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FROM THE EDITORS

We are privileged to be able to present in this edition of the AAIMHI Newsletter, an abbreviated version of Professor Peter Fonagy's Plenary Address at the WAIMH 6th World Congress. The theme of the Congress was "Early Intervention and Infant Research: Evaluating Outcomes", and as there is increasing demands on those working within the health field to demonstrate the efficacy of their work, Professor Fonagy's paper is particularly important.

In his paper he looked at the area of conduct disorder in childhood, a disorder which child mental health workers see as increasingly prevalent. At the same time it is becoming clear that this disorder is very difficult to treat, and that the long term effects lead to increasing delinquency and anti-social behaviour with pressure on courts and penal institutions. Professor Fonagy suggests this is an area where we may be able to demonstrate an important contribution in prevention.

We expect in the next Newsletter to present summaries of a number of other papers, and comments from some of the Australians who were there. In this edition we include an account from Julie Campbell and Joan Croll on their experience of the Meeting, and we invite other participants to send us their comments.

As we go to press, planning is well advanced for the Annual Clinical Meeting of AAIMHI which will be held in Melbourne in early December. It is important that we make this a successful national meeting as we move increasingly towards a federal body with active state branches. With active branches now in Western Australia, South Australia, Victoria, New South Wales and Queensland, the chance for us to get together and share our experiences is most important. We should not have to go half way across the world to see each other!

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PREVENTION, THE APPROPRIATE TARGET OF INFANT PSYCHOTHERAPY

Keynote Address given by Peter Fonagy, London, at Tampere on Saturday, July 27, 1996[1]

The speaker began with the statement that he would focus his evaluator's microscope not on early interventions in general, but rather on early preventive interventions in particular since he firmly believes that the future of mental health work in infancy lies in prevention. It was arguably the case that, in essence, all clinical interventions with infants are preventive in nature.

Turning then to the terminology of prevention, he drew attention to the three-way distinction proposed by Gordon (Gordon, 1983, 1987) as most appropriate for Infant Mental Health:

a) Universal preventive measures which must be cost beneficial for everybody in the eligible population. Prenatal and perinatal care would be universal preventive interventions.

b) Selective preventive measures which are cost beneficial only to a sub-group of the population whose risk of becoming ill is above average.

c) Indicated preventive measures are applied to groups who are asymptomatic regarding the disease but on examination are found to manifest a risk factor which may justify more costly and extensive interventions. In this system treatment and rehabilitation are quite separate and not regarded as prevention.

In considering the next decade, Professor Fonagy pointed to the formidable task ahead for infant mental health clinicians and researchers: *to persuade society and its agents, the*

[1] Peter Fonagy is Freud Memorial Professor of Psychoanalysis and Director of the Sub-Department of Clinical Health Psychology at University College London. He is Director of Research at the Anna Freud Centre, London and Director of the Child and Family Centre at the Menninger Foundation, Kansas. His research interests include the study of the outcome of psychoanalytic psychotherapy and the impact of early parent-child relationship on personality development. Dr Fonagy has recently completed a review commissioned by the United Kingdom Department of Health on the outcome of the psychotherapies which is to be published shortly. He is also a grant holder for the Centre for Clinical Outcomes Research and Effectiveness at University College London.

politicians and the administrators of mental health budgets, to invest in the mental wellbeing of its infants, to accept and internalise what we all believe to be a fundamental truth of our field, that the preservation of the mental health of our infants is the key to the prevention of mental disorder throughout the lifespan.

The general case for prevention rests on a number of well established facts:

a) Approximately 20% of children and adolescents suffer psychiatric impairment (Anderson et al., 1987; Bird et al., 1989; Costello, 1989a; Matsuura et al., 1993; Offord et al., 1989; Velez et al., 1989; Zahner et al., 1993; Zill and Schoenborn, 1990).

b) **Of these only 10-15% find their way to psychiatric services** (Knitzer, 1982; Tuma, 1989; Kolko and Kazdin, 1993). This is the case in the US where financial barriers to psychiatric care are considerable, but also in New Zealand (Pavuluri et al., 1996) only 19% in the 0-5 age range were found to reach needed mental health services. It must be asked however, if this number been higher could services have coped?

c) **Poor long-term outcome of untreated impairment is now increasingly recognised for disruptive behavioural problems** (Offord and Bennet, 1994; White et al., 1990; Cantwell and Baker, 1989). Early psychiatric disorder persists to later childhood; a review by Campbell (1995) showed that 2/3 of 3-year-olds who showed significant disturbance still had difficulties when assessed at 8-12 years of age. This is particularly true for the disorders which are of greatest cost and concern to the wider society: violent conduct disorder (West and Farrington, 1973; Lefkowitz et al, 1977; White et al., 1990; Cantwell & Baker, 1989). This with many other childhood disorders progresses beyond adolescence, to adult pathology: eg disruptive behaviour to antisocial personality disorder (Offord and Bennet, 1994; Weiss and Hechtman, 1986; West and Farrington, 1973); depression to affective disorders in adulthood (Kandel and Davies, 1986; Garber et al., 1988; Harrington et al., 1991, 1994). **The infant mental health professional's goal from an evaluator's point of view is to target these long term problems.**

d) **Much more is known currently about risk and protective factors for almost all child psychiatric disorders than was the case in the 1960s** (Rutter et al.,, 1981; Rutter, 1989; Rutter, 1993; Rutter, 1994; Harrington et al., 1994; Quinton et al., 1993). This, as I shall attempt to illustrate, is the key for the appropriate targeting of interventions in early childhood.

