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FROM THE EDITORS

Welcome to another edition! We have all returned from Sydney where the National Conference was a great success. I continue to be impressed by the level of energy and enthusiasm in the field of Infant Mental Health.

First off in this edition an article by Briget Jordan on Infancy and gender politics. Following this a summary of Marinus van Ijzendoorn's work which he presented at the National Conference in Adelaide in 1997. Also, in this edition, a brief description of some interesting research in process at the University of Melbourne.

The First National Committee Meeting for AAIMHI has occurred and an update is included to keep you up to date with the organisational changes.

Paul Robertson & Sarah Jones

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GENDER, POLITICS AND INFANT MENTAL HEALTH

by Brigid Jordan

This article was previously published in The Signal (Newsletter of the World Association for Infant Mental Health, Vol. 5, No. 3, July - September 1997). Brigid is a Social Worker in the Infant Mental Health Program, Royal Children's Hospital, Melbourne.

The invitation to write this paper arose from a paper I wrote several years ago when new to the field of infant mental health. At the time I was struck by how unselfconsciously the field, at least in the literature, used language and relied on concepts that had been recognised in other discourses as highly problematic. Notions of good and bad mothers, the role of fathers, the needs of infants, and 'normal' mother infant interactions continue to permeate the literature in a largely unexamined way. This paper is an attempt to reflect on our social position as therapists, question some taken for granted assumptions and think about the particular economic and historical conditions that lead us to write and say what we do, and the social effects of what we say and don't say, ask and don't ask, in the clinical room, the academy and the research laboratory.

Infant mental health clinicians see first hand many of the material and psychological effects of current social arrangements and discourses about family life, and theoretically the field has the scope to problematise and *critically* discuss the development of infants, the formation of early relationships and the process of socialisation. The study of infant attributes and infants' contributions to relationships could call into question romantic beliefs in the unity of mother and children's interests, the harmony of their relationships and the perfectibility of children. However, we tend to approach mothering and sexuality and institutions such as the family, as unproblematic except as individual instances of deviance from an achievable norm.

Sociocultural factors such as race, class, poverty tend to be treated as 'white noise' or 'add on' factors

rather than recognised as the social and economic relations that structure the internal dynamics of the family. In this discussion I am suggesting that we can't understand infants or mothers or fathers or families without taking account of the historically and culturally specific practices in which the individual subject is produced and this includes the social organisation of gender ie the ways in which society places the biologically different sexes in particular positions in the social and economic order [Thorne, 1982]. Gender also refers to one's sense of self acquired though the experience of one's body, as well as the social meanings given to sexual difference through culture, language and ideology [Flax, 1990].

Although 'grand narratives' on how the socioeconomic and political order structures family life and linear models of relations of domination are out of favour, the questions that these grand theories sought to address remain and are insistently present in everyday clinical problems. For example, the topic of my own area of clinical research - the treatment of persistent crying or 'colic' - traverses the domains of infants' social and emotional experience, the relation of psyche and soma, the infant's encounter with culture and socialisation processes, power relations in families including between infant and mother, and the social expectations of mothers and mothering.

Post modern theory has described how knowledge building has little to do with the gradual accumulation of increasingly accurate facts about *'out there'* external reality. Commonsense views are only common sense in a particular historical and cultural moment - witness, for example, the major shifts in our thinking in the last two decades about the psychological boundary of an infant and the repudiation of previously clung to beliefs about the symbiotic phase. Theorists proposing a new paradigm sometimes have a sense of this - Stern introduced his theory of the development of an infant's sense of self as an invention based on inference [Stern, 1985]. Infant mental health's account of its history tends to be in terms of pioneers who discovered new knowledge about infants and their capacities and have faithfully mapped these findings in order to optimise the development of infants and inoculate against future psychopathology [McIntyre and Jordan, 1992]. An alternative view is that this field has emerged and flourished at a time when, in western advanced capitalist societies the child has replaced participation in the community as the focus of family life [Leupnitz, 1988] and the mobility and isolation of the modern nuclear family and dissolution of community bonds has reduced access to and the status of local folk experts. It has been argued that the highly mobile and malleable ['flexible'] workforce required by modern capital has produced individuals and social environments characterised by uncertainty and a sense of the provisional [Richards, 1989] and that therapeutic discourses rather than overt processes are the main means of [self]regulation of individuals by society [Rose,1992].

In the absence of grand theory that can reveal ultimate truths it has been argued that "the ultimate test of a theory is its political consequences" [Flax, 1990]. Thus I want to raise some questions about the political and social place of infant mental health in terms of theory, research and clinical practice and to suggest that attention to gender as a fundamental category of analysis [Goldner, 1988] could lead to a deeper understanding of the context in which an infant develops and becomes a gendered subject, and allow the possibility of a theory of mothering that avoids simple mother blaming on the one hand and the idealisation of motherhood on the other.

The Competent Infant

The premises and assumptions we make about the relationship between individuals and society are most transparent in our discussion of the mother infant relationship but also evident in out theories about the development of infant capacities and preferences.

The construction of the infant as having *inbuilt social* characteristics [eg prewired for communication and social interaction] and using these features to account for social relations implies that social arrangements are 'natural' and inevitable and a consequence of individual factors [Urwin, 1986]. Notions of 'basic motives' including biologically prepared social fittedness [Emde, 1990] obscure the arbitrary nature of social arrangements and privilege an idealised view of the individual's relationship with society. There is little room in this account of the competent infant for an inner fantasy world. This over rationalised view of a competent infant prewired for social interaction is complemented by an impoverished view of the mother infant relationship.

