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NEWSLETTER

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FROM THE EDITOR:

There goes another year. Looking ahead to 2002 fills this editor with excitement and enthusiasm. The joint conference with NIFTeY in November and the Emotional Availability Scales Workshops in June should both prove to be most stimulating. With reflection to the events of the past year, in particular September the 11th, the best way ahead is forward. Hopefully the new improved edition of this Newsletter should be out this coming March. There is much to look forward to.

This edition packs a fascinating article by Margaret Booker, I look forward to your feedback on her approach. There is a review of Your Social Baby by our regular contributor Anne Southan as well as valuable info on the up coming Emotional Availability Scales workshop. Please get your interest applications off ASAP.

On behalf of the AAIMHI Newsletter team I will take this opportunity to wish you a safe and happy time over the holiday period.

Looking forward, looking ahead.

Best wishes

Victor Evatt

2000 - 2001 CALENDAR OF EVENTS

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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IDEAS OF LOVE IN ONE PARENT - INFANT THERAPY

BY: Margaret Booker (MSW)

Synopsis

The author is seeking to describe how ideas of love were used in a Parent-Infant therapy group to assist in three ways. First, ideas of love were used to slide between two 'ports of entry' (Stern 1998,p16) to change; that of the interaction between mother and infant and that of the intrapsychic world of the mother. Second, the facilitators used ideas of love to stimulate excitement in mothers about the relationship with their infants. Finally ideas of love were used to structure the program; to make it cohere. Members find most meaningful that which they rework (Yalom 1995): the group returned time and again to the ideas of love that it had generated.

Introduction

The primary objective of Parent-Infant therapy, whether the method is group or individual, is to enhance the mother's ability to 'carry in her heart and mind the feelings of her baby' (Orbach 1999, p61) as this becomes the means by which she is able to assist the infant feel recognised and real. The mother's ability to hold her infant's needs in her mind is variously referred to as 'primary maternal preoccupation'(Winnicott1971) 'maternal reverie'(Bion1967) and 'attunement' (Stern 1987). The impetus behind this approach comes from the new 'cognitive sciences' (which draw on psychology, neuroscience and linguistics). There is the suggestion that getting this attuned relationship right is crucial to infant development (Stern 1987). Parent-Infant, which is *relationship focused* therapy, is designed to develop the mother's ability to reflect on the potency of this relationship for her infant.

The cognitive sciences offer Parent-Infant therapists the chance to share with mothers the kinds of things that may be occurring in the minds of infants. It is now understood that humans actually teach their offspring, though as can be seen with the use of 'motherese' this teaching often occurs unconsciously (Gopnick and Meltzoff and Kuhl 1999). Central to the infant's ability to learn is the 'attachment relationship' a relationship that enables him/her to use the mother as a 'secure base' from which to discover the world. This relationship is used when needed to manage distress (Dolby 1999). The attachment relationship is also central to the mother's mental health: if she does not feel she is getting this right she is likely to experience depression (Solomon 2001).

Therapists still wonder at the process of attunement: how thoughts and feelings are passed from one person to another via projective identification (Ogden 1982). This presents a challenge in conveying the aim of attunement to mothers which can, perhaps, be mastered by incorporating ideas of love. Thus projective identification can be explained as a prototype of the sort of deep attachment all humans seek *throughout* life and as something both parent and infant are seeking. For throughout life, if another human is able to accept, to receive one's distressing emotional states, to acknowledge that one is struggling with a terrifying emotion, one is more able to contain and bear the emotion without retreating in to emptiness. Love requires more than this empathy though, it also requires that the receiver of another's feelings makes sense of and *returns* the feelings in a reassuring manner (Bion 1967; Orbach 1999). Love then is made of actions as much as feelings and can be identified by the group in the microevents (Stern 1998) between mother and infant.

'Love' was also used as a general tool, as whatever-it-meant for the mothers, to give both mothers and facilitators (who adopt the mothers' words) the means to 'cross and re-cross the boundaries between the interpersonal and the intrapsychic'(Stern 1998,p138); to slide between these two ports of entry. Again, ideas of love helped the mothers attend to the work, **the primary task** of the group: enlivening the parent-infant relationship.

