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NEWSLETTER

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FROM THE EDITOR:

What a time it's been! What's going on?! This editor was just starting to grasp the inspired new approach to his Newsletter responsibilities with a new zest and verve extolled from the recent annual conference in Fremantle, appropriately titled; **Coming Together: Development of Self-Regulation.** Then there were the tragic events of September 11. I mourn the death of a dear friend and colleague that I was lucky to have shared with many and who to others was a, husband, father of three, brother, uncle, cousin and son. How to manage the shock and emptiness that I feel as a response to this atrocity has been a constant battle that grows more cloudy with each breathe. In my work with troubled young ones, it has been there that, I have found strength. Through the positive connections that are their success I have had to come right back to basics, to self-regulation. Congratulations to all those connected to the conference, it was a triumph.

This edition comes equipped with a response to the Chinese adoption article by Adele Smout, a reflection on one birth by Anne Southan and a terrific paper on attachment by Chris Ciancio, a member from South Australia.

Please contact me, even if you have only an idea, for copy contributions. The December edition should be a little quicker in getting out. My apologies for the delay in this edition.

Best wishes,
Victor Evatt.

2001 - 2002 CALENDAR OF EVENTS

NOVEMBER 2001 (ACT)

21 November:

Postnatal Depression Awareness Week:
Twilight Seminar (See Pages 15 - 16 for details.)

MAY - JUNE 2002 (NSW)

Emotional Availability Workshop
(AAIMH is seeking expressions of interest)

More Detail in the next issue, or contact:

Dr Frances Gibson at frgibson@laurel.ocs.mq.edu.au

NOVEMBER 2002 (NSW)

14 - 18 November:

AAIMH NSW & NIFTeY
Joint Conference (See Pages 13 for details.)

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ATTACHMENT:
The Template for Life

By Chris Ciancio

A child forsaken, waking suddenly,
Whose gaze afeard on all things round doth rove,
And seeth only that it cannot see
The meeting eyes of love.

George Eliot

Attachment Theory

According to John Bowlby, the goal of attachment behaviour is the attainment of proximity to the primary caregiver or attachment figure, usually the mother. It is activated when the infants feels frightened or anxious and is deactivated by proximity to the mother and successful comforting. When the system is not activated the child can explore its environment, vital to mental and physical development looking back at mother, the secure base as it does so (Lyons-Ruth & Zeanah 1993, p. 26).

The initial attachment within the dyad forms a template for all interpersonal relationships throughout life. An infant's attachment is based on actual interaction between itself and the attachment figure. If the interactions between the two have been of a generally positive emotional experience, from caring and responsive parenting then the child forms "internal working models" that he/she is worthy of love and affection and uses those early positive interactions as a model for future relationships (Zeanah et al 1993). This is a protective factor against psychopathology later in life.

Attachment to the mother or caregiver serves to regulate the emotional homeostasis of the infant. As well as having physical needs met, an infant requires a relationship from someone who can react to his or her cues: "I'm not feeling ok right now." A special relationship needs to form. The dyadic relationship is mutually regulated (Tronick & Weinberg 1997) by the mother and infant. Stern (1985) refers to this as "affect attunement," here mother and child *tune in* to each other emotionally; each bringing something to the relationship that initiates a response from the other. Mother remains close, encourages baby's gaze with her face, observes for visual cues from the baby and responds with care. If she is successful the baby "tells" her this, eg smiling. When the baby cries an emotional response is initiated in the mother, and depending on a number of factors including her cultural background, the stressors in her daily life and her own attachment representations, she responds to her baby. Mothers discovering that they are able to respond successfully to their infant feel less anxious themselves. Children who have received loving and responsive parenting see their parents as reliable and caring, and view themselves as worthwhile beings. A child develops attachment to a small number of people and there is generally a hierarchy in terms of preference (Goodman &

Since time began poets have been alive to the first love, the love of a mother, and the tragedy of its loss. Science has in the last fifty years realised what poets have always known: That the first love is so essential to the emotional survival, growth and reproduction of the human species. Humans unlike other species are born at an undeveloped stage and consequently are more dependent on an adult for survival.

A major survival strategy for the infant is to manipulate the nurturing behaviour inherent in that adult. The child comes to the relationship with pre-programmed skills in eliciting the nurturing response from its mother. Yarrow (1979) citing Bowlby (1969) refers to these inbuilt behaviours of "attachment" as smiling, clinging, crying and following. These elicit nurturance from the mother and keep the infant in close proximity. The mother in turn reciprocates and protects and nourishes the infant.

This is the basis of attachment theory.

Scott 1997), but most of the time it is the mother. By the time a child is 12 months the attachment system has formed, is fully functional and can be measured (Ainsworth et al 1978).

There is disagreement amongst authors as to whether a child's constitution or temperament is a product of genetics or attachment. Certainly 'goodness of fit' between the mothers' temperament and that of the child promotes secure attachment (Stern 1985 pg 189). A child capable of responding to their external environment and cope with their internal affective state will relate easier than one who can't. Most caregivers find it easier to relate to a child of mild temperament, and such a child will get more positive feedback. A child with a compromised constitution won't necessarily be destined for an unhappy future; however, it depends on how they adapt. An insecure attachment is one way of adapting.