e) **Much has been done to identify which of these factors are malleable to interventions** (e.g. Seitz, 1990; Farran, 1991; McGuire and Earls, 1991; Kochs, 1993; Heinicke et al., 1988; Olds and Kitzman, 1993; Van IJzendoorn et al., 1995). Prevention is underpinned by the modification of risk by selecting accessible and modifiable vulnerability or protective factors in the developmental causal chain of a disorder.

f) Treatment interventions available for many of the most recalcitrant mental disorders of childhood are sadly relatively ineffective (Kazdin, 1994; Target and Fonagy, 1996).

g) **One of the strongest arguments for prevention/early intervention is in terms of "sensitive periods" in the development of the CNS.** This has now been demonstrated in a number of areas including: emotional reactivity (Dawson et al., 1994; Trevarthen & Aitken, 1994), self-organization (Cicchetti; 1994), motivation (Derryberry & Reed, 1994), relationships (Zeanah et al., 1989, Carlsson & Sroufe, 1995) and the irreversible damaging impact of certain types of early sensory experience (Courchesne et al., 1994), the overwhelming destructive effect of early emotional stress (Benes, 1994) and the sensitization to (or kindling effects of) these experiences (Post et al., 1994). **There can be no doubt, for example that the early maltreatment of a child has profound neuropsychological as well as behavioural sequelae** (Cicchetti and Toth, 1995; Hart et al., 1995). The observation of infants with mothers who are depressed has also helped us to realise the importance of early interaction for later development (eg Lyons-Ruth et al., 1986). Work by Laucht and colleagues in Germany has offered an elegant illustration of the importance of disturbed mother-infant interaction as mediating this effect. As the work of Tiffany Field illustrates, infants of mothers who are still depressed when their infants are six months old begin to show growth retardation and developmental delay (Pelaez-Nogueras, 1994; Field, 1995).

Remarking that the sceptic was unlikely to accept the case for the value of early preventive intervention stated in such general terms, the speaker then turned to his overview of past evaluations and follow-up. Fortunately, over the last 25 years substantial evidence for the effectiveness of early preventive intervention has been accumulated (e.g. Field, Scanberg, Scafidi, Bauer, Verga-Lahr, Garcia et al., 1986; [illegible], Widmyer, Stringer & Igatoff, 1980; Kraemer & Fendt, 1990; Brooks-Gunn, Klebanov, Liaw & Spiker, 1993; Horacek, Ramey, Campbell, Hoffman & Fletcher, 1987). Despite several outstanding reviews (e.g. Cox, 1993; Rae Grant, 1991; McGuire and Earls, 1991; Seitz, 1990; Farran, 1991) the results of this effort are hard to summarise. Programmes have been heterogenous with regard to a number of critical variables such as whether the child or the parent is the centre of the intervention, whether intervention needs to start during pregnancy or at birth, whether it needs to continue to the second or even third year of the child's life and if so at what rate the intervention should be tapered, whether the intervention is best administered by nurses, psychologists or other professionals or by volunteers, whether the intervention is best kept focused or broad-based, educational, behavioural, relationship or psychodynamically oriented. Given the number of parameters and the unsystematic way in which

they vary across studies, strong and generalisable conclusions are hard to draw.

One of the largest studies so far reported is the Infant Health and Development Program (Brooks-Gunn et al., 1994) aimed at reducing the educational, health and behavioural risks associated with low birthweight. Home visits (once per week in the first year after neonatal discharge and biweekly for the subsequent two years), educational programs in specially designed preschools (4 hours per day) and parent group meetings was provided for a randomly selected one third of the 985 infants across 8 sites. The impact on IQ, health status, and behaviour (CBCL) was powerful and significant during the period of intervention (first three years) but declined on follow-up with only the heavier babies (2,001 to 2,500 g) continuing to show IQ benefits at five years and neither group manifesting significant health or behaviour benefits in the longer term. Looking at the nature of the home visits, perhaps our disappointment with the follow-up results might be mixed with a bit of smugness. As clinicians we would have known that the physical presence and educational and supportive input from a home visitor alone was unlikely to benefit these disadvantaged mothers in the long term.

The speaker also mentioned specially the Pre-natal Infancy Project, also known as the Elmeira Project, conducted by David Olds and his colleagues. A high risk sample was drawn on the basis of socioeconomic status, single status and age, and was recruited before the 25th week of pregnancy. The intervention consisted of home nurse visits throughout the first two years of life (weekly for the first six weeks, then decreasing to once every six weeks during the second year). Visits included an educational component (risk behaviours), parenting techniques, enhancement of social support, and advice. Benefits were evident at childbirth, particularly among young adolescent mothers (Olds et al., 1986a). During the first two years there was a 32% reduction in emergency room visits, particularly for injuries and ingestions (56%). Verified child abuse was reduced in the highest risk group, of unmarried teenagers, from 19% to 4% (Olds et al., 1986b). Child control practices included fewer restrictions and punishments and more intellectually stimulating material was available. Once the nurse home visits ceased (in the 3rd and 4th year) the differences in the rates of child abuse and neglect between the two groups were reduced and so was the difference in the children's scores on intelligence tests (Olds et al., 1994a). However, there remained some statistically significant differences in terms of number of injuries and ingestions, a clear impact on behavioural problems and lasting IQ gains in the children of mothers who smoked during pregnancy (Olds et al., 1994b).

