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CONTENTS:

Contemplating The Face of Trauma:

Understanding the Enduring Consequences of Abuse and Neglect in Infancy

Report on the Symposium by Mary Sue Moore and Janet Dean on Thursday 3 September 1998 at the AAIMH National Conference in Sydney

by Paul Robertson

Dr Mary Sue Moore and Dr Janet Dean returned to our shores in September 1998 for the AAIMH National Conference in Sydney. They jointly presented a full day symposium on Infancy and Trauma to begin the conference titled " Contemplating The Face of Trauma: Understanding the Enduring Consequences of Abuse and Neglect in Infancy". They brought together an impressive grasp of the research literature ranging from the impact of neglect and trauma on infants, the neurobiology of the early brain development, memory and the role of dissociation. Intertwined with this was an array of detailed clinical work shown on video by Janet Dean of families treated in her Community Infant Mental Project in Boulder Colorado. The interplay of theory and clinical work with the luxury of a whole day to listen, watch and ask questions was quite a feast.

Janet Dean's opening comment about the aim of our work stayed with me and has helped me immensely at the often confusing 'coal face' of clinical work with infants and their families. She saw the aim of parent - infant work as working on , "How to allow adults to make choices in parenting without giving up the survival mechanisms that have helped them through life." Later in explaining what helps she described (1) the need to hold on to and not deny the amount of terror experienced by the infant and (2) to accurately perceive the capabilities of the parents and to make use of these capacities.

Continues on Page 3

1999 CALENDAR OF EVENTS

AUGUST (NSW)

The next clinical meeting will be Thursday, August 19th at 7:00pm at St. John of God Hospital, 13 Grantham Street, Burwood. Dr. Stephen Malloch will be the guest speaker.Topic "Mothers & Infants and Communication Musicality"
(Page 4)

The Australian College of Psychotherapists in association with The Institute of Contemporary Psychotherapy invites you to their conference and workshop August 28 - 30, 1999 in Sydney on "Understanding the Self". (Page 4)

SEPTEMBER (VICTORIA)

17-18 September: Marce Society, Melbourne (Page 16)

NOVEMBER (VICTORIA)

20,21 November: Dr Allan Schore presents a 2 day workshop in Melbourne at the Albert Road Clinic (Page 13-15)

26,27 and 28th of November: National Conference for AAIMH (University of Melbourne) which will be held over the weekend, concluding Sunday mid day. (Page 16)

JULY 2000 (CANADA)

26-30 July, Montreal - the 7th International Congress of the World Association for Infant Mental Health. (Page 16)

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Continues from Page 2

Picking out the threads of such a rich day is hard. Below I have out lined what I took from the day and what has helped my practice in parent-infant (and other) work. It is a good measure of a conference that you can return to your practice and find it helps you clinically! I have not tried to describe the case studies discussed and shown on video as I could not do them justice. The speakers overviewed (and I have tried to describe this overview) the converging research that points towards how contextual, family and environmental factors organise the brains neurobiology and future personality organisation. This notion that environment influences the biological development of the brain revolutionises our thinking of people.

ATTACHMENT RESEARCH

Overviewed firstly was the Attachment Research particularly that focusing on Disorganised Attachment. Many of you will know that Mary Sue has long argued for this attachment style to be called 'Traumatic Attachment' as it occurs in the context of trauma either directly to the infant or unresolved trauma in the parent's background. This type of attachment appears to be an individuals adaptation to unpredictable relationships with caregivers. The infant becomes hypervigilant (extremely watchful) of the care givers behaviours and emotional states. These dyadic relationships which looked 'disorganised' in the early research setting appear, on closer inspection, to be highly organised, rigidly arranged relationships that are frequently encounted in clinical settings.

MEMORY

A second body of literature is around our understanding of Memory. Research about memory has exploded revolutionising our understanding of memory. Mary Sue drew our attention to a particular type of non declarative memory called Procedural Memory. A bodily memory of what you do when you do a particular thing (but which we may not 'know' we are doing it or even that we know it). This is important to us as infants code early interactions into procedural memory which are then carried forth in their development. Such procedural memories allow a developing child to learn how to interact with others. A developing child will learn both sides of a relationship and is therefore prone to enact procedurally both. For instance if a child witnesses domestic violence they will procedural encode both the violent and the victim role! Such procedural memories are highly linked to environmental context. Return to the same environment, or if the environmental context acts as a cue in some way, may lead to procedural enactment. This is in contrast to declarative or non procedural memories that are not context bound. Events in adult life may act as contextual cues that lead to the emergence in behaviour (not necessarily in awareness) of procedural memories laid down as a small child. To follow on from the above example of a child who has encoded in procedural memory an early experience of family domestic violence we may see an individual, adult or child, who is at increased likelihood of enacting behavioural both the passive victim role or the role of the violent perpetrator. Such behaviour may be cued by environmental events such as the witnessing of violence as an adult.

NEURO-PHYSIOLOGICAL DEVELOPMENT

Overviewed thirdly was the emerging body of literature on the early neuro-physiological development of the infants brain. This research with the recognition that the infant's brain develops or is organised in response to the infant's environmental experience, especially relationship experiences with care givers, represents the cutting edge of our field. Mary Sue and Janet reflected on the work of Bruce Perry, Allan Schore and van der Kolb[1]. Perry described the infant's brain developing in a 'use dependent fashion', that is, if neuronal pathways are used they will have increased connections. The brain's structure (ie. number of neuronal connections and complexity) organises around experience, especially relationships experiences. For instance if an infant spends long periods in an activated fear state then the pathways mediating a fear state will be greater and consequently more quickly triggered and with greater intensity with smaller provocation in the future. Infants function on an alarm - fear - terror continuum. They respond to these states with a freeze or a flight or fright response. In view of the infants lack of opportunity to fight or flee the freeze response is frequently seen as an adaptive way to deal with overwhelming terror. Freezing seems to be the antecedent of dissociation that is seen in later clinical populations. Traumatic or fear inducing experience in early development will influence the organisation of the brain regions (ie. brain stem, mid-brain and limbic systems) that mediate the fear response. The individuals sensitivity to terror states and capacity for dissociation is being organised not just behavioural but also neurologically. In this way early affect states (such as terror in response to abuse or witnessing domestic violence and how this is responded to such as with freezing) become enduring personality traits (such as the capacity to modulate arousal and affects or the capacity to dissociate).

The two hemispheres of the brain have different functions. The right is sensitive to affects and interpersonal experience. While the left is more cognitive, logical, involved in cause-effect thinking and involved in reality testing. The infant's brain is right hemisphere dominated. The right hemisphere functions form birth with the left developing more slowly over the early childhood years. Because of this infants will pick up and respond very sensitively to the affects and interpersonal behaviour of others. This can be confusing for adults, such a therapists, who are left hemisphere dominated. Infants are capable and available for relationship experiences while their cognitive development is still rudimentary.

Before finishing I will touch on one further topic and that is the use of video. In emphasising its importance Janet Dean described video to the infant mental health worker as comparable to the telescope to the astronomer. Video allows the therapist to stay in contact with what is actually happening for the infant and what affects, such as terror, it is experiencing. It allows the therapist to not deny but rather to gather and hold the affects and knowledge of what happened and then work with the family

Continues on Page 7

What is a Baby?

This paper was presented by Helen Belfrage at the Anglicare conference held in Melbourne in May 1999. The audience was made up of Anglicare Family Support and Foster Care workers.

