Australian Association for Infant Mental Health

VOLUME 14, Number 2

Affiliated with the World Association for Infant Mental Health | June 2002 | ISSN 1442-701X

NEWSLETTER

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FROM THE EDITOR:

Verbum sapienti sat est

With our submission to HREOC for -The Inquiry Into Children in Immigration Detention- in on time, it now seems to be a waiting game for the results of the collective effort made toward the submission's production. Once again, on behalf of AAIMHI, I would like to extend a huge vote of thanks to Rosalind Powrie for the effort she made towards putting the submission together. Also a vote of thanks goes to all those who championed the submission by way of distributing it on to like minded colleagues and others. For those who did not get a clear look at the submission or, would like to get a copy, you can e-mail Rosalind Powrie at rmpowrie@hotmail.com or me at the address bellow.

For several years AAIMHI has been concerned about the use of "controlled crying" or "controlled comforting" as it is sometimes called as a method of managing babies' sleep. The issue has been canvassed in this newsletter and the following statement has been developed with input from all branches of AAIMHI and accepted as a position statement for the organisation. Please feel free to forward any suggestions regarding the statement either to Pam Linke linkes@newave.net.au or to me.

As a prelude to our forthcoming joint conference with NIFTeY I have published an article written last year by Sarah Jones (Victoria) canvassed from the 2001 UK AIMH AGM on the enduring consequences of trauma and neglect. A fitting subject to prepare your thoughts leading up to the conference. There is a perspective on PND and controlled crying by Guy Avisar, a therapist from Victoria, that compliments our Controlled Crying Statement. Also the latest information on the conference which is shaping up to be a most stimulating event.

Best wishes
Victor Evatt

2002 CALENDAR OF EVENTS

NOVEMBER 2002 (NSW)

14 - 16 November:

AAIMH NSW & NIFTeY Joint Conference

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The AAIMH Newsletter is a quarterly publication of the Australian Association for Infant Mental Health

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• AAIMH Position Paper

CONTROLLED CRYING STATEMENT

DRAFT

Introduction:

The Australian Association for Infant Mental Health aims (in part):

• To improve professional and public recognition that infancy is a critical period in psycho-social development,

and

• To work for the improvement of the mental health and development of all infants and families.

Definition:

Controlled crying (also known as controlled comforting and sleep training) is a technique that is widely used as a way of managing infants and young children who do not settle alone or who wake at night. Controlled crying involves leaving the infant to cry for set periods of time before providing comfort. The intention of controlled crying is to let babies put themselves to sleep and to stop them from crying or calling out during the night.

AAIMHI is concerned that the widely practiced technique of 'controlled crying' is not consistent with what infants need for their optimal emotional and psychological health, and may have unintended negative consequences.

Background:

• This statement is premised on an understanding of crying to mean crying that indicates distress, either psychological or physical, rather than the "fussing" that many babies do in settling or adjusting to different circumstances.
• Babies have to adapt to a totally new world and even small changes can be stressful for them. Leaving babies to cry without comfort, even for short periods of time, can be very distressing to the infants.
• Crying is a distress signal from an infant or young child. Although controlled crying can stop children from crying, it may teach children not to seek or expect support when distressed.
• Infants from about six months of age suffer from differing degrees of anxiety when separated from their carers, This continues until they can learn that their carers will return when they leave, and that they are safe. This learning may take up to three years.
• Almost all children grow out of the need to wake at night and be reassured by three or four years of age, many much earlier than this.
• Infants are more likely to develop secure attachments when their distress is responded to promptly, consistently and appropriately. Secure attachments in infancy are the foundation for good adult mental health.
• Infants whose parents respond and attend to their crying promptly, learn to settle more quickly in the long run, as they become secure in the knowledge that their needs for emotional comfort will be met.
• The demands of Western lifestyle and some "expert" advice has led to an expectation that all infants and young children should sleep through the night from the early months or even weeks. In fact infants have the potential to arouse more often in the night than older children or adults because their sleep patterns are much shorter. These short sleep cycles allow infants to experience more REM sleep, which is considered to be very important for their brain development.
• Many parents become distressed and exhausted when their infants and young children cry at night, in part because of the physical strain of getting up and going to their babies to re-settle them, and sometimes in part because of the unrealistic expectation that babies "should" sleep through the night.
• Many infants and parents sleep best when they sleep together. There is no developmental reason why infants should sleep separately from their parents, and in most of the world infants do sleep with their parents or other family members, either in the same bed, or in a cot next to the parents' bed. [Co-sleeping with infants should never occur when a parent is affected by drugs or alcohol, or where the bedding is overly soft]
• The expectation that infants will sleep alone and sleep through the night has arisen out of the needs of Western civilization and the opportunities offered by houses which can afford separate sleeping places for children.
• Many parents find controlled crying helpful and this is one of the reasons for its popularity. For other parents it does not work, or causes so much distress for the parent and the infant that it is discontinued.
• There have been no studies, to our knowledge, such as sleep laboratory studies, which assess the physiological stress levels of infants who undergo controlled crying, or its emotional or psychological impact on the developing child

