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NEWSLETTER

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# FROM THE EDITORS:

We are very pleased to offer a bumper edition which includes a number of contributions on the theme about the sleep technique called "Controlled Crying". We are privledged to have this topic approached by people from the backgrounds of sociology, psychology, early childhood, child psychiatry, and pychoanalysis. It stimulates encouraging debate and offers a critique of the methods employed. We hope that other readers might respond with their own views.

In anticipation of the November National Conference the editors (&Victorian AAIMH) wanted to whet the appetites of potential attendees. We have done so by summarising two articles by plenary speakers Stephen Seligman and Col Trevarthen, and offering first hand impressions of Col Trevarthen and Bernard Golse. Victorian AAIMH, under the creative and inspiring eye of Campbell Paul and Brigid Jordan and others, have designed a conference with a focus on treatment interventions. Attempting to keep the conference low cost there is an early bird registration, budget accommodation and a central conference venue. We hope all this will tempt members to go South for the last weekend in Sping.

Not only has this edition enlarged but we are please to see that for each print run the number of copies ordered also enlarges. We have approximately 380 members of AAIMH; 450 copies are produced. Surplace are sent to State Presidents, a small number are kept for archives. We look forward to hearing about your view and experience of Controlled Crying and seeing as old and new faces in Melbourne in November.

## 1999 CALENDAR OF EVENTS

**NOVEMBER (VICTORIA)**

**20,21 November: Dr Allan Schore presents a 2 day workshop in Melbourne at the Albert Road Clinic**

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

**MAY 2000 (SOUTH AUSTRALIA)**

**Dr Bruce Perry visits South Australia in early May next year (planning stage), in conjunction with the Australian Paediatrics Conference.**

**JULY 2000 (CANADA)**

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

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# INFANTS AND CONTROLLED CRYING

**Controlled Crying, I suspect, requires little introduction to AAIMH members. It is a behavioural technique aimed at getting babies and toddlers to sleep through the night. It requires the baby being left to cry for predetermined periods in their cot until the baby learns to manage the night alone ie. "to sleep through".**

**Recently discussions have occurred within AAIMH in NSW about the issue of Controlled Crying and whether AAIMH should have a position statement about the technique and if so what should such a statement say?**

**In this edition we have published a series of articles on Controlled Crying with the hope that this will trigger further discussion amongst the membership. We aim to publish a further series of articles around Controlled Crying in the next edition of the newsletter. If you have something to say now is the time to put pen to paper and send it to us. From such a debate we hope that AAIMH's position will emerge.**

*Editor - This article was published in Sydney Child and Melbourne Child and is reprinted with permission. Beth and Anne have been generous enough to summarise some of the emotive responses the article drew from the public and this is included following the original article.*

## 1. Cry Baby, Cry - Why Controlled Crying is Bad for Babies

**by Ann Gethin[1] and Beth Macgregor[2]**

The couple hold each other for support, watching the clock, while their baby sobs away in the next room. "She has to learn", they say, "She's eight months old - she really should be sleeping through the night". When the allotted time is over they go to their child, pat her and murmur reassurances. She is then left to cry for another twenty minutes. Three hours later she finally falls asleep. In the space of a week the baby is sleeping through the night and her parents feel happier than they have in a long while.

"Controlled crying" is extremely popular in Australia, recommended by countless paediatricians, GPs, hospitals, infant health centres and family care services. Dr Chris Green of Toddler Taming fame is a long time supporter, as is American Dr Richard Ferber (in the USA it is know as Ferberization). Many parents are pleased to learn this technique because it means at last they can enjoy unbroken sleep and greatly reduce the time spent settling their babies. What is rarely considered is that controlled crying can damage babies emotionally and psychologically. Human infants have evolved to expect comfort when they cry. Controlled crying, which teaches parent to ignore their babies' signs of distress, involves enforcing a model of how babies should behave contrary to their actual needs. So accepted has controlled crying become that parents who rock or nurse their babies to sleep are criticised for spoiling them and preventing them from learning how to sleep independently.

### What is controlled crying?

The goal of controlled crying is to train babies into falling asleep by themselves. This is achieved by putting a baby in its cot then letting it cry for successively longer periods before offering comfort. After a few nights of this the baby 'decides' it is 'not worth the effort' to keep crying each time it is left and so learns to go to sleep by itself. Babies are thought to be ready from around 6 months, but many parents use controlled crying on much younger infants. Depending on who one listens to, the longest period a baby is to be left to cry ranges from fifteen minutes to over an hour.

If you are a parent it is likely you have either used controlled crying or know a number of other parents who have. Thousands of new mothers stay at family care centres (for example, Tresillian) where they are specifically taught how to 'control cry' their babies. So what is the problem? Although it might be a bit heartbreaking at first, clearly it works: parents get more sleep, babies get more sleep, and it is claimed that everybody is happier during the day. However, consider for a moment the infants and children in Romanian orphanages exposed to the world after the fall of Ceausescu.

The babies and children in these places were virtually silent day and night. They had learnt there was no point crying because no-one was going to respond to them. An Australian woman who adopted two 10 month old Romanian orphans commented how quiet they were until they discovered that she would comfort them when

they were upset. These terribly neglected children were experiencing what is know in psychology as learned helplessness, where humans passively accept the ongoing misery of a situation because they believe that they can do nothing to stop their unhappiness. Controlled crying operates using exactly the same principle: it stops babies from crying because they learn that they cannot escape the distress of being alone and away from human contact.

Infant sleep experts like Dr Green and Dr Ferber assert that teaching babies to sleep by themselves is actually important for their psychological development. They say that this establishes early patterns of independence which will have lifetime benefits. In reality, however, controlled crying does not teach independence but helplessness. If most babies cry when left alone and wake through the night then there are good reasons for this.

## Why babies cry

Babies do indeed cry because "they can't tell us what is wrong": they use crying to communicate with their parents. It could variously mean that they are hungry, tired, frightened, uncomfortable, in pain, sad, or that they just want to be held and touched. It may be something seemingly unfathomable; for example, Sheila Kitzinger suggests that babies may cry more often if their mother has had a very stressful pregnancy or if the baby has had a difficult birth. They may cry due to an allergy to a particular food passed through the breast milk, because of an ear infection or a stomach upset.

We can never be sure, even if we think the baby is crying for 'no good reason' - "he's been fed, changed and burped" - that a baby is not experiencing genuine distress. Desmond Morris, author of Babywatching, comments that just being alone can make babies feel insecure and they will cry until they are 'scooped up in parental arms'. This makes perfect sense: a human baby left by itself is extremely helpless and vulnerable: it is to be expected that it will cry for the protection of its carers.

There are also biological features of humans that suggest that babies are designed to wake frequently in the night. Research by anthropologist James McKenna has shown that children up to the age of two have more periods of REM sleep (the light dreaming sleep we have before waking up) than adults. This means that in their natural state babies will wake more often than adults; it has been suggested that the associated periods of lighter sleep are essential for brain development. Human mothers and infants are also more closely related to animals that are in constant contact with their young than to animals who 'cache' their babies (hide them while searching for food). Breast milk has a relatively low fat content, corresponding to other animals who suckle their young frequently. This implies that we should expect babies to want to be fed throughout the night and that, perhaps, we should be concerned rather than delighted when very young babies sleep through.

