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NEWSLETTER

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FROM THE EDITOR:

Fama nihil est celerius

With our joint conference with NIFTeY around the corner and over 175 lucky people getting in their early bird registrations there is little time for the paper trail. Tongues have been wagging about the exciting program and list of keynote speakers and other thought provoking material that this conference is sure to spark. This editor, expecting the arrival of his first child with Imogen on November 12, has made a request that Imogen hold off for a few days so he wont miss any of the action. Imogen met this request with reserve so I showed her the conference program, she was enthralled, and she is pursuing all domains for staving off of the birth. Now I just have to convince the baby. Perhaps there is a similar technique to Controlled Crying available for keeping baby in the womb. Congratulations to all those responsible for the conference.

The response to our draft statement on Controlled Crying has been dynamic to say the least. In this edition I have included some positive feedback. We did receive some critical feedback, which I will endeavor to publish in the December edition. There is an interesting perspective titled the Secret Cost of Shame by Robin Grill and Beth Macgregor as well as a report on the recent visit by Zaynep Beringen and the workshops she ran on Emotional Availability by Frances Gibson. As well you will find our usual support pieces and information on upcoming events. You will also find the minutes from last years AGM and the agenda for the forthcoming AGM to be held at the conference.

Looking forward to the conference and seeing you all.

Best wishes

Victor Evatt

2002 CALENDAR OF EVENTS

NOVEMBER 2002 (NSW)

16 November:

AAIMH Annual General Meeting
(see Page 21 for details)

14 - 16 November:

AAIMH NSW & NIFTeY Joint Conference

18 - 21 November:

Attachment in Adolescence: Seminar / Workshop
(see Page 13 for details)

MARCH 2003 (London, UK)

13 - 14 March:

International Conference on Infant Development in Neonatal Intensive Care
(see Page 23 - 24 for details)

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• AAIMH Position Paper

'Good Children' - At What Price?

The Secret Cost of Shame

By Robin Grill and Beth Macgregor

A five-month old baby is lying in his mother's arms. He is close to sleep, then wakes and begins to grizzle. His mother tells him that he should stop being a naughty boy, and that she will be cross with him if he doesn't sleep.

An 18 month-old child is taken to a restaurant with her father and uncle. Her father goes to the bar, leaving the child with the uncle at the table. The child gets down from the table to follow her father. She is grabbed by her uncle and told that she is a bad child, and to stay in her chair. She looks around worriedly for her father.

At an adult's birthday party a six-year old is awake long past his bedtime. He is running around the hall with the helium-filled balloons. His father yells at him to leave the balloons alone, and tells him to stop being a trouble-maker.

What did these children learn from these experiences? Many would say that the adults' responses were necessary to teach the child the difference between right and wrong: between 'good' and 'bad' behaviour. Verbal punishment is common in almost every home and school. It relies on shame as the deterrent, in the same way that corporal punishment relies on pain. Shaming is one of the most common methods used to regulate children's behaviour. But what if shaming our children is harming our children? Could it be that repeated verbal punishment leaves children with an enduring sense of themselves as inherently 'bad'? If so, what can we do differently.

What is a 'shame'?

Shame is designed to cause children to curtail behaviour through negative thoughts and feelings about themselves. It involves a comment – direct or indirect - about what the child *is*. Shaming operates by giving children a negative image about their *selves* - rather than about the impact of their behaviour.

What does shaming look and sound like ?

Shaming makes the child wrong for *feeling, wanting* or *needing* something. It can take many forms, here are some everyday examples: The put-down: 'you naughty boy!', 'you're acting like a spoilt child!', 'you selfish brat!', 'you cry-baby!'. Moralising: 'good little boys don't act that way', 'you've been a bad little girl'. The age-based expectation: 'grow up!', 'stop acting like a baby!', 'big boys don't cry', The gender-based expectation: 'toughen-up!', 'don't be a sissy!', The competency-based expectation: 'You're hopeless!'. The comparison: 'Why can't you be more like so-and-so?', 'None of the other kids are acting like you are'.

How common is shaming ?

Shaming is very common, and is considered by many to be acceptable. Shaming is not restricted to 'abusive' families, in fact it occurs in the 'nicest' of family and school environments. A recent study of Canadian schoolchildren, for instance, found that only 4% had *not* been the targets of their parents' shaming; including "rejecting, demeaning, terrorising, criticising (destructively), or insulting statements".

As parents we tend to resort to shaming when we feel overwhelmed, irritated or frustrated, and we feel the need to control our children. Until very recently little consideration has been given to its harmful effects.

Shame: a new frontier of psychological study

The use of corporal punishment against children has been hotly debated, and under increasing negative scrutiny in recent years. More and more nations legislate against it, schools ban it, international organisations devoted to its elimination are proliferating, and research psychologists have amassed mountains of evidence of its long-term damaging effects. In the meantime, the issue of 'shaming' as punishment has been largely overlooked. Only recently have psychologists begun to discover that shaming has serious repercussions.

Daniel Goldman (author of 'Emotional Intelligence') says that we are now discovering the role that shame plays in relationship difficulties and violent behaviour. There is a new effort by psychologists to study shame, how it is acquired, and lastly, how it affects a person's relationships and functioning in society. The study of this previously 'ignored emotion' is such a new frontier because it is the most difficult emotion to detect in others. Dr Paul Eckman, from the University of California, says that shame is the most private of emotions, and that humans have yet to evolve a facial expression that clearly communicates it.

Is this why we might not see when our children are suffering from this secret emotion?

Is there a place for shame?

It's not that shame is always undesirable, but that shaming is used too much, and used inappropriately. In his book 'Healing The Shame That Binds You' theologian and psychotherapist John Bradshaw suggests that 'healthy shame' comes from being clearly shown the impact that our actions have on our relationships – it doesn't come from being called names like 'naughty' or 'bad'. Shame can have a healthy role for those who are old enough to be fully responsible for their actions. For instance, teenage or adult offenders cannot be rehabilitated unless they feel genuine shame for their offences.

How shame is acquired

No-one is born ashamed. It is a learned, self-conscious emotion, which starts at roughly two years of age with the advent of language and self-image. Although humans are born with a *capacity* for shame, the propensity to become ashamed in specific situations is *learned.*

This means that wherever there is shame, there has been a shamer. We learn to be ashamed of ourselves because someone of significance in our lives put us to shame. Shaming messages are more powerful when they come from those we are closest to, from people we love, admire or look up to. That is why parents' use of shaming can have the deepest effects on children.

However, shaming messages from teachers, older siblings and peers can also injure children's self-image. Since children are more vulnerable and impressionable than adults, shaming messages received in childhood are significantly more difficult to erase.

Messages of shame are mostly verbal, but there can be great shaming power in a look of disdain, contempt, or disgust.

Why shaming is so common?

Shaming acts as a pressure valve to relieve parental frustration. Shaming is anger-release for the parent, it makes the shamer feel better - if only momentarily.

When made to feel unworthy, children often work extra hard to please their parents. This makes the parent think that the shaming has 'worked'. But has it?

SO, WHAT IS WRONG WITH SHAMING?
The Damaging Effects of Shaming

To understand the damage wrought by shame, we need to look deeper than the goal of 'good' behaviour. If we think that verbal punishment has 'worked' because it changed what the child is doing, then we have dangerously limited our view of the child to the *behaviours* that we can *see.* It is all too easy to overlook the inner world of children; the emotions that underlie their behaviour and the suffering caused by shame. It is also easy to miss what the child does once out of range of the shamer!

Even well-meaning adults can sometimes underestimate children's sensitivity to shaming language. There is mounting evidence that some of the words used to scold children - household words previously thought 'harmless' - have the power to puncture children's self-esteem for years to come. Children's self-identity is shaped around the things they hear about themselves. A ten-year old girl, for example, was overcome with anxiety after spilling a drink. She exclaimed over and over: 'I'm so stupid! I'm so stupid!' These were the exact words her mother had used against her. She lived in fear of her parents' judgement, and learned to shame herself in the same way that she had been shamed.

If children's emotional needs are dismissed, if their experiences are trivialised, they grow up feeling unimportant. If they are told that they are 'bad and naughty', they absorb this message and take this belief into adulthood.

Shame makes people feel diminished. It is a fear of being exposed; and leads to withdrawal from relationships. Shaming creates a feeling of powerlessness to act, and to express oneself: we want to dance, but we're stopped by memories of being told not to be 'so childish'. We seek pleasure, but we're inhibited by inner voices telling us we are 'self-indulgent' or 'lazy'. We strive to excel, or to speak out, but we're held back by a suspicion that we are not good enough. Shame takes the shape of the inner voices and images that mimic those who told us 'don't be stupid', or 'don't be silly'!

Shame restrains children's self-expression: having felt the sting of an adult's negative judgement, the shamed child censors herself in order to escape being branded as 'naughty' or 'bad'. Shame crushes children's natural exuberance, their curiosity, and their desire to do things by themselves.

Thomas Scheff, a sociologist at the University of California, has said that shame inhibits the expression of all emotions – with the occasional exception of anger. People who feel shamed tend toward two polarities of expression: emotional muteness and paralysis, or bouts of hostility and rage. Some swing from one to the other.

Like crying for sadness, and shouting for anger, most emotions have a physical expression which allows them to dissipate. Shame doesn't. This is why the effects of shame last well into the long term.