(continues next page)

AAIMH - Controlled Crying Principles (draft):

- It is normal and healthy for infants and young children to not sleep through the night and to need attention from parents. This should not be labeled a disorder except where it is clearly outside the usual patterns.
- Parents should be reassured that attending to their infant's needs/crying will not cause a lasting "habit".
- Waking in older infants and young children may be due to separation anxiety, and in these cases sleeping with or next to a parent is a valid option. This often enables all to get a good night's sleep.
- Any methods to assist parents to get a good night's sleep should prioritise the infant's developmental and emotional needs.
- If "controlled crying" is to be used it would be most appropriate after the child has an understanding of the meaning of the parent's words, to know that the parent will be coming back and to be able to feel safe without the parent's presence. Developmentally this takes about three years.
- A full professional assessment of the child's health, and child and family relationships should be undertaken before initiating a controlled crying program. This should include an assessment of whether in fact the infant's crying is outside of normal levels. All efforts should be made to link parents with community supports to minimise the isolation and frustration felt by many parents when caring for a new child. Other strategies, apart from controlled crying, should always be discussed with parents as preferable options.
- If an infant or child has already experienced separation from a parent due to sickness, parent absence or adoption, or if he or she becomes very distressed the method should not be used. This is because children who have already experienced traumatic separation are more vulnerable to negative effects from theis kind of stress caused by controlled crying.

Where parental stress due to infant crying may lead to risk of abuse it is essential that parents are linked with social supports and therapeutic intervention.
Parents should be told that the method has not been assessed in terms of stress on the infant or the impact on the infant's emotional development.
Where it is used recommendations should be for exercising caution and playing safe.
For example,

- paying attention to level of distress rather than number of minutes baby has to be left to cry

- not continuing with any given technique if it does not feel right

If you have any suggestions or comments regarding this draft, Pam Linke would be delighted to hear from you. Pam can be contacted via e-mail at: linkes@newave.net.au

FROZEN FUTURES:

A Conference Exploring the Effects of Early Stress on Later Outcomes

University of Sydney
Thursday, 14th November – Sunday, 17th November, 2002.

The Registration Brochures for the Annual National Conference, which is being co-sponsored by National Investment for the Early Years (NIFTeY) with AAIMHI will be mailed in July. The Conference is being held at the University of Sydney, Camperdown, and good accommodation at reasonable rates will be available near the University for delegates from interstate. The University is close to Glebe Pt Road which offers food for the mind (Gleebooks), and food for the body (numerous restaurants).

The Conference program is being finalised. Over forty abstracts were received, and a program which reflects the multifaceted work in early childhood being undertaken in Australia and overseas will attract a widely based group of professionals. In addition to the Plenary Sessions given by the Keynote Speakers, there will be concurrent sessions which allow work in the area of Infant Mental Health in Australia to be showcased. Although the standard of the abstracts submitted is uniformly high, grouping the papers into areas of similar topics hopefully will reduce the inevitable conflict of choosing what to attend. The Program will be circulated with the Registration Brochure.

Plenary Sessions include:

- *Developing brains and building minds: the role of prenatal experiences* - Professor Peter Hepper, Professor of Psychology and Director of the Wellcome Trust Fetal Behaviour Research Centre at Queen's University, Belfast.
- *Infant Development; Stress and its effects* - Megan Gunnar, Professor in the Institute of Child Development (ICD) of the University of Minnesota.
- *The Fragile Infant* - Joy Browne, Assistant Professor of Pediatrics, University of Colorado School of Medicine, Department of Pediatrics and Director of the Center for Family and Infant Interaction, JFK Partners.
- *The Effect of Prenatal Cortisol Exposure on the Developing Foetus* – Julie A. Quinlivan Senior Lecturer in Obstetrics and Gynaecology, The University of Melbourne
- *Children in Immigration Detention; Stress and its Developmental Effect*

The Winnicott Lecture will be presented by Professor Bryanne Barnett, Professor of Infant Mental Health, University of NSW.

Because the Conference is being co-sponsored by AAIMHI and NIFTeY, we expect this Conference to provide a unique opportunity to discuss research, clinical work and program development in Infancy in Australia.

Registration Brochures will be mailed to AAIMHI members. However, information about the Conference will also be available from Conference Action, PO Box 576
Crows Nest NSW 1585 Telephone: 02 9437 9333 Facsimile: 02 9901 4586; www.conferenceaction.com.au

Postnatal Opression:

One Therapist's Perspective

By Guy Avisar

Post-natal depression is a valid diagnosis for many mothers. Medication seems a real rescue for those mothers and their babies. However, sticking to a medical approach while ignoring other contextual factors seems to have taken a serious toll on the long-term well-being and self esteem of many mothers. The act of underestimating the cultural, social and psychological aspects of PND is a subtle form of oppression. This is not oppression by intentional action but by inaction combined with certain expectations. I call it oppression since it involves direct and indirect messages that diminish the power of the woman.

