Australian Association for Infant Mental Health

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NEWSLETTER

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FROM THE EDITORS

By the time you receive this you will have noticed that we have a new look newsletter. With may thanks to Vladimir Tretyakov in Sydney we have launched ourselves into the hi-tech era. Now we are looking for a name for our newsletter. We welcome suggestions from members; the "winner" we go down in IMH history. Most people know that the World Association's bulletin is called "The Signal", and I recently read that the Japanese Association is called "Four Winds", based on their readiness to be informed and influenced from all directions. We are inviting you to help us. Suggestions to be sent on to one of the editors please. Perhaps the different state associations could take this task to their next meeting?

As the millenium draws to an end Melbourne will be ending the year with opening the National AAIMH in November. Convened by the indefatigable Campbell Paul, we have firm commitments from Paris (Bernard Golsse) and Edinburgh (Colwyn Trevarthen). To know more, move to Campbell's RVP Column (Page 10). We are very excited to have the style of the conference already past the planning stages. For those of you who joined us in 1996 we hope you will return with your friends and colleagues to make the last AAIMH conference of the century such a success. At least next year we can finish with the end of the millenium messages.

We welcome any articles however big or small from members, please feel free to send us something or to ring and consult with one of us should you wish. Thanks to all our contributors from 1998.

Sarah Jones and Paul Robertson

1999 CALENDAR OF EVENTS

MAY (NSW)
6 of May: Susan McDonough is speaking at AAIMH Clinical Meeting on cognitive interventions in the mother-infant relationship (see NSW Committee, Page 13)

JUNE (Victoria)
15 of June: Professor Jeanette Milgrom speaking at the 1999 Dean's Lecture Series (The University of Melbourne, Faculty of Medicine, Dentistry and Health Sciences) presents: "Who is pushing our kids into the river?" The critical function of the first twelve months of life (see Victorian Committee, Page 14,16)

SEPTEMBER (VICTORIA)
17-18 September: Marce Society, Melbourne

NOVEMBER (VICTORIA)

20,21 November: Dr Allan Schore presents a 2 day workshop in Melbourne at the Albert Road Clinic (see Page 4)

26,27 and 28th of November: National Conference for AAIMH (University of Melbourne) which will be held over the weekend, concluding Sunday mid day.

JULY 2000 (CANADA)

26-30 July, Montreal - the 7th International Congress of the World Association for Infant Mental Health.

Editorial Staff

Editors:
Sarah Jones
Paul Robertson

Newsletter Design
Vladimir Tretyakov

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Please address all suggestions on content to :
Dr Paul Robertson
Albert Road Consulting Suites
31 Albert Road Melbourne 3004
Tel: (03) 9256 8344
Fax (03) 9820 9588
pauljvd@netspace.net.au
All comments and suggestions on design and distribution:
Vladimir Tretyakov
(02) 9311 7792
tretyakov@go.com

THE NEW LOOK NEWSLETTER: AN UPDATE

To function as a national vehicle for communication and collaboration is the broad aim of the AAIMH Newsletter. It does this by reporting on state activities, local activities, the work of the annual conference, as well as book and conference reviews and in general any material that relates to infants and their families. As such the Newsletter is a dynamic organ which develops as the Association develops. A relatively recent change with each state having a nominated representative who reported on state activities in 'State network News' reflected a more national flavour in the Newsletter. This year heralds further change and growth. Here I shall endeavour to outline these coming changes and challenges.

By now there should have been discussion within your state branch about the newsletter developments. We welcome member's suggestions and contributions, either directly to the editors or through your President who sits on the newly formed National AAIMH Committee. Although substantial changes are under way the process needs to be seen as one in evolution. It is a process that allows the Newsletter to facilitate the aims and goals of the organisation and met the needs of the growing membership. These changes also reflect the growth of AAIMH as an organisation.

The Newsletter was born over a decade ago under the editorship of David Lonie. At that time AAIMH was a small organisation. Its membership now is between 300 - 400 and growing very rapidly. The increased membership means an increased budget for the Newsletter allowing us to meet greater production costs and expand the scope.

The first change to describe is the appointment of a desktop publisher to produce the Newsletter in a more professional way and lend assistance to the editors. Secondly a proposal for an Editorial Advisory Committee for the AAIMH Newsletter. Finally I will attempt to give an overview our current editorial policy with the hope this will encourage members to write for the Newsletter.

APPOINTMENT OF A DESKTOP PUBLISHER

To date the newsletter has been assembled on my home computer usually in the late evening. Prior to the current editorial team of Paul Robertson and Sarah Jones this occurred David Lonie's computer. Although this is inexpensive and has greatly improved my computer skills it has many disadvantages and draw backs. Because of this we have engaged Vladimir Tretyakov to provide desktop publishing and production assistance. Vladimir will collect material (after review by the editors), assemble the newsletter, sort out format and provide originals to the printer. Vladimir is also married to Sabina Kleitman who is providing secretarial assistance to the new AAIMH National Committee including managing the membership list. This will facilitate mail outs of the newsletter after printing.

Vladimir's assistance in producing the Newsletter will free ourselves, both in space and mind, to function as editors doing such things as chasing material, encouraging others to write and the like.

Vladimir has worked with us, over recent months, to bring a new look and feel to the newsletter. Notice the different colour and style!

PROPOSED EDITORIAL ADVISORY COMMITTEE

This proposal emerged out of the AAIMH National Teleconference on 16 November 1998. As a result I wrote to all Newsletter State Correspondents and State Presidents in early February about this proposal seeking discussion in the state branches.

In brief it involves divesting some of the editorial function to a committee structure with each state branch contributing one member. The members of the Editorial Advisory Committee would be part of the local state branch committee. A chief editor(s) would be appointed and have the central role of ensuring the newsletter is published.

Initially, we would propose, that the state correspondents becoming the Editorial Advisory Committee with myself and Sarah Jones becoming chief editors. This will not mean a lot of change for the state correspondents immediately. We need to 'feel' our way forward slowly. Over time the state representative will have a much greater role in the newsletter.

The benefits of an Editorial Advisory Committee are multiple -

Better ensures the newsletter is national in its representation.
Help encourage contributions from each state.
Allow a broader base for editorial work and opinion.
Easier transition of responsibility between state branches. For instance chief and assistant editor would move around the states. This would be less disruptive then one state handing over full responsibility at one time.
Maybe in time allow recruitment of "distinguished" people to be appointed to the Editorial Advisory Committee.

EDITORIAL POLICY

Remember this is your newsletter. We hope the newsletter provides an avenue for those working with infants to begin writing about their clinical or other work experience without having to met the rigour required in a journal publication. It maybe the place to begin your professional writing. Perhaps something written for the newsletter could be further developed for publication in a recognised journal. The major editorial requirement is that it is about infants and their families or is of important interest to infant mental health workers. If at all in doubt, call us!

As editors we are always looking for material to include in the newsletter. Indeed there is often anxiety that we will find ourselves without copy for an edition. Fortunately this has never happened yet. Although we hold final editorial decisions we are keen to facilitate members to get something in writing for themselves and their colleagues. Feel free to discuss ideas with us if you wish.

We will continue to publish articles from particular experts or other items of interest along the way. We also endeavour to keep members informed of the "goings on" in our organisation through "State Network News" and Campbell Paul's column in his role as Regional Vice President of WAIMH.

A number of themes are particular on our mind. Firstly we hope to include descriptions of detailed case material showing the work of infant mental health professionals Secondly to encourage descriptions of programs around the country that are providing services to infants. A third topic is that of family therapy and infants.

Remember it is your Newsletter. Look forward to your contribution!

Paul Robertson

AAIMH NATIONAL CONFERENCE IN MELBOURNE: A NOTICE

AAIMH National Conference, Melbourne, November 26th, 27th and 28th 1999.

"The Baby Speaks: The Therapeutic Process, the Baby and Her Family"

The Conference will be held at the University of Melbourne; more detailed information will be distributed to members very soon.

