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NEWSLETTER

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FROM THE EDITORS:

This last edition of the year is filled with news about the last Conference of the millenium. We have included an extensive article describing the occasion. (But we would be delighted to have more perspectives from aspiring newsletter contributors). There is also a report of the "First Conference Newsletter Breakfast", something we hope may become a conference tradition. As current editors we aim to bring you four edition in 2000, and then pass over to a new team in 2001. We hope that the AAIMH Newsletter will be taken up by new editors, with contributions from members, State Committees of Management and others. We have been delighted to look back over the editions in 1999 and see so many new writers. In particular the debate on Controlled Crying has been the catalyst for many to argue their views; other perspectives are included in this edition. Both authors argue sensitively from their different experiences. We hope that the newsletter can continue to offer a vehicle for thoughtful debate yet also value differing perspectives. Controlled crying seems to have sparked much interest, but there are other controversial infant issues that also deserve attention.

We welcome a new member to the editorial team, Dr. Michael Daubney from Queensland who will be co-ordinating the Network News Section. Paradoxically this section, by describing local news, also gives the newsletter more of a national feel.
Despite our constant work over the last few weeks we must apologise again for the late delivery.

Sarah Jones & Paul Robertson

2000 CALENDAR OF EVENTS

MAY (VICTORIA)

5th of May: Dr Bruce Perry can be heard at the Royal Children's Hospital. One day seminar. See Page 19.

JULY 2000 BRIGHTON, UK

16-19 of July: XII Biennal International Conference of Infant Studies. See Page 20.

JULY 2000 (CANADA)

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

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THE INFANT SPEAKS: THE BABY, HER FAMILY AND THE THERAPEUTIC PROCESS MELBOURNE, NOVEMBER 1999.

A Conference Report by Sarah Jones

A "cook's tour" of the conference for those who wish to remember the experience and for those who were not able to attend.

THE SETTING AND THE SPEAKERS

Victoria AAIMH hosted a most successful conference; one that fittingly saw the incorporation of science and art, work and play, humour and heated debated. The foyer of the Architecture Building at the University of Melbourne provided the setting with a strong sense of light and space for casual meeting. In contrast the downstairs Prince Philip Lecture Theatre gave a sense of learnedness and privateness to think and explore meaning. We had plenary speakers from Edinburgh, San Fransico and Paris. All three performed their task with grace. Their talks gave light to a multitude of aspects about the infant and brought to life different ways of thinking about clinical work with infants. In short we had Trevarthen the playful, Golse the Gaelic theoretician and San Fransico Seligman in the Fraiberg tradition.

PRE-CONFERENCE WORKSHOP – PROFESSOR STEPHEN SELIGMAN

The Thursday pre-conference work shop with Stephen Seligman was booked out weeks in advance. Professor Seligman worked hard with the audience to bring to life the power of the infant to communicate and to use of projective identification as a potent means. Paul Robertson will review this workshop elsewhere[1],therefore, suffice to say the day afforded an opportunity to encounter some very interesting discussions on the dyadic nature of communication, and the difficulties for workers in the painful clinical material of working with distressed mother-baby relationships. The importance of the worker remaining mutually available for both the baby and the mother was a most useful notion.

THE CONFERENCE BEGINS

The conference proper started on a hot Friday morning, with a buzz in the air for what was to come. Some early birds attended the Newsletter Breakfast (also reported here separately). But for most the opening address by the actor and parent Tracey Callendar was the first taste of the voice of the mother in vivo. Ms Callendar began by telling us of her credentials to open the meeting; " I was an infant, I am a parent, and I have been a consumer of infant-parent mental health". She went on to speak in a very moving and self-effacing way, of her experiences of finding herself in the latter two roles. This conference included the raw pain of maternal anguish.

PROFESSOR COLWYN TREVARTHEN

Professor Trevarthen, academic biologist and baby studyer of great repute followed with a series of vignettes, infant videos and an encyclopaedia knowledge of studies and findings. Professor Trevarthen, with his collection of video tapes spanning three decades, is a sort of Richard Attenborough of babies. His "infant" is the playful, engaging, competent infant.

He wanted us to know from the start that he was not a clinician, but a long-term studier of babies. It was Prof. Trevarthen who gave us the leitmotiv of the conference by introducing the idea that babies have the capacity to experience pride and shame. [2]Professor Trevarthen's work is with normal babies, and it is through his video laboratory that he has identified and put forth the notion of play being the way the baby learns. The baby both can learn pride and has to deal with feelings of shame. He argued that babies have the power to communicate non-rationally and unconsciously and

Michelle Meehan, Cambell Paul and Stephen Seligman

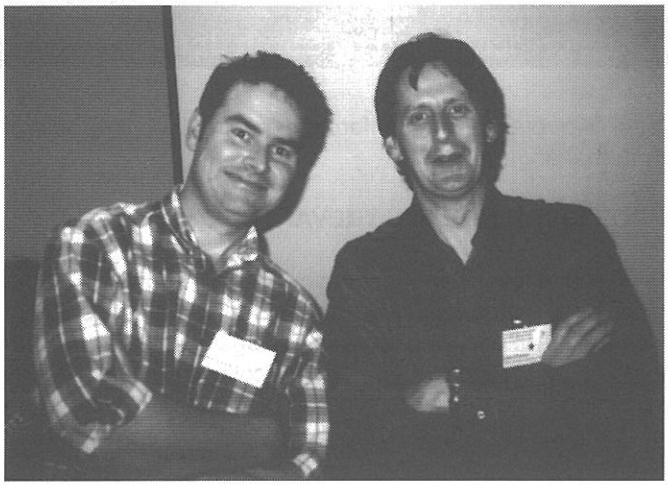
that there is a strong desire for companionship. He argued the idea of companionship is richer than the notion of attachment.

His talk entitled "Intersubjectivity: the infant as Communicator in Relationships" gave us further ideas on culture, protoconversations etc. His thesis of inter-subjectivity looks at how the infant and parent develop a shared consciousness and shared experience, which then influences the baby's neurological developments. His talk enabled the concept of "transgenerational themes" i.e. the transmission of emotions/conflicts/pleasures to make sense at a theoretical level for me. He thinks that humans are unique in picking up

skills over generations, and that this is part of the development of culture. Learned meaning becomes cultural meaning.

LOCAL DISCUSSANTS

Ms. Sue Morse[3] gave a moving and enlightening case study of a child with whom there were great worries that were



Paul Robertson and Liam O'Connor

seemingly intractable. It was, in part, her capacity to allow the whole baby to be seen, and the babie's motives to be known that enabled her intervention to have maximum therapeutic change.

Ms. Brigid Jordan[4], responded to Professor Trevathen's plenary. She spoke on how problematic it was to learn or discover the babies intention in its communication if the baby and mother have no games. Her extensive clinical experience over a decade of working with ill infants in hospital has shown her the different ways infants let others know that they are in difficulty and how strong a motive the infant has to interact with the world.

FRIDAY AFTERNOON

Friday afternoon provided rich presentations from New South Wales participants, Doctors Stephen Malloch and Ben Bradley. Stephen Malloch, is a muscian, trained violinist and psychologist. He has worked with Professor Trevarthen to complete his PhD. Stephen spoke on the vocalisation capacity of the infant. He proposes that there is an intrinsic human musicality in the infant which facilitates communication. He demonstrated this with the use of a recording of an infant's proto-conversation using spectographic analysis. Intriguing Stuff ! Sadly I missed Ben Bradley's talk, and I shall endeavor to have it summarised.

INFANT OBSERVATION

Professor Bernard Golse and Mrs. Frances Thompson-Salo both spoke on the Observed Infant. The usual model of an Infant Observation for training is the observer doing a home based observation of a non-clinical infant as well as being a member of a Infant Observation seminar. It is thought that the direct observation of a baby with the input from the seminar group is the way in which observers can best learn the richness of the babies' capacities to communicate. Learning at first hand the feelings that are stirred by the infant-parent interaction. The seminar can function as a safe place for those feelings to be recalled, expressed and then considered clinically and theoretically. Infant Observations began about forty years ago, as a training tool for child psychotherapists, as a means to increase the psychic abilities of the observer. In particular it is argued that the capacity for understanding projective identification is developed.