"There is no such thing as a baby," declared Winnicott. "If you set out to describe a baby you will find you are describing a *baby and someone.* A baby cannot exist alone but is essentially part of a relationship." (Winnicott, D.1964)

At last the journey is over! A gasp, a cry, a breath! What strangeness! Noise! Brightness! Sensations, inside, outside, everywhere! Confusion! A touch! So new! That familiar voice, (sniff) and smell, oh, a warm safe feeling, held close, nuzzling, sucking. A face appears through the blur! Sweet warmth and softness! Wrapped! Secure! So this is life! (slower) So this is life! Then sleep!

The newborn baby (let us call her Susie), for the first few weeks has no sense of separateness from her mother. She has no sense of 'me' and 'not-me.' She is absolutely dependent, both physically and emotionally. She is in a state of 'unintegration'. She has no sense of herself. She does not know where she begins and ends. The inside sensations and the outside happenings all merge. She needs to be contained by some one who knows her. She is 'hungry,' she cries, the breast appears, she sucks and the hunger goes away, this happens as if she created it all. She has a sense of omnipotence! As she develops she becomes less dependent and experiences occasional moments of separateness, 'I am' moments, and begins to recognise familiar faces, particularly her mother's. With the special care that the ordinary mother provides Susie starts to experience life as predictable. As her brain develops she has memories of her needs being addressed and she develops a sense of agency, she has the power to make things happen. She begins to trust her environment. Susie has a sense of 'continuity,' of 'going on being.' Her mother's reliability, her warmth and devotion give Susie a sense of who she is. When she looks at her mother she sees herself mirrored in her mother's eyes and smile, and knows that she is valued.

Mother and baby form a unit. For the last few weeks of pregnancy and the first few months after the birth it is normal for a woman to be preoccupied by her baby. Nature has provided that she is specially tuned in and can identify with her baby's needs and desires and confer meaning on them. The mother is uneasy if her baby is not with her and feels that something, someone, is missing. She is very protective of her baby. She carries her baby in her consciousness. It is only gradually that her baby separates from her. Because she is in love with her baby she provides a safe, reliable, continuous physical and emotional environment. Winnicott refers to this as the function of 'holding.' Her strength and reliable care allow her baby to feel safe and not spill out in those times of 'unintegration'. Her baby feels held by her voice, by her eyes, by her smell, by her touch. Mother can show Susie that she is in tune with her pain and anger. She is still there, even when Susie is enraged, still loving her and caring for her. She has been able to survive Susie's love and hate and this gives Susie a sense of continuity, security and wellbeing.

The father also has an important role to play, particularly in supporting the mother emotionally, so she can develop

Continues from Page 3

In offering this summary I feel I have left more out then included and missed the central essence of the day which was the detailed consideration and thoughtfulness around the clinical material and research from two such speakers who are both clinicians and researchers. I can only encourage readers to avail themselves in future, as no doubt there will be, to listen and talk with Mary Sue Moore and Janet Dean.

Paul Robertson

REFERENCES:

[1] To guide the reader I have included some references to access these researchers -

Perry, B., et al (1995) Childhood Trauma, the Neurobiology of Adaption, and "Use-dependent" Development of the Brain: How "States" Become "Traits". Infant Mental Health Journal. 16(4):271

Schore, AN. (1996) The Experience-Dependent Maturation of a Regulatiry System in the Orbital Prefrontal Cortex and the Origin of Developmental Psychopathology Development and Psychopathology. 8(1996), 59-87. or
Schore, AN. Affect Regulation and the Origin of the Self Lawrence Erlbaum, 1994.

van der Kolk, BA. Chapter 9 "The Complexity of Adaption to Trauma: Self-Regulation, Stimulus Discrimination, and Characterological Development" & Chapter 10 "The Body Keeps the Score: Approaches to the Psychobiology of Posttraumatic Stress Disorder" in Traumatic Stress Edited by Bessel A. van der Kolk, Alexander C. McFarlane and Lars Weisaeth The Guilford Press, 1996.

her maternal role safely and with balance. Father relates differently to baby from the way mother relates to her. Mother tends to provide an environment that contains baby when she is interacting. Father is more likely to play heightened stimulating games with her, exciting her. He provides a base from which play can emerge. Baby quickly learns to distinguish between the two. The two different sets of responses will enrich baby's cognitive and affective experience of her world.

Having a baby and caring for it is a great challenge for parents. It is not all sweetness and light. Feelings of ambivalence are normal. All parents know about interrupted sleep and fatigue. All mothers know the feeling of uncertainty, sometimes verging on panic 'What is the matter with this baby? Why is it crying? Has it had enough to eat? Why won't it go to sleep? Why won't it leave me alone? I just want a few hours to myself. This baby has taken over my life!' Although a baby is totally dependent, it is certainly not powerless. Its penetrating cry is meant to distress the parents so that they will respond quickly. When a new baby comes all the relationships in the family undergo change. Fathers often feel jealousy, a stranger has taken over their partner and they feel displaced. They no longer have a lover! Mothers can feel unsupported and put upon and can easily start to resent the baby. Just as a woman is stretched physically when giving birth, so she is also stretched emotionally as she makes room in her heart and life for this new human being. When parents can recognise and acknowledge these ambivalent feelings they can start to deal with them. They learn about themselves as nurturers as they respond to and interact with their new infant. However, if the parents were not adequately cared for as infants themselves, they will find it more difficult to cope with their own baby. If their own infant cries went unheeded, their baby can be experienced as another persecutor, as another uncaring person in their world and can be resented.

What does the baby bring to this relationship? How does she contribute? A newborn baby looks appealing to her parents, with her big eyes and little face. The distance the baby can focus her eyes is about twenty five centimetres, so when she is feeding at the breast she seeks out her mother's face, especially her eyes, and looks at her. A newborn baby can recognise her mother's smell and her father's smell as different. She knows her mother's voice and is more readily soothed by her, and soon learns to recognise her father's voice. Her cry is powerful and stirs up strong emotions in her parents. Baby communicates her needs through crying, when she is hungry, uncomfortable, lonely, bored. By about six weeks baby can smile and often initiates interactions. A typical interaction may go like this; baby smiles and mother smiles back, speaking softly in a voice that is specially modulated for her, then baby makes her little noises. They take turns and mother learns when to stop, when baby has had enough. This rhythmic interplay is specially suited to baby's needs. Baby and mother are getting to know each other. Baby feels part of *this* person, understood and 'held' by *this* person. She feels loved and therefore lovable. Gradually through many such experiences baby grows in the knowledge of herself and a sense of security in the predictability of her world.

If the total care is not good enough the baby has a very different experience. If Susie's mother cannot protect her, cannot provide adequately for her needs, or is constantly not there when Susie cries, Susie feels abandoned. Her world disintegrates. Infants have no sense of time and if an 'object' including a person, is not seen it ceases to exist. If there is no one there to 'hold' her, to keep her together, to prevent her from spilling out, to contain her anxiety and rage, the continuity of her being is interrupted. She has to react by developing ways of holding herself that she is not ready for. She has no words for this awful experience. If Susie is neglected or abandoned many times, or worse still if she is abused, she experiences trauma, which means that is she has experiences that her primitive ego cannot tolerate. In the extreme, trauma at the beginning of life relates to the threat of annihilation, the experience of 'unthinkable anxieties,' of complete isolation because her communications go unheard, the sensation of going to pieces, and the terror of falling forever!

Aloneness! Aloneness! Falling! Falling! Spilling out! A different feel. No holding! Nothingness! Fear! Fear! Fear! Screaming! Screaming! Badness, badness everywhere! Exhaustion! Screaming! Screaming! Exhaustion! Silence!

