THE AUSTRALIAN ASSOCIATION FOR INFANT MENTAL HEALTH (Inc)
AFFILIATED WITH THE WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

Volume 8, Number 2 NEWSLETTER June, 1996

## FROM THE EDITORS

Our lead article this issue comes from Kerry Lockhart who emphasises the need for mother and infants to learn to talk to each other. Kerry who is an active member of the AAIMHI Committee has had considerable experience in working with parents and their infants and her article bears ample testimony to this wealth of clinical experience. In this issue also is a article reprinted from a 1993 WAIMH News, by Stephen Seligman. This is by way of introducing Stephen to an Australian audience as he will be one of the major contributors to the 1996 Annual Clinical Meeting, more about which is also in the Newsletter. Dr Seligman is writing about the importance of countertransference, so there is a nice balance about the Newsletter as following his paper is a contribution from Melbourne which is also about countertransference, but here in relation to infant observation.

Elsewhere there is news of the organisation and plans for the future. In the most recent WAIMH Newsletter, the President of WAIMH, Dr Joy Osofsky writes about the importance of affiliate organisations such as ours. She suggests that an affiliate organisation allows for a 'level of networking and sharing among individuals not usually done without a formal organisation.' Certainly in Australia AAIMHI has worked well in fostering communication between infant mental health professionals, and with the institution of a regular yearly clinical meeting, we should move further in this direction.

TABLE OF CONTENTS


| | Page |
|---|---|
| Learning To Talk To Your Baby - Kerry Lockhart | 1 |
| Why how you feel matters: Countertransference Reactions to Intervention Relationships - Stephen Seligman | 4 |
| Why is it hard to see the baby. - Royal Children's Hospital Infancy Group | 9 |
| Video Review | 9 |
| Branch News- AAIMHI (QLD) | 10 |
| Meetings, etc | 11 |


## LEARNING TO TALK TO YOUR BABY

Kerry Lockhart

### INTRODUCTION

Communicating messages to a baby can be done in many different ways. It is my intention to briefly explore some approaches, look at how the helper can assist the mother/baby dyad, and consider a few of the theoretical opinions of the early researchers in language development and attachment. I also hope to capture the significance of how the mother views her baby as an individual, and her role of providing protection and providing comfort.

### EARLY DAYS TOGETHER

Paediatricians Klaus and Kennell[1] were amongst the first to talk of mothers and babies needing time together to get to know each other. They criticised the clinical approach obstetrical hospitals employed of "baby ownership" until discharge. Instead, they encouraged the experience that is mostly commonplace today of placing the baby skin to skin with its mother, involving fathers in the delivery process, and encouraging the mother to allow her baby to suckle at the breast right after birth. This is often the time when mothers can gently say their first hello before moving on, if they want, to sensitively explore their offspring from top to toe. This is their first (and important) introduction to talking by touch!

Not all mothers want, or can have this experience immediately after birth. Some things that can impede mother/baby relationships starting off well are maternal pain following a difficult delivery, limited movement after Caesarean sections, maternal exhaustion or tiredness, incredibly tender breasts, feeding problems, a premature, sick or tired infant, maternal anxiety and/or depression to name a few. Naturally, the bonding process is still further delayed for adoptive parents. Such issues need to be discussed in antenatal classes so parents are prepared for what lies ahead. What parents need is to be behind the wheel controlling the introduction to their newborns at their own pace. Helpers can

with own experiences, and more critical and hostile towards their infants. The mothers' interactions were less responsive, sensitive or attuned to their babies.

Experience managing a specialist postnatal depression unit has shown that therapies aimed at helping mothers with postnatal mood disorders must incorporate support for enhancing infant attachment to deal with the issues that came to light in Lyn Murray's study. Fathers, along with other family members, can help by spending time talking to their baby. Health professionals can assist in many ways: providing group support, counselling, information, medication (sometimes), but, most of all, model nonjudgmental behaviour and a sensitive way of communicating with the baby for mothers.