Mother Infant Relationship

A curious development in the infant mental health literature has been the 'degendering' of mothering - the literature is full of references to infant - 'caregiver' or infant - 'parent' relationships. At first glance this 'gender neutral' language might seem less

discriminatory and less mother blaming. However the work of mothering which is done by women is done from a particular social position and the silencing of this obscures the role of gender in shaping psychological attributes and social conditions and reinforces an individualistic view of difficulties in the mother infant relationship.

Observations from videotaped sequences of interaction between a mother and her infant have been a major source of data for infant mental health theory. This emphasis on the infant's contribution to the relationship and the construction of interactions as a 'reciprocal exchange' or 'dance' might seem a move away from traditional mother blaming approaches that did not take into account the child's contribution. However the extraction of mother infant interaction from its context and minute measurement of behaviours can be seen as increasing the status of mothering while regulating its activities even more [Ingelby, 1986]. Words like 'precise adaptation' 'synchrony' 'negotiation' are used, with disharmony seen as the result of individual pathology in either the infant or mother and not inherent in the human condition. The vexed question of how 'accurately sensitive' a 'normal mother' ordinarily can be, is rarely discussed and the relationship of the mother infant relationship to other relations and social formations is obscured. Thus a voluntaristic view of family life and a bias toward the need for personal individual adjustment rather than social change is reinforced [Adlam et al., 1977].

Idealised views of infant mother relationships are called into question when one considers the tenacity of infant symptoms and the enormously high rate of distress [so called 'postnatal depression'] in mothers of infants in western advanced capitalist societies. The name 'postnatal depression' has been challenged by those who argue that it refers to timing rather than any intrinsic qualities of the distress faced by women mothering young infants. Any 'psychiatric condition' suffered by between 10 and 20% of a given population raises questions about the emotional cost of the social conditions of mothering and the conflicts and challenges of the infant - mother relationship. In an Australian study women saw their own depression as explicable in the context of their lives as mothers and identified salient factors as lack of support, isolation, physical fatigue or ill health, having little time or space to themselves and also described the positive effect that the infant had on their well being [Small, 1994]. Adverse social situations and social isolation, the low esteem accorded to child rearing and the loss of identity for women who have given up paid work have been identified in the clinical literature as salient factors in addition to individual dynamics [Daws, 1989]. However the infant mental health literature and research on depression in women mothering young infants tends to pay little attention to social contradictions of mothering and the simultaneous idealisation and denigration of motherhood where mothers are portrayed as Madonnas but women enjoy marginal status when pregnant and a mother, and often become financially dependent.

The field's over reliance on attachment theory and the increasing use of the latter as a means of classification and codification obscures the fact that psychic reality is not the same as the level of reality at which a mother manages her infant - the unconscious of the mother and infant cut across actual mother infant interactions [Adams, 1983].

The development of infant representations is increasingly portrayed as a rational cognitive process based on lived experience of actual mother infant interactions [Stern, 1996]. An alternative view is that the capacity for representation is initiated by a sense of loss and absence, by the inevitable disruptions and misattunements that are part of life; "knowing people is what we do to them when they are not there" [Phillips,1990].

The rational, competent infant developing a coherent sense of self, from internalised interactions with a 'primary caregiver' attuned to the infant's needs, is very different from the [infantile] infant beset by intense often intolerable anxieties whose mental growth relies on a relationship with an other who works hard to contain these anxieties and help the infant to gradually tolerate the experience of psychic pain and distress [Rustin and Rustin, 1984]. Psychoanalytic theory provides a richer, denser and more complex account of the development of guilt, reparation and creativity than the notions of biological based social fittedness and it is a theory that allows for the articulation of a connection between internal and external experience while allowing a place for the unconscious.

Normal maternal ambivalence and hate [Winnicott, 1947] are written out of most infant mental health discussions of the mother infant relationship and an idealised view of motherhood perpetuated. Elsewhere I have argued that what is required is to theorise the connections and contradictions of infant needs and

desire, actual maternal practice, maternal desire and the social context that constructs and is constituted by women's mothering [Jordan, 1992] Such an approach would question the harmony of the relationship of mother and infant and pay due attention to the often precarious nature of a woman's maternal identification and to the 'play' of the unconscious of the mother's psychic life and that of the infant [Adams, 1983]. In contrast to sociological accounts of mothering which assume that the internalisation of social norms works, psychoanalytic theory offers a challenge to the notion of 'natural' mothering [Rose, 1983].

Mothering and Power

Questioning the presumed isomorphism between the infants psychic life and social experience is not to ignore or deny the infant's helplessness and the importance of sensitive maternal care. On the contrary a more complex theory of mothering that acknowledges power dynamics and the complicated and ambivalent feelings between mothers and infants, and allows for desire to be distinguished from need, may offer more possibilities for understanding and for thinking about the social arrangements needed to support the difficult job of mothering than romantic notions of 'natural', 'intuitive' 'biologically based' mother infant relationships.

