participants with some of her knowledge and expertise in how to run parenting groups for 'at risk' parents. She highlighted the need for support and training of group facilitators and presented a number of useful clinical tools and ideas for clinicians wanting to set up or facilitate a therapeutic group. Issues that group facilitators encountered included cultural issues, domestic violence and abuse. Using appropriate people from a person's own culture if the need arose was proposed. Allowing parents an opportunity to reveal their own experiences of abuse was very useful. In the cases of domestic violence it was important to engage abusive men in the program as well.

Martha Erikson concluded her insightful workshop by asking participants to think about how they can help to create a socio-political climate that values work with parents and infants.

"Parent/Infant Psychotherapy. Intergenerational Transmission of Psychopathology: How to Intervene".

Report of Workshop by Dr Hisako Watanabe on Sunday 26 October at Australian Association of Infant Mental Health Conference in Adelaide

Prepared by Robyn Leeson

Dr Watanabe started by explaining that the transmission of psychopathology from generation to generation is a very complex issue, as is the question of how to deal with it, recognising that the therapist herself can easily be caught up in the relationship.

As a background she quoted from the work of others in the field, including Frieburg, Cramer and Stern. She discussed the concept of ghosts in the nursery - visitors from the unremembered past of the parent. By resolving these early conflicts in the mother, hopefully intergenerational transfer can be prevented.

The infant is very sensitive to the mother but has such an impetus for growth and healing that he or she takes off rapidly once impediments to forward movement are removed. The challenge is to find out what holds them back.

The infant's basic sense of self is built up over time as she or he responds to the mother's subtle and repetitive cues. The mother conveys to the infant what is expected of him or her and what frightens or pleases the mother. This happens in a duet with the baby's receptive responses. As the mother and baby look at each other, they mutually see in each other the state of mind of the other and their own state of mind as mirrored in the other's eyes. Any psychic trauma of the mother thus enters into this reciprocal system and therefore into the developing self of the infant.

This system is complicated by the influence of the father and his background experiences on the mother and hence on the infant, and the influence of the community and wider society on the whole family.

On another plane there is the interacting triad of what is real for the baby, the mother and her parents, what is imaginary for all of these and what is fantasy ("fantasmic"). Dr Watanabe described the imaginary level as referring to the imaginary baby the mother had in her mind as a girl, growing up and experiencing her mother's parenting. She still harbours this image as she sees her real baby. The fantasmic refers to memories, deeply buried in the subconscious, of the mother as a baby and her experiences. These are brought up, but still at a subconscious level, by the real baby in front of her. The mother moves between the real, imaginary and fantasy levels as she interacts with the baby and also with the therapist. When the therapist steps into this triad she is immediately involved as the mother projects all three levels onto her. The therapist, in an authority role, needs to keep in touch with reality, but in identifying with the baby may be seen by the mother as projecting criticisms onto her. The mother may see the therapist as perpetrator and may put herself in the position of a baby being abused and abandoned.

It is vital that the therapist is aware of the mother's urge to project unwanted traumas on to her. By

observing the mother's response to the therapy situation the therapist can work out how to deal with it. This constructive use of counter-transference can help break down negative intergenerational patterns.

Dr Watanabe illustrated these points with three cases, recounted with her usual warmth and good humour and illustrated with video segments.

In all these cases the mothers' unhappy childhood experiences (usually involving abandonment and rejection) were causing difficulties in their relationships with their young children, difficulties that were reflected in their children's behaviours. The therapist was drawn into these situations in a variety of ways and used this experience both to get to the basis of the problem and in a therapeutic way to help the parents overcome the difficulties.