Recent research tells us that shame motivates people to withdraw from relationships, and to become isolated. Moreover, the shamed tend to feel humiliated and disapproved of by others, which can lead to hostility, even fury. Numerous studies link shame with a desire to punish others. When angry, shamed individuals are more likely to be malevolent, indirectly aggressive or self-destructive.

Psychiatry lecturer, Dr Peter Loader, says that people cover up or compensate for deep feelings of shame with attitudes of contempt, superiority, domineering or bullying, self-deprecation, and obsessive perfectionism.

Severe shame and mental illness

When shaming has been severe or extreme, it can contribute to the development of mental illness. This link has been underestimated until now. Researchers are increasingly finding connections between early childhood shaming and conditions such as Depression, Anxiety, Personality Disorders, and Obsessive Compulsive Disorder. In his book, 'The Psychology of Shame', G. Kaufman goes further to assert a link between shaming and addictive disorders, eating disorders, phobias and sexual dysfunction.

WHY SHAMING DOESN'T WORK

Shame doesn't teach about relationship or empathy.

While shaming has the power to control behaviour, it does not have the power to teach empathy. When we repeatedly label a child 'naughty' or otherwise, we condition them to focus inwardly, they become pre-occupied with themselves and their failure to please. Thus children learn to label themselves, but learn nothing about relating; about considering or comprehending the feelings of others. For empathy to develop, children need to be shown how others feel. In calling children 'naughty', for example, we have told the child nothing about how *we* feel in response to their behaviour. Children cannot learn about caring for others' feelings, nor about how their behaviour impacts on others, while they are thinking: 'there is something wrong with me'. In fact, psychotherapists and researchers are finding that individuals who are more prone to shame, are less capable of empathy toward others, and more self-preoccupied.

The only true basis for morality is a deeply felt empathy toward the feelings of others. Empathy is not necessarily what drives the 'well-behaved' 'good boy' or 'good girl'.

The myth of morality

We are naïve to confuse shame-based compliance with morally motivated behaviour. At best, repeated shaming leads to a shallow conformism, based on escaping disapproval and seeking rewards. The child learns to avoid punishment by becoming submissive and compliant. The charade of 'good manners' is not necessarily grounded in real interpersonal respect.

DECONSTRUCTING SHAME

What should we consider shameful?

Shame varies among cultures and families: what is considered shameful in one place may be permissible, un-remarkable, even desirable in another. What is called 'naughty behaviour' is usually arbitrary and subjective: it varies significantly from family to family.

In one family, nudity is acceptable, in another unthinkable. Being noisy and boisterous is welcome in one family, frowned upon in another. While one family might enjoy speaking all at once around the dinner table, another family might find this rude. Such examples help us to realise that our way is not the only way: that our own way of deciding what is shameful behaviour can be arbitrary and variable.

The history of Shaming

Children have been shamed for many hundreds of years. Historically, they have been thought to be inherently antisocial, and their behaviour was seen through this lens. One seventeenth century author wrote: "the newborn babe is full of the stains and pollution of sin, which it inherits from our first parents through our loins". In the Middle Ages, the ritual of Baptism actually included the exorcism of the devil from the child. Children who were felt to be too demanding were thought to be possessed by demons. Some early church fathers declared that if a baby cried more than a little, she was committing a sin. It has been an age-old tradition to blame the child for the numerous challenges and difficulties encountered by parents.

This way of thinking about children has persisted into modern times, although in less extreme ways. For example, a child having a tantrum is often seen as 'spoilt', and deliberately trying to antagonise his parents. A crying child risks being described as a 'little terror' or 'whinger' who is 'just trying to get attention'.

There is no question that parenting can be frustrating sometimes. But it is groundless to automatically assume that the child is out to upset us, or to attribute some kind

of nasty intention to the child. This imagined malevolence is usually what underlies the impulse to shame children.

A SHIFT IN ATTITUDE

Respecting the child

It is entirely possible to set strong boundaries with children without shaming. However, this requires a fundamental attitude shift, beginning with re-evaluating what we *think* is motivating our children's behaviour.

Children have a natural desire to develop a social conscience. When treated with the same respect as adults, and exposed to adults who respect each other; children will *naturally* develop a capacity for empathic, caring and respectful behavior.

'Misbehaviour' - or developmental stage?

Sometimes what we condemn as 'misbehaviour' is simply the child's attempt to have some need met in the best way they know, or to master a new skill. The more parents can accept this, the less they are tempted to shame children into growing up faster. For instance, it is normal for toddlers to be selfish, possessive, exuberant and curious. It is not unusual for two-year-olds to be unable to wait for something they want, as they don't understand time the way adults do. It is quite ordinary for three year-olds to be sometimes defiant or hostile. If we shame instead of educate, we interrupt a valuable and stage-appropriate learning process, and our own opportunity to learn about the child's needs is lost.

A three year-old who defies her mother by refusing to pack up her toys - after being told to do so repeatedly - may be attempting to forge a separate and distinct self-identity. This includes learning to exercise her assertiveness, and learning to navigate open conflict. Toddlers can be exasperating. But does this mean they're 'misbehaving'?

Strong limits are essential, but if children are shamed for their fledgling and awkward attempts at autonomy, they are prevented from taking a vital step to maturity and confidence. In the period glibly called the 'terrible twos', and for the next couple of years, toddlers are discovering how to set their own boundaries. They are learning to assert their distinct individuality, their sense of will. This is critical if they are to learn how to stand up for themselves, to feel strong enough to assert themselves, and to resist powerful peer pressures later in life. If we persist in crushing their defiance, and shaming children into submission, we teach them that setting boundaries for themselves is not okay.

Even babies are thought to misbehave, such as when they don't sleep when they are told to. How could a five-month old child, for example, possibly be 'naughty' for failing to go to sleep? Though it's difficult for parents when babies experience disturbed sleep, it is nonsensical to see a non-sleeping baby as 'disobeying' the parent, and to blame the baby for this.

Consider the example of an eight month-old who crawls over to something which has flashing lights and interesting sounds. He pulls himself up to it and begins to explore. He does not know that it is his father's prized stereo. He finds himself being tapped on his hand by his mother, who tells him to stop being naughty. He cries. At eight months, a baby is unable to tell the difference between a toy and another's valuable property, and would be incapable of self-restraint if he could. Children's ceaseless curiosity - a frequent target for shaming - is what drives them to learn about the world. When children's exploration is encouraged in a safe way, rather than castigated, their self-confidence grows. Unfortunately, we frequently call a behaviour which may be entirely stage-appropriate 'naughty', simply because it threatens our need for order, or creates a burden for us.

A flustered mother and her distraught four year-old daughter emerge from a local store. The girl is sobbing as she is forcefully strapped into her stroller. 'Stop it, you whinger!' screams the mother, as she shakes her finger in the little girl's face. Children are often berated for simply crying. Many people believe that a crying baby or child is misbehaving. Strong expressions of emotion – such as anger and sadness - are children's natural way of regulating their nervous system, while communicating their needs. Children cry when they are hurting, and they have a right to express this hurt! Even though it is often hard to listen to, it must be remembered that it is a healthy, normal reaction that deserves attention. It is tragic to see how often children are shamed for crying.

Here's a further example of what happens when we are unaware of developmental norms. Until recently, toddlers were started on potty-training far too early, before they were organically capable of voluntary bowel control. Many found this transition to be a battle, and toddlers were commonly shamed and punished for what was a normal inability. What was once a struggle both for parents as for children has been greatly alleviated through more accurate information about childhood development. Shaming often takes place when we try to encourage or force a behaviour that is developmentally too early for the child's age.

We have come a long way in our understanding about child development in recent decades, and made many advances in childcare as a result. Easy-to-read child-development books fill the stores, by authors such as Penelope Leach and William Sears, and these can help parents to have reasonable expectations of their children. Children and parents are both happier when parents have 'reasonable' expectations of the children.

Understanding instead of shaming

Is it possible to *understand* what motivates children when they are 'behaving badly', instead of shaming them? What might 'bad' behaviour be a *reaction* to?

When we don't seek to understand children's bad behaviours, we risk neglecting their needs. For instance, sometimes children repeatedly behave aggressively - over and above what can normally be expected of children their age. This could be due to conflict in the home, bullying at school, or competition with a sibling. Often what we expediently label as 'bad' behaviour, is a vital signal that the child in question might actually be hurting. Research has repeatedly shown that a consistent pattern of antisocial behaviours, for example hostility and bullying, are children's reactions to having felt victimised in some way. Children often 'act out' their hurts aggressively, when they have not found a safe way to show that they have been hurt.

Ironically, shame itself can be the underlying cause of difficult behaviour. Since shaming is a judgement from someone with more power than the child, this makes the child feel small and powerless. Sometimes, children turn the tables: they reclaim this lost power by finding another person to push around - usually someone smaller or more vulnerable than themselves.

Children are usually highly sensitive to the 'vibes' in their environment, they pick up tensions between their parents, or other family members. At times 'naughty' behaviour may be the child's way of reacting to this tension.

Kids are less given to act out when they are receiving enough attention, when their hunger for play, discovery and pleasurable human contact is satisfied. Provocative behaviour can indicate boredom, or perhaps the need for another 'dose' of juicy engagement with someone who is not feeling irritable, someone who has the time and energy to spare.

Finally, children can be grumpy or 'difficult' simply from over-tiredness. In this case, what is dismissed as 'bad' behaviour might be a child's way of saying 'I'm over the edge, and I can't handle it'. Curiously enough, when we as parents react with verbal assaults, we are communicating the same thing. Isn't yelling at children that they are 'naughty' or 'terrible' (or worse) a kind of adult tantrum, a dysfunctional adult way of coping with frustration?