The Program

Tresillian Family Care Centres are trialling Parent-Infant group therapy for mothers identified as experiencing distress in their relationship with their infants. 'Jane' and 'Jack's' path through the group will be described because Jane felt that it was a highly positive experience for her

relationship with Jack. Jane had been referred to this group from a Postnatal Depression Therapy group and was the only member with a non-depressed Edinburgh Postnatal Depression Score (the modal score was moderate depression). The program was designed for a maximum of six dyads. The age limit for infants was eight months.

Theoretical Position

Parent-Infant therapy draws its interventions from a range of theories as diverse as psychoanalytic constructions of infant thinking on the one hand and neuroscience on the other with infant development and attachment theory in between. Individual facilitators bring different theoretical preferences (in this instance the practice theories of Cognitive Behavioural Therapy (CBT) and Narrative Therapy). These are all incorporated into the practice theory Parent-Infant therapy which 'assumes a rough equivalence among therapeutic approaches' (Stern 1998, pp4-5). This assumption argues Stern, has been made for decades in evaluating the adult psychotherapies. He quotes Frank and Frank's arguments that it is the significant common features in all types of talking therapy that determine effectiveness. These features, the ones that the clients value, are all in the manner of the therapist: 'presence is the hidden agent of all forms of therapy' says Yalom, 'you do by being, by being there' (Yalom 1995, p96) in a warm, empathetic, genuine way (Truax and Carkhuff 1967) and also by conveying that you believe, unequivocally, in the therapeutic value of the work being undertaken.

Unique features of this therapy as a group therapy

Parent-Infant group therapy has been described as 'Parent-Infant therapy in a group rather than group therapy' (Turner, B. 2001, per. comm. 8 Aug) as one of the basic practice principles of letting the infant do the work (Erikson and Kurz-Reimerk 1999) means that much adult-to-adult interaction is left implicit. The *main therapeutic target* is the interactive behaviour between parent and infant (Stern 1998, p138).

The *pace* of the group is unique as it has to follow the infant members. Erikson describes parenting as 'slow dancing letting the baby lead' (2000). This dance, initially modeled by the facilitators, provides the rhythm of the group. The *content* is unpredictable. One facilitator describes this in her group as 'roaming through infant development based on the interactions of the members' (Robinson,C. 2001, per.comm, 10Jul). The 'here and now,' the *process* with which the facilitator needs to work is, again, the interaction between the parent and her infant. Thus the facilitators are always thinking 'how can I relate this issue to the group's primary task of enlivening the relationship between these mothers and infants?' and 'how can I take this issue from the outside to inside, from the abstract to the specific, from the general to the personal?'(Yalom 1995,pp129-144). The Parent-Infant therapist is always bringing the infant into the 'here and now' though this is achieved by demonstrating interest in the mother as well, for example 'what is happening for your baby now?' and 'what do you feel when he does that?'(Robertson 2000,p4).

Therapeutic Factors

Yalom (1995) describes extensive research on groups that shows a large discrepancy between what members and facilitators see as of most help. *'Existential'* factors were always highly ranked by members. First was 'responsibility': learning that I must take ultimate responsibility for the way I live my life no matter how much guidance and support I get from others. Second was 'basic isolation': recognising that no matter how close I get to other people I must still face life alone (Yalom 1995,pp.98-99). Philosophical debate is used increasingly in talking therapy and contains 'a sense of human complexity, of depth, an exigent demand to struggle against one's own refusals and a respect for the difficulty of human life' (Luhrmann 2000, p290).

The existential therapeutic approach encourages philosophical discussion and provides Parent-Infant therapy group facilitators one way to compensate for the restriction on adult interaction. It gives the group a way to validate mothers' emotions without raising anxiety (which the facilitators cannot focus on except in its meaning for the relationship) while simultaneously working at 'waiting, watching and wondering about the infants' (Johnson et al.1980). This addresses Yalom's warning, axiomatic to group therapy, that 'if something important in the group is being actively avoided, then nothing else gets talked about either' (1995,p31). It also offers the group a picture of the different 'inner worlds' (Yalom 1995, p40) of each of the mothers in an efficient manner through enabling non-threatening self-disclosure.

