Australian Association for Infant Mental Health

NEWSLETTER

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FROM THE EDITORS:

This edition comes to you on our return from the World Association of Infant Mental Health (WAIMH) Conference in Montreal, Canada; an excellent conference . In excess of 20 Australians attended (of 900 delegates from around the world) reflecting the tremendous interest in Infant Mental Health in this country. We hope to bring you a report on the event in the next edition. Of great importance for all Australians in the infant mental health field is our National President, Ms. Brigid Jordan nomination to the Board of the WAIMH. Congratulations Brigid.

Following the success of the series of articles on "Controlled Crying" in recent editions we introduce 2 further themes in this edition – (1) Infants in NICU and (2) Infants in Group Therapies. There will be further articles on these themes in coming editions. If you have something to add please write to us. We would love to have a brief article on your responses or experiences. Even "a letter to the editor" adds to the local level to the debate.

We are fast approaching our National Conference in Adelaide. It is being held from 9 – 12 November. Some details in this edition (see SA Network News) with greater details in the coming September edition. If you want details about registration please contact - The contact is:

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Paul Robertson

2000 CALENDAR OF EVENTS

AUGUST (NSW)

25 & 31of August: Clinical Evenings. See Page 14 for details.

SEPTEMBER (VIC)

2 September: Parental Loss and Postnatal Depression: A Half Day Conference. See Page 6.

SEPTEMBER (VIC)

14 & 15 September: Trauma & Treatment Program presented by Professor William Yule. See Page 19.

NOVEMBER (South Australia - National)

9 - 12 November: AAIMH National Conference in Adelaide. See Page 20.

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NICU and Infants:

Co-ordinated by Norma Tracey and Colleagues

Sydney AAIMH Conference Papers

I am glad to introduce a special Edition of the AAIMHI Newsletter on Neonatal Intensive Care. Think on it - here in one small Hospital Ward, the highest medical technology combines with our most primitive fears to do with life and death. In the five Conferences we have had in Brisbane, Sydney, Melbourne, Perth and Adelaide on our book, "Parents of Premature Infants", we learnt so much. The professionalism of the staff, the incredible strain under which they were working, their wish to get it right not only for the babies medically but for the parents was obvious wherever we went. "You're speaking to the converted" one mother said to me, "like where are the others?" she added. We had to think – " Is the stress of this ward so great that in order to do their life saving work there, they could not afford the time or mind space to join us in thinking about the meaning of all this for the mothers and fathers? Surprisingly the mothers themselves made efforts to come to the Conferences. The mothers in Adelaide taught us more than we could ever teach them. The fact that we sold 200 books of "Parents of Premature Infants" to the staff that came and these were mostly nurses, spoke of the intensity and the interest and concern of those professionals working with the mothers. "Nurses don't buy books!" said our distributors here in Australia. They proved her so wrong.

Even if you never work in such an incredible space age environment, anyone who works with mothers and infants will benefit from the models exposed in the material in this edition. It is the work of people who create a thinking space to understand not only the responses of these parents to trauma but their own responses in daring to be open to receive the parent's feelings. The model of trauma for the mother whatever the problem with the infant or with her own health as mother to that infant is enunciated here. So too is the father's trauma in trying to hold together a world fractured at it very basis, as mother and infant struggle for a survival they do not necessarily achieve. It was exciting to have a mother run back to me twice after she had left to shake my hand again and say how validated she felt in her distress by the presentations of the day. "I ticked everywhere in the book where it applied to me or the mothers I knew", another mother Angela said, " and the columns are full of ticks". Praise indeed from a woman who works directly with staff to help them understand parent's needs on the ward.

I want to now write that I am particularly grateful for the support and input we received from Psychiatrists, Social Work Colleagues, Speech Pathologists and Physiotherapists, some of whose work appears here. The papers from my Social Work Colleagues I sent it for publication without them knowing. They thought it was "just ordinary everyday work" and nothing to write about. If for no other reason than we need to know the good that is occurring on our wards however much more there is to do, these deserve publication. I hope everyone that reads this edition finds it of meaning and value to them.

(Pamela Petty has now bought in another 200 books so if anyone would like to purchase same just email Norma on nortrac@ozemail.com.au or telephone (02) 94272028.)

The following papers were presented at the Sydney AIMHI Conference on Parent of Premature Infants. This was where Norma's book was launched in Sydney. Seventy four people attended from every Obstetric hospital in Sydney.

Ms. Jill Ditton

Social Worker, NICU New Children's Hospital Westmead

The Neonatal Intensive Care Unit at the New Children's Hospital Westmead, cares for premature and full term infants in need of medical and surgical care.

Infants from all over NSW and Noumea are admitted to the unit.

Parents of these sick babies often exhibit signs of trauma on arrival and during their newborn's stay in the Neonatal Intensive Care unit. Sadly, they are often given bad news about their infant's condition.

They have to make difficult decisions about his or her care. Sometimes it is here they mourn the death of their precious newborn.

The Social Worker, in this Neonatal Intensive Care Unit works as part of a multidisciplinary team, in a highly technical world staffed by expert medical, nursing and allied health professionals. In essence the role of the social Worker in this environment is to listen to Parents with empathy and to offer them support.

LISTENING -

- Listening means spending time with a parent - uninterrupted time. This spending time with a parent is paying them a compliment, it says you are important enough to spend time with.

- Listening affirms parents' value as a human and an important part of their baby's healing.

- Listening means not talking at parents, but talking to them, not telling them things but sharing their experiences, not interrupting or correcting but letting them say what they need to say.

- Listening means not giving advice but believing that parents have their own solution and they will find them as the meaning of events becomes clearer to them.

- Listening means we listen with the ears and heart, we stand beside someone and support them. When we listen we encourage people to be themselves.

- Listening means starting where the parent is a not pushing them to be where they are not. It means not expecting a parent to make a decision the first time they have heard an issue discussed and indicate to you they are not yet able to decide.

- Listening means picking up the cues when parents say they want to be alone, don't want to talk right now or want to think about the matter and come back later to discuss it.

- Listening means hearing a parent's anguish.

- Listening means having a person say, I would rather talk to a friend or a chaplain or another person and hearing them.

- Listening is empowering. It helps create the invisible fuel needed for decisions and actions.

- Listening means not judging what a parent is saying even if it is unusual or not current thinking.

- Listening with eagerness conveys a respect for the parents.

Finally listening means hearing the meaning of what is said.

PREMATURE INFANTS - THEIR EMOTIONAL WORLD. WORKING IN THE NICU.

Ms. Dierdre Chiu

Social Worker for the NICU Unit, Royal North Shore Hospital.

I would like to share with you some reflections on working in the NICU.
I came into work one Monday morning and as soon as I came through the door, one of our families asked to see me. guessed the weekend had not gone well as they looked and sounded anxious.

We went to our Quiet Room and before we had even sat down, they started to tell me one of their very prem twins was extremely ill and the doctor had spoken with them about withdrawing care.

They had a lot of questions. Particularly they wanted to know if other parents had faced this moment and in fact what did it mean? I was sure the consultant or medical staff would have spoken to them at length so to me this was another step they were taking into the world of trauma and fear. I immediately started to feel a sinking feeling in my stomach and dreaded how the day would go. As we sat and talked I was concentrating very carefully on their body language as if being able to gauge that would somehow protect me from their anxiety. I chose my words carefully and tried to slow the pace giving me time to think and them time to hear.

This is such a critical point and I have never felt sure whether this is a time during which each word is branded **in** their memories, or whether the fear is so great that they hardly hear a word. It is difficult for families to say exactly what they feel. I suspect they are afraid to say **it** out loud in case what they are thinking will then really happen.

This for me is the hardest part of our work because we also carry part of that fear within us. In a life and death crisis with their baby, families are functioning on a primal level, which leaves us also disturbed. I have to try really hard not to allow that to paralyse me. So we sat down and I asked them to tell me what had happened already this morning. They had not been home since early yesterday,. Their little boy had been struggling all through the night hovering between life and death, with medical staff attending, desperately trying to improve his condition.

They also are powerless at times!

These parents then asked **me** to tell them honestly if he was suffering. I hesitated because 1 knew they trusted me. We had spent a lot of time together but I always feel it is not my place to tell them these things. The mother was then able to say that she could not possibly make a decision "to withdraw care" as her own mother would see this action as going against God's will and would never find it an acceptable option.

> ***"She reminded me of our discussions in the previous week. She had told me she would go "mad" if her babies died and now was afraid she would.."***

Feeling my way through their dilemma of so desperately wanting this baby boy to live, fearing he was in pain, not wishing to prolong that and also conscience stricken regarding withdrawing further treatment, I waited a moment hoping I could offer something helpful. I struggled with my own feelings around what I could say and admitted ill babies do sometimes suffer pain despite everything being, done to avoid that.

At this point they were both crying. I went on to say that however these little ones also sometimes make the decision for everyone before too long. Being premmie, fragile and critically ill they let go. I had to repeat this for them and they wanted to go and see him. The moment we came back through the door it was obvious to me he was already at the threshold. Doctors were working on him. 1 was also acutely aware that the parents did not know this yet. These things we know and see because we work there are a burden we carry. What they donot know makes me feel guilty and uncomfortable.

And this is not just about death!! Parents hold on grimly to every perceived improvement their baby gains- such as ventilation rates decreasing, or coming off the ventilator altogether. However it is not unusual for the staff to be aware that despite survival, some of these babies will have very significant problems. We have all felt the sadness when parents are finally aware that their fantasy is not really fulfilled. In some cases, we even say, it is a tragedy worse than death.
Within a few minutes the consultant told them their baby boy was dying and in a very short time ....he had gone.

Add to this the knowledge that this couple are 40 years old have been on IVF for years and this is their first pregnancy. Their babies, a twin boy and girl were born at 24 weeks gestation the very edge of viable life, and like all these babies so desperately wanted. They had come into the NICU with tremendous hope and terrible fear. Now 3 weeks later their baby son died and their baby daughter remained fragile in intensive care.

If you cannot bear to feel totally powerless this is not the place to work.

We spent the day doing what they needed. Finally they held him - but how that must have hurt them and this is truly the most exhausting work.

When the baby was finally freed from all the attachments and lines, the father totally broke down sobbing and shaking.

His wife also cried. I waited.

When some time had passed and they were quietly sitting, we took them to our Quiet Room with their baby. She reminded me of our discussions in the previous week. She had told me she would go "mad" if her babies died and now was afraid she would.

> ***"When the baby was finally freed from all the attachments and lines, the father totally broke down sobbing and shaking."***

We frequently have twins admitted to our unit and often they are IVF babies. It is also not unusual for families to lose one of their twins as did this couple. It is incredibly difficult for families and in particular this couple to deal with the complex and contradictory feelings. They are suffering an overwhelming loss and yet have to remain positive for their daughter who still needs them. The mother told me last week she absolutely hated coming to the unit every day for long periods, yet she had to because it is her responsibility. The emotional investment in this living child and her new found understanding that the world is not necessarily a benign place has increased her vigilance to such a degree we have had to talk about it to help her get through the long haul yet ahead.

She watches very closely every single moment of her day, noticing both the subtle and the obvious differences in the way staff handle her precious baby. She observes, challenges and suggests when and how different decisions are made by various individuals.

So she is now not the only one feeling she will go mad!

The father tells me he curses God every day much to his wife's distress. He is deceptively cheery, until I talk with him.He is a sensitive man who shows his feelings easily, consequently he is suffering because he feels people at work do not adequately acknowledge his loss and appear to have no idea of the implications of having a baby in intensive care. Every day he has asked me to write a letter about his daughter so he can take it to work and every day his wife asks me not to. She believes they should protect their daughter not use her to educate people. This week I wrote a letter which was acceptable to both without too much detail but giving some indication of the impact on the family.

I am not convinced however this will improve his situation. My experience is that most people are uncomfortable with other people's pain. There is definitely a time limit you are given by the outside world to grieve or suffer. 1 am still seeing them daily. Their little girl is now doing much better and in some ways so are they. The work I do with them is a parallel process with the family and the baby. As the baby improves, the parents progress a little and my work with them moves forward as well.

When I started this job over 4 years ago I saw as many people in NICU as I could. However, at some stage of my developing a more sophisticated understanding of what happens to NICU parents I moved from a crisis model to a trauma model and that means I see less families on a daily basis; my work with them is very different and I believe much more meaningful. The work we do together is around their internal processes and in this work, my hope is always to help them move to their adult selves with their dignity intact.

THE MELBOURNE INSTITUTE FOR PSYCHOANALYSIS
and
THE INTERNATIONAL PSYCHOANALYTICAL ASSOCIATION'S
Committee on Women and Psychoanalysis
with
THE AUSTRALIAN ASSOCIATION FOR INFANT MENTAL HEALTH

present a half-day conference

PERINATAL LOSS AND POSTNATAL DEPRESSION:

Absence, The Capacity for Loss, and the Consequences for Mother and Baby

Saturday September 2nd 2000

9.00 am (Registration at 8.45) - 12.30 pm

Ella Latham Theatre, Royal Children's Hospital, Melbourne

Cost $33 (incl. $3 GST) Tickets at door, or by sending name and address details, with a stamped addressed envelope to: 63 Heidelberg Road Clifton Hill Vic 3068
Enquiries: Tel 03 9489 1761

featuring papers from

PROF. JOAN RAPHAEL-LEFF

(British Psycho-Analytical Society)

"The Presence of Absence"

Joan Raphael-Leff is a practising psychoanalyst and Professor of Psychoanalysis in the Centre for Psychoanalytic Studies at the University of Essex. She chairs the IPA's Committee on Psychoanalysis and Women, and has specialised in reproductive issues with some 50 publications in this field, including books such as *Psychological Processes of Childbearing* (Chapman & Hall 1996, 4th ed) and *Pregnancy – The Inside Story* (Sheldon 1993, Jason Aronson 1996).

DR RUTH SAFIER

(Australian Psychoanalytical Society)

"The Impact on a Woman of Becoming a Mother – Loss, Growth and Distress in the Postnatal Period"

Ruth Safier is a psychoanalyst and child psychiatrist in private practice in Sydney, with a special interest in infant observation, and early intervention work with parents and infants. She is clinical consultant to the Early Intervention Programme of the NSW Benevolent Society.

The Neurodevelopmental Impact of Childhood Abuse and PostTraumatic Stress Disorders

A Report By:

Jeannette Milgrom, Caroline De Paola, and Jennifer Ericksen
Infant Clinic, Department of Clinical and Health Psychology
Austin & Repatriation Medical Centre Melbourne

A one day seminar on the impact of traumatic experiences on child development and function was recently presented by Dr Bruce Perry, Child Psychiatrist, Texas, USA, and hosted by The Gatehouse Centre, Royal Children's Hospital (5/5/2000). As part of the Infant Clinic research and treatment team we attended with the aim of updating our understanding of neurobiological development in infancy and expanding our intervention and screening techniques for infants who have been subjected to severely dysfunctional caregiving. Dr Perry's main message was that the sensitivity of the developing brain in infancy means that traumatic experiences at this time have a substantial impact and influence on future emotional, behavioural, cognitive, social and physiological functioning. The vast majority of brain development and organisation takes place in the first years of life. Furthermore, a child's neural system develops in accordance with the patterns to which it is exposed, and if these are chaotic and unpredictable, then the child's functional development capabilities will reflect this disorganisation. By contrast, in adulthood the brain is already organised, so whilst traumatic experiences alter this homeostasis, the brain is less sensitive to the change with respect to impact on future behaviour. Thus, there are significant differences in the consequences of trauma experienced by children and adults, and therefore the implications regarding prevention. Highlights of Dr Perry's argument are described below.

Diagram 1

PRIMARY BRAIN AREA	Brain Stem	Midbrain	Limbic	Cortical Subcortex	Frontal Cortex
DEVELOPMENTAL STAGE	Prenatal	0-6 months	one year	2-5 years	> 7 years

Critical Periods

Neurodevelopment is sequential in nature. Any developmental insult therefore has a differential impact on the neural system most actively being organised. An event is traumatic if it overwhelms the organisation of the brain and disrupts homeostasis. The following sequence of critical brain development was described in **Diagram 1**

"A growing body of evidence suggests that the developing brain organizes in response to the pattern, intensity and nature of sensory, perceptual, and affective experience of events during childhood. This is mediated by neurotransmitters and hormones. Stress responses can affect the development of the brain by altering neurogenesis, migration, synaptogenesis, and neurochemical differentiation...Neural systems that are activated change in permanent ways, creating 'internal' representations - literally, memories. The brain makes cognitive memories, emotional memories, motor-vestibular memories and state memories" (Perry, 1996, p. 5).

Perry argued that whilst negative experiences can influence brain development, it is just as

important for positive experiences to occur in attunement with the current developmental phase. The absence of crucial organising experiences at key times in development may result in profound neurobiological problems. Any brain area or system, once organized, is less sensitive to experience, less plastic. Thus, for example, neglect of synchronous interactions between a mother and infant may interfere with the child learning how to read the social-emotional language of others.

In addition, positive experiences such as secure attachment, which is accompanied by pleasure derived from the ability of an attachment figure to soothe and calm the infant, may facilitate important development perhaps as a result of the increased release of dopamines and opioids. Is it possible that problems such as drug abuse may have their roots in disrupted attachment? The brain creates memory owing to the capacity of neurons and neural systems to change from one homeostasis to another.

Postulated mechanisms of the effect of trauma

A theory was offered which proposed that certain cognitive states are linked to developmental stages as an individual's brain organises and forms. It was suggested that an infant's cognitive state is reflexive during the first year of life and evolves from this state through reactive, emotional and concrete thought until eventuating in the capacity for abstract thought during adolescence. Similarly, certain emotional mental states of functioning are also linked and formed relative to the development of particular areas of the brain. These mental states are hierarchical in nature, beginning at the most primitive end with terror and progressing through to fear, alarm, arousal and then calm.

It was implied that if a child is 'grounded' in a particular mental state (eg terror) then it is not possible for them to move through to the higher cognitive levels. Furthermore, it was suggested that severe trauma re-sets a child's baseline mental state as a terrified state. This means that even minor stresses thereafter would result in a more extreme level of emotional reactivity from these individuals.

In addition, it was postulated that the brain of a traumatised child develops to be hypervigilant and focused on non-verbal cues potentially related to threat. The hyperaroused state associated with fear and pervasive threat results in a brain that has created cognitive, motor, emotional and state memories adapted to a world characterised by unpredictability and danger. It was implied that even with the absence of threat over time, a child would remain in this hyperaroused, 'fearful' state. It is likely that if a child is in a persistent state of arousal then they would also experience persistent anxiety. Hyperarousal has been observed to be linked with increased muscle tone, increased temperature, increased startle response, sleep disturbances, affect regulation problems and generalised anxiety. In addition, there are changes in cardiovascular regulation. Whilst these adaptive changes help the child to avoid danger they are not adaptive in school, or amongst peers, or in other social relations.

Interesting gender differences were pointed out in that females were suggested to be most likely to dissociate or internalize when placed in a threatening or stressful situation, whilst when males were hyperaroused, their most likely response was fight or flight. Males may have cognitive distortions that accompany this state, such as being more likely to misinterpret behaviour as threatening and as a result are reactive and externalize, responding in an impulsive violent fashion when threatened (e.g. eye contact is perceived as threat, touch as seduction/rape).

Perry presented a case of a traumatised child with subsequent impairment in social and emotional functioning. WISC scores indicated a mean Verbal scaled score of 8.2 and a Performance score of 10.4. He noted that there is often a prominent Verbal-Performance split in this clinical population, and this may be related to traumatized children being highly focused on non-verbal cues (to alert them of dangers). Teachers' reports of smart kids who have trouble learning are often found when abuse is in the background.

Resilience

Negative experiences have the potential to wound and scar the vulnerable, developing child, and thus the issue of what might be predisposing factors for children who are more resilient to these effects was raised. It was proposed that the resultant effects of traumatic incidents in early life are moderated by an underlying genetic or constitutional vulnerability.

Resilience is also developed in response to early experiences. If a child is exposed to stressful events that are predictable and moderate in their severity, he/she will have the opportunity to develop and adapt to this environment, to become resilient.

In contrast, unpredictable and severe stress predisposes a child to vulnerability. For maltreated children, unpredictable stressful events are perceived as the norm, not as isolated occurrences that other children may have. Results of this persistent trauma may be behavioural impulsivity, increase in anxiety, increase in startle response and sleep abnormalities.

Intervention

The necessary steps for rehabilitating a child who has suffered a traumatic event were briefly covered and major principles included, (1) activating those specific experiences that have been missed, in a developmentally sequential order, (2) the earlier the better, (3) no part of the brain will change unless activated, and (4) repetition is important. The most important part of intervention is challenging a child's cognition of the world to create an expectation of hope that the world is not full of unpredictable abusive adults and that positive models can be idealized. This is facilitated through providing safety, predictability, nurturance and valuing the child for what he is. However, although the importance of early intervention was emphasised, the viability of successfully rehabilitating profoundly traumatised children was omitted. Current interventions were described as simplistic and too broadly based, not targeting developmental deficits. This is significant because, whilst Perry suggested that exposure to traumatic events may be a causal factor in the development of a broad range of disorders later in life, he did not detail his treatment approaches but focussed on the severity of the experience that may result in neuropsychiatric disorders and that "even with optimal clinical 'techniques', treatment of maltreated children would overwhelm the entire mental health and child welfare community in this country" (Perry, 1996). During the seminar Dr Perry stated that "13 years of therapy could not reverse the damage done by one year of abuse and neglect". He criticized current DSM-IV diagnostic labels as not capturing the diversity of adaptive and maladaptive symptoms that appear to be related to early traumatic experiences. He talked in broad terms about the need to provide enriched cognitive, emotional, social and physical experiences in childhood, and suggested that improved childrearing and major attempts at preventing maltreatment could transform our culture.

Commentary

The seminar presented by Dr Perry was very interesting, presented in an entertaining manner, emotive and intuitively sensible. It provides an important theory to explain the severe long-term effects of abuse and neglect in infancy. However, the proposed theory was not substantiated by empirical psychophysiological evidence in its support. This reduced its potency substantially. Whilst the sequential development of the brain seems well established, the impact of stress on the brain in infancy was mainly supported by clinical material of an anecdotal nature or retrospective evidence. Either there is a lack of research in the field to draw from, in which case, more research obviously needs to be undertaken to allow for the possibility of substantiating the theory, or it was simply not addressed in this presentation. In addition, the major interventions for treating traumatised children were not delineated.

Another issue that needs to be explored more thoroughly in relation to treatment, and especially the 'immunization' strategy for maltreatment, is the need for a more systematic approach to prevention. Although child abuse and neglect pervade all sections of society, some factors make certain sections of society more vulnerable. For instance, lower socio-economic status, substance abuse, history of mental illness or marital or family problems. Given the expanding literature identifying factors that contribute to a family's vulnerability to child abuse, emphasising a sociological approach to prevention techniques seems prudent, as well as supporting these families in their very early parenting practices. Perry's message is certainly likely to increase awareness and interest in the impact of early experiences on later development.

Perry, B. (1996). Neurodevelopmental adaptations to violence: How children survive the intragenerational vortex of violence. Violence and Childhood Trauma: Understanding and Responding to the Effects of Violence on Young Children. Ohio: Gund Foundation. (handout provided at conference)

Perry, B. (1997). Memories of fear: How the brain stores and retrieves physiologic states, feelings, behaviours and thoughts from traumatic events. In J. Goodwin & R. Attias (Eds.), Images of the Body in Trauma. Basic Books (in press).

A Mother / Baby Interaction Treatment for Postnatally Depressed Mothers

By Dr Beverley Turner Child Psychiatrist, Royal North Shore Hospital, Arndell. North Ryde NSW

The group was targeted at women who were experiencing depression in the post natal period who had an Edinburgh score of 13 or above, whose infants were up to six months of age, and who had recognised difficulties in their relationship with their infants.

The aims of the group were based on attachment theory. The aims were to:

1) Provide a secure base
2) To facilitate expression of distress
3) To explore the mother's capacity to resolve current distress
4) To facilitate sensitive mother/infant interaction
5) Thus hopefully alleviate some of the symptoms of post natal depression.

The program ran for six consecutive weeks, using infants as the focus for the group.

Prior to the first group starting, sessions were divided into topics, though as the groups proceeded it was clear that this needed to be quite flexible. The rules of the group were articulated at the first group and they were that each member had a right to speak without
ridicule, that what was said within the context of the group was confidential, that discussion and participation would be actively encouraged and that the group would meet for six weeks for two hours per week.

The first group meeting also opened up the possibilities for the women themselves to raise issues by nominating things that they would want from attending the group. The overall plan was explained, that being some discussion of normal infant (emotional) development, infant abilities and vulnerabilities, mother's self-talk, looking at what can work now, and then transferring that and generalizing it to the outside world.

Videos of babies were also used in the first group and only one video in the second group and none in the last group.

Themes:

Themes within the group were predominantly the loss of self, and the need to "find" the self again. The women felt overwhelmed by the task of mothering and juggling their other commitments in the face of fatigue and a new and challenging job for which they felt they had few qualifications. They were also quite perplexed about what was "normal", continually striving to be as good a mother as they could, not knowing exactly what the goals were. They all expressed disappointment in their experiences and their estimation of how they had managed their mothering role at the point of their entry to the group. Most of the women had felt a sense of isolation, although some women knew each other from previous group work that they had done together, directly addressing P.N.D. by itself. In general though, they felt isolated in their suburbs / community / family. They did try to address elements of self-forgiveness, i.e. being kinder to themselves for not being the "perfect" mother. The strong theme for these women was also their sense that they were a life support system for their infants, that they could not take their eyes off them or their attention from them in case something drastic happened, and that they felt more like an intensive care nurse than a mother.

The groups were run on group therapy lines, though many methods of intervention were used, such as family therapy techniques, circular questioning, some psychodynamic interpretations, and general education.

The features of the group which appeared to be most helpful were:

1) The neurobiology of normal infant development.

Most mothers were fascinated by the idea that infants' capacities for memory and self soothing are very

limited and that their brain development depends on not only nutrition and environment but also their relationships. Memory development was an important aspect of an introduction to normal attachment behaviour and the essential need for this attachment behaviour to be present in infants. Cognitive reframing around infants' problematic behaviour could be understood in the context of their developmental stage and their attachment behaviour. Normal attachment behaviour was described beyond the ages of the infants in the group so that the mothers could understand what to expect as their children developed.

2) The notion of a 'good enough' mother was also discussed and received quite well especially in view of the fact that most of these mothers felt more like an intensive care nurse. The first video shown in the first group showed a distressed baby from the video "Baby of Mine". This lead to a great silence in the group and no response and it was eliminated from subsequent groups. The second video which was shown in group one and group two, i.e. the first group of mothers and the second group of mothers, was a 'Still Face Procedure' of a securely attached infant. Although this produced some discussion, it was also generally negatively received and therefore not repeated in the third group. Changes notable in the group were related to the maternal perceptions of their infants, **quote:**

"I can see now how much he really loves me".

"If he sleeps more than 45 minutes that will be a bonus".

"I am the expert on my baby and I can work it out".

"He looked at me as if to say, 'how did you know that's exactly what I wanted?'

"I can't change my family, I can only change my expectations"

"When I feel calmer, he's more settled"

These were particularly noticeable in the first group of mothers. The second group of mothers were a different population from the first and were essentially much more severely depressed, some of them having been hospitalized, and one of them experiencing a psychotic illness. Because of this, the group process had to be adjusted to lower expectations and goals and minimized information so as not to overload and to confuse. The neurobiology was covered but less well received and the notion of good-enough mothering was also less well received. It was clear that these mothers were probably too depressed to be able to participate in this group, although there were some shifts, for example, one mother realizing the extent of her depression and seeking medical and psychiatric help, and another mother moving on towards community health centre support for her other two children who were exhibiting disruptive behaviours.

The third group of mothers started out very small with three members and quickly reduced to two members only. It was, therefore, an intense experience for these women who sometimes felt a bit more under scrutiny than the other mothers in the other group. Once again, these mothers were able to view their infants behaviour differently and think about ways to manage problems in a more calm manner, although one of the mothers herself, clearly had a major anxiety problem with panic disorder and was subsequently referred for psychiatric assistance.

Focus groups indicated that all mothers felt their had been some benefit from meeting in this way and they felt that it had made a difference to their relationship with their babies and dealing with their disappointing experience. Interestingly, the first group nominated filling out the questionnaires as being helpful as it clearly articulated and showed how distressed they had been. They also felt that not having to "pretend" , as they usually did in the community, that everything was all right, was a great relief, i.e. total acceptance of a depressed state in the group was reassuring. Being totally accepted for their faults and failures was also a comfort. Which is, of course, part of attachment theory, and they also nominated learning to recognise cues that their infants give them and understand their meaning, helpful in reframing their infant's relationship with them.

The second group wanted to know more about medication which was pertinent to their more severely depressed state, but they felt unable to ask for that during the group.

The second group also felt that their adverse psychosocial situation, as perceived by them, could not be addressed by the group.

Continues on Page 18

BOOK REVIEW

"The Emotional Needs of Young Children and their Families: Using Psychoanalytic Ideas in the Community"

Review:
by Ms. Kerry Judd, Psychotherapist and Psychologist
Private Practice, Melbourne

Edited by Judith Trowell & Marion Bower
Routledge London 1995 $45.00
(ordered through Readings Books Melbourne)

I wandered across this book in my meanderings and thought that it would be of general interest. It is not hot off the press but my impression is that it has not had the exposure it deserves locally. I would certainly have found it helpful last year when I was running a therapeutic group for infants and their depressed mothers.

The Emotional Needs of Young Children and their Families offers a straightforward description of a number of intervention programs in the UK. All are psychoanalytically informed; all reveal flexibility and creativity in the way a service is oriented to the needs of the target population. Nineteen different programs for babies or young children and their families are discussed. Most take place in the public setting. Separate sections of the book deal with interventions at the levels of- individuals and families, groups, institutions and social issues. The editors provide an introduction to general concepts and links for each of the sections.

The nineteen contributors are psychotherapists, social workers, psychologists and psychoanalysts. Most of the contributors have some connection with the Tavistock. Some are already known to us, like Dilys Daws, Lynn Barnett and Isabel Menzies Lyth, however this book represents a wealth and breadth of experience not commonly available to us. It is most interesting to read of programs in the public setting and psychoanalytically informed discussion of public policy. In Australia we all too often retreat to private practise where we may feel more able to get on with the work without too much intrusion from beaurocrats.

Judith Trowell and Gillian Miles discuss the contribution of training in infant observation to professional development. They provide clinical vignettes to depict the relevance of accurate infant observation skills and a range of approaches to teaching infant observation varying from the traditional one hour of observation and one seminar per week for two years to a brief program with five fortnightly observations with a fortnightly seminar. They have used infant observation in a number of different courses and tailored them to the particular focus of these programs.

Rosalie Kerbekian discusses consultation to a premature baby ward. A sympathetic outsider is able to support staff, ease institutional conflict as well as providing parents with an opportunity to explore their hidden fears before they become stuck in negative interactions with their babies. Dilys Daws discusses a similar style of work in a general practice setting. We became familiar with this work during her visit to Melbourne in 1995. She makes herself available for scheduled or impromptu contact with parents and babies as they make their regular visits to a baby clinic. Her interventions often are only for one or two consultations and can be most helpful in relieving difficulties before they become entrenched and in reaching individuals that may be reluctant to become involved in a more formal service.

Psychoanalytic family therapy with parents and under fives is addressed by Marion Bower. She gives a delightfully simple theoretical overview; projective identification is made an accessible concept in just

a few words. These concepts are also illustrated clinically.

Anna Kerr discusses the work of the Guardian ad litem from a psychoanalytical perspective. This gives a space to contemplate who considers the interests of the child caught up in the social service system.

A novel format for a group for depressed mothers and their children is described by Marion Bower. A toy library was used as a focus and rational for separate mother and child psychotherapy groups in a deprived area with hard to access parents.

The South Bucks area of London, has an integrated approach to PND. They routinely screen mothers with the Edinburgh Post Natal Depression Scale and if necessary they are referred one of five groups run by psychotherapists, social workers or health visitors. Zelina Adam discusses the benefits of group involvement for the mothers and indeed the whole community and the importance of appropriately supporting the workers. The Newpin program for therapeutic and social support offers an alternative intervention for parents who are having difficulty managing. Peer supports and lay helpers play a major role in this program. Distressed parents also have access to a psychotherapeutic group program called Mellow parenting.

Families referred by the courts or department because of abuse issues are helped in the Monroe Young Family Centre. Judith Trowell describes an intensive program of assessment one day per week for six weeks and treatment two days per week for up to a year.

A number of the interventions focused on the educational milieu. Eva Holmes discusses an educational intervention for 3-year-olds at risk of not succeeding in the school system. The program involved providing a stable setting and an available adult who can help the child learn to play and offer opportunities for sustained conversations. These relationships were novel for the children, many of whom had already been in child care for many years. Follow up two years later showed adjustment in school well beyond the usually expected level. Sue Kedgerees discusses why children from special schools (for emotional and behavioural difficulties) may see their change for the better as a desperately difficult challenge, even when they are achieving it. Groups for school aged children who had been abused and had high anxiety about the transition to high school are discussed by Michael Morose and Bobby Cooper. These children were able to manage their anxieties differently and negotiate change in new ways following their group involvement.

The later part of the book outlines the use of external psychoanalytically informed consultants to facilitate the functioning of institutions for children. Staff support and review of operational policies and individual management plans in the light of children's psychological needs can transform an institution from a depriving and potentially abusive culture to a therapeutic experience that allows for children and staff to grow psychologically. Institutions discussed include a long-term orthopaedic ward, a home for behaviorally disturbed boys, children in residential care and childcare. Common principals included fostering bonding by assigning carers and devolving as much decision making as possible to those who were involved in the moment by moment care of the children. Meetings for discussion and staff support were also important. Following intervention the children showed fewer negative effects of institutionalisation, eg aggression and indiscriminate attachment, but the staff were much more fulfilled with less turn over and illness.

Finally there are discussions of psychoanalytic perspectives on racism and the management of refugee children. The authors here list fundamental concepts that are helpful to keep in mind in such work.

The Emotional Needs of Young Children and their Families offers a wealth of experiences in working in the community and using psychoanalytic ideas. There is much we can learn from this book. It describes contemporary psychoanalytic concepts in a straightforward and practical manner, assuming little prior knowledge so it should be accessible to all practitioners interested in helping children and their families. Unlike the Melbourne Model, few of the interventions directly address the infant. In fact often conjoint interventions are not attempted, but separate therapists manage the child and parent. Perhaps we could contribute to the field by highlighting the benefits of working with the child in the parent and the parent and the child and learning form their interaction. This book is helpful in keeping us thinking about how we can continue to be creative in the way we apply our theoretical knowledge and tailor it to the community that we are attempting to serve.

AAIMH NETWORK NEWS

NSW COMMITTEE MEMBERS

President: Mary Morgan
Vice-President: Mrs Beulah Warren
Secretary: Victor Evatt
Treasurer: Mrs Marianne Nicholson
Corresponding Member:Ms Kerry Lockhart

From: Kerry Lockhart

We've had a busy couple of months with meetings around Sydney.

In May Dr Bruce Perry held a very successful meeting in Sydney attended by over 800 representatives from fields including health, politics and education.

Dr Perry has researched many facets of brain development and has been instrumental in describing how childhood experiences shape the biology of the brain. This day proved vitalising for all of us involved in the infant mental health field.

Norma Tracey conducted a seminar sponsored by AAIMHI based on her book "The Emotional World of Parents of Premature Infants". This provided an opportunity for those who work with mothers, fathers and babies to come together, especially those working in neonatal intensive care nurseries. A most successful meeting!
Norma featured again at a clinical evening seminar in mid June held at ICP Petersham. Here Norma presented on her paper "Thinking and Working with Depressed Mothers in the First Year of Life". Again a most stimulating evening.

Important Dates for your Diary

- AAIMHI National Conference Adelaide 9th-11th November - flyers should be out soon.

- We have more clinical evenings to look forward to. On 31st August there will be a presentation and dialogue on infants and crying. Thursday 31st August at St John of God Hospital, 13 Grantham Street, Burwood 7pm. - Saturday 26th August "A Space to Think" Early Intervention Programme - see enclosed flyer.

- PICRIC Meeting Wednesday 26th July 9.30 am to 4.30 p.m. St John of God Hospital, Burwood "Enhancing Mental Health for Parents and Infants - Strategies and Barriers to their Implementation".

QUEENSLAND COMMITTEE MEMBERS:

President: Dr. Susan Wilson
Vice President: Dr. Janet Rhind
Treasurer: Ms. Margaret Rebgetz
Secretary: Dr Michael Daubney
State Representative: Dr. Elizabeth Webster
Steering Committee: Ms Debra Sorensen

From: Michael Daubney

Following the recent workshop on the emotional world of parents of premature infants, a dinner meeting was held at the end of May at which professionals working with premature infants and their families in Brisbane discussed their work.

The presenters were Lyndall Franklin, an Occupational Therapist at the Mater Children's Hospital; Dawn Edwards, a Social Worker in the Neonatal Intensive Care Unit at the Mater Mother's Hospital and Abigail King, an Occupational Therapist at the Royal Children's Hospital. The speakers discussed what the scope and focus of their work involved, with clinical cases to highlight several issues.

Lyndall's work includes assessing developmentally delayed infants, infants with complex medical problems often involving lengthy admissions, involvement with an informal playgroup which allows screening of children with difficulty feeding, developmental

delay or parent child interaction difficulties. In working with parents of children with disabilities, she discussed the importance of helping families know how to adapt to their child and the aim of targeting small steps in development and interaction. Her OT focus includes helping children develop skills, and motivation with play being an important therapeutic tool.

Dawn discussed in depth her role as a support and advocate for parents, being a constant person to help guide them and allowing space for parents to concentrate on their infant. She facilitates a Parent Support Group for all parents in the Neonatal Nursery.

Dawn also highlighted the emotions parents feel including feeelings of guilt, loss of privacy and also the unspoken worries that parents often have. Abigail's presentation centred around a case of a 10 year old who had been born premature and had experienced a stormy medical course. The referral was due to developmental delays and eating problems.

Abigail discussed developmental issues, dynamic issues from the mothers perspective related to the premature birth and developmental delays and the ongoing impact of these factors. She noted that as an infant the baby had been difficult to nurse, leaving the mother feeling both angry and useless. All three presentations were excellent and stimulating.

At our June evening meeting, we were encouraged and our thinking stimulated by Frances Thomson-Salo's discussion of the potential toxicity of working with troubled families and infants at risk.

Dr Janet Rhind introduced the discussion with an account of her recent experience of a week spent hearing about a succession of difficult cases and the impact of this on her.

Frances began with a consideration of some of the global and more general factors, which impinge on us e.g. the potential tyranny of not being able to be "off-line" due to mobile phones etc. She then explored more particularly the various difficulties encountered within both public and private clinical settings and provided a framework for understanding how interactions with these infants and their parents may impact on us emotionally.

Throughout the discussion Frances highlighted the importance of taking care of our own psychological health and indeed, our responsibility in this regard. She offered a broad range of approaches to facilitate our individual consideration of this at a personal and a professional level. A lively discussion ensued, particularly with regard to some of the frustrations encountered in people's attempts to obtain adequate supervision in a range of settings.

Dr. Sue Wilson presented a Paediatric Grand Rounds at the Mater in June on Infant Mental Health, in conjunction with Neil Alcorn from the Infant Clinic at Yeronga. Sue provided an overview of the scope and rationale for IMH and earlyintervention/prevention. Neil gave some data on the clinic's first 12 months. Both then gave a brief case vignette, of two very different cases, highlighting the role of infant mental health in hospital and community settings.

The presentation was repeated, by Sue and Dr. Janet Rhind, for the North Brisbane Child and Youth Mental Health Services, who are looking at setting up a strategy to enhance the service to under 5s.

WANTED: NEW NEWSLETTER EDITORS

Sarah Jones & Paul Robertson will vacate as Newsletter Editors with the last edition of 2000.

AAIMH is looking for new editors for the Newsletter.

Members interested in further information should speak with their **local state committee** as soon as possible.

Please feel free to discuss the position with either Sarah Jones (03 9345 5511 or nickcarr@melbpc.org.au) or Paul Robertson (03 9256 8366 or paujvd@netspace.net.au).

SOUTH AUSTRALIAN COMMITTEE

President: Elizabeth Puddy
Treasurer: Margaret Lethlean
Secretary: Pam Linke

Committee Members: Donnie Martin, Karen Fitzgerald, Terry Donald, Akhter Rahman, Ros Powrie.

From: Pam Linke (email: linkes@newave.net.au)

National Conference.

This year's conference "The Infant and Some-one" has the theme of looking at the impact on the infant of different situations - A keynote presentation and workshop on Intervention and Treatment Approaches for Young Children who Witness Violence" will be given by Dr Joy Osofsky".

Joy D. Osofsky, Ph.D. is a clinical and developmental psychologist and a psychoanalyst who is Professor of Public Health, Psychiatry, & Pediatrics at Louisiana State University Health Sciences Centre in New Orleans. She is Director of the Harris Centre for Infant Mental Health in New Orleans and the Violence Intervention Program for Children and Families. Another keynote will be give by Professor Klaus Minde.

Professor Minde is Professor of Pediatrics and Psychiatry at McGill University in Canada. He has written numerous publications in the field of infant development and mental health including (in press) "A guide for parents on hyperactivity in children", "The assessment of infants and toddlers with medical conditions and their families" in WAIMH Handbook of Infant Mental Health, "Effect of day care on children" in Comprehensive Textbook of Psychiatry/VI".

Professor Graham Vimpani will give the Winnicott Lecture on advocacy for infants. Professor Vimpani is Professor of Paediatrics and Community Child Health at the University of Newcastle. He was the instigator of the National Investment in the First Three Years movement in Australia and is a committed advocate for the best interests of children. He has gathered together a body of research to support the importance of the early years. Unfortunately Dr Bob Marvin who was also to be a keynote speaker is unable to come and we are working to get another presenter to take his place. Adelaide is very attractive in the springtime and a number of tours of the local region including the well known Barossa Valley will be arranged for those who want to mix some pleasure with business.

State Branch Activities

We have been very busy during the last few months because as well as preparing for the conference we have had workshops from Dr Bruce Perry and Dr Martha Erickson. Both these were very successful. Dr Perry talked the impact of environment on the developing brain and Dr Erickson's workshop was about the importance of attachment and ways to enhance this in different early childhood settings. We have had high quality videos made of both sessions and the fliers for these are included in this newsletter.

At the end of October Professor Fraser Mustard will be in Australia and we will be linked in a video conference with his presentation in NSW as he is unable to visit SA at this time.

The SA Branch is also very involved in the setting up of NIFTEY in this State. We have recently had a meeting of interested stakeholders from major government and voluntary agencies and professionals to begin to work on strategies to support the importance of the early years. There is a lot of enthusiasm for this work and we look forward to getting some worthwhile projects going.

WESTERN AUSTRALIA COMMITTEE MEMBERS

President:
Caroline Zanetti, Consultant Child Psychiatrist
Secretary:
Susan Brill, Clinical Psychologist
Treasurer:
Patrick Marwick, Senior Social Worker

Committee members:
Elaine Atkinson, Clinical Psychologist
Carmel Cairney, Clinical Psychologist
Kathie Dore, Registered Mental Health Nurse
Lyn Predis, Clinical Psychologist
Julie Stone, Child and Adolescent Psychiatrist
Yap Lai Meng, Clinical Psychologist

From: Carmel Cairney

The Conference 2001 committee has been busy and has successfully invited Mary-Sue Moore and Alicia Lieberman to present. Dilys Daws is almost sure to attend.

Congratulations are due to Dr Julie Stone, who has been awarded a Churchill Fellowship to study overseas with clinicians who are experienced in working with distressed infants and their families. The Fellowship sponsors Julie to study for 10 weeks, and she is planning this for next year.

Dr Caroline Zanetti, President, is nurturing a relationship between Infant Mental Health and the Post Natal Depression Professional Association. Caroline spoke at a recent PNDPA meeting on the interface between infant mental health and post natal depression, describing the impact of maternal depression on the relationship between mother and infant, and thus on the infant. This was well received.

At the June general meeting, the presenter was Lee Peters, a social worker with many years experience in working for Family and Children's Services. Lee now manages the **Parent Help Centre**.

Lee generously invited us to the Centre and spoke about its services and showed us the Centre. The Centre provides assistance and a range of programs to parents of children aged 0 - 18 years, and has many services for parents of preschool children. Parent Education Courses are offered, as well as direct intervention and guidance about the interaction between parent and child. One of the most popular and successful courses is **Talk and Play,** a 6 week, interactive parenting program for parents of children aged 0 - 2 years. The centre also offers the Positive Program, a Parenting Line telephone service, and an Aboriginal Parenting Service, among many services. Lee's enthusiasm and commitment to assisting young families was commendable and contagious. It was a thoroughly enjoyable and useful "show and tell'.

The writer has recently read "A better woman, a memoir" by Susan Johnson, a writer and journalist, living in Melbourne. This is a beautiful and evocative account of one woman's journey into motherhood. Susan Johnson honestly records the many and powerful feelings aroused by becoming a mother.

Despite the physical trauma she suffered as a result of childbirth, her described experience is one many readers will resonate with. A sample: -

"When Caspar exploded into my life I was forced to put aside forever any notions of effort equaling outcome. I had to teach myself to expect nothing, to let whatever situation he and I were in to reach its own conclusion.

Caspar was my ultimate Zen test."

VICTORIAN COMMITTEE OF MANAGEMENT

President: Michele Meehan
Secretary: Jeanette Milgrom
Treasurer: Kerry Judd
Scientific Program: Liam O'Connor

From:Sarah Jones

There has not been a lot of activity this quarter with so many of our committee away. Dr. Ann Morgan has been in Israel for the International Group Psychotherapy conference, and Dr. Campbell Paul and Ms. Brigid Jordan are in London.

They are attending the ISIS conference in Brighton, UK en route to the WAIMH conference in Montreal. There are a small number of Victorians attending this last event, hopefully we will have an opportunity to learn from those who did participate.

In June we were fortunate to have the indefatigable Ms. Norma Tracey from Sydney present a workshop on "Parents of Premature Infants: Their Emotional World". Held at the Royal Women's Hospital, this AAIMH sponsored event was well attended and highly praised by those who did attend. Norma's co-presenters included Jeanette Milgrom, Lorraine Rose, Sheila Sim, Beulah Warren and Frances Salo. Norma's book was reviewed in the last edition.

Agenda items for Victoria include reconciling the books from last years conference, debating the proposal of implementing a publicity port-folio for the committee, and the 2004 World Conference for Melbourne.

As many of you know Victoria has managed the Newsletter for the past 3 years. Paul Robertson and myself will be retiring from this appointment at the end of 2000. The National President of AAIMH has asked all States to take this back to their committees to respond to an open invitation to be the next State to hold the Newsletter.

Continues from Page 11

A Mother / Baby Interaction Treatment for Postnatally Depressed Mothers

Future directions:

Mothers agreed that this sort of intervention at an earlier stage would have been a lot more helpful and that fathers also need to have a father / infant interaction group.

It is clear that this stand-alone group has some merit and value but would be more effective in an integrated service attached to an established service provider. Issues such adequate / inadequate treatment of the depression need to be addressed as some of these women had not had a full or adequate assessment which a comprehensive service could provide. It is also clear that the need for some home visiting is advisable as the women in the second group, although discharged from hospital, were experiencing ongoing difficulties. For those women with older children who were either disruptive or had experienced their own mother as depressed since their birth, for example six years of depression, family admissions to help the family get on top of the disruptive and oppositional behaviours, would facilitate better control of depressive symptoms in the parents.

MH SKY Mental Health Services for Kids & Youth

Program

14 September : Evening Lecture

The Body and the Mind - Post Trauma Biological and Existential Sequelae in Children

The impact of traumatic experiences on children is greater than the classification of PTSD. Traumatic experiences can initiate processes which have a lasting effect on the biological development of children, on the child's sense of self and their perception of other people, on the development of the child's moral code, moral judgement, on the nature and quality of their interpersonal relationships and emotional and behavioural functioning. Professor Yule will explore current thinking and discuss current research in these areas. There will be an opportunity for discussion at the close of the lecture.

Date: *Thursday 14th September 2000*
Time: *7:45 pm, Registration at 8:00 pm*
Venue: *Ella Latham Theatre, Royal Children's Hospital Flemington Road ,Parkville*

15 September : All Day Workshop

Trauma Reactions in Children – current understandings and treatment options

Professor Yule will discuss the current understandings of trauma reactions and PTSD in children and the range of treatment options in use on being developed. He will give particular attention to behavioural processes, cognitive functioning, resilience and post-trauma coping strategies engaged by children. Opportunities for discussion will occur throughout the day.

Date: *Friday 15h September 2000*
Time: *9:00 am – 4:30 pm (Registrationat 8:30 am)*
Venue: *Ella Latham Theatre, Royal Children's Hospital Flemington Road ,Parkville*

Trauma & Treatment

International Presenter

Professor William Yule

William Yule is Professor of Applied Child Psychology, University of London, Institute of Psychology. He is a former Head of Clinical Psychology Services, the Bethlehem Royal and Maudsley Hospitals.

For the past ten years he has been heavily involved in the study and treatment of PTSD in both adults and children. He has shown that PTSD is both a common and more chronic in reaction children and adolescents than had hitherto been expected.

He has published over 300 articles and books on a range of topics in child psychology including; *reading retardation, epidemiology, autism, parent training, the effects of each on child development and the effects of the Chenobyl radiation on children.*

He has studied and advised on the effects of war on children including advisor to UNICEF in former Yugoslavia and the sinking of the cruise ship Jupiter in Athens Harbour.

Contact

As there are limited spaces early registration is recommended. Payment must accompany your Registration Form and can be made by cheque payable to;- *Mental Health Services for Kids and Youth* (MH-SKY)

Attention: Sofia Damianidis
Mental Health Services for Kids and Youth (MH-SKY)
Royal Children's Hospital
Ground Floor, South East Building
Parkville Vic 3052

Program enquiries:
Ruth Wraith 93455511, e-mail: wraithr@cryptic.rch.unimelb.edu.au

Registration enquiries:
Sofia Damianidis (03) **93455526**
e-mail: damianis@cryptic.rch.unimelb.edu.au

Price

Registration closes **Friday 8 September.**
Full payment required, no deposits accepted. These prices are GST inclusive.

Evening Lecture (Thur 14 Sept)	**$ 20** ***(Before 18/8/00)***	**$ 25** ***(After 18/8/00)***
Day Workshop (Fri 15 Sept) (includes light lunch and refreshments)	**$ 130** ***(Before 18/8/00)***	**$ 150** ***(After 18/8/00)***

Cancellation

Cancellations must be made in writing (fax accepted). As an alternative to cancellation, registrations may be transferred to another person without penalty. Written notification must be sent to verify transfer.

For cancellation after 1st September 2000, the registration fee is non-refundable.

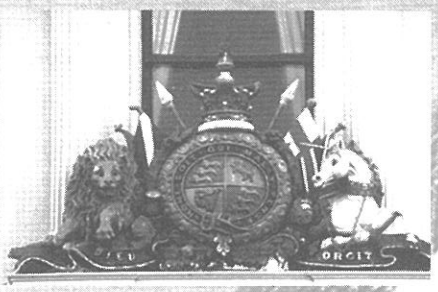
Cancellation of registration for the workshop will incur a $50 administration fee. Cancellation for the lecture will incur a $10 administration fee.

Location

Ella Latham Theatre, Royal Children's Hospital

Enter the Royal Children's Hospital via the Front Entry Building on Flemington Road; walk up the immediate staircase. This will lead you to the 1st level, walk through to the back of the hospital and into the **Ella Latham Theatre**.

AAIMH BILLBOARD



AAIMH NATIONATIONAL CONFERENCE

"Infant and Someone"

Adelaide, SA
9 - 12 November 2000

Speakers include:

Dr Joy Osofsky (USA)
Prof Klaus Minde (Canada)
Prof Graham Vimpani (Australia)

SAPMEA Conventions
Tel: +61 8 8274 6053
Fax:+61 8 8274 6000
Email:
Mailto:kcoats@sapmea.asn.au
Web: http://www.sapmea.asn.au
Paul Robertson

INFANT MENTAL HEALTH, ATTACHMENT THEORY AND "OUT OF HOME" PLACEMENT

DEVELOPMENT OF A REFERENCE LIST

CAN YOU ASSIST ?

As advocacy representative for AAIMHI I am sometimes asked by professionals in the health and welfare field to suggest references. They are understandably concerned about the placement of a young child away from the person to whom the child is attached. I would like to create a bibliography related to this, which could be provided in response to such queries. If you are aware of suitable articles could you please send me the references? When I get the bibliography together it will be published in the newsletter.

With thanks.
Pam Linke

Pam Linke
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Fax: (08) 83031656,
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