REPORT FROM THE SPECIAL GENERAL MEETING IN SYDNEY WEDNESDAY 24 JUNE CONCERNING CONSTITUTIONAL CHANGES FOR AAIMHI

Those of us who were present at the Special General Meeting held in Sydney on Wednesday June 24, 1998, threw up our hands in the air and cheered as the Special Resolution that the Amended Rules for The Australian Association of Infant Mental Health (Inc.) be adopted was passed unanimously by a quorum of members. We were also pleased to receive a number of postal votes which were also unanimously in favour of passing the resolution. On behalf of AAIMHI, I should like to thank all those Members who took the trouble to communicate in this way for their interest and involvement.

As you will know, the new rules will now enable us to become an Australia-wide organisation with State Branches, many of which have already been formed. Some of you may be wondering what these changes mean in practical terms, so I thought it might be helpful to set out what will be happening in State Branches, and how this will relate to the National body.

1. The National Committee consists of (a) One representative nominated by each State Committee, and (b) The Regional Vice-President of the World Association for Infant Mental Health, who is currently Dr Campbell Paul of Melbourne. The Regional Vice-President is elected by the Committee of the World Association for Infant Mental Health in the course of a General meeting during its International Conference, currently held every fourth year.
2. Each State Branch will need to elect a representative to the National Committee and to attend the National AGM scheduled this year to coincide with the Annual Conference in Sydney on Friday, September 4th, 1998.
3. When the National Commmittee meets, it will elect the President, Vice-President, Treasurer and Secretary from its membership, and shall appoint one of the office-bearers as its chairperson.
4. Each State Branch will now need to hold a list of Members, and to send out notices for annual fees. These are currently set at $40.00, of which $20.00 is sent to the National Committee to fund the newsletter.
5. Each State Branch will in future process applications for membership, and where the applicant is successful, will notify the National Secretary who will then enter the applicant's name on the register of National members, whereupon the applicant will become a Member.

Finally, I should like to remind Members that the AGM will be held in the course of our Annual Conference, which is being held in Sydney this year from Thursday September 3rd through till Saturday September 5th, and is to be on the theme of **Trauma in Infancy: "With no Language but a Cry."**

I hope that we will all have a very happy and fruitful time working together for the wellbeing of infants and their parents and caregivers, and for the the growth of professional and public recognition that infancy is a critical period in the development of social skills and a secure sense of self.

Isla Lonie,
President.

DR PAT CRITTENDEN ATTACHMENT WORKSHOPS

PERTH MARCH-APRIL 1998

Report from Dr Noel Howieson

Dr Patricia Crittenden returned to Australia for the third set of workshops on the dynamic-maturational approach to attachment theory in March 1998. This year the workshops were held in Perth but locals were outnumbered by visitors who came from New Zealand, Queensland, New South Wales, Victoria and South Australia.

The dynamic-maturational approach is directed particularly at the need to differentiate, with "at-risk" and clinical populations, among the patterns of disturbance (ie among those classified as "cannot classify" or 'disorganised" in other approaches to attachment theory.) This year a two and a half day workshop was given on applied theory for social workers, nurses, psychologists, and others who make decisions regarding child-parent relationships and children's risk for psychological or behavioural disorder. In addition a research oriented presentation was given at Edith Cowan University.

Other professionals attended the intensive training with various attachment instruments. One group which included participants from all over Australia and New Zealand attended the two week training in the use and scoring of the *Adult Attachment Interview.* In addition to learning the Main & Goldwin scoring system these researchers and practitioners were introduced to the dynamic-maturational clinical system that Crittenden has developed. This system of discourse analysis describes the self protective strategies used by disturbed adults who experienced self threatening danger as children and who carry their early distorted mental processes into their adult functioning.

A second group who had previously completed the two week training in Perth or Sydney undertook one week's intensive instruction in using the dynamic-maturational system for analysing the Adult Attachment Interviews of adults in treatment. These researchers are now working to achieve reliability in the differentiated classification of clinical samples.