Self-disclosure is absolutely essential if a group is to be meaningful to its members (Yalom 1995). It enables mothers to see and hear themselves in certain ways for the first time and this offers a new form of knowledge (Storr 1990; Orbach 1999). It could be said that mothers are actively constructing knowledge about themselves and their infants.

Therapeutic factors in a developmental sequence.

An important concept for structuring groups is that the more the members rework the same themes the more powerful a group becomes (Yalom 1995). Because they

engage mothers emotionally existential ideas which include 'love' aid this reworking.

In the first session the mothers were encouraged to generate these BIG ISSUES which included the question WHAT IS LOVE? The responses were: 'empathy', 'always putting Jack first,' 'hard' 'self-discipline', 'actions not words,' 'very mixed emotions,' 'scary,' 'not like I thought it would be' 'overwhelming' 'disappointing' 'loss'. These ideas were kept on the whiteboard throughout the program. Being conscious of the level of depression the facilitators added Solomon's description of depression as a failure of love to protect from what becomes a disease of loneliness (2001).

Jane was an enthusiastic leader in this exercise, having just emerged from an experience of depression, and the facilitators reinforced her contributions by encouraging her to retell and thus rework the story of her pregnancy, birth and early parenthood which included a suspected foetal abnormality, an emergency caesarian during which she felt sure she would die and subsequent feelings of 'failing to bond' to Jack.

While 'pregnancy and birth stories: your infant's story: your first meeting: her/his introduction into your inner and outer world' was suggested as a topic in the early sessions there was no ordered turn taking: in order that the interactive behaviour of the dyads remained the focus, the facilitators had to suggest other ways of working. Thus while Jane's invaluable contribution was reinforced - she was thanked for reassuring others that they weren't alone in believing themselves inadequate mothers (universalising) - we reassured mothers that they could talk about their unique journeys (infants and their own) at any stage. And while Jane was readily able to nominate 'big issues' for the whiteboard, the facilitators suggested an alternative route to self-disclosure as well: the homework 'Secrets'. On the board the facilitators wrote: 'it's the secrets you keep that make you sick' (Greer1989, p171). Mothers were asked to bring back the following week their secrets, which the facilitators would then place anonymously on the whiteboard. The most common secret to emerge was 'I don't love my baby'. Also, more than once was 'I've ruined my life' and 'there's something seriously wrong with me'. Mothers could identify similarities in their problems and make a commitment to the group.

Jane's contribution enabled the facilitators to do what is imperative at this stage: establish the 'working norm' that members can help each other. Facilitators set this norm by identifying mutual help as a group goal and by pointing out this behaviour when it happens. For example, once the 'secrets were out' we noted that Jane, who had come from a program that uses amongst other strategies CBT to shift depression (Booker 2001) was able not just to dispute her own thinking but also the pessimism in other mothers' thoughts. While the facilitators were positively reframing the infant's behaviour, and modeling this as a way to work (e.g. 'she's doing this (whingeing) to get at me' into 'she knows she can take her frustration to you'), Jane was pointing to maternal behaviour that contradicted negativity: for example 'if you didn't really love him you wouldn't be so sad about it'. The facilitators set the group norms both implicitly (they cannot *not* communicate) and explicitly. Once set these modi operandi are difficult to change (Yalom 1995).

Another working norm was spelt out when one parent stated:'I know this is *my* stuff'. The facilitators acknowledged the 'stuff' and the frustration of not being able to address this in group time by the intervention: 'this requirement you are feeling to push aside your own emotional needs is a demonstration of your putting 'Tom' first. This is hard to do. As facilitators we too struggle with putting aside your emotional needs for a different place: you have this struggle constantly' (Warren B,2001, per. comm., 28 Aug paraphrased).