Our work as Family Support Workers and Foster Care Workers is with an environment that is not good enough, hence the need for intervention. Sensitivity to the emotional needs of the infant is of paramount importance. Infants and small children require nurturing and love, consistency and permanency and a reliable opportunity to identify with a responsible adult. Let us remember "when babies enter families either through birth or adoption relationships begin that will shape the baby's entire life and that will change parents' lives forever." (Goldberg, R. L. & Klerman, L.V. 1999)

Helen Belfrage currently works as a Family Support Worker in Melbourne. She has had a long interest in infants and their families and facilitates a Mother-Infant Support Group. Having previously trained as a teacher, more recently she finished the Graduate Diploma in Infant-Parent Mental Health,University of Melbourne.

References

Goldberg, R.L. & Klerman, L.V. (1999) Prenatal Care: A New Perspective. Zero to Three 19 (4)

Winnicott, D.W. (1964) The Child, the Family and the Outside World. (London: Penguin Books)

INFANTS IN THE LAST CENTURY: AN UNWRITTEN STORY

Historian, author and academic Dr. Janet McCalman is well known to Melbourne members who read The Age newspaper. We have come to look forward to her irregular and irreverent contributions, in which she often turns a topic on its head. Dr. McCalman has been a much sought-after public speaker. Thus we were very fortunate to have her present her work on the history of one of Australia's first hospitals.

The publication of her highly praised history of the Royal Women's Hospital titled "Sex and Suffering, Women's Health in a Women's Hospital" has enabled the stories of forgotten women to be told. The book's provocative title provides only a small clue to the woefulness of many women's lives in the last century, especially poor women, as they were documented in the annuls of the hospital medical records. Dr. McCalman started her talk with:

" I do not have a story to tell you. Babies did not matter very much until very recently. This is the absent history of the place of the infant in the hospital, in midwifery and in society."

Dr. McCalman's talk covered the first hundred years of the hospital's existence, which was also a time of huge social change for the new colony of Victoria. Thus her account is in part a medico-social history of the early women of that new colony. Her book has as its focus the poorest of women, the group for whom the hospital was established. Her study rests heavily on the discovery of the hospital's earliest records. Due to the Scottish background of one of the early founders, the Simpson Midwifery Book, already a standard recording system in Scotland, was introduced.

Advanced even for the period, these weighty tomes are now like time capsules, reporting briefly but fully on the health of the women and their subsequent babies. These very old records are particularly detailed, giving exact hand written entries of the date, age, place of birth, parity, marital status, dates of confinement, dead or live infant at birth, hours of labour and recorded infant weight. Even the labour complications and interventions were all noted and signed. These sets of nursing notes under the Simpson's Midwifery model are apparently unequalled in the English speaking world for their quality of detailed information.

It is noteworthy that most of these women's birth place was England, Scotland, Wales or Ireland, with few being identified as being from Victoria or New South Wales. The patient population reflected the wider general population, a large number of young immigrants, far from home, far from familiar surrounds and far from family. Many Tasmanian women also came to the hospital, usually because they were convicts fleeing from the very under-developed Tasmania. They were often freed women who had turned to prostitution for lack of other work. Unlike similar hospitals in Britain at the time, the Royal Women's Hospital took the progressive view of not excluding single pregnant women from their care.

The model of maternity care introduced by one of the founders of the hospital, Dr. Tracey, was very progressive. Tracey had trained in Glasgow, where he himself had caught typhus. When he established the Royal Women's in the 1850's he designed his own 'lying in' ward which included facilities for women delivering in a room on their own. Radical for the time, he kept women isolated for nine days, and then transferred them to a general ward. Infection rates were kept very low, and very few women died in child birth. Even for the time it was known that fewer interventions lead to fewer complications of infection. What McCalman did discover was that a lot of women were severely malnourished, with evidence of rickets being common. Her research took her to analysing probable food sources and general diets. Some women would have been very small physically but because of different nutrition as adults were then delivering larger babies. This often resulted in very nasty long deliveries, themselves sometimes resulting in a dead infant.

By the 1880's the outcomes were not so good. The population of Melbourne was over-crowded. The death rate of women in labour was one in fourteen. Infection control, such as isolating labouring women, as used on the obstetric wards, was not generalised; germ theory had yet to be understood. Of the 35% of women that McCalman traced during this period, she found that of their children the mortality was about 58% for infants under 12 months. Older children, 2 - 3 years, had a slightly better chance, but still an appalling 35 % died. If anything, deaths are likely to have gone unreported, so that the overall mortality figures are probably even higher than these. This is the tragic silent story of infants of the poor.

Those infants who did survive were usually the ones who stayed with their mothers. Of the others, some of whom turn up in the records of the neglected children welfare societies; many lived short and presumably unhappy lives. Some children would have been abandoned or given away so their mothers could have survived as wet nurses for other women's babies. Others were in the care of "baby farmers", often unscrupulous women who offered their services to take in

other's children. Frequently these babies lives were very short, but often the financial payments from the mothers were not. Diarrhoea, typhoid, sepsis, would have contributed to the very high mortality rate, as would the poor diet and low hygiene.

The hospital's charter from the outset was to offer a service to the very poor working class women of the time. Up until 1974 a means test on income was part of the admission procedure. This stipulation has enabled McCalman to embark, via documentation, on a long and detailed process of discovery of not only the hospital but the history of a class of women whose story is not usually told. These women were mainly uneducated, impoverished, often destitute, stricken by disease and a shortened life. As part of her research she looked at the life expectancy of a small number of patients whom she could follow through the use of other government records. By using the name and date of birth from the Simpson books she was then able to track a number of these former patients. In conjunction with data from the State Registry of Births, Deaths and Marriages McCalman learnt of the women's subsequent marital status, subsequent children, age and place of death. To her consternation this history of the hospital also revealed a later horrible history for many of these women. Other official records told of lives of poverty, incarceration in mental asylums and early death.

Dr. McCalman reported that enormously rich research material exists for historians and medical anthropologists. She encouraged the audience to take up the challenge to tell the story of previous generations and continue the search to discover as much as possible about these early pioneering women and their offspring. She referred briefly to researchers working on the Barker Hypothesis using these records. This is a theory that relates life expectancy to maternal and infant health, using old medical records to substantiate the theory.

McCalman's talk was held at the University of Melbourne, virtually next door to the Royal Women's Hospital and built at the same time. The audience was given a poignant painful picture of Melbourne's early women inhabitants and their dependants. As we stepped out into the night, and into the frosty fashionable café society of Carlton, a stones throw from the hospital, the ghosts of the past seemed not very far way.

Sarah Jones

Janet McCalman, "Sex and Suffering, Women's Health in a Women's Society"
Published by Melbourne University Press

A PERSON JOURNEY
Infant Mental Health: From Perth to Melbourne and back again

Julie Stone,
Child Psychiatrist,
Perth, Western Australia

It is many months since I said "yes" to Paul Robertson's (Infant Psychiatrist and Co-Editor of this Newsletter) invitation to write something for the AAIMH journal. Often I hear myself saying to colleagues working in a variety of contexts, that we must create a space to "share our best thinking" about young children and their families. Despite my knowing that we can learn so much when we do just that, it has been extremely difficult for me to create the space to write this piece. Many of us are reluctant to put our thoughts onto paper because we experience writer's block/panic/phobia – me too. The fear that *I know nothing* must be tempered with both the knowledge that I learned so much during my year in Melbourne, and with my ever-present awareness that I still have so much to learn.

It is my privilege to work in Perth as an Infant, Child and Family Psychiatrist with a new and evolving mental health service for infants, toddlers, pre-school children and their families. In Western Australia there is no well-established tradition for young children, zero to three, to be seen by anyone working in a mental health setting. This is changing, and quite rapidly, and those of us interested in promoting the mental health of infants and toddlers are encouraged and supported by an active group of colleagues in AAIMH. However, during my Psychiatry training, there was no where in WA I could find concentrated experience working psychotherapeutically with infants and very young children and their families. So during February to October 1998, I spent a year working in Melbourne. It was a wonderfully rich time for me and for the development of my thinking and my clinical work.