Some questions were posed -

- What is it that makes Infant Observation so powerful for workers?
- How does the baby observe the observer?
- The infant also speaks in the Observation, but in what way and how?

CONFERENCE DINNER

Those with stamina attended the most unusual conference dinner in the grounds of Victoria's original Astronomical Observatory adjacent to the Botanic Gardens. The evening offered perfect Summer weather, superb summer style nibbles in the courtyard, followed by a sit down dinner. Speakers include the famous and sagacious "Professor Liam O'Connor"[5] whose hilarious talk cum performance is unable to be summarised in coherent form (!). Dr. George Christie[6] enlightened us about his early working days in the Observatory Clinic, which was then the a child psychiatry service for the whole of the state, located on the very site where we were dining, for some of us this significance added to the occasion. The food, the night sky, a view through the telescopes at Saturn all made the occasion remarkable.

SATURDAY

Early birds interested in how the different states have set up, or want to set up, Infant training programs attended the Saturday morning Breakast Meeting on Training Courses. Attendees were able to learn about the different structures in the various States for funding of programs, courses, organisations etc. What will work in one state needs very careful consideration of its adaptability to another. Suffice to say there is a lot going on and the "smaller" States are developing some unique programs which we hope to hear more about at future conferences.

PROFESSOR BERNARD GOLSE ON PARENT-INFANT PSYCHOTHERAPY

Saturday's program opened with a paper from Professor Golse on Infant Parent Psychotherapy. He gave us an insight into the French scene, and the way the field has developed in France. He credits Alice Dumic with pioneering the work at the end of World War II. An important influence in their work is the idea of "reparation of missed times" using the Winnicott notion of the therapist as "transitional object". He referred to the inter-generational transmission of pathology with the term "unconscious intergenerational mandates".

Not able to do justice in summarizing Bernard Golse' talk I shall just pull out the gems I captured from my notes all referring to Infant-Parent psychotherapy Gaelic style:

- "insist on finding what is positive in the baby"
- take into account the interactive sequences with

infant and parent

- Notice where the baby is used to "prevent" the parents mourning a psychic loss eg. Where the baby reminds mother/father of a dead sibling
- Are your interventions through the mind of the parent or of the infant?
- The baby becoming therapist to her parent
- Bi-sexuality in the context of the setting: "maternal – holding" and "paternal-regulation"

PSYCHOANALYSIS IN UNCOVENTIONAL CONTEXTS – PROFESSOR STEPHEN SELIGMAN

Professor Seligman's paper with the above title, enabled us to see the developments of the late Selma Fraiberg's work since she published in her seminal article "Ghosts in the Nursery". He reminded us that the "patient" is the mother-infant relationship. It is this that psychodynamic workers must keep in mind. He emphasised their therapeutic interventions are not only psychoanalytically focused but also pragmatic and home based. Working within this context with deprived and traumatised infants and parents enables the therapist to be more available practically and emotionally. The world of the infant is non-verbal and "in action". The therapist's understanding of projective identification and how the parent projects unwanted feelings unconsciously into the infant is central. He spoke on the emerging field of infant research which allows us to understand the process of unconscious communications. There is an emerging

Andrew Walker (Vic AAIMH member), Brigid Jordan (Vic President of AAIMH) and Paul Robertson (AAIMH Newsletter Editor)

conceptualisation of the infant development within a two-person field.

For Professor Seligman, psychoanalytic theory offers an understanding of how parents transmit their own psychopathology to their children. The traumatic self of the parent is transferred to the infant through the process of projective identification. He draws on Kleinian theory to describe affective bodily states, and the centrality of self-object concepts. It is through the process of projective identification the infant's sense of self is constructed with others. The parent-infant dyad thus becomes an observable form of the parental internal representations of past relationships.
Professor Seligman illustrated his theoretical discussion using a video taped interview of a very young infant in the presence of his two parents and a therapist. It is in a hospital setting. The context of the meeting is unclear but it relates to the question of whether the parent is able to care for the child. This film includesa poignant vignette of the new-born infant being passed around the room and held in the hands of his father without care or concern. Most salient is the way the infant is "dealt with"; as if an inanimate object he is held nearly upside down, with no time to recover between each subsequent move. The view of the infant being handled, the unutterable distress of the infant is shocking. In this way the father's internal world emerges.

The tape is brief, yet enables some kind of understanding of how the violence of the father's past history, with in his internal representations, becomes projected or enacted with the infant. This infant would have no way of defending itself from the experience, but to perhaps join with the father in the enactment of father's internal world of abusing and being abused. The infant identifies with both sides of the relationship – the aggressor and the abused. The infant itself offered a communication but this can not be received by either parent. The video shows how inner states are communicated; the inner world inter plays with the dyadic interpersonal world. The behaviour of the father over-rides the infant's communications of distress. The infant is treated without agency. The infant takes on the father's dyadic-interactional style which dominates the relationship. The infant then takes in an identification of both sides of the abusive relationship – of being the helpless one without agency and of being the aggressor, thereby possibly reproducing a relationship like his father's with him. The asymmetrical nature of the relationship is visible. This video leads the observer to ponder on the inner states of the infant.

The distressing impact of watching the video was mitigated by Seligman's juxtaposition of the theoretical concepts with the clincial material. It is through the use of these kinds of video that Professor Seligman proposes that one can observe the earliest details of psychic reality. The patterning very early on, outside perceptual awareness is seen.

SATURDAY AFTERNOON

Saturday afternoon the topic of Professor Colwyn Trevarthen talk was "The Function of Emotions in Understanding Persons". The program allowed further debate on the infant's capacity to express emotions, and their function. The infant has a full range of emotions. Trevarthen argues that it is their expressive behaviour that evolves from the infants' self-regulatory behaviour.

Professor Trevarthen's was followed by Dr. Mary Brown[7] presented a case of a young boy and what a possible diagnosis of autism meant for the parents.

PROFESSOR BERNARD GOLSE – EUROPEAN CONCEPTUALISATIONS OF AUTISM

Bernard Golse ended the afternoon with an interesting exploration of the way he and his colleagues approached the notion of autism. He made a strong plea to to keep the psychological point of view. He spoke of areas of research that focused on examining the warning signs of the autistic making process. His diagnostic considerations are influenced by

i. Contemporary views,
ii. Family and social factors and
iii. Checklist of autistic-style behaviours.

- Contemporary views:

In France, he said, they do not regard autism as an intellectual handicap if there is capacity for social referencing. It appears to be reversible, he said, at an early stage, but more fixed later on.

- Family and social functions:

It is difficult to define these as primary or secondary influences. One asks "Is the child's lack of psychic connection a meeting of a vulnerable child in a pathological environment"?

- Checklists

Classically we are assessing children at 16 – 18 months. Curious to wonder why we are not seeing them earlier. We are interested in the cognitive capacities using psychoanalytic concepts. We have cognitive / psychoanalytic theorists who have common interest in developing a tool useful for assessment in the first year of life.

SUNDAY MORNING - DR ANN MORGAN AND MS JOANNA MURRAY-SMITH

Melbourne dispelled all the weather myths and put on another glorious day. Despite the unpopular time slot most candidates stayed to the Sunday end to hear Dr. Ann Morgan give the Winnicott Lecture. She spoke of her understanding of the infant, reflecting on her fifty years of work. In particular she explored how long it took for the infant to be prominent in the minds of hospital practitioners and concluded with how the infant emerges now at the end of the millenium. She asked "When working with infants and parents what is it that one "sees"? One can only observe one's own understanding of things. Every speaker who has come to speak to us, comes with his/her own understanding of the infant. Why now, she asked, and only sometimes, can we hold onto the mind of the infant in our work? Dr. Morgan has taught us the centrality of this question in all infant work. It is striking how hard it is for clinicians to hold on to the mind of the infant. As always it was a memorable experience to listen to Dr. Morgan's visual and passionate talk. Her addition of using art as a way of seeing was refreshing after such dense theoretical material.