A third group attended a two week course on *The Pre-School Assessment of Attachment.* This group studied videotapes of pre-school children in the "Strange Situation" and applied the maturational-dynamic system to classify their behaviour in this situation. As with the AAI courses the emphasis was on clinical populations and implications of the classifications for diagnosis and treatment planning. This group is also preparing to achieve reliability on this procedure. The tapes used for this will be compromised entirely of Australian children to facilitate adaptation of the procedures to unique features of the Australian culture.

Plans are under way to have Dr Crittenden return next year to Sydney and Perth. Anyone with interest in these courses to be offered in Australia at that time or in any other country should contact Dr Crittenden by fax on 1-305-251-0806 or by letter at F.R.I. 9481 S.W. 147 St Miami Fl 33176, U.S.A.

CONFERENCE UPDATE

The Australian Association for Infant Mental Health Fifth Annual Meeting, will be held at the Rex Hotel, Sydney on Thursday, Friday and Saturday, 3-5 September, 1998. The theme for the Meeting is "With no language but a cry": Trauma in Infancy.

The quotation is from Alfred Lord Tennyson:

Behold, we know not anything;
I can but trust that good shall fall
At last - far off - at last, to all,
And every winter change to spring.

So runs my dream: but what am I?
An infant crying in the night:
An infant crying for the light:
And with no language but a cry.

We are, of course, hoping that in early September in Sydney, our winter will be changing to spring and that we will be able to welcome you to some really fine weather. These two stanzas however are saying something which I think is very important for those working in the Infant Mental Health field. Trauma in infancy is of the utmost importance for future development both physical and emotional. We know something about the long term effects of trauma from

working with children or adults who have been traumatised earlier in their life. The way in which trauma effects both the neurophysiological and structural development is being slowly pieced together. The research in this area is allowing us to understand more about normal development as well as abnormal development and the relationship between 'mind' and 'body'. Eventually the significance for us as clinicians is how does the research inform our interventions.

The Fifth Annual Meeting sets out to explore some of these issues. It is spread over three days, and we hope that most people will attend all three days. A more detailed program will be available shortly, but the essence of the Meeting is as follows.
Day One, Thursday 3 September, is devoted to the effect of trauma in infancy, and will consist of work presented by Mary Sue Moore and Janet Dean. The model used is neurodevelopmental, but the emphasis will be on how this informs clinical work. The impact of trauma on the clinician will also be explored. Video material will be used to illustrate the approach to the management of trauma in infancy.

Day Two, Friday, 4 September, will open with a plenary address by Dr John Byng-Hall which will link attachment theory and family therapy with particular emphasis on infancy. There will then be two 'streams' of presentations. One will start with clinical papers around post-natal depression, followed, in the afternoon, with a workshop on interventions with young infants and their families. The other 'stream' will look at issues of what might be regarded as the public face of AAIMHI. A workshop on Advocacy in Infant Mental Health in the morning will be followed in the afternoon by a workshop on training and education. An underlying question here is about the direction as an organisation we should take in fostering the conditions which might facilitate healthy emotional development.

Day Three, Saturday, 5 September also starts with a plenary speaker, Professor Barry Nurcombe, who will present some work on a project in which he was involved in Vermont - a home based intervention program for low birthweight infants. There will then be a number of 'streams'. Two workshops, one which will offer participants an opportunity to consider and prepare to run multi-disciplinary mother-baby groups using the Parent and Infant Relationship Support group model; the other will present the ongoing work of a Sydney group in the area of the trauma of parents and their infants in neo-natal intensive care units. This work which has already led to a number of published papers, and this workshop will be a part of the continuing dialogue which is allowing an understanding of what is trauma and what it means for infant and parent. The third stream has some clinical papers in the morning and a symposium on Fathers in the afternoon, which will be convened by Assoc Prof Graeme Russell who was one of our plenary speakers at the WAIPAD Meeting in Melbourne in 1991. Also on Saturday, John Byng-Hall will be holding a workshop under the joint auspices of the NSW Family Therapy Association that will occupy the entire day. It is hoped that this workshop will be attended by family therapists as much as by those working more with infants, as there is a risk that the infant who 'has no language but a cry' often gets sidelined in therapies where words are more privileged than cries.