The question of maternal power in patriarchal societies is difficult and vexed and prone to primitive ideological splits as Penelope Leach [1977] described in her recent discussion of childcare. A thoughtful rather than ideological approach needs to take account of the costs to mothers of isolated and economically and ideologically unsupported care of infants and the costs to infants of group care [Rustin and Rustin, 1984.]

Gender of the Infant

Until Alicia Lieberman's [1996] recent article, readers of our journal might be forgiven for thinking that having babies had nothing to do with sex or sexuality. Lieberman notes how the baby's body and aggressive and sexual drives have disappeared from our discussion of the infant. The place of the infant in the parent's sexuality and the relationship of this to the symptom is rarely mentioned. Although the gender of the baby does not feature in our literature it is unlikely that it the gender of the infant has no effect on our perception of the infant. [In fact its influence may be greater because it is not acknowledged and articulated]. In one experiment, subjects watched a videoclip of an infant and then described the emotions they observed. Half the subjects had been told that they were viewing a boy and half were told that the infant was a girl. Subjects were more likely to describe 'negative' emotion in the infant as fear if they thought they were observing a girl and anger if they thought they were observing a boy [Condry and Condry, 1976]. Although the subjects were American college students rather than experienced clinicians, the findings provide food for thought. Gender is the fundamental category of difference in our culture and society and thus the gender of the infant is crucial to understanding the development of subjectivity and the socialisation of infants.

Cultural Difference

It seems to me that this difficulty with gender may reflect a difficulty that the field has with difference generally. Much is made of the multidiciplinary nature of the field and we have tended to try and be inclusive, to minimise difference, to for example attempt to 'integrate' developmental psychology and psychoanalysis. This may not be as benign and straightforward as it first seems. The appeal to pregiven prewired characteristics implies a universality [and thus exportability] of our constructions of the competent infant. However it is worth pondering the degree to which we have constructed a western, even American, infant in our own image [Cushman,1991] - motivated by curiosity, preferring novelty, keen to explore and develop mastery and to maintain self esteem [Emde, 1990] ie a rational scientist in a 'pioneering' field. Exporting this infant for overseas consumption could border on a form of cultural imperialism. Although there is an interest in crosscultural studies and individual variation there is a danger of effacing difference and viewing culture as an 'add on' embellishment of an essential biological 'core'[western] infant for example in encouraging cross cultural collaboration to then "strip away local language embellishments" [Emde, 1990]

As argued earlier, attempts to link or integrate developmental psychology, attachment theory and psychoanalysis in the main end up by stripping psychoanalysis of its radical content. The absence of a gender in the infant under discussion and the side stepping of sexual difference and the social organisation of this in our field reflects a more general anxiety about and repudiation of difference and avoidance of important but difficult questions about the social position of infants and their mothers and fathers and power relations between them.

Implications for Research and Clinical Practice

A feminist approach to any field of practice is a lens rather than a set of techniques [Leupnitz, 1988]. I am advocating a critical ear - to listen for social and political processes as well as the unconscious logic that resists these. Current opinion is that many different clinical models of intervention can lead to change in the mother's representations and thus they are equally valid [Stern, 1996]. However approaches that involve tinkering at the level of interactions or transactions between a mother and her infant, "perfecting the unexamined life" [Leupnitz,1988] without addressing the social roots of the distress or what transpires unconsciously between mother and infant are more likely to result in mother blaming and cooption of the therapeutic encounter into a regulatory rather than emancipatory event.

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INFANT AND ADULT ATTACHMENT: REFLECTIONS ON THE ROLE OF PARENTAL SENSITIVITY AND INFANT TEMPERAMENT IN BRIDGING THE TRANSMISSION GAP.

Summary of Keynote Address by Professor M. van Ijzendoorn at the Australian Association for Infant Mental Health National Conference in Adelaide, October 1997.

by Paul Robertson and Pam Linke

Professor van Ijzendoorn is a prominent researcher in the area of attachment theory. He works at Leiden University's Centre for Child and Family Studies in the Netherlands. In his address he presented an understandable and coherent over view of the meta-analytic empirical research on human attachment. As he referred to numerous research publications in his address we have endeavoured to direct the reader to salient references where possible.

Attachment classification from the Strange Situation Experiment cannot, Professor van Ijzendoorn said, be explained by differences in infant temperament. It is related to contextual and family factors, such as parental sensitivity. This is at odds with earlier assertions from behavioural genetics which argued that attachment classification is explainable by differences in infant temperament.

Professor van Ijzendoorn contended that attachment behaviour is a universal phenomenon seen across different cultures and described historically. There is considerable research to illustrate that not only are distributions of attachment qualities the same across cultures but even the dynamics of the development of attachment are explainable in the same kind of terms across the world. Attachment relationships are based on an evolutionary bias. Infants come into this world with a genetic or evolutionary based bias to show attachment behaviours and become attached to protective adults. This bias has survival value for the human species. Thus, he maintained, genetics do play a role in the emergence of attachment behaviour in general but do not explain individual differences in the quality of attachment relationships. Rather individual differences are secondary to child rearing and other contextual factors.