The concept of 'object constancy' provides further evidence that controlled crying, especially in infants, cannot possibly be teaching independence. Before roughly eight months of age babies think if they can't see something it no longer exists (for example if you hide a toy they won't bother to look for it); it therefore doesn't matter if parents leave them alone for one or twenty minutes - as far as the child is concerned the parent is gone for ever. Reassurances that "we'll be back in five minutes" are meaningless (even if a baby could understand the words). The child is not able to reason that it is safe and its parents will return; all it feels is abandonment.

We need to ask ourselves: what impact will it have to ignore a baby's cries? Is it really acceptable to disregard a baby's crying because we feel it should be asleep? From infancy children learn to trust other people through the responses of their parents. The baby who is fed when it is hungry, comforted when it is sad, and frequently held and cuddled grows up feeling secure and lovable. If a child knows it can rely on its parents in times of stress it can confidently explore the world and try new experiences. Controlled crying disrupts the trust and attachment between parents and babies through a deliberate denial of a baby's needs.

## Controlled crying as a social invention

It is evident that controlled crying has developed due to the dictates of culture and society. Babies only started to sleep alone in cots in the last two hundred years, mainly as a response to problems resulting from overcrowding and filthy living conditions. Although cot sleeping began for health reasons which are not widely an issue in Australia today, a baby's presence in the marital bed is still considered inappropriate, vaguely improper and likely to interfere with the parents' sexual relationship. However making a baby sleep separately creates its own problems. When he or she awakens the parents need to become fully alert in order to get up to attend to its needs. Sleep deprivation makes life difficult for those having to work the next day inside or outside the home; a tired mother often has no-one to help with the care of her baby during the day. Combine these factors with a societal tendency of looking to 'experts' for advice on childbirth and child-rearing rather than trusting our own instincts and the origins and appeal of controlled crying are readily understandable.

Recent research has found that excessive infant crying is quite uncommon in preindustrialised cultures and concluded that changes in child rearing practices, such as the reduction of close physical contact through the use of cots and prams, might be linked to extended periods of crying for babies.

Balinese children spend most of their infancy (around the clock) in the arms of another person; it is rare to see a crying or distressed infant. The !Kung babies of the Kalahari desert are reared similarly, and have been described "as being as serene and contented as well fed young puppies". Bedouins respond to their babies' every cry, fuss and never leave them alone. Ironically, it is in societies where the needs of infants are identified and

completely indulged that children become independent at an age unheard of in Western society. Whereas many Australian parents still dress their four year olds or get drinks and snacks for them, children of a similar age in other cultures are making important contributions to their household (like fetching water, cooking, and helping with child care). Despite a fixation with babies becoming independent, Western children right up to young adulthood (and beyond!) are effectively dependent on their parents to meet most of their needs.

## Sleeplessness as a moral failing

In our culture there is also a moral dimension to babies' crying and sleep habits. Child psychologist Penelope Leach commented in her book Children First that "in many households an infant's sleeping hours are a yardstick of both his virtue and his parents' efficiency". Indeed, as anyone who has had a baby knows, the question "is he a `good' baby?" is actually referring to the child's sleeping and crying habits. A `good' child is one who sleeps a lot and is easy to manage. A `bad' child by implication is one who constantly demands its parents' attention and is difficult to settle. Such evaluations can create feelings of inadequacy or even shame for parents when comparing themselves to the parents of those `fantastic' babies sleeping through the night from six weeks.

This type of attitude is peculiarly Western and has its origins in behavioural psychology and some early religious beliefs about children. In the early twentieth century behavioural psychologists told mothers that they shouldn't comfort their distressed babies because to do so would reward that behaviour and lead to more crying - hence the popularity of letting infants 'cry it out'. Controlled crying is simply a modified form of this approach.

Historically, Western child-rearing has been about controlling children's anti-social impulses by establishing a parent's authority, based on the idea that children are inherently naughty. It has been considered essential for parents to master their child's behaviour and enforce wholesome habits. Although most Australian parents don't try to beat the devil out of their children any more, the beliefs underlying this practice have some things in common with the Western understanding of infant sleep.

The opinions of some contemporary paediatriaicans reflect the notion of the need to control a child's impulses. Sleep is seen to be a battle of wills which parents must win; to fail is to risk being manipulated by the unreasonable demands of little people. It is their understanding is that it is the sleepless child who abuses its parents. They see it as essential to get babies into a sleep routine from which they will derive lifelong benefit; not having a routine is equated with neglectful parenting and is viewed as harmful to infants. Babies are said to variously 'love', 'thrive on' and 'need' such routine. Behaviours that disrupt parental control - in particular children coming into their parents' bed at night - are regarded with particular disapproval. For example, so determined is Chris Green to stop this practice that he even suggests tying a child's bedroom door closed. And the opinion of Richard Ferber that even if you and your child are happy sleeping together "in the long run this habit will probably not be good for either of you", has distinctly moral overtones.

The question also needs to be asked: why should parents believe what experts tell them is necessary for their children? Just as women have questioned (and continue to fight against) the need for routine medical control of childbirth, so it is important to take a critical view of what is best for our children. Dr Spock, the fifties guru of child-rearing, advised introducing solids as early as one month and that a mother should harden her heart when her baby 'bullies' her by deliberately vomiting. Our grandparents firmly believed in toilet training children under twelve months. The rationale of today' child development professionals can be equally dubious. Infant health nurses tell new mothers, despite thousands of years of contrary evidence, that carrying babies for long periods interferes with their physical development and without adequate 'tummy-time' (where babies lie on their fronts on the floor) they may not learn to crawl properly.

Caring for babies in this society can often be boring, frustrating, lonely and incredibly wearying. Techniques like controlled crying that give us some respite and space from our little ones can appear most welcome. But if we can reject ideas like 'gin to make the baby sleep' or 'bottle is as good as breast', so too we can say NO to controlled crying. Unfortunate as it may seem, human babies are a long, long way from adapting their biological needs to fit in with Western industrial society. What right do we have to break the will and trust of a baby to fit the dictates of the modern world? Rather we need to look to giving more support to parents so that they can bring up their children in a way that is profoundly attached and loving.

"My early years are connected in my mind with my mother. At first she was always there; I can remember the comforting feel of her body as she carried me on her back and the smell of her skin in the hot sun. Everything came from her. When I was hungry or thirsty she would swing me round to where I could reach her full breasts; now when I shut my eyes I feel again with gratitude the sense of well-being that I had when I buried my head in their softness and drank the sweet milk that they gave. At night when there was no sun to warm me, her arms, her body, took its place and as I grew older and more interested in other things, from my safe place on her back I could watch without fear as I wanted and when sleep overcame me I had only to close my eyes".
**(A statement by an East African chief, quoted from Ashley Montagu's Touching.)**

We thought that AAIMH readers would be interested in reading extracts from letters sent to Sydney's Child and Melbourne's Child following the publishing of 'Cry Baby Cry' in those magazines in July of last year. We were astounded by the response that the article provoked. Many people contacted us after it was published, some expressing their heartfelt thanks for the article, and others expressing their anger. The number of letters that the paper received was so great that they could not publish them all. We also heard many stories from friends and col-

## Letter from Beth Macgreggor and Anne Gethin discussing the public response to the above article

leagues about the debate that the article sparked in New South Wales and Victoria.