Joanna Murray-Smith, playwright, author, journalist and mother was the discussant to Dr. Morgan. She reflected on her experiences of motherhood. She acknowledged how the paper gave her another way of understanding her own experience as child and mother. A number of delegates had seen Joanna's current play "Nightfall" the previous evening – a play around the family's experience of childhood trauma with sexual abuse. She spoke elegantly of her experience as a playwright in grappling with the difficult topic. As a mental health worker it was fascinating to see how a playwright worked with these themes.

FINALLY THE PANEL

The panel of speakers, chaired by Ms. Sue Morse was a delightfully light and humorous conclusion. The panel answered questions and responded with such playful repartee. At times it almost occluded the brief pockets of brilliant thought. The prize fighter award must go to Ben Bradley, who literally jumped hurdles to stake his claim to answer one particular question. (Well done. If only we had taped these interactions for a micro-analysis(!)).

THE ARTIST

Juan Devillas' painting stared at all the conference. It was a bloody thing. A body, disfigured with a mother and her tortured face, a metaphor of mayhem. I will not try my hand as art critic. The artist attended some of the conference, and spoke from the floor during the panel session. The work stirred some feelings and caused great debate. Why this painting with this audience. Perhaps AAIMH readers would like to write in with their views?

THE CREDIT

All the AAIMH Victorian committee worked exceptionally hard to "pull off" such an ambitious event .. The number of unconventional ideas that were generated and eventually adopted and incorporated are too numerous to mention, but those who attended were, we hope, satisfied consumers of them. With out doubt the person who carried the lion's share of creativity, passion, energy and perseverance was Campbell Paul. It was said at the conference, but should be stated in a conference report what a huge load he carried, not just hard work but late night anxiety! Alongside Campbell special thanks should also go to Brigid Jordan, President of AAIMH-Vic who worked long and hard into the night, to bring such a wonderful conference to so many people. Brigid as AAIMH Vic President, presided over many committee meetings and had an enormous task of handling them, plus all the hundreds of extra meetings with the Conference Organisers., Many thanks to them both, and to the Victorian Committee, Ann Morgan, Liam O'Connor, Kerry Judd, Sarah Jones, Paul Robertson, Michele Meehan, Helen Belfage, Sue Morse, Jeannette Milgron and Zipporah Oliver for such an occasion.

[1] In the next edition of the Newsletter

[2] see Barnes, Understanding Agency, Pride and Shame, Sage 2000

[3] Sue is a Speech Pathologist and Infant Mental Health worker at the Royal Children's Hospital , Melbourne

[4] Bridgid currently doing her PhD in Infant Mental Health, and is alsothe current President of AAIMH (Vic).

[5] Dr Liam O'Connor, AAIMH(Vic) Committee member and Child Psychiatist revealed a yet to be discovered career as a stand up comic!

[6] Dr George Christie is a Psychiatrist and Psychoanalyst practicing in Melbourne

[7] Dr Mary Brown is a Peadiatrician in rural Victoria and a n Infant Mental Health Practitioner.

Acknowledgements: My thanks to Paul Robertson for his assistance in preparing for this article.

What Happened At The Newsletter Breakfast ?

Report by Sarah Jones, AAIMH Co-editor.

At seven am on the first morning of the conference 117 people plus the two editors left their beds early, walked, drove or trammed into Carlton in the early morning heat, found the University of Melbourne and discovered the Architecture Building. Was it to enroll? Was it to view the beauty of the building? Was it to catch the early bird? No it was to be attendees at the first official conference breakfast of a National AAIMH meeting. This inaugural meeting was a marvelous success as measured by bodies, danish pastry consumption and that now very fashionable notion of achieving outcomes.

The seventeen people were Beulah Warren, Victor Evatt, Marianne Nicholson, Trish Glossip, Renate Barth, Sam Menahem, Carmel Cairney, Helen Bevan, Lee-Anne McCaffer, Mary Morgan, Pam Linke, Elizabeth Puddy, Michael Daubney, Isla Lonie, David Lonie, John Reddington.

The editors were Paul Robertson and Sarah Jones.

A summary of the 7.30-8.45 am discussion chaired by Paul Robertson follows.

1. History of the Newsletter.

To our delight the very first newsletter editor was present. A large number of us did not know that the newsletter was started by Renate Barter from Sydney in September 1988. She gave us a wonderful version of the newsletter inauspicious origins. The mention of work done on kitchen tables, and regular anxiety of lack of material seemed all too familiar. It began as an attempt to bring people together in NSW, before there were even regular meetings. Then as now she recalls how difficult it was to get copy, but Renata loved it because she felt she could keep up with everyone and what events were happening at the time. In 1991 Renata departed for Germany, passing the newsletter over to Kimberley Powell. Not long after the now famous Doctors Lonie duo took it over and breathed a certain life into it of their own making. David told us how he introduced numbering the editions, going back to Renata's first and calling that number one in retrospect. David and Isla then began with Volume 4.

2. Editorial Advisory Committee

Proposal to set up a committee to assist in the newsletter. Such a group could compose of the following: two Chief Editors, Members from each State Branch and others skilled and interested.

Paul Robertson spoke in detail about the advantages for the newsletter in having a more broad based membership of people to advise on direction and orientation. His proposal would encourage national representation. Initially the Network News Correspondents for each state would be each States' representative, but in time this may change or develop as required. People with specific expertise could be invited to join, and those people may write for one or two editions a year on their own field of interest, or may simply be where the editors send articles for editorial comment. Paul was keen to get more people involved, and increase the available expertise currently involved with its quality.

TASK: All Correspondents were asked to put this motion on the agenda for the next local branch meetings agenda.

3. Plan change of Editors for 2001

The current editors, Sarah Jones and Paul Robertson, announced they will finish as newsletter editors at the end of 2000 and the search is on for new editors. The current editors will have spent 4 years editing the newsletter by the end of the year and it seems an appropiate time to have others make their own imprint and improvements. The experience for the editors has been both exhilarating and exhausting. There was a strong feeling the new editors should come from a different state, but with such advancements in telecommunications two new editors could be anywhere in the country and work well.

The development of the above Editorial Advisory Committee will allow a more gradual handover. Sarah Jones and Paul Robertson would remain on this committee as past editors so that experience is not lost. It maybe sensible for Paul Robertson to assist the new editors in their initial year.

Task: State branches to consider who might be interested in becoming AAIMH Newsletter editors in 2001.

3. Web Page

David Lonie reported on his efforts to set up the AAIMH Web Page. At present David indicated that it is the process of development, and currently sponsors do not require payment. It has the facility for an on-line discussion group. The priority now is to have someone dedicated to maintain the Web Page and preferably someone who is or can be in close liaison with the newsletter.
The meeting debated what links could be made with other organisations. David proposed that further work could be done with the Brazelton Institute or the Tavistock Clinic in London and the Journal of Child Development or Bulletin Board.

TASK: David Lonie to liase with editors and volunteers re the above.

3. Developing the Newsletter

Sarah Jones spoke on ideas to improve the newsletter. They were as follows:

(i) Publication of the best Essays from Infant-Parent Graduate Diploma Courses
(ii) Student Research projects published
(iii) Single Case design papers to develop section on therapeutic interventions
(iv) More book reviews: each state taking one edition per year to do two reviews, we could approach publishing houses to provide new editions.
(v) Theme based editions; offering lead up time for authors to prepare material
(vi) Advertising and advertising revenue were mooted as proposals for future years, but not something the current editors wish to launch at present.
(vii) Re-introduction of Membership Application form into body of newsletter. This issue requires some negotiation with each state, as some states require referees' names etc. and could be taken up with the National Committee to debate.
(viii) Annual Newsletter meetings to be held at future National Conferences

TASK: Following feedback from state branches these issues could be taken up by editorial advisory committee or taken up now by current editors.