Professor van Ijzendoorn defined individual differences in attachment behaviour as the differences in the way infants deal with stressful circumstances in the presence of their attachment figure. The strange situation experiment examines this by looking at reunion behaviour after a brief separation between the infant and caregiver. Three types of infant-caregiver relationships are derived from the Strange Situation experiment. These are called insecure avoidant (about 25% of infants), insecure ambivalent (about 10%) and secure (about 65%). Secure infants neither minimise or maximise their negative emotions while expressing them quickly after reunion with their caregivers. They are comforted quickly and return to exploration of the environment (ie play). They have a balance between, on the one hand seeking proximity to the attachment figure, and on the other hand exploring the environment. Insecure avoidant infants remain focused on the environment and show insufficient proximity seeking behaviour to the caregiver. Insecure ambivalent infants remain focused on the attachment figure and do not settle to attend to the environment. (Note: In edition to these 3 classifications a further discriptor about the presence

or not of disorganised behaviour in the Strange Situation exists. Professor van Ijzendoorn's workshop the previous day focused on such disorganised attachments. Video clips of examples of the three categories of attachment relationships were shown.

Professor van Ijzendoorn went on to consider the antecedents of these differences in infant behaviour in the Strange Situation, in particular the relationship to the parents' own past or childhood experiences of attachment. Until recently it had not been possible to assess the attachment status of adults. Clearly they would not be distressed by a 3 minute separation from their partner in a strange situation! Fortunately Mary Main developed a device, looking at verbal rather than non-verbal behaviour, to assess adult attachment status. It is called the Adult Attachment Interview (AAI). This is an interview where open ended questions are asked. The adult subject is asked to provide some adjectives which characterise their childhood relationships with their own parents. They are then asked to provide examples with illustrations of those characteristics. The interview covers special stressful situations like illness or separations from parents. It asks about the development of the attachment relationships with both parents and its influence on their personality. Any loss or trauma experienced is explored during the interview.

This interview has similarities with a strange situation procedure. Professor van Ijzendoorn drew a parallel between the AAI and the Strange Situation. There is a tension in the AAI between, on the one hand, the discourse context where the interviewer wants to hear a coherent story, and on the other hand the attachment biography of events in the past. Three styles or forms of dealing with the interview emerged. One group emphasise the discourse context, ie creating an impression with the interviewer, and do not tell sufficient details about their attachment experiences. Their focus on the discourse context can be seen as paralleling the avoidant infants who remain focused on the environment while showing insufficient proximity seeking behaviour. They are called the Dismissing group and represent about 24% of cases. A second group emphasise the events in the past or the attachment biography at the sake of the current context. For example they may show anger about what happened in the past and lose sight of being involved in the interview through giving irrelevant or surplus details. They are called the Preoccupied group and represent about 18% of cases. They parallel the ambivalently attached infants. Between these two groups are those who strike a balance between providing enough details of the past while at the same time being sufficiently aware of the discourse context. They tell the interviewer a coherent story, whether positive or negative, that is plausible and shows consistency. This is the Secure Group. Security means that they are able to talk in a coherent way about their past experiences whether positive or negative.

There has been considerable research examining the relationship between parental security (on AAI) and infant security (on Strange Situation). This research has looked at fathers with their infants as well as mothers. There are also studies measuring parental security (AAI) before birth and subsequent infant security (on Strange Situation) at 12 - 18 months of age. This research shows a clear and strong relationship between parental attachment security (AAI) and the security of the infant (Strange Situation). Dismissing adults have avoidant infants (effect size .45). Preoccupied adults have ambivalent infants (effect size .42) and secure adults have secure infants (effect size .47)[1]. Parental experiences, or at least the way they recall or represent their experiences, are very important in shaping the parent-infant relationship.

An over view of these studies shows a stronger correlation between maternal security (AAI) and infant-maternal security (SS) (correlation .50), compared to paternal security as related to infant-father attachment security (correlation of 0.37)[2]. There is a low correlation between the infant's attachment security to the mother, compared with the same infant's attachment security to the father (correlation .15). That is attachment security to mother does not predict attachment security to father. Assortive mating where adults tend to choose partners with similar attachment security to themselves would tend to strengthen this correlation hence the low correlation is particularly striking.

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[1] For details see Van Ijzendoorn, m.H. et al. (1995) Breaking the intergenerational cycle on insecure attachment: A review of the effects of attachment based interventions on maternal sensitivity and infant security in Journal of Child Psychology and Psychiatry, 36, 225-248.

[2] For details see article footnoted in previous paragraph and Fox,N.A., Kimmerly,N.L.,& Schafer,W.D. (1991). Attachment to mother/attachment to father: A meta-analysis. Child Development, 62. 210-225.

Hence the finding that the same infant has different attachment relationships with different caregivers then this is a strong argument to say that caregivers are important not the infant's temperament or constitution.

So what in caregivers is important? A crucial concept in attachment theory is sensitive responsiveness - the ability to accurately perceive and interpret an infant's attachment signals and to respond to them promptly and adequately. (Mary Ainsworth's definition in her book on patterns of attachment[3]). There is strong evidence that differences in parents' sensitivity is associated with differences in infant attachment security. In a compilation of studies involving over four thousand families Professor van Ijzendoorn found an effect size of 0.24 between parental sensitivity and attachment security. The more sensitive the parent is, the more secure the child. With factors such as contiguity and physical contact which measure frequency of parental behaviour rather then quality then effect sizes, in relation to attachment security, are smaller. With more complex constructs such as synchrony and mutuality, which take into account the response of the child to the parents initiative, the effect size is larger[4]. Remember these figures are correlations and not necessarily an indication of causality. To take the argument further intervention studies are needed to support the claim that the relationship between parental sensitivity and infant attachment security is a causal one.