It is worth remembering that some causes of 'misbehaviour' are a lot less obvious. For instance, children need to feel our strength, they are uncomfortable with weakness in our personal boundaries. They need exposure to our true feelings, and they sense when we are hiding or pretending. They need their feelings and opinions validated, and are highly sensitive to poor empathy. Frequently, they react to any of these conditions by becoming provocative. Sometimes we blame and shame children for their vexing behaviour, because the causes are hard to see.

Cultivating empathy: through remembering

Parents often do to their children as was done to them. It is known that violence can be passed down across generations. Many parents realise that they are perpetuating a cycle in which they are shaming their children, in the same ways that they were once shamed by their own parents. Those that have forgotten the sting and humiliation of being shamed, risk being insensitive to the shame they inflict on their own children. Change requires deepening one's empathy toward the child, and this comes from remembering how it felt to *be* a child. The understanding that comes from seeing the world through a child's eyes can help adults to influence children without shaming them.

Managing emotions

As parents, it is not unusual to find ourselves struggling, frazzled, or nearing an emotional boiling-point. When we don't find healthy ways to discharge this frustration, we risk taking it out on our children. Although irritation is a normal part of parenting this is not because children are 'too demanding'. Children are children, and the fact that child-rearing can be difficult is not their fault. There are many ways to re-route our excess anger, such as screaming into a pillow, chopping some wood, going for a walk, or talking our frustration through with friends.

Everyone's capacity for loving patience is finite; that's human. When parents experience excessive strain this is largely due to our adherence to this myth: that it takes just two parents to raise a child. Our society has grossly underestimated the energy required to truly meet children's needs. We can avoid shaming simply by sharing the load - by asking for, and accepting, practical help from trusted friends and community. When we hear ourselves shaming our children, we might take this as a sign that we are needing more assistance.

WHAT DO WE DO NOW ?

A new paradigm for boundary setting

Respectful boundary-setting implies a strong statement about *you*, as opposed to a negative statement about *the child*. In this way, children gradually develop a good capacity to hear and comprehend the feelings of others. Children benefit from open expression of emotions; from seeing when their parents are angry, or upset. It is OK to be angry with your children, to let them see you are

annoyed at something they have done, (as long as you don't shock or terrorise them). Children learn best when they can see the kind of impact that their behaviour has on the feelings of others.

Finally, it helps children to listen to and respect your feelings, if their right to express their feelings is equally respected.

Redirecting the child's impulses

From time to time we are compelled to intervene in our child's activity, when we fear that either a person or a treasured object might get hurt. Shaming can be avoided if, instead of just chastising or stopping the child, we also provide a safer, alternative activity. For instance, occasional aggression is part of normal, balanced healthy development. Children are often shamed and punished for this, when instead they could be shown ways to channel their natural aggression safely.

Sometimes it is important to re-evaluate whether we need to chastise at all. A guideline comes from considering whether the behaviour in question is actually causing harm to anyone, or creating a concrete risk.

The role model

Role-modelling is the most powerful teaching tool. Children don't do what you *say*, they do as you *do*. The kind of respect they show others and themselves is a reflection of the kind of respect they have themselves been shown - and the respect they have witnessed displayed between the important people in their lives. Are we role-modelling the kind of behaviour that we want our children to display?

CONCLUSION:

Many people are still convinced that smacking or shaming are the only antidotes for preventing antisocial behaviours in children. The suggestion of giving up shaming or smacking is misinterpreted by some as attempts to dis-empower parents; to turn them into guilt-laden, ineffectual and permissive wimps. Not so. The most effective and healthy boundaries can be set without resorting to violence or shaming. Being strong with children does not mean being harsh, or humiliating.

There are alternatives to shaming - which are healthier and more effective. Children who are shown consistent boundaries by parents who are able to express their feelings and needs, grow up with stronger self-worth and social awareness, free of the toxic effects of shame.

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Response to controlled crying statement

We have received a number of responses to the controlled crying statement which came to the committee, as well as those which came to the newsletter. Overwhelmingly these were positive. There were three who had criticisms of the statement some of which were very helpful. As we don't have permission to print the letters, which did not come to the newsletter directly, we will not do so but the following is a summary of the points that they made. We encourage people to respond to the editor about any articles in the newsletter as this will help to raise awareness of all the issues around advocacy for infants.

Points made in the three letters

The statement should be referenced. *Thank you for making this point. References will be included with the statement. Although there are currently no studies that we know of that have specifically studied the impact of controlled crying on infants, there are relevant studies that are a basis for the statement. These include studies about separation and stress in infants, as well as relevant cross cultural studies.*

It ignores the genuine need of parents for sleep. *We are planning to develop a paper in the near future offering other options to parents that take into account both parents' and infants' needs. This will accompany the controlled crying statement.*

It ignores the considerable research supporting the effectiveness of controlled crying in improving sleep and decreasing the distress for parents. *This statement is about the impact on infants rather than the effectiveness for parents. It is the other side of the balance from the research about effectiveness for parents. It should be noted that even in supportive studies it is not effective for all families and can be very distressing for some parents as well as for infants.*

It offers no evidence based alternatives. *As stated above we intend to offer some alternatives which are not stressful for babies and which have been shown to be helpful for parents.*

We should make people aware of the controversy about the safety of co-sleeping and caution against co-sleeping if one of the parents is a smoker. *We will re-look at the paper and strengthen the safety aspects regarding smoking and other known risks for co-sleeping.*

The statement is confusing and repetitive. Could definitions be clearly stated with ages and times included. *We will have another look at this aspect of the paper. Although general ages can be given a lot also depends on the individual infant's response so it is difficult to be very prescriptive about this.*

As these letters came to Pam Linke and have not yet been discussed by the committee the responses in italics are my own at this stage and not necessarily those of the AAIMHI committee.
We plan to tidy up the statement in the next few weeks and to promote it, in its final form, at the AAIMHI conference in November. At the same conference we are hoping to do some work on the accompanying paper on other ways to help babies to sleep safely and securely.

Pam Linke
Chair , Advocacy Sub-Committee.

Dear AAIMH
Your draft about the controlled crying technique is a brilliant service for mothers and babies. Please press on with it!!!
Good luck.

Guy Avisar
Psychologist, Victoria

Dear Colleagues
Recently I have begun to rationalise and cut back on all my subscriptions. Partly Due to thinning finances and partly due to the fact that I have been unable to attend the clinical meetings during the past year. I had planned to terminate my AAIMHI subscription. Then the June 2002 newsletter issue arrived.
I am so very pleased with the draft position statement on controlled crying that I have written my cheque for the coming year. In my position as midwife, lactation consultant, women's health nurse, mother and new grandmother I will watch and read the responses and final statement with great interest. The epidemic of controlled crying and other settling programs is an area of increasing concern to me. I do hope that the statement remains strong and that many mothers will benefit from the confidence shown in the ability to follow their own instincts and not be devalued by some 'expert program'.
Keep up the good work.
Kind regards,
Suzanne Murray EM, IBCLC
(International Board Certified Lactation Consultant)
Victoria

Dear Victor,
I both enjoyed the article and agreed with everything in it. I suppose as a dedicated co-sleeper with a baby who is currently delighting us with an 11-hour stretch of sleep every night (with occasional feeds) that is not a surprising position. I think controlled crying is vile, but I keep meeting mums determined to try it... I guess I understand why, but it does upset me when I hear about it. By the way, there are other safety factors to consider when deciding whether to sleep with a baby, including maternal smoking, and the kind of bed (ie no couches or waterbeds) but that is probably stuff for another article.

Anne Southan
Mother of Ned, NSW

Emotional Availability

Report on Sydney Seminar and Workshop

Compiled by Frances Gibson PhD

Earlier this year AAIMHI invited Associate Professor Zeynep Biringen PhD of Human Development and Family Studies, Colorado State University to Sydney to conduct a *Seminar, Workshop and Clinical Consultation* Day (June 2-6 2002) on the use of the Emotional Availability Scales (3RD Edition).

The Emotional Availability Scales (EA) is an observational measure designed to evaluate mother-child interaction across the dimensions of parental sensitivity, structuring, nonintrusiveness and nonhostility in addition to child responsiveness and child involvement of the parent. Presented here is a report on the training and a brief outline of the construct of emotional availability.

There was a strong interest from the AAIMHI membership nationally and participants came from Perth, Adelaide, Brisbane, Melbourne, regional NSW with one international representative from New Zealand. The seminar and workshop were conducted at Liverpool Hospital, Sydney. Over 70 people attended the seminar where the theoretical underpinnings (attachment theory) and dimensions of emotional availability were described as well as the use of the EAS in research and clinical practice. Videotaped case presentations were shown demonstrating the various dimensions of emotional availability.

Thirty five participants attended the EA workshop conducted over 4 days. The workshop was for postgraduates and professionals who planned to use the EA for research or evaluation of services and intervention. Finally a small group met for a consultation day held at the Early Intervention Program at the Benevolent Society, Scarba Family Centre Bondi where selected local video-taped case examples were presented for discussion of procedural and scoring issues.

Assoc. Professor Zeynep Biringen PhD received her doctoral degree in developmental psychology in 1987 from the University of California, Berkeley. She spent the next stage of her career as a MacArthur Postdoctoral Fellow at the University of Colorado Health Sciences Center with Robert N. Emde and Inge Bretherton. She then completed the graduate program in child clinical psychology at the University of Colorado, Boulder, including an APA accredited clinical internship at the Albert Einstein College of Medicine, NY in 1993.