Let's have a closer look into the messages to expose how this oppression works.

"You are a victim of a disease" - By pathologising the distress and labeling a woman with PND people probably try to help by making sense of it and then control it by medication. Unfortunately labeling is often a way to keep professional distance from the person and prevent the human touch that is so much in need at this time. The community maintains this distance by sticking to scientific / medical approach resulting in medication rather then offering a social support. The woman from now on is locked into a set of expectations and beliefs and the label takes over. Years later this label may still colour the chapter of their early experience of parenting with guilt and shame.

"You fail to cope independently" - Mothers are expected to cope alone with the extremely challenging task of looking after a baby (crying, sleep deprivation). Obviously this is an unreasonable expectation. When they find it hard to cope alone they feel like they failed to live up to the cultural ethos of independence. They are defeated. Their sense of competence diminished. Rather then support they receive criticism.

"Intense emotions are bad" - Mothers are often blamed by partners and others for being overemotional as if rational is good and emotional is bad. Crying out one's distress is perceived as a sign of weakness, of failure to cope.

"If only you acted on our advice (e.g. "controlled crying")" Many mothers constantly get the message that only if they had followed advice and acted consistently the problem would be solved. Unfortunately some mothers end up believing that either something is wrong with them or with their babies if the problem persists. This is a blow to their self-esteem.

To my view while some mothers benefit from the rational-medical-scientific-authoritative approach some turn to be victims of it. This approach emphasises biological aspects rather then cultural, social and personal ones. The underlying oppressive assumption is that it is all either in their mind or in their body. It conveys the message that it is really all up to the mother and our job as a community is minor. We further say that there are many mothers out there who can prove that you can cope alone. These social-cultural expectations expose the mothers as vulnerable and bring many of them to a sense of guilt, failure and isolation. To me it is nothing but oppression.

My suggestion here is to turn away from this medical approach towards more holistic and preventative one; one that takes into consideration psychological, social and cultural aspects of the experience of birth. Recent studies on PND have showed that it is culturally bound syndrome and its onset is associated with social stressors.

Such holistic approach will look comprehensively into the needs of mothers after birth in order to address them effectively. Birth has traditionally been a tribal event and only modern life brought us to experience it as a matter of the individual. The most pressing need of a mother after birth is to be surrounded by social support. In a most dramatic transition the mother changes her entire focus from herself and her partner into her baby. She now needs someone to emotionally feed her. Understanding this process and acknowledgement of mother's needs might bring us all to stress the importance of solidarity.

Solidarity is about interdependence rather than independence, about connectedness rather then individualism, about the path of the heart rather than the path of rational economy. The resulting liberating message is this: "During infancy stage your needs for security, emotional support and attachment are pretty parallel in their intensity to those of your baby. Therefore it is absolutely valid and legitimate that you seek social support during this developmental stage. Your grief over the loss of social roles and parts of identity is normal and natural. The job of your partner, your family and your community is to understand your experience and be there for you. That is, to be responsive, accepting and supportive and let you discharge your emotions. This is the child's right to have a mother whose needs are met and this is your ultimate right to work towards meeting this goal".

Yes, There is an Alternative to Controlled Crying

Bedtime and sleep problems take a great emotional toll from parents all around the world. The search for solutions involves scientific facts as well as values, beliefs and personal feelings. In Australia I found the technique called "Controlled crying" to be highly popular among professionals. For parents, however, it is far less popular. Many of them find it extremely disturbing to let the child cry for as long as 1-3 hours. It is quite understandable when one thinks, for example, about

the mother of a 4-year-old girl who acted on the advice to close the door and let the girl cry. That intervention resulted in a situation that was too hard for the parents to contain: their girl screamed, kicked the door, vomited and so on. It lasted 4 nights one after another, each time for more than an hour, until the parents had enough of it.

In the last years I have tried to help hundreds of parents, as groups and as individuals, to deal with bedtime related problems. The vast majority of them would say straight away that they have tried the controlled crying technique and they don't want to hear about it.

So, I offer them an alternative technique to controlled crying, which I call "Reassurance technique". Often the parents are pleased with the procedure and wonder how come parents don't get to hear more about that. With this encouraging response I now wish to share this procedure with many more parents. Like any other technique I don't believe this one is the ultimate one, but should be one of the tools available to parents.

Since how we understand and interpret the behavior of our children affects the way we respond to them I would like to start by suggesting a way to understand the problem. In the majority of cases bedtime problems (like many others in my view) occur as a result of fears rather than manipulations to have parents' attention. All young children have a common fear and this is the fear to be left alone, to be abandoned. This fear is essential for their survival because they are dependent on the adult. If we acknowledge that fact then our job would be to reassure them that they are safe and they are not alone. This is why I call it "Reassurance technique", as its goal is to reassure the child he is not alone and he is safe. The core idea of the reassurance technique is that we "make a deal" with the child: we give something to him and he gives something in return. Our part in the deal would be to come back to him time and again in a pace that would allow him to increasingly tolerate the time he stays on his own. All it takes from the parents is a fair bit of walking. Good physical exercise! The child's part in the deal would be to stay in bed. The power of this technique is in the message it conveys to the child: "You don't need to do anything to make me come back to you. You can feel safe, trust and let go".