The results hint at the process of change: the strongest effects might have originated from the long term consequences of changes in the mothers' lives associated with the home visits. For example, they improved their child's chances by delaying their next pregnancy and entering productive employment (Olds et al., 1988). Thus, some of the lasting effects of preventive interventions are probably tied to structural changes in the lives of parents, which in turn continue to impact upon the development of the child. This underscores the rather obvious observation that the engagement of parents is an essential precondition for the success of a programme, even if this is focused principally upon children. The Perry preschool project (Schweinhart, 1987) which seems to have been a highly successful preschool educational preventive intervention, included a probably crucial home visit component and had detectable effects at 19 years in terms of educational and behavioural outcomes.

There is some agreement among studies that early commencement of preventive interventions is essential. Experimental studies (e.g. Larson, 1980) show that intervention during pregnancy brings additional benefits. A prevention strategy devised by Spivack and Shure (1979), involving the teaching of interpersonal problem solving skills, was also more effective in preschoolers than older children (Shure & Spivak, 1979, 1982, 1988). Although early intervention is more effective, there is a need to sustain any improvements that may have been brought about (Cox, 1993). Thus, the overall cost of prenatal intervention will be greater.

There is less consistency in the literature on the qualifications required to perform preventative work. Most studies-in the UK use Health Visitors (specially trained nurses) who have a statutory obligation to visit young children and their carers. Preventative programmes tested added to this training by providing additional didactic seminars (eg Appleton et al., 1988), providing back-up consultation (Hewitt and Crawford, 1988), support groups and joint case work (Thompson and Bellenis, 1992) and a combination of didactic, supervisory and mutual support case discussion formats (Bellenis and Thompson, 1992). It is important to note that, despite the highly trained nature of this group and their excellent integration with the statutory services, controlled evaluation studies have not yielded striking results either from the point of view of the caregiver or the child (Nicoll et al., 1984; Weir and Dinnick, 1988; Stevenson et al., 1988) or from the point of view of reduced referral on to secondary services (Thompson and Bellenis, 1992; Bellenis and Thompson, 1992).

Interestingly, although formal comparisons have not yet been made, the outcomes from volunteer-based schemes are somewhat more promising (Cox, 1993). In such schemes there is no expert helper and the distinction between befriender/volunteer and the befriended mother is not stressed (Pound and Mills, 1985). A controlled trial (Cox et al., 1991, 1992) showed that these minimally trained volunteers were effective in bringing about improvements not only in the mother's mental state but also some degree of improvement in mother-child relations as revealed by blind rating of video recordings. This pattern of findings confirms one of the paradoxes in the evaluation of psycho-social interventions (Roth and Fonagy, in press): that, while the therapist is a key source of variability in accounting for differences in treatment effects (Luborsky et al., 1986), therapist's experience or

training accounts for only a very modest proportion of this (Durlak, 1979; Hattie et al., 1984; Berman and Norton, 1985; Lyons and Woods, 1991; Stein and Lambert, 1984, 1995). Experience may be particularly helpful in reducing drop-out rates while professional training seems hardly relevant according to therapeutic modality and client group.

In a large measure due to the ground-breaking work of Kathryn Barnard, **we have evidence that a relationship based approach is an essential component of successful prevention.** She demonstrated that a didactic approach was less successful than one that focused on relationship building, treating the mother as the person with the responsibility to promote the development of her child (Barnard et al., 1985).

The promise of preventive intervention is considerable, having the potential to improve in the short term the child's health and welfare (including reducing the potential for maltreatment) while the parents can expect to benefit in various ways including improved social support, self-efficacy and relationship with their child and partner. In the long term children may benefit in critical ways behaviourally (less aggression, delinquency), educationally and in terms of social functioning and attitudes while the parents can benefit in terms of employment, education and mental well being.

These conclusions should be qualified substantially in the following ways:

1. Outcomes are selective - no study achieved all these effects together.

2. Many of the studies reported unacceptable rates of refusal, threatening generalizability. Unfortunately, it is most likely those in greatest need who decline the invitation to take part.

3. Attrition is high in most studies, making conclusions from long term follow ups doubtful; the low perceived risk of adverse outcome may account for the low uptake and high rates of attrition observed in many prevention studies. For example, three of the most influential studies, the Houston Parent-Child Development Centre Program (Johnson, 1990, 1991; Johnson & Walker, 1987), the Parent-Child Interaction Training Project (Strayhorn & Weidman, 1991) and the "I Can Problem Solve: An Interpersonal Cognitive Problem-Solving Program" (Shure & Spivack, 1988, 1982) had attrition rates of 50%.

4. Results are generally poorer with more high risk samples.

5. Theoretical models of prevention lag behind those underpinning treatment interventions.

6. The heterogeneity of the studies-does not permit clear recommendations about THE effective preventive intervention programme.