## CONCLUSION

The value of engaging babies in a dialogue from the beginning, provides a good start in life. It Is best seen when the child eventually achieves the capacity to develop and sustain personal relationships, eventually becoming a well balanced, self-reliant individual. Parents weave this fabric of attachment and, in so doing, pass on a wonderful legacy to the next generation.

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## Why How You Feel Matters:

## Countertransference Reactions In Intervention Relationships


Stephen Seligman, D.M.H.


The importance of relationships, especially two-person relationships, has been highlighted by the wide array of research findings about the infant and its caregivers that has transformed our view of early development in the last quarter-century. Clinicians in infant mental health-related fields are increasingly seeing the infant-caregiver system, rather than any individual, as the focus of their efforts. Similarly, developmental researchers are finding that early relationships are the most powerful predictors of subsequent developmental outcome (Sameroff & Emde, 1989). Along the same lines, there is an increasing consensus that the quality of the intervention relationship is among the most important factors in the success of all interventions (Heinecke, Beckwith & Thompson, 1988; Seligman & Pawl, 1985).

In all their varied fields, professionals who work with infants and their parents are similarly affected by the evocative power of the infant-parent relationship. Even the most ordinary encounters with babies can produce especially strong reactions -- both positive and negative -in most of us, and these reactions are amplified when the infants are in distress, as in most intervention situations. In addition, strong reactions to parents are common, especially when the parents themselves are in great distress or, as is sometimes the case, appear to be the source of their babies' agonies. The range of reactions in such situations is very broad, including extremes of sympathy, frustration, blaming and even hatred of parents, and self-criticism when interventions do not have the desired effect. Other professionals may also evoke strong reactions, especially in the face of bureaucratic tangles,

puzzling clinical situations, or cultural, disciplinary or other differences. It is almost impossible to stay detached when working with babies and their families, and those workers who do are often the least effective. Indeed, the emotional power of infancy is one of the most fulfilling elements of our often disappointing and trying work. But our strong reactions can also impede the progress of our most well-intended and technically sophisticated efforts. Whether these responses become exhausting obstacles or sources of insight and vitality will depend on how we handle our reactive thoughts and feelings. The twin pitfalls of unreflective action or unnecessary self-censorship can be best avoided when we can become aware of our reactions and tolerate and use them as informative data, even when they initially seem negative or inappropriate.

In the face of such challenges, basic concepts drawn from psychoanalysis can be usefully applied in all infant intervention. Psychoanalysis always has focused on the transaction between the inner world of representations and motivations and the outer world of other people and things. Freud proposed the concept of *transference* to capture the omnipresent and dramatic influence of the individual's thoughts, feelings, memories, fantasies and anxieties on current experience and interaction with other people and organizations; all experiences are viewed through the template of earlier ones, especially early relationships with parents and other key caregivers. In some situations, these prior experiences are decisive in determining how current experience is felt and lived, as if the present *were* the past; the "ghosts" of the past are dominating the present (Fraiberg, 1975). In other situations, the actuality of the present blends with the internal representations of the past in more balanced ways.

Since the concept of transference was initially proposed, a controversy about its proper emphasis has evolved (Sandler, Dare, Holder, 1973). Some have insisted on a 'narrow' definition of transference, regarding it is a special artefact of the psychoanalytic situation as the arena where the most irrational and distortive elements of the mind are given free play. These writers have emphasized the inappropriate and capricious aspects of transference. Greenson (1967), in a textbook of psychoanalysis that is still widely accepted, wrote:

> *"Transference is the experiencing of feelings, attitudes, fantasies, expectations, etc. toward a person in the present which do not befit that person but are a repetition of reactions originating in regard to significant persons of early childhood, unconsciously displaced onto figures in the present (p. 171)."*

The hallmarks of these reactions are that they are repetitions of the past, and that they are inappropriate, intense, capricious, tenacious, and often, ambivalent. Thus, they are peculiarly powerful, and are not readily altered by explanations or behavior that would normally correct misperceptions or misunderstandings in usual interactions, but instead seem to have a life of their own (Schafer, 1983). Despite its apparent inconsistency with the "actual situation," the sense of the current situation as "replaying" the past is experienced as an objective reality,. rather than a subjective feeling.