Gender is an influential factor, girls tend to internalise their feelings and self soothe and an adaptive response may be to dissociate. Boys need more help to regulate their internal states and become demanding and oppositional in order to get their needs met (Perry et al. 1995, p. 283).

Bowlby focused mainly on the period around and after 8-9 months of age and has been criticized for neglecting the development that occurs in the first 6 months (Parke 1979). Parke (p. 554) cites the work of Cassel and Sander (1975) and Klaus and Kennell (1976) that the process of mutual recognition and regulation begins from birth, or early in the post partum period (Osofsky & Danzger 1974; Parke et al., 1972), long before Bowlby's theory suggested, as it is during this time that the attachment system is forming. Recent research indicates; it is during this time that major physical structural changes occur in the brain and the experiences of the infant influence this structure and are significant (Perry et al 1995).

I will discuss the different types of attachment using the framework provided by Goodman & Scott (1995) as well as Zeanah (1993), referring to other authors as necessary. Ainsworth et al. (1978) identified three types: Secure; Insecure-avoidant; Insecure-ambivalent (sometimes known as resistant); and then later, Main and Solomon (1990) identified disorganised/disoriented.

Mary Ainsworth developed the Strange Situation Procedure (SSP), a tool for assessing child attachment between the ages of 12-18 months. The child is observed in a strange room through a one-way mirror where his/her responses are noted in relation to his/her parent as well as a stranger who leave and re-enter the room in a predetermined sequence. Of most significance is the child's behaviour toward the parent on reunion. According to Ainsworth this determines the security level of the attachment (Goodman & Scott 1997, pp 201-202). However, this procedure is in a clinical and artificial environment, so questions about the validity in normal life situations and across cultures could be asked. This procedure requires special training and is complex to interpret. Helen Mayo House, a unit in Adelaide for infants and their caregivers who are suffering from mental health problems use the Louis MACRO (Mother And Infant Risk Observation) (Louis et.al. 1997) assessment tool, which does not require special skills to administer; although it does require observation for a longer time.
Mary Main developed the Adult Attachment Interview (AAI); results from this indicate what the parents own attachment relationships are like. The classifications are not equivalent to, but can be associated with SSP types: *Dismissing (Avoidant); Autonomous (Secure); Preoccupied (Ambivalent)* and *unresolved-disorganised* (Goodman & Scott 1997).

I will relate each type of child relating style with a corresponding parent relating style and attachment history, and suggest a possible relationship future (Trethewey 2000) for the child using the format provided by Goodman & Scott 1997 in chapter 27, and expanding it to incorporate the work of Hazan & Shaver (1987). It is important to keep in mind that attachment is only one aspect (albeit significant), of the development of an individual. Rutter (1995) states, "...that we pay attention to one of the first features of attachment theory, namely that attachment is not the whole of relationships." (p. 566).

Family systems are complex and focusing on dyadic interaction is only one dimension. It also needs to be clarified that both insecure- ambivalent and avoidant subtypes are not in themselves negative or pathological, rather an adaptive response in order to get needs met. Whether this is a risk or a protective factor can be debated. Bowlby himself would probably have been classified under insecure-avoidant type of attachment (Holmes 1993). If Bowlby had been brought up in a secure family relationship he may not have developed the impetus and the passion to pursue the work that he did!

SECURE ATTACHMENT

Child Behaviour: Uses parent as a secure base when playing/exploring. Coming to the parent if feeling anxious, is successfully comforted and continues exploring. May or may not cry on separation. Not comforted by stranger.

Parent relating style: Responsive and sensitive to child's cues. Promptly comforts. Allows infant to explore. Not intrusive. Since synchrony between mother and child in reading cues occurs only about 25%-50% of the time, the ability to " repair errors" is critical (Tronick 1997). The parent of a secure child is able to do this more frequently and more consistently.

Parents own attachment history: Likely to have had a secure attachment to own parents. Gives history of supportive relationships as a child or has resolved and come to terms with inadequate history. AAI classification is *autonomous.*

Possible future for child: Secure relationship has supported positive 'internal working models' as a template for future relationships. Cooperative and responsive with parents. Empathic, likely to be popular in school. Makes friends easily. As adults believe in the possibility of life long love. Likely to view others as trustworthy (Hazan & Shaver 1987 p. 513).

INSECURE AVOIDANT ATTACHMENT

Child Behaviour: Explores with little reference to mother. Not distressed on separation. Ignores or little response on reunion. Often is friendly to the stranger (Lyons-Ruth & Zeanah p. 24). This is likely to be an adaptive measure to get needs met if mother unreliable. Child may be very compliant in an effort to please mother, to get at least some attention. Despite the lack of expressed emotion, these children are physiologically highly aroused and stressed (Ungerer 1999 p. 49).

Parent relating style: Rejecting or insensitive to infant cues for attention. Lacks tenderness, rough or hurried care giving. Lacks empathy. Likely to have shown "mock-surprise" in response to infant anger (Lyons-Ruth & Zeanah pg 25). Particularly rejects emotions of fear and distress (Ungerer 1999, p 49). AAI classification is *dismissing.*

Parents own attachment history: Presents an idealised picture of own parents. Generally minimizes the importance of attachment relationships, and the expression of negative emotion. Unable to recall specifics of childhood, feelings are repressed.