Let's discuss in more details the procedure for 2 age groups. For children older than 18 months: Once the child is in bed and ready to sleep, explain to the child that you are going to come back to see that he is fine until he falls asleep. Say that you will continue to come back as long as he stays in bed. Check with him if he understood the procedure. Leave the room with the door open and stay close so he can't see you. After 3 seconds approach the child and say: "you see, I am always coming back as I promised. Well done for staying in bed". Engage in a very brief interaction and leave the room. Now stay outside for 5 seconds and then repeat the process. In the third time stop your engagement with the child and simply demonstrate you continue to check he is fine as you promised. Now gradually increase the time you stay outside. Be sensitive about the length of time. Roughly double the time each time. How long it will take before he falls asleep depends on the history of the problem. You can expect that in the first evening it may take 30 minutes before he is calm and reassured enough to let go and fall asleep. This means you will be walking in-out during that time. In the following evenings the child is likely to fall asleep earlier each time. What if the child gets out of bed? Remind him that you continue to come back only as long as he stays in bed. If the child is unimpressed threaten to close the door. If he is still out of bed close the door for 10 seconds and then open it. Say:" this is what I am going to do if you don't stay in bed. Now go back to your bed and I am continue to come back to see that you are okay". Continue with the procedure.

For children under 18 months: Apply the same principles with one important difference. Since babies respond better to touch we will use the sensual modality for reassurance rather than visual one. Tap the baby for 5 times and have a break of 1 second then tap again 5 times and have a break of 3 seconds. Repeat the same number of taps while gradually increase the time between the patting.

To succeed in this technique remember this key point: Always come back before he fails to tolerate your absence. So be sensitive to his time perception.

Here are some points by which Reassurance technique is different to controlled crying:

The cause of the problem is neither bad behaviours nor bad habits but normal fears that need to be addressed.

The goal of the intervention is to instill the belief "I am safe" rather than teach self-settling.

It is a proactive approach rather than reactive one in the sense that you don't wait for the child to call you. You are in control and you take action to deal with his fears. The technique takes into major consideration the child's inability to grasp correctly time span.

I believe this technique is appealing to parents because it regards the children as fearful, weak and dependent rather than manipulative, controlling and tyrant. Child rearing is not a story about power struggles but about understanding, giving and teaching.

Guy Avisar is a psychologist with 15 years experience working with families. Guy's private practice is in Elwood, Victoria, and he can be contacted on 0403-352056.

The Enduring Consequences of Trauma and Neglect:

A Case for Prevention and Early Intervention

Report from:

U.K. Association of Infant Mental Health Annual Conference and AGM, London, March 13th, 2001

Report by Ms. Sarah Jones

It has been said that America and England are two English speaking countries divided by a common language. This was not the case at all at the recent UK Association of Infant Mental Health's annual conference. In fact there were many languages within the multi-disciplined audience; none of them divided on the need for a greater appreciation of infants' responses to trauma. The day was focused on the work of Americans Janet Dean and Mary-Sue Moore, Infant Mental Health consultants from Colorado. The audience of members of UK AIMH and guests had a very rich opportunity to observe and consider the myriad of ways infants communicate. The one-day conference provided an excellent opportunity to consider the questions of how do infants respond to trauma; i.e what is their 'language'. It also allowed us learn what interventions are possible with parents and infants. This report will give an overview of the day.

- Ms. Janet Dean, Clinical Director, Community Infant Program, Boulder Colorado

Janet, Clinical Social Worker and Infant Mental Health consultant, provides consultation and training to infant programs in many parts of the United States. She is a most popular speaker at Australian AAIMH conferences. She has also been a visiting scholar at the Royal Children's Hospital in Melbourne and consulted to that state's Victorian Department of Social Services. Janet began her professional life by working with the internationally respected Paediatrician Dr. Henry Kempe. His early work in understanding and diagnosis of child abuse lead to the medical professions formal recognition of child abuse and neglect.

Over the last eighteen years ago Janet developed one of Boulder's first community based infant programs The program incorporates a team of workers whose perspectives include psychoanalytic thinking, family systems approaches and developmental models. Staff includes mental health social workers, health visitors and midwives, clinical psychologists and psychotherapists. Most of the work is home based, and their approach draws heavily on the work of Freighberg, Kempe, Barnard and Olds. The program takes referrals from all hospital and social service agencies, most infants seen accepted on to the program are under nine months.