The two main key speakers are Professor Colwyn Trevarthen from the University of Edinburgh and Professor Bernard Golse from the University of Paris.

We hope that this Conference will be able to provide a means of integrating some of the exciting research on the capacities of babies and their interactions with parents right through to direct clinical application in therapeutic work with babies and families.

There will be a call for poster presentations and in addition to the plenary presentations by the key speakers we hope to have some targeted workshops and panel presentations to support this theme of the movement from basic research and understanding of the baby to its clinical application.

Enquiries to the AAIMH Conference Organising Committee C/- Mental Health Service, Royal Children's Hospital, Flemington Road, Parkville, 3052.

Email paulc@cryptic.rch.unimelb.edu.au or Fax No: 03 9345 6002.

DR ALAN SCHORE IN AUSTRALIA

PICTURE: LEFT TO RIGHT:

Dr Allan Schore, Dr Isla Lonie, Dr David Lonie

Dr Schore is Assistant Clinical Professor of Psychiatry and Biobehavioural Sciences at UCLA Medical School. He is an eminent researcher in the field particularly looking at infant brain development and how it is influenced by early relationship experiences. He is author of *Affect Regulation and the Origin of the Self: The Neurobiology of Emotional Development*, Lawrence Erlbaum, 1994.

Dr Schore presented at the Faculty of Child and Adolescent Psychiatry Meeting, in Sydney, in October 1998. Lecture notes provided by Dr Schore to accompany these papers can be found on the internet at the APT Bi-National Website (Association of Psychiatrists in Training) at:

http://www.ozemail.com.au/~auspsych

This material will be of great interest to those in our field.

There is also an interview with Dr Schore on the internet available at:
http://www.aronson.com/ppp/schore.htm

Dr Schore is returning to Australia in November this year. His visit is being organised by the Royal Australian and New Zealand College of Psychiatrists Section of Psychotherapy. He will present a 2 day Workshop on the weekend of **November 20 and 21** in Melbourne at the Albert Road Clinic. **For details contact Dr Peter Wigg on 03 9439 9782.**

We hope to bring you more about Dr Allan Schore's work in coming editions.

Ken Wright

The Silent Couple in the Individual - Which Couple?

Reprinted from: Society of Psychoanalytical Marital Psychotherapists, Bulletin 1, Inaugural Issue 1994, pp12-18

Dr Ken Wright is a practicing psychoanalyst of the Independent Group. He is a past staff member and past medical consultant to the then Tavistock Institute of Marital Studies (TIMS). He trained at the Tavistock Clinic.

When Evelyn Cleavely asked me to speak on the silent couple in the individual, my first reaction was to say: 'Which couple?', - hence the title of my talk. I knew she was referring to the inner parental couple - at least, I thought she was - but I couldn't stop thinking about all the different couples we live *within* from the cradle to the grave and this was why I asked: 'Which couple?

In a way, it was this misunderstanding which shaped my talk. This was supposed to be about the couple within the individual, but I decided, perversely perhaps, to begin with the individual within the couple.

I mean by this the couple of which we are always a part. And I'm not thinking here just of marriage, or even of adult partners, but of something far wider - the fact that human life itself is fundamentally relational. Take object relations theory, for example. This theory implies a couple in its very essence. When we work within an object relations framework, there's always an other person, another object, in the background. It's not so much T S Eliot's question: "Who is the third who walks beside you?" that we have to think about; it's more a question of "Who is the second? - "Who is that Other with whom you're involved in interaction at this moment?"

I remember as a trainee at the Maudsley Hospital being in supervision with Dr Henry Rey, an analyst who never tired of making this point. Rey, a colourful French Mauritian, would drive home his points with Gallic emphasis: 'You must always ask yourself' he would say, "Oo is doing what, to oom, and with what result?" Rey was stressing the fact that there's always a fantasised *action* hidden in each innocent statement of feeling. But less directly, he was reminding his students of the objectrelational aspect of every emotional event: feelings arise in a context of object relations, never alone; and impulses are directed at objects, never into thin air. Finally, he was reminding us that objects are not just passive recipients of impulses - they react and retaliate. The hidden fantasy may thus be nothing less than a small drama. "Oo is doing what, to oom, with what result?"

We can't remind ourselves often enough that every human action takes place within a social or object relational matrix. Even when we think we're doing something on our own we're probably not; there's always a fantasised Other to whom we're reacting, and that Other, in turn, is reacting to us.

This social matrix of our experience was forcefully brought home to me on reading Brian Keenan's account of his time as a hostage in the Lebanon, narrated in his moving and deeply truthful book: *An Evil Cradling*.

Keenan spent long periods in solitary confinement and it's fascinating to discover how much of this time was spent interacting with imaginary objects. Sometimes such objects were vivid memories, at other times hallucinated presences. Even when he felt utterly abandoned by human others there still remained an Other in the form of God who became for Keenan a more real and vivid experience than normal.

The point I'm making is that we cannot escape from the Other. Even when we go mad we are persecuted by some Other: we feel attacked or hear voices accusing us. But whatever the situation, it seems there's no getting away from some kind of object relationship. We're always part of a couple.

To give just one more illustration: an old man who was brought to see me by his social worker because he wouldn't stop smoking in bed and she was afraid that he would set fire to himself. He suffered from a chronic paranoid illness and had spent many years in psychiatric institutions. His illness and its effects had pushed him to edge of society and he lived a life of unutterable loneliness in a rather run down bed-sit. Probably his only human contact was with the social worker when she visited and maybe with the 'meals on wheels' lady. But for many years his life had been ruined, as he experienced it, by the insufferable intrusions of 'the man from South Norwood'. This persecutory figure shone rays into his room and through these rays interfered with his life in every conceivable way.

Rey, a colourful French Mauritian, would drive home his points with Gallic emphasis: 'You must always ask yourself" he would say, "Oo is doing what, to oom, and with what result?"

He complained bitterly about these unwanted attentions from which no treatment had succeeded in freeing him; and I was struck by the contrast between his utter aloneness in reality and the unremitting attentions of his persecutor within the world of his psychosis. I found myself remembering an old advertisement for Strand cigarettes, the punch line of which ran: "You're never alone with a Strand." It was as though the attentions of his persecutor in some way compensated for his isolation in reality; and this caused me, one day, to say to the social worker, as a wry comment on the man's condition "You see, he's never alone, with the man from South Norwood!"

The reason for this irreducibly social nature of our constitution needs little stressing. It lies in the fact that we're born into a social milieu which is as fundamental and necessary to our lives as the air we

breathe and the food we eat. "There's no such thing as a baby!" said Winnicott - only a mother-and-baby; and his whole work is really an elaboration of this basic idea. The two together - the mother and baby as a couple - form the first delicately attuned system which supports the baby's physical and psychological growth. Out of this system is born the baby's self. So this self is indissolubly social, not just in its needs, but in its very essence.

I find it a curious fact that although from the beginning we're embedded in such social systems - we're always part of a dyad - we're frequently not aware of this fact at all. If it takes a long time for the baby to become aware of the mother as a separate person, for how much longer does the dyad itself remain outside of personal awareness?

This lack of awareness of the couple of which we're a part is something we have to confront, not only in thinking about babies, but also when we consider marital couples. Each partner in the marital couple sees only the Other: From where I stand , I can only see you. You're the cause of everything that happens. From where you stand, all you can see is me. From your point of view, I'm the cause of everything that happens. "It's your fault!" is how it seems from this dyadic perspective. So how do we get from here to seeing ourselves as part of a couple? How do we get to seeing the system of which we are a part? To seeing ourselves as equal players in a dyadic game? This is not only a developmental question but also a therapeutic one. As marital therapists, for example, how do we help the couple to make this dynamic shift?

It was Archimedes, thinking of the power of the lever, who said: "Give me a place to stand and I'll move the world!" The point was that the world could not be moved from any place *within* the world; there had to be a fixed point outside of the world on which to stand for there to be any leverage possible. This, I think, gives us a clue. There has to be a point outside of the dyad, from which to view the dyad, just as there has to be a point outside of the world from which to lever the world (1). Only from the outside can the dyad be *conceived* as such.