With permission from the paper, we have compiled short extracts from some of the letters. A large proportion of these were from health professionals. What is particularly interesting about these letters is the intensity of the feeling response. People described their response with words like 'horror', 'anger', 'very real appreciation' and 'delight'. The article was also described as being 'refreshing', 'excellent' and (in a different letter!) 'destructive claptrap'. We wonder if any AAIMH members have any theories for why this issue causes such intense polarisation of feeling?

### Extracts from the responses:

Congratulations to the authors of the excellent article 'Cry Baby Cry'. It confirmed and expanded my deep concerns about the recent proliferation of 'controlled' crying and all its variations under different names. Crying has been described as "the acoustic umbilical cord" between the helpless baby and the caretaking environment. The authors' description of the detrimental effects on the baby of breaking this cord should alert mothers, and support them in following their own powerful instincts to respond to their baby's distress **(Lactation Consultant)**

The behaviour of adults and children is moulded by subtle feedback. The feedback that decides behaviour and establishes the warmth of relationships comes through the tone, closeness, sparkle of eye and gentle magic that moves both ways between parents and children. Stressed, unhappy and overtired parents lack the emotional energy to transmit and receive these all important messages. Children have the right to a warm, emotionally rich, relationship. When this is lost through parental exhaustion, it's time to discard unproved academic theory and respond to this right. **(Prominent proponent of controlled crying)**

How refreshing it was to read 'Cry Baby Cry'. Controlled crying has become so much talked about that parents who choose to respond to their child's needs by feeding and comforting are unlikely to admit to the practice, let alone admit to anything so taboo as co-sleeping. Too many parents have no idea that it is normal for babies to wake and feed at night through the first year. An explanation of why controlled crying is bad for babies is long overdue. **(Senior Lactation Consultant)**

I'm currently having success with controlled crying. It wasn't easy but at no stage did Benjamin (18 months old) shed any tears. He was just crying out in anger. I think that he didn't want to change. Now that he is sleeping through the night and we make sure we get those extra day hugs, he has a happier mother with a lot more energy. **(Mother).**

How refreshing, at last, to read an article explaining the contradictions of 'controlled crying'! My husband and I tried this procedure with our first child with great difficulty and much trauma to us and our little girl. It felt much more positive to hold her in our warm and loving arms to settle and rock her to sleep. I believe our western society tries to make today's child conform to a world that is ruled and lives by the clock. Many parents feel they are even more of a failure when unsuccessfully using controlled crying as it tears, unnaturally, at their heart strings, despite being recommended by many 'Health Professionals'. **(Mother)**

Parents do not need to be told once again how to be better parents, instead we need the support we can get to find our own ways to perform the most difficult job on earth. **(Mother)**

I would like to congratulate Sydney's Child for publishing 'Cry Baby Cry'. As a mother of four children aged 6,5,3 and 9 months it was so refreshing to read an article reinforcing my belief that controlled crying is both distressing for the infant and for the parents. It has taken me till my last son was born to have enough confidence to go with my maternal instincts instead of sticking rigidly to previously instilled behavior patterns If only I had read an article like cry baby cry when I had my first daughter six years ago, I could have saved may hours of unnecessary stress and anxiety.thank you so much. **(Mother)**

I can't remember the last time I've read an article which stirred up so much anger in me. I work hands on with families in the area of infant sleep management, and feel compelled to respond to the emotive and destructive claptrap espoused by [the authors of this article]. One only has to look to see the strong positive correlation between parental sleep deprivation and child abuse, maternal and paternal depression, and subsequent family breakdown. If controlled crying as one small and valuable, can restore some sense of control, order, self esteem and love into our family life, then who has the right to moralise and denigrate its use? (Co-ordinator of a mother-baby unit)

The sentiments of 'Cry Baby, Cry' are rarely viewed in the same way by health professionals who spend hours every week actually helping families, nor by people who are parents. Parents seek advice about their baby's sleep patterns because they are sleep deprived and exhausted, not because of some perceived moral failing of the baby. If health professionals speak strongly against nursing of babies and co-sleeping it is because they are inundated with unhappy parents and babies who need other options. **(Clinical Nurse consultant)**

There seems to be a fear expressed by some experts and their followers that if you don't control your baby it will control you. Well, in the beginning, it can feel like that! But make no mistake, that baby is totally dependent on its parents' goodwill for its very survival. To allow our fears to dictate that we should control our baby is to abuse the very considerable power we as parents have. On the other hand, if we surrender to the relationship, and learn to listen to our babies, it is to the mutual benefit of both mother

and baby and the rewards as the child grows into adulthood are well worth the initial, temporary, sacrifice. **(Mother)**

I was appalled by some statements made in 'Cry Baby Cry' **(Maternal Child and Health Nurse)**

I would just like to express my very real appreciation for 'Cry Baby Cry'. It is so wonderful to be able to find such clear thinking, loving and truly caring thoughts on how to treat our precious babies and children. I have often despaired of child rearing practices in our country.

I would just like to say that I found 'Cry Baby Cry' very upsetting. I have used 'controlled crying' on both my children, who are well adjusted and affectionate.**(Mother)**

It was with horror that I read the article 'Cry Baby Cry'. Only the child's parents know what is best for their child. **(Professional nanny)**

I would like to express my delight at reading the article 'Cry Baby, Cry'. I urge mothers. to ignore the so-called health professionals and their 'controlled crying' and do what's right for our babies. **(Mother)**

**We wrote the following response to these letters, which were published in the same edition:**

Clearly some people were extremely upset by our criticisms of controlled crying; the perception being that we were attacking them as loving parents or in their profession as health workers teaching controlled crying. However we feel that these letters miss the essential point of our article. We agree that parenting can be extremely hard work, that parents have a great deal of pressure on them and that sleep deprivation causes distress (as a parent of a high need baby I am particularly aware of how debilitating this can be!). However all this does not detract from the evidence that babies as human animals expect to be comforted when they cry and expect to be in almost constant close contact or proximity to their care givers. Babies' needs are not determined by the needs for their parents, or the society in which they live.

We object to controlled crying because it involves both deliberately ignoring the distress of babies and the instinct of parents to give comfort. Its widespread use has the additional effect of the introduction a culture of indifference to crying, regardless of health practitioners' emphasis on doing it 'safely'. Thus such behaviours as controlled crying newborns, letting babies cry it out for prolonged periods, ignoring babies' cries when busy, not dealing with underlying health problems of babies (eg ear infections, teething, digestive problems) or meeting the extra needs of extremely sensitive babies, become acceptable to some parents.

Our criticism of controlled crying is grounded in our deep commitment to the happiness of children and to supporting parents to follow their instincts in loving and comforting their babies. (Ann Gethin and Beth Macgregor)

## 2. Responce to Ann Gethin and Beth Macgregor's Article

**by Beulah Warren** [3]

The concept of "controlled crying" takes no account of the development of the baby or developmental challenges to a baby. I agree with the writers that looking after a new born baby is exhausting and anxiety provoking. However, the problem for new parents is the great difficulty of meeting the 24 hour needs of a new baby. In other words, where can the new parents get help in meeting these needs. Mahler (Mahler et al,1975) has talked of a 12 month pregnancy; i.e. 9 months in the womb, plus three months outside, close to mother's body. If a mother can be available for this period, encouraged and supported by the baby's father, then at the end of the period the baby will begin to turn out to the world, and to take the initiative in interacting with the world. Some babies in this 3-4 month period are capable of going to sleep on their own, not on the breast, and out of their mother's arms. Other babies, for a variety of reasons, and often because they are unable to contain their movements, are not able to get themselves to sleep. These babies will need to be wrapped or contained for some further time, until they are relaxed before being put into a cot. "Controlled crying" does not encourage parents to focus on getting to know their baby and what works for their baby and themselves. Nor does it encourage parents to tune into their baby's cries, thereby adopting a more child centred approach. Such an approach recognises the importance of the parent's response to the baby's cries as an element in the baby's developing sense of him or herself as of value. It is now over twenty years since Ainsworth and Bell (1977) demonstrated that the responsiveness of a mother-figure to the baby's signals promoted the development of infant communication, and hence the development of social competence.