Her research has focused on emotional availability, infant-parent and child-parent attachment, parental attachment representations using the Adult Attachment Interview and Parent Attachment Interview, developmental transitions of infancy, and she is embarking on research to examine the effects of divorce on children. She began developing the Emotional Availability Scales during doctoral work at Berkeley and has been refining it ever since. She consults both within the United States and internationally on the use of this observational system and has developed a training system for this purpose.

AAIMHI would like to acknowledge our thanks to Assoc. Professor Biringen for providing a wonderful training. She revealed a great depth of knowledge in attachment theory, emotional availability and observational methodologies and a very real and warm commitment to developing a deeper understanding of relationships.

Emotional Availability Framework

The following excerpts describing the framework of emotional availability have been reproduced from the manual for the third edition of the EA with the permission of Zeynep Biringen PhD and solely for the purpose of this report (Biringen et al., 3rd ed., 1998).

"Emotional availability (EA) is a method to assess dyadic interactions between a caregiver and an infant or child . . .The caregiver may be either a parent or any adult in the child's life . . .. The EA scales consist of six dimensions of the emotional availability of the parent/caregiver toward the child and of the child toward the parent. The parental dimensions are sensitivity, structuring, nonintrusiveness, and nonhostility, and the child dimensions are the child's responsiveness to the parent and the child's involvement of the parent." Goals of the third edition were to make the scales linear, to separate structuring and non-intrusiveness, and to make the system more user friendly.

Several general but significant points must be made about the emotional availability framework. First, observation of an interaction via the EA framework requires a sensitivity about context. In contrast to approaches using counts of discrete behaviors, EA is a global or holistic judgment by which the observer uses contextual cues and clinical judgment to infer the appropriateness of behaviors. Second, clinical sensitivity of the observer to emotional cues is key. Here we refer not only to the emotional signaling of the parent to the child but also the signaling of the child to the parent. For example, a parent who is behaviorally doing all the right things but is not emotionally present for the child and/or does not appear to receive the child's emotional signaling (including the absence of emotional displays) cannot be viewed as highly sensitive. Emotional signaling is important for all the dimensions of EA. Third, we view all EA dimensions as relationship variables. For example, a given parent is sensitive within

the context of a particular relationship. Thus, we do not believe it accurate to make judgments about a "core" or "trait" of emotional availability, but prefer to view this construct as indexed by particular styles in a relationship context. What the **range** of a particular individual's emotional availability (in the context of different relationships) might be is an interesting research question that remains to be explored.

The foundation for EA assessment comes from the integration of attachment (Ainsworth, Blehar, Waters, & Wall, 1978) and emotional availability perspectives (Emde, 1980; Mahler, Pine, & Bergman, 1975). Emotional availability as described by Emde refers to an individual's emotional responsiveness and affective attunement to another's needs and goals; key is the individual's acceptance of a wide range of emotions rather than responsiveness solely to distressful situations. In a similar vein, Sorce and Emde (1981) contended that it is not simply mother's physical availability but her emotional availability that promotes infant's self-expression. Mahler et al. (1975) used the term "emotional availability" to describe a supportive maternal presence in the context of the child's exploratory forays and practicing of autonomy. In their view, the mother's "quiet supportiveness" signals her encouragement and acceptance of such explorations, and of the child's returns for emotional refueling. Mother facilitates the child's explorations, and her emotional availability provides a secure base for the child.

The attachment view is also integral, yet recast into an **emotional** framework. On the parental side, the construct of parental sensitivity has been heavily influenced by Ainsworth's conceptualization of sensitivity as responsiveness to infant signals and communications. Yet there are notable exceptions (and in some cases, additions) to her view. First, the EA sensitivity assessment is broad in that it includes all the qualities described by Ainsworth as well as the role of affect and conflict regulation. The role of affect, appropriate affect in particular, is key. How the parent not only picks up the emotional signals of the child but also emits his/her own emotion signals is important. For example, a parent who acted very warmly can be viewed as highly sensitive if and only if the parent's affect is genuine rather than pseudo- or forced-positive **and only if the parent appears to be picking up the child's emotion signals and taking them into account.** Second, EA sensitivity includes the role of conflict negotiations or the negotiations of mismatched states. A relaxed climate with respect to mismatches or dyssynchronies in interaction, and the successful repair of such situations (Biringen, Emde, & Pipp-Siegel, 1997; Tronick & Cohn, 1989) are viewed as a critically important aspects of sensitivity. Third, EA sensitivity emphasizes specific behavioral indicators of sensitivity. The Ainsworth system was developed for understanding naturalistic interactions in the home, whereas the EA was developed for videotaped play interactions of much shorter duration. Fourth, EA sensitivity takes into account the age-appropriate behaviors of a sensitive parent, with separate infant/early childhood and school-age child versions.

We now turn to the EA views of parental structuring, nonintrusiveness, and nonhostility. These views, too, are greatly influenced by attachment theory, mainly because of the emphasis on subtle, context-sensitive, holistic, and clinically based judgment. Yet, the constructs also are embedded within an emotional framework. Parental structuring refers to the ability of the parent to structure/scaffold in a way that is received by the child. In other words, if a parent does structuring/scaffolding of play but the child is emotionally unengaged in the process, the parent's structuring would be viewed as lower than if the child were emotionally engaged in the interaction. A parent thus is viewed as higher in structuring if s/he at least tries to structure but is simply not successful in her/his efforts. However, a parent is viewed as more optimal if his/her efforts are successful at structuring the child's behaviors and/or play. Effort is not everything. In the EA framework the parent cannot look good without the child.

Parental nonintrusiveness refers to the parent's ability to be available without intrusions on the child's autonomy. Intrusions refer to different forms of limiting child autonomy. Such behaviors include interference or moving against what the child is doing or doing too much for the child that the child can actually do him/herself. Again, the child's behavior and reactions have much to do with the judgment of parental nonintrusiveness. For example, if a father is engaging in physical play with his son, and the son is really enjoying it, such an exchange is more likely to be judged as nonintrusive than if the child appears tortured by the overstimulation.

Parental non-hostility refers to ways of talking to or behaving with the child that are not abrasive, impatient, or antagonistic. The hostility shown may be covert or overt. Covert hostility manifests as impatience, discontent, boredom, and the like, whether directed toward the child or not. Overt hostility manifests as obvious negativity clearly directed toward the child or others. The ability to relate in a nonhostile manner would appear to be a key feature of emotional availability to a child.

The child's side of emotional availability to the parent also is affected by the attachment and emotional availability frameworks. The child's side involves a combination of "secure base behavior" and affective or emotional availability to the parent. The child's responsiveness to the parent refers to the child's age- and context-appropriate ability to explore on his/her own as well as to respond to the parent in an affectively available way. It includes affect (e.g., smiling, fear, anxiety, etc.) as well as behavioral responsiveness. In other words, a child who is very behaviorally receptive to his/her parent's bids is rated as lower in responsiveness if his/her affect is not very positive. The child's involvement refers to the ability of the child to invite the parent into play; of course, there needs to be a balance between autonomy and invitations of the adult into play. Visually involving behaviors as well as more clear signals, such as giving and talking, are taken into account."

(Biringen et al., 3rd ed., 1998, p. 3-6).

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Life after the Workshop

The use of EA in Australia

Compiled by Frances Gibson PhD

In the first instance a number of participants who want to achieve reliability in scoring the EA have ordered the reliability test tapes to complete.

On the last day of the workshop participants shared their plans for the use of the EA in professional practice and research. Presented here are a few summaries to provide some idea of the diversity of interests amongst workshop participants and the broad application of the construct of emotional availability and the use of the EA scales.

Dr Catherine McMahon Macquarie University and colleagues: "We are using the Emotional Availability Measure in two studies currently. The first is a prospective study of the impact of postnatal depression on infant development. Here we have used the EA at 15 months and again at 4 years. We hope to explore relationships between security of attachment, emotional availability and maternal depression. We also hope to explore stability of the measure over time and relationship to preschool adjustment.

The second application is that we plan to use the measure as an outcome measure to assess the effectiveness of a Strengths Based Home Visiting Program with depressed mothers. This study is being conducted in collaboration with Tresillian Family Care Centres. The Chief Investigator is Dr Cathrine Fowler. Mothers in the intervention group receive 10 visits from a nurse home visitor, which includes feedback to mothers on videotaped interactions. Mothers in the comparison group receive only developmental education materials".

Dr Robyn Dolby: "I am trying to use the EA in the childcare study I'm involved in at the Social Policy Research Unit at UNSW. I am following children over a two year period who have been offered a place in child care as part of a DOC's case plan for children considered at risk of abuse or neglect. The children are still living with their parents or grandparents and we wish to see if the early offer of childcare may play a part to keep the children within their families, rather than go into foster care. I cannot videotape because of confidentiality issues. I am using the EA scales to see whether childcare gives the children an emotional safe base, through the relationship they build up with their primary worker or teacher at childcare. I observe the children over a morning using the EA scales to describe the interaction between parent and child when the child is dropped off in the morning and to describe the developing relationship between childcare worker and child (over a 3 hour period). ! I'm also using the attachment Q-sort to describe this relationship. It's also an opportunity to see how well the EA scales can capture the childcare staff's role in helping the children connect to their group (of children) as well as to them. It is fun trying this out."