One intervention study which demonstrates that increasing parental sensitivity leads to greater attachment security is that of Anisfeld et al[5], using a population of deprived mother's. The experimental group of mothers were given a soft baby carrier which increased parent infant contact and asked parents to use it for a considerable amount of time in the first year. The control group were given hard baby seats. At the end of the first year more than 80% of the experimental group was securely attached compared with the control group with less than 40%. This simple intervention had an enormous effect on attachment security. This is one example of a series of studies looking at interventions that enhance parental sensitivity and there by improve attachment security. Professor van Ijzendoorn explained that if you combine available experimental interventions studies (total 12 studies) the effects of intervention on attachment security is quite low. However if you split the intervention studies up into two groups- (1) short term focused behavioural interventions and (2) long term broad band interventions there is a strong effect on attachment security for the short term behavioural interventions but no effect on attachment security for the long term broad band behavioural interventions. Overall there is support that short term behaviourally based interventions increase parental sensitivity and attachment security.

Professor van Ijzendoorn went on to describe some early results of a large intervention study that he, along with other investigators, was currently undertaking. This research is on going. The results described were for the first thirty dyads in the study. A group of non clinical insecure mother-infant dyads where identified from screening 600 mothers with the AAI. These insecure dyads were randomly allocated to one of 3 groups - (1) control, (2) video feedback only and (3) video feedback and discussion group. The interventions occurred over 4 sessions of 2-3 hours each. They found a large increase in parental sensitivity for both interventions. Additionally, and uniquely to this study, they found a differential effect based on the attachment statue (AAI) of the mother ie. dismissing or preoccupied. Dismissing mothers profit much more from the behavioural video feedback intervention while the preoccupied mothers, who are still focused on their past experiences, profited less from the video feedback intervention and more from the video feedback and discussion group intervention. The type of intervention needs to fit the needs of the mothers as expressed in the type of mental representation of attachment they display in the AAI. Maybe for dismissing parents it is important to give direct behavioural feedback and not go into parental representation of attachment experience. For the preoccupied group it is important to acknowledge their needs to discuss their own previous attachment experiences. This combined with the video feedback

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[3] Ainsworth, M.D.,Blehar, M.C., Waters, E., & Wall, S. (1978) Patterns of Attachment: A Psychological Study of the Strange Situation. Hillsdale, NJ: LawrenceErlbaum Associates.

[4] See article published in 1997 in Child Development titled Sensitivity and attachment. A meta-analysis on parental antecedents of infant-attachment.

[5] Anisfeld,E.,Casper,V.,Nozyce,M.&Cunningham,N. (1990) Does infant crying promote attachment? An experimental study of the effects of increased physical contact on the development of attachment. Child Development, 61. 1617-1627.

of their behaviour produced a larger effect than just the video feedback alone.

Professor van Ijzendoorn described details of the interventions. Firstly a video feedback which involved looking at 4 elements -

1. The balance between contact seeking and exploration,
2. Speaking for the baby,
3. Three step interactions (mother-infant-mother),
4. Affective attunement.

Secondly an attachment discussion group which included 4 elements -

1. Themes of early parental separation,
2. The parent's own experience of being parented,
3. Breaking away from the family of origin,
4. Being the child of my parents and the parent of my child.

Professor van Ijzendoorn concluded that the research indicated that it is the parent's behaviour, especially parental sensitivity, that shapes the nature of the parent-infant relationship not the infant's constitution or temperament. There may be a complex interplay between temperament, parental sensitivity and attachment but from the data a relationship between temperament and attachment classification cannot be found.

In discussion with the audience it was raised that the above argument would suggest that a parent would have the same attachment with all their children. Professor van Ijzendoorn acknowledged this is unlikely to be true and understanding the dynamics of how a different attachment relationship comes about with different children would be important. However there is little empirical data about whether such differences between siblings exists or not. Professor van Ijzendoorn indicated they were attempting to look empirically at this question currently. If there are differences between siblings it might be the unique aspects of the child's environment, rather then the shared environment, that leads to a difference. For instance the loss for a parent of an attachment figure at or near the time of a particular child's birth may lead to a more insecure or disorganised attachment relationship for that child.

In response to another question Professor van Ijzendoorn presented further data from studies[6] that have used physiological measures of temperament (ie cortisols, heart rate, EEG etc). These studies did not find a relationship between temperament and attachment classification. There may be a relationship between temperament and observed attachment behaviour(ie a child rated with difficult temperament may show more crying) but not to attachment classification.

A third question raised the issue of change over time. He said the attachment relationship is changeable. Change is evident in response to contextual changes and to treatment. The idea of a critical period for the development of attachment security has been disconfirmed. A number of studies have followed up infants seen in the Strange Situation at 12 months to the age of 17 or 18 (when security was again measured on AAI). They show moderate continuity over time. There is lawful or predictable discontinuity or change that is understandable due to contextual change. There is also discontinuity that is not understandable.