So where is this outside point? It's not enough for the child to move into the mother's position and see himself through the mother's eyes. The capacity to do this marks an important developmental achievement but it will not help the child to conceive of his mother and his self as a couple. For this to be possible there has to be a third position. And in the nuclear family we can think of this position as that of the Father (mother = 1; self = 2; father—3). If I can move to his position (I am the child now), suddenly I can see something quite new. Until now I had looked out from where I was and seen my mother - the other person in the dyad. Or I had looked back from her position and seen myself. But from the third position, this new thing, "the couple", swims into view. This 'third position' is the Archimedean point

To my mind, this is one of the most fascinating things about the couple that it can *only* be conceived of from the outside. It's only when you're *not* a part of it, in a sense excluded from it - that you can comprehend what such an entity is. Only when you're standing back and looking, only when you can see 'this one' interacting with 'that one' and can see that what they are doing has a kind of coherence about it, only then does the notion of 'the couple' begin to take shape It's almost as though the very word 'couple' put a boundary round the two participants and made of them something new (but it's not really the word that does this; the word marks a way of seeing that has already been achieved). I'm reminded here of Jean Paul Sartre's comment (1976, p. 115) that the unity of the dyad can only be constituted by the third that looks at them. One could almost say that if there were *only* an Adam and Eve in the world there could never be a couple. There had to be a third party, a God, before the couple could take shape.

So perhaps one could say that when you are the marital therapist there is a real sense in which *you* are this constituting third, this father, this god. It's only through your eyes that these warring and fighting individuals may begin to see themselves as a couple.

I ought to stress that what I'm talking about here is being aware of the couple as a meaningful unit, not being aware of it in some more immediate, less conscious and perhaps bodily way. I could perhaps be an adequate dancer without being aware of myself and my partner as a couple. I could also be a good lover who responds to the rhythm without being aware of the two of us as a couple. Awareness of the couple as couple always involves the outside, 'looking' perspective.

In this sense, it could be asserted that 'the couple' is essentially a visual concept. But I'll come back to that later. For the moment, I want to characterise more fully the nature of the dyadic interaction which precedes the arrival of the third (and in that sense, the realisation of the couple).

Henri Rey's dictum, in keeping with much psychoanalytic thinking, sees the individual as involved in an *instinctual* relationship with their dyadic Other. By contrast, Winnicott's work on play, and even more, some of the work that comes out of empirical observation of mothers and infants, suggests that this view is too limited. Empirical infant research particularly sees the interaction of mother and infant as structured in complex *non-instinctual* ways which often have a repetitive, almost game-like quality about them. Brazleton and Cramer (1991) for example, in their book *The First Relationship*, emphasise not only play as a form of structuring of the mother-infant dialogue. They speak of synchrony, symmetry, contingency and entrainment as characterising the developing relationship. About entrainment they write:

> ***"The reason for this irreducibly social nature of our constitution needs little stressing. It lies in the fact that we're born into a social milieu which is as fundamental and necessary to our lives as the air we breathe and the food we eat."***

"Infant and mother begin to anticipate each other's responses in long sequences. Having learned each other's requirements, they can set up a rhythm as though with a set of rules. The power of this rhythm soon establishes an expectancy: both for the results of complying with the rhythm and for interrupting it. So powerful is this expectancy that it seems to carry each member of the dyad along ... Like a first violinist, one member can then "entrain" the behaviour of the other by instituting a rhythm of attention and inattention which has already been established as a base for their synchrony. Their interaction thus takes on a new level of involvement "(p. 124).

The musical analogy seems apt. Reading about this work on early development, it's easy to think of the mother-infant interaction as a kind of dance - what we begin to see is an interaction that is structured in time. Each partner builds on the other's moves; each learns the Other's moves and then initiates the Other into new and more complex variations. The resulting 'dances', as we might call them, are unique to that couple. From the *outside,* the position of the third, *we* can perceive their dance-like form. But from the inside this is probably not so - they are mutually cued sequences unfolding according to an inner programme that is sensed, but not known.

In what form these 'dyadic dances" are registered is an intriguing question (and one that Daniel Stem (e.g. 1985), among others, is attempting to answer). They are not available to consciousness, though the totality of the dance is in some way engraved in the body of each partner and can be called out and unfolded in the field of action. In this sense they are *un*conscious. Their totality is not registered on the level of thought - it is pre-symbolic and pre-representational. The point I'm trying to make here is that the dance can be enacted from the inside in an unconscious fashion, dyadically,

"The presymbolic nature of the dance's encoding adds to the poignancy of the loss. If the dance could be recalled in its totality, if it existed in some kind of notation within the remaining partner, it could be replayed, and eventually cherished as a comforting memory."

but it can only be known and conceived of from the outside, from the third position. In this sense, knowledge of the dance as a totality is exactly similar to perception of the couple as a couple - a perception that I've already argued is only obtainable from the outside, third position.

But to go back to the dyadic interaction - I've tried to delineate this kind of interaction in some detail for two reasons. Firstly, it helps us to understand how damaging the loss of a dyadic partner may be. In the case of the infant, for example - it's not just the loss of a mother who knows how to satisfy her baby's needs that is in question; nor the loss of the mother as a unique attachment object with her particular face, voice and smell. It is something more complex and kinetic than this - the loss of the only partner who knows each step of a dance uniquely created by that couple. The presymbolic nature of the dance's encoding adds to the poignancy of the loss. If the dance could be recalled in its totality, if it existed in some kind of notation within the remaining partner, it could be replayed, and eventually cherished as a comforting memory. But as it is, it's as though lost forever - unless it can be resurrected in a new embodied form. I wonder if this could be one way of thinking about the repetition compulsion and the transference? I'll try and say more about this later.

My second reason for dwelling on these shared dyadic structures is because they offer a new slant on adult partnerships. It's fairly easy to transpose the mother-infant relationship to 'marriage as a kind of dance', each manage having its accumulated and unique steps as part of its fabric. The search for 'the right partner' may be determined in part by the need to find someone who dances a similar step. And over the long years of a marriage many improvisations and thematic variations may be added to the repertoire.

All of this is about the couple as an interactive dyad. I'm now ready to talk about the more familiar sense of 'the couple' - the parental couple as some kind of representation or phantasy within the individual. But again, I want to develop the theme in my own way.

One of Freud's main attempts to discuss the origin of the inner parental couple was in The Ego and the Id (1923). At this time he was trying to work out the resolution of the Oedipus complex and the structural consequences of this for the individual. He had already established in Mourning and Melancholia that the giving up of a libidinal object in some way led to its incorporation in the ego as an introject (obviously, I'm using Freud's language). He now applies this idea to the Oedipus complex. With some difficulty, and a certain lack of clarity, he decided that the resolution of the Oedipus complex involved the child in giving up its libidinal relationship to *both* parents, *not* just to the parent of the opposite sex. This means that the little boy, say, did not just give up his libidinal attachments to his mother, internalising or introjecting her into his ego. For this would have created a theoretical problem, giving the little boy a predominantly female identification. He also had to give up his father as libidinal object and in similar fashion introject him. Having got to this position with evident relief Freud considered the fate of these introjects. He writes:

"The broad general outcome of the sexual phase dominated by the Oedipus complex may, therefore, be taken to be the forming of a precipitate in the ego, consisting of these two identifications in some way united with each other. This modification of the ego retains its special position; it confronts the other contents of the ego as an ego ideal or superego." (P. 34).

Freud doesn't use the word 'couple' here, but note his language: ..."a precipitate in the ego consisting of these two identifications in some way united [or we could say, coupled] with each other."

It's not clear if he imagined them as being in some kind of intercourse with each other, or whether he was speaking in a purely structural way. I think it was more likely the latter and I guess it was left to the Kleinians to develop the sexual connotations of the inner parental couple more fully. In any case, I don't want to get bogged down in such historical considerations. Instead, I want you to feel your way into the Oedipus complex and imagine how it might unfold experientially. The aspect I shall emphasise is the *experience of exclusion* - as I mentioned earlier, it is the sense of being outside the dyad which seems to be constructive of 'the couple' as a new element of experience. I think what I'm saying has quite a bit in common with Ernest Abelin's concept of triangulation (e.g. 1971 and 1975).