Associate Professor Judy Ungerer PhD, Macquarie University: "We are going to use it (EA) in a study of the impact of multiple and changeable child care arrangements on children in the 1-3 year range. It will form part of Katelyn Tasker's PhD project being done within the context of a linkage grant to Macquarie University (Jennifer Bowes, Johanna Watson. Judy Ungerer), Charles Sturt University (Linda Harrison. Tracy Simpson), the Australian Institute of Family Studies (Sarah Wise, Ann Sanson), and the NSW Department of Community Services. Katelyln is a student at Macquarie University."

Martha Birch, parent infant therapist: Martha will be using the EA scales as a measurement of parental sensitivity to assess the outcome of video interaction guidance in a research project. She will be using it to help DOCS assess some of their clients parenting abilities. "such a useful tool".

Early Intervention Program (EIP) run by the Benevolent Society: *EIP has been using the EA to evaluate the*

outcome of their work with families and they have made some very preliminary evaluations. EIP originally gained familiarity with the second edition of the EA and the workshop helped to consolidate use of *the third edition.*

Sharon Laing, Department of Neonatology, The Children's Hospital at Westmead: "We are conducting a study investigating developmental and behavioural outcomes of infants following
major surgery in the first month of life. As part of my doctoral studies (with supervisor Judy Ungerer) we will be using the EA scales to look at parent-infant interaction at 18 months corrected age".

Mia Markovic and Margaret Stuchbery Jade House Fairfield Heights Sydney , propose to look at the EA of mothers and infants entering a Residential Unit for sleep and settling regulation. "We are interested to unravel the relationship between emotional availability and the dysregulation of infant sleeping and feeding. We will also examine whether EA at admission is related to the success of the Residential Unit program."

Frances Gibson PhD Royal North Shore Hospital: Frances recently prepared an abstract for submission to SRCD 2003 based on research conducted using the second edition of EA. The aim of the current research was to further validate the use the Emotional Availability Scales, through examining the relationship between dimensions of emotional availability (EA) and security *of* infant attachment in two groups of families: one group conceiving following assisted conception (in vitro fertilisation (IVF)) and a naturally conceiving control group. Preliminary findings reported in the abstract indicate that more adaptive dyadic emotional availability was found to have a positive association with security of infant attachment. There was also some evidence that specific dimensions of EA might be more strongly associated with certain sub-classifications of attachment.

AAIMHI would be pleased to here via submissions/letters to this newsletter from other researchers and service providers on their progress in further training and the use of EA.

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Attachment in Adolescence :
Seminar/Workshop and Training in the Separation Anxiety Test for Early Adolescents (SAT-EA)

Dr Gary Resnick, Senior Study Director of Westat, USA, will present training sessions on the Separation Anxiety Test for Early Adolescents (SAT-EA) at the Dept. of Psychology, Macquarie University, November 18-21, 2002. The program is hosted jointly by Charles Sturt University and Macquarie University.

The SAT-EA is an interview procedure designed by Dr Resnick to tap key dimensions of attachment relationships between young adolescents and their parents. His initial research at Tufts University and Auburn University assessed attachment among young adolescents and its prediction of high-risk behaviour. Since then, his measurement technique has been used in many international studies of attachment, including the Israel longitudinal study of kibbutz-raised children and the Canadian adoption study which is following a large sample of Rumanian orphans.

Dr Resnick's training program will be of great value to researchers, practitioners, and professionals interested in the role of attachment in later childhood. The focus will be on the use of the SAT-EA in research and clinical practice. Training includes the option of a two or four-day program. The two-day seminar/workshop will cover the administration of the SAT-EA and the dimensions underlying the scoring system. The four-day program includes two additional training days for participants who want to become proficient in scoring the SAT-EA and achieve reliability on the scoring system.

For further information please contact Linda Harrison (02) 6338 4872; email: lharrison@csu.edu.au)) or Judy Ungerer (02) 9850 8045; email: jungerer@psy.mq.edu.au)). Registration forms are available on the Charles Sturt University website: http://www.csu.edu.au/faculty/educat/teached/harrison.html

AUSTRALIAN CONSENSUS STATEMENT ON UNIVERSAL NEONATAL HEARING SCREENING

2001

Ratified by the Australian National Hearing Screening Committee, November 2001

On 24 March 2001, a Forum was held in Adelaide entitled "Universal Neonatal Hearing Screening in Australia: a National Forum for Consensus and Implementation". There were more than 110 participants from all states and territories of Australia, as well as from New Zealand; they included parents of children with hearing impairment, audiologists, teachers of the hearing impaired, paediatricians and neonatologists, ear nose and throat surgeons, nurses, epidemiologists and community child health professionals.

A Draft Consensus Statement on Universal Neonatal Hearing Screening (UNHS) was presented, discussed and further developed at and after the Forum.

Following the Forum, a National Newborn Hearing Screening Committee was formed with members from all States and Territories and broad professional and lay representation. The National Committee ratified the Consensus Statement at a meeting in Melbourne on 17 November 2001. We are encouraged by recent progress towards UNHS in several states, most substantially in New South Wales and the ACT. Nevertheless, this Committee sees a need to continue the drive for nationally coordinated, systematic early detection of childhood hearing impairment, with appropriate subsequent intervention and parent support throughout Australia.

Bellow is the Australian Consensus Statement on Universal Neonatal Hearing Screening. We urge the Australian Association for Infant Mental Health to consider formally endorsing this Consensus Statement. Endorsement might include one or more of the following:

- authorising the addition of the Australian Association for Infant Mental Health's name to a list of endorsing bodies to be compiled at the bottom of the Consensus Statement;
- publishing the Statement in the Australian Association for Infant Mental Health's newsletter, journal and/or website;
- adopting it as the Australian Association for Infant Mental Health's formal policy, with acknowledgement of the source;
- authorising the National Newborn Hearing Screening Committee to include the name of the Australian Association for Infant Mental Health, along with other endorsing bodies, in lobbying for the adoption of effective, systematic newborn hearing screening throughout Australia;
- other forms of endorsement appropriate to the Australian Association for Infant Mental Health.

Please feel free to contact Dr JD Mansfield on 08 8303 1509, or the Chair of the National Committee Dr Melissa Wake on 03 9345 5761 email wakem@cryptic.rch.unimelb.edu.au for further discussion at any time.

This Consensus Statement was agreed upon at 'Universal Neonatal Hearing Screening in Australia: a National Forum for Consensus and Implementation', held on 24 March 2001 at the Women's and Children's Hospital, Adelaide. There were over 110 participants from all states and territories of Australia, including audiologists, teachers of the hearing impaired, neonatologists, paediatricians, ear, nose and throat surgeons, nurses, epidemiologists, and parents of children with hearing impairment

The Forum notes that:

1. Hearing impairment is a significant condition in newborns. Significant permanent hearing impairment (defined here as hearing impairment of more than 40 dB HL in both ears) affects 1-1.5 per 1000 live births,[1, 2] or approximately 250-400 births in Australia each year. This is more frequent than other conditions for which newborn screening occurs.[3] Significant bilateral hearing impairment, if undetected, will impede, and can have profound effects on speech, language, and cognitive development,[4] and thus emotional and social well-being. Unilateral and mild hearing impairments can also have significant educational impacts.[5]
2. Current international research indicates that babies whose permanent bilateral hearing impairment is diagnosed before the age of six months, and who receive appropriate and consistent early intervention, have significantly better language levels than those children identified after the age of six months.[6, 7] Of children aged 5 years with permanent significant hearing impairment, it is estimated that 80-90% have had the impairment since the neonatal period.[8, 9]
3. Acceptable technologies are now available, viz., measurement of otoacoustic emissions (OAE) and

automated measurement of the auditory brainstem response (A-ABR), that enable effective screening of hearing impairment in newborns during natural sleep or quiet rest. Such technology has been used in screening programs since 1990.[9, 10]

Research studies of universal (i.e. non-targetted) screening programs using OAE and A-ABR show sensitivity (proportion of infants with abnormal hearing who fail the screen) close to 100%, and specificity (proportion of infants with normal hearing who pass the screen) above 90%.[10, 11]

Research studies using currently manufactured A-ABR equipment can achieve false-positive rates as low as 2%.[3]

4. The average age of diagnosis of hearing impairment in some centres which have implemented universal newborn hearing programs is reported be as low as 3 months.[2, 10] In contrast, the average age of diagnosis of hearing impairment in centres which screen only infants known to have pertinent risk factors is estimated at 24 months.[12] Data from Australian Hearing indicate that the median age at detection of Australian children with the most severe hearing impairment (>90dB) is between 12 and 18 months while the median age at detection of children with moderate hearing losses (40-60dB) is between 4 and 5 years.
5. Estimates of the cost of hearing screening per child are of the order of $25 to $50, depending on the technology used and how the program is delivered, and are consistent with experience in other countries.[3, 9, 10] Testing in more remote areas will be more expensive. It is likely that the cost of a successful program will be offset within a few years by the consequent reduction in the cost of the higher teacher-student ratio and greater life-long support required for children whose hearing impairment is diagnosed late.[3].
6. Although there is variable access to full audiological assessment for infants, especially outside metropolitan areas, Australia already has excellent facilities for audiological rehabilitation. The fitting and monitoring of hearing aids is financially accessible to all Australian children as a result of federal government funding.
7. Thus the WHO preconditions[13] for the establishment of a screening program are fulfilled.
8. The American National Institutes of Health Consensus Statement, 1993,[14] the European Consensus Statement, 1998,[15] the American Academy of Pediatrics, 1999,[4] and the US Joint Committee on Infant Hearing[16] have all supported the introduction of screening. It is mandatory to offer neonatal screening in most states of the USA. Universal newborn hearing screening is being implemented nationally throughout England and Wales. A large scale trial of newborn hearing screening is currently under way in Western Australia.