Possible future for child: Continuing the pattern of repressed feelings is possible throughout adult life even into romantic relationships. Hazan & Shaver (1987, p. 515) report that love partners of these adults are not as affectionate as they would like them to be. These adults fear close relationships and have difficulty implicitly trusting another. Tend to hide feelings of insecurity or vulnerability.

INSECURE: AMBIVALENT ATTACHMENT

Child behaviour: Clings to mother. Doesn't explore or want to play. Highly distressed on separation and difficult to comfort on reunion with mother. Emotional expression is maximized. Main & Hesse (1990) believe this sort of behaviour is an attempt by the child to elicit a response from an unresponsive parent (something is better than nothing). Demonstrations of clinginess alternate with pushing the caregiver away, arching back.

Parent relating style: Disengaged and less responsive to child crying. Inattentive. Tend to have fewer interactions with child than either secure or avoidant subtypes. Tend not to be very affectionate. Inconsistent in responsiveness. AAI classification is *preoccupied.*

Parents own attachment history: Felt unable to please their own parents as children. Enmeshed with own childhood events. Anger with parents is unresolved.

Possible future for child: One possible scenario here is that these children continue the 'clingy' behaviour with love partners and become possessive and controlling in the relationship, or fearful that their lover does not really love them, or may leave them (Hazan and Shafer 1987). Tend to fall in love easily but can't find true love.

INSECURE AVOIDANT ATTACHMENT

Child behaviour: Lack of pattern in either exploratory behaviour or in seeking comfort on reunion with mother. Unpredictable alternations between approach and avoidance of mother. Fearful and or confused in mother's company. Defensive behaviours such as rocking, freezing. Lack of consistent strategy for organizing responses for the need for comfort or security when under stress.

Parent relating style: Parental behaviour can be frightening, intrusive and unpredictable for the child. Not responsive to child's cues. Sends out mixed messages of accepting then rejecting child. No consistent relating style. Parent is child's refuge as well as its greatest threat (Erikson 2000). Child may represent a negative personification of the parent's formative years (Newman 2001). AAI classification is *unresolved-disorganised.*

Parents own attachment history: Lack of resolution of loss. Unresolved trauma in their own childhood, eg physical and or sexual abuse, or death of a parent.

Possible future for child: This type is the most likely to result in psychopathology in later life. Borderline traits (Newman 2001), conduct problems, aggressive behaviour and attention problems in school are possible, (Fonagy 1998).

MOTHER - INFANT THERAPIES

Fraiberg et al. (1974) in the self explanatory and evocatively titled "Ghosts in the nursery" present case studies involving mothers who were not coping with their parental responsibilities and neglecting and/or abusing their infants. Through exploration in a therapeutic relation-

ship context they discovered they were reliving and being haunted by the 'ghosts' of their formative years. Many authors refer to this as the "transgenerational transmission of abuse". These authors of infant/parent therapies refer to " Ghosts in the nursery as a template or starting point for their own work (Lieberman, 1992; Erickson, Korfmacher, Egeland, 1992; van Ijzendoorn, Juffer, Duyvesteyn, 1995; Newman 2001). The emphasis, in the present day is now being applied to prevention. Knowledge is empowering, and if mothers in the antenatal period are educated about attachment and positive parenting, future psychopathology may be prevented. The existence of the Perinatal/ Infant mental health team at the Women's and Babies Division of the Women's and children's Hospital, Adelaide is testament to its validity.

Martha Erickson and her team in the STEEP (Steps Towards, Effective, Enjoyable, Parenting) project believe if at risk mothers are identified and offered therapeutic intervention prior to, during and following the birth of their babies, future pathological relationships may be prevented. Having come from an abusive background herself, she is passionate about the project, which has been going for about 25 years now (Erickson 2000).
Maskan, the name of a programme run by a dedicated group in Stockholm focuses on the baby as the "patient." Mothers are taught to link the baby's attachment behaviour to their feeling state. Staff teach mother to interpret what the baby is doing and "saying" and to respond appropriately. Therapy is in the form of a group setting with the group meeting three times a week for several months. The frequency of meeting is a crucial component in successes. Another therapy "Watch, Wait, and Wonder, a descriptive term originally described by Johnson et al., (1980) is discussed by Elizabeth Muir (1992) in which parents are encouraged not to "do" anything but to wait for cues from their baby and to follow their infants lead. A parallel is made between the infant using the mother as a secure base, and the mother using the therapist as a secure base.

There is the possibility for improvement for the relationship, although as the child grows older the template is more resistive to change. One needs to pose the question, however: Why is it that some parents that have been abused themselves don't abuse their own children? One protective factor that Erikson et al. (1995) outline in their STEEP project, which refutes the notion, that childhood history always becomes the child's adult destiny is thus:

> "Mothers who had a childhood history of maltreatment but were not classified as abusive towards their children usually had either a positive, additional relationship with an adult as a child or a significant, positive relationship in their adult life."(Pg499).

The "significant, positive" other could have been a childhood teacher, grandparent, uncle or aunt in adulthood, a love partner or a long-term therapeutic relationship. This influence serves to change the "internal working model" of the parent, which in turn can change the development of the infants' working model for the next generation.

CONCLUSION

What would the world be like if we were all securely attached as infants, and had long lasting and happy marriages as adults? Would we be so content that there would be no drive for progress or development? This essay has emphasized the importance of attachment in infancy and also that a secure relationship is ideal, but not the be-all and end-all.