Yet another working norm, that of identifying and building on strengths in the dyads needs to be put in place. Mothers who are deeply negative about their own parenting are often adept at identifying strengths in others. For facilitators, building on strengths is one way to offer mothers guidance and hope: both essential in maintaining membership.

Throughout the program facilitators make much of the hopeful interventions in Parent-Infant therapy. Hope makes life's existential misery bearable as well as motivates one to persevere with new skills (Seligman 1991). Thus the facilitators raise four ideas. The first is repair: you have the rest of your life to get this right (Stern 1987). The second is that development proceeds largely automatically once the attachment relationship is 'secure' (Bowlby 1969). The third idea is that one needs only to be 'good enough' which can be defined to include contingent responses in one third of interactions (Karen 1994). The final idea is that the infant is hardwired to find the relationship. All infants will turn to the primary parent for solace: 'it's in the species' (Erikson 2000).

Interventions using the concept of hope help facilitators tackle 'guilt' and 'ambivalence' which are major themes in Parent-Infant therapy. Guilt is seen to be functional as it motivates mothers to adjust their own behaviour to better suit their infants (Lerner1998). It also makes a mother assume responsibility for her predicament: a prerequisite for change.

The responsibility she assumes, to love her infant, means she must allow herself to 'be shaped, arranged, explored in the service of another's self expression' (Mitchell 1993,p147). Ambivalence is the consequence of registering and bearing, processing before returning one's infant's intense negative emotions: the consequence of being forced to deal with another's hurt, rage and disappointment. A mother must bear her mixed feelings in order that her infant learns an attachment pattern that teaches him/her how to both regulate his/her own emotions (self-soothe) and relate to others (Dolby 2001). Jane described how she had managed to get a pram, Jack and herself on a crowded bus. Feeling embarrassed at Jack's screaming then angry, she verbalised: 'this is as horrible for me as you Jack as no one is helping. I think we've become invisible.' Jane was also unconsciously helping

Jack with the transition between 'soft and hard experiences'; both equally important in personality development (Rose 2000,pp58-63).

Educational input was designed to increase sensitivity to infant cues; to infant abilities to signal needs. Used in each session was a list of communication cues. Facilitators began two (group long) processes immediately. The first was drawing attention to mothers who were reading these cues well, often unconsciously. For example Jane 'had no idea' how well she responded to Jack's use of 'gaze': she would hold it and thus him, emotionally, for as long as he asked. The second was interacting contingently with infant members themselves. Because of the constraints on adult interaction, more use has to be made of the therapeutic factor of imitation. Facilitators both model and identify ideal responses. This encourages imitative behaviour which, even if only temporary can 'unfreeze', can shift enough psychologically in a mother, to give her the courage to continue to try something different. A basic principle of change in CBT is being used. These mothers are grappling with what being a 'mother' means and facilitators are trying to convey what this looks like, behaviourally speaking. Yalom (1995) says imitation has 'a solid therapeutic impact' as 'finding out what we are not is progress towards finding out what we are'(1995,p16). The mothers are reassured that they need not look for a specifically definable maternal instinct as mothering skills are learnt from our own experiences as infants: the challenge for the mother is to assist the infant develop a secure relationship (Fowler 2000).

Another technique used to help mothers with identity or 'fit'; with the type of mother emerging in the relationship with their unique infant, was visualisation. Facilitators introduced this exercise with an exploration of the philosophical idea of 'mindedness' (thinking about the thinking about) applied to their infants (Fonagy 1991). This skill of looking at things from one step back and simultaneously resisting the urge to analyse and act was explored through homework. Mothers were given the instruction to visualise an ideal mother and infant relationship, to make this fantasy as real as possible through conjuring it up via all senses, and to practice evoking this relationship, which when brought in to the group could be tried with their infant. For example Jane revealed she had always seen herself as 'a mother to a *daughter* never for a second a *son'* and recounted how she had been unable to reveal the crushing disappointment she felt when Jack was born (she had asked not to be told the sex earlier). After the pregnancy-long query of disability her one attempt to raise her disappointment was met with 'be thankful he's alright'. Her visualisation was based on her best friend who 'is rapt with a son a bit older than Jack'. She re-enacted her friend's 'goo-ing' and 'gaa-ing' and the group laughed at Jack's thrilled response. Facilitators thus got to current interactions with the infant as well as the 'parallel world of the imaginary, subjective, mental representations' that develops through the experience of 'being with' another person' (Stern 1995,p18).