Once a baby has been observed to go to sleep on his or her own, without parent support, it is reasonable to try and foster this skill. This behaviour is often observed around 5-6 months. Babies, like adults, do not go to sleep immediately. The baby often makes sounds and little" whinges" as he settles down. After a little time he may realise he is on his own and begin to cry in a more serious way. If the parent goes in immediately, quietens and resettles baby and then leaves again, the baby has a sense of agency: "when I call my parents respond". He can then quietly tackle the task of going to sleep alone with this knowledge. The parent can talk to the baby along the lines of, "I know this is a difficult new skill you are learning, but you can do it, and we will not be far away". Of course this sequence may have to be repeated a few times, especially when it is first tried, usually at around 6 months of age. This is a new skill being learnt. It is also better to introduce this new routine at the first daytime sleep of the day when the baby is fresher and less

vulnerable. But no matter what age, the message we want our children to internalise is, "when you need me I will respond". We cannot make our infants sleep, but we can help them as they manage the transition from being awake to sleep.

In relation to the behaviour of babies co-sleeping with their parents mentioned in the article, according to Susan McDonough who spoke in our Clinical Seminar in May, 80% of the world's babies co-sleep. It seems we are demanding something "unnatural" of Western babies!

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## 3. Infant Sleeping Behaviour

**by Marianne Nicholson [3]**

When babies arrive most of them are very quiet for about two weeks assuming they are born at term. After that they tend to have a wakeful time for about 4 hours a day when they do not want to be put away but they are not to distressed if they are held or rocked or in the company of others. This is often in the evening or corresponds to the time the baby was active in the uterus, which for those going to work was after they arrived home and started to relax. For a mother looking after a toddler often when the toddler is in bed and dinner is finished. At about 9 weeks this "colic" is replaced by a calmer more regulated baby who wants to go to sleep in the evening. ( the neurobiologists relate this to the rate of myelination of the spinal cord and the connecting of synapses etc) The behaviour in this time often makes parents think that they are spoiling the baby because as soon as they pick it up it stops crying. "Look, he was only crying to be picked up". "You cant spoil a baby under three months" does not seem to get as much press, "pick it up and enjoy a cuddle is not often heard".

There is the problem of not knowing when to put it down and they get over tired, stiffen out and scream. After two weeks if the baby goes to sleep in the arms they wake about 10 minutes after being put down. This is OK if the parents are then happy to do some settling when the baby wakes, or go to bed with the baby or strap it on in a pouch. This is when we talk about settling, by wrapping under four months. giving a cuddle and placing in the cot , then walking away until called back by the baby. If the baby cries go back give a cuddle and put down again. If this is not going to work then someone stays with the baby and rocks or pats or sings the baby to a relaxed state so that they can go to sleep. It can take 20 minutes and may only last for the 20 minutes of deep sleep that a baby under four months has every hour. Some babies cry while being settled but if the person settling can stick with it it usually works. In this instance it works in a Day Stay like situation because the person settling the baby is not distressed or sleep deprived and they are confident that it will work. Mothers can do it at this time because someone is giving them confidence.

This can be really demanding if the baby is distressed and there is a only a mum at home to do this. Babies do well with parents who are supported by family etc. So settling is hard work for some . At three months babes cycle through twenty to forty minute sleep cycles until they learn to go from light sleep to deep sleep at around four months. At four months they wake at night after four hours then about every hour. If they can settle themselves they do not need their parent to go to them. This is when talk of control crying starts because babies who have been held or fed to sleep find that they have to change the going to bed routine. The baby has enjoyed mum lying down and feeding them to sleep and being there if they wake to soothe them back to sleep. By about five months Mothers become restless and don't want to do this any more and they are tired of providing night room service. If the baby is in the bed with them often this is the time they will want to teach them to sleep in a cot. Just for safety sake to stop them rolling out if nothing else. Change happens mostly when the mother has made up her mind what she wants and is confident that she can cope with the anger and protests of the baby. This gives her the confidence to go in and soothe but stick to her plan. This involves a lot of crying in some children but there is a emphasis on listening to the crying and not on watching the clock. Sometimes it does not work for unknown reasons and then we are looking at the work of Dilys Daws and the like.

Most mothers know when the time is right to expect some independence from their child and they do it naturally in response to the hormonal changes in them at this time and the movement of the parents back to the state of being a couple. It is about parents feelings impacting on the baby

It is probably important to say we are dealing with well babies and parents, clinical populations probably should not be challenged in this way but refereed to Margaret Hopes book[4].

## 4. The Long-Term Effects

**by Isla Ionie [5]**

It would probably shock many of us these days to consider the words of Sir Truby King, a prominent baby health expert, who recommended that babies should be trained

from birth to feed at four hourly intervals, and that they should be expected to sleep from 10.00 p.m. until 6.00 a.m. "Don't form in the baby at the dawn of life any avoidable habit which would be injurious afterwards," he wrote in bold print. "Were the secretion of milk and the feeding of the baby functions of men and not of women, **no man – inside or outside the medical profession – would nurse his baby more often than five times in the twenty-four hours** if he knew that the child would do as well or better with only five feedings. Why should it be otherwise with women? Mothers have too much to do in any case: why should they throw away time and leisure by useless frequency of nursing?" (King, p. 39)

However, far from having no ill effects, psychotherapists have for long been aware that many patients who come for therapy with a sense of inner emptiness and an inability to feel real have had an experience early in infancy such as this (Winnicott, 1960). In their professional lives, psychotherapists see people who are experiencing a variety of problems in living. Very many suffer from problems of low self-esteem, which means that they do not believe that they are valuable or worthwhile people. Often enough this extends to thoughts that the world might be a better place without them. Moreover, they often believe that they should never expect that they will ever have a sense of being able to act on the world in a positive way to achieve some personal goal. In this part of the world with this group of patients, where parents are still living, or there has been transmission of information about infant care practices, it can often be established that the recommendations of Truby King were greatly influential.

We should ask ourselves what happens if a baby wakes hungry and the mother believes that he will develop an impossible sense of entitlement if she 'gives in to him' and feeds him before the clock says that it is time. What happens to the baby where the mother is steeling herself not to respond to her cries because she has become convinced that this is the "best thing"? What happens if this is the experience in the first six months of life when the baby's need is for a responsive environment to provide a **gradual transition** from the total provision of essential nutrients in the womb to achieving the possibility of becoming a person able to open the refrigerator? What happens to a baby who consistently experiences a situation where the caregiver seems unable or unwilling to answer the baby's message? Colwyn Trevarthen (Trevarthen & Aitken, 1994) has been an important recent influence in showing us how responsive to emotional cues the newborn baby is, and has remarked that while cognitive skills must be developed outside the womb (or the head would be impossibly large for birth), the human infant comes fully equipped to engage in human interaction at an emotional level. He and many others (e.g. Stern, 1985) argue that it is a meeting of this emotional responsiveness with a receptive other which forms the essential core of a sense of self.