Other writers have taken a broader approach, emphasizing the ways that all relationships are viewed through the template of expectations originating in the past, especially prior relationships; transference, in this view, is a ubiquitous, everyday phenomenon, since the past is always influencing current experience. An integration of these two perspectives will be most useful for most infant workers: While it would be destructive to assume that every client's reaction to every situation and every intervention is a distortion rooted in the past, it would be similarly limiting to neglect the fact that the apparently opaque surface of the present always contains and expresses inner presences and processes that may not be initially obvious. The past and present and the inner and the outer are always in ongoing, dialectical interaction, with the various influences being more or less dominant at different moments.

Such thinking may be especially useful for workers who are not directly involved in psychotherapeutic work with infants and parents, since they are not as likely to be explicitly concerned with the array of emotional reactions that may arise for parents who find themselves in distressing situations with their young children. Even under the most fortunate circumstances, becoming a parent stimulates parents' memories of their earliest experiences, and where these experiences were difficult and even traumatic, the "ghosts" that are evoked may be fearfully haunting (Fraiberg, 1975). In other situations, developmental or bureaucratic factors may interact with such personal experiences to further complicate the situation, as in cases of infants with developmental disabilities (Kalmanson and Seligman, 1992) or where social service organizations have become involved after reported episodes of child abuse or neglect. In situations of

bureaucratic transference (Seligman, 1992) parents' reactions to interventions may be especially complex and difficult to manage since they are conditioned by the experience of having been compelled to use services that would otherwise be rejected. A brief vignette from such a situation will now be presented.

An infant-parent psychotherapist was visiting the home of a young mother who had been required to begin therapy after allegations that she had abused her twenty-eight month old daughter. Herself a resilient and resourceful social worker, she approached the door of the client's apartment in a tough housing project with some apprehension, but expecting to be greeted acceptantly, if not warmly, since the initial telephone call had been surprisingly amiable. However, her knock was met with a long silence, ended by a gruff female voice shouting, "Who the hell are you?" The therapy had begun.

Although the main focus of the work here was not supposed to be the mother's feelings about the worker, this reaction poignantly illustrates the extent to which preconceptions about intervention are central from the first moment onward. This mother was fully prepared to see the therapist as intruding on her privacy, accusing her of wrongdoing, and as treating her as an anonymous, bureaucratic client. To her, the therapist was someone to be greeted with aversion, whom she could allow into her home only with an armor of hostility to protect her from the dangers that, in her past experience with her own parents as well as public agencies, always accompanied offers of help. This episode also illustrates one other key point -- that transference reactions usually have important ***self-protective*** functions. These may not be obvious, especially when these reactions are so intense, don't make good sense, and as they so often do, are implicitly, if not explicitly, hostile. Transference and transference-like reactions are ambivalent in two important and essential ways: they are always expressing something very important about the client's inner worries at the same time that they are concealing them, and they thus invite some form of involvement from we who are their objects as they simultaneously keep us at a distance (Freud, 1914). When these complex purposes can be "decoded" by providers, greater clarity and progress can result. Many of these essential points were made in earliest conceptualizations of transference, but they are often lost in the more technical or jargon-laden contemporary discussions.

Nevertheless, it is difficult to function as a "decoder" when one is the target of the same feelings and expectations that one is expected to understand. The therapist here, for example, felt caught off-guard -- stunned, discouraged, confused, disappointed, angry and hurt. She was tempted fleetingly to respond reciprocally and rudely to the mother, by getting angry herself or even leaving. Although most situations may not provoke such intense reactions, professionals routinely find themselves confronting their own inner responses to clients' self-protective manoeuvres. What kinds of resources--professional, conceptual, and personal--can we call upon to handle such challenges so as to maximize our therapeutic effectiveness?