So what is this experience which we call the Oedipus complex? As long as the child is immersed in dyadic relationships, each parent will appear to the child as an object who is gratifying for *him alone*. This can mean anything from need satisfier, in the instinctual sense, to being the required Other in a 'dyadic dance'. We can build into

"Freud doesn't use the word 'couple' here, but note his language": ...a precipitate in the ego consisting of these two identifications in some way united [or we could say, coupled] with each other".

this story the various stages of separation-individuation; and later we can add in the father, perhaps as an alternative organising centre for rapidly accumulating experience of the world 'out there' - the world of 'other-than-mother'. But through all of this -whether it be the earlier stages of bodily involvement, or the later stages of 'practising' (Mahler, Pine and Bergman 1975) with distance and separation - the self orientated availability of each parent remains paramount. Experientially, the parents 'belong to' the child.

But now comes the Oedipal 'moment'. The child sees the parents together and suddenly -a new insight.. and a potential trauma: Mummy and Daddy are the dyad and he is the outsider. Something

has turned the world on its head. No longer are these pivotal figures his two reliable sources of satisfaction. In *this* moment they exist *for each other alone*. He, the child is the excluded third party.

The structure of this new relationship is fundamentally new. If the dyadic relationship was exclusive , this new triadic relationship is exclud*ing*. The child is no longer part of the inter-acting dyad but is forced into an *observer* position. He is audience, not actor, and has to look on - allowing unwanted events to take place between these two loved figures which have nothing whatever to do with him. It's as though a new boundary has been thrown around the interacting parents; at one and the same time *this excludes the child from participation* and *constitutes* the new unity - the couple.

We, the theoreticians, can get very hung up about what specifically the parents are doing within their new boundary - and maybe this reflects the child's curiosity about what is going on there. Is it something physical, a primal scene, for example? Or are the parents merely engaged in intense conversation with each other, as John Padel once wondered (personal communication)? The child's *need to know* must surely be fuelled by the sense of exclusion, but from a formal point of view the detail is not that important. What is important is the sense of a new space having been created (in the child's world) - this space of the couple - from which the child is utterly excluded. Equally important is the realisation that an interaction is taking place there which is wholly independent of the child himself.

"In this sense, the interpretation can be seen as continuing a process of empathic or maternal 'holding' which is the underpinning of every therapy. This is the dyadic or maternal aspect of therapy."

I referred to this development as the Oedipal 'moment'. I'm not suggesting by this that the child's realisation of the new situation comes often or necessarily as a 'road to Damascus' kind of experience. Much more likely is a long period of struggle and working through, in which an initial glimpsing of the new reality is denied, fought against, resisted - but eventually allowed.

Acceptance means internalisation - the setting up of a new pattern within the individual. I mean of course the setting in place within the child of a structure formally corresponding to the new external triadic structure. Psychic structure, at least in part, begins with structuring of the outside world. Outside then becomes inside.

I now want to ask what is the importance of this development for psychological growth. Clearly it marks an enormous stride in the acceptance and development of 'reality'. It also marks a major curtailment of infantile omnipotence. But perhaps even more important - it introduces into experience a new triadic structure which is altogether different from the dyadic structure it replaces.

To recapitulate on these differences: The *dyadic* structure is an action structure, in which I (the child) am centrally involved and utterly immersed. It includes no space for reflection or observation - it is irrevocably tied to the object/action world. The triadic structure is quite a different matter because it establishes for the first time a *purely observational position*. Because I am excluded from the dyad, acceptance of the Oedipal structure implies that I cannot any longer move freely from 'looking' to 'doing' - there is no way that I can 'have', for example, the body of the Oedipal mother. Equally, there is no way that I can prevent or interfere with this new boundaries action that the couple are engaged in - all I can do is reflect upon it and attempt to understand it.

It is this creation of a 'non-doing' space - a space of 'pure looking' or observation - which creates, as I see it, the internal conditions for symbolic activity. I can here only assert such a position, though I've argued it at length in my book (Wright 1991). The triadic Oedipal space establishes once and for all the space of representational thought - the space of symbols which *reflect* action rather than participating directly in it. I think it was Claude Levi-Strauss who wrote somewhere that the incest barrier was the underpinning of all culture. I would argue that in the form of the Oedipal achievement it is the underpinning of all representational symbolic activity. The Oedipal space, the space of the silent couple in the individual is, in a very real sense, the space for reflection and thought.

We can take this argument one stage further. If the representation of the Oedipal *space* is the space for thought, the representation of the Oedipal *couple* is the basic unit or tool of thought. We can, if we wish, imagine an *isolated* representation , a symbol existing on its own. But we can't really do anything with this: a symbol on its own is just there. When we think, we have to think about 'events'; and there have to be at least two objects together before there can be an event, before anything can happen. So when we try and represent reality to ourselves, it seems to me that the basic unit of such representation, the building block out of which we make all the rest, is the interacting couple - two objects, out there, creating an 'event' that is totally independent of me.

Just to highlight this connection between thought and the silent inner couple, I want to quote to you from Archibald MacLeish (1960). MacLeish, a poet, was examining the nature of metaphor in his book: *Poetry and Experience*. I would argue that metaphor is also a basic tool of thought, the means by which we relate one thing to another and draw the unknown into the orbit of what is known. Listen to what MacLeish says about metaphor:

"I think that one of the means to meaning in this art" (he's talking about poetry) "is a certain relationship of images: what might be called a coupling of images, though the coupling may include more images than two. One image is established by words which make it sensuous and vivid to the eyes or ears or touch - to any of the senses. Another image is put beside it. And a meaning appears that is neither the meaning of one image nor the meaning of the other nor even the sum of both - but a consequence of both - a consequence of both in their conjunction, in their relation to each other,. (p. 66).

So this poet, who as far as I know had no close connection with psychoanalytic ideas, thinks of metaphor as a coupling of images, and of a new meaning being born from their conjunction. Underpinning the structure of metaphor, the silent couple seems to lie at the very heart of our way of making sense of the world. One implication of such linking of representational thought to the Oedipal development would be that the capacity to think might somehow be impaired if resolution of the Oedipus complex were incomplete. I'm not suggesting that a person would be unable to talk in such a case. But it might be possible to detect some difference in mental functioning - in the capacity to stand back and contemplate sensuous events, for example, when a person is still locked into the dyadic mode. I shall leave you to think about this in relation to your own clinical experience, and perhaps we can return to it in the discussion.

Let me summarise this important shift in psychological development from dyadic to triadic organisation. The critical factor is that of exclusion the development of tolerance to being the excluded third party. The world is no longer composed exclusively of dyads that include me. It can, and mostly does, consist of interacting dyads which are independent of me, and which get on with their business as though I didn't exist. In this sense the Oedipal scenario is the prototype of all reality; and the structure it engraves in our experience is the template with which we make sense of all reality. Because it creates an internal space from which the child (the subject) is excluded, the Oedipal scenario establishes in the mind a space for

"What I'm doing here is asking the patient to move from the dyadic action mode (the dyadic inter-action with the therapist) to the triadic observing mode. I'm saying: "Gan you step into this third position which I've just moved into and look at what is going on between us from there?"

a new kind of object - a "no-action object" or symbol. If we think of symbols as the non-material reflections of objects which re-present them to us, then perhaps we can also imagine them as the "looking patterns" of objects - there to be discovered when we are excluded from engaging with objects in a dyadic, action mode.

You will now understand better what I meant when I said that the origin of "the couple" was in that new kind of looking which can be done from the third position. The couple is constituted through an acceptance of standing off - an acceptance, if you will, of an observational stance. In relation to the parental couple, this is the position of the excluded child who has to learn to let the couple get on with it.