[6] These studies are-

1. Calkins,S.D.,& Fox,N.A. (1992). The relations among infant temperament, security of attachment, and behavioural inhibition at twenty-four months. Child Development, 63. 1456-1472.
2. Dawson,G.,Klinger,L.G., Panagiotides,H.,& Spieker,S. (1992). Infants of mothers with depressive symptoms: Electroencephalographic and behavioural findings related to attachment status. Development and Psychopathology, 155. 471-486.
3. Gunnar,M.R., Mangelsdorf,s. Larson,M.&Hertsgaard,L. (1989). Attachment, temperament and adrenocortical activity in infancy" A study of pyshoendocrine regulation. Developmental Psychology, 25. 355-363.
4. Izard,C.E., Porges,S.W.,Simons,R.F., & Jaynes,O.M. (1991). Infant cardiac activity: Developmental changes and relations with attachment. Developmental Psychology, 27. 432-439.

RESEARCH

STUDY ON YOUNG CHILDREN'S SOCIAL AND EMOTIONAL DEVELOPMENT

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Editors Note: Earlier this year I became aware of this important research project. I suggested out membership would be most interested and prevailed on them to write this brief report.

A research project on children's social and emotional development has been taking place at the University of Melbourne over the last two years. The Social and Emotional Development Study is examining how child characteristics such as temperament interact with styles of parenting and family characteristics to influence the later development of problem behaviours such as anxiety, depression, social withdrawal, and aggression in the child. We expect that the knowledge gained from this project will have important implications for preventing emotional and behavioural disorders in children. The study involves a community sample of 2-year-old children and their primary care-giving parents who are being followed up when the children are 4 years old.

Participating parents have completed some questionnaires about their child's behaviour, their own parenting behaviour, and general family life. In addition, they visited the study's playroom laboratory at the University with their 2-year-old child on two occasions, 12 weeks apart. On the first visit, the child played with toys, was visited by a clown and another adult, experienced a brief separation from their parent, and had some physiological measures taken. In the second session, the child played with a peer, and then both children's parents were invited to play as well. These sessions were videotaped. The data are used to derive measures of child temperament (eg. inhibition) and parenting behaviour (eg. warmth and responsivity). The families are soon to be invited back to the playroom for another two visits as the children are about to reach 4 years of age. The parents will again complete some questionnaires, and during one visit the child will play with three other peers, while in the other visit the child will engage in activities with his or her parent. Measures of child emotional and behavioural adjustment, peer interaction, and parenting behaviour will be coded from the videotapes.

In total, a community sample of 112 children (58 boys and 54 girls) and one of their parents have participated to date. About one-third of the children were only children at this time. Most children (93%) lived with both of their biological parents, and they came from a wide range of areas around Melbourne. About 70% of children received some form of childcare (13 hours average). These families were generally coping well, with relatively low levels of stresses and daily hassles.

One aim of the study is to examine agreement between mothers' reports of child temperament and measures of temperament taken from observation. A modest level of agreement was found between parent and observer reports on one important aspect of temperament, inhibition, which assesses how readily a child approaches a new person or situation. Mothers and observers did not agree well on the child's emotional reactivity and their capacity to maintain attention. Parental stress and mother psychological adjustment were related to her ratings of temperament, and also to observer ratings of temperament, suggesting that these background characteristics have an impact on the child's actual temperament, not simply on maternal report.

Child rearing practices of the parents were also assessed (inductive reasoning, power assertion and warmth), and the effect of child temperament, family stressors and maternal psychological adjustment on parenting style was examined. Results showed agreement between questionnaire and observational measures of parenting for inductive reasoning and power assertion, but not for warmth. Questionnaire data suggested that boys received more parental power assertion than girls. Levels of child reactivity and persistence were related to the amount of warmth and power assertion used. The family stressors and maternal adjustment measures were related to all three parenting dimensions as assessed by questionnaire (but not by observation).

At this stage of the project the researchers want to invite some parents who experience anxiety or depression and who have 2-year-old children to participate in the study, since the rate of child

emotional and behavioural problems tends to be higher in these families. We would much appreciate your help in contacting and recruiting these additional families for the project. Participation would not interfere with families' ongoing contact with services. Participating parents will be paid $30 per visit (a total of $120 for all 4 visits). In addition, transport to and from the university can be provided for families, and free copies of the videotapes of the observations will be offered to the parents. An easy way to encourage families to take part in the study is to display a coloured poster advertisement, and to draw it to the attention of potentially interested parents who have anxious/depressive difficulties and who have 2-year old children. Please ring us at the laboratory on 9344 6370 if you would like to discuss the project further. We could then send your organisation a letter describing the project in detail, as well as the poster. We will be grateful for any interest and assistance with this research!

UPDATE

REPORT ON THE FIRST MEETING OF THE NATIONAL COMMITTEE OF AAIMH

In Sydney in September 1998 we had our first AGM as a National body and the first meeting of the National Committee of AAIMH was held at the Rex Hotel on 4 September 1998 during the annual conference.

The State Representatives on THE National Council are as follows - Dr Isla Lonie (NSW), Dr Janet Rhind (QLD), Dr Elizabeth Puddy (SA), Ms Brigid Jordan (Vic) and Dr Caroline Zanetti (WA). Contact number are listed below.