The psychoanalytic concept of ***countertransference*** provides a useful tool here. Even more than transference, countertransference is difficult to define rigorously. The broadest definitions refer to all those feelings that arise in the provider in the course of the intervention relationship, while narrowest are limited to those of the worker's responses to the client that are inappropriate projections -"transferences" -- of her own prior relationships and inner fantasies, defenses and feelings. Although early conceptualizations of this idea suggested that therapists' emotional reactions to their patients usually impeded the therapeutic work, most contemporary writers now argue that *these reactions are to be treated as data that can provide essential insights about the client's psychology and experience of the intervention, as well as about the intervention relationship itself.* In addition, the psychoanalytic perspective adds the crucial emphasis on *unconscious processes;* that is, that both the client and the service provider are not fully aware of some of the most important elem of their experiences in the intervention situation.

From this perspective, the worker's first task in the face of her own reactions is ***self-monitoring,*** rather than responding interactionally. Like infants and parents, interveners and clients are always involved in processes of mutual influence; that families are always affecting our own inner states and actual responses is so obvious as to be neglected regularly. All workers will benefit from adapting an ***analytic attitude*** (Schafer, 1983), in which self-reflection -- as opposed to unscrutinized reaction -becomes a routine part of the worker's style. Schafer proposes that the analyst maintain a flexible inner image or "working model" of the analysand through the data that emerge in the intervention relationship should be filtered; this model is not always systematic or

verbally organized. While workers in the more pragmatically oriented infant intervention professions do not have the same secluded, "reflection-promoting" atmosphere of the psychoanalytic consulting room, the basic discipline of the analytic stance can be applied in a modified way to most interventions. Here, I return to the case example introduced earlier.

The infant-parent psychotherapist in the above example was aware of her feelings, but understood that the mother's insult was an indication of how bruised she felt by all that was happening to her, and perhaps much that had happened to her in the distant past. Specifically, the worker drew on a central theoretical postulate to organize her understanding of what was going on in this first stormy minute of clinical interaction: that people in distress will try to inflict the pain that they feel coming at them from the outside on others in their external worlds. Descriptions of such "identification with the aggressor" have been used to account for how frequently parents who have been abused as children will abuse their own children, as well as to explain why so many distressed parents will turn on the same therapists whose offers of help seem so apparently reassuring to them (A. Freud, 1936; Fraiberg, 1975).

With this in mind, in only an intuitive way, perhaps, the therapist said, through the door: "You seem ready for a fight. You must feel very put upon lately."

Relying on a combination of explicit thinking, intuition, and a general position of self-reflective detachment, the therapist used her reactions as the basis for a useful and empathic interpretive comment that got the therapy off on the right foot.. Such comments may be useful in a variety of intervention contexts, including those with no psychotherapeutic intent. For example, a physical therapist who feels intimidated as a mother persistently criticizes her by noting the slowness of her infant son's progress may rely on such thinking to interpret the mother's irritation as an expression of her own frustration and despair at her baby's disability. She could then explore the issue of what developmental expectations would be appropriate in the case with a more sensitive awareness of the mother's disappointment, grief and ongoing frustration.

**Conceptualizing Countertransference Reactions**

Some of the controversy about the boundaries of the concept of countertransference may be clarified by specifying some categories that can differentiate different types of provider reactions. A useful, if somewhat. approximate, schema would differentiate along. three axes, mindful of the fact that such differentiations are imprecise continua, rather than rigid distinctions. The three overlapping oppositions proposed here are: 1) those that are rooted in general issues of the working situation vs. those specific to the case; 2) client-based vs. worker-based; and 3) reactions that impede the intervention vs. those that do not.