The facilitators needed to introduce some deeper insights into infant communications: again ideas of love were used.

Love as attachment compensates humans for the existential fear of 'basic isolation' (discussed earlier): of separation anxiety. The facilitators began by describing the way the infants were using physical distance to communicate their ability to tolerate emotional 'space'. They were variously comfortable with this, being at different developmental stages and of different temperaments (the group had earlier identified 'high, medium and low signallers' and debated where the infant members stood in relation to the temperamental constellations of 'easy', 'slow to warm up' and 'difficult' Carey 1997). The mothers proved to be struggling with managing closeness and distance in the relationship too: several of the infants were 'mergers' which their mothers found 'suffocating'. This infant behaviour was reframed as 'when humans are little they get very worried when their big person disappears; you can't be sure she'll be back. It's the same way grown-ups feel when they feel abandoned: there's sadness but more often fear.'

Jane felt Jack's comfort with distance was 'too independent, not like other babies'. The facilitators pointed out his constant 'checking back' and her significance to him: he was waiting for recognition that he was on an adventure and that this was O.K. The facilitators reinforced the importance of the relationship as a 'secure base' by reiterating that attachment is how love protects humans from the acute anxiety of separation. Furthermore humans need a long period of dependency: the independence one achieves later in life gains its strength from the love from which one extricates oneself (Modjeska 1999).

A parallel connectedness could be seen at this juncture in mothers working together, for example pointing out contingent responses by other parents and cues in other infants' behaviour. 'Cohesiveness in group therapy is the analogue of relationship in individual therapy' (Yalom 1995, p47): you need it to work together. The mothers had accommodated 'weaving' in the adult work (given as homework) into group time. Jane had found looking in the mirror and saying her own name first with no emotion, then with love and finally with anger a powerful experience (Mitchell 2000). She also felt strongly the different effects of saying to herself 'the problem with you is...' versus 'what I really like about you is...' and was surprised that Jack enjoyed praise when she verbalised: 'what I really like about you is...'.

Love as empathy was defined as the ability to perceive the subjective experience of another person; a 'feeling into' the emotional state of another person (Goleman 1996, p98). This definition lead to some anxiety about *how* this was done; and the following discussion ensued. Communications research suggests ninety percent of an emotional message is nonverbal (Goleman 1996) and nonverbal messages are mostly taken in unconsciously. This unconscious reading is learned early through attunement.

Being aware that direct information is ineffective and that Parent-Infant therapists 'ask never tell' (Robertson 1999, p4) the facilitators decided to use 'love as eros' to reduce defensiveness through humour. Mothers were asked to remember their last encounter with passionate sex, sex which 'involved the experience of sensing the other's

subjective state: shared desire, aligned intentions, and mutual states of simultaneously shifting arousal' (Stern 1987, p30). Jane found this useful as well as comic: it helped explain the mood swings in her relationship with Jack as she recognised these feelings as echoes of previous experiences of falling in love. However, anxiety appeared in the group in questions of whether or not infants could 'catch' their mother's intense negative moods. While reminding mothers that there are reparative opportunities throughout life which can reshape one's 'working model' of relationships (Bowlby 1969) the facilitators covered the latest evidence that there is 'mirroring' (Solomon 2001, pp.180-182). Another idea that helped restore hope was that neurological research shows how emotions are read from faces (Brothers 1989) as this led the group to the 'fake it till you make it' skill so useful in CBT.