- Dr. Mary-Sue Moore is a Clinical Psychologist Boulder Institute for Psychotherapy and Research

Mary-Sue,Psychologist and Child Psychotherapist, has many years of experience both in America and England in infant mental health clinical practice, teaching and writing. She has also been a consultant/supervisor to the Boulder Community Infant Program. She has been a plenary speaker at many international forums, including Australia's Association of Infant Mental Health annual conferences. She also consults to many agencies and organisations. Having established the Boulder Institute for Psychotherapy and Research, and being an Honorary Senior Psychotherapist with the Child and Family Department at the Tavistock Clinic, London, she also has an international reputation in this field.

UNDERSTANDING MORE ABOUT THE IMPACT OF TRAUMA ON THE INFANT'S BRAIN AND THE INFANT'S MIND.

The major themes of the workshop focused on helping professionals understand more about the impact of trauma on the infant's brain and the infant's mind. Quite an agenda for the speakers, given the mixed audience and the complexity of the topic. Janet set the scene by describing the context of her program and introducing the questions

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Sarah Jones, from Victoria, spent the first half of 2001 in England. She is active in AAIMHI, having been most recently co-editor of the newsletter. She reports here on the United Kingdom AGM held in March 2001, at the Royal Free Hospital. Given the recent tragic events in New York the themes of the workshop have become even more significant and relevant to everyday clinical practice.

Sarah Jones
Psychotherapist,
Private Practice and Mental Health Clinician,
Royal Children's Hospital, Melbourne, Australia

and the purpose of the day. Primarily the seminar focused on thinking about interventions for infants and their parents, in order to allow the infant and parent to alter their relationship experiences following trauma.

Community Infant Program, Boulder, Colorado

The program has developed a bio-psychosocial model, which incorporates many different beliefs and approaches to working with infants, creating a richer program than a model where one approach dominates. Most of the work is home based interventions. The agency invests in supervision for all its therapists, video-taping interviews allows for them to develop their specialist skills. As video-taping and reviewing is used as an essential part of the program workers are all trained specifically in the uses of such tools.

The Work and its Impact on Staff

Janet discussed how important it is for professional involved in clinical work with infants to be very attuned to their own somatic experiences in order to integrate many of the aspects of the infants' experience. The subtle ways of parent-infant interactions are so complex that the therapists need to be constantly reviewing and revising their interventions and knowledge. She feels video-tape analysis enables this process of learning. She emphasised how important good supervision and organisation support is essential for professionals working with infants.
Janet also proposed it is the workers' brains that will be developed by this work, not just the infants. "If we can hold in our own minds the capacity to work with traumatised infants we must develop a part of our minds which can be very sensitised to the micro-interactions we will be exposed to". She said that there are enduring consequences for us to develop our own capacities for such work. Through the work we will keep changing our own brains; by attending to the interactions we observe we begin to notice and make sense of clinical phenomena differently.

Summary of work presented by Mary-Sue Moore and Janet Dean.

1. The Infant's developing brain:

In order to understand how the infant responds to traumatic experiences we need to know more about how infant's brains develop. The infant's interaction with a parent/ caregiver has the potential to be arousing and soothing. Both kinds of responses will, over time, impinge on the infant's brain.

When an infant is born she will use both hemispheres of her brain. The right hemisphere allows her to become skilled at facial expressions, recognising negative affect etc. The left hemisphere allows her to learn from experience, think and make plans for the future. The infant learns to recognise the secure/safe individual and to discern the threatening stimuli/individuals. Facial expression recognition is one of the earliest capacities an infant develops. Memory is not a one sided unitary process. Various levels of memory are processed, and located in different parts of the brain.

2. Preparation for survival & the need for physical safety and connectedness.

Using ideas from Ainsworth and Main's work on attachment, infants are seen to have survival responses in the earliest interactions and relationships. Infants' need for proximity to caregivers is as strong as the need for food, oxygen and water. Physical survival for human beings comes before psychological survival. The infant's body and her brain learn interactively with the environment. For example an infant who recognises her mother is more likely to demonstrate ways of staying close to her mother, thus promoting her survival. An infant who can not discriminate between caregivers is more at risk of harm.

Infants are born with a capacity for attachment. Infants like all other humans have a primary need to be physically safe and nurtured. It is one of the primary mechanisms of human behaviour. We can see from observational studies that most infants have very attuned mechanisms to achieve safety and connectedness from their caregivers. Crying is one way of achieving this in a healthy child. However if crying creates an adverse response from the parent the infant may quickly subdue this approach, if it is perceived to be dangerous by negatively arousing the parent.

3. Procedural memories

Procedural memory is one mechanism by which the infant, through repeated experiences/procedures, develops internal mental representations of attachment figures. Through this she begins to achieve physical and psychological safety. Procedural_memories underpin attachment to caregivers. Infants develop the capacity for "reading" (discriminating) or "leading" interactive processes. They do this by the use of facial expressions, movements of their body and expressions of affect. When caregivers respond to these messages in a complimentary way, the infant may repeat them to gain the same effect. When hungry an infant may know if she opens her mouth and moves her head she may be offered a teat or a nipple to satisfy her hunger. Through the application of procedural memory this behaviour is repeated and the infant begins to develop her own sense of agency through such successful series of interactions. Infant traits are developed through sequential procedures/memories, which induce appropriate responses from an attuned caregiver. If the caregiver is non-attuned or perceived as threatening by the infant, that stimulus may induce the infant to respond in other ways which appear not to threaten/over stimulate the caregiver further. An example may be that when the infant perceives such a threat is to avoid the caregiver's gaze, become vigilant. Procedural memories develop in the unconscious; thus influencing our object relations templates.