David Lonie, Conference Convenor.

FROM THE DESK

COMMENT FROM DR CAMPBELL PAUL WAIMH REGIONAL VICE PRESIDENT

The last few months has been an interesting time again in our region. The workshop by Heidelise Als was extremely well received in Sydney and stimulated much discussion. In June a visit by Jay Belsky highlighted some of the difficult and depressing issue( ) to do with long day care for very young infants.

We also have had visits from Infant Psychiatry colleagues from French speaking countries. D( ) Francoise Muller from Paris and Dr Marie Odil( ) deMontclos who is in charge of child psychiatry and infant mental health for New Caledonia. It was very productive to meet with overseas colleagues and to hear in particular about the provision of services in our own particular region. We hope this will lead to some ongoing contact and collaboration. Dr deMontclos was a guest at the Royal Australian and New Zealand College of Psychiatrists Annual Congress and was able to meet colleagues from New Zealand as well as Australia to develop further connections.

The Congress was also important in that there was a large well attended symposium devoted to the issues of Infant Mental Health and Perinatal Psychiatry. This

continues the critical dialogue there is between those in adult mental health who are working with mothers and their partners and those of us in infant mental health who have the particular perspective of the baby. This dialogue about areas of overlap and the need to develop further collaborative approaches to service and research will continue.

Much energy continues to be put into the forth coming Conference in September and some of the associated meetings. The four main speakers now are Dr Mary Sue Moore, Dr Janet Dean, Dr Barry Nucombe and Dr John Byng Hall. It should be a very important conference focusing on a particular group of infants and families at great need.

Training in infant mental health continues to move ahead with the establishment of Infant Mental Health Training Program through the Institute of Psychiatry in Sydney. Members of the Association are continuing to present at conferences and workshops around the country from Perth through to Townsville.

The final amendments and arrangements have been implemented for the adoption of our national new constitution. This looks a confident and long awaited development which will facilitate communication and new enterprises in Infant Mental Health through the country. *(Editors note: See above report from Isla Lonie regards outcome of the Special General Meeting.)*

STATE NETWORK NEWS

NEW SOUTH WALES

Kerry Lockhart

Firstly, our postal address has been changed, Double Bay postal code is now 1360. The Heidelise Als seminar was very successful.

The Postgraduate Infant Mental Health Programme has now been set up at the NSW Institute of Psychiatry. There are already 10 applicants and the course will go ahead. The organisers are to be congratulated for this magnificent achievement.

The AAIMH Conference in September is well under way. It is now clear that there will be a three day conference. Participants wishing to attend for only two days may expect some financial disadvantage. There will be a discount for members. Membership forms should be included in the mail out.

The Infant Parent Outreach Program currently running is very successful. The topics have been varied, including *New Infant Research* by Isla Lonie, *Inner World Processes during Pregnancy* by Norma Tracy, *The Shock of the New* by Lorraine Rose *and The Great Debut! - partnered by parents* by Beulah Warren to name a few.

QUEENSLAND

Marianna Huxley

At our most recent clinical meeting held on May 6th Professor Barry Nurcombe, Professor of Child Psychiatry at the University of Queensland presented the findings of a nine year followup of a three-month, 11 session intervention program for the mothers of low birth weight babies. Our next clinical meeting on June 16th will see Professor John McGrath present his paper entitled "Infant and Childhood Antecedents of Schizophrenia". Professor McGrath is currently director of the Queensland Centre for Schizophrenia Research and Associate Professor, Department of Psychiatry, University of Queensland. These clinical meetings generate considerable interest among, not only professionals working in the area of mental health, but other health professionals as well. As a consequence our membership numbers continue to increase. The contribution of our local speakers is highly valued and we appreciate the opportunity to learn more about the work being undertaken in the state. As the year progresses we are hoping to invite some overseas speakers to present some of their work.