After careful consideration and negotiation I was able to establish a small private practice at the Albert Road Centre for Health. In doing so I was privileged to be one of four psychiatrists working at the Pathway Parent-Infant Unit at the Albert Road Clinic. This is a private psychiatric hospital in central Melbourne.

To develop my work further I also attended six months of the Victorian Child Psychiatry Training Program. Alongside this, during my stay was the inaugural year of the University of Melbourne Masters of Infant and Parent Mental Health course. I had the opportunity of attending theses seminars as well. Each of these experiences

augmented my knowledge of working directly with young children.

The Pathway Parent-Infant Unit was a rich working environment: stimulating, supportive, respectful. Never have I so enjoyed team meetings nor so valued my colleagues' experience and their willingness and capacity to share their thinking and their knowledge. The baby was central to the team's thinking and provided the organising focus for the day to day pondering and the Unit's therapeutic work. Paul Robertson, Director of Parent-Infant Unit of Pathways provided regular supervision of my clinical work; I value his wisdom and support.

Clare Fiddler, Child Psychiatrist supervised my psychotherapy treatment with a five-year-old boy. The therapy was often tough going, for him and for me. Clare's experience and reflections enabled me to continue the difficult work through which I learnt so much. Rob Gordon, Clinical Psychologist, Group Psychotherapist and Director of Victoria's Disaster Plan help me develop my understanding of working with groups.
In my work at Albert Road I co-facilitated a group for mother's and babies. with one of the nursing staff at Albert Road. It was called the "Watch, Wait and Wonder Group", incorporating some of Elizabeth Muir's ideas. Both the group and the group supervision were marvellous.

Some Melbourne readers may have taken the opportunity of enrolling in the Graduate Diploma of Infant and Parent Mental Health that Campbell Paul, Brigid Jordan and Frances Thomson-Salo present at the Royal Children's Hospital. It is very fitting that they now also offer a Masters Program. The richness of their knowledge, the sensitivity of their clinical work, and their openness and capacity to share their thinking and to support others in finding their way with their own clinical work is phenomenal. I learned so much from being part of the Masters Course seminars and valued the discussions and case material shared by the five others in the group. As part of the course Fiona McDermott, academic lecturer and researcher presented a series of lectures/seminars on qualitative research. They were the most absorbing lectures about research that I have ever attended – and I have attended quite a number in my time. I am really looking forward the end of the year and reading the research stimulated by them when my colleagues present their research projects at.

Weekly supervision with Frances Thomson-Salo, Psychoanalyst, Infant Mental Health Specialist and lecturer was simply the highlight of my rich and busy week.

In my private practice work in Melbourne I worked only with families with children under 5 years. It was my honour to work with many different families and with many issues related to a family's journey with young children. One woman was pregnant, hostile to her baby and very fearful of becoming a mother. One couple had lost their baby who died just prior to birth. The mother wanted to die to be with him, and the father was desolate at the thought of loosing his wife as well as his baby. One five-month old girl and her mother could not understand one another very well and both were miserable. The little girl's grandmother had been psychotic when her mother was born and during her early years, so affect attunement did not come naturally. I was invited in to many nurseries. There were many ghosts. Grief and death of a grandparent or death of sibling during pregnancy were recurring themes.

Liam O'Connor, Child Psychiatrist, advised me in my first month that mother-infant psychotherapy is not just psychotherapy with the mother while having the baby present. At first I was not sure what he meant. Selma Fraiberg's writing, which inspired so many of us, gave me a few clues. Daniel Stern's simple model linking internal representation and behaviour of the therapist/parent/infant has also helped me to clarify my thinking. The need for direct work with the infant, as outlined in a letter Campbell and Frances wrote to The Child Psychotherapy Journal, has also influenced my practice. I try to remain mindful that experience shapes brain development, and that time is precious and important for the baby – he or she cannot wait. If the parent(s) cannot keep their child's needs in mind, then it is our task to ensure that we do so while working to help the parent(s) come to see their baby more clearly and more really. And infant mental health work offers such a wide canvas for our work, informed by our knowledge, skill, creativity and imagination.

In the final pages of this paper, I would like to share some thoughts about one family I worked with during my time in Melbourne. I have chosen this family because there were so many elements of our work together: supportive psychotherapy, grief work, mother-infant psychotherapy, parental and developmental education, interactional guidance, marital and family work. I hope to illustrate how working with families with young children offers us such a wonderful array of opportunities.

The Two-four-six family
Cathryn was referred with possible postnatal depression when her second child Fiona was four months old. Cathryn and Fiona had just had two unsuccessful days in a private mother and baby unit. Baby Fiona was not sleeping and the family had hoped the admission would help her sleep. Cathryn was left two days into the five-day program. She was furious with everything about the place She also found the separation from her first child, her two-year-old daughter, Ann, intolerable.

From March until my departure from Melbourne in October, I met with members of this family weekly. Most often I saw Cathryn and little Fiona, sometimes Cathryn alone, sometimes Cathryn and the two girls, Fiona and Ann. Twice I met Cathryn and her husband Charles with the baby and once I met with Charles alone.

Catherine's way in the world has been to fight with everyone. At the beginning of our work it was very hard for me not to fight with her too. She was very dismissive of everyone – critical, harsh, and judgmental. She told me she "did not suffer fools" and she seemed to meet a lot of them.

Cathryn could not bear to hear either of her children cry. It left her feeling frightened, "awful" and distressed because she "could not attend to them both". Cathryn was the eldest of four children, with 11 months between her self and her next sister. There was intense sibling rivalry, which she managed by discrediting everything about her sister and her sister's two children. She recounted a story from her mother about Cathryn being able to make a cup of tea from a very early age, and how she was sent on errands alone. She shared her mother's anxiety about money, and remembers worrying about how they were going to be able to pay the electricity bill. At five she recalls deciding that she would go to university to study science, and that she would never be poor. Her father was something of an artist and an armchair philosopher. In her final year at high school, Cathryn's parents separated acrimoniously, but not completely; she was caught up in her mother's bitterness. Devaluing men and their opinion was a dominant theme in the work, and mother and daughter relationships were, of course, central to our work. Early in my notes I wrote, "difficulty with separation seems to be an intergenerational issue."

Early in the Cathryn and Charles' marriage there had been a pregnancy of twin boys which ended abruptly just before 20 weeks. Cathryn was admitted to ICU with a massive postpartum bleed. She returned to work three weeks later. Her sons, although they were named were buried without ceremony or shared mourning. The couple never spoke about them together. After this experience they had great difficulty conceiving. Four years and much gynaecological investigation and intervention later Cathryn conceived. She acknowledged that she was "very anxious" during the pregnancy with Ann.

Notes from my observation of the first session included the striking absence of any mention of the children's father. Ann was encouraged to read a book and not to explore or play with any of the toys in my room. Her mother mentioned how Ann was "just like me... does not really like toys, likes to read." Ann was an alarmingly "good little girl". She was watchful and rather sad and subdued. I am pleased to report that this changed as the work progressed. She responded lovingly to her mother's tears about her twin brothers and offered her mother a tissue to wipe her eyes with "Here mummy". I wondered how much looking after Ann did of her mother, and how much this replicated Cathryn's own experience of looking after her mother. Ann's language was well developed. Fiona was a placid baby with a lovely smile. Her mother handled her competently but I felt that she did not really see the baby as a whole person; a sentient child who needed her.