3. Production, Lay out and Design

Vladimir Tretyakov and the editors were congratulated on the "new-look" newsletter. Unanimous approval of the changes and praise for the effort required to launch such changes. The product was described as more professional and easier to read. The problems in production and posting delay are being worked upon. Ideally the editors would like to set four deadlines for 2000 and work closely to them.

TASK: Editors to work with Vladimir to set deadline dates for 2001.

ATTACHED

By Lisa Quadrio

Lisa Quadrio is a mental health professional. She is a final year law student and has a BA (in anthropology). Lisa is a mother of two, and co-founder of APA (Attachment Parenting Australia).

INTRODUCTION

One of our children's favourite books is called *This Little Baby's Bedtime,* it goes like this:

> "One more story, a cuddle and a hug -
> this little baby's warm and snug.
> A kiss on the nose, then turn out the light -
> Shh! this little baby's asleep for the night."

Before my first child was born this kind of nightly ritual was what I had been expecting. I thought that putting my new baby to sleep would be a simple matter of reading a story, singing a few lullabies and the rest of the evening would be mine. After all, that's what happens in the movies and on TV.

I soon discovered that I had been a little naive. The reality of the last two and a half years has been that we have struggled to find a reliable way of getting our children to go to sleep. Throughout this time concerned friends and relatives have encouraged us to 'do controlled crying'. We discussed this option but decided that we couldn't do it. I have spent a lot of time over the last two years looking into the issue of children's sleep and trying to find alternatives to the 'cry it out' approach.

CONTROLLED CRYING AND TEACHING TO SLEEP

All of the mainstream baby books that we consulted contained some variation on the 'cry it out' theme. Even Robin Barker's book, *Baby Love,* virtually the Australian baby bible, promotes a form of 'teach to sleep'. This literature gave no real options apart from the sleep training approach. (We do not consider the use of sedation as an option.) We consulted a number of specialists all of whom told us initially 'no, we don't teach controlled crying'. Instead they proffered, The Boring Routine, Sleep Training or Teach to Sleep. These techniques allow for a frequent checking and resettling of the child which is absent from strict 'controlled crying'.

Obviously these techniques are more gentle than the 'cry it out' method described by Ferber, where a child is left to cry for longer and longer periods of time regardless of the level of distress. Unlike Ferber they do not require you to ignore a child who is crying in a sustained manner or very distressed. However their are still variations on the 'cry it out theme'. We did not consider them as acceptable alternatives because they are based on the same premises: firstly, that a child should be made to sleep in her own bed in her own room. Secondly, if the child protests this arrangement it is simply a matter of the parents staying firm, the child will eventually accept this program and there will be no harm done to either the child or the relationship. We found no research that proved inconclusively that it would not damage the child or the relationship and in the absence of that evidence we felt it was too great a risk, particularly when it just felt so wrong.

At the core of all Sleep Training programs is the idea that the parent must tune out from a child's attempt at communication. I am assuming that crying, resisting sleep, climbing out of the cot and calling for the parents, all constitute a communication from the child. By teaching parents to ignore or override these messages from the child, Sleep Training regimes become effective desensitisation programmes for the parents. I find it alarming that experts are encouraging parents to became less attuned to their child's cues and signals.

Most parents feel an instinctive urge to respond to their baby. However the belief that a child requires Sleep Training is widespread in our society and the pervasiveness of these ideas leads parents to fear that a child will never learn to go to sleep by herself unless she is taught. It is very confusing for parents who instinctively feel opposed to 'cry it out' or Sleep Training approaches to be told constantly that their instincts are wrong.

We felt very confused when we realised our instincts were at odds with the mainstream of parenting practice. When every book we read, every friend and professional we contacted, told us we were wrong and that our child would never learn to go to sleep by herself, we certainly wondered if we were doing our baby some harm. We were persuaded that we must not let our baby sleep with us under any circumstances, that we must encourage her to go to sleep in her own bed in her own room. If we did not she would never learn to go to sleep and she would remain dependent on us at night for years to come.

ATTACHMENT PARENTING/ EMPATHIC PARENTING

Just before the birth of our second baby, 15 months ago, I found an article on the Internet called *Go Ahead Sleep*

With Your Kids - The Urge Is Natural. Surrender To It, by Robert Wright, who says: "I'm puzzled. It isn't obvious to me how a baby would develop a robust sense of autonomy while being confined to a small cubicle with bars on the side and rendered powerless to influence its environment. [1]" This funny, articulate piece seemed to put into words all my own doubts about current parenting practices and I began to realise that a counter movement does exist. We discovered that, mainly in USA and Canada, there is a small group of professionals who are against the 'cry it out' approach and who also question the benefit of all forms of Sleep Training. This school of thought encourages parents to become more responsive to their baby's cues, one author stating that "[p]romptly responding to your baby's cries increases your sensitivity to your baby. Sensitivity helps develop your parental intuition[2]". Such professionals encourage us to listen to our babies and to own inner voices, and to develop our natural empathy to recognise and respond appropriately to our child's signals.

These ideas have become know as the Attachment Parenting (AP) approach, also known as Empathic, Gentle or Natural Parenting. Attachment Parenting is a term which was coined by Dr William Sears in recognition of Bowlby's Attachment Theory.

ATTACHMENT THEORY

Attachment Theory was proposed by the British psychoanalyst, John Bowlby (1907-1990). Importantly it recognises that infants and young children have an intense need for emotional security. For the child this need is met by remaining near to one or more carers, usually but not necessarily the mother. Attachment is "a warm and continuous relationship[3]" with that person or people.

A baby is born with the ability to behave in such a way as to elicit care from its mother/parents. That is, the baby is born with the ability to behave in a way which can signal its needs for food or for closeness to the carer. For example an infant may cry until picked up and nursed or cuddled. These cries trigger a response in the carers who find it difficult to resist their child's cry.

A newborn baby may require almost continual contact with her parents for security. When her carer is close she feels secure but when the child senses that her carer is not near, that she is separated, she begins to feels anxiety. This anxiety will be relieved if when the child cries the parent/carer responds.

An older child develops a sense of trust in her carers, trust that her need for security will be met. She knows that when she cries her mother comes, she has developed a secure attachment to her carers and she will begin to internalise this feeling of security. If a child's anxiety is not appropriately responded to by the parent she may not develop this trust nor form a secure attachment. A child needs an internal feeling of security in order to feel safe to venture away from her carer to explore the world around her. If a child is unsure that her parents will respond to her when she cries out she may internalise a sense of anxiety rather than one of security. This child may experience difficulties in progressing towards autonomy.

As a securely attached baby grows she will actively seek to explore her world and develop autonomy. This child uses her carer as a secure home base from which to explore, returning to her parent when she begins to feel anxiety. This process is one of a gradual weaning away from the parents, it occurs throughout one's life.

A baby or young child who cries out in the night may be expressing a need to touch base with her attachment figures. During the night the child may continue to express a need for closeness with the parents/carers to feel secure, she may requiring comforting to re-settle each time she wakes. This is quite normal for a child up to four or more years of age.

Attachment Theory suggests that if parents chose to ignore their child's night time need for security they may compromise their relationship with that child. The child may lose her sense of trust in her carers and her internal model of the world may become one of distrust and anxiety. This may cause difficulties in the child's quest for autonomy.

Attachment Parenting recognises the importance of responding appropriately to a child's needs both during the day and the night. Health professionals who promote this approach encourage parents to follow their instincts and respond to their child, to foster their natural empathy and build a healthy attachment relationship.