The speaker then went on to note that these studies are nevertheless extremely helpful in **identifying the goals of the field for the next decade.** He said the potential of early prevention has not yet been developed, and that he now wished to consider a somewhat different approach which might move us closer to the goal of preventing mental disturbance **through interventions in the early years.** The field of early prevention could benefit from some of the lessons which treatment research has learned over the past 25 years. In the recent review of the effectiveness of psychosocial treatment interventions, commissioned by the UK Department of Health, Fonagy and Roth reviewed the existing outcomes literature from the point of view of providing guidance for purchasers, managers and providers of services and produced a report for the Department entitled: "What works for whom?". The review was in its turn peer-reviewed by 30 or so international experts before being endorsed by the Department and will be published by Guilford Press. Some of its conclusions which are of relevance here are:

1. The era of generic therapies is over. No treatment can be equally applicable without modification to every disorder. Equally, it is unrealistic to hope that a generic preventive intervention will be able to reduce the risk for all psychological disorders. Prevention, as treatment, will need to be disorder specific. This means that we should address ourselves to those disorders where longitudinal studies have given us sufficient clues about identifying 'at risk' populations. Further, while universal prevention is desirable, the very generality of such an approach mitigates against any particular individual experiencing it as relevant to them. It may indeed be very difficult to modulate a programme so that it is perceived to be of equal relevance to all groups (McGuire and Earls, 1991).

2. Non-specific, poorly strucutured treatments, such as generic counselling, non-focused dynamic therapy and a variety of experiential therapies are unlikely to be effective with severe presentations. Similarly, prevention needs to be focused on specific risk or protective factors, firmly rooted in empirically based formulations of the development of the disorder.

3. Short term, non-intensive dynamic therapies are often more helpful as intensive and long-term ones for non-severe cases but they are commonly associated with negative outcomes when applied to more complex and difficult (multiply co-morbid) cases. Unfortunately, the latter is the context in which they are most commonly offered. Similarly, preventive efforts need to be titrated to the severity of the disorder they are intended to prevent. In the past, the net being cast too wide, it was inevitable that in many cases the intervention was too weak to permit clinically and economically significant reductions of risk and prevention was only partial. **The prevention of serious disturbance needs to be a long term and intensive enterprise.**

4. The long term outcome of most treatment interventions is rarely explored. When long term follow-ups are provided they tend to highlight the limitations of the intervention. Effective interventions take on board the cyclical nature of serious mental disorder and provide specific relapse

prevention strategies. Similarly, in prevention provision needs to be made to maintain short term gains.

Attrition is not just a problem of prevention interventions and techniques applied in trials here attrition is a problem could be applied to prevention.

In our review, we found a great deal of evidence for what has come to be known as the "efficacy" vs "effectiveness" debate. Many findings of randomised controlled trials simply cannot be replicated in clinical practice (e.g. Weisz, Donenberg, Hans & Weiss, 1995; Hoagwood, Hibbs, Brent & Jensen, 1995; Kendall & Southam-Gerow, 1995). The early prevention literature is not yet at a stage when this could be a significant problem but tests of generalisability should be built into prevention trials so that similar methodological problems are prevented.

The sheer number of Randomised Control Trials performed makes psychotherapy the best validated medical treatment intervention. Sadly, the vast majority of studies (particularly those undertaken with children) fail to meet the minimal methodological requirements which might permit generalisability. In particular, and this is sadly true for the early-intervention literature, authors appear frequently to be far more concerned with maintaining the homogeneity of their technique, than the more important task of ensuring that the sample description permits generalisation.

The case for the prevention of conduct disorder

Professor Fonagy in asking why conduct disorder should be be the principal target of early preventive intervention gave the following reasons:

1.It is very serious. It is the most common reason for referral to mental health services for boys (Offord et al., 1987). It is strongly developmentally linked to delinquency and adult criminality. Maintaining juvenile corrective facilities costs in excess of one billion dollars per year in the US alone (Reid, 1993).

2.Conduct disorder is resistant to treatment, particularly in adolescence (eg Kazdin, 1993).

3. The early identification of conduct disorder is becoming an increasingly realistic goal. Elevated aggression and a disruptive behavioural pattern reliably identify such children (Ensminger et al., 1983; Farrington, 1991; McCord, 1991; Tremblay et al., 1992, 1994; White et al., 1990). The earlier the onset, the more serious the outcome (Blumstein, 1985). Thus elevated aggression and its precursors, such as negativity, may be an excellent target for universal and selective interventions (Tolan and Loeber, 1993; Tolan, Guerra and Kendell, 1995b). Lochman and the Conduct Problems Prevention Research Group (1995) designed an elegant multiple-gating procedure based on teacher and parent rating. Thus procedures are already in place for identifying a high risk group.

4.Although the cause of antisocial behaviour is still a subject of debate regarding the relative importance of individual versus environmental factors (eg Dodge, 1990; Lytton, 1990; McCord, 1993; Rowe, 1993), preventive interventions could be theory-driven directed against either individual characteristics or characteristics of the social environment. In brief, by understanding the antecedents of serious antisocial behaviour, early preventive interventions may be effective in modifying trajectories and thus interrupt the course towards chronic antisocial behaviour (Tolan, Guerra and Kendall, 1995a,b).

There are five kinds of interlinked risk factors in conduct disorder: 1) biological (temperament, psychophysiology); 2) social; 3) family adversity, disruption and stress; 4) ineffective parental management and socialsation and 5) problems in early parent-child relations (insecure attachment). Mark Greenberg and his colleagues (Greenberg et al., 1993) proposed that insecurely attached children might develop internal working models "in which relationships are generally viewed as characterized by anger, mistrust, chaos and insecurity" (p.201). This would account for the attributional biases which have been noted in aggressive children (Dodge, 1991).

