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FROM THE EDITORS

As we write this, we have just returned from Melbourne and the National Conference. (Note the use of the grandiloquent editorial we - as we are about to relinquish the position of editor, we are going to use we as much as we can in this editorial.) Future Newsletters will, it is hoped, contain news of that most successful meeting. However, this issue, the final one for 1996, has its own riches. We are indebted to Mark Allerton for the lead article, a summary of Patricia Crittenden's work, a very appropriately timed atrticle, as she is about to visit Australia again, and there is news of this visit elsewhere in the Newsltter. Mark has previously contributed to this publication, and members may remember his summary of the Attachment Meeting with Lyn Murray, Peter Cooper and Bob Marvin. We also have two reports from the Finland WAIMH Meeting, the plenary sessions given by Dan Stern and Kathryn Barnard. Finally, we have included AAIMHI's submission to the National Inquiry into the Separation of Aboriginal and Torres Strait Island Children from their Families. The issues involved are very complex, and it is hoped that the inclusion of his in the Newsletter will create some discussion.

This is our last Newsletter. We would like to thank those who have contributed since we took over the Newsletter. The new Editor is Paul Robertson from Victoria, and we wish him well, and hope he enjoys producing it as much as we have.

David and Isla Lonie.

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Patricia Crittenden's Developmental Model of Attachment

Dr Patricia Crittenden, a world-famous researcher and developer of attachment theory, visited Australia in 1996 to run workshops and give seminars. She is a provocative speaker who has developed a fascinating theory of human attachment behaviour and its consequences. Here is an introduction to some aspects of her approach to attachment theory, adapted by Mark Allerton, Deputy Principal Psychologist, NSW Department of Community Services, from an article he wrote for the Department's magazine "Outlook".

What do babies need from their mothers? Humans associate feelings of comfort with safety, and feelings of discomfort with danger. A very young baby can express its discomfort very directly. In well-functioning families, the baby decrees what should be done by being unsettled until it is fed, changed, comforted or whatever. The caregiver accepts the vague but forcefully expressed directions offered by the baby and responds, often on a trial - and-error basis. Following Winnicott's description, a "good enough" mother[1] (see footnote I below) is sensitive and flexible in the way she studies and reacts to her baby, and learns how to supply what the baby needs. In this way, as Bowlby explained, the primary caregiver can become a "secure base" for the child. The child knows the mother is there to alleviate discomfort and provide security, so that he or she can then safely learn about the world through personal exploration.

A baby brought up in a predictably secure, nurturing environment learns to expect relationships to be reciprocal and direct. A signal from one person leads to a straightforward response from the other, and so a "secure" attachment pattern (or Type B, following Ainsworth's classification) is established. From this start, these children are more likely to

[1] For brevity's sake I will frequently resort to the word "mother" to describe the primary caregiver, as it is a mother who usually fills this role. Similarly, I will use the gender-neutral term "it" as a personal pronoun when referring to infants.

learn that the world behaves according to intelligible principles, they will expect rewarding relationships based on assertiveness and empathy, they are comfortable with bodily contact, and will be predisposed to enjoy school and other learning activities.

For a human baby, born the most vulnerable of species, it is highly dangerous to be unattended, or not responded to appropriately. Babies are constructed, both biologically and psychologically, so as to engage with, and elicit care from others. The caregivers who make them most comfortable are those who can make them feel safe. Such people will be perceived as stronger, wiser, safer than others, and irrationally interested in their welfare. Naturally, a primary, predictable caregiver often manages to fulfil these demanding criteria. Home should be the safest of places, yet we know that for some people home is the place of greatest danger. How do babies and infants manage to survive in some homes?

Survival from a feral perspective When the mother does not respond to the baby's cues (e.g., eye contact, crying, physical movements), the baby has to adapt differently. Dr Patricia Crittenden's studies in attachment theory have focused on how these adaptations are made. She sees herself as a "feral" attachment theorist, interested in the exciting ways infants adapt to dangerous family experiences by using the "anxious" strategies of "defended"(Ainsworth's "Type A insecure" or "avoidant" strategy) or "coercive" (or "Type C insecure" or "ambivalent") attachments. She regards these anxious attachment strategies as inherently adaptive, in that they protect the infant, and help it force unresponsive caregivers to meet its needs.

Attachment researchers such as Mary Ainsworth and Mary Main have shown that maternal sensitivity is the primary determinant of the quality of a baby's attachment behaviour at 12 months of age. Sensitive mothers have secure children, inconsistent mothers have children who behave ambivalently towards them, and interfering/rejecting mothers' children have avoidant attachment patterns. Traditional attachment classification methods allocate children into such categories, on the basis of controlled observations of mother/infant interactions.

Crittenden has theorised that underlying these different categories are the effects of infants' styles of thinking and behaving, learned on the basis of their mothers' behaviour towards them. She has dissected the components of the "internal working model" of attachment proposed by Bowlby to explain the predictability of consistent attachment behaviour. She claims that humans can use two kinds of information to predict danger (the most important decision we have to make, all through our lives): cognitive information, based on understanding the apparent order or pattern of events we observe in the world, and affective or emotional information, based on our reading of our own and others' emotional states. Her model of attachment theory predicts that a baby's behaviour is determined by the relative usefulness it finds for one or the other kind of information.

Infants who are rejected, either explicitly, or by receiving inappropriate responses from caregivers, are in effect being punished for their care-eliciti behaviour. Consequently, they learn to inhibit the expression of affect (usually crying) normally used to bring their mother closer. This reduces maternal rejection and anger, while teaching the infant that expression of affect is dangerous or counter-productive. As such caregivers are often misleadingly positive or cheerful in their affect, these infants also learn to mistrust such affective signals from others. If the mother is psychologically unavailable to the child, or neglectful, the child has to learn to inhibit the experience of its own painful affect, as these feelings will not be resolved otherwise. If the mother is openly hostile, the child must inhibit expression of affect for self-protection. Such children learn that affect is misleading and dangerous, and they have to learn to understan how events follow one another (for example, "When I cry I might get hit"). They find that they can trust their capacity to comprehend the temporal sequencing of events, so as to survive in an otherwise dangerous world. Cognitive activity, in the context of inhibited affect, becomes a predictable and relatively satisfying basis for interaction with caregivers.

On the other hand, children whose mothers are inconsistent learn that increasing their affective expression is a way of eliciting care. They may find that when they cry, their mother occasionally responds, and so, being placed on what behaviourists call an intermittent schedule of reinforcement (the most powerful way of inducing learned behaviour - as used by designers of poker

machines) they may escalate the protest: "She didn't come that time - I'll crank it up a notch or two". Because their mothers are unpredictable, these infants don't rely so much on understanding events or analysing temporal sequences, and they learn to associate desire and its satisfaction with anger, uncertainty and fear.

Coercive and coy behaviour If we watch a pair of dogs begin to fight, we will frequently see the loser adopt an "underdog" strategy, exaggerating its vulnerability, by exposing its stomach to the stronger dog, hiding its teeth, and turning its neck aside, while glancing intently at the victor. This strategy clarifies the dominance hierarchy, and re-establishes the underdog's position as one who has a right to protection. By 1821 months, a human infant begins to show the organisation of such a strategy, called coy behaviour. The child does this by learning to split the mixed feelings of anger and vulnerability. When it wants to elicit nurturance it may escalate an angry, demanding, whingeing display to demand attention, until the parent begins to show anger. At this point, the child starts to show an endearing, vulnerable display (such as the constellation of upturned, glancing eyes, exposed neck and teeth-hiding smile used so effectively by supermodels) which disarms the mother's aggression and encourages her to be soothing or comforting. If the parent gets fed up with the child's helplessness, the child may repeat the pattern so as to extract the nurturing behaviour once more. This strategy can trap the parent, who will be sensitised to these affective displays. A mother who may then try to use distraction ("I'll bring you a Chupa Chup when I come back" - and then doesn't) will inadvertently train the child to distrust her logic, and demand its own way, not wanting to think about the future. In such situations these children will evolve a tendency to discard cognitive information and exaggerate affective information. In this way, an infant who may have been endangered by the unpredictability of its parent's behaviour, gains some control over its mother, thereby meeting its basic survival needs, and also learning a way of controlling the world.

Dimensions and probabilities to predict clinical disorders Cognition and affect are thus vital dimensions in the development of attachment and later relationship styles. A securely attached child learns to use both, in an integrated, effective way. Children who have picked up a defended, or avoidant-type attachment style, learn to mistrust affect and depend on cognition, and those who have learnt an ambivalent, or coercive, style, mistrust cognition and rely on affect to enable their needs to be met. In contrast to the prevailing categorical models of attachment, Crittenden has developed a dimensional paradigm, based on the degree of emphasis a child places on cognition or affect, and the extent to which the two sources of information are effectively integrated. This allows a richer description of attachment behaviour than the earlier models, particularly as she has considered how the patterns interact with developmental changes in cognitive abilities, leading to different modes of mental and behavioural functioning. It enables a clinician to design remediation for disturbed mother-infant relationships, based on assessments of their present faults and strengths. It also predicts some of the factors which will lead to changes in attachment patterns over time.

Her model also considers the role of temperament, or one's genetic endowment, which interacts with caregiver behaviour, maturation, chance circumstances, and interpersonal feedback. Temperament does not create attachment type, nor vice versa, but the interaction of the two creates personality. Similarly, chance is a big factor in development, so developmental pathways are seen as changing probabilities rather than fixed continuities leading to specific outcomes. Her model predicts kinds of disorders in childhood, adolescence and adulthood. For example, coercive kids' behaviour problems could be expected to draw attention to themselves, and their cognitive disorders to deflect responsibility from themselves. These disorders could fall along the lines of angry/threatening/fearless acting out, or meek/submissive/fearful incompetence. Their thought problems could emphasise hostility, power and control, or vulnerability, victimisation and helplessness. Both patterns imply that others are responsible for the problem, and that others must change to resolve it. Crittenden's (1993) paper describes one child's Attention Deficit/Hyperactivity Disordered behaviour as an attempt to coerce/threaten others in order to control relationships. The majority of children referred to psychologists fit the coercive pattern. The model would also suggest that coercive children may be physically abused by a parent lashing out in response to a power struggle over who controls whom. A

parent behaving along coercive lines may similarly respond on the basis of angry impulse rather than according to considered judgment.

Defended children would possibly be seen by others as too withdrawn, although most would be expected to please adults, or be popular with peers because of their skill in activities such as sport. As they do not tolerate intimacy well, they may find themselves alone and lonely during adolescence, either compulsively self-reliant, or using promiscuity to provide physical intimacy with psychological distance. Those who demand perfection of themselves may be at risk of suicide from denied feelings of shame and failure. Unlike the suicides of secure or coercive individuals, these suicides will rarely be associated with signs and warnings of desperation and hopelessness. The physical abuse suffered by defended children, and perhaps perpetrated by defended parents, may take the form of over-punishment.

She has generated a theory of psychopathology which predicts patterns of isolation/ promiscuity/compulsive perfectionism in defended adolescents, conduct disorders in coercive adolescents, and different kinds of depression according to attachment patterns. Her model of psychopathy (or sociopathy) describes a deceptive, seductive, angry, fearful person who has developed an inverted, anti-integration of affect and cognition.

Some new leads for attachment theory Psychologists and others interested **in** attachment theory have often speculated about how the roots of our childhood experiences grow into the patterns of adult behaviour. Crittenden has elaborated a model which allows understanding of the dynamics behind observed behaviour, and, by integrating attachment theory with theories of cognitive development, has suggested means by which our childhood patterns evolve into adult relationship styles. It will be exciting to observe the research generated to test her predictions.

The Department of Community Services' Child and Family psychologists are currently studying some of Crittenden's work, and considering the extent to which it may be relevant to our assessments and case planning. It can be seen that attachment assessment and interpretation is a complex skill requiring knowledge, careful observation and other assessments, and thoughtful analysis. If you wish to learn more about Crittenden, the reference below may offer a good start.

Reference

Crittenden, P.McK. (1995). Attachment and Psychopathology. In Goldberg, S., Muir, R. and Kerr, J (Eds) Attachment Theory: Social, Developmental and Clinical Perspectives. Hillsdale, NJ: Analytic Press.

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH, 6th World Congress, Tampere, Finland, 1996

In the past two issues of this Newsletter, we have presented summaries from the keynote papers of the WAIMH 6th World Congress. We conclude this series with two keynote papers, both Intervention.

THEORIES OF INTERVENTION

Keynote Address given by Dan Stern, on Thursday, July 25.

Stern opened his paper with the metaphor of oxygen - pointing out that it was only in the *absence* of oxygen that we became aware of its importance; when it runs out we become aware of our need. So too, with theories of infant development. It is only where the theory lets us down that we become aware of its lack. Treatment of the parent-infant relationship, he suggested, is relatively new, and the challenge provoked by the development of this form of treatment has meant that the established theories (of infant development) need to be re-evaluated, and sometimes modified.

He suggested there were a number of special characteristics of parent-infant treatment were leading to this re-evaluation. First of all the presence of the baby was a major element in the difference which this sort of therapy brought. This meant that what was remembered was remembered *in the presence of the baby.* There is a special context in which the therapy takes place, and that part of this is the evocation of memory which may be stimulated by the presence of the baby. The sorts of fantasies and fears that a parent might have are likely to be changed by the presence of the infant. For example, a father in an interview in which his infant is present is more likely to be aware of his changed role from

husband to father if the actual object of that changed role, the infant, is actually present. His memories of *his* father, as a father to him, are likely to be close to the surface, so there will be an interplay between his memories of himself as child and as father. Moreover, the baby can't be ignored, but in fact demands attention, interaction, both on the part of the parent *and* the therapist; and as the infant is not able to talk, there is a change in the emphasis from verbal to non-verbal interventions. Finally, the presence of the baby means that there is now a mix of *interactive behaviours and intrapsychic events* taking place.

A second major characteristic of parent-infant therapies is that *change* is built into the system. Change is inevitable, part of the developmental thrust, so that whatever the therapist does, there will be change. The therapist then does not act as a motor or starter of change, but more as a rudder, effecting the direction of change. And the change is a change within the system - it is not only the baby who changes, but also the parents.

A third characteristic is that the parents of the infant have a different defensive structure, which is a product of being a parent - they are, for example, likely to see themselves as responsible for the baby's distress, and thus looking for ways in which the distress can be ameliorated by their behaviour towards the infant. On the negative side, this sense of responsibility however, makes the parent vulnerable to feelings of guilt about the infant's distress, and to the possibility of becoming a victim in the system. This vulnerability results in another aspect of the therapy, namely that the parents are very open to environmental influence. The vulnerability of the infant is expressed very concretely in the need of the infant for a caregiver, and the caregiver needs to love the baby, although the nature of the love is an important variable.

Finally the mother is a very special sort of client, in that, Stern suggests, she has a particular sort of intrapsychic organisation, which he calls *the motherhood constellation.* In his book on this subject, he makes the following observation:

I have come to realise that a mother is not just another patient, nor only a parent to a young patient, nor simply another member of the system. She is a woman in a unique period of her own life, playing a unique cultural role and fulfilling a unique and essential role in the survival of the species.[2]

Stern suggests also that there may be a particular organisation within the father which is the equivalent of this - but that this is an area needing further exploration.

He then looked at a number of models of intervention, pointing out that in this area practice is well ahead of theory, which needs to catch up. Fraiberg, Lebovici and Cramer have all offered insights from a psychoanalytic viewpoint where the mother's *fantasy* is considered the main pathogenic feature. In such therapies there is no couch, no free association, they take place within a much warmer environment than usual and within a positive transference and therapeutic alliance, which are not interpreted.

John Byng-Hall, coming from a family therapy *systems theory* approach, also stresses a positive therapeutic alliance noting that when there is a change in the context in which people are being framed, then their thinking will be different. If they are being seen as parents in an interview, they will be more likely to *think* as parents

Behavioural theorists have come up with the idea of *interactional* guidance based on the principle of reinforcement of positive aspects of overt behaviour. When the mother discovers that she can interact with her baby positively and evoke a positive response, she will be stimulated to do this more. Equally the baby's discovery that interaction increases the mother's responsiveness reinforces her involvement in the manner of a mutually reinforcing feedback loop.

Finally, Kathryn Barnard has advocated a multidimensional approach which can take account of all these different approaches. While appearing to be essentially empirical, it is beginning to take in theories such as Sameroff's transactional models which provide a background theory of multidimensionality.

Having suggested this classification of techniques of parent-infant therapy, Stern went on to consider where we might be headed in terms of *clinical theory*. Such a clinical theory would need to take

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[2] Stern, D. *The Motherhood Constellation.* N.Y. Basic Books, 1995.

into consideration what all theorists, regardless of background, recognise, that is the need for a positive holding environment for the mother to discover and realise her potential. The therapist must provide some "holding" in what may be considered to be a *corrective attachment experience.*

Furthermore, mothers have a particular psychic organisation as a result of becoming mothers - *the motherhood constellation.* Of central importance here is *grieving* for loss of freedom and girlhood; together with the *cathexis of the baby* which pulls the mother out of depression. This leads to the formation of a new psychic organisation which pushes aside the previous organisation, the oedipal relationship. The motherhood constellation takes centre stage for a while, slowly moves to one side again as the child gets older. Mothers who are ill may not allow the motherhood constellation to take central position.

Aspects of the change in her psychic organisation which make her see herself as different include the following:

1. She has a new responsibility unique in the life cycle: to keep another person alive.
2. There is a shift in her reality because she is now a mother, rather than a daughter. She is now more involved with her own mother than her father, she sees her husband as a father rather than a lover and is concerned with the protection of her baby with some competitive feelings towards her mother. Instead of the triad mother, father, baby, there is now for her a new triad: *mother, grandmother, baby.*
3. From this time, the woman has a new calendar of events, dating them from the time of the birth of her baby.

From this, Stern suggested several themes emerge:

- A survival theme: A psychobiological focus on the question as to whether she is a competent animal and can keep her baby alive. This may lead to fears that she will not manage this. Nature has programmed mothers to be hypervigilant, which may become problematic. There may be questions about whether she can feed the baby enough; enough "good" things, can she satisfy? Other issues include bathing, sleeping, falling, suffocation, gaining weight.
- A primary relatedness theme: Here the new mother is concerned with questions such as "Will I love my baby in ways that this baby will love me?" She will look at other mothers to see what they do, and needs the encouragement and validation of other women. Her husband cannot give her this support. Mary Main has accessed the importance of the relationship with her own mother in the adult attachment interview. The situation requires the new mother to improvise. She may have a fear of not being spontaneous.

Duration and temporal spacing of therapy.

Therapy is brief because of the factors mentioned above. There is a tendency to require re-application 3-4 months later , and again after a further 6 months. While improvement might be dismissed because of this as "just transference cures" it is in fact probably the only way to do good therapy. In terms of working through, the mother and baby haven't been there yet, so it is not, as it is in the psychotherapy of individual adults, a matter of working through repetitions of old patterns. Rather, we may think of it as a process of the same problem being worked on at different levels of development.

Finally, Stern proposed that there were a number of necessary new directions for research and for the development of fundamental theory.

1. What is the developmental course of the family? The Lausanne group is evolving a theory of how a family develops. The reality is that at birth, the dyad becomes a triad. The basic structure of this triad is laid down by the time the baby is 3.
2. How do you account for changes in people about the ways in which they conduct their relationship. In psychoanalysis, it has been seen as a process of interpretation plus *something else.* But there has been considerable discussion as to what is the *something else.* Theorists have talked about this in terms of procedural knowledge, but how do changes take place in this procedural knowledge?
3. Finally, he suggested that there was a need to reconsider who in fact is a mother (or a father)? is the concept of *the motherhood constellation* a useful in defining the essentials that a mother brings to the relationship with her infant.

LESSONS LEARNED ABOUT EARLY INTERVENTION

Keynote address given by Kathryn Barnard, Head of the School of Nursing, University of Washington, on Sunday, July 28, 1996.

In the final paper of the Congress, Kathryn Barnard, a long standing member of the Executive of WAIPAD and then of WAIMH, presented a paper which took up the theme of the earlier keynotes, that is, the importance of devising interventions for infants and their caregivers.

First, she identified the at risk population as those suffering from:

- Poverty
- Parents with emotional difficulty
- Pre-term
- Adolescent mothers

She then posed the question "What works for who?" "We know how to be effective in early intervention," she said, "much more often than we put it into practice."

The concept of parenting readiness is an important topic and includes such factors as

- Life experience
- Intellectual capacity. This is especially important in adolescent mothers where a mean IQ of 85 was found in a research project of the speaker's.
- Emotional maturity, including a concept of internal representations about relationships and security.

Breaking the Cycle of Poverty

In Kathryn Barnard's area, a Comprehensive Child Development Program has been set up to break the cycle of poverty. This has the following aspects:

- The intervention is made early - i.e. before the child is one year old.
- It involves the whole family
- Services are comprehensive: health, mental health, transportation, housing.
- It is continuous from birth to 5 years.
- Community involvement gives a seamless degree of care and offers a better holding environment.

In a total of 2694 families aided by this scheme, the breakdown of usage of services was as follows:

Housing	69%
Parenting skills	67%
Child care	58%
Transportation	58%
Health care	57%
Income	48%
Community resources	47%
Nutrition	41%
Parent-child relationship	36%

Barnard commented that basic needs have to be met before anything can be done about the parent-child relationship.

Child outcomes were measured when the child reached the age of 2. These were assessed in terms of cognitive development, language skills, adaptive behaviour and physical health and growth.

Outcomes for the families were as follows

↑	Preventive health care
↓	Alcohol
↓	Abusive
↑(slight)	Positive interaction
↑	Problem solving
↑	School involvement for mothers
↑	Fathers living at home

Kathryn Barnard made the point that when people are offered continuous and comprehensive services they use them. Many families were very slow to engage, about a third taking more than a year. This probably represented differences in the attitudes of the parents, many people having learned that it is best not to depend on other people. The children concerned in fact only increased one point on the Bailey, but did not show the expected developmental loss. The mean income of the families increased over the period. The main point about this intervention was the question "How do we hold an environment for the children while the parents are catching up on their learning?"

Mental Health Model for High Risk Mothers

This program offered

- A supportive relationship with a nurse from the 20th week of pregnancy, with the aim of helping the mother to develop a feeling that she could trust another person.
- An affiliative system

- Input about parent-child interaction

The case of Kim, an unmarried 19 year old, with an insecure attachment on the AAI and an IQ of 76 was presented to illustrate the work of the service. Kim had a poor employment record, always part-time, had been educated only to the age of 11 years, and her mother had died when she was 2. She had then lived with her grandmother who hated her, was mean and shouted at her, and spanked her every day.

The nurse assigned to her care made 24 home visits, 43 phone contacts and 46 contacts with other people on her behalf. Kim was not receptive to information about parenting or her child's cues. She also had a violent relationship with a suspected serial killer. Three months after the birth of the child, counselling began for Kim. When her child was 16 months, the theme of violence increased and child protective services were involved. The child was put into day care in a head start programme.

It has been found that children in this sort of situation who are doing better have been fortunate enough to fall into the care of other adults very early on. In a follow-up sample it was found that where the children were doing better the mother's IQ had gained an average of 10 points. These programmes need to help the parents in the development of their own skills. Kim had never had any models, and so took her cues from the TV soapie "Dynasty" which she used to watch.

Asking if it is a wise philosophy to expect young parents to care for young babies, Barnard observed that there were increasing numbers of parents in the USA who were not ready for parenting. In Kim's case, the outcome was that she found employment, was able to come off welfare, she could say very proudly that she had been a good mother, and her child was cognitively normal, although the was some difficulty with attention and he had been noted to be "unhappy" at the age of 5. Such children begin to turn around when they get a teacher who takes an interest.

Intervention issues

- Comprehensiveness
- Focus
- Duration
- Relationships

It is important to remember how the maternal role changes during pregnancy., gradually giving more emotional space for the baby, together with a search for role models of mothering. 85% of women have decided on a role model, usually their own mother. Women at risk do not choose their own mother and may look instead to home visitors or other women in the community. There is a chance here to role play. Videotape techniques may be useful for interactional guidance