The strength of character and adaptability shown in some insecure relationships is evidence of this.
Various authors have shown that it is possible to change parental behaviour and get rid of the "ghosts". In therapeutic relationships the mother is able to use the therapist as the secure base to explore herself, and return for comfort and reaffirmation when needed. I believe that it is never too late. It is never too hopeless for a positive outcome if that is what one desires!

(Also see Appendix 1, Page 8)

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Appendix 1

	Child Behaviour	Parent Relating Style	Parent Attachment History	Possible Future for Child
SECURE ATTACHMENT	Uses parent as a secure base when playing or exploring. Coming to the parent if feeling anxious, is successfully comforted and continues exploring. May or may not cry on separation. Not comforted by stranger.	Responsive and sensitive to child's cues. Promptly comforts. Allows infant to explore. Not intrusive. Since synchrony between mother and child in reading cues occurs only about 25% of the time, the ability to " repair errors" is critical. The parent of a secure child is able to do this consistently.	Likely to have had a secure attachment to own parents. Gives history of supportive relationships as a child or has resolved and come to terms with inadequate history. AAI classification is *autonomous.*	Secure relationship has supported positive 'internal working models' as a template for future relationships. Cooperative and responsive with parents. Empathic, likely to be popular in school. Makes friends easily. As adults believe in the possibility of life long love. View others as trustworthy.
INSECURE: Avoidant Attachment	Explores with little reference to mother. Not distressed on separation. Ignores or little response on reunion. Often is friendly to the stranger. This is likely to be an adaptive measure to get needs met if mother unreliable. Child may be very compliant in an effort to please mother, to get some attention. Despite the lack of expressed emotion, these children are highly aroused and stressed.	Rejecting or insensitive to infant cues for attention. Lacks tenderness, rough or hurried care giving. Lacks empathy. Likely to have shown "mock-surprise" in response to infant anger. Particularly rejects emotions of fear and distress. AAI classification is *dismissing.*	Presents an idealised picture of own parents. Generally minimizes the importance of attachment relationships, and the expression of negative emotion. Unable to recall specifics of childhood, feelings are repressed.	Continuing the pattern of repressed feelings is possible throughout adult life even into romantic relationships. Love partners of these adults are not as affectionate as they would like them to be. These adults fear close relationships and have difficulty implicitly trusting another. Tend to hide feelings of insecurity or vulnerability.
INSECURE: Ambivalent Attachment	Clings to mother. Doesn't explore or want to play. Highly distressed on separation and difficult to comfort on reunion with mother. Emotional expression is maximized. This sort of behaviour is an attempt by the child to elicit a response from an unresponsive parent (something is better than nothing). Demonstrations of clinginess alternate with pushing the caregiver away, arching back.	Disengaged and less responsive to child crying. Inattentive. Tend to have fewer interactions with child than either secure or avoidant subtypes. Tend not to be very affectionate. Inconsistent in responsiveness. AAI classification is *preoccupied.*	Felt unable to please their parents as children. Enmeshed with own childhood events. Anger with parents is unresolved.	One possible scenario is that these children continue the 'clingy' behaviour with love partners and become possessive and controlling in the relationship, or fearful that their lover does not really love them, or may leave them. Tend to fall in love easily but can't find true love.
DISORGANISED: Disoriented Attachment	Lack of pattern in either exploratory behaviour or in seeking comfort on reunion with mother. Unpredictable alternations between approach and avoidance of mother. Fearful and or confused in mothers company. Defensive behaviours such as rocking, freezing. Lack of consistent strategy organizing responses for the need for comfort or security when under stress.	Parental behaviour can be frightening, intrusive and unpredictable for the child. Not responsive to child's cues. Sends out mixed messages of accepting then rejecting child. No consistent relating style. Parent is child's refuge as well as its greatest threat. Child may represent a negative personification of the parent's formative years. AAI classification is *unresolved-disorganised.*	Lack of resolution of loss. Unresolved trauma in their own childhood, eg physical and or sexual abuse, or death of a parent.	This type is the most likely to result in psychopathology in later life. Borderline traits, conduct problems, aggressive behaviour and attention problems in school are possible.

• Story from SA

HELEN MAYO HOUSE

Dr Anne Sved-Williams, Medical Unit Head Mayo House, Adelaide

Helen Mayo House is a ward of the Women's and Children's Hospital in Adelaide. During the eighties, it developed initially as an inpatient ward for mothers with mental illness who were admitted with their babies and toddlers, and occasionally their partners. The service has gradually expanded to its current form.

The service comprises several branches including an inpatient services for six women, any of their children up to the age of five years and their partners, if it is appropriate for the partner to be admitted.

The women all have a mental illness, ranging in severity but clearly severe enough to warrant admission. Many women are depressed, and some have psychotic illnesses. Their offspring are on average age twelve months, so we have a range of ages from neonates through to toddlers. We have far less children in the older range ie from three years. We have developed an intensive interest in the offspring of women with mental illnesses, and do a great deal of work on the women's parenting, the developmental level of the child, and mother-infant therapy as appropriate.

Nursing staff continue to develop their interest in this area, and several are currently undertaking research projects. A playgroup is soon to start in the ward, and we are hoping to enhance a woman's support services in this area by greater use of playgroups when she is discharged from hospital. We have also adopted a primary nurse role, and this is clearly more oriented towards a secure base for the mother, knowing that at any one time to whom she can turn to for support whilst in hospital.