Sidestepping the controversy concerning the relative importance of these factors, the speaker offered for consideration a heuristic bidirectional developmental model of the early phase of conduct disorder which might form the basis of an early prevention strategy (Belsky, 1984; Shaw and Bell, 1993). He asked that we should assume that certain temperamentally difficult (Bates et al., 1991; Greenberg et al., 1993) boys have mothers whose past experiences, the mental representations in which these are encoded and current mental state (West and Prinz, 1987; Avison, 1992) make it hard for them to relate in an attuned way to a male child (see Husmann et al., 1984; Frick et al., 1992; Lahey et al., 1988; Serbin et al., 1991). Perhaps as a consequence of unresolved experiences of trauma (Maine and Hesse, 1990, 1992), they are frighteningly intrusive (Lyons-Ruth, 1995; Lyons-Ruth et, al., 1993), and are certainly relatively unresponsive (Shaw et al., 1995). **This creates a particular risk in that non-responsive parenting we know exacerbates the irritability or demandingness of the infant** (Shaw et al., 1995; Lyons-Ruth et al., 1993), **which in turn increases the mother's difficulty in parenting** (Martin, 1981). **Anxious attachement or disorganisation of attachment develops** (Erickson, Egeland and Sroufe, 1985; Greenberg et al., 1993; Richters and Walters, 1991) to the mother as part of a strategy to avoid being blocked from access to her, and approaches decline in frequency in the middle of the second year (Main, et al., 1985). Thus a holding environment that could contain the childs, perhaps constitutionally determined impulsivity (Earls, 1994) or hyperactivity (Offord et al., 1992) is absent. **With increased mobility come more frequent episodes of undirected anger and negative reactions which may provoke mothers of these infants to view their child's behaviour as demanding and difficult** (Bates, Maslin, & Frankel, 1985; Sanson, Oberklaid, Pedlow, & Prior, 1991). **The disengagement in the mother-child dyad which is reflected in the infant's reduced expectation of security from her, also disrupts the child's opportunity to learn about mental states in the**

normal course of interaction. Mentalising, conceiving of interpersonal experience in terms of mental states or minds we believe gives coherence to the self representation. Without it the self is experienced as at risk of disintegration. **Oppositional, and at times aggressive, behaviour serves the function of protecting a fragile side of ourselves** so expectably the child's behaviour will become increasingly negative in approaching the mother yet simultaneously shielding himself from her. (At this stage difficult children are only difficult with their attachment object.)

By 24 months the dyad may be predisposed to a coercive style of interaction. **It is hard to control a child whose bond to the caregiver is deeply insecure**, as a major means of control (threat of loss of love) has significantly reduced potency. Gradually, the characteristics of the dyadic process will be generalized to others. For example, the child may extend his expectations of interaction to a pre-school situation. **Coercive intervention strategies become more extreme and therefore almost by necessity less consistent** (Patterson et al, 1989), harsh or threatening punishments cannot be employed to address every instance of rule violation. The child's motivational system is extrinsic. Self control, based on sensitivity to internal signals fails to emerge.

A few findings may help us take some of these ideas further (Fonagy & Target, in press; Fonagy, Target, Steele & Steele, in press):

1 5 year old children, who were securely attached at 12 months, manifest greater competence than those who were insecurely attached in tasks requiring the understanding of mental states (Fonagy, Steele, Steele & Holder, submitted; Fonagy, Redfer & Charman, in press).

2 Overcoming childhood adversity, as indexed by developing a secure attachment relationship with one's own child, is associated with an above average capacity to represent one's childhood in terms of the thoughts and feelings of one's parents and ones reactions to them (mentalising) (Fonagy et al, 1994).

3 Individuals with unresolved childhood experiences of severe trauma show a marked inability to use mental state language in childhood (Beeghly and Cicchetti, 1994).

4 In adulthood this lack is associated with the diagnosis of severe personality disturbance (Fonagy, et al. 1996).

5 The reluctance or inability to incorporate mental states in narratives of past experiences is most marked in a sample of criminals, and even within this group there is differentiation of individuals committed for violent crimes (Levinson and Fonagy, 1996).

In brief, we may hypothesise that at least a proportion of those children who move from negativity, through conduct disorder, to delinquency and crime, do so because of harsh and abusive parenting which in some way undermined their understanding of or concern with the mental states of those around them. One can empathise with the unwillingness of an abused child to think too intensively about the thoughts and feelings which may motivate the individual who is maltreating them. There is little room in such relationships to play with ideas, to joke and pretend, situations which as we shall see may be key to the acquisition of an understanding of minds.

There are at least two ways in which inadequate mind reading skills may be causally linked to disordered conduct:

1. Lacking a full sense of intentionality or agency may cause an individual to feel less personally responsible for his actions.
2. Limited concern with mental states disables the normal aversive reaction to distress in others when this is caused by the self.

Implications for Prevention

There are three obvious targets which, were this heuristic model to be accepted, might serve as the focus for early prevention:

1. The caregivers can be assisted to modify the nature of their interaction with the child to be less harsh and coercive and thus less threatening to the child' s vulnerable sense of emerging self. This might in turn reduce the child's need to display negativity. Theoretically there is no reason why parents should not be able to do this since the motivation for their harshness may not be deep-seated and multiply determined, but rather a natural response to the child's confrontational behaviour (Gill, 1969; Reid, 1978). What is envisioned here is a parent-training and social skills development programme of the kind described by Patterson and others (Patterson, 1982; Kazdin, 1987; Webster-Stretton, 1991) which is effective in improving child management skills (Barkley, 1992), increases pro-social behaviours (Webster, Stratton et al., 1988) and reduces behavioural problems in middle childhood (eg Bank et al., 1991). The modification would be to implement the program far earlier and t broader population than is normally the case; before the highly maladaptive patterns of parent-child interaction had already undermined aspects of the child's developental potential. One such prevention study has already been undertaken by Richard Tremblay and colleagues (1995) in Montreal. They demonstrated that parent training based on the Oregan model together with social skills training for the child administered to kindergarten children reduced self-reported delinquency and teacher-related disruptiveness throughout early and mid-adolescence. Unfortunately, the impact of the intervention appeared to diminish as the child approached 14-15 and did not impact on the likelihood of legally defined delinquency. There are several major groups in the US actively working in this area. These programmes are promising; I think they could be improved by moving the intervention to an