SOUTH AUSTRALIA

Pam Linke

We have been working hard on our "What about Fathers" video launch. The leader's guide is completed. It was launched by the Governor on 1 July. I also attended a presentation by Chris Sidoti, the Human Rights Commissioner, on the state of Australia's Children. I will be suggesting that our branch joins Defence for Children International in order to better support the Convention and the campaign for a commissioner for children.

VICTORIA

Sarah Jones

The Victorian branch has introduced monthly evening meetings following demand for more food for thought from hungry members. We now have alternating clinical and scientific meetings. In May Dr Liam O'Connor and Dr Julie Stone both from the Albert Road Clinic presented a case discussion at a clinical meeting. In June Dr Prannee Laimputtong Rice was our guest speaker at the scientific meeting. She spoke on Cross Cultural Child Rearing Practices, focusing on the Hmong culture from South East Asia. She was followed by Ms. Marita Thompson who spoke on families from Latin-American and African Cultures. Both evenings were well attended, with over thirty prople coming out in the Melbourne winter. The talks were very thought provoking. The general impression is that workers are looking for ways to extend their thinking and that our asociation is providing them these opportunities.

John Byng-Hall, well known family therapist, author and clinician is coming to Australia in September. His visit is being hosted by the Victorian branch. Dr. Byng-Hall is speaking at the AAIMH Conference in Sydney.

In Melbourne it is planned for him to be a Visiting Scholar in the RCH's Mental Health Service, attached to the Infant Mental Health Team. He will then conduct a workshop at the Royal Children's Hospital in Melbourne. AAIMH Victoria is co-sponsoring with the Victorian Association of Family Therapists (VAFT) a workshop entitled "Re-writing Family Scripts: A New Model of Family Therapy: Implications of Attachment Research for Family Therapy". This is AAIMH's fist joint venture with VAFT. The joint collaboration we hope will be mutually beneficial to both groups. As the infant mental health world has a commitment to promoting work with infants and their families, inevitably theories that have not only an intra-personal but inter-personal focus need to be considered. In one of Dr. Byng-Hall's more recent articles[1] he writes of his work over a four year period for the World Association of Infant Mental Health Interfaces Study Group. He explored the interfaces between intrapsychic, interactional and intergenerational aspects of triads.

His final speaking engagement will be at the National Family Therapy Conference in Brisbane in September Dr. Byng-Hall also wants a holiday with his wife Sue

[1] Fivas-Despeursinge, E., Stern, D., Brugin, D., Byng-Hall, J., Coboz-Warney, A., Lamour, Lebovici, S., and an Anonymous Family (1994) The dynamics of interfaces: seven authors in search of encounters across levels of description of an event involving a mother, father, and baby. Infant Mental Health Journal, 16:69-89

The **Australian Association of Infant Mental Health** with co-sponsors VAFT, QAFT and RCH Mental Health Service for Kids and Youth announces the forthcoming visit of **John Byng-Hall**, object relations family therapist, to **Melbourne** in September 1998.

John Byng-Hall has been a consultant child and family psychiatrist at the Tavistock Clinic, London for twenty years. He has published widely on topics such as family myths, stories, legends and scripts, attachment within the family, distance regulation, 'too close/too far' family systems, marital problems, adolescence, impact of chronic illness in the family, and supervision. His recent book 'Rewriting Family Scripts' (1995) has been widely praised.

Having presented his ideas at training conferences in many countries, John Byng-Hall has an international reputation. Hi is past chair of the Institute of Family Therapy London, founder member of the Journal of Family Therapy and joint founder of the first Tavistock Clinic Family Therapy Course.

John Byng-Hall is a member of the UK Association of Infant Mental Health and a member of the World Association of Infant Mental Health international study group in Lausanne Switzerland; 'Interfaces between intrapsychic, interactional and transgenerational factors'. He has also published in the Infant Mental Health Journal on Attachment theory and family therapy.