The Forum believes that:

1. Universal neonatal hearing screening is feasible, beneficial, and justified.
2. Principles of equity and efficiency demand the establishment of a high quality program of universal neonatal hearing screening in Australia as soon as possible.
3. Prompt audiological assessment must be achieved for all neonates identified by hearing screening, and prompt, effective intervention must follow for those in whom the impairment is confirmed.
4. To be effective, a neonatal hearing screening program should

   be universal (i.e., include all neonates), since selective screening based on high-risk criteria in practice detects at most half of all infants with congenital hearing loss.[2, 9]

   achieve high coverage and follow-up rates, relative to the total number of births in the population.

   be comprehensive in its approach, ie it should include training and supervision of personnel, full and accessible information for parents at all stages of the program, quality assurance, the follow-up of identified children, systems for reporting and monitoring outcomes, and counselling for parents of children with hearing impairment.[9]
5. Models for the delivery of a neonatal hearing screening program need to be designed to take account of Australian patterns of population distribution and service delivery.
6. Effective universal neonatal hearing screening will not replace the need for vigilance and for continued surveillance of hearing behaviour and language development to detect hearing impairment in children who have not received neonatal screening or who develop permanent hearing loss at a later age.
7. Further research is required to determine benefits, costs and harms of screening for children with unilateral and milder hearing impairments.

The Forum resolves that:

1. A program of universal neonatal hearing screening should be introduced across all states and territories in Australia in order to detect children with hearing loss at the earliest possible age.
2. The Australian federal government should work together with state and territory governments to establish a coordinated screening program.
3. A universal hearing screening program must be sufficiently resourced to enable high quality monitoring and evaluation.

4. A range of national strategies will be necessary to achieve effective and efficient universal neonatal hearing screening programs for all Australian children.
5. Clear time lines should be specified for the planning and implementation of universal neonatal hearing screening across Australia.
6. Audiological assessment, diagnosis and habilitation at the earliest possible age, as well as parental support, should be achieved for all Australian children with hearing impairment.

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- Report from a clinical meeting

Focus on Strength

Report by Frances Gibson PhD

A clinical evening meeting was held Thursday August 22nd, 7 - 9pm at St John of God Hospital Burwood on "A strengths based approach to working with families". Over 50 people attended a very successful workshop. Indeed the evening was oversubscribed and we hope to be able to offer a follow-up session next year.

The workshop was presented by **Michael Durrant and Don Coles from the Brief Therapy Institute of Sydney (BTIS).** Michael Durrant is Founder and Director of the BTIS and he is a psychologist with an international reputation in Solution-focused Brief Therapy. He has published books and articles on applications of Brief Therapy and apart form an extensive background as a therapist he has worked as a consultant overseas in strength-based approaches to child and adolescent treatment.

Don Coles is a Senior Associate at BTIS. He is a Social Worker with and he is currently Clinical Coordinator of the Intensive Family Support Options (IFSO) program at Allambie Heights. IFSO is an innovative program using solution-focused with families who are seeking placement support for their child with a disability. Don has a strong background in strengths based work and is sought for consultation and supervision in this area.

A copy of the handout provided on the evening is reproduced here with the permission of the BTIS. For further information about training courses contact Michael or Don (see details below).

"A STRENGHTS BASED APPROACH TO WORKING WITH FAMILIES"

What is the "strengths" perspective ?

What is the "strengths" perspective?"At the very least, the strengths perspective obligates workers to understand that, however downtrodden or sick, individuals have survived (and in some cases even thrived). They have taken steps, summoned up resources, and coped. We need to know what they have done, how they have done it, what they have learned from doing it, what resources (inner and outer) were available in their struggle to surmount their troubles. People are always working on their situations, even if just deciding to be resigned to them; as helpers we must tap into that work, elucidate it, find and build on its possibilities." (Saleebey, 1992)

"Modern psychology has been co-opted by the disease model. We've become too preoccupied with repairing damage when our focus should be on building strength and resilience ... I want to remind our field that it has been side-tracked. Psychology is not just the study of weakness and damage, it is also the study of strength and virtue. Treatment is not just fixing what is broken, it is nurturing what is best within ourselves."

Martin E. P. Seligman, Past President of American Psychological Association(1998)

Building family strengths

"Operating from a family strengths perspective, we are reminded how important it is to focus on how families can succeed rather than get lost in endless discussions of why they fail..... One advantage of this type of perspective is that it tends to change the nature of what one finds in families. Simply stated, if one studies only family problems, one finds only family problems. Similarly, if educators, community organisers, therapists and researchers are interested in family strengths, they look for them. When these strengths are identified, they can become the foundation for continued growth and positive change ....." (DeFrain, 1999)

"In any discussion about family strengths ..... it is easy to categorise families as strong/functional or troubled/ dysfunctional. Indeed some family strengths research is based on this dichotomy, proposing that the study of strong families and their strengths will provide a format from which we can educate troubled families on practices used in stronger families.

.....We run the risk of imposing cultural assumptions on family life, and overlooking the existing skills within the family. Rather than teaching families a set of strengths practices, our task is to facilitate families in the process of identifying their own strengths. This process empowers families to regain faith in their own abilities to rebuild resilience. Family resilience is an inherent property of families that can be nurtured and mobilised by approaches ranging from family therapy to social policy." (Silberberg, 2001)

"The ability to envision a goal, determine a plan of action, and act to achieve it is a major contributor to a sense of self-efficacy. The role of the helper is to assist a parent, sibling, or person with a disability to clarify goals and to develop strategies to achieve them." (Singer & Powers, 1993)

PROBLEM SOLVING OR SOLUTION BUILDING?

THE SOLUTION - FOCUSED APPROACH:

- **Solution development is not connected to problem exploration**

".....the problem or difficulty which brings clients to therapy need not determine the direction in which the discussion proceeds. Rather, recognising that clients wish things to be different, Solution-focused Brief Therapy embarks upon an exploration and elaboration of that difference ....." (Miller & de Shazer, 1998)

- **Developing a "picture" of how the client wants things to be different**

"The most useful way to decide which door can be opened to get to a solution is by getting a description of what the client will be doing differently and/or what sorts of things will be happening that are different when the problem is solved, and thus creating the expectation of beneficial change." (de Shazer, 1985)

"It is quite normal for clients to not know what they want when they first meet with a practitioner. The process of sorting this out usually begins by talking about what they do not want. Therefore, be prepared to repeatedly help clients to define what they want by building from what they find troublesome. The word "instead" is very useful: eg What would you do instead of 'screaming at the kids'?" (DeJong & Berg, 1998)

- **When are things different? What difference does this make?**

"Central to the solution-focused approach is the certitude that, in a person's life, there are invariably exceptions to the behaviours, ideas, feelings, and interactions that are, or can be, associated with the problem. There are times when a difficult adolescent is *not* defiant, when a depressed person feels *less* sad, when a shy person *is* able to socialize, when an obsessive person *is* able to relax, when a troubled couple *resolves* rather than escalates a conflict, when a bulimic *resists* the urge to binge, when a child does *not* have a tantrum when asked to go to bed, when an overresponsible person *does* say no, when a problem drinker *does* contain their drinking to within a sensible limit, etc." (Cade & O'Hanlon, 1993)

- **Developing a sense of competence**

"Clients are 'stuck' in a view of themselves as incompetent or powerless. Change comes not from understanding why but from seeing oneself differently. Seeing oneself (or situation) differently can be a result of experiencing oneself differently. Thus, therapy seeks to maximise opportunities for experiencing or noticing success and difference." (Durrant, 2001)

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Minutes of the Annual General Meeting

of the Australian Association for Infant Mental Health (inc)

HELD ON: at 5.15 pm on Friday August 31st, 2001 at the Esplanade Hotel, Freemantle, Western Australia

Minutes Secretary: Caroline Zanetti

1. Caroline Zanetti appointed Minutes Secretary

2. PRESENT: Pam Linke (SA), Rita Hayes QLD, Michelle Weston, Vic, Isla Lonie NSW, David Lonie NSW, Anita MacPherson, Margaret Doherty WA, Helen Milroy WA, Prue Stone WA, Inge Meyer WA, Bev Turner NSW, Dulcie Veldtman WA, Pia Duffy WA, Victor Evatt NSW, Kim Wehner, Tracey Capom WA, Beufah Warren WA, Janet Rifkin QLD, Kerry Judd, Mary Brown Vic, Miriam Kowarzyk, Robin Baker QLD, Sue Wilson QLD, Debra Svensen QLD, Abigail King QLD, Ella Scott WA, Ann Morgan Vic, Rachel Bryant QLD, Campbell Paul Vic, Julie Searle WA, Caroline Zanetti WA, Brigid Jordan Vic, Marianne Nicholson NSW

APOLOGIES: Elizabeth Puddy SA, Frances Salo Vic, Judy Underdown NSW, Sarah Meares NSW, Elizabeth Webster QLD, Mary Morgan NSW, Judith Edwards NSW.