The nursing staff evaluate mother infant interaction each week, using the Louis Macro scale, a scale that was developed and validated by Andrea Louis, a Clinical Psychologist who worked in the ward for several years. Nursing staff gradually learn important and valuable skills regarding playing with mothers and babies, enhancing their own interactional skills and adding to the confidence of mothers, which is very frequently reduced when mothers have a mental illness.

Outreach service.

One day a week, women can attend a group run by expert allied health staff, around issues relating to women themselves, their mood, their self esteem, parenting issues, relationship problems, relaxation techniques, and a wide range of other issues. The women can bring babies to these groups but generally attend alone so that they can focus on their own problems. This service has recently branched out to undertake groups for mothers and babies in a child care centre, and is currently planning a group for women and infants in a other area of high need in Adelaide.

Telephone counselling

is available twenty fours hours a day, seven days a week for the whole of South Australia, both to consumers who have mental health difficulties and to professionals who want to update their knowledge on issues relating to the treatment of post natal psychiatric problems or infant mental health issues.

Teaching

Staff at Helen Mayo House have developed expertise both in postnatal psychiatric illness and in mother infant attachment issues. We teach to a wide range of professionals, throughout Adelaide and South Australia. Recent initiatives have included teaching to the Child and Adolescent Mental Health course in which Chris Ciancio (whose excellent article accompanies this) is a student. We also provide faculty for group teaching which has ensured that the Infant Mental Health Diploma or Masters offered through the Institute of Psychiatry in New South Wales is undertaken in South Australia with local expertise, as well as teaching volunteer groups working in the community with mother infant pairs.

A Reflection of One Adoptee Parent

by Adele Smout

A Reflection of one adoptee parent; to the article by Sarah Jones; The Smallest Ambassadors: Adopting Chinese Babies

Being an adoptive mother, I read with interest the article on China's littlest ambassadors. In reply I share some of my own experiences.

As stated, the paperwork involved in adoption is emotionally draining, intrusive, often infuriatingly slow, and requires a staying power that many don't possess.

In frustration I found myself questioning the validity of the process. Biological parents don't have to prove they are good parent material, and I honestly don't think it would be too difficult to fabricate the "credentials". Who would be stupid enough to leave the empty bottles, chains and whips out when a home study visit is imminent?

I read all I could find on international adoption. The outcomes were usually bleak. I convinced myself that the results were from adoptions of past eras where ignorance and mystery were tantamount, and that the good stories remained untold. I constantly questioned myself whether I should go on to the next step. I went through a stage of intense jealousy towards biological parents for not having to make such choices. Was I mistakenly going to foist myself on some unsuspecting, defenseless child, only to find that I was not good parent material after all?

I went to support groups and spoke to adoptive parents and others finding their way through the process. Unlike the gloomy literature, they were all incredibly encouraging and supportive. It was almost like a team heading for the finals of a sporting event.

All my reading and preparations were to no avail when I finally found myself holding my wonderful son. Apart from that joy, I don't think anything can prepare one for the chasm of need an infant presents. It may be worse for adoptive parents. Friends tell me that pregnancy hormones give scant, but at least some, preparation for the sleep deprivation and the loss of self that ensue.

Coming up for air from the whirl of getting to know and adjust my (and my husband's) lifestyle to include an infant, I ask myself what would have better prepared me?

Initially, a few words on those first infant tears would have been good. He won't be consolable. It is not you specifically that is making him cry. It is his grief and loss. Comfort, hold and give him time, time and more time to adjust. And then give him some more time – don't expect him to attach to you as quickly as you attach to him.

I would also have liked more follow up support. Many adoptive parents are unsure of their parenting skills. They need reassurance they are doing okay. They need interaction with other adoptive parents going through the same thing. They need practical tips and practical skills on how to cope with those prying questions, how to stop their child's personal history becoming a conversation piece.
I think some adoptive parents feel a subliminal pressure to perform better than biological parents. They have to live up to that hard-earned good parent material label. There is a danger that they will try and silently muddle through any problem that arises, rather than seek advice and assistance. Also, usual parent gripes can be met with unusually insensitive responses. As one acquaintance said to me "Well, you brought it on yourself, it was your choice to adopt".

When we moved back to Australia I was cut off from my former support network. I looked around for local support groups, but felt alienated from the local parenting groups that biological parents form during pregnancy, breastfeeding etc. Most of them had been together as a group from the start of their pregnancies, and all had shared experiences I had not been through.

I was pleased to find that a statewide adoption group exists. In my area there is an informal monthly playgroup and a monthly luncheon. The interaction is social and anecdotal – a lot of experiences and information are shared. However, I find that it is not enough.

As adoptive children grow older the challenges and issues change. At present there seems to be a void to help one through these changing demands. I haven't found any information sessions to attend. Books, apart from being

hard to source, are often irrelevant or out of date. Informal chats with other adoptive parents usually reveal that they are as uninformed as oneself. Counsellors and psychologists are often not familiar with international adoption issues.

The pre-placement information sessions on coping and do's and don'ts are generally over a year previous to a child coming home. They may as well have been in another lifetime. And that strong contact and encouragement from others going through the pre-adoption process dissipates as couples "cross the finish line" bring their child home, and become engrossed in their own family life.