Donald Winnicott has been a seminal writer in this area and is particularly important because his work as a paediatrician brought him into contact with normal mothers and babies while his work as a psychotherapist was with people who had suffered from experiences of too-early frustration of normal baby needs, such as in the matter of parental responsiveness to crying and the need to be fed or held. His writings are of the greatest significance as we struggle to understand the importance of the earliest infant experiences in shaping later personality development.

"For the mother," he said, " the child is a whole human being from the start, and this enables her to tolerate his lack of integration and his weak sense of living-in-the-body.[...] By believing in the infant as a human being in its own right she does not hurry his development and so enables him to catch hold of time, to get the feeling of an internal person going along." He is especially famous for commencing a paper at one of the psycho-analytic meetings with the words: "There is no such thing as a baby!" surprising himself as much as his audience, as he subsequently confessed. The concept that one cannot think of a baby in isolation, but must also think of the baby's mother, and so of the mother and infant as an indivisible pair, can be taken as the theme of his work.

Over the past twenty years or so, Winnicott's popularity as an exponent of the importance of early experiences has been steadily increasing, along with the findings of the infant researchers which are so compatible with his theoretical formulations (Stern, 1985; Murray, 1991, 1992). This may again be related to the introduction of visual records such as videotape which seem to have a capacity to compel belief where verbal accounts have often been dismissed as examples of subjective bias. In effect, it has become possible for observations made of infants and mothers to be subjected to a process of validation, since these records may be examined over and over again and very subtle effects may be picked up which were probably missed earlier.

These new insights relate especially to the discovery of many abilities in the newborn infant which were previously dismissed as wishful thinking on the part of over-fond mothers. These include various concepts introduced by Dan Stern, such as **cross-modality** where infants as young as three weeks have been shown to have the capacity to link sensory perceptions obtained from one sense such as touch, to another, for instance, sight; the idea of **vitality affects** of anger or joy or sadness, typically experienced as a 'rush' of feeling; and **affect attunement** between mother and infant, where the mother responds to her infant across sensory modalities - for instance she may respond to a smile by making a vocalisation. Where a mother and her infant are interacting, this effect may be seen every thirty to ninety seconds, and according to Stern, involve the vitality affects as a continuous process rather than discrete emotional interruptions. Winnicott (1951) would have called this **play**, which he considered as a phenomenon taking place in the transitional space between the mother and child: "the mother is in a 'to and fro'", he said, "between being that which the baby has a capacity to find and (alternatively) being herself waiting to be found."

The baby, according to Winnicott (1959, p. 138), is at first doubly dependent. By this he meant that not only is

dependence on the mother and her care absolute, but that it is so profound that it cannot even be appreciated by the infant at the very beginning. If a very young infant becomes aware of dependence, this is because the mother has somehow failed him in her **holding function**. It is important, he says (1962, p. 56), "to think of the infant as an immature being who is all the time on the brink of unthinkable anxiety. Unthinkable anxiety is kept away by this vitally important function of the mother at this stage, her capacity to put herself in the baby's place and to know what the baby needs in the general management of the body, and therefore of the person." Winnicott lists the unthinkable anxieties as follows:

1. Going to pieces
2. Falling for ever
3. Having no relationship to the body
4. Having no orientation (1962)
5. Complete isolation because of there being no means of communication (1968)

By using language which ties these concepts to proprioceptive, tactile and sensory imagery, (that is, to experiences of the existence of one's body in space and in relation to the outside world), Winnicott has captured a sense of the precariousness of the world of the infant. He evokes the idea of the threat of annihilation of the self if the environment fails to be supportive. It is very important that these anxieties are unthinkable, since they arise long before the development of speech and so must be experienced as bodily states, rather than being thought about, for human beings need language in order to be able to think.

Events which are experienced before the development of language are deeply entrenched in the body's memory and are often expressed in later life in terms of the "unthinkable anxieties" . For instance, when we say someone is going to pieces, we do mean losing a sense of psychic integration. In therapies with people who come because they keep "losing it", we often find that there has been some form of early trauma which occurred before there was speech to be able to think about it, and so to manage the event at an intellectual level. Studies on early brain development and the regulation of emotion are now giving us information about the ways in which brain pathways from areas where emotions are experienced are connected up with the cortex which can think about the total picture. Good evidence is emerging that situations of stress in infancy causes damage to these important nerve tracts (Schore, 1994, 1996, 1997; Trevarthen & Aitken, 1994).

What, then, is **holding**? Winnicott stressed that at the beginning of life, he meant maximal adaptation to the infant, implying not only fulfilment of physical needs, but also that the immature ego of the infant was given support from the mother's ego function because "she has the child in her mind as a whole person". He referred to this as **ego-relatedness** in contrast with a relationship based on the satisfaction of instinctual needs. "The good-enough mother", he says (1960, p. 145), "meets the **omnipotence** [he means here the self-centred demand for immediate attention and the belief that this is a right – (ed).] of the infant, and to some extent makes sense of it. She does this repeatedly. A True Self begins to have life, through the strength given to the infant's weak ego by the mother's implementation of the infant's omnipotent expressions. The mother who is not good enough, is not able to implement the infant's omnipotence, and so she repeatedly fails to meet the infant gesture; instead she substitutes her own gesture which is to be given sense by the compliance of the infant. This compliance on the part of the infant is the earliest stage of the False Self, and belongs to the mother's inability to sense her infant's needs." Winnicott refers to the second situation as **impingement**, and links it with later psychological difficulty such as borderline and schizoid elements in the personality, or to a dissociation between mind and body with a tendency to psychosomatic illness, as I have outlined above. Others have written about this state of affairs in terms of "premature ego development".

Winnicott continues, saying that where the mother is good-enough, "the infant can now begin to enjoy the **illusion** of omnipotent creating and controlling, and then can gradually come to recognize the illusory element, the fact of playing and imagining. Here is the basis for the symbol." (1960, p. 146). This opposition of reacting to existing, together with the concept of **going-on-being,** underlies much of Winnicott's understanding of the developmental process from double dependence through relative dependence, to increasing independence. He singles out two further areas of achievement: **integration** and **personalisation**, both interdependent and overlapping with the ideas of interpersonal relating embodied in the careful delineation of the mother's response to her infant's gesture. These states are reached only momentarily at first, but may be expected to be established firmly by the about six months.

By integration, he refers to the sense of "I am", relating this to the sense of agency in the development of the True Self, and the mother's availability leading to a feeling of inner security. He links this concept with the idea of **unintegration**, which he defines as the infant's equivalent of relaxing, and which could happen when the mother was reliably present and the infant could be "alone in her presence" - a pre-requisite to the ability to be alone. By contrast the idea of **disintegration** belongs with the unthinkable anxieties – a going to pieces, and is essentially a destructive experience, from which the mother must rescue the infant by "spoiling" her until she feels integrated again.

By **personalisation**, Winnicott meant the "psyche indwelling in the soma", with linkage of motor and sensory and functional experiencing in a sense of self. He also makes the point that the infant develops a sense of body boundary located in the skin, and related again quite literally to the mother's handling, which is very well expressed in Esther Bick's famous paper (1968).