4. Bruce Perry's work: Infants' capacity for flight, freeze and fright mechanisms

Bruce Perry demonstrates how the infant is born with the capacity for:

i. fight
ii. flight
iii. freeze

The freeze response is one of the ways infants will respond to threatening stimuli. When flight or fight will not work on her behalf, i.e. would increase danger, then her mind and body will produce a freeze response. As the very young infant does not have much capacity for the first two responses she may freeze all her responses, as this may appear to produce the best likelihood for her survival. The repeated use of this kind of response kind is now being able to be seen on brain imagining technology.

5. Brain imaging demonstrates impact of trauma brain:

From birth the infant has a partially functional brain. Brain imaging can see structural changes in the brain of the parts of the brain that are being used. The brain is use dependent, which means that the infants' repeated use of some mechanisms will enhance those responses, and the underdevelopment of other mechanisms/responses means the infant may not develop the neurological pathways of the normal infant.

With the advent of brain imaging technology we can now demonstrate how trauma can influence young brains. The influence of continuous adverse events like trauma, can been seen on brain stem images. If the brain stem is over-stressed or over used, as it is when there the infant has had repeated traumatic responses to externally threatening stimuli the images of the brain are different from infants who have not had these experiences.

6. Self-regulation capacities

One of the first tasks for the infant is to develop a capacity to self-regulate. The infant is helped to develop self-regulation by attuned caregivers, who can anticipate and predict what will give the infant pleasure. The infant is also helped to 'down-regulate' so that she is not overly stimulated and becomes disorganised and distressed. The emotional environment has a major part to play in how the infant develops these capacities. If the caregivers are not able to read the infants cues or give ambiguous or ambivalent messages back to the infant she may have greater difficulty in learning how to regulate her affect, her body and her responses. Gaze is a highly arousing experience, it is very difficult to look straight into someone's eyes when in conflict with them.
With the example of gaze avoidance, we can discern how the infant may use this response as a way to self-regulate. The infant protects herself by avoiding the intensity of caregiver contact. What can be captured easily on video is the way the infant finds a gaze, then a response gets activated, increase arousal, then when this is in conflicting state, the infant down regulates by averting her eyes. Infant then looks back when arousal is less disturbing.

7. Impact of Traumatic environments

Traumatic environments, where the caregivers are perceived as threatening are very problematic for infants. In the example of a drug-abusing mother the infant may on some occasions see a 'safe mummy' and on others see a 'dangerous mummy'. The infant will find this inconsistency very difficult to read; one response maybe to dissociate or to become vigilant of her mother. The watchful infant is using one side of her brain, which is at the cost to her developing the other sides. She does this because it is necessary for her survival. The loss or absence of spontaneous synchronicity with in the mother-infant dyad can have long lasting effects on the infant. Her procedural memory may be one of heightened suspicion of close attachments, because of the dangerousness in the unpredictability of caregivers. Use dependent brain patterning may mean that the infant's personal style/ temperament will be by emotionally withholding in the unpredictably anticipated threat of the caregiver being both the nurturing loving mother but also the threatening mother.

9. Abusive responses from parents; why?

Attacks on infants come about from a deeply perceived sense of threat from the parent-caregiver. The parent/ caregiver sees the infant as something that will deeply hurt/ attack her; a threat to mother herself. The parent develops such a distortion in the transference that there is an enactment by the adult to the child. This leads to thoughts that the child must be controlled, damaged, distanced from or abused purposefully in order for the parent to protect herself further from the intense feelings being generated by the parent-infant relationship. The professional worker themselves may receive a similar transference by the parent. The worker may be seen as an object that will damage/threaten the parent.

Using the ideas above we can see that sometimes a parent's intent is not to be abusive but their own mismatched interactions with their infant create great distress. The infant who uses gaze avoidance to protect herself from the distress may inadvertently be activating something distressing for her parent.

Example 1.

The infant who down regulates/gaze averts may induce in the parent anxiety about feeling rejected. The parent then pursues her infant, out of her own need to be validated by the infant. These kinds of interactions set a template for non-attuned parent-infant behavioural sequences, and unconscious processes. Infant traits are being developed during these sequences, procedures and memories, which are repeatedly inducing inappropriate parent-infant relationship patterns.

Example 2.

A Mother with no controls over her own regulatory behaviours brings about a series of disturbing interactions. Baby then anticipates something dreadful will happen, and becomes hyper-vigilant with vigilant eye responses. Mother's severe and distorted transference to the baby,

induces the infant to dissociated state when she perceives danger. She does this in part to de-escalate the sensory input from the threatening parent.