Let me come back for a moment to the *first* triadic shift which I described. This involved finding an external point - a third position - from which to view oneself as part of a dyadic couple. Where does this come in a sequence of development? Almost certainly it comes after the realisation of the standard Oedipal constellation. First the child realises he is excluded from the parental couple, accepting the observer position; later, he excludes himself from the dyad of which he is a part, giving up his action stance within it in order to observe it. Knowledge is the compensation for expulsion.

Why I come back to this is because the possibility of therapy - or at least one important aspect of it - depends on being able to make this manoeuvre of moving out of the dyed and seeing oneself and it from a third position. The situation I have in mind is the interpretation of the transference, but what I am saying would apply equally to any interpretation in which we are asking the patient to stand back from his own experience and contemplate it.

Take the following example: a patient is attacking me for my lack of understanding. "You don't care about how I feel! You just sit there and do nothing. You're probably just thinking about all the money you're earning and what you're going to spend it on. I'm nothing to you. You forget about me as soon as I leave the room."
I do indeed sit there, but I'm thinking about this patient. I think about his relationship with his mother and how he had often described her as rather cold and undemonstrative. I remember that she used to go out to work and that when he was older he was a land of latchkey kid who had to let himself in from school. I'm also aware of the fact that I've just been on a week's holiday and he has missed a session because of this. And somewhere in the back of my mind is the recollection that it's not that long since I put up the fees.

I put all these things together and make an interpretation. I suggest to the patient that he may be angry because of the missed session which reminds him of the fact that my life does not revolve around him. This stirs up all his old resentments about him mother who always seemed to be too busy to care for him; and it stirs up doubts about whether she really loved him at all. I might also have reminded him of the increased fee and how he's always hated paying his bills because they remind him of the limited nature of my involvement - the fact that I can never be the mother he has longed for, even though it now feels as though I'm the mother he has always had.

I give you this just as a hypothetical example. In a way the details don't matter. The question is: what have I done in giving the patient this interpretation?

The first thing is that it conveys my attempt to understand the patient and my determination to go on understanding him even though he is attacking me. In this sense, the interpretation can be seen as continuing a process of empathic or maternal 'holding' which is the underpinning of every therapy. This is the dyadic or maternal aspect of therapy.

But at the same time - and this is the second point - I am saying to the patient something like this: Can you stop a moment and reflect on what is happening? Can you stop attacking me (in other words "doing something to me") and hold off for a minute? Can you let there be a space for reflection? Can you stand back and look at what you are doing and the context in which you are doing it? Can you try and remember the things you've told me from quite a different context of your childhood? And can you compare the one situation with the other and see the similarities?

What I'm doing here is asking the patient to move from the dyadic action mode (the dyadic inter-action with the therapist) to the triadic observing mode. I'm saying: "Can you step into this third position which I've just moved into and look at what is going on between us from there?"

In other words, I'm trying to arouse in the patient the couple and excluded observer type of structure which I've already described: "Step outside yourself and look at you and me!" In asking the patient to make a comparison with the childhood situation with the mother I'm doing the same thing again but with different elements. Putting it slightly differently, I'm *coupling images* within the special space that is created by the third position in a way that is similar to the coupling of images so well described by Archibald MacLeish.

And what is the purpose of this? Isn't the intention, or the hope, the same as that which resides in any coupling - to create something new, a kind of baby. In this case we hope to create a new meaning from the patient's experience - to unhinge a pattern or personal symbol from the lived material of the patient's life. It's almost as if I'd said to the patient: "If you can give up trying to be part of the couple and allow their interaction to proceed; if you can have the courage to look on, to let what is happening unfold, then you yourself may create something from out of this shadowy and silent space of the couple." What I have in mind is that the patient will discover a new pattern, a new tool with which to understand himself- and perhaps the world.

Postscript. ***In my original presentation I gave a clinical example to try and illustrate the impairment of creative mental activity in a patient whose giving up of the oedipal involvement was far from complete. For reasons of confidentiality I have omitted this from this transcript.***

(1) A somewhat similar point was made by John Padel in the reference below.

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REPORT FROM THE REGIONAL VICE PRESIDENT: Dr. Campbell Paul

Infant Psychiatrist Royal Children's Hospital Melbourne

Like the Sydney Olympics in the Year 2000 there are preparations underway for the World Conference in Montreal in the Year 2000. People who require advance notice and information about the conference can obtain this from the conference secretariat in Montreal. Details in our news AAIMH Billboard in this newsletter.

The World Congress will provide an exciting opportunity for people to get together and share their work and experience in the infant mental health field.

Closer to home the organisation of our National Conference on the 26th, 27th and 28th of November this year is well underway. Professor Colwyn Trevarthen, Professor Emeritus of Psychology from the University of Edinburgh, and Professor Bernard Golse of the University of Paris have both agreed to participate in our meeting. Colwyn Trevarthen is of course the pioneer of the work 'looking at the detailed analysis of mother/infant interaction'. He promulgated the notion of a primary inter-subjectivity that exists for infants in their relationships with their parents. He will talk about his early work with infants parents, and how this has influenced his later understanding of the development of the mind in the baby. Bernard Golse similarly is very interested in the baby and her mind. He comes very much from a clinical perspective, working at Hospital St. Vincent de Paul in Paris. His work there is with infants hospitalised with medical and surgical problems, and particularly has worked with a neonatal intensive care unit. He has also got an interest in autism in very young children as well as approaches to infant/parent psychotherapy and the application of infant observation to child psychiatry.

The National Committee of AAIMH has had a further teleconference recently and discussed many matters both organisational and those relating to the welfare of infants and their families. Pam Linke in South Australia has been responsible for identifying the ways we can effectively lobby for better care of infants and young children. She is happy to receive submissions from people about our role in public lobbying and advocacy.

As an Association there may be a role for us to assist with refugees, both very recent and those already in our country. As clinicians we are only too well aware of the impact of major social disruption upon babies, toddlers and their families. If the Association can facilitate clinical and consultation work for such dislocated families, the Executive Committee would be very pleased to hear.

CAMPBELL PAUL

WHAT HAVE THEY DONE TO MY BREAST, MA?

Michele Meehan R.N. R.M.
Maternal & Child Health Nurse Consultant
Royal Children's Hospital
Melbourne, Victoria

The title for his paper sprang into my mind as I was thinking about the baby's experience of weaning from the breast. For those for whom it rings no bell, the song by an American folk-pop singer Melanie is:

" Look what they've done to my song Ma,
it's the only thing I could do half right
and it's turning out all wrong, Ma"

Weaning a baby from the breast during a hospital stay goes against all notions of attachment, well being and security. However situations arise when it may be necessary, desired or unavoidable. The meaning of the breast to the baby, mother and father may often be a far cry from that attributed by the health professional in a care management plan. Too often breastfeeding may be seen as merely a food, and persistence with breastfeeding an "interference with good management": at best a whim of the mother, at worst an obsession.

The development of the Paediatric Baby Friendly Hospital Criteria[1] and the development of a policy on breastfeeding in paediatric hospitals, can allow health professionals to be more assertive in advocating for the baby. Acknowledging the baby's desire and need of the breast can provide empathic support for the mother who needs, reluctantly to wean.
Eating is fundamental to life, but the infant enters life dependent on the mother providing food for survival. Feeding is therefore an interaction between mother and child, with the development of feeding and eating skills dependent on the growth of this relationship.
The progress from one stage to the next depends on the infant signalling his readiness and the mother responding and encouraging the development of independence.
If they are not in synchrony in this process feeding problems may arise.
In the earliest relationship feeding comes to mean more than the giving of nourishment, for in the tie forged between mother and baby, feeding symbolises love. Emotional conflicts may therefore be played out in the act of feeding. Acceptance and rejection of the food by the baby may be interpreted by the mother in terms of her emotional needs.

What then if the baby finds his enjoyment of feeding is removed and a less than satisfactory substitute is forced up on him/her ?

Working as a Maternal & Child Health Nurse Consultant with families who may be breastfeeding, the distress of both mother and baby when weaning is necessary, is similarly distressful to see.
The title came to me in the words of a mother "poor darling he must wonder what we are doing!"