even earlier phase of the child's life. Early parent-training approaches could be made more effective by taking on board recent advances in behaviour genetics. A substantial body of evidence now suggests that the environment predictive of conduct problems is not that shared between siblings (based on the behaviour of parents with both children) but rather the specific behaviour of the parent with the specific child. The difference in level of conflict-negativity or warmth-support directed toward one child substantially correlates with that child's anti-social behaviour (Plomin et al., 1995). Furthermore and interestingly, a high level of conflict directed towards one sibling can lead to lower than expected levels of anti-social behaviour in the other. These findings suggest that parent based preventive interventions should not be addressed to the general levels of parenting skills but to the behaviour of the parent to the child, relative to the parent's behaviour to other children in the family.

2. An obvious alternative target for prevention in this model is the attachment relationship between parent and child. Fortunately, there is already lively work in this area. Marinus Van IJzendoorn and colleagues (1995) reviewed studies to date aimed at modifying infant attachment classifications. Echoing our findings from the psychotherapy review they found short term focused interventions more effective in achieving this than longterm unfocused ones. Although most of these interventions aim at enhancing parent-sensitivity, the relation between changes in sensitivity and attachment is relatively weak. Observed sensitivity changes more readily than the infant's classification. This suggests that either parental sensitivity is not what determines quality of attachment or that our measures of sensitivity are too blunt, picking up many "pseudo-sensitive" behaviours which are not critical in creating a secure base for the infant (Bowlby, 1969) and reestablishing his emotional equilibrium following arousal (Sroufe, 1991). Dymphna van den Boom surprised us all in how effective a realtively brief (3 session) personalized parent sensitivity training could be with infants screened for difficult temperament. At 12 months 62% of the intervention group were classified secure as opposed to 22% of controls; at 18 month this discrepancy increased to 72 vs 26% (van den Boom, 1994, 1995). Large differences in mother child interaction, still evident at 42 months suggest that this approach may be of value in selective prevention. The data, if replicated, (Maria Bakermans-Kranenburg in Leiden is attempting this) suggests that such well timed focused early intervention may set up a virtuous cycle of protection rather than the various vicious cycles of vulnerability which we are far more used to studying. The modification of attachment classifications is the target of a number of ongoing interventions with very high risk samples. There are two, which I would like to single out for mention. Martha Erickson's STEEP [Steps Toward Effective, Enjoyable Parenting] project (Erickson, 1996) in Minnesota and Christoph Heinicke's Home visiting program at UCLA. Both studies bring much needed clinical sophistication to the field of prevention. Both are outstanding in terms of methodological rigour and ingenuity of programme design. Long-term follow up of these samples will tell if the powerful observed changes in caregiving behavior will be sufficient to prevent the emergence of behavioural problems later.

3. Finally, Professor Fonagy offered his own current area of interest. In his view, the quality of the attachment relationship is a correlate of the risk for potential problems but does not constitute a risk itself. Insecure and even disorganised classifications are far too common within normal samples for insecure attachment classification to be other than a necessary, but not a sufficient criterion for potential difficulty. Secure attachment is necessary for the development of a sense of psychological self, for a mentalizing capacity which we assume enhances resilience and effectively inhibits natural anti-social tendencies. There are two possible ways of stating the relationship between mentalization and attachment. First, it is possible that secure attachment predisposes the child to social experiences wherein, given propitious circumstances, mentalisation will be acquired. One of these may be pretend play. Securely attached children manifest stronger engagement in fantasy play (Rosenberg, 1984 (cited in Carlson and Sroufe, 1995; Main et al., 1995) and children who are better able to engage in joint pretend play do better on tests of 'mind reading' and emotion understanding (Dunn, Brown Slomowski et al., 1991; Astington and Jenkins, 1995; Taylor Gerow & Carlson, 1993, Youngblade and Dunn, 1995). **It is possible that the experience of sharing a world of pretend may foster an understanding of the mental states of others and that this capacity is in turn facilitated by secure attachments in infancy**. Engaging in conversations about feelings and the reasons behind people's actions is linked to the relatively early achievement of mind reading (Dunn, Brown & Beardsall, 1989; Dunn & Brown, 1993; Brown, Donelan-McCall & Dunn, 1996; Appleton and Reddy, 1996). Discourse patterns between mothers and children at age 6 of dyads classified as secure tend to be more fluent (Strage and Main, 1984, cited in Carlson and Sroufe, 1995) and to create patterns of narration that support thinking about feelings and intentions which lie at the root of theories of mind. Secure attachment in infancy is associated with ratings of peer competence (Elicker, Englund & Sroufe, 1992; Pancake, 1985; Sroufe, 1983; Kestenbaum, Farber & Sroufe, 1989; Lieberman, 1977; Park & Waters, 1989; Seuss, Grossman & Sroufe, 1992). Children are more likely to talk about mental states with siblings or friends than with their mothers (Brown et al, 1996) and their use of mental state terms with friends predicts best performance on experimental tests of mentalisation. Thus, securely attached children are more likely to engage in the kind of playful, cooperative **interactions with their peers** which we may expect will facilitate learning about minds.