3. Confirmation of Minutes of AGM November 11th , 2000

CORRECTION: Item 1 - DONNY MARTIN and the Queensland Report should mention MICHAEL DAUBNEY as treasurer. Confirmation moved by Susan Wilson, seconded by Campbell Paul

4. Business arising: nil

5. Correspondence: Letter from Magna Data for Website support - currently in dispute: A letter from a Conference Organiser requesting access to our mailing list, and a letter from Williamson, Solicitors re the Website.

6. President's report: Brigid Jordan

2001 continued to see the growth of AAIMHI. The Aims of the Organisation have been restated, and the Committee format described. The organisation's Advocacy role continues to develop, with a position paper on Controlled Crying prepared during the year. Overall, the role of the National Committee has been to oversee the production of the Newsletter, and liaison with the International body. Thanks were given to the 2001 Conference Committee for all their hard work. Thanks were also given to Victor Evatt for his work with the newsletter.

Brigid announced her retirement from the role of National President. Elizabeth Puddy has accepted the National Committee's nomination to take the role of President over the next two years. She thanked the Committee members for their support and advice, and also David and Isla Lonie for their ongoing support during her term. Brigid announced she has accepted a role as Affiliate Representative of WAIMH, with particular focus on the World Congress 2004. Campbell Paul will be Chair of the Scientific Programme.

7. WAIMH Regional Vice President's Report: A/Prof. Campbell Paul

Congratulations were offered to the local organising committee for an uplifting and stimulating experience, which demonstrates the importance and benefits of being part of an international body. There are lots of meetings coming up: ISIS in April 2002, NIFTI - combined meeting in Sydney 2002, local Marce Conference in Christchurch NZ Sep 2001, international Marce Conf in Australia September 2002. Submissions for WAIMH Amsterdam 2002 close in 2 weeks. PACFA - the Psychotherapy and Counselling Federation of Australia - this organisation is developing a register of counsellors and psychotherapists across the country. It is important that our organisation has a role in saying who we think is working in this area with adequate training and experience to be useful to patients. He asked that State bodies discuss this as an issue, and notes it could add to the credibility of our advocacy and networking and conferencing. Campbell will be attending a meeting in New Caledonia in Nov 2001 with the Child and Adolescent Psychiatry Conference, and this will provide an opportunity to solidify links with NZ AIMHI.

8. Treasurer's Report: Marianne Nicholson

(see attached documentation) - After giving a vote of thanks to Elizabeth Puddy for all her work as Treasurer, Marianne gave the following report: National AAIMHI has had an income this year of $27,996.80. this is composed of revenue from Membership appearing this year as $16,563.15, and $11,000.00 Govt. grant which passed through the account. Some income earned in 1999-2000 was paid in 2000-2001, so the projected income for 2001-2002 from Membership income at $25.00 per member

would be about $10,000.00. This is not enough to cover expenses, so at the last National teleconference it was decided to give the National Committee $35.00 per member. This will bring income to about $14,000, which will just cover expenses. We do not want to deplete our resources. The Newsletter is our biggest expense, and we have plans to address this, which Victor Evatt will discuss.

Pam Linke suggested that we keep working towards the development of a uniform membership form/brochure, with the different States' addresses. In answer to another question, Marianne stated that the national body carries public liability insurance of $5,000,000.

Beulah Warren moved that the Meeting accept the Financial Statement. Seconded by Isla Lonie and passed unanimously.

9. Public Officer's Report: Marianne Nicholson

Marianne asked for permission for herself and Janet Rhind to submit the Annual Statement to the Department of Fair Trading. Motion passed unanimously.

10. Report of Advocacy Committee: Pam Linke

Pam gave a talk on the role of advocacy at a recent S. Australian conference, and has continued to participate in other organisations such as NIFTI and the Australian Early Childhood Association, attempting to keep infant mental health issues in focus. Pam has asked for suggestions from members for means of helping isolated workers in Child Health to gain clinical support. Caroline Zanetti suggested that a call could be placed in the Newsletter for workers to get together.

The Federal election will provide an opportunity for us to put an agenda to national politicians on things we think are important. We could send post cards to local candidates with AAIMHI's agenda e.g. the formation of a Children's Commission, promotion of high quality childcare - could this be done in conjunction with NIFTI and ECA, or should it be done separately? There was general consensus in the meeting that a combination of both avenues would be helpful. Pam Linke suggests that we write to all political parties to say what issues we believe should be on the Mental Health platform. She will seek agenda items from the State bodies, liaising with State Presidents. She will take this issue to the NIFTI Board, to see if our concerns can be accepted in their agenda, and will aim also for us to write to parliamentarians on our own behalf.

10.1 Controlled Crying Statement

Pam Linke and Elizabeth Puddy have worked consistently on developing a statement from AAIMHI on this issue. The draft paper was circulated, and prompted considerable discussion. Campbell Paul suggests circulating to the State bodies an example of the American Academy of Paediatricians' policy and the draft document of enable a final consensus to be reached. He also suggested that references, and some positive suggestions for settling techniques also be included in the paper. Beulah Warren moved that the meeting endorse what Pam has done as a principle, but would like to see the document couched in more 'baby-friendly' terms, and the Meeting's response be given to the Executive Committee for further action. Seconded by Isla Lonie, and passed unanimously. Beulah Warren (NSW) and Tracey Caporn (WA) have offered their assistance.

11. Report from Newsletter Editor: Victor Evatt

Victor is working on developing efficient links with Vladimir Tretykoff, and they expect to get the publication of the Newsletter back on schedule. Victor has circulated a Questionnaire at the Conference enquiring about the feasibility of Internet publication wherever possible. There has been some support, and he noted that the costs of the Newsletter will be substantially reduced by Internet distribution. He will be making some adjustments to the format, and the next edition will come as both hard and email copies. It is hoped that the Internet will eventually allow members access to the entire newsletter archive. Victor requested that the National Executive ultimately have the responsibility for deciding whether to go online. There was general agreement within the meeting. Victor has suggested that it would be necessary for at least 80% of the Membership to have Internet access before moving entirely to this modality.

12. Website: David Lonie

People will be able to access the Website this year, but it will not be possible to modify it. Originally, Magna Data had offered free posting to us, as a non-profit organisation, but this is no longer offered, and legal considerations are currently in train. David and Isla Lonie have offered interim support and a place for the website, while these matters are being sorted out.

13. Announcement of National Committee

To date the following members have been elected: Victor Evatt , Elizabeth Puddy (President), Janet Rhind, Brigid Jordan and Campbell Paul. The WA member will be announced after their AGM in September.

14. State Reports:

Queensland: Janet Rhind reported that they have had a busy year, with a mixture of closed and open meetings. The Branch size is currently around 45 members. They are continuing to work on increasing their networking within and outside the State. There is some local interest in developing the Branch's advocacy role. Preparations are beginning for the 2003 Conference.

New South Wales: Continuing activities. (Please note that I do not appear to have recorded the report from the NSW Branch, and the Minutes will have to be amended accordingly, prior to the next AGM - C.Z.)

South Australia: Pam Linke reported that there have been some new members, including on the Committee. The 2000 Conference consumed a lot of time, but some

open meetings have been conducted since. Mary McLeod from the UK National Parents Association and AIMH gave a successful oration. The Branch is also inviting politicians to come and give their positions on various policy areas. Representatives from all parties have indicated they will attend.

Victoria: Michelle Meehan reported continuing interest in the Association is gradually leading to an increase in Membership. High attendance at their monthly scientific meetings has been most rewarding. Several of these have been presentations of work being done by members. The Branch has welcomed some new members to their committee, boding well for expansion of the base of involvement in infant mental health. With 2004 coming up, and Victoria hosting the World Conference the increasing interest and membership bodes well for working with the National Body to bring this off.

Western Australia: Caroline Zanetti reported that the Branch has been concentrating all its efforts on the Conference, and there have been only a few talks arranged during the year. Caroline announced that she will be standing down from the National Executive and the local Branch Executive Committees at the State AGM, which will be held on September 27th.

15. Report from Conference 2000:

Pam Linke announced that the Conference made a small profit, assisted by a grant from the Commonwealth Government.

16. Report from Conference 2001:

Caroline Zanetti reported that the Conference was going well, with wonderful speakers. The committee expects to break even financially.

17. Future Conferences:

Conference 2002 - NSW: David Lonie reported that the conference would be conducted in confunction with NIFTI. He noted the Committee's intention to keep our identity separate from that of NIFTI. The preliminary theme is to be: Positive Connections: Infancy in Tomorrow's Society, and will be concerned with links between early intervention programmes and longterm outcomes, especially conduct disorder. This has been NIFTI'S current focus. David signalled the need to ensure that it is really early intervention that is examined. He would really like to showcase what is available in Australia.

Conference 2003 - QLD: Nothing to report as yet.

18. Other Business:

Bev Turner from NSW requested that a statement be sent to John Howard regarding the disregard for human rights that has characterised the Government's treatment of refugees. Caroline Zanetti suggested that the Newsletter could be used as a forum for discussion. It was suggested by others that the President could perhaps write an editorial. This will be brought to Elizabeth Puddy for consideration.