I think it is unfortunate that I cannot access information sessions on things my family will have to deal with – as they arise. I would also like access to an up to date and extensive library on adoption issues, and an up to date list of specialists well versed with international adoption issues, but these don't appear to exist.

With regard to China: The first placements have arrived in Australia. The second placements should arrive soon. I believe China is taking a very good step in making sure their children have citizenship and adopted status as soon as they leave China.

It is not the same for children from other countries. I am not sure what happens in other states, but in NSW the final adoption order is not made until a year later, and DOCS has the power to remove the child during that period. I wonder how many adoptive parents and their children suffer in silence for that first year, with a fear of removal hanging over their heads. One mother confided that one pretends everything is okay even if it is not, because of that fear of removal.

Despite the difficult processes and uncertainty inherent in international adoption I willingly went through the whole process a second time to adopt a daughter, and am now mother of two beautiful children.

One Birth Story

by Anne Southan

My partner Mark and I were surprised and happy to discover that I was pregnant. We had not been trying to have a baby, in fact I had had many concerns about my fertility over the years, due to having only one ovary, and having had surgery to remove endometriosis.

We waited 3 months before announcing our news to family and friends and to my boss. I had to leave work soon after as I was doing very physical work, rigging lights and drapes and speakers setting up Audio Visual gear in a hotel. I was able, with difficulty to do the work, but I was terrified about hurting the baby in a fall, so decided to leave.

I felt great during the pregnancy, right up to the eighth month when minor niggles with short breath, and a swollen itchy vaginal area, and a couple of doses of thrush caused me some discomfort. I restricted myself to short trips into the world, and concentrated on getting ready for baby, doing yoga, buying baby clothes and supplies on the internet and thinking pleasant thoughts.

I had planned a home birth and was attended monthly by an excellent caring midwife. My previous surgery was a cause for some concern, but I was quietly confident that a home birth would be possible.

When I visited my gynecological surgeon for an assessment in week 36 I was tremendously disappointed when he recommended an elective ceasar. I had been looking forward to labour and a normal home birth, and cried off and on for days. My sadness turned to elation when the results of my ultrasound and CT Pelvimetry caused him to change his mind, the baby's head was small, my pelvis seemed roomy, I was fit and well, and was given the go ahead for the home birth I had wanted.

So, I unpacked my hospital bag and put plastic down on the bed and got things cleaned up in a frenzy in my 40th week, and waited.... and waited.

I had small contractions that woke me up over the last weeks, but when they started coming every 25 minutes 2 days after my due date on Friday night, I believed things were coming to a head. I had been trickling small amounts of amniotic fluid, enough to want to wear a pad during the day, I could not really tell if it was urine or what it was. On Friday Mark and I went to bed as usual, and I was regularly woken by contractions that were painful enough to make me gasp, but mild enough that I could sleep through all but the peak.

All day Saturday this pattern continued. We called my midwife Jan and my mother and told them to standby, I was on the phone to Jan sitting on my birth ball during a contraction when my waters gushed out in a fairly big rush. From that moment on water trickled out, pink stained and copious during every contraction. By then they were coming every 5 minutes.

Jan and my mum came over, and Mark stayed close to me, but I found I was most comfortable being alone. Jan checked the baby's heartbeat with a doppler periodically, and there was no problem.

It was not until about 3 in the morning that things all slowed down and we all realised that this was probably pre-labour. I regretted using so much energy on it, and getting so excited, when Jan did an examination she found me fully effaced but only minimally dilated.

I was able to sleep, and Mark held me during the contractions that continued during the night at half hourly intervals, but much weaker.

On Sunday not much was happening, we went for long walks, where occasional contractions would cause me to walk in a funny waddle like I was doing the funky chicken. When we came home from our walk I had a minor breakdown, and started crying and crying because I was so scared about the baby being hurt from my waters being broken for so long, and so much blood stained fluid coming out of me, I was frightened of labour hurting me, of tearing my old scar, and I was embarassed about having the hours of false labour and having got everyone ready days early. Periodic contractions continued on Sunday night, and I did not sleep very well.

Mark had to go out to a job interview on Monday morning so I asked Mum to come round and sit with me for a few hours. I was cross and cranky, and could barely talk to her. It was about lunchtime, I couldn't sit still, and after Mark called me to tell me he had got the job, labour pains started in earnest. By three o clock I was on my hands and knees panting, and later on vocalising with a song that ripped out of my lungs, long notes, I could not understand where the sound was coming from, it expanded my lungs beyond the capacity I could have comprehended. Mark sang along too, I was beyond speech apart from basic commands like tea, shawl, hold me, and go away. The contractions were a minute or so apart and lasted 45 secs to one minute, but they seemed shorter, about ten seconds. Sometimes I would walk or dance through them, other times on my hands and knees singing again, it helped the pain, which was intense.

Baby was descending a little, and moving towards my cervix, I stood up leaning against the washing machine, and had to urinate, I was so far gone it was just trickling out of me, and I asked mark to fetch a bucket. There was still so much amniotic fluid coming out, I could hardly believe there was any more.

Jan examined me, and found me to be 7.5 dilated, we all believed the baby would be born soon. I spent some time sitting propped upright on pillows on the couch breathing through the contractions very calm as Jan talked me through them, I could feel my cervix moving, and felt very calm.