AAIMH and VAFT WORKSHOP

REWRITING FAMILY SCRIPTS: A NEW MODEL OF FAMILY THERAPY: Implications of Attachment Research for Family Therapy

This workshop will provide an introduction to a new model of family therapy which draws on attachment theory, script theory and narrative theory. The overall aim is to enable families to feel secure enough to risk new ways of relation rather than following old problem laden scripts. In this way families can rewrite their own scripts. This workshop is designed to help clinicians to be more effective by integrating their current techniques into the model as well as extending their repertoire. Videotapes of clinical material will be used to illustrate the theoretical material.

Friday, September 11th 9:30am to 4:30pm
Fee $100.00 (lunch included)
Ella Latham Theatre, Ground Floor
Royal Children's Hospital Flemington Road, Parkville

BOWLBY LECTURE:
'A Secure Family Base; a Useful New Systemic Attachment Concept'

John Bowlby is known as the father of attachment theory. He used concepts from ethnology and systems theory as well as psychoanalysis to propose a new model for describing 'The Nature of the Infant's Tie to his Mother' (1958). The work of Bowlby and his colleagues John and Joyce Robertson on the importance of continuous and sensitive care by a primary attachment figure led to a revolution in the treatment of infants and young children in nurseries, hospitals and institutional care.

This is the second Melbourne Bowlby Memorial Lecture. The first given by Juliet Hopkins, English child psychotherapist and author in December 1996. The paper was entitled 'Clinical Applications of Attachment Theory'. In a recent interview John Byng-Hall who worked with Bowlby at the Tavistock Clinic credited John Bowlby as having written the first family therapy paper in 1949.

Tuesday 15 September 8:00pm
Fee $25.00 Non-members; AAIMH members $10.00
Ella Lathum Lecture Theatre Royal Children's Hospital

Enquires:
Sarah Jones, Hon. Sec. AAIMH VIC.
AAIMH/VAFT WORKSHOP
M.H.Sky
Royal Children's Hospital
Flemington Road, Parkville 3052
Telephone: 9345 5522

SIDS, INFANT SLEEPING ARRANGEMENTS AND CULTURE

What are the connections?

with

Professor James McKenna

Friday 31 July 1998	Perth
Wednesday 5 August 1998	Sydney
Friday 7 August 1998	Brisbane

Professor James McKenna is the Professor of Anthropology, Dept of Anthropology, and Director, Centre for the Study of Maternal-Infant Sleep and Breastfeeding Behaviour, University of Notre Dame, Indiana USA. He was Senior Researcher, Dept of Neurology, University of California, Irvine CA from 1984-1997. Pfrofessor McKenna's special interests are: infant sleep and SIDS, evolution of human behaviour (especially parenting and infant development), evolutionary medicine, primate social behaviour and human evolution.

Professor McKenna will present data from physiological studies of mother-infant bedsharing anong breastfeeding Latino mother-infant pairs, and discuss the data in terms of the epiemiological data indicating that bedsharing increases SIDS risk.

QUESTIONS & BOOKING TO
Jan Cornfoot, CAPERS
PO Box 412, Red Hill Qld 4059 Australia
Tel 07 3369 9200 Fax 07 3369 9299
email: capers@gil.com.au

Professor James McKenna will also be speaking at a series of One day Conferences entitled:

Breastfeeding the Best Investment.

His presentation is entitled **"Breastfeeding with Mother-Infant Co-sleeping as an adaptive system: Historical and Biocultural Perspectives".**

The conference also includes a range of other international speakers on breast feeding.

Perth - Saturday 1 August 1998
Adelaide - Monday 3 August 1998
Melbourne - Tuesday 4 August 1998
Sydney - Wednesday 5 August 1998

QUESTIONS & BOOKING TO
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