THE AUSTRALIAN ASSOCIATION FOR INFANT MENTAL HEALTH (inc)

affiliated with the WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

NOTICE OF

AAIMH ANNUAL GENERAL MEETING

To be held at The Holme, University of Sydney, Science Rd, (from Parramatta Rd., via Ross St. Entrance) Sydney, NSW, at 4.30pm on Saturday 16th November 2002

1. **Appointment of Minute Secretary**
2. **Apologies**
3. **Confirmation of Minutes of AGM August 31st 2001**
4. **Business Arising**
5. **Correspondence**
6. **President's Report:** Dr Elizabeth Puddy
7. **WAIMH Regional Vice President's Report:** A/Professor Campbell Paul
8. **WAIMH Affiliate Representative:** Dr Brigid Jordan
9. **Treasurer's Report:** Dr Janet Rhind
10. **Public Officer's Report:** Ms Marianne Nicholson
11. **Report of Advocacy Subcommittee:** Ms Pam Linke
    - 11.1 **Controlled Crying Statement:** Ms Pam Linke
    - 11.2 **Children in Immigration Detention:** Dr. Ros Powrie
    - 11.3 **Neonatal Hearing Screening:** Dr Elizabeth Puddy
12. **Report from Newsletter Editor:** Mr Victor Evatt
13. **Website**
14. **Announcement of National Committee**
15. **State Reports:**

Report from New South Wales
Report from Queensland
Report from South Australia
Report from Victoria
Report from West Australia

16. **Report from Conference 2001**
17. **Report from Conference 2002**
18. **Future Conferences:**

Conference 2003: Ms Pam Linke (SA) to report
WAIMH Congress 2004 to be held in Melbourne

19. **Other Business**

REPORT to the TELECONFERENCE for the NATIONAL COMMITTEE for the AUSTRALIAN ASSOCIATION FOR INFANT MENTAL HEALTH Inc:

Held on August 28th, 2002

The Executive Committee of WAIMH met from Sunday evening prior to the Congress and for one day afterward. A meeting was also held of Affiliate Presidents or their representatives, and another with some Exec Committee members and delegates from countries that do not have a WAIMH Affiliate (Poland, Turkey, Uruguay, Japan). The European and American affiliates also held meetings of their respective affiliates.

There was support among Affiliate Presidents for a bulletin board and email list where Presidents could share information. The new column in The Signal profiling Affiliates was welcomed, but realising how long it will take before all are published, it was suggested that each affiliate prepare a summary or description of their affiliate for circulation to other Affiliate Presidents.

There was also a suggestion that each affiliate organization prepares a Poster describing the affiliate and their activities and these should be permanently displayed during the Melbourne Congress. This could include a summary of activities the Affiliate had undertaken in the previous two years.

Affiliates should have a meeting as a group scheduled within the Melbourne Congress and then a meeting with the Executive Committee later in the week. Agenda items should be called for 3 months in advance so that Affiliates could discuss them prior to the meeting.

Brigid Jordan PhD
Affiliate Representative
World Association for Infant Mental Health.

AAIMH NETWORK NEWS

Qld NETWORK NEWS

Qld BRANCH REPORT **by Debra Sorensen**

In August the branch hosted a panel discussion on Infant Mental Health in South-East Qld. Five groups were invited to join in the discussion, the Future Families Project, North Brisbane, the Infant Mental Health Program, Gold Coast, Infant Clinic, South, CL Service, Mater Hospital, Logan area. One member also spoke about plans to develop services in the Bayside area. Staff from each organisation outlined the service being offered (or plans for a future service). A discussion followed around common concerns, particularly the very important issues of child protection, and maternal mental health in relation to infants.
More recently the AGM was held, with several new members coming on to the committee. Dr Robin Sullivan, Commissioner for Children and Young People attended as guest speaker and discussed her role as an advocate for children in Queensland. An interesting and informative discussion about the importance of early intervention followed.

The next meeting will be held on the 15th October at the Mater Hospital.

Our new committee is as follows:
President: Dr. Janet Rhind
Vice President: Dr. Susan Wilson
Treasurer: Dr. Michael Daubney
Secretary: Ms. Debra Sorensen
State Representative: Ms. Debra Sorensen
Committee: Ms. Helen Baker, Ms. Kathy Eichmann, Dr. Sanjay Patel,Ms. Abby King, Ms. Valda Dorries, Ms. Raleigh Bryant

WA NETWORK NEWS

WA BRANCH REPORT **by Patrick Marwick**

The winter quarter has been a quieter period in WA with most activity occuring in relation to the auditing of the WA branch accounts.
Julie Stone's recent Churchill Fellowship expereinces have provided impetus to local training and supervision intiatives and a presentation in July by Dr Jennifer Barnard on play therapy with young children was well received.
Having the books with the Auditor for a prolonged period of time has influenced our capacity to finalise some outstanding accounts including $400.00 owed to the National Association. GST liabilities flowing from the Conference have been fairly significant although GST liability only applies for that activity.
An AGM is scheduled for November and arrangements for a quest speaker are being coordinated with NIFTeY.
The WA Branch committee continues to develop the interests of new members such that a generational change is in process providing new energy and enthusiasm. The accounts are in reasonable shape with strong local interest in the annual scientific program. Newsletter distribution problems seem to be largely resolved through a clearly identified local system for forwarding members membership applications and renewals.

Patrick Marwick, President, WA Branch

International Conference on Infant Development in Neonatal Intensive Care

13-14 March 2003, London, UK

OVERVIEW:

This conference will link developmental neuroscience and early intervention. The focus will be on pre-term brain development, the impact of neonatal intensive care, and research on developmental interventions. It will be a multidisciplinary forum for clinicians and researchers.

The conference will be built around 15-20 papers, which will give an up-to-date account of research and practice on infant development in intensive care.

The programme has been endorsed by leading researchers and clinicians and the speakers will form a distinguished team of international experts. There will be plenary sessions and workshops with opportunities for questions and debate.

THE MAIN CONFERNCE THEMES WILL BE :

1. The developing brain and sensory systems
2. The impact of neonatal intensive care on development
3. Reducing distress and promoting development in the NICU
4. Approaches to research in early intervention

WHO SHOULD ATTEND ?:

The conference will be multidisciplinary and will attract neonatologists, paediatricians, nurses, and other health professionals.

SPONSORS:

For details of sponsorship packages please contact Mrs Inga Warren on + 44 (0) 20 7886 1283 or
E-mail: inga.warren@st-marys.nhs.uk

POSTER SESSIONS: INVITATION FOR ABSTRACTS

If you would like to participate in a poster session on Early Intervention please send an abstract of not more than 350 words as an email attachment to:

inga.warren@st-marys.nhs.uk

no later than **30th September 2002.**

Abstract Requirements:

- A4 paper (210mm x 297mm) with 2cm margins
- Font: 12-point Arial. Title: bold capitals
- Text; Single spacing; justified;
- Authors; last name then first initial of presenting author in bold followed by any other authors
- Contact: One contact address per presentation
- No diagrams or artwork

• INFANT DEVELOPMENT IN NEONATAL INTENSIVE CARE

To receive further information and details of registration please complete in **BLOCK CAPITALS**

FIRST NAME: Mr/Mrs/Miss/Ms/Dr.....

SURNAME: .....

DEPARTMENT: .....

ORGANISATION: .....

ADDRESS:.....

CITY: .....COUNTRY: .....POST/ZIP CODE.....

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

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

Please also send information on the conference to:

Signed:

Date:

Forward this form to the address overleaf ⟶

International Conference on Infant Development in Neonatal Intensive Care

Contact details:

Infant Development in Neonatal Intensive Care
c/o Meeting Makers
Jordanhill Campus
76 Southbrae Drive
Glasgow
Scotland
G13 1PP

Conference co-ordinator:
Mrs Inga Warren,
Winnicott Baby Unit
St Mary's Hospital
London W2 1NY

VENUE :

The Royal College of Physicians is an attractive and convenient location looking out on Regents Park in the centre of London. It is easily reached by all methods of transport, and from airports.

LONDON :

London, one of the most interesting cities in the world, is a popular choice for international conferences. Its colourful cosmopolitan atmosphere is reflected in the variety of its restaurants, street life and events. It has fashionable shops, lively markets, famous theatres, museums and art galleries, legendary historic sights and beautiful Royal Parks, making it everything a capital city should be. Accommodation can be found to suit a range of budgets

ADVISORY PANEL:

Professor John Wyatt, London
Professor Dieter Wolke, Hertford
Dr. Simon Bignall, London
Dr. Tom Lissauer, London
Dr. Lena Hellstrom-Westas, Lund

Co-ordinating Committee for the ESF Research Network on Early Developmental Care:

- Professor Hugo Lagercrantz, Sweden
- Dr. Claudine Amiel-Tison, France
- Dr. Marina Cuttini, Italy
- Professor Gorm Greisen, Denmark
- Dr. Dominique Haumont, Belgium
- Dr. Petra S. Hüppi, Switzerland
- Dr. Jacques Sizun, France
- Assoc. Professor Karin Stjernqvist, Sweden
- Dr. B Westrup, Sweden

FURTHER INFORMATION:

In order to receive further information, please complete and return the reply form to the conference secretariat at the address shown below:

International Conference on Infant Development
in Neonatal Intensive Care
c/o Meeting Makers, Jordanhill Campus,
76 Southbrae Drive, Glasgow
Scotland G13 1PP
Tel: +44 (0) 141 434 1500
Fax: +44 (0) 141 434 1519
E-mail: idnic@meetingmakers.co.uk

This conference is being held at the Royal College of Physicians by kind permission of the treasurer.

- **INFANT DEVELOPMENT IN NEONATAL INTENSIVE CARE**

In order to receive further information, please complete and return the reply form to the conference secretariat at the address shown below:

International Conference on Infant Development in Neonatal Intensive Care
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