She said by midnight the baby would be born, it was 6pm, and tears came to my eyes at the thought of another 6 hours, as I felt exhausted.

I got into the shower and Jan had a rest. Mark fed me some rice pudding in the shower and joked with me, I felt pretty good in there sitting on my rubber ball, and the contractions did not bother me.

When I got out I propped myself onto the couch leaning forward onto some cushions where I thought I could nap cosily between contractions. Lo and behold I nodded off for over half an hour and the contractions stopped totally. I could not believe it.

I was in no shape to do much about it so Jan advised me to try and sleep for a couple of hours, and then we could all discuss what to do, either get things moving, or go to hospital for some oxytocin, and an epidural.

My waters had been broken for more than 48 hours, I was exhausted and overwrought. When I tried to sleep I was in terrible pain, I could feel my cervix fibbrulating and vibrating in an agonising motion, and all I could think was that the darned thing was closing up again. It was now about 2 in the morning.

When I got out of bed to go to the toilet I said to Jan "I can't stand this anymore, I just want someone to knock me out, and hand me the baby when it is all over". I meant it too, I had had enough.

We drove to the hospital in convoy and I was admitted fairly quickly. A photo Mark took of me in bed after the epidural shows me in a state of bliss, no pain, and I drifted off to sleep for 2 hours as the oxytocin took effect and I had massive contractions that I could not feel. Mark and my mum had the terrifying experience of hearing the baby's heart slow down and speed up during these contractions as I slept blissfully unaware.
Jan examined me after 2 hours of this and it was decided that I should have the ceasar as baby was in some distress. My surgeon was on the way and I was whisked off to be prepped for surgery.

To be honest, at this stage it was a tremendous relief to have others, more awake and experienced than I to look after my baby and me. The aneasthetist and nurses were very kind and explained everything they were doing. Mark was with me in theatre and I was awake and aware throughout. Tears came to my eyes when I heard our baby's cry at 7.15 on Tuesday morning, and they showed him to us before they sponged him down, I had never seen anything more beautiful. They lay him against my cheek all naked and soft, and I was overwhelmed by the soft sensation. After weigh in Mark brought him back to me as I was stitched up, and he was bundled so tight I could do no more than stroke his tiny forehead with one

finger. Baby did not open his eyes the whole time, but he did not cry either.

I was taken to my room after some time in recovery and Mark and Mum came upstairs with my little darling, who opened his eyes for the first time in the elevator, we spent some time gazing at each other in bed before the nurse tried to help me get breastfeeding started. It did not work then, but that night I rolled onto my side and got him attached. He slept with me in the hospital, I could not bear to put him in the plastic crib.

Ned is now ten days old and the light of my life. I don't have any regrets about my birth experience, in a way I feel I experienced both the extreme experience of home labour and the protected environment of a hospital, and got the best from both experiences. The most important thing is my little son, I would swim ten rivers of fire for him, a few days of pain is nothing.

AAIMH NSW & NIFTeY Joint Conference

14th - 18thNovember 2002

DETAILS:

In 2002, from the 14th – 18th of November, the NSW chapter of AAIMHI will be sharing our National conference with NIFTeY. The editor has strung a few words together about what it is that NIFTeY does.

NIFTeY is an acronym for...

N *ational*
I *nvestment*
F *or*
T *he*
e *arly*
Y *ears*

NIFTeY's Objectives:

The general community knows that:
the first three years of a child are foundationally important;
action must occur to provide all children with the best possible early life; and
policies and programs will be integrated across government and 'society'.

NIFTeY's Vision:

To build a lifetime on the first three years: ready for school, ready for life.

NIFTeY is a child advocacy movement that began in 1999 and aims to increase awareness of the importance of the early years of life amongst all sections of the Australian community. The idea emerged following the International Society for the Prevention of Child Abuse and Neglect conference in Auckland in September 1998, when a number of Australians present were challenged by American neuropsychiatrist Bruce Perry's presentations high-lighting the critical part played by environmental circumstances in the fine-tuning of early brain development. Perry provided data from human and animal studies suggesting that various kinds of early trauma – neglect, physical and emotional abuse, exposure to domestic violence – could have lifelong effects because of the lasting impact on the way the brain affected the body's response to stress.

This joint conference will be a prolific opportunity to extol, what we believe, the very essence of what we represent to a broader audience then ever. Please contact me should you have any ideas or suggestions toward the success of this conference.

QUEENSLAND NETWORK NEWS

SOUTH AUSTRALIAN COMMITTEE MEMBERS

President: Janet Rhind
Vice President: Elizabeth Webster
Correspondence Secretary: Susan Wilson
Treasurer: Michael Daubney
Committee Members: Debra Sorensen, Kathy Eichmann, Helen Baker, David Pinchin