THE PRINCIPLES OF THE ATTACHMENT PARENTING

While trying to keep this paper concise I can only touch on the basics of Attachment Parenting. I have selected two ideas to discuss in detail, these are: extended breastfeeding and co-sleeping. These two practices are so bound up together that they are difficult to discuss separately and they are important here because they are the basis of night time nurturing. The third idea which I think is essential to an Attachment Parenting style is the practice of babywearing, that is, the practice of carrying or wearing the baby close to a carer, usually the mother. In other cultures the baby is placed in a sarong or sling and carried with the mother at all times. That is why we have heard of the non-crying babies of other cultures, the infant in the sarong has 24 hour access to the mother and may suck at the breast as a western baby would use a pacifier. Proponents of AP recognise that a baby who is kept close to her mother, with unlimited access to the breast, will feel secure and will have no need to cry for food or comfort as these are always available. The worn baby will therefore be more settled and contented than an infant who is left on the floor or in devices such as rockers, bassinettes, swings and prams.

Babywearing, co-sleeping and extended breastfeeding are three important principles in AP which are thought to foster the parent-child bond and build a mutual empathy which, in the long term, makes the job of parenting hap-

pier and easier. These form the basis of the Attachment Parenting style, these practices help parents and child to develop a secure attachment.

CAN ATTACHMENT PARENTING HELP MY BABY TO SLEEP THROUGH THE NIGHT?

As a sleep deprived parent this was my first question. All of the mainstream books that I had consulted presented ways to solve, fix or cure sleep 'problems'. I expected AP to offer its own neat solution. But AP does not do this, rather it looks at the issue of sleep in the context of the whole relationship between parent and child. Following the principles of AP may improve the night time situation for some families but this requires parents to accept the reality that the job of parenting involves a 24 hour commitment. This may seem particularly unpalatable when mainstream theories have fostered the unrealistic belief that parents should be able to put their child to bed and then go off duty for the rest of the night. The Sears & Sears book *Nighttime Parenting* discusses in detail the AP approach to the subject of sleep.

Sears and other AP authors argue against Sleep Training, arguing that these regimes merely produce "a short-term gain for a long-term loss[4]", and may not work at all. Attachment Theory suggests that a child who has difficulty sleeping alone is expressing her natural dependency needs. The idea of AP is that an unmet need does not go away but will surface later, possibly as more profound difficulties in adjustment. Therefore the long term loss is that the relationship with the child may suffer, and the child may lose her sense of well-being and trust in her parents.

The AP approach argues that the ability to sleep alone for long periods is a stage of development that each child will reach at her own pace, therefore to 'teach' a child to sleep alone before she is developmentally ready to do so may have a negative long term effect. Proponents of AP stress the benefits of co-sleeping[5], that is, sleeping with or near to the child, but not necessarily in the same bed[6].

The issue of co-sleeping is often reduced to a debate centred around the family bed, however Sears emphasises the importance of finding a sleeping arrangement that is suitable for everyone, with the family bed only one of a range of co-sleeping practices.

The family bed has all members of the family sleeping in one big bed or on mattresses pushed together on the floor. This is not always practical when there are several children. An alternative to the family bed is known as the side-car arrangement where one side of the cot is removed and then the cot is fastened to the side of the parent's bed, ensuring that the mattresses are at the same level. The baby is then close enough to mother to nurse easily during the night. Some proponents of AP recommend that the parents take the baby into the parental bed and have other children sleep together in another bed, in the parent's room or possibly another room if the children are happy with that. Other co-sleeping arrangements have children put to bed initially in their own room but then welcoming them into the parental bed when they wake during the night. For older children a mattress could be available next to the parent's bed should they wish to be close when they wake during the night. There are a range of possibilities and it is important to find a set up that is acceptable to the whole family while providing the night time security that children need.

Parents who find the Attachment Parenting style preferable to Sleep Training may have to readjust their expectations of what is normal in a child's sleep pattern[7]. Attachment Parenting does not have 'sleeping through' as its goal, but aims to find ways to minimise night time disturbances. Rather than advising parents to teach their children to sleep, Dr Sears and colleagues prefer to educate them about co-sleeping as well as extended breastfeeding, and the other benefits of adopting the Attachment Parenting style.

BENEFITS OF ATTACHMENT PARENTING

Ideally, the process of becoming connected with your baby will start before she is born but it is never too late to improve your relationship with your child. From the moment of birth the connection between mother and child will be consolidated by breastfeeding, co-sleeping and babywearing. Although a father cannot breastfeed he can participate in the nurturing of the baby, strengthening his bond to the child by babywearing and sleeping close by.

Not only do these practices meet the needs of the baby, in many respects they also make life considerably easier for the parents. In particular the combination of breastfeeding and co-sleeping allows children to be gently parented to sleep, and gives parents the best chance of waking refreshed, even after a broken night. The combination of breastfeeding and co-sleeping is culturally and historically the most common night time parenting practice[8]. It is a practice that is still widespread in most non-western cultures.

BREASTFEEDING

AP emphasises the importance of extended breastfeeding and child-led weaning with the focus on the child who is allowed to indicate when she is ready to move on to the next stage of development. When a child is allowed free access to the breast she may continue night nursing into the toddler years. Co-sleeping definitely makes breastfeeding during the night easier[9]. Mothers who practice extended breastfeeding often acknowledge that nursing back to sleep is far easier and more peaceful. Settling a child who is weaned may involve getting up, getting a bottle or dummy, by which time mother and child are wide awake, and possibly everyone else in the house as well.

Mothers who breastfeed older babies and toddlers describe many benefits. An older baby usually refers to a 12-24 month old child, but the majority of babies (60%) are fully weaned by 6 months of age. Breastmilk retains its nutritional benefits no matter how old the child and the breast remains a unique source of comfort even for the

older baby and toddler. There is much misinformation regarding breastfeeding and mothers who choose to breastfeed into the toddler years may meet with social disapproval. However some mothers believe that their toddlers are more secure and confident because they have had that extra closeness to their mother which is gained by prolonged nursing[10].

There are less well known benefits of breastfeeding, Sears describes breastfeeding as building a "hormoneous" relationship between mother and child. Breastfeeding mothers have high levels of prolactin, sometimes called the mother love hormone, which has a calming effect on the mother and allows her to cope better with broken sleep. Hormones produced during breastfeeding suppress the return of menstruation, this is called lactational amenorrhoea, which delays the return of fertility. There is evidence that night feeding and allowing the baby access to the breast for comfort sucking may further delay the return of menstruation[11]. That is, the so called lactational amenorrhoea method of birth control is believed to be most reliable for mothers who allow a baby unrestricted access to the breast, particularly at night.

CO-SLEEPING

Shared sleeping promotes bonding and security. Additionally, the physical closeness of co-sleeping families allows for a synchronising of sleep cycles, in which co-sleeping parents and child pass through periods of light sleep at the same time. If the child wakes while passing through a period of light sleep, the parent is in light sleep at the same time and can wake and comfort the child quickly. Breastfeeding mothers often report that they are able to nurse their children without fully waking. Parents feel better if woken from a light sleep than a deep sleep and the child will resettle much sooner when attended to before growing distressed. Even though the night is broken the disturbance is less and parents and child will feel more refreshed in the morning.

Another benefit of co-sleeping for parents who are at work is that this closeness at night can add eight or more hours every day to the time a family spends together. The family bed or other sleep sharing practices can build and strengthen all relationships within the family. There is evidence too that co-sleeping siblings may exhibit less sibling rivalry.[12]

Recently there has been some discussion regarding the possible dangers of co-sleeping. There have been some cases of overlaying, that is accidental suffocation of the child by a parent during the night. Recorded cases of overlaying usually involve drugs or alcohol or unsafe bedding such as waterbeds. However, research in sleep labs has shown that co-sleeping babies may actually be safer than those sleeping separately. Sleep lab observation has shown that co-sleeping parents remain aware of the position of their child during the night, their faces remain within 30 cm of each other through most of the night[13]. It is possible that this makes co-sleeping infants actually safer overall, the close contact and the shared breath (which is high in CO_2) may help to regulate the baby's breathing and therefore protect against SIDS[14]. Cross cultural comparisons bear out this conclusion, in Japan, one of the few industrialised cultures where co-sleeping is the norm, SIDS rates are among the lowest in the world[15].