**"General vs. specific"**

Many situations recur in interventions with infants and their families that routinely generate strong feelings in providers. For example, many workers - at least in the United States - are routinely frustrated by the difficulties of the legal and social service bureaucracies set up to protect children who have been victims of abuse and neglect. Similarly, the poignant problems of children with chronic and severe developmental disabilities may bring grief, anger and even despair to those who work with them on a daily basis. These reactions may not vary much across cases, but can affect a workers' emotional state and conduct in important ways.

Other evocative factors vary from case to case. For example, a mother may be especially competitive with the worker's competently offered developmental guidance and defend against her sense of humiliation and failure by criticizing trivial details of the worker's style. Alternatively, a pediatric practitioner who may be exasperated by an extremely difficult-to-soothe infant thwarts his efforts to help the baby's parents find effective soothing strategies.

**Worker-Based vs. Client-Based**

There is wide variation in how different workers will respond to the particular intervention situation. With the competitive mother just described, a worker who is herself prone to competition might become quite irritated and even become actively competitive with the critical mother, while another with fragile self-esteem might feel like there was indeed something wrong with her. A third might be less susceptible to the mother's defensiveness, and might more immediately adapt or bring the issue to the mother's attention.

But some things that clients do can be expected to evoke strong reactions in almost anyone, although the nature of these reactions will vary from person to person. Most of us would be vexed when a mother with whom we thought we achieved a

Phillip Boyce interspersed with and supported by clinical vignettes, firstly a 'standard', relatively uncomplicated instance of post-natal depression

1. not picked up by the G.P., and illustrating the subsequent deterioration in the health of the woman and of her relationships, *and*

2 replayed, with a more attentive G.P. who intervenes appropriately.

Secondly, a woman with pre-existing personality difficulties and thus a more difficult illness to manage well. In this instance a well-coordinated team approach is even more important.

I found the vignettes really brought the issues to life and made the background information more readily appreciable and obviously applicable tot my practice. The video is accompanied by a booklet which us a comprehensive additional resource and which will be useful and accessible in the consulting room. It contains a copy of the Edinburgh Post Natal Depression Scale.

Overall I found the package of video and booklet to be an excellent resource for the education of health professionals.

*Dr Stewart B. Cameron is a general practitioner in Marrickville. He participates in Ante-Natal Shared Care with KGV Hospital and has an interest in mental health.*

†DETAILS: **Caring For The Family's Future:** A Practical Workbook And Video On Recognising And Managing Postnatal Depression. Cost of Video and Booklet $30-00, available from Tresillian Family Care Centres, phone (02) 569 8146, Fax (02) 569 5394.

## BRANCH NEWS

### AAIMHI (QLD)

The Inaugural Meeting of the Queensland Branch of AAIMHI was held on March 16, 1996 at the Mater Children's Hospital, South Brisbane. The size and multi-disciplinary nature of those who attended - there were 60 professionals from a variety of professional backgrounds - reflects the interest in infant mental health in Brisbane. The Meeting was organised by Elizabeth Webster, and opened by Dr Peter Steer, Chief Executive Officer, Mater Children's Hospital. The Mental Health Branch of Queensland Health enthusiastically supported the venture. The Guest Speaker was Lyn Barnett who is well known to Australian audiences. Lyn is an Australian ex-patriate, who can probably be best described as a developmental anthropologist. At this meeting she used some of her videos to talk about infant and child development.

Plans are now underway for a second meeting with an interstate guest speaker.

Queensland professionals who work with infants and their parents are looking forward to the imminent arrival of an ex-Queenslander, Professor Barry Nurcombe. Barry is a child psychiatrist who worked both in Brisbane and Sydney before going to the States twenty years ago. Barry is Deputy Editor of the prestigious journal Development and Psychopathology, which is edited by Dante Cicchetti. Cicchetti has made major contributions to the literature on child development - perhaps AAIMHI might think about him as a potential visitor, now that we have an Australian link with him?

## The Australian Association for Infant Mental Health (Inc).

Extraordinary General Meeting - 17th April, 1996.