A first step was to appoint an Executive Secretary, Ms Sabina Kleitman, who is doing her PhD in Psychology at Sydney University. Sabina has done quite a lot of work already for AAIMHI, organising various outreach programmes, and has always been most effective and resourceful, as well as enthusiastic about our activities. Our membership list will now be well organised with Sabina coordinating a national mailing list. State committees will need to inform Sabina of new members or changes in membership details for members to keep the list up to date. For mail outs, such as the newsletter, the list can be sent electronically to ourselves as editors and a set of labels printed making the whole process very much more efficient.

It was decided at the AGM that Ms Pam Linke will chair an Advocacy Subcommittee. She will communicate with State Representatives to nominate a person who would be willing to join this subcommittee. Pam will also take the necessary steps to involve AAIMHI in the Coalition for Children, a peak body advising the government on policy.

Hopefully something will happen about the AAIMHI webpage soon. This should greatly simplify the dissemination of information about our activities, conferences, workshops, visiting speakers, and so on.

We need to think a bit about how to organise a video library. Possibly this could be something that Sabina might be able to oversee.

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FROM THE DESK

COMMENT FROM DR CAMPBELL PAUL WAIMH REGIONAL VICE PRESIDENT

Congratulations go to the organising committee for a wonderful conference in Sydney. Again people enjoyed a relaxed but intellectually stimulating time with exposure to the work of many infant mental health workers. There was the opportunity to meet with and discuss the work of colleagues from all over Australia, London and Colorado.

Intervention with high risk neonates and their families was one of the most important streams to the conference. Janet Dean and Mary-Sue Moore presented powerful work with infants at high risk and helped us consider our own inner processes in this clinical context. John Byng-Hall helped draw us closer to colleagues in family therapy and like all our speakers generously shared his clinical expertise informally and in other presentations. We really do live in a global village - with such conferences the village pump - centers for sharing common and diverse clinical perspectives.

The conference next year will be in Melbourne probably in November. Prior to this Ed Tronick, from Boston, will be a visitor for the Marce Conference in Melbourne 16-18 September, 1999. We will conduct a joint workshop with the Marce Society then.

Dr. Stephen Malloch, a psychologist and musician who has worked with Colwyn Trevathen in Edinburgh is back in Australia and keen to link up with those working with babies. He has a special interest in babies and the musicality of vocal communication.

Colleagues from Christchurch, New Zealand both in infant mental health and the psychiatry women in the puerperium have made links - the trans Tasman connections are very helpful.

There are new Associations of Infant Mental Health forming from Texas to Padua to Maine and London. A theme emerging from other WAIMH affiliates has been the engagement of parents in therapeutic alliances to promote infant mental health. Much work in this area has been done here. Also perhaps we could publish articles about this in our new look newsletter. Other area of mental health and psychiatry are building upon the exciting developments from early infancy

research to develop new understandings of adult psychopathology and therapy. Professor Joseph Lichtenberg was a recent keynote speaker in Australia and at the Venice conference. David and Isla Lonie heard much of the newer developments in infant-care giver interaction and brain development. Following her recent field trip to China, Sarah Jones will report in a future newsletter, on one of the many services that arranges the adoption of Chinese babies to overseas parents. We live in interesting times.

STATE NETWORK NEWS

New South Wales

Kerry Lockhart

At the third National Child and Adolescent Mental Health Services Conference in Sydney, conference delegates unanimously passed a resolution to found a national representative peak body. The Australian Association of Infant, Child and Adolescent Family Mental Health is intending to represent child and adolescent mental health bodies with a view to being able to obtain a seat at the National Mental Health Council who will advise the Federal Minister of Health. They are requesting set up funding from Commonwealth Mental Health Branch.

It was decided at the Annual General Meeting of AAIMH (NSW) in August to produce a quarterly broadsheet to highlight local NSW issues and events. We also resolved to establish clinical seminars during the year which will be free to members, $10 for non-members and we are hoping to do this regularly for our members continual education, focussing on case presentations, literature reviews, clinical issues etc. The first one is being organised for November the 18th, starting at 7pm at St. John of God Hospital, Burwood with Bryanne Barnett facilitating a Multidisciplinary team panel of a discussion of a hypothetical case presentation.

Coalition for Australia's Children Membership is $500. This organisation is holding a Summit in Canberra in December. Discussion took place regarding whether AAIMH might formally join.

SOUTH AUSTRALIA

Pam Linke

The South Australian group has a strong focus on advocacy which resulted in a presentation at the National Conference in Sydney. One idea that we feel would be very worth pursuing is one that was developed by Nigel Stewart, a paediatrician from New Zealand who now works in our northern country area. Because of the lack of understanding of children's rights in the community in New Zealand where he worked, the health service where he worked developed a Children's Rights poster to be displayed at all their centres. It was developed in conjunction with parents and attractively presented. The result of this was not only that those who worked together on the project gained more of an understanding of children's rights, but both staff and clients were made more aware of what children's rights meant to them in their services. It would be great if children's services across Australia followed his lead and it would do much to lessen the fear of children's rights that exists in some sections of the community. Here are the rights that are displayed on the poster.

THE RIGHTS OF A CHILD WHEN RECEIVING HEALTH CARE

My Rights as a Child are:

To have someone I love with me whenever possible,
To be told what is happening to me,
To ask questions and be given answers understand,
To not be alone if I am sad,
To be able to play, even if I have to stay in bed,

And:
That people are honest with me,
That the people who care for me understand
That I am safe,
That my body is my body,
That I am respected as a real person with feelings and rights of my own,
And
That my well-being is the most important thing.