There has also been the suggestion that co-sleeping families may be more likely to sexually abuse their children. There is no evidence to support this idea and most authors feel that in fact there is probably a lesser risk of all forms of child abuse in families who practice co-sleeping[16], as it is probable that abuse is more likely when parents lack empathy.

CONCLUSION - TOWARDS EMPATHY & FOLLOWING OUR INSTINCTS

It is a cultural myth that most new babies 'do nothing but feed and sleep' and, to the dismay of new parents, many wakeful newborns may seem to require very little sleep at all. Having a child sleep through seems such an important aim in many child care manuals that parents of a child who continues to wake at night may worry that their child is abnormal, or that they are doing something wrong. This doubt is compounded by those questions which seem to be so often asked of new parents: 'Is she a good baby?', 'Does she sleep through?'.

Anxious and exhausted parents of wakeful babies may wonder why their child's behaviour differs so radically from what is perceived as the norm, and often seek expert guidance. In these cases it would be beneficial to contact a professional who could offer reassurance and provide accurate information about the reality of children's sleeping patterns. Health professionals might better assist these parents with the support to foster their natural empathy, rather than handing out 'teach to sleep/controlled crying' doctrine as the only solution[17].

Many child care experts dismiss the parent's instincts and continue to perpetuate unrealistic ideas about childhood. They may insist that parents push their child to 'sleep through' the night alone when for many young children this may not be a realistic goal. Some form of co-sleeping may provide a means of meeting a child's night time needs, and at the same time allowing the whole family to get much needed sleep.

With our first child we thought we were on the right track, we followed the advice of experts rather than our instincts. All the literature told us we would be doing our child a huge disservice by allowing her into our bed, so we were strong and kept her out but we hesitated at the thought of sleep training, we used the car or pram or rocking our baby to sleep. Still we feared that we were being bad parents, that our baby would never learn to go to sleep, we worried that she would become dependent (this now seems ridiculous, the child was only about seven months old at that stage). When sleep grew increasingly difficult we consulted everyone we knew, no one said 'just go with what you feel is right'. A close friend of ours, a children's health professional, gave us Ferber's book. Ironically, this friend also has Bowlby's books, *Attachment, Separation*

and *Loss,* displayed prominently on his bookshelf, and yet he practices controlled crying with his own children.

For the first year of our daughter's life we tried to do it the mainstream way. She had her own cot in her own room, she was weaned at seven months. She was a relatively placid baby and usually woke only once a night, but even so it was an exhausting 12 months. For us AP was not a more difficult or more demanding approach to parenting. We found the job of parenting less stressful once we realised we did not need to fight our instincts and resist our baby's attempts to remain close to us at night. For our little girl this meant putting her bed in our room and welcoming her into our bed whenever she needed closer contact. When we started this arrangement she was 12 months old and at that stage she would climb into our bed at some time every night. At two and a half years old now she very rarely comes into our bed. In retrospect I can't believe we spent 12 whole months getting up one or more times a night, going to the baby's room, settling her and then trying to creep out, return to bed and get back to sleep before she woke again.

We have never 'taught' our daughter to sleep but around the time she turned two she began telling us "tired, go to bed now", she takes her bear and climbs happily into bed. This isn't every night but whenever she wants to put herself to bed we encourage her, she doesn't always fall asleep on her own but, like all new skills, it is improving with practice. It seems that the ability to go to sleep by herself was, like walking, talking and toilet training, a developmental milestone and that all we had to do was to be patient.

With our second child we used an Attachment Parenting approach from the start, we could not have done it any other way. When our son was born he was not such a placid baby as his sister. I have heard mothers with similar experiences say that their 'high need baby'[18] trained them how to be an attached parent[19]. This is more or less what happened to us. We realised within days that the only way to get any sleep with our new baby was to sleep with him in our bed and to breastfeed him *many* times during the night. During the day he was very unsettled and was only content when he was worn in a pouch and breastfed *often* for comfort. At 15 months he is still breastfeeding and spends the majority of each night in bed with me. He still wakes up to six times a night. I can't imagine how anyone would cope with a child like this in a separate room, getting up six or more times a night, feeding him and then trying to put him back into his own bed.

As the theory of Attachment Parenting suggests, a baby will be more content when worn or carried and when kept close to his carers at night, and this was certainly true for our son. The AP approach can be very helpful in the care of such unsettled babies, however babies of all temperaments will benefit from this style of parenting, they will grow to be securely attached children who strive for independence and are comfortable with intimacy.

AP represents a true alternative to the Sleep Training or 'cry it out' approach to parenting, however, it is seldom promoted or even suggested by the current mainstream of child-care experts. AP practices can be valuable tools for all parents whether or not they wish to whole-heartedly adopt an AP style of parenting. It would be valuable for any parents who seek professional support to have AP presented as an option for their family. Child health organisations should be able to offer parents accurate information about the long and short term benefits of AP practices. Health professionals could help parents to develop their own instincts, and to become more attuned to their baby's signals rather than be taught to ignore them. "[A] cue giving child and a responsive parent bring out the best in each other[20]"

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http://lightning.prohosting.com/~attached

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Dr McKenna has indicated that co-sleeping is a positive prognostic indicator for adult adjustment Dr McKenna is a Professor of Anthropology and the Director of the Center for Behavioral Studies of Mother-Infant Sleep, Notre Dame University.
Dr Servan-Schreiber is chief of psychiatry at Shadyside Hospital & Assistant Professor of Psychiatry at University of Pittsburgh. He has gone so far as to suggest that the reason many adults have problems with intimacy these days is that their mothers listened to those baby experts who advised 'cry it out'.
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19.Servan-Schreiber (ibid) suggests that this type of child is more likely to be found in the family bed because the parents quickly learn that this is the best means of settling the high need child. He stresses that this child is not made more wakeful and unsettled because she has been 'spoilt' by her parents meeting her needs.

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Controlled crying - Idealism versus reality

by Pauline Sampson

(Pauline is currently completing her Masters in Health Sciences (Infant and Parent Mental Health) with a research project investigating Parental Experiences of Controlled Crying. She has worked as an Associate Unit Manager in a Mother Baby Unit for the past 3 years).

Advocacy on the infant's behalf is an important and worthy feature of the work of the AAIMH, and the concerns brought by this role are reflected in the articles on Controlled Crying in the latest journal. Some of the articles are emotive, indicating the personal prejudices of the writers; others provide a more objective viewpoint. When considering this subject, caution is needed in ensuring that idealism does not preclude assisting families in distress.

A balanced assessment of the practice of Controlled Crying needs to consider the entire environment of development, particularly the baby's most immediate environment, the mother, followed closely by the rest of the immediate family. Infants need their parents to be responsive, to interact with them and affirm them as being of value. Winnicott asks, "What does a baby see when he or she looks at the mother's face?" suggesting that the baby sees him or her self. The mother is looking at her baby, and her facial expression is related to what she sees there. What happens when the mother is so chronically exhausted that she can no longer see her baby, operating in automatic mode as she attends to his physical needs? What does the baby see then, when he looks at his mother? When her emotional availability has shut down? "Wouldn't it be awful if the child looked into the mirror and saw nothing!" exclaimed one of Winnicott's patients. How, when this happens, can the baby develop a sense of self?

A mother in a state of exhaustion feels inadequate and guilty at her tiredness and frustration. These feelings are exacerbated by members of her own environment, who lecture her on what she should be doing to so that her baby will sleep, often making comparisons to their own babies who sleep so well. What does this do to her internal representations of herself as a mother? How does this then affect her confidence and ongoing relationship with her baby? How, in turn, does this affect the baby's development?

What most of the critics of Controlled Crying techniques appear not to understand is that most mothers who seek help with their babies' sleep have already tried to respond to them in ways in which the idealists of early infant development would applaud. For periods often exceeding twelve months, their babies have been the prime focus of their attention and energies, as they have tried to provide their very best for them. These mothers

have responded to their baby's cries by holding them, rocking them in their arms, breastfeeding them on demand, and taking them into their own beds.