The evidence from Dunn's work suggests that behaviour in these different contexts (pretend play, management of conflict and discourse) correlate poorly with one another (Brown et

al, 1996; Slomkowski & Dunn, 1992; Youngblade & Dunn, 1995). This suggests a second type of model: the variables which prima facie could be considered to be mediating the attachment mind reading relationship are not on the causal path at all but that early experience with the primary caregiver in the first year of life creates the bedrock of theory of mind competence.

In asking what evidence we have to support this contention, the speaker said that first, it was important to note that a mother's attachment classification before the birth of the child is a powerful predictor of the child's theory of mind competence at 5 years. In his sample 75% of children of secure, autonomous mothers passed the cognitive emotion task, while only 16% of children of preoccupied mothers and 25% of those of unresolved mothers did so. This suggests that **the caregiver brings her capacity to envision the child as a mental entity to the parent-child relationship**, evident soon after the birth of the child, which may be critical in the child's establishment of both secure attachment and mind reading.

Professor Fonagy then turned to the question as to what is the nature of this competence. First, he noted that he had already touched on how the caregivers' capacity to envision the mental states of their own parents is predictive of the infant security of attachment to each of the caregivers. Ratings on this scale were found to predict the child's performance on cognitive-emotion tasks for both mother and for father. Even more important, the mother's capacity to reflect on her own childhood in the Adult Attachment Interview shared that portion of the variance with the child's theory of mind performance which was predicted by the quality of mother-infant attachment. Thus, the child's attachment security was not the only predictor. **The mother's capacity to envision the child as a mental entity also proved to be important in predicting mentalizing.**

He stated his belief that the caregiver's capacity to observe the moment to moment changes in the child's mental state is critical in the development of mentalising capacity. The caregiver's perception of the child as an intentional being lies at the root of sensitive caregiving, which is viewed by attachment theorists to be the cornerstone of secure attachment (Ainsworth, Blehar, Waters & Wall, 1978; Bates, Maslin & Franco, 1985; Belsky & Isabella, 1988; Egeland & Farber, 1984; Grossman, Spengler, Suess & Unzer, 1985; Isabella, 1993; Isabella & Belsky, 1991). Secure attachment in its turn provides the psychosocial basis for acquiring an understanding of mind. The secure infant feels safe in thinking about the mental state of the caregiver and is thus more readily able to construct a mentalised account of the caregiver's behaviour. What he believes is far more important for the development of mentalising is that **exploration of the mental state of the sensitive caregiver enables the child to find in the caregiver's mind an image of himself as motivated by beliefs, feelings and intentions, in other words, as mentalising.** There is considerable evidence to support the view that secure attachment enhances the development of the self, inner security, feeling of self worth, self reliance and personal power of the emerging self, as well as the development of autonomy (Bates et al, 1985; Gove, 1983, in Carlson & Sroufe, 1995; Londerville & Main, 1981; Matas, Arend & Sroufe, 19-78).

I am thus suggesting that **the enhancement of mentalizing should be at the core of prevention in early childhood.** This could be achieved in a variety of contexts. It should be remembered that the caregiver may be the first but is by no means the last teacher the child has in his passage to learn about minds. Thus structured interactions with siblings, group work for preschoolers run along the lines of the transactional groups of the West Coast of the 1960'3, structured family pretend games with emotional foci (mock arguments, discussions of preferences), just encouraging parents to talk about people and their actions; there are infinite possibilities. Perhaps preventive interventions should borrow from the exciting work of those, such as Tony Charman and Simon-Baron Cohen, who are working on designing strategies to teach autistic children about minds.- Bob Pynoos, in San Francisco has established an intervention program with aggressive children where understanding the minds of others is the implicit focus of a graded intervention. Regardless of the therapeutic stance the strengthening of mentalising will serve to enhance the patient's core self structure leading to desirable outcomes such as encouragement of concern, the creation of whole person representations and meaningful and predictable experiences in relation to the understanding of the behaviour of others.

Mind reading may not be an unequivocally positive experience. Judy Dunn's work however gives us an indication that at least the understanding of emotion at 3½ predicts a positive perception of social relations, mature moral sensibility and the understanding of complex emotions (Harrera and Dunn, 1996). Whether bonding creates the social situations which will encourage mind reading or secure attachment is that social situation, perhaps matters less than the better understanding of the nature of early experience which can predictably lead to desired social outcomes. I believe that the systematic facilitation of the development of the child's awareness of the mental states of those around them is an important target for preventive intervention in social and behavioural disorders in children as well as personality disturbance and antisocial behaviour in adolescence and adult life. I believe the task is clear and experimental work now needs to be performed.

NOTE: The references for this paper are extensive and a valuable resource. It was not possible to include them in the Newsletter, as it would have doubled the size of the current edition. However, they are available from The Editors, AAIMHI Newsletter, PO Box B7, BORONIA PARK, NSW 2111. To cover the cost of photocopying and posting them (the document is 12 pages) a charge of $5-00 will be made. Cheques should be made payable to AAIMHI.

THE WORLD CONGRESS AT TAMPERE

Finland seems a long way to go for a conference, but even the weather seemed specially organised to make this an extremely worthwhile experience. There were over 1000 delegates from 43 countries including an Australian contingent of 32 representing a range of professional and academic interests in infant mental health.