And I am part of a Whanau/Family.

(Maternal and Child Health Services, Manukau Health)

We are still working on bringing Dr Robert Marvin out next March. If you have not had any information about this and would be interested in having him in your state or region, or knowing more about it, please contact Pam Linke on (08) 8303 1566 (day) or (08) 8357 8779 (evening).

The Fathers video is continuing to sell. For information about it contact Foundation Studios, phone (08) 82047339 or Fax (08) 82046699.

VICTORIA

Sarah Jones

The Victorians wish to thank the News South Welsh people for a most stimulating National conference held in Sydney in September. A large number of us from Melbourne and surrounds attended. The Victorian committee has got underway with planning for the 1999 National Conference.

Prior to the conference it was announced that AAIMH would now have a National Committee. Thanks to all those people who worked so hard at making this happen. At the National level we have two representatives. Ms. Brigid Jordan has been appointed Vice President (President elect) of the Committee. Dr. Campbell Paul as our Regional Vice President is also a member. They both will be working with the President, Dr. Isla Lonie, to develop a National focus for our organisation and to co-ordinate information between all the states. Congratulations Campbell and Brigid to their appointment to the first National Committee.

Campbell Paul has recently been appointed an Associate Professor of the University Melbourne. This appointment is in recognition of Campbell's enormous contribution to the academic development in infant mental health. With Brigid Jordan and Frances Thompson-Salo he has been instrumental in setting up the first Post Graduate Diploma and Masters in Infant Mental Health.

AAIMH Vic continues to be very active. The September calendar included a talk by Dr. Mary Sue Moore on the some of the clinical work being undertaken with children who have experienced extreme violence. Most of those who attended left feeling very stimulated by the discussion and mindful of how children use drawings to gain express pain. Dr. John Byng-Hall from London ran a workshop in Melbourne after the Sydney conference. This was the first AAIMH has co-auspiced with the Victorian Association of Family Therapist. The goal of creating an opportunity of having a closer dialogue with family systems therapists was certainly achieved.

WESTERN AUSTRALIA

Carmel Cairney

In September, an intrepid band of our members crossed the Nullarbor (with our bottled water!!) to attend the National Conference in Sydney. We appreciated all aspects of the conference - the stimulating presentations, the accommodation, the food and the company. Our thanks and congratulations to the NSW Branch.

In August, we had a delightful morning with Dr Mary Sue Moore , at which she spoke to a large group of enthusiastic clinicians about the transmission of intergenerational traumatic experience through the attachment relationship and its effects on the developing brain. This talk generated a lot of excitement among the many who attended.

We were also very fortunate to have a weekend visit from Drs David and Isla Lonie, in June, providing us with a chance to catch up with our interstate counterparts, and to learn about the latest developments in getting together a National Constitution. They also gave Perth clinicians some wonderful talks. David Lonie gave a comprehensive overview of latest developments in the neuropsychiatry of infancy, while Isla gave an engaging clinical presentation, which demonstrated the profound and lasting impact of early experiences, particularly, traumatic separation.

Since the conference our energies are engaged in two projects -
1) A small group were inspired by the presentation on Advocacy, and have arranged to meet with Elizabeth Puddy during her visit to Perth.
2) We have started to plan for Bob Marvin's visit next year.

We have a larger Executive Committee this year. - President and State Rep. - Caroline Zanetti,
Secretary - Carol Smith,
Treasurer - Patrick Marwick,

Associates - Susan Brill, Carmel Cairney, Manita Beskow, and Yap Lai Meng.

Bridget Boultwood recently resigned from our committee. Bridget has been a guiding light in our branch, helping with our birth, and being there to provide the nurturing essential to a new-born. She has also helped us connect with the wider world through her networking and friendships with leaders in the field.. We are very grateful for Bridget's caring contribution and will miss her.

BABY LORE

Boy babies are celebrated and identified with the colour blue;
girl babies with the colour pink.
Why?
The practise of associating different sexed babies with different colours dates back to ancient times. Boy babies, thought to be more prized and superior, required special protection in order that they would thrive. Blue, the colour of the heavens, was chosen to ward off the powers of evil by offering heavenly protection. The belief in the forces of malevolence, were wide spread. Evil spirits were thought to be particularly attracted to times of great joy; the births of a babies, weddings or events of grand success. It was at these times that superstitions were thought to prevent evil spirits "spiriting away" the baby, or causing damage and destruction. Dressing boys in blue was believed to be a way of protecting the people and controlling such evil forces. Evil spirits were thought to be held in check and driven back by the magical powers of the sacred blue.

Why not also dress girl babies in blue? According to Desmond Morris the answer seems to be that there was a practical reason for some kind of immediate distinction between the male and female infant. A non-blue colour was essential. Pink was chosen as it was the colour of the babies skin (in ancient Europe, at least). Pink is associated with health and cleanness, and there an added attraction as the symbolic female colour.

Morris, D., Babywatching, Johnathon Cape, London, 1995.

NOTICE

After Trauma in Infancy
AAIMH Conference, Sydney
- Requests for H.U.G.S. Manual

Unfortunately, the names of those who requested copies of the manual went missing when someone picked up my pink folder by mistake. Could anyone still interested contact me by email at bfrazer@patash.com.au or fax (03) 9496 4148?

My apologies.

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