As a result, many mothers have become sleep deprived as they provided for the baby throughout the night. Many husbands who work in the outside economic world are desperate for their own sleep, which is interrupted by the baby in the bed. Insufficient sleep affects their ability to function and provide for their family. These concerns cause them to abandon the marital bed and sleep in the spare room, or on the couch, or leave home altogether. This can result in further loss of self-esteem, and further damage to the representations of the struggling mothers.

It is counter-productive to compare mothers of our Western societies and cultures to those of the Kalahari Desert, Bali, or any other society idealised for their child rearing practices. Comparisons like this only serve to increase the guilt that many mothers carry as they identify inadequacies in their maternal capacities. I can recall two mothers who tried very hard to rear their babies as the proponents of these cultures suggest: it did not work! The mothers ended up completely drained by carrying their babies everywhere with them, with their breasts immediately available to their infants whenever they indicated needs of hunger or comforting. For these practices to work, all of society must be supportive – ours is not. Our society is post-industrial, existing in a culture of striving to survive within the requirements of an economic rationalist world rather than supporting the practices of the cultures cited as ideal for child rearing. However we may wish it otherwise, *this* is the reality of the environment of the parents we are endeavouring to help and the framework to which their child rearing, and our professional assistance, must adjust. Rather than wishing for something that cannot be without our whole society undergoing a radical turn-about, let us direct our energies to working out how best to work with parents within the realities of *their* culture so that they can provide optimal developmental environments for their children.

"It is counter-productive to compare mothers of our Western societies and cultures to those of the Kalahari Desert, Bali, or any other society idealised for their child rearing practices."

In the Unit where I work, we assist families who have disintegrated into chaos because of their infant's difficulties in sleeping. The whole family has become sleep deprived in response to the baby's frequent and vocal wakening. Mothers are exhausted and in tears, and with varying elements of post natal depression. Partners are bewildered, and tend to distance themselves to the more familiar and safer work environment, reducing further the support that the mother needs to carry out her maternal role. Other children become behaviourally difficult, as they try to fulfil their own needs for parental attention.

In babies from six months of age, we practice a form of Controlled Crying called Modified Controlled Comforting. This teaches parents to focus on getting to know their baby and to read their baby's cues. It teaches parents to listen to, and determine the meaning of the different cries of their baby. If the baby is indicating rising distress, then the parents are supported in picking him up and calming him – but then he goes straight back into his cot, and the settling techniques of patting, stroking, or rocking are continued for up to ten minutes at each intervention. Gentle music is often used to assist these techniques. For many babies from eleven and a half or twelve months, we find that the original Controlled Crying method brings better results. With these babies, no matter how long somebody stays with them, the door opening as their carer leaves results in their immediate transformation from a quiet, almost asleep baby, to full-on protest again. Adopting the boring context of Controlled Crying (regular but short interventions with a couple of pats, maybe a "shh"or two, then leaving) results in the realisation to the baby that there is not much point in yelling if that is all the result it brings. Then they accept the fact that Mum really means it, and they go to sleep.

"It is important to point out that in Controlled Crying, the baby's cries are not ignored. Many people seem to confuse Controlled Crying with the Extinction method, ie. just leaving the baby to cry."

It is important to point out that in Controlled Crying, the baby's cries are *not* ignored. Many people seem to confuse Controlled Crying with the Extinction method, ie. just leaving the baby to cry. The base of Controlled Crying is to let the baby know by regular interventions that "It's o.k., we hear you, and we are close by – *but* we know that you need to sleep, and that is what we want you to do."

With both Modified Controlled Comforting and the original Controlled Crying methods, previously unhappy, irritable, grizzling, sleep deprived babies begin smiling again as their sleep complement increases. Parents are delighted at the change in their babies. They are told that these techniques establish a basis to the structure of their baby's day. All babies like to have a sense of predictability, of "what's next," which these techniques help to provide. This means that if the parents manage to arrange a well-deserved holiday with their baby, they take the techniques with them and practice them wherever they are so that the baby, even if the rest of his world is different and strange, knows what will

REGIONAL VICE PRESIDENT'S REPORT

by Campbell Paul
Regional Vice President

As we begin the year 2000, it is useful to reflect on the busy year we have just had. Elsewhere in this issue are details about our National Conference that was held here in Melbourne in November. We have had very pleasing feedback from each of the overseas speakers who reiterated how much they enjoyed visiting Australia and participating in the Conference. They each enjoyed that opportunity to meet with a broad range of Australians working with infants and their families and also to meet with people from the arts who are interested in people, their development and their families. It is proposed that some of the talks presented at the Conference will be printed at a later date in the newsletter.

Professor Bernard Golse from the Paris highlighted the international nature of the infant mental health movement at a talk he gave at a dinner at the University of Melbourne. He described the activities of the World Association of Infant Mental Health (WAIMH) in its outreach to countries in Eastern Europe. In many countries attention to the details of mental health on a community basis has been unable to be as high a priority as professionals would like. The dialogue that was facilitated by WAIMH has been an exciting and productive one. Professor Golse demonstrated throughout the Conference his capacity to share his broad knowledge of infant psychiatry in a fruitful and collaborative manner.

Contacts and relationships made with other speakers including, Professor Seligman and Professor Trevarthen will lead to further joint presentations in other conferences such as the forthcoming World Congress in Montreal. We also look forward to further national collaborative projects and creativity. Some ideas are already being followed up with Professor Ben Bradley and Dr Stephen Malloch. The Conference was a real opportunity to continue the essential work of our Association in reaching out to the broader community.

In February we will have a visit by Professor Hiram Fitzgerald who is the Executive Director of the WAIMH. Professor Fitzgerald will be visiting Melbourne to present some of the work of his team which has been evaluating the 'Early Head Start Program' in the United States. He will also be exploring possibilities in Australia for hosting subsequent conferences. Professor Fitzgerald contributes to the 'Signal', the newsletter of WAIMH. This is an excellent vehicle through which you can keep in touch with overseas colleagues and trend in infant mental health.

Preparations are well advanced for the year 2000 National Conference that will held be in Adelaide this year from the 10 – 12 November 2000. Overseas presenters at this Conference include Professor Bob Garvin and Professor Klaus Minde. This promises to be simulating conference full of important issues relating to our clinical and research practice. Our Association in Adelaide has been very busy this since they have also organised a presentation by Bruce Perry on 6 May 2000. Professor Perry will be discussing his findings about the impact of early adverse events and trauma upon infant development. Adjacent to the National Conference in November there may be an opportunity for further training in the strange situation methodology.

Members of our Association will also be presenting at the 3rd World Conference for the Intentional Society in Traumatic Stress Studies in Melbourne in March 2000. There will be many fascinating presentations at this conference looking at trauma from many different perspectives. In the year 2001, we hope for a major translocation of infant mental health workers from east to west when Perth hosts the national conference. Meanwhile there should be considerable movement to and from Adelaide in November and before that we anticipate that many Australians will meet colleagues from around the world in Montreal at the end of July. These conferences provide critical opportunity for us to share the toils, torments and triumph in our work with babies and families. Hopefully they encourage further innovation and a regeneration of enthusiasm. The state and national committees are always keen to hear from members about the problems we face and the way that we work.

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happen at sleep time, providing a backbone to his sense of safety and security.

There are at least three centres in Melbourne which have developed excellent reputations for assisting sleep deprived babies and their families: Queen Elizabeth Centre, Tweddle Child & Family Health Service, and Masada Private Hospital. These centres have long waiting lists of families in distress. All three centres practice forms of Controlled Crying. They practice these methods because they have such positive results in turning families which have disintegrated into chaos and dysfunction back into families enjoying each others company once again. As a result, the baby's environment has returned to one of stability and emotional responsiveness to assist his developmental needs. It seems to me that this is what we, as infant mental health workers, are all about.