Early in our work together I muddled some appointment times, just to prove I was incompetent, and was then grilled about my mothering qualifications. I learned that Charles was "very bright", he had accelerated academically, that he was inflexible and had a great many rules and rituals. He was the middle of three sons. His father died when he was in his early 50s and father and all three sons shared the same prestigious profession. Charles' family was monied and privileged. Cathryn was very envious and very critical.

My first real affective contact came during an early session when Cathryn remarked that Fiona was "very determined". I said, "she sounds rather like her parents". Cathryn was shocked. This was not how she saw herself at all.

Early in our work we returned again and again to the boys. She said of David and James, "I wouldn't have been able to manage". She also experienced a recurring thought "I have two girls, I should have had two boys... two would have been enough." When people asked her how many children she had, Cathryn said she replied "Two" and then said silently in her mind, "Not two, really four". Cathryn believed that it would be too difficult for the one inquiring if she were to tell them the truth of her experience of being the mother of four children.

Finding the proper place for first born children in the family story was a major part of our work. On the anniversary of their son's birth, Cathryn and Charles bought a potted plant and took Ann and Fiona to the cemetery. The talked together with Ann about her brothers and Cathryn learnt that Charles could bear her tears.

Cathryn was over identified with Ann and was distressed by her thought "I shall never be as important to her as she is to me". Cathryn said both of her relationship to her mother and of her relationship with her first born daughter, "we are very close". Cathryn had a sense of doom about the daughters and was fearful she might "damage them", particularly Ann. She remarked, "I am not a very happy person". This was her mother's story.

Cathryn often interrupted the baby's play abruptly. On one occasion, without any warning, she swept Fiona up from the floor where she was absorbed with some toys and plonked her in the pram. Frequently Fiona made no protest. It had not occurred to Cathryn that Fiona might be disturbed by this sudden change of activity. During an early session I commented on some positive gesture Cathryn made toward Fiona and highlighted Fiona's delight. Cathryn burst into tears. Building on strengths was a new experience for Cathryn. Her expectation was to be derided, criticised and bossed about. Her tears told me so eloquently of how gentle I needed to be with this mother and her daughters, how imperative it was that I not be seduced into fighting with her.

Cathryn utilised the reflective space in our work together extremely well. Together we created a space where Cathryn could think about herself and her daughters. She was able to work through what issues were her own and what were her mothers. She wanted to see her daughters, for who they were, separate from herself.

The aim of our work was simple enough: to decrease Cathryn's anxiety about her children and to increase her enjoyment with them. She was courageous to continue to the psychotherapeutic work. Charles was supportive of the work; her mother enraged and attacking. My departure was a real loss for Cathryn and her family. We prepared for it as best we could and made plans for

ongoing therapy. When we said goodbye ten month Fiona was still not sleeping through the night. I think her sleeplessness was a sign to me, and to her mother, that their work had not finished, there was still much to be done.

I will not forget Cathryn, Charles and their four children. I am grateful to them for what they entrusted to me and shared with me. Their story is one of the many that I now bring to my work with young children and their families. As I said earlier, I still have much to learn. This work is a joy and a privilege. The infants and families with whom we work with are our greatest teachers; if we allow ourselves to listen to them.

Much of the material in this article formed part of a presentation to the WA Branch of AAIMH early 1998.

REFERENCES:

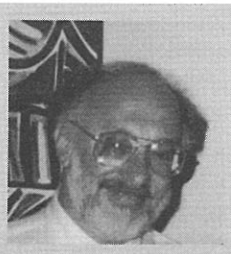
Fraiberg S, Clinical Studies in Infant Mental Health, Basic Books Inc, New York, 1980.

Muir E. Watching,Waiting, and Wondering: Applying Psychoanalytic Principals to Mother-Infant Intervention Infant Mental Health Journal, Vol 13, No.4, Winter 1992

Stern, D. The Interpersonal World of the Infant, Basic Books, Inc., Publishers Mew York 1985

Stern, D. The Motherhood Constellation Basic Books 1995

Thomson-Salo & F Paul C, Letter to the editors, Journal of Child Psychotherapy, 1997, Vol 23, pp 470-475.



Dr Allan Schore: *NOTES*

In the March newsletter we introduced Dr Schore and directed readers to a website where they could find information about his work (Association of Psychiatrists in Training Bi-National Website: http://www.ozemail.com.au/~auspsych). At the request of some members we have included a full copy of these Notes in this edition. This is done with the kind permission of Dr Schore.

Dr Schore is Assistant Clinical Professor of Psychiatry and Biobehavioural Sciences at UCLA Medical School. He is an eminent researcher in the field particularly looking at infant brain development and how it is influenced by early relationship experiences. He is author of **Affect Regulation and the Origin of the Self: The Neurobiology of Emotional Development**, Lawrence Erlbaum, 1994.

He presented at the Faculty of Child and Adolescent Psychiatry Meeting, in Sydney, in October 1998. The material re-printed below are lecture notes provided by Dr Schore to accompany these papers.

THE RELEVANCE OF RECENT RESEARCH ON THE INFANT BRAIN TO CLINICAL PSYCHIATRY

The relationship between early failures of development and the origin of a predisposition to later forming psychopathology has been a central concern of psychiatry.

"The best description of development may come from a careful appreciation of the brain's own self-organizing operations." (Cicchetti & Tucker, 1994)

The self-organization of the developing brain occurs in the context of a relationship with another self, another brain.

"We now need to ask... how do docial factors modulate the biological structure of the brain?" (Kandel) This necessitates an interdisciplinary approach.

To this end, in *Affect Regulation and the Origin of the Self* , I offer ideas about the origins of social functioning from the developmental sciences, recent data on emotional phenomena from the behavioural sciences, and new research on limbic structures from the neurosciences in order to generate an overarching model of emotional development.

Infant psychiatry offers knowledge of the interactive creation of an attachment bond of affective communication. The failure of the dyad to create this bond is central to the intergenerational transmission of emotional disorders.

Neuropsychiatry describes how these affect-transacting experiences shape the organization of a regulatory system in the orbital frontolimbic areas of the right hemisphere.
Clinical psychiatry is now demonstrating that affect regulation is an important concept that can bridge the 'mind-body gap'.

THE PSYCHOBIOLOGY AND NEUROBIOLOGY OF A SECURE ATTACHMENT:

The essential task of the first year of human life is the creation of a secure attachment bond between the infant and primary caregiver.

In the process of 'contingent responsivity' the more the mother tunes her activity level to the infant during periods of social engagement, the more she allows him to recover quietly in periods of disengagement, and the more she contingently responds to his signals for reengagement, the more synchronized their interaction.

Mutually attuned synchronized interactions are fundamental to the ongoing affective development of the infant.

In light of the fact that misattunements are a common developmental phenomenon, the primary caregiver must also modulate nonoptimal high levels of stimulation which would induce supra-heightened levels of arousal in the infant, and, most importantly, participate in interactive repair to regulate stressful infant states.

Psychobiological attunement is the fundamental mechanism that mediates attachment bond formation. (Tiffany Field)

Attachment is, in essence, the dyadic regulation of emotion. (Sroufe)

Attachment is built into the nervous system, in the course and as a result of the infant's experience of his transactions with the mother. (Mary Ainsworth)

The baby's brain literally requires brain-brain interaction and occurs in the context of a positive affective relationship between mother and infant. (Trevarthen: 'primary inter-subjectivity')

"The emotional experience of the infant develops through the sounds, images, and pictures that constitute much of an infant's early learning experience, and are disproportionately stored or processed in the right hemisphere during the formative stages of brain ontogeny".

The child is using the output of the mother's right cortex as a template for the imprinting, the hard wiring of circuits in his own right cortex that will come to mediate his expanding cognitive-affective capacities.