CASE EXAMPLE AND INTERVENTION

Video material of clinical work with a lethargic infant was presented.
A four week old infant was taken to local clinic by parents to see the doctor and Health Visitor.
Infant in physical danger zone due to continuing weight loss, parents seen as co-operative were the referral details. Normal health education interventions by professional staff seen as failing, eg. feeding and baby's development advice. Paediatrician who sees the child becomes more concerned, and all staff's anxiety increased. Referral to Community Infant Program and seen by Janet Dean. Janet arranges urgent home visit with request that both parents be present. Mother, father and infant are seen on video with Janet talking with the family. The infant is observed as too weak to move, very watchful expression of her face, lack of energy, not able to cry, depressed affect.

Description of interventions

Janet interposes observation of the videotaped interview with a discussion of her interventions with this family. With the use of the video-taped clinical material Janet highlights her most important principles of doing infant-parent assessments.

First, she tells us, we have to bear in mind that these parents themselves are in a heightened state of arousal by the visit from Janet, and will be trying to avoid further negative arousal. They may well fear the outcome of the visit will be removal of the child, and there may well be a negative transference to Janet as a damaging intrusive object. Janet emphasises that everything she does in the interview has to be taken in context of the parents' experience. She tries to develop her own relationship with the parents, by gently making a connection with them, and with the infant, so as not to arouse such anxiety that it interferes with the process. Janet is careful to watch the infant, and the interactions between the infant and parent, and bears in mind what information she has about the referral. She knows the parents themselves were co-operative about seeking help early on, but something has interfered with the normal infant health advice being used. Further weight loss would necessitate an admission to hospital with possibly foster care provision.

Second, Janet emphasises the importance of the father's presence. She suggests that if we do not have fathers, we lose 50% of the available information. She stated how much one can learn from the way the infant is communicating to the different parents, and how much more is available to the therapist when she has access to both parents to aid the therapeutic work. For each individual infant the father-infant relationship can be different from the mother-infant relationship, what strengths are available and from what dyad?

Third, as the presenting problem was feeding difficulties, Janet needed to find a way to engage the parents around this symptom, a very common way infants will show their distress. We watch Janet on video artfully contain the emotions generated by her visit, and by her interest in the 4-week-old infant. Some of the questions she uses to explore the situation are very subtle, and purposefully selected to help the parents reflect on the baby girl, not exacerbate a very threatening experience. Janet obtained some family of origin information by asking the lateral question, "Are you planning to raise your child the way you were raised?" This question elicited information from the mother about not feeling important to her own mother, stating "My mother did not take me seriously".. This was useful in thinking about the role this infant may play in this mother's fantasies of what the child should be to her. It helped Janet to attend to the importance of appearing to take this mother very seriously.

Fourth, Janet talked to us about how useful it is to offer the parents a way to think about the baby, by the therapist speaking for the baby. She described this as helping the parents find their own intuitive voice. With this couple she asked, "What kind of things does she do to let you know she is hungry". Mother responds with a statement that the baby does not look hungry to her. Father offers something a bit more hopeful to work with about the baby's gestures. Janet is trying all the time not to lose the mother's confidence in the process of thinking about what the baby is telling us, but to join enough with the father who has more of a capacity of seeing the infant as a separate person.

Outcome

Janet reported on the outcome of her interviews with the family. Following the early interviews the infant put on weight, coming out of physical danger. Janet summarised that this infant-parent problem was not centrally one of feeding, but one of a distortion in the mothers' own mind of the infant being not interested in her. It was crucial here that Janet attended to the mother's internal representation of the infant as being a threat to her survival, but also working directly with what the infant knows and how the infant was responding. This lead to Janet being able to use her own relationship with the mother/father dyad and bring in the infant and her needs, with out threatening the situation to one of removing the child.

Principles of ifant - parent work

Janet emphasised that some of the basic principles of infant mental health clinical work. She works very much with the notion of starting exactly where the family is when she first meets with them. She questions herself about 'how do I not harm them further? 'What is this family doing to take care of themselves, which may inadvertently be contributing

to the problem? What is the infant telling me about her experience, her current survival responses and what she needs from me? To think about all these things aids the assessment of the infant further

Janet concluded the discussion of this case example by saying the more she works with infants, the more she works non-verbally. By this she means attending to her own internal processes to assess what is happening, to attend to the micro-interactions of the parent-infant dyad, and to watch and wait with acuity. She inverts the well known saying "Don't just stand there, do something," into "Don't just do something, stand there". It is this principle she says helps us

i. to be able to watch by not defending against what we see

ii. gain confidence in our ability to bear some unbearable things, but not resort to over-action

iii. increases our capacity to be with parents and infants in distress, by making us more reflective.

The language of the infant became more accessible during our day with Janet and Mary-Sue. They gave of themselves, articulated their decades of clinical work, and through their superb capacity to talk to a disparate audience enhanced our own understandings of the infant and her many languages.