Pauline Sampson

References

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SOUTH AUSTRALIA

From: Pam Linke
Senior Project Officer

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

From: Pam Linke

We have been working on the visit of Dr Bruce Perry to South Australia next May. We have a morning and afternoon session on Saturday May 6. The morning session will be on "The Neurodevelopmental view of child development, theoretical, clinical and policy perspectives". The afternoon session will be on "Applying brain research to early child development." If any AAIMHI members will be in South Australia at that time and would like to come let us know. It should be a very interesting day.

We are also busy planning the 2000 AAIMHI conference after a very enjoyable time in Melbourne this year. We have invited Dr Robert Marvin and Professor Klaus Minde so far. Dr Marvin's time in Australia is more or less spoken for at this stage, but if any other states would like to have Professor Minde please let me know and I will check what he is willing to do. His most recent publications include a chapter in the new Handbook for Infant Mental Health (in press) entitled "Prematurity and serious medical conditions in infancy: implications for development, behavior and intervention" and (also in press) "A guide for parents on hyperactivity in children" and "Effects of daycare on children".

We have also been working on getting a South Australian Initiative for the Early Years, to link with the National NIFTEY project. So far we have had a very successful meeting of interested people, and agencies and we now have a small committee and a project officer (supported by Child and Youth Health) working on the next step. This will be a truly inter-disciplinary, inter-agency initiative and we are linking with the Department of Justice who are working on strategies based on the Pathways to Prevention Report, The Department of Education, Training and Employment, Parenting SA, Child and Youth Health and the Department of Human Services. There is lots of enthusiasm and energy to use this as an opportunity to advocate for children in the first three years of life. If anyone wants to find out more about the National Initiative you can join the NIFTEY list by emailing nifty-list@newcastle.edu.au and putting SUBSCRIBE NIFTEY LIST in your message.

I have been invited to work with the Department of Education, Training and Employment experts group in supporting the writers of the new curriculum for 0-3s in out of home care. A lot of work has gone into this effort in South Australia (and in some other States) to try to make it clear that infants need more than minding. What is going into the curriculum is about building safe attachments, helping infants and toddlers to manage separations, supporting their development and offering opportunities for them to explore their worlds. However the word "curriculum" has different meanings for different people and we will all need to be able to counter messages in the press and elsewhere that infants need to learn the 3Rs.

We have also prepared a response to the proposed changes to the Children's Services Act as part of the review of the Education Act. The new act seeks to enshrine the rights of all children to high quality care. One of the important things that we have found here is the need, when supporting the provision of high quality care for infants and young children who are in out-of-home care, not to present it in a way that makes parents feel that they cannot provide what their young children need. In some cases, of course, this is true - but conscientious caring parents may feel that their children will "miss out" on educational experiences if they do not spend time in day care.

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

From: Sarah Jones

It has been an exciting year for the committee with the conception and delivery of a wonderful National AAIMH conference in Melbourne in November 1999. (A conference summary is included in this edition). Needless to say these events consume energy for all of us. Writing this now in January, I am aware that all of us feel a bit jaded but overall very pleased with the result. Following the exhaustion of the years activities, especially the conference, we have not yet nominated office bearers for 2000!

We have had a very talented committee, with old hands and new ones. Brigid Jordan's presidency has meant we were well organised and there was the appropriate blend of work and play. Kerry Judd did a really marvelous job as Treasurer, and Liam O'Connor our Secretary will not be forgotten for his outstanding performance as our after dinner speaker at the conference. Most people will know that Brigid is now moving on to be President of the National AAIMH Committee. Congratulations to Brigid for being elected to

follow Isla Lonie in such an auspicious role. Campbell Paul will continue to be the Regional Vice President of the Pacific Rim of AAIMH.

In August the AAIMH Scientific meeting was dedicated to a Research Forum. We had a fascinating evening of debate, discourse and didacticism. We heard Jan Smith from Monash Medical Centre and Sue Morse and Michelle Meehan from the Royal Children's Hospital talk on three Infant Assessment Tools. I learnt a huge amount and am grateful to them all for their time and energy in bringing such a topic alive.

In September AAIMH Vic participated in a joint Marce Society event co-hosting the Ed Tronic workshop. Campbell Paul presented work which allowed an examination of clinical practice alongside thinking further about Tronic's ideas.

Dr Allan Schore presented a weekend workshop over the weekend of 20 & 21 November 1999 in Melbourne under the auspices of the Royal Australian and New Zealand College of Psychiatrists Section of Psychotherapy. He presented details of his work integrating affect regulation, neurobiology of infant brain development, infant mental health research and psychotherapy research. For those who attended it was a marvelous experience. Readers will remember we included Notes about his work in the Newsletter during 1999. For those wishing a more in-depth look at his work I can recommend his book - "Affect Regulation and the Origin of the Self".

Paul Robertson and myself will remain as co-editors of this newsletter for 2000. This means that Victoria will have had the newsletter for 3 years, following this we aim to hand over to new editors. They do not have to be in the same state. We welcome Michael Daubney from Queensland on to the newsletter team. As usual we are very keen to hear from anyone who has an idea, workshop of book review they would like to see in print. We hope to have more first time writers contribute for this years' editions.

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

From: Carmel Cairney
Congratulations to the conference organizing committee for the recent Melbourne National conference. The presenters were stimulating, the food, fabulous, the conference dinner hilarious and memorable, and the inclusion of the arts was enriching.

Prior to the conference, we continued our monthly presentations.

In September, Dr Susan Priest, Clinical and research psychologist, spoke about a study of the psychological outcomes which followed a brief stress debriefing intervention with 1700 women who delivered full term infants. The puzzling result was that the intervention made no difference.

At the October meeting, Caroline Radford gave us a very thorough overview of services provided by Ngala Family Resource Centre. They provide services for parents of babies and young children and have the motto "Building Confident Parents".

In November, Lisa Studman, Developmental Psychologist, gave a talk on "Family Adjustment to Disability". Lisa described an impressive programme that she and her coworkers are using with families with young disabled children. The programme is called "Stepping Stones".

In 2000 we plan to continue the monthly presentations. We also plan to develop more of a focus on Advocacy, as well as start planning for the National conference in 2001.

Dr Bruce Perry (key note speaker at the Adelaide Infant Mental Health Conference) can be heard at the Royal Children's Hospital on Friday 5th May 2000. The one day seminar will focus on four areas of Dr Perry's clinical and research interest with traumatised children exposed to abuse and neglect:

1. Brain development
2. The Impact on the first Few Years of Life
3. Post Traumatic Stress Disorder
4. Treatment Aspects, including the art of healing with music and art

Brochures can be obtained (enquiries) to Lisa Richardson, Royal Children's Hosptial, Melbourne, Gatehouse Centre on (03) 93456800

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.

XII BIANNUAL INTERNATIONAL CONFERENCE:

This conference will bring together the world's foremost researchers on infancy for the dissemination of knowledge on all aspects of the development of babies. This meeting is only the second occasion that the conference has been held outside North America in 22 years. About 1200 delegates are expected from the USA, Europe, and the UK. Organised by the International Society for Infant Studies (ISIS).

XII BIENNIAL INTERNATIONATIONAL CONFERENCE OF INFANT STUDIES BRIGHTON, U.K. 16-19TH JULY, 2000

For further information; ISIS Secretariat,
Email:icis2000@cogs.susx.ac.uk
Web:www.isisweb.org/confs.htm
Telephone: 001144 1273 678448
Fax: 001144 1273 671320

INFANT MENTAL HEALTH, ATTACHMENT THEORY AND "OUT OF HOME" PLACEMENT

DEVELOPMENT OF A REFERRENCE LIST

CAN YOU ASSIST ?

As advocacy representative for AAIMHI I am sometimes asked by professionals in the health and welfare field to suggest references. They are understandably concerned about the placement of a young child away from the person to whom the child is attached. I would like to create a bibliography related to this, which could be provided in response to such queries. If you are aware of suitable articles could you please send me the references? When I get the bibliography together it will be published in the newsletter.

With thanks.
Pam Linke

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