The mothers had by this stage worked hard at the skills that define loving; worked at deep attentive listening or 'wondering,' of contingent communication, of praise. All this requires a forgoing of one's own needs and this selflessness needed validation. Discussed was the hopeful and existential intervention, that loving selflessly ultimately rewards with an appreciation of oneself as capable of this love (Rose 2000). 'The sacrificial, other directed work that parents do is the wellspring of compassion, competence and commitment in society' (Taylor and Taylor 2001). Another compensatory argument is that happiness or 'flow' when analysed can be seen to be a result of the skill of delaying one's own gratification, of 'stifling impulsiveness' (Goleman 1996, p43; Seligman 1991). Mothers spend years honing this skill. The nexus of the clinical problem in Parent-Infant therapy argues Stern, is 'almost always' concerned with altering the 'mother's representational shift' towards altruism and away from narcissism (1998, p25).

Love as Loss

Pushing mothers towards altruism is likely to generate anger, anger at a society that defines motherhood as 'that which gives and gives' and yet offers only a 'radical social demotion' (Wolf 2001, p7). There is anger at the personal losses not only of real sources of identity and satisfaction such as a career, but also at failed expectations: the hopes of combining work and home, of both partners being able to work flexibly and share the child care.

The facilitators have to allow these painful emotions 'space' without exploring them: the therapeutic context must enable the mother to feel 'held' when she brings these painful emotions into the relationship (Rose, 2000). The Parent-Infant therapist is very conscious of this 'parallel process': the facilitators must hold and attend to difficult feelings in the mother in the way they are asking of the mother and her infant (Erikson 2000). Thus while facilitators are not exploring anger in an active way, they are modeling a popular view in anger management: don't suppress it but don't act on it (Dowrick 2001; Tavris 1995).

A mother needs 'space' to express intrapsychic loss also. For example she may crave 'perfect attunement' herself (Paul and Thomson-Salo 1997,p229) and feel disappointed that her infant hasn't fulfilled this need. Infants re-awaken memories of early family relationships, emotional memories that are often overwhelmingly felt but for which we have no matching articulated thoughts: they were laid down as chaotic feelings before we had words for them (Goleman 1995; Paul et al, 1997). Jane expressed grief at the separation from her own mother who lives overseas. She felt distressed also with the memory that her early care had been left to 'servants'. This memory made her intensely sad for her infant self: it never had before as she had simultaneously recalled love for these nannies. Through the lens of Parent-Infant therapy and a new identification with Jack, Jane recalled with sadness that 'her mother had just told her she had *hated* the baby stage'. Jane wondered whether she also hated the 'baby stage' or whether she could differentiate her 'self-as-mother' (Stern 1998) from her own mother to whom she was very close. Jane was differentiating herself in other ways. She was identifying that which she wanted to repeat: 'she taught me right from wrong' and that which she did not: 'she used punishment more than discipline' (the group had discussed the difference, e.g. one teaches 'might is right' the other self-control).

The facilitators used Jane's memories to introduce the idea that attachment relationships will throughout life reflect early experiences: though it is the memories we select from our past that haunt the future. 'I used to think that truth was single and error legion, but I know now that none of us grasps more than a little splinter of the truth' (Greer 1990,p9). The splinter one selects and whether or not it can be worked into a coherent narrative influences our current relationships: our ability to seek comfort in intimacy and support from people we see as 'stronger and wiser' (Bowlby 1969; Stern1998). If humans can come to think constructively about their histories they can move beyond them.

Towards the end of the program the mothers were asked to record for homework parental messages which they recalled of their own early childhood. In a symbolic gesture the facilitators asked them to rip up in the group the messages they disliked (Erikson 2000). The group helped each mother (and there was overlap in the messages, several remembered 'children should be seen not heard') arrive at an understanding of why *their* parents had behaved as they did.

The final session addressed endings in a positive way: through an exercise called Positive Postman. This was adapted to this group by asking the group to write only to each other as mothers. Thus each mother anonymously 'mails' (passes to) each other, a list of the positives they see in each other as mothers. At the reunion session Jane recounted keeping these glowing messages in Jack's carry bag and recalled telling Jack that he was lucky to have a mother who was 'passionate' and 'determined to get it right'. This Parent-Infant therapy group had changed Jane 'through the dual process of emotional experience and reflection upon that experience' (Yalom 1995,p78). She had left the group more attuned to her son and confident about this: 'I know what love is now'.