From: Michael Daubney

On July 17, we had our AGM which was well attended. As well as election of office-bearers, several business items were discussed. Prior to the Meeting, Dr. Bill Bor, Child Psychiatrist at the Mater Children's Hospital, presented a paper called "Maternal attitude towards her infant and child behaviour five years later. The data was drawn from the Mater-University Study of Pregnancy which recruited about 7700 mothers and live infants born at the Mater Womens Hospital in the early 1980's. The mother were questioned at antenatal, five days post birth, at six months and when the child was five years old. A brief questionnaire asked the mothers their attitude toward their infant at six months and this factor was assessed as to its impact on later child behaviour. The study was able to control for numerous factors that confound any explanation of early experience on child behaviour, controlling for factors such as maternal depression, parenting at five, social class, marital disharmony, maternal age and other factors. Once the study controlled for these factors, maternal attitude was still a significant factor in explaining later child behaviour especially aggression in boys. The findings tended to support the theory of the early years being a sensitive period in terms of later behavioural adjustment and the need to look beyond postnatal depression at other difficulties mother's may be experiencing in the early months following birth. At the end of July over 20 people attended a Workshop given by Lorraine Rose entitled "Understanding the Emotional World of the Baby: The Path of Empathy". This was to celebrate the publication of her new book "Learning to Love". The presentation by Lorraine was very rich, and the discussion at the end reflected her great capacity to involve the audience in thinking about these early days of anew family. In October, Brigid Jordan and Michele Meehan are presenting several talks and workshops on their work with irritable babies.

NSW NETWORK NEWS

NSW COMMITTEE MEMBERS

President: Judith Edwards
Vice President: Mary Morgan
Treasurer: Marianne Nicholson
Membership Co-ordinator: Leanne Clarke
Secretary: Ian Harrison
Committee: Elke Andress, Leanne Clarke, Victor Evatt, frances Gibson, Patricia Glossop, Sharon Laing, Kerry Lockhart, David Lonie, Beth Macgregor, Beulah Warren, Robert Woodfield

We have had a busy time in NSW to date. We are starting to focus our efforts on Next years conference – November 14-18.

- The conference steering committee has been meeting with NIFTeY representatives to develop ideas around next years conference in Sydney
- Arrangements are underway to bring Dr Zeynep Biringen to Australia next year. Dr Biringen designed the 'Emotional Availability Scale' which is already being used by a number of practitioners to evaluate and inform their work. Dates and structure of workshops/ training are still to be determined.
- Seminars and Courses continue to be organised eg: Norma Treacy's clinical meeting on 'Sleep' and Robyn Dolby's presentation on 'D' attachment in October

Membership numbers in NSW are good and there is now a membership coordinator, Leanne Clarke.

Best wishes,
Judith Edwards.
President

Postnatal Depression Awareness Week

TWILIGHT SEMINAR

Speaker Profiles:

Jan Taylor RM MN

Jan is a Midwife and the Coordinator of the Bachelor of Nursing at University of Canberra. In 1995, as a visiting scholar at the Centre for Women' Health Research, University of Washington, Seattle, she became interested in the high levels of fatigue experienced by some women after birth. She is currently enrolled as a doctoral student and her thesis topic is postnatal fatigue.

Beulah Warren

Beulah is a registered Psychologist who has worked with infants and their parents for over 24 years. She has studied in USA and worked at Westmead Hospital and the Royal Women's Hospital. She is currently coordinator of the Graduate Diploma in Infant Mental Health conducted by NSW Institute of Psychiatry. She has numerous publications and her practice focuses on families with infants & young children & interpersonal relationships.

Registration & Information:

When:
Wednesday, 21 November 2001
5:00 PM to 10:00 PM

Where:
Hellenic Club,
Matilda Street,
Phillip ACT

The Hellenic Club is here, in Woden Valley. From Parliament House travel south along Yarra Glen to a large roundabout. Stay on Yarra Glen then turn right at the next intersection into Launceston Street. Turn second left into Callam Street then first right into Matilda Street

Carparking is adjacent to the club but fees apply until 6pm.

Complete the form overleaf, tear off & return with your payment to :

PND Resource Network PO Box 126 Curtin ACT 2605 (Receipts will be available on the night.)

Please circle the following as appropriate:

Early bird until 1st November:	Member of PANDSI ($35.00)	Non-Member ($35.00)
2ND November to 16 November:	Member of PANDSI ($35.00)	Non-Member ($40.00)

POSTNATAL DEPRESSION AWARENESS WEEK

2001 SEMINAR PROGRAM

Program:

5:00 pm Registration

5.45pm Welcome & Opening

6:00pm Presentation to V. Davies

6.15pm So, How do they feel?
Women's Experience of fatigue in the first six months after birth.
Jan Taylor

7:00pm Dinner

8:00pm Bonding & Attachment across the PND Barrier.
Beulah Warren

8.45pm Dessert & Coffee

9:00pm Bonding & Attachment cont.

9.30pm Question time

10:00pm Close

Topics:

Women's Experience of Fatigue in the First Six Months after Birth
&
Bonding & Attachment Across the PND Barrier

How to register:

Complete the form below, tear off & return with your payment to :

PND Resource Network
PO Box 126 Curtin ACT 2605

(Receipts will be available on the night.)

Cost:

Early bird until 1st November:

Member of PANDSI ($35.00)
Non-Member ($35.00)

2ND November to 16 November:

Member of PANDSI ($35.00)
Non-Member ($40.00)

I am interested in attending the Postnatal Deparession Awareness Week Twilight Seminar on 21 November 2002 and enclose a cheque / money order payable to the PND Resource Network. A tax invoice / receipt will be issued.

Name: Mr/Mrs/Miss/Ms/Dr .....
Surname:..... .....

Address:.....Postcode.....

Phone: (W) ..... (H).....
Special Dietary Requirements (eg. Vegetarian):
.....