It is of interest to consider Winnicott's (1960) job description of mothering, again with the stress on its continuity as a process of unfolding development. He

commences by saying that soon after birth a large proportion of infants show clearly that they have at times contact with the woman who is their mother: "Let us attempt to study the mother's job. If the infant is to be able to start to develop into a being, and to start to find the world we know, to start to come together and to cohere, then the following things about a mother stand out as vitally important:

She exists, continues to exist, lives, smells, breathes, her heart beats. She is there to be sensed in all possible ways.

She loves in a physical way, provides contact, a body temperature, movement, and quiet according to the baby's needs.

She provides opportunity for the baby to make the transition between the quiet and the excited state, not suddenly coming at the child with a feed and demanding a response.

She provides suitable food at suitable times.

At first she lets the infant dominate, being willing (as the child is so nearly a part of herself) to hold herself in readiness to respond.

Gradually she introduces the external shared world, carefully grading this according to the child's needs which vary from day to day and hour to hour.

She protects the baby from coincidences and shocks (the door banging as the baby goes to the breast), trying to keep the physical and emotional situation simple enough for the infant to be able to understand, and yet rich enough according to the infant's growing capacity.

She provides continuity.

By believing in the infant as a human being in its own right she does not hurry his development and so enables him to catch hold of time, to get the feeling of an internal person going along.

For the mother the child is a whole human being from the start, and this enables her to tolerate his lack of integration and his weak sense of living-in-the-body."

To conclude, it seems that the current trend towards applying the techniques of controlled crying (originally introduced for children at the toddler stage where verbal communication is finally becoming possible), to increasingly younger age groups including the newly born, is to recreate the problems which have been seen in those who were subject to the Truby King regime in their earliest days. While controlled crying may be an excellent technique for older children, we do need to remember that the age of the child is important here, and that a very young infant uses her cry to communicate. It is important to make the struggle to understand what the cry is telling us, and not to apply a technique of behaviour modification to babies who must develop premature ego function to shut down their natural emotional responsiveness when their caregivers do not respond appropriately – in Winnicott's inimitable language, when "the mother instead substitutes her own gesture.".

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## 5. Crying Babies and the "Controlled Crying" Technique

### by Dr Harry Edhouse [5]

The things people do with and to one another! Let's start near the beginning. Parents want their baby to feed well, be contented whilst awake, and to sleep readily and regularly. My guess is that babies would want this also. Often however, this can be difficult to achieve and difficult to maintain, as many influences can disrupt this pattern. Briefly, "Controlled Crying" is a behaviour modification routine, aimed at training the baby to not-expect attention to its cry, by means of gradually increasing the amount of time it is left to cry before it is attended to. Carefully done, it can succeed in reducing the readiness of the baby to signal its need-state in this way. The problem is that it often invades the natural development of cooperative mother-child interaction, and is imposed upon the baby before it is ready to tolerate delay in need-satisfaction. The pity is that tolerance will happen naturally in due course anyway. My practice sees the results of such rushing of the maturation programme, and they are not good. What are the costs?

There is a young family with their first baby living opposite us and they nurse their baby boy on the porch. We hear how often the baby cries and for how long. I listen to the note in the baby's voice. I hear it change after ten minutes of crying from that of discomfort, to that of alarm, to that of a sad low-grade sobbing. It is at the latter stage that the mother attends to it. I think to myself that this conditioning, repeated several times each day, is surely guiding this babe along the path towards sadness as a character trait, towards not expecting his needs to be read or responded to, and towards not remaining in touch with his own needs. When I see them in the street, the mother seems to interact closely with him, and you would think them an ideal couple. But, once again, I hear him cry for prolonged periods when they are in the house alone. My impression is that the mother is meeting her needs of the baby, but not the baby's needs of her. Father, a member of the defence forces, comes home week-end. Over the six months of his life, his crying has become less and less. I worry that he has given up. I think that I am witnessing the making of a man who will neither weep socially nor relate sensitively in a sharing sort of way, and who may have a reservoir of intense rage directed at females and mother-figures.

### DISCUSSION

All organisms sleep according to their needs and according to the conditions to which they are exposed. Babies who are content in themselves, physically and mentally, will sleep contentedly according to their needs. Sleep is determined by the circadian rhythms which have been set by Mother Nature and Father Time and are built in to the genes and chromosomes. It is not possible for any one set of earthly parents to improve on this system. It is possible however for the prevailing conditions affecting the nursing couple to inactivate, disrupt or distort this system. For the record, and excluding passing illnesses and indispositions, there are physical organic conditions which disrupt these patterns, but they are few, and they are usually identifiable, and are usually treatable on organic grounds.

The touted notion of 'Sleep-Resistance' is a patently ridiculous one as sleep will ensue if the conditions are suitable. The term 'Sleep Resistance' implies that the babe is at fault, and is perverse and malign toward the person on whom its life depends, - which does not make sense. A term like 'Sleep-Pattern Disruption', or even "Nursing Couple Dysfunction" would be the more accurate and would direct attention to the conditions the two persons involved are having difficulty with. Sleeping, as a rhythmic biological function, like breathing, will occur dependably if the biologic state is not thrown out by the physical, social and emotional surroundings.

In my view, the ideal situation exists when the parent, usually the mother, is herself mature, is from a stable loving background, has wanted the baby, has had a good pregnancy and confinement, and is well supported by husband and family of origin in her mothering preoccupation in the early months of parenting. If to this person is born a normal child who is in a normal state of health, then I would expect there to be no problem produced if the nurturing is geared to the needs of the infant. Saturating each need as it arises enables the infant to progress through the need-calendar without interruption or deviation. This is the situation which prevails during intra-uterine life and which proceeds reliably and optimally, (excepting the exceptions), producing normal full-term babies.

Biologically the newborn is outfitted to want and expect a continuation of something resembling the intra-uterine arrangement initially. It is already pre-programmed to tolerate increasing discontinuity in maternal attention with the passage of time. This is roughly correlated with the various milestones of development, and the increasing ability to utilise and interact with its environment, culminating in the ability to play, to crawl, and to walk away from and back towards its parent, and to climb up and down over obstacles. The infant can thus be separate from its caretaker for increasing periods, secure in the ability to summon or to return to contact as needed. Over this time there is a transformation from a need for continuous care to a need for episodic care.

In Nature, the attainment of this degree of competence and mobility allows for the occurrence of the birth of the next new babe, itself in turn requiring the almost continuous attention of the mother initially. Optimal progress through all the milestones of development for the babe, and optimal development of the mother as a mother, occurs, if the period of infancy is managed without stress or distress arising between them. From such an

experience each emerge with competence and confidence to encounter and participate fully in other or similar relationships. Anything less than this is less than ideal.

For the less than ideal situations presented clinically it is a matter of helping the participants to approximate to the ideal wherever possible. Many parents are in fact are delighted to achieve a much closer approximation to the ideal if they are informed of its desirability, and are helped to do so.

With an ideal mother and an ideal babe, the ideal arrangement is for the baby's needs to be met such that the crying reaction is not required. A cry is never a sign of contentment. A cry is always a sign of internal disturbance. There is no advantage to the ideal babe for it to be left to cry. There is no advantage to the ideal mother to leave her baby to cry. While crying is occurring, neither consolidation of the present status nor advance to the next developmental stage can take place. Crying time is lost development time, and delays progress.