About the Author

Margaret Booker completed a Masters in Social work at UNSW in 1989. She currently works at Tresillian, Wollstonecraft, offering groups and family counselling. Margaret would be delighted to hear from you should you have any comments.

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• Book Review

Your Social Baby - Understanding Babies: *Communication from Birth*

A Book by: Lynne Murray & Liz Andrews

Reviewed by: Anne Saunders (mother of one)

My boy Ned was 3 weeks old when I was given a copy of Your Social Baby to read. I showed him the cover and he stared intently at the smiling baby on the cover.

The book is interesting in the way it both shows and tells its stories about how babies engage with the world. The text accompanies photographs from dozens of encounters with babies and their parents and other care givers. They are presented comic-strip style and are stills from a video camcorder.

The shots of newborn Ethan engaging with his mother, cooing and staring just minutes after birth are so charming and touching that it made me want to rewind Ned's first hour, as he was shown to me only briefly before I was taken to recovery after my caesarean.

The authors certainly are convincing as they show the tiniest babies can recognise a human face, identify the smell of their mother and the sound of her voice.

I particularly enjoyed the picture stories that showed the babies interacting socially, and discussed signs that a baby was becoming tired or was no longer interested in playing. I have found however that no book is a substitute for the hours and hours of baby watching that naturally occur when you spend the day together.

Your Social Baby avoids a preachy "how to care for your baby" tone, and concentrates on helping you read the cues and signals a baby will send you. The sleepy signals discussed were a help to me, as were the tips on adjusting the environment to help with a sensitive baby. Ned would freak out when being changed or dressed, and the suggestion to put a cover over him to make him feel secure was useful.

Darkening the room and removing stimulation when baby is distressed was also a good tip. Our bedroom has venetian blinds, which Ned loved staring at when he was alert, but if he was tired the sight of them would over excite him and prevent him from sleeping.

I liked the way they stressed that babies are all very different in the rates of crying, and sensitivity, I think that would be reassuring for the parents of the 20% of babies who cry for several hours a day in the first weeks.

The book shows lots of soothing techniques, which might be useful to some parents, but I think most of them would have tried all those listed and twenty more, in the quest to induce sleep or calm in a shrieking baby. Those nerve shattering howls are an incredible motivator, you'll try anything.

The sleep section was, fortunately, one that I did not really need help with. Ned's father and I are committed to co-sleeping and find that our nights are calm, and never interrupted by any crying, or necessity to get out of bed. I was pleased that co-sleeping was discussed and described in the book, as a lot of child rearing texts frown on it, or don't even mention it as an option.

Your Social Baby is an informative and fun to read book that has helped me to become a little more knowledgeable in the way I have watched my baby grow over the last 3 months. But ultimately, nothing can teach you about babies as effectively as caring for your own baby, Ned has been an incredible teacher, occasionally noisily vocal in his criticism, but also very patient with my occasional mistakes.

Your Social Baby can be purchased through ACER Press or retailers for $24.95 or over the net www.acerpress.com.au ISBN 0-86431-394-2

VICTORIA NETWORK NEWS

VICTORIAN COMMITTEE MEMBERS

FROM: Sarah Jones

We are mindful that the latter part of 2001 seems to have held many awful events in the different parts of the world. The experience of the infant needs to be thought about in both Afghanistan and America, and also for those children and families in the Middle East, and as refugees charting uncertain paths. The people of these countries have often felt assailed. It is part of the mission of AAIMH that we can consider world events in terms of the impact on infants.