Dan Stem was the first of the plenary speakers, in many ways setting the stage for the discussions and debates of the following four days. In describing the "motherhood constellation" he drew attention to the psychic structure of mothers and the supportive role of women for each other, as grandmothers, friends, and professional mentors. He proposed, as extension of the mother-infant dyad, a triad made up of baby, mother and her own mother and argued that such a definition required modification in existing theories of intervention. "In fact, the sum of all of the unique features of the parent-infant system is starting to shape the technical interventions that are performed regardless of the traditional theory that originally informed the intervention, be it psychoanalytic, systemic, behavioral or cognitive."

A move beyond the mother-infant dyad to consider aspects of the social context which were of particular importance in i...ncy was also evident in a pre-conference meeting of the Social and Public Policy Group, chaired by Sonya Bemporad. The two issues set for debate here were day care and child protection services. We were involved in the discussion on day care and, in spite of some dispute over basic assumptions ("those noisy Australians" commented someone behind us), there was a high level of agreement about the need for high quality training for day care staff. This was taken to mean an understanding of all aspects of children's development including their emotional needs. It will be interesting to see what directions emerge from this group. It was clear that day care is very much a part of varying social and cultural contexts and influenced by changes in governmental policy. More than one speaker used the term "institutionalisation" as if it were synonymous with day care - perhaps in some communities it is, but this is not so in NSW. Until we know more about particular social contexts of this aspect of infant experience, it is difficult to make generalisations.

( ) following days offered a multitude of symposia, workshops, posters and poster discussions from Finland, France, South America, Taiwan, and Japan, to name a few. The breadth of research activity was impressive and the models of programs and services all represented initiatives continuing to explore ways of meeting the needs of young families. Since fathers were not getting a great deal of attention, we were fascinated by the work of a local agency which provided a "father's box" for new fathers. It included big and little T-shirts, recipes, songs and stories - a great idea.

The presentation of our three papers attracted a good response from an audience of about forty. I talked about interaction between mothers and blind children, Judy talked about fathers interacting with their children who are disabled and how this can be evaluated, and we jointly presented a paper about the Families First program. We enjoyed meeting people involved in similar programs and catching up with old friends. Altogether it was a most valuable experience.

Julie Campbell and Judith Croll.

AUSTRALIAN ASSOCIATION FOR INFANT MENTAL HEALTH.

ANNUAL GENERAL MEETING.

The Annual General Meeting of the Australian association for Infant Mental Health will be held in Melbourne in December, 1996 at the time of the Annual Clinical meeting. At this Meeting, the Committee plans to introduce amendments to articles and memorandum of association which will allow a more appropriate structure for the Association as it increasingly becomes a federal organisation. Further details of these changes, and calls for nominations for office bearers will be mailed before the Meeting.

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

At the Sixth World Congress of WAIMH, Campbell Paul became the Australian Regional Vice President. Campbell takes up this position at an important time in the evolution of WAIMH. At the meeting in Tampere, the Executive discussed at length the role of the Regional Vice Presidents, and also the relationship between the affiliate groups, such as AAIMHI and the world organisation. What was clear in these discussions was that both these issues had not been clearly articulated in the past, and that although the move from WAIPAD to WAIMH was carefully planned, there were likely to be significant changes which might not have been foreseen at the time of the merger. Campbell comes in to the position of Regional Vice President when the role of Regional Vice Presidents will be a major topic for discussion with hopefully some resolution by the time of the next Congress which will be held in the year 2000 in Montreal. I am sure all members of WAIMH will wish him well in the next four years s this process evolves.

I would like to express my thanks for the opportunity to represent Australia in this position over the last eight years. I have found it an interesting task, and although I am very aware of what has not been done in that time (for example I think we need to move to establishi links with our Asian neighbours), a very good start has been made in establishing a regional organisation.

David LONIE.

FORTHCOMING MEETINGS

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 - NSW Branch.

An open meeting will be held on Monday, December 16, 1996 at the Holme Building, University of Sydney at 8 pm. The speaker will be Mrs Juliet Hopkins who will present a paper "Facilitating the development of intimacy between nurses and infants in day nurseries: Improving the quality of care.

Further details will be available closer to the date. However, as it is close to Christmas, please note in your diary now!.

Institute of Early Childhood, Macquarie University:

1996 Child Development Conference. Infants and Toddlers: The Research, Practice and Policy Triangle.

When: Saturday, October 19, 1996.

Where: Macquarie University Building X5B

Cost: $100-00; Student $50-00

Enquiries (02) 9850 9826

The Benevolent Society of NSW Centre for Children's Programmes.

Prematurity: Its Impact on the Developing Infant and Their Family. A Workshop for people working with premature infants and their families.

When: Wednesday, 20th November, 1996

Where: Hardwick House, 171 Glenmore Rd., Paddington

Cost: $100-00

Registration : Mrs J Osborne, EIP, PO Box 171, Paddington, 2021 by November 4, 1996.

Enquires Jan Osborne, phone 9339 4440; Beulah Warren, phone 9360 5888, or Fax 9360 2319.

Joint National Conference - NALAG, ACISA & ASTSS. Trauma, Grief and Growth - finding a path to healing.

When: May 7-10, 1997

Where: University of Sydney

Closing date for papers November 30, 1996.

Enquiries P.O. Box 79, Turramurra NSW 2074, phone (02) 9988 3376, Fax (02) 9988 3856.

AAIMHI Committee

Elected 25 October, 1995

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