## Preventive Management

I regard the ideal course to be some version of the following :-
(1) following a normal pregnancy and birth with rooming-in and support of the mother in establishing "the nursing-couple", the babe continues to sleep in the mother's sleeping environment, i.e. is nursed in her bed and bedroom.
(2) when the babe can be managed without disturbance in the bassinette alongside the mother's bed, this can be done.
(3) when the babe responds better to being managed from a cot in the mother's bedroom, this can be done.
(4) when the babe is not requiring night feeds and is sleeping throughout the night, its own room can begin to be utilised for day sleeps.
(5) when the day-sleeps in its own room are occurring without disturbance, reliably, the babe can be put to sleep (not left to sleep) in its own bed in its own room at night.
(6) any intercurrent problem with this step-wise progress can usually be dealt with by temporarily dropping back a level, then moving forward again.

The principles guiding this plan are :-
(1) continuity of contact and attention of the mothering person on a sliding scale according to the babies' needs.
(2) recognising that there are physical contact needs, feeding needs, stimulus needs, leading up to sleep needs.
(3) not confusing your needs for the baby to sleep with the babies' needs for sleep
(4) not allowing the settling-to-sleep or waking-from-sleep to be experienced as an anxiety-making separation experience

## Corrective Management

I am realist enough to know that most of the parenting situations existing in the community are far from this ideal. For many parents, parenting is not the main priority, and closer attention is paid to matters other than parenting. It can be a nuisance for them when the parenting-needs begin to demand higher priority. They then seek a remedy for the nuisance of parenting. "Controlled Crying" seems like a remedy for this nuisance factor. It takes no account of the causes or consequences. It is a procedure for disengaging the infant from the parent against the infant's wishes. It is likely to be resorted to in situations where there is already a degree of disharmony. Usually the situation has gotten out of hand because the parents have been following a course of handling of the baby that the baby can't yet manage to adapt to, such that its rhythms are thrown out, or the parents aren't willing to modify their own patterns for this period of time.

The central issue for the advising clinician is that of helping the parents manage the situation so as to not-allow the sleep experience to become coloured with separation anxieties as this leads to many later adjustment and behaviour problems.

This can be done by the parent:-
(1) stage-setting of the end-of-the-day routines (reduce light, sound, physical activities; see to appetite satisfaction, bodily comfort etc etc ) to induce in the infant a total mental-set towards withdrawing attention from the surroundings and becoming absorbed in its own inner state.
(2) taking the child to the sleeping situation, settling down there with the child, gently pat or sing or read the child into a sleepy state.
(3) engage upon some activity of interest to yourself (reading, knitting, pencil and paper work etc) to be there if the child should rouse until the child is well asleep.
(4) when this routine is well established, the whole process will become more efficient until the child is more and more able to be left and get to sleep quickly and contentedly.
(5) seek out a parenting-therapist to obtain individualised guidance back to harmony and progression.

**[1] Anne is a sociologist and Free Lance writer who is currently completing her PhD in Sociology**

**[2] Beth has a Bachelor in Psychology and has worked in Child Protection since 1993**

**[3] Marianne is well known to AAIMH members. She is an Early Childhood Nurse working in the Eastern suburbs of Sydney. She has a soecial interest in postnatal groups.**

**[4] "For Crying Out Loud!" Published by Children's Health Education Service, Sydney Children's Hospital, High Street, Randwick NSW 2031.**

**[5] Dr Edhouse is a Melbourne Child and family Psychiatrist**

After discussing attachment theory and its relevance, Dr. Newman initially reviewed "Good enough parenting", features of maltreating parents, preverbal traumatic memories and why birth can precipitate confusing and powerful feelings in borderline mothers. She also discussed carers who harm infants and stressed the importance of risk assessment as well as assessing the mother's parenting capacity. A central part of the presentation was an in depth discussion of borderline personality disordered mothers' parenting and the impact on their children. This was illustrated by a case discussion and a video highlighting interactional issues. Assessment, management and research issues were also included in the seminar. An impressive breadth and depth was covered with a permeating theme of attachment disturbances with borderline mothers and the subsequent impact on the child's development highlighted.

The major meeting in August will be the AAIMH (Qld) Annual General Meeting on August 17.

Michael Daubney.

## VICTORIAN COMMITTEE OF MANAGEMENT

**President: Brigid Jordan**
**Vice President: Ann Morgan**
**Treasurer: Kerry Judd**
**Newsletter: Sarah Jones *with Paul Robertson***
**Scientific Program: Michele Meehan**

**Membership Secretary:Helen Belfrage**
**Regional Vice President:Campbell Paul**

**Committee Members:**
**Sue Morse**
**Jeanette Milgrom**
**Zipporah Oliver**

The Victorian AAIMH Committee has been working tirelessly to finalise the National Conference to be held in Melbourne over the Friday to Sunday of the last week in November. See Conference advertisement elsewhere in this newsletter. AAIMH Victoria's aim is to have a conference for the large group, with out dilemmas about competing programs or venues and also to devote the conference to infant focused treatment. The mind of the infant is paramount in our thinking, and we have attempted to work with that as our focus. Infant-lead work can often be very vexed, and can be confounded by so many additional variables such as maternal depression, environmental vicissitudes and other overwhelming medical issues or neglect/abuse problems. We are privileged to have Bernard Golse and Colwyn Trevarthen as plenary speakers. As a way to bring their ideas to life, Paul Robertson suggested I speak to Frances Salo and Campbell Paul, both of whom have met them, and ask them what were their thoughts on their work. Their answers are somewhere in this newsletter!

The last AAIMH monthly Clinical and Scientific Meeting was dedicated to thinking more about fathers. We were able to have Infant Psychiatrist Dr. Liam O'Connor talk to us about father-infant work based on his experience in the Infant-Parent Program of the Albert Road Clinic.

Liam's talk initially focussed on how economic and social changes are leading to increased expectations regarding fathers' involvement with their children and partners. Examples from group and individual therapy highlighted some of the difficulties currently facing fathers.

The group described was for partners at the Albert Road Clinic Parent Infant Unit. A pattern was highlighted re the initial concerns for the men focussed around the experience of having partners who were depressed or not coping with their infants. This tended to lead to a description of the mens' own levels of stress during the post natal period. Finally after these stages, the men in the group were able to consider their role as fathers and the development of the relationship with their infants. The individual cases looked at examples where men had been involved in at least half the full day to day care of their infants. It was highlighted that these men were experiencing symptoms and issues very similar to those traditionally associated for women with post natal depression. The talk concluded that it was vital for services aimed at helping infants and their families, were fully aware of the needs of fathers.

Sarah Jones

## SOUTH AUSTRALIA

**From: Pam Linke**
**Senior Project Officer**

**Marketing and Corporate Communications**
**Home email: linkes@newave.net.au**

Following the visit of Dr Susan McDonough the SA Branch of AAIMHI, in conjunction with Helen Mayo house, are using the profit from her session to make an award to a member of either organisation to assist with attending the World Infant Mental Health Conference in Montreal next year. The award will go to someone who would not otherwise be able to attend the Conference and who has submitted an abstract for presentation at the Conference.

Elizabeth Puddy has had a number of invitations to take the Fathers video to country areas to present sessions showing how to use the video as a discussion starter with various groups, including men's groups, ante-natal and post-natal groups and hospital staff. There has been a lot of interest in using it in these

At our AGM on 30 August, Dr Harry Edhouse discussed relationship management in infancy and the impact in both infancy and in later life of early parent-child relationship difficulties. He included reference to "controlled crying" and "time-out". Respondents were Dr Anne Sved Williams, Dr Chris Pearson and Dr Robyn Leeson.