The right hemisphere is dominant in human infants, and indeed, for the first three years of life.

'Joint attention': a form of nonverbal communication in which the infant coordinates his visual attention with that of the caregiver, and is now not only aware of an object but simultaneously aware of the mother's attention to the object. (Trevarthen: 'secondary intersubjectivity')

THE ORGNIZATION OF A REGULATORY SYSTEM IN THE OR5:25 PM:

Bowlby asserted that attachment behaviour is organized and regulated by means of a 'control system' within the central nervous system, and that the maturation of this control system is open to influence by the particular environment in which development occurs.

Recent neurobiological studies show that the orbitofrontal cortex, which is enlarged in the right hemisphere, acts in the highest level of control of behaviour, especially in relation to emotion.

Studies show that the orbitofrontal regions are centrally involved in attachment functions, processing facial information, and affect regulation, and that this system matures in the last quarter of the first year.

<u>The orbital frontal cortex is:</u>

- Situated at the interface of cortex and subcortex
- Acts as a 'convergence zone'
- Sits at the hierarchical apex of the limbic system
- Acts as a major centre of CNS hierarchical control of the energy-expending sympathetic and energy-conserving parasympathetic branches of the ANS

In optimal environments, a system emerges in which rostral brain areas can modulate, under stress, a flexible coping pattern of a coupled reciprocal autonomic mode of control, in which increases in the activity in one ANS division are associated with decreases in the other.

The orbital prefrontal region is expecially expanded in the right cortex, and indeed it comes to act in the capacity of an executive control function for the entire right hemisphere.

The right side of the brain contains a circuit of emotion regulation that is involved in 'intense emotional-homeostatic processes' and in the modulation of 'primary' emotions. (Porges)

The prefrontal-limbic cortex plays a unique role in the regulation of motivational states and in the adjustment or correction of emotional responses.

IMPLICATIONS FOR THE ETIOLOGY OF PSYCHIATRIC PSYCHOPATHOLOGY:

"The attempt to regulate affect – to minimize unpleasant feelings and to maximize pleasant ones – is the driving force in human motivation." (Westin)

The mother of the securely attached infant permits access to the child after a separation and shows a tendency to respond appropriately and promptly to his/her emotional expressions.

In contrast the mother of an insecurely attached infant is emotionally inaccessible and reacts to her infant's expressions of emotions and stress inappropriately and/or rejectingly.

Early forming psychopathology constitutes disorders of attachment and manifests itself as failures of self and/or interactional regulation. These regulatory failures are manifest in a limited capacity to modulate the intensity and duration of affects.

All forms of psychopathology have concomitant symptoms of emotion dysregulation. This dysfunction is manifest in more intense and longer lasting emotional responses.

A dysfunction of internal reparative mechanisms is most obvious under stressful and challenging conditions that call for behavioural flexibility.

'Growth-inhibiting environments' negatively influence the ontogeny of homeostatic self-regulatory and attachment systems.

Loss of abilty to regulate the intensity of feelings is the most far-reaching effect of early trauma and neglect.

Early failures in dyadic regulation skew the developmental trajectory of corticolimbic systems.

Structural limitations in the mother's emotion processing right brain are reflected in a poor ability to comfort and regulate her child's negative states.

These experiences are stamped into the insecurely attached infant's right orbitofrontal system and its cortical and subcortical connections.

Stressful alterations in the chemistry of the developing brain also produce significant changes in the numbers and functional capacities of the frontolimbic receptors for neuromodulatory and neurohormonal agents.

Nonoptimal psychobiological experiences induce a severe and extensive pruning of the sympathetic ventral tegmental and/or parasympathetic lateral tegmental limbic circuits.

Early deprivation of empathic care, either in the form of excessive arousal reduction or intensification, creates a growth-inhibiting environment that produces immature, physiologically undifferentiated frontolimbic systems.

The orbital cortex shows a 'preferential vulnerability' to a spectrum of psychiatric disorders.

A central goal of all dynamic therapies is to increase the flexibility of a person's emotional control structures.

The psychotherapist is an important regulator of the patient's physiology by acting on the patient's unconscious affect regulating structures.

There is an interview with Allan Schore on the net at
http://www.aronson.com/ppp/schore.htm

"EARLY TRAUMA AND THE DEVELOPMENT OF THE RIGHT BRAIN"

INTRODUCTION:

The etiology of PTSD is best understood in terms of what an individual brings to a traumatic event as well as what he or she experiences afterward, and not just characteristics of the event itself.

Most serious maltreatment occurs to infants under two years of age.

Early abuse is also negatively impacting on the developing brain, thus producing enduring effects.

THE NEUROBIOLOGY AND PSYCHOBIOLOGY OF INFANT TRAUMA:

The good-enough mother of the securely attached infant permits access to the child after a separation and shows a tendency to respond appropriately and promptly to his/her emotional expressions.

In contrast, the abusive caregiver not only induces traumatic states in the infant, she also is inaccessible and reacts to her infant's expressions of emotions and stress inappropriately and/or rejectingly.

The infant's psychobiological response to trauma is comprised of two separate response patterns, hyperarousal and dissociation. (Bruce Perry)

Initial stage: a state of fear-terror mediated by sympathetic arousal

Later stage: dissociation, in which the child disengages from stimuli in the external world and attends to an 'internal' world.

This latter parasympathetic dominant state of conservation-withdrawal occurs in helpless and hopeless stressful situations in which the individual becomes inhibited and strives to avoid attention in order to become 'unseen'.

In traumatic states, both the sympathetic energy-expending and parasympathetic energy-conserving components of the infant's developing autonomic nervous system are hyperactivated.
In the developing brain states organize neural systems, resulting in enduring traits. (Perry).

The loss of the ability to regulate the intensity of feelings is the most far-reaching effect of early trauma and neglect. (van der Kolk)

Early states of terror, in particular, are associated with a vulnerability to later forming PTSD. (Perry)

THE NEUROPSYCHOLOGY OF AN INSECURE-DISORGANISED /DISORIENTED ATTACHMENT PATTERN:

Main and Solomon studied the attachment patterns of infants who had suffered trauma in the first year of life.

'Type D', an insecure-disorganised/disoriented pattern of attachment is found in 80 of maltreated infants. This pattern consists of simultaneous display of contradictory behaviour pattens, including:

- apprehension and confusion
- behavioural stilling
- stereotypies that are found in neurologically impaired infants

Early trauma more so than other trauma has a greater impact on the development of dissociative behaviours.

EXCESSIVE ORBITOFRONTAL PRUNING AND PTSD

Children with early physical and sexual abuse show EEG abnormalities in frontotemporal and anterior brain regions.

The developing infant is maximally vulnerable to nonoptimal and growth-inhibiting environmental events during the period of most rapid growth.

Psychological' factors 'prune' or 'sculpt' neural networks. Excessive pruning operates in the etiology of a vulnerability to later forming PTSD.

Imaging studies document altered orbitofrontal metabolism and impaired blood flow in patients with PTSD.

Regulatory failures are manifest in a limited capacity to modulate sympathetic-dominant affects like terror, rage, excitement, and elation, or parasympathetic-dominant affects like shame, disgust and hopeless despair.

PTSD patients exhibit pathological 'dissociative switches' between states, which occur rapidly, and are manifest in:

'inexplicable shifts in affect'
discontinuities in train of thought
changes in facial appearance, speech and mannerisms

Small disruptions associated with interpersonal stresses could too easily become rapidly amplified into intense negative states.

RIGHT HEMISPHERE DYSFUNCTION AND PTSD PSYCHOPATHOLOGY:

Early traumatic experiences specifically negatively influence the development of the right hemiisphere.