The AAIMH committee has been very productive this year with a lot of behind the scenes activities. Michelle Meehan has been our very thoughtful president holding the committee together. Two of our Committee of Management members hold portfolios on the World Association of Infant Mental Health Committee, and in that role have recently visited America. Brigid Jordan as the Affiliates Representative to the board of WAIMH attended a meeting in East Lansing, Michigan. Campbell Paul as a member of the WAIMH's Scientific Conference Committee also attended a meeting in Michigan to prepare for the Amsterdam Conference in July 2002. The attendance at these meetings is Australia's contribution to WAIMH. It is also another way to demonstrate Australia's active profile in the infant mental health world. In the light of world events, we thank Brigid and Cambpell, who gave a lot of personal time and energy in attending these occasions.

Plans for the WAIMH meeting in 2004 are slowly proceeding. The conference is expected to be in January and we are hoping many people across the world, but also across Australia will join us in Melbourne. This will be the first WAIMH conference to be held in the Southern Hemisphere. Stay tuned for further information.

The last Scientific Meeting for 2002 was an opportunity to consider infant mental health in Vietnam. A number of people have visited Vietnam and presented on their work at the National Institute of Paediatrics in Hanoi. We were especially delighted to have the opportunity to have a visitors to meeting a social worker, psychologist and psychiatrist all of Vietnamese origin. This enables us to consider many of the cultural beliefs held in families and extended our knowledge and cultural understanding.

AAIMH NSW & NIFTeY Joint Conference

14th - 18th November 2002

NIFTeY is an acronym for...

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

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'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 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 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 systems.

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

NIFTeY's Vision: **"To build a lifetime on the first three years: ready for school, ready for life."**

Emotional Availability Scales Workshop:

EXPRESSIONS OF INTEREST

Details:

AAIMHI is considering sponsoring a training workshop on the Emotional Availability Scales (EA) conducted by **Assistant Professor Zeynep Biringen** PhD, of Human Development and Family Studies, Colorado State University, USA (See box below / overleaf).

At this point we are asking for expressions of interest from those who would be interested in participating in a **2- 3 day Workshop in early June 2002.**

The EA Scales are already being used in Australia in research and evaluation of treatment outcomes. The Scales have great potential for clinical use. They are an observational measure designed to evaluate mother-child interaction across the dimensions of parental sensitivity, structuring, intrusiveness and hostility in addition to child responsiveness and child involvement of the parent.

The Emotional Availability (EA) Training Workshop is typically conducted in 2 - 3 day block.

It is full - time on the first two days and a half day on the last day

Please phone, fax or e-mail your interest in this Workshop to:

Frances Gibson PhD:

Phone: 02 94134389, Fax 02 94134574
Email: frgibson@laurel.ocs.mq.edu.au

Emotional Availability Scales Workshop:

EXPRESSIONS OF INTEREST

Details (continues from Page 11) :

Who can attend ?

The EA workshop is designed for clinicians and researchers. Undergraduate students can attend but it should be presumed that they will need a significant amount of time to reach reliability than more experienced observers. Typically, the workshop is best attended by graduate students or professionals in the field. Past workshops have been attended by graduate students, professional research assistants (with BA or masters degrees and life experience) doing scoring for research or intervention projects, mental-health professionals, research psychologists, and professors from universities or medical centers.

The workshop begins with lecture on emotional availability, attachment, and observational methodology. An overview of emotional availability and its research use, with the most recent findings, will be presented. This is followed by the main core of the workshop, involving group viewing of videotapes brought by Biringen and illustration of the scoring. This large-group then evolves into a smaller-group viewing where participants then do their independent ratings and compare their scores. The large-group then meets to resolve and discuss differences in scoring. The last phase of the workshop involves viewing of participant tapes and group scoring, with inputs from Biringen.

It is hoped that after the workshop participants can go away and score criterion/reliability tapes already scored by Biringen's team to obtain inter-lab reliability, followed by establishing reliability on their own samples. A buddy system is helpful in terms of the training after the workshop, although not a necessity.

Please, phone, fax or e - mail your interest in this Workshop to Frances Gibson PhD:

Phone: 02 94134389, Fax 02 94134574
Email: frgibson@laurel.ocs.mq.edu.au

Name: .....

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

Phone: ..... Fax : .....

E-mail address: (please print very clearly) .....