To understand the distress need to understand the meaning of feeding.

It's not just good health, nutrition or food, but may even seem a matter of life & death. To feed a baby is to keep it alive, and daily weight gain is a phenomenon of these early months and years, a sign to the parent that they and the baby are doing well.
To be a good parent is to nurture and help your baby grow both physically and emotionally. The dependence of a baby on its parents for food is part of the development of trust and love in this relationship. Feeding especially at the breast is often synonymous with offering comfort, and the predicability of receiving food, when he signals hunger, enhances a baby's sense of security and trust

The meaning of the breast
The motivation for the decision to breastfeed or not is different for many parents. To parents, the decision to breastfeed may be because it is promoted as best for the baby; it is a commitment gladly undertaken, a gesture of effort, time and emotion.
Pleasure in being able to nurture, to enjoy the baby's pleasure as well as the time together during feeding, may be synonymous with the decision to breastfeed; ensuring the baby's well being by giving the best possible nutrition. While it may not always be easy, the struggle may seem worthwhile.
Whatever one's own personal experience or beliefs, health professionals have a responsibility to promote breastfeeding as best nutrition and best for baby.
The predictable availability of the breast and it's food is linked for the baby as all things; mother herself, comfort, food, pleasure, love, physical contact, learning, quenching the thirst/hunger.

The meaning of weaning
"Substitution of milk other than breastmilk" ,"Physical separation from the breast" is just a definition but it is also an important developmental progress: a sign that it is time to move on, an ability to take other food, and/or an interest in the outside world.
Separation: a sign that the baby is ready to separate, and mother is feeling right about letting him/her go.
Loss of the intimacy of babyhood and the exclusiveness of feeding and nurturing.
A transition time: an acknowledgment that the baby is growing, that time is moving on.
Independence: a need to accept that the baby doesn't need the same, that parents are ready and want him/her to move on and grow up.

When is the time to wean ?
This personal decision or preference is usually decided by the mother or the baby, or both, not outsiders.
It may be based on past experience: if breastfeeding was for a short period last time, parents may want to do it longer now, or they believe this age was a good time.
Weaning is usually when mother is ready, sometimes also when the baby signals readiness. Sometimes the baby's signals of his /her readiness may come as a shock to mother.
The hardest time is when breastfeeding is no longer possible though still greatly desired.
When feeding is going well the decision or need to wean may be devastating to mother but too often we presume the baby will go along with our decision.
However what does the baby say about this? In a strong statement of independence he may categorically declare "NO WAY!!"
" It's the only thing we could do half right, and it's turning out all wrong..."

CASE STUDIES

The impetus for this paper came after a surprising 5 week period where I was involved with 3 cases of undesired weaning.

For one child Alan, weaning was desired only by the mother, but Alan was experiencing a slowing down of weight gain over 3 months. Between 3 months and 11 months of age Alan begun refusing any food other than breast milk. Mother had been trying to introduce another food from 6 months of age. The constant

breastfeeding was tiring her, feeding had developed into constant attachment to the breast.

In a second case, Bill 5 months, had been diagnosed with a condition that meant he needed specially monitored protein intake, a rare instance where breastmilk was not suitable.

The third baby Colin, 2 months of age, was premature, born at 28 weeks. His weight gain progress with breastmilk and breastfeeding was slow. Mother felt a bottle might be better, and could mean Colin may leave hospital earlier.
The response to the plan to wean each one of these babies, caused mixed feeling from the parents and was universally the same from the babies, absolutely negative.
Alan was furious. He refused a bottle / cup / food, refused to have his mother holding him when she wouldn't let him feed, hit and pulled her hair. He screamed and threw things at her when he woke in the morning, his mother was distraught by his distress, and became tearful whenever he behaved like this.
Bill's mother's distress was severe. For her and her husband breastfeeding was equated with being a mother. Bill had become acutely ill, and on recovering from a coma found he had lost not only the breast, but also his mother. Bill's mother felt she was unable stay with the baby and cope with his own distress when the baby was so angry and upset at not being able to feed. This led to her feeling more guilty, especially when Bill refused the bottle as well. He occasionally took food / bottle from Grandmother / staff, but this only exacerbated his mother feelings of distress and loss.

Colin's response was somewhat different. He had been slowly growing and developing, gradually increasing the amount of breastfeeding. This was then stopped and he was offered a bottle. His response might be termed as "passive aggression". He seemed confused, refused the bottle. But he had started to wake 3 hourly for the breast now, he needed to be woken. He stopped gaining weight, and took a long time with the bottlefeeds.

Too often the decisions regarding feeding are made around the needs and / or difficulties of those caring for the baby. Workers in Infant Mental Health need to promote thinking about not only the baby's reaction to changes in feeding but also his contribution to the feeding interaction.
How can we help both mother and baby in these situations? What response from us will help the baby and his / her parents ?

Unfortunately the refusal of the baby to wean is too often seen as a win / lose situation. "If you give in to him, you'll never get there" By helping the mother/father understand and accept the baby's response whether angry, passive or distressed, and by validating the strength of the baby's reaction, the issue of who 'wins' is diminished. By talking to the mother and baby, using language that was genuine you are able to offer understanding and interpretation of the baby's messages. E.g..: "He's really angry with you refusing him the breast ". Some parents laugh at the baby's 'tantrums' (too strong emotion from babies), it can be seen as amusing by adults. These 'tantrums' are not acknowledged for what they really are - an honest expression of feeling.

By ensuring there is time for mother to spend with the baby other than feeding attempts, the relationship does not deteriorate into a battle of wills. Allowing or introducing aggressive play with older babies, acknowledging their anger through play, hammering, throwing games, drumming, allows suitable aggressive outlets. When talking with Alan's mother he wanted to feed and she refused putting him in the cot with some toys. His response was to fling a ball at her; I caught it and flung it back to the foot of the bed. This developed gradually into a quieter response of a tossing and catching game in which he let his mother join. If parents respond to this play and verbalise the anger, the baby may feel less compelled to act this out in the feeding situation. Similar responses of banging a tattoo on the bed in rhythm to his kicking helped acknowledge that anger was okay, and we would continue to interact with him.

We needed to replace for the baby and the parents that which is lost with the loss of breastfeeding.

The lost security of the change from the normal routine / familiarity is emphasised by the change in feeding 'what does this bottle have to do with my being hungry!" The mother's separation from her infant especially if others are trying to feed him may also seem as a desertion that is hard to understand. The feelings of unfamiliarity, the need to learn new skills both by the baby and parents especially by mother who may have never given a bottle (weaned a previous baby straight to a cup) may be a major adjustment. The subsequent feelings of loss of confidence in parenting role may lead to the baby being affected by parents' hesitancy and distress.
Helping the family through this stressful time takes patience, empathy and support. In these cases it meant time in hospital. The baby won't start drinking in 24-48 hours, and sending them home to manage alone is a recipe for disaster. The father's needs were also huge, as he was seen as the one to intervene with the baby as well as support the mother. Active involvement by fathers was a strong feature in all but the Colin's case.

Bill's father was as committed to the value of breastfeeding as his wife and found it hard to reassure her when he felt the loss greatly. He was thrust in the role of supporting her, and being go-between with the hospital staff when Bill was being most adamant about refusing the bottle. Mother felt that staff perceived she wasn't rea[illegible] trying.

Alan's father took over a lot of the care of him and encouraged his drinking and self feeding skills. He found it hard to balance doing things for Alan while trying not to feel he was taking him over from his wife. He stayed at night to attend to him and ensured they had time all together when it was not meal times. He was sympathetic and caring to his wife, listening to her doubts and assuring his support in any decision At one stage he stated that he would help her with her decision if he could work out what it was! She laughed and agreed that she wanted to wean and they'd do it together. This seemed a turning point for her in not being so tearful over Alan's behaviour.

What have they done to my brain, Ma....I think I'm going insane, Ma!