Plans are going ahead to have Dr Bruce Perry visit South Australia in early May next year, in conjunction with the Australian Paediatrics Conference. We are hoping to involve community leaders, professionals and parents in his sessions on the implications of early influences on brain development.

At our infant mental health discussion group this month Terry Donald and Jon Juredini presented a model they have developed for assessing parenting for children who have been abused. It is hoped that the model will assist where decisions are being made about whether a child should be re-united with his or her parents after a foster placement.

## WESTERN AUSTRALIA

**President:**
**Caroline Zanetti, Consultant Child Psychiatrist**
**Secretary:**
**Susan Brill, Clinical Psychologist**
**Treasurer:**
**Patrick Marwick, Senior Social Worker**

**Committee members:-**
**Elaine Atkinson, Clinical Psychologist**
**Carmel Cairney, Clinical Psychologist**
**Kathie Dore, Registered Mental Health Nurse**
**Lyn Priddis, Clinical Psychologist**
**Julie Stone, Child and Adolescent Psychiatrist**
**Yap Lai Meng, Clinical Psychologist**

We have just had our AGM. Thank are due to our retiring secretary, Carol Smith. Carol has been a diligent and gracious secretary and is now preparing for the birth of her first baby. Our thanks are also due to Manita Beskow, who has been a willing and dedicated committee member.

Our new committee is:
President: Caroline Zanetti, Consultant Child Psychiatrist
Secretary: Susan Brill, Clinical Psychologist
Treasurer: Patrick Marwick, Senior Social Worker
Committee members:
Elaine Atkinson, Clinical Psychologist
Carmel Cairney, Clinical Psychologist
Kathie Dore, Registered Mental Health Nurse
Lyn Priddis, Clinical Psychologist
Julie Stone, Child and Adolescent Psychiatrist
Yap Lai Meng, Clinical Psychologist

The AGM was very well attended. It was followed by a talk by Carol Bolton, Clinical Psychologist on INTERVENTIONS FOR BABIES WITH SLEEP PROBLEMS. based on the work of Dilys Daws, as described in her book "Sleeping Through". Carol carefully set up a pilot study of short-term work (3 to 4 sessions) with parents and babies. The work focused on making space to "think together" about the sleep problems, and letting parents tell their stories. Carol found issues of loss and separation in these families as well as a high degree of emotionality. She further found that as their stories were listened to, and understood at both a cognitive and affective level, there were improvements in the sleep problems. Carol included some lovely case vignettes, which demonstrated her compassionate and skilled approach to the families. Carol's results are very positive, and she is planning further research. We hope to hear more about her work in the future.

At the June meeting, Joy Eichorn, Clinical Psychologist with Family and Children's Services gave a talk, titled REUNIFICATION AFTER APPREHENSION NEAR BIRTH. Joy presented the results of her research into the factors which influence reunification following the apprehension of a child near birth. Her study analysed data from cases in which a child had been apprehended within 30 days of birth.

The findings indicated that to facilitate a higher rate of successful re-unification, Case practice could be changed in the areas of – re-unification planning; concentrated authority-driven services to the family in the first 6 months after apprehension; more engagement of family support; recognizing the significance of the partner; addressing the mothers' alcohol and substance abuse; promotion of counseling; more emphasis and training on re-unification in case practice and in the organization; and the contact/attachment of the mothers.

This was a thought provoking and poignant presentation, reminding us of the fragility of early mother infant relationships and how distressing it is when things go very wrong. Joy showed a great sensitivity in her study of this difficult area.

Congratulations on the new newsletter format – most impressive!!

We are looking forward to the national conference in Melbourne.

Carmel Cairney

# AAIMH and ADVOCACY

by Pam Linke

Currently the main issues in advocacy for AAIMH has been our involvement with the National Initiative for the First Three Years. This Initiative was begun by Professor Graham Vimpani late last year and is to coincide with the first three years of the new century. I attended a meeting in Canberra in July on behalf of AAIMHI. The meeting, which was to plan the next steps of the Initiative, was attended by 20 representatives of different disciplines and advocacy groups. Louise Newman was also there, representing child psychiatry and her strong support for the importance of attachment was much appreciated.

This initiative has now been given the acronym NIFTY.

Some of the outcomes of the planning meeting include:

A vision for NIFTY - "To build a life time on the first three years: ready for school, ready for life".

NIFTY's objectives.

- That the general community knows that the first three years of life are foundationally important. Action must occur to provide all children with the best possible early life
- Achievement of better integration of policies and programs for young children across government and society.

NIFTY's guiding principles

- The changing socio-economic circumstances of today's society pose a major challenge to our institutions that affects families and their children's development in the early years.
- Early brain development is strongly influenced by the nurturing environment and security of relationships surrounding the young child that sets a base for learning, behaviour and health throughout life.
- Perinatal and early childhood factors especially nutrition and growth have lifelong impacts on adult health in a number of domains eg cardiovascular domains.
- A society that wants a highly competent population will have to ensure that all its children have the best opportunities during the critical early years of development, regardless of family circumstances.
- Changing nature of families requires increased support for parents outside the traditional inter-generational support system.
- Investment in early years will have substantial long-term benefits.
- Targeting those at risk works best within a system available to all.
- Families, communities, governments and the corporate sector each have a stake in ensuring that all children have the best start in life and will need to work in partnership to achieve this. (Adapted from the Canadian Early Years Report by Mustard and McCain, 1999).

NIFTY now has a Steering Committee with an Executive as well as the broader Supporter's group. The executive consists of Graham Vimpani, Barbara Wellesley (Good Beginnings, NSW), Alan Hayes (Macquarie University), Craig Patterson (Royal Australian College of Physicians), Judy Cashmore (University of NSW), June McLoughlin (Royal Children's Hospital Melbourne). The rest of the steering committee represents different organisations across Australia and includes Pam Linke/ Di Hetzel from AAIMHI.

What is on the agenda for NIFTY?

The executive have been meeting with representatives of different State and Commonwealth governments and with Fraser Mustard, co-author of The Early Years Report, from Canada.

The main focus for NIFTY is to develop an Institute without wall for the first three years. The ten-point plan for this multidisciplinary Institute is:

1. To persuade governments and the community that investment in the earliest period of life is as important as investments in education and health and will have substantial long-term benefits for society.
2. To develop and implement a public communications and marketing strategy that highlights the importance of the early years
3. To ensure that early child development is a priority and shared responsibility among governments, employers, communities and families
4. To identify existing models of community-based early childhood and parenting supports that improve health, education and social outcomes
5. To establish and maintain a database on existing activities and identified best practice and make this material freely available
6. To encourage governments, non-government agencies and philanthropic groups to ensure sustainability and expansion of successful programs
7. To encourage collaboration between agencies working in the early childhood area
8. To undertake and promote research and evaluation in the field including long-term studies into the determinants of healthy growth and development
9. To identify gaps in policies and services for young children and their families
10. To develop training models and guidelines for training and practice for those working in an integrated service environment.

As a result of the establishment of NIFTY we want:

1. To have captured the hearts and minds of all Australians about the importance of the early years of life;
2. To see a renewed commitment from all sectors to having policies and programs that promote optimum experiences during those easy years;
3. To have better quality Australian data to guide policy and program development

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