NETWORK

NSW NETWORK NEWS

NSW BRANCH REPORT

Contact Ian Harrison NSW Secretary:
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NSW has been busy with the organisation for this year's joint conference with NIFTeY. All is coming along well, for more info see the Conference page in this edition.
Our first clinical evening was held in March, Norma Tracy spoke on her experiences running therapeutic parent/ infant groups. On May 29th a workshop by Robyn Dolby covered A B &C attachments. Dr Dolby will follow this up later in the year with a workshop on D attachment.
Zeynip Biringen, who developed the 'Emotional Availability Scale' conducted an introductory workshop on 3rd June and followed this with a three day training workshop for those who wanted to go into the scale in more depth and begin to work towards gaining reliability. We will now be focusing on the conference.

Judith Edwards
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SA NETWORK NEWS

SA BRANCH REPORT

Contact Anita MacPherson SA Secretary: anita.macpherson@dhs.sa.gov.au

The Branch has met twice and formulated a program for the year, which will involve some committee meetings and some general meetings, the first of which will be in June on the subject of sand tray therapy. There is a review of the child protection act in South Australia and the branch will be preparing a submission for this. Robyn Dolby will be visiting South Australia in August at the invitation of the branch, to do some presentations and will be guest speaker at our AGM. We are also arranging for her to go to one major country centre. We are in contact with Alicia Lieberman with a view to her visiting SA and WA in September next year. Ros Powrie has arranged for John Condon to speak at a public lecture night at the Women's and Children's Hospital. Also participating in this is Steven Sheedy and Rama McHaney. The focus of the evening will be working with fathers. This evening will be jointly sponsored by Infant Mental Health and the Women's and Children's Hospital

Advocacy

The controlled crying statement has gone into the this newsletter for use by members as an organizational position. It should of course be reviewed at regular intervals and when new information becomes available. (For example Child and Youth Health in SA will be doing some research into the impact of the controlled crying strategy on infants using cortisol testing later this year.)

Elizabeth Puddy had a letter published in the Adelaide Advertiser about the implication that it is OK for young children in detention to sleep separate from their parents. The South Australian response to the children in detention issues has been submitted to the enquiry. We thank Ros Powrie for her dedicated work on this.

Pam Linke
Branch President
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VICTORIA NETWORK NEWS

VICTORIAN BRANCH REPORT

Our last committee meeting was taken up with planning for 2004 Conference. An exciting discussion elicited lots of ideas. We discussed possible themes and title as well as how to include other child organisations as well as practical issues of hospitality, tourism, and conference dinner. The current committee all expressed enthusiasm in being involved in the management as we get close rot the time.

BJ will report on the conference planning update

Our last Scientific meeting addressed issue of adoption 'Adopting the Subject Some thoughts on the Adoption experience" The speaker Marilyn Gross is a psychoanalyst psychotherapist and an adoptive parent.

The Committee supported the proposal of making an award (e.g. a book) available to students participating in the University of Melbourne Infant Mental Health courses. The award would be granted to the highest achieving student and a condition of the award is that the essay would be published in the AAIMH Newsletter.
We are also slowly trying to develop a draft for the role of advocacy.

We also want to clarify the contacts for the National treasurer. We are concerned that there were difficulties in disseminating information to National Committee.

Michele Meehan
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WA NETWORK NEWS

WA BRANCH REPORT

The committee, although still recuperating from last years conference, continues to operate with enthusiasm and committment wirth new members settling in to their roles with competence and energy. The first terms scientific program included presentations by Carol Bolton "Grannie goes to baby obs", a very personal and insightful look at Carol's recent experiences during a twelve month course of baby observation; a review of one of the Robertson films and a presentation by Carmel Cairney, another local Clinical Psychologist who presented on the impact of parental depression on attachment processes.

Term 2 commences next week with a presentation by Lyn Priddis on her PhD research project looking into the school age assessment of attachment. The monthly meetings are well attended with committee meetings held for one hour prior to the presentation. The accounts are still with the auditor who is taking care of the audit as well as the BAS. The WA PNDPA has invited AAIMHI WA Branch to collaborate in their annual seminar in November 2002. Guest speaker is to be Professor John Condon on the PND and fathers.

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QUEENSLAND NETWORK NEWS

QUEENSLAND BRANCH REPORT

The smallness of our group and low energy levels on the committee persist, so it has been relatively quiet up here. With the scientific program, we started the year by showing three of the Robertson films over consecutive weeks) and they were stimulating as usual. We have decided to buy the 3 shown (a 2 year-old goes to hospital, Jane and John) as a resource for AAIMHQ.

Last week Doreen Westley presented her research done in Melbourne some time ago now on PND and the long term implications for children. There followed an interesting discussion about doing research, an area that needs more activity up here. Our next meeting postponed to August will be locally groups coming together to talk about their activities and aspirations!

Janet Rhind

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