The aptness of Melanie's song is further demonstrated by the second verse.
The outcomes for these babies were that we were successful in achieving weaning in the first two cases, the babies established bottle and cup feeding. Colin the prem baby went back to the brea[illegible] and we just had to wait ! The true success can only be measured by the ongoing relationship between the mother and baby.
The distress around weaning can be severe for both mother and baby, and this stress can make normal behaviour and decision making impossible. feelings of 'going insane' acknowledging a strength and motivation of the individual's (both parent and baby) commitment to the breastfeeding relationship, should be a vital ingredient in management advice and ensuring a caring response to weaning decisions whether voluntary or not.

Minchin M. Minogue C. Meehan M. et al Expanding the WHO/ UNICEF Baby Friendly Hospital Initiative (BFHI): Eleven Steps to Optimal Infant feeding in a Paediatric Unit
Breastfeeding Review Vol4 No 2 1996

STATE NETWORK NEWS

NSW COMMITTEE MEMBERS 1998/99

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From: Kerry Lockhart

The AAIMHI (NSW) Committee is very excited about our new series of clinical papers and presentations which commence this year with Professor Ben Bradley from Bathurst who will be speaking about his book: "Visions of Infancy". Ben Bradley will be talking about the ways in which our thinking about infants changes the models we use to describe and explain their behaviour. Those of us who have heard Ben speak before will know that he is an entertaining, informative and engaging speaker who will be getting our year off to a great start. The date is Friday 19th March, 7 pm at St John of God Hospital, Burwood.

Our "Hypotheticals" evening held last December was an excellent start for this venture, with A/Professor Bryanne Barnett leading a group of experts in the area through a maze of difficult clinical problems and situations. Those who attended were all highly delighted with the event which provided an excellent overview of how to manage the problems presented in a case of post-natal depression.

Susan McDonough will be our next guest speaker for our AAIMH Clinical meeting on May 6th. She speaks about cognitive interventions in the mother-infant relationship, especially the use of video feedback techniques.

Elizabeth Noble, physical therapist, author, mother and childbirth educator, is visiting Australia from Massachusetts. She was trained initially in South Australia, but has been living and working in the States for some years. She will be presenting at the RHW, Barker Street, Randwick Friday, April 9th from 1:30pm to 2:30pm. Topic: *Bonding with Multiples* and the next day presenting a half day workshop, Lecture Theatre, RHW with two presentations *Pre & perinatal Origins of Dysfunction and Disease* and *Prenatal Memories*. Contact Dr. Leo Leader, Dept. of Gynaecology, RHW. Cost $50:00 for half day workshop.

Welcome new members! Greetings to Kari L'Anson, Director of Van Services in Penrith and Natasha Figon who is working at Karitane Mothercraft Society. Also, welcome back Dr. Denise Guy who is working at the Child and Family Service in the Hutt Valley, Wellington, New Zealand.

QUEENSLAND COMMITTEE MEMBERS:

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From: Marainna Huxley: **craig@dyson.brisnet.org.au**

Greetings to all

Like most around the country we are looking forward to Susan McDonough's visit. I am quite sure the woman will be bombarded as soon as she arrives in Queensland. There is quite a lot of activity in this neck of the woods in the use of video as a therapeutic tool with mothers and their babies. Many of us are combating our technophobia and in this regard perhaps some of you can help. I am planning to buy a digital video camera and computer software to facilitate editing etc. What is everyone else using? Something incredibly simple would be wonderful, however I am a realist ! If anyone has any advise I would be most interested. My email address is **craig@dyson.brisnet.org.au**

Even if you would just like to let us know what you are going in Well on with the news from the (wet) north. We are busily organising our meetings, clinical and otherwise for 1999 and I am not sure I agree with the old adage "If you want a job done, ask a busy man" (or woman) ! Although we are a moderately small group our members are increasing and I think this reflects the level of interest and knowledge surrounding infant mental health. More and more therapeutic intervention programs are being established in the state and I hope to bring you news of this, as the year progresses. With a little luck we will learn more about the effectiveness of these interventions as they are evaluated and presented.

A recent clinical meeting was hosted by AAIMH (Qld) in which clinical material was presented and supported by video footage. The discussion generated could have gone on but time was against us. This brings me to yet another request. We are interested in coding video of parent - infant interaction styles. If you know of any empirically based work could you mail me at the above address. Many thanks.

SOUTH AUSTRALIA

Pam Linke
Senior Project Officer
Marketing and Corporate Communications
Home email: linkes@newave.net.au

From: Linke, Pam (CYH)

We have plans well under way for the visit of Dr Susan McDonough in May, in conjunction with Helen Mayo House.

We are also negotiating with Graham Vimpani to have a resentation by Bruce Perry when he is here for the paediatrics meeting next May. We were hoping to have the national meeting at that time so we could have him as a keynote speaker, but unfortunately there were too many clashes. We are now planning tentatively to have the national meeting at the end of October.

Our video "What about fathers?" is selling well. We have had a grant from the South Australian government to take it to country centres, using it as a discussion starter for groups. Sessions have already been arranged in two country towns.

Elizabeth (for the Child Health Council) and I (for AAIMHI) attended a meeting in Canberra last Friday to look at an initiative to promote the interests and needs of the 0-3s in the first 3 years of the new century. A group from different professions and organisations across Australia met to look at the proposal and make preliminary plans. The meeting supported the proposals and there were different ideas suggested the best way to go about it. The next step is for a planning committee to get together a strategic plan from the work achieved on Friday. More news about this in the next newsletter.

VICTORIAN COMMITTEE OF MANAGEMENT

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Sue Morse
Jeanette Milgrom
Zipporah Oliver

From: Sarah Jones and Michele Meehan

The Victorian Committee is busy organising the next National conference for AAIMH which will be held over the weekend of November 26, 27, and 28th , concluding Sunday mid day. We are very pleased to have two international speakers whose contribution to the field has been enormous. From Paris we have Bernard Golse and from Edinborough Colwyn Trevathan. Currently we are in the process of working with the conference organisers in creating an interesting conference both professionally and culturally. We hope that members of AAIMH from other states will travel south for the occasion.

Michele Meehan is our Scientific Program Coordinator and she has arranged an exciting program of monthly meetings for us. We shall continue to meet at the Graduate Centre of Melbourne University.

The words of Melanie's song 'What have they done to my song MA?"was used as the opening theme of a presentation by Michele Meehan, Maternal & Child Health Nurse at the first Clincal Meeting of the Infant Mental Health Association. The words of the song seemed to express the confusion and anguish of babies who have had no say or control in the weaning process "It's the only thing I could do half right ,and it's turning out all wrong Ma ".Michele discussed the meaning of the breast and of the subsequent decision to wean from the parent's, baby's, and health professional perspective. Asking the question 'what does the baby think of weaning' was illustrated by three case studies, of varied scenarios of situations where the decision to wean was based on medical diagnosis, or poor growth. The response of the babies, two who were absolutely furious and one who seemed to withdraw and become sleepy and undemanding, gave credence to the thinking that this is an emotional and mental health issue not just one of feeding. Melanies' song continues with the line 'what have they done to my brain? ... They've picked it clean like a chicken bone and I think I'm going insane Ma?... While understanding the role of a mother's ambivalence about weaning, how do we help the baby cope with his anger and distress.
The response of Alan (9months) to an approach by his mother, was to fling a toy straight back at her. Using aggressive play (flinging the toy back to the end of his cot) and talking about how cross and angry he was helped Alan and his mother see that there was powerful emotion involved and that responding to it in like manner was more helpful than trying to just understand it. The angry response of the babies was seen as rather a joke, babies aren't supposed to be so angry. Discussion eventually had to be cut short but the issue of thinking about the baby's response and advising that this be verbalised and acknowledged may help babies and their parents cope with this difficult situation.

Sarah Jones and Michele Meehan

WESTERN AUSTRALIA

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Newsletter correspondent:
Carmel Cairney, Clinical Psychologist

From: Carmel Cairney

We commenced our monthly presentations with a stimulating talk from Dr Julie Stone, Consultant Psychiatrist, about her training in Melbourne, and about the new plans for a mental health service for Under fives and their families. There was a good attendance despite the Festival of Perth, and the heat.

Susan McDonough is planning to visit in May and we are looking forward to two workshops presented by her.

Our advocacy sub-committee is alert for opportunities to speak on behalf of infants. Letters have been written and sent on a few relevant issues.

Carmel Cairney

• *NEWS FROM ABROAD*

INFANT MENTAL HEALTH IN JAPAN

BY JULIET HOPKINS,
Consultant Child Psychotherapist, London

"Four Winds" is the name of the Japanese Association for Infant Mental Health, chose to indicate its openness to ideas blowing in from all directions. In November 1998 I had the very great privilege of being invited, at the instigation of Dr. Hisako Watanabe to participate in its second annual conference, held in the Peace Memorial Centre at Nagasaki. So I came with the West wind to join three hundred delegates from many different disciplines: paediatricians, child psychiatrists, psychologists, social workers, nursery nurses and nursery teachers. They were eager to learn about the clinical application of attachment theory from me, via my interpreter, Hisako Watanabe. Much of the conference was lost to me because of the language barrier. It included many case presentations made by teams of mental health workers concerned with various aspects of the family or network systems. Two case presentations were translated for me so that I could comment on them.

Case 1 concerned the development of a 7 year old girl in a children's home after she and her mother had escaped from her violent father. The child-care workers in the children's home gave a vivid account of the difficulties posed by the girl's violent behaviour and by their hatred of her which her violence aroused. There was nothing the least "inscrutable" about this honest admission of feeling. A paediatrician recounted, with slide of sand tray play, the girls progress with her weekly play therapy and a social worker described her weekly meetings with the girl's mother who had gained confidence to tell of her own abusive behaviour to her daughter. A senior team leader coordinated and supervised the work.

I was most impressed by the clinical sensitivity of all the work presented, by the openess of the worker's feelings and by their mutual collaboration and respect. What they lacked in theoretical concepts, they compensated for with intuition. It was surprising to hear about a seven year old, but it seems that the Japanese concept of infancy is much wider than our own.

Case 2 concerned a boy of five years who had been in a day nursery since the age of 4 months. The nursery workers gave a very thoughtful account of the boy's development within the nursery and of his relationship with his mother. They were concerned that despite their efforts to help him, the boy had become a bully in his primary school. It seemed to me that the boy had an intensely ambivalent attachment to his mother whom he had dominated with coercive behaviour at home while behaving in a passive and timid way in the nursery. I thought that the support offered by these observant and caring nursery nurses had enabled him to reveal his underlying anxiety to them whilst he was at nursery, but then at primary school he had been thrown back on his defences. Nursery workers had collaborated closely with school teachers and with the mother, as far as she allowed. Once again containment appeared to have been outstanding, but the workers' perplexity about some of the issues, like mother's hidden rivalry with them could have been resolved with more conceptual understanding.

In Kochi I visited a home for abused and abandoned babies and a state run day nursery. In both places there was a very high staff ratio. At bed time in the bay home there was a worker for every two babies and the staff took great pleasure in holding them as much as possible. The large bath was designed to hold a nurse and her two toddlers together and I watched them all luxuriating in it. Newly admitted babies share a futon at night with their assigned nurse until they have settled in, in line with the general Japanese custom of babies and toddlers sleeping between their parents.

Later, I taught more implications of attachment in Tokyo, where nearly 200 professionals took unremitting notes and sat on hard chairs without fidgeting for a long day of slow translation. I was enormously impressed by the great longing to learn from the West and the ease with which attachment concepts can be assimilated to Japanese thinking – certainly it seems to be one of the most easily exportable forms of psychoanalysis which can pave the way for more complex and subjective ideas to follow.

The great barrier to understanding is the language. Although Japanese study 7 years of English in secondary school, it is language so utterly different from their own, that few Japanese can read it adequately and even fewer can speak. I was grateful to the BBC' " Get By in Japanese", which helped me utter a few polite phrases, but the mutual language barrier prevented me from asking all that I would have liked to know. My general impressions was of a very caring, well ordered society with much value placed on mutual interdependence, close family ties, hard work and conformity. I was immensely well and considerately cared for by everyone I met and I am embarrassed to think how casual, rude and detached the Japanese may find us to be.

Tavistock therapists may like to know that I also visited Kyoto in order to see Shozo Hirai , who had left the Tavi in 1997 after 7 years training. Together with his wife, Mariko, a speech therapist, and their delightful baby, Nao, he took me to dine at a famous restaurant where we feasted on an amazing meal of thirteen courses. We sat on the tatami matting while Nao crawled happily about, reliably returning to his mother to nibble morsels from her chopsticks. Shozo reported to his satisfaction that his colleagues were catching on to the idea of working in the transference, but he was finding it difficult to maintain the interest in Freud of some of his university students. There are no analytically trained therapists in Kyoto, so Shozo is eager for other Japanese to train and return to support him.

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AAIMH BILLBOARD

MONTREAL CONFERENCE 2000

News From the World Association for Infant Mental Health

The 7th International Congress of the World Association for Infant Mental Health is being held in Montreal, July 26-30, 2000.

We would like to invite Australian members of AAIMH to the WAIMH congress. As we are all affiliated with the World Association we are hoping members will get the word out to all professionals concerned with infant mental health.

WAIMH will be advertising the conference widely and there will be further notices in your newsletter. We hope you will consider this wonderful opportunity to meet with infant mental health colleagues from all over the world.

Email address: **waimh@UMS1.Lan.McGill.CA**

Further information is available from:
WAIMH Secretariat
550 Sherbrooke Street West
West Tower, Suite 490
Montreal, QC, Canada H3A 1B9
Joan Gross at
waimh@ums1.mcgill.ca or
Dr. Lee Tidmarsh of the Local Arrangements Committee at
mdlt@musica.mcgill.ca.
We look forward to seeing you at the Congress.

Bellvue Child and Family Clinic:

We wish to let you know that the Bellvue Child and Family Clinic has been established in Bondi Junction. The clinic specializes in the assessment and treatment of children and families who are experiencing emotional and behavioural difficulties. The clinic provides services that extend from birth to early adulthood with particular focus on early intervention work in pregnancy, the post-natal period and parent-infant psychotherapy; there is an Under 5's Assessment and Counselling Service; and individual, couple and family psychotherapies. Psychotherapy is avaliable for children as well as for adults.

The team is a multi disciplinary one comprising of child psychiatrists, clinical psychologists, developmental psychologists, psychoanalysts, psychotherapists and social workers.

The model of thinking is psychoanalytic and developmental.

We would be pleased to accept referrals.

Bellvue Child and family Clinic
(02) 9388-9846
58 Grosvener Street Bondi Junction NSW 2022

Dr Ruth Safier Child Psychiatrist, Pychoanalyst and Clinical Director
Ms Pam Shein Psychologist, Social Worker and Psychotherapist
Dr Rachel Henry Clinical Psychologist and Psychotherapist
Mrs Beulah Warren Developmental Psychologist
Ms Leone Sullivan Consulting Social Worker and Psychotherapist
Ms Libby Dunn Psychoanalyst
Dr Eva Balint Psychiatrist and Psychotherapist

Enquiries to Ms.Pam Shein
Bellvue Child & Family Clinic
58 Grosvenor Street
Bondi Junction 2022
Phone 9665 6677 or 9388 9846

1999 DEAN'S LECTURE SERIES

The University of Melbourne
Faculty of Medicine, Dentistry and Health Sciences

15 June 6.00 - 7.00pm **Admission is free.**

Lecture: Who is pushing our kids into the river? The critical function of the first twelve months of life.

Presented by: Professor Jeanette Milgrom, Director of Clinical Psychology, Austin and Repatriation Medical Centre

Sunderland Lecture Theatre
GroundFloor,Medical Building,
corner of Grattan Street and Royal Parade,
The University of Melbourne, Parkville.

For further information phone: (03) 9344 5888