The right hemisphere is central to the arousal dysregulation that characterises PTSD.

Transactions with an emotionally misattuned and unresponsive caregiver who induces traumatic states and provides poor interactive repair are stored in procedural memories.

Unconscious working models of disorganized-disoriented attachment encode an enduring prototypical cognitive-affective schema of a dysregulated-self-in-interaction- with-a-misattuning-other. (pathological internal object relation)

The right hemisphere provides the structural substrate for episodic and autobiographical memory of early childhood.

Visual and auditory stressors, that are nonconsciously processed in the right hemisphere, especially the perception or memory of images and sounds of threatening and humiliating faces, are potent triggers of dysregulation in PTSD patients.

IMPLICATIONS FOR MODELS OF EARLY INTERVENTION:

The concept of critical periods describes the extraordinary sensitivity of open dynamic systems to their environment, and asserts that these systems are most plastic in transitional periods when they are in the process of differentiating.

Preventive interventions that utilize an interactional approach should be targeted to these critical periods.

STATE NETWORK NEWS

NSW COMMITTEE MEMBERS 1998/99

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Hearty congratulations to Professor Bryanne Barnett, newly appointed Professor of Perinatal and Infant Psychiatry. We are all delighted for you with your latest achievement and the timely recognition perinatal and infant psychiatry richly deserves.

AAIMHI (NSW) have decided to develop a position paper on infant settling. Anyone interested in contributing to this paper, please contact asap, Dr. Isla Lonie, President, NSW Branch, AAIMHI, PO Box B7, Boronia Park, NSW 2110.

Our website is almost ready. We will have more news next newsletter. The communication possibilities via this media will really launch us into the twenty first century. Numbers for our regular clinical evenings have been steadily growing. In March we had Prof. Ben Bradley from Charles Sturt University in Bathurst who gave us a marvellous insight into the mind of a very careful researcher. His topic was "Visions of Infancy" and he spoke to us about the ways in which our thinking about infants changes the models we use to describe and explain their behaviour. There was a lively discussion after the talk and much to our delight, he has indicated that he hopes to become a regular attender in future.

For the clinical evening in May, we hosted Assoc. Professor Susan McDonough visiting from the University of Michigan where she directs an Infant Mental Health certificate program for post-graduate students in psychiatry, psychology, social work and nursing. Those who attended were highly delighted with her theme "Interaction Guidance in Infant Mental Health" as she captured our attention on the work she does in prevention and early intervention projects with cognitively limited, mentally disturbed and adolescent parents who have infants with feeding, sleeping and attachment disorders.

The next clinical meeting will be Thursday, August 19th at 7:00pm at St. John of God Hospital, 13 Grantham Street, Burwood. Dr. Stephen Malloch will be our guest speaker. His topic "Mothers & Infants and Communication Musicality" which will be about the interface between music and infant development. Cost: $20:00 payable at the door or to book, send cheque to AAIMHI (NSW), PO Box 39, Double Bay, 2028. There is no cost for members to attend.

The Australian College of Psychotherapists in association with The Institute of Contemporary Psychotherapy invites you to their conference and workshop August 28 - 30, 1999 in Sydney on "Understanding the Self". Their international speakers will investigate the traumatised self, the delinquent self, the sexual self and the professional self. For more information please contact Sarah Purdy, Institute of Contemporary Psychotherapy, 4/4 Charles Street, Petersham, NSW 2049. Phone 61-2-8585 1000. Fax: 61-2-8585 1010. Email: icpaus@icp.com.au

QUEENSLAND COMMITTEE MEMBERS:

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The Queensland conference with guest speaker Susan McDonnagh was a big success. So much information to digest. The feedback was very positive an we are sure everyone took away something they can use in their practice.

AAIMH (Qld) is committed to continuing their regular clinical meeting in which local work is presented and members are invited to contribute their comments and experiences. In February a meeting was held at Belmont Private Hospital in which two case studies and video of mother - infant interaction was presented. Video is such a wonderful medium and the meeting generated live discussion and exchange of views. Our next "video evening" is planned for June.

Dr.Louise Newman has kindly conceded to conduct a halfday seminar in Brisbane in July. She will present her work on attachment and therapeutic issues in working with borderline mothers and their infants. The staff at the Brisbane Centre for Post Natal Disorders are very anxious to benefit from Louise's knowledge, skills and

ability and we feel sure many practitioners will attend for the same reason.
Dr. Michael Daubney will take on Queensland's Network News correspondent responsibilities for future newsletters.

Marianna Huxley

Thank you Marianna for all your work and regular contributions to this newsletter. We have been grateful to all our correspondents, who work as volunteers and help bring to life a national feel. Many thanks for being the inaugural Queensland rep.

VICTORIAN COMMITTEE OF MANAGEMENT

President: Brigid Jordan
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Scientific Program: Michele Meehan

Membership Secretary:Helen Belfrage
Regional Vice President:Campbell Paul

Committee Members:
Sue Morse
Jeanette Milgrom
Zipporah Oliver

Despite the Winter gales members have turned up to two of our most fascinating Clinical Scientific Meetings. The April event exposed us to the world of the blind child. The speakers lead a discussion about the physiology of sight and how the blind infant differs from the sighted infant. Blind infants appear to have significantly different behavioural signs compared to sighted infants, and parents need considerable help in learning how to compensate for the lack of attunement that is often experienced. There can be an ensuing struggle for the each parent to learn what their special tasks are with their child, and how to read their signals in order to promote the child's attachment relationships. Working with parents involves helping them understand these different messages so that parents themselves can facilitate the child's capacities to develop relationship with those she can not see. Dr. James Elder Paediatric Opthalmologist and Dr. Glen White, Psychologist from the Royal Institute for the Blind shared with us their considerable expertise in clinical knowledge of working with blind babies and their families. Dr. White allowed us to visually experience this difference by showing a video tape of 12 month twin girls, one of whom was blind. We could see how different were the responses of the infants to the interactions of the mother when she was feeding her daughters.

The audience was very moved by witnessing the juxtaposition of the two children, identical in age, sex, and family background, but different in the most profound of ways. The sighted infant gazed at the food, the mother and looked around as a car noise distracted her from outside the kitchen. The blind infant seemed unable to locate herself nor her mother. She had trouble holding her head and seemed not connected to the task at hand in quite marked contrast to her sighted sister. We were able to view how much more "work" was needed to enable the blind child to develop a sense of self and space when "visual reference points' like mother's eyes, food on spoon, and location of herself in relation to others was missing. How the blind child develops during the early months when it is thought of as a period of primary intersubjectivity; a time when the infant sets down the capacity for shared emotional experience is still an important question.

Dr. Elder's Opthalmological opinion generated much debate around how early infants vision developed. It appeared that conventional medical view of infant sight suggests that the infants vision is not well developed until around three months. This view is in contrast with some whose work brings them in close contact with infants and parents in psychotherapy.

At an even colder May meeting members were warmly rewarded by the consummate speaker and erudite Dr. Janet McCalman. She spoke on her history of the Royal Women's Hospital, admirably linking her research with the little documented accounts of infants born in the last century. An account of the talk appears in another section of this newsletter.

Most AAIMH members will know that the next National Conference, and the last of this century occurs in Melbourne in November. The Victorian committee has worked very hard this year working on making the occasion a great success. We have a mission statement which promotes the conference focus on treatment for infants and their families. Thanks to Campbell Paul's decades of incredible networking skills we have some of the most renowned international infant mental health specialists as our plenary speakers. The program looks very interesting clinically, with the conference dinner being held the Observatory Café, which is situated in the old astronomy observatory station on the edge of the Botanical Gardens; visitors will be treated to a viewing of one of Australia's earliest telescopes. We hope members from across the country will come.

Sarah Jones

SOUTH AUSTRALIA

From: Pam Linke
Senior Project Officer
Marketing and Corporate Communications
Home email: linkes@newave.net.au

The SA Branch of AAIMHI combined with Helen Mayo House sponsored the visit of Dr Susan McDonough, from the University of Michigan Family Study Program. She gave two sessions; an all day session for infant clinicians for Helen Mayo House, and an "after work" presentation organised by AAIMHI with a more general audience. There was a great deal of interest in our session which had an excellent attendance including social workers, nurses, paediatricians, psychologists, child protection workers and early childhood workers. Dr McDonough spoke about her work with hard-to-reach families and some of the ways in which she engages with these families, especially working in their own homes. Many of the attendees found her ideas very affirming of their own work with families and children. She emphasised the importance of using video with parents to help them to "wait, watch and wonder" about their interactions with their children.

We are still working on getting Dr Bruce Perry for a session in May next year. He will only be in Australia for about 10 days and so far has not confirmed his timetable here but it is expected that he will be attending the Royal College of Paediatrics Conference in Adelaide, hopefully giving a session in Adelaide for AAIMHI and doing some work in Melbourne .

Conference 2000. We have confirmed the dates for the Year 2000 national meeting in Adelaide. It will be on 27,28,29 October. More about it in future newsletters.

We are still promoting the Fathers video and sales are steady to a wide variety of different organisations.

Pam Linke and Elizabeth Puddy presented our understanding of Heidelise Als' work with infants in the neonatal nursery at the Women's and Children's Hospital Infant Mental Health meeting. There was a lot of interest from the group who attended. We are hoping to develop this further by getting someone who has actually trained with Heidelise Als to present the work to staff who work with infants at our major hospitals.

Following up on our concerns about publicity which is damaging to children we had a letter from the South Australian Attorney General saying that he has been able to have the law changed in South Australia so that the courts may order a child's name to be suppressed if it is in the interest of the child's well being to do so. This only applies to South Australian residents and it may be helpful for other branches to take this issue up with their own Attorneys General.

The recently published book, Silent Nights, written by a South Australian doctor has been of some concern to the local branch of AAIMHI. The book is about "sleep problems" in infants, and the author advocates leaving infants to "settle themselves to sleep" from birth onwards. His method of sleep training was also featured on an evening TV program, although fortunately a speaker from Child and Youth Health gave an alternative opinion on the same program. We are thinking of taking infant sleeping and crying as themes for the Year 2000 conference.

WESTERN AUSTRALIA

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Dr Caroline Zanetti, Consultant Psychiatrist
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Susan Brill, Clinical Psychologist,
Manita Beskow, Psychologist
Yap Lai Meng, Clinical Psychologist.

Newsletter correspondent:
Carmel Cairney, Clinical Psychologist

Our monthly presentations have continued to be stimulating. In March, we had the opportunity to view the Robertson film, "Lucy", followed by a talk about the Association for the Welfare of Children In Hospital (AWCH). The film eloquently displayed the effect of separation from both parents on "Lucy"; and her later attempts to repair this. It was impressive to hear how AWCH attempts to minimise the trauma of a hospital stay.

In April, Dr Susan McDonough visited and presented a 2 day workshop on "Reaching Hard to Reach Families Through Interaction Guidance". The workshop was well-attended and well received. Among other things, it was good to be reminded about the vital importance of the clinician's relationship with the family in parent-infant work and the need for a non-judgemental stance.

Our local committee worked very hard to make Susan McDonough's visit a success. Particular thanks are due to Caroline Zanetti, Patrick Marwick and Carol Smith.

In May we had a talk from Brigid Jordan, Infant Mental Health Specialist from the Royal Children's Hospital in Melbourne, and the National AAIMH president-elect. With some passion she presented her PhD research on her treatment intervention of irritable infants admitted to hospital. There was a very lively discussion from the large audience.

Our advocacy sub-committee remains alert for opportunities to speak on behalf of infants. We have received letters in reply from a newspaper, and from our State Attorney-General. **Carmel Cairney**

AAIMH BILLBOARD

AUSTRALASIAN MARCE SOCIETY CONFERENCE
September 17th-18th 1999
Cato Conference Centre Melbourne.

Melbourne this year hosts the third Australasian Marce Conference; Louis Appleby from U.K, the current International president will be speaking on Treatment of Postpartum disorders, and of particular interest for AAIMH members, Ed Tronick will be conducting a workshop/ lecture on mother-infant interaction in postpartum disorders.

Registration can be for the whole conference or for the workshop only. There will be a number of other workshops, including transcultural, early intervention and art therapy, as well as current research in risk, management and prevention.

For details contact the AMS Conference Organiser, email; conorg@ozemail.com.au or phone 0393801429, or Anne Buist on 0394962940.

AAIMH 6th Annual Conference: The Infant Speaks: The baby, her family and the therapeutic process

Conference Theme

The conference will focus on new understandings of the infant's shared inner world and their capacities for communication and the implications of these for psychotherapeutic work with infants and their families. These developments offer the prospect of innovative clinical approaches to common practice dilemmas. These issues are of vital importance for mental health and other professionals working with troubled infants, toddlers and families in a multitude of contexts.

Keynote Speakers:

Professor Colwyn Trevarthen, Emeritus Professor, of Psychology, University of Edinburgh will present research on the development of infants' capacities to enter into the minds of others. He has a particular interest in infant play, communication, humor, teasing, creativity and inventiveness. He has made important contributions to the understanding of the problems faced by children with autism. **Professor Bernard Golse,** Child Psychiatrist, Professor of Child and Adolescent Psychiatry, Universitaire Rene Descartes (Paris V). Paris. Professor Golse will present a European perspective on infant parent psychotherapy, the emergence of infantile psychic life and early signs of the development of disorders of empathy and the infant parent relationship. **Dr Ann Morgan,** Psychotherapist and Paediatrician, Melbourne will present the **Winnicott Seminar.**

Call for Abstracts for Poster Presentations

The conference committee invites conference participants to submit abstracts for poster presentation. This innovative method of presentation involves the preparation of a poster for display during the conference and a 5 minute oral presentation. Posters may be of clinical, research or program developments. Posters will be scheduled for presentation with similar posters and a chairperson will be allocated to each poster session. It is hoped this innovative format will provide the opportunity for lively discussion and debate that can continue in the plenary sessions.

Conference Secretariat

For further information please contact
Fiona Campbell, The University of Melbourne, f.campbell@pb.unimelb.edu.au
Michael Sullivan, The University of Melbourne, m.sullivan@pb.unimelb.edu.au

Friday 26th to Sunday 28 November 1999
The University of Melbourne
Victoria
Australia

MONTREAL CONFERENCE 2000

News From the World Association for Infant Mental Health

The 7th International Congress of the World Association for Infant Mental Health is being held in Montreal, July 26-30, 2000.

We would like to invite Australian members of AAIMH to the WAIMH congress. As we are all affiliated with the World Association we are hoping members will get the word out to all professionals concerned with infant mental health.

WAIMH will be advertising the conference widely and there will be further notices in your newsletter. We hope you will consider this wonderful opportunity to meet with infant mental health colleagues from all over the world.

Email address: **waimh@UMS1.Lan.McGill.CA**

Further information is available from:
WAIMH Secretariat
550 Sherbrooke Street West
West Tower, Suite 490
Montreal, QC, Canada H3A 1B9
Joan Gross at **waimh@ums1.mcgill.ca** or
Dr. Lee Tidmarsh of the Local Arrangements Committee at mdlt@musica.mcgill.ca.
We look forward to seeing you at the Congress.