Members will be aware that an Extraordinary Meeting of AAIMHI (Inc) was held on April 17th to discuss a resolution which would change the Rules of association to bring them into line with the model rules for the Incorporation of Associations. A large number of proxies were received all of which were in favour of the resolution. The Meeting was adjourned, and permission is now being sought from the Office of Charities to make these changes. Members will be advised of the progress of these negotiations.

**Membership Dues**

A membership form is enclosed with Newsletter, and members who are not financial for the 1996-7 year are requested to return it with their payment to the Treasurer. In general if a member joins or rejoins towards the end of the financial year, their membership is taken to cover the following year. The September Newsletter will be the last one sent to members who are not financial for the 1996-97 financial year - there will be a reminder notice enclosed with it for those who are not financial.

The Annual General Meeting of AAIMHI will be held at the time of the December Clinical Meeting in Melbourne. At that time, we hope to introduce changes to the Constitution which will facilitate federal activities, and also promote state branch activity.

## WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

At the forthcoming WAIMH Meeting in Tampere, Finland, I will be standing down as Regional Vice President of WAIMH, a position I have held since the Lugano Meeting in 1989. There have been major changes in the organisation of what was then WAIPAD; and those changes have been reflected in the Australian scene. It is now much clearer how the World and the regional affiliate organisations can facilitate each other's work. The President, Dr Osofsky, has foreshadowed that there will be discussion on the role of affiliate organisations in Tampere, and I look forward to participating in this. It seems that a large contingent of Australians will be attending the meeting, and it would be good to lobby WAIMH Executives with respect to what, as an affiliate organisation we might expect from WAIMH. In an article in **The Signal**, the WAIMH Newsletter, Dr Osofsky has suggested that affiliate organisations might have different roles depending on where they are, but she indicates that it is likely that affiliates will take an increasing part in WAIMH's overall function. The success of the Pacific Rim Meetings held in Melbourne and Sydney has demonstrated how vigorous an organisation we have going here.

As this will be my final contribution as Regional Vice President, I would like to thank all those who have taken part in the activities of WAIPAD and WAIMH in the past seven years. I have some regret that we are not hosting the World Congress here in Sydney in a month's time - but I think should we want to host a Congress in the future we should be well in the running. And I do look forward to being a consumer rather than a provider at Tampere!

David Lonie, Regional Vice President, WAIMH

## FORTHCOMING MEETINGS

**Narrative of a Mother with a premature infant**
**Narrative of a Father with a premature infant**
**Presented by Norma Tracey**

Norma Tracey has undertaken several years of specialised research into the emotional world of parents with premature infants and has published widely on this subject. She has conducted 216 audiotaped interviews with mothers and fathers as part of this research. The research protocol was designed by Henry Luiker. Material for these afternoon lectures has been produced from a detailed study of the interviews by a group - Peter Blake, Beulah Warren, Helen Hardy, Pam Shein, Sylvia Enfield. These afternoons provide a first hand account of their findings and the implications of their research for health care professionals. Professor Bryanne Barnett will present the introduction, and chair the discussion. There are three identical afternoons...

17 June Conference Centre Rozelle Hospital.

22 July Centenary Theatre . North Shore Hospital Grounds St. Leonards.

18 November Paediatric Health Dept. 13 Elizabeth St. Liverpool.

Time for each is 2.15 to 4.30. Cost $12.00. Please book, making your cheque payable to Emotional Care of Families in NICU Trust. 11 Mars Rd. Lane Cove 2066. Tel. or fax. Norma .(02).4272028.

## CHILD PSYCHOANALYTIC FORUM

Valerie Sinason, a consultant child psychotherapist and trainee psychoanalyst from the Tavistock Clinic, London, working mainly in the field of learning disabilities and sexual abuse, will be in Sydney on August 13th and 14th, 1996. She is recognised for her work on learning disability, sexual abuse and trauma, and has published widely in these fields, and is the author of two books *Mental Handicap and the Human Condition* and *Treating Survivors of Satanist Abuse.* Valerie Sinason will give a public lecture titled **Abuse, Trauma and Handicap: The Impact on the Capacity to Think and to Know** on Tuesday 13th August, at the Conference Centre, Rozelle, cost $20-00, enquiries George Haralambous phone 887 5830. A Workshop **Violent Sons/Absent Fathers.** This workshop will be useful for those who work with children and adolescents, and will be held at Arndell Children's Unit on Wednesday evening 14th August, Cost $100-00. Bookings essential. For further information contact Pam Shein phone 389 5365.

## Association for the Welfare of Children in Hospital

4th National Conference - "Who Cares?": Before and after the hospitalisation of children

**Date**: 10 -11 October, 1996

**Venue**: University of Western Sydney, Nepean

**Enquiries**: Ms Lynn Shaw, Phone (02) 633 1988, Fax (02) 633 1180.

# THE AUSTRALIAN ASSOCIATION FOR INFANT MENTAL HEALTH (Inc)

## ANNUAL CLINICAL MEETING, Melbourne, Victoria, December 6 - 8, 1996.

### THE INTER - PLAY OF INFANTS, PARENTS AND THERAPISTS

This conference aims to present those who attend with an overview of ideas about infant-parent psychotherapies and how these ideas may be applicable to workers in diverse settings from consulting rooms to the homes of troubled families.

Speakers include Juliet Hopkins, Consultant Child psychotherapist, Tavistock Clinic, London; Steven Seligman, Infant-parent Program, University of California, San Francisco; and Mary Sue Moore, Community Infant Program, Boulder, Colorado.

An integral part of the programme will be presentations of theoretical and clinical work by infant-mental health clinicians in Australia.

**Programme Highlights:**

Friday December 6. Pre-Conference Workshop: A Relationship Oriented Approach To Intervention With Infants And Young Children: Applying Mental Health Concepts In Diverse Situations. Stephen Seligman

Saturday December 7. Infant-Parent Psychotherapy Contributions from Stephen Seligman, Juliet Hopkins, Mary Sue Moore, and clinical presentations from AAIMHI members.

Sunday, December 8th. Winnicott Lecture. "Too Good Mothering." Juliet Hopkins.

**Venue** : University of Melbourne

**Accommodation**: May be available at one of the University Colleges.

**Note:** The Pre-Conference Workshop with Dr Seligman may be attended separately.

**Enquiries:** Conference Organiser, Jean Leitinger, Phone and Fax (03) 9347 6683; email Leitingj@cryptic.rch.unimelb.edu.au

**AAIMHI Committee**

**Elected** 25 October, 1995

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| PRESIDENT | Marianne Nicholson, S.R.N., S.R.M. (London), M.C. |
| VICE PRESIDENT | Beulah Warren, M.A. (Hons).,M.A.Ps..S |
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| David Lonie | F.R.A.N..Z.C.P. |
| Isla Lonie | F.R.A.N..Z.C.P. |
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| Deborah Perkins | M.B., B.S., B.Sc., Dip. Paed. |
| CORRESPONDING MEMBER | |
| Elizabeth Puddy | M.B., B.S., Grad. Dip. Parent Education and Counselling. Cert. Fam. Therapy |

## KARITANE

### Research Applications

Karitane has established an annual budget to support research into Child, Adolescent & Family Health Issues. Applications are therefore called for proposals in any area of research concerned with all aspects of infant, child, adolescent and family health.

In considering applications, Karitane will favour proposals focused towards its strategic objecti Additionally, emphasis will be placed on the academic merit of the proposed research, its feasibility and the likelihood of an outcome, its impact on and value to the provision or improvement of parentcraft care and its potential benefit to Karitane, its staff and clients.

Those interested in applying to undertake either funded or unfunded research are encouraged to obtain Karitane's Research Guidelines available from the Chief Executive Officer's Secretary by telephoning (02) 794 1828. Applications should be submitted by 12 July, 1996 to:

Chief Executive Officer
(Attention: Patient Care Review Committee)
Karitane, PO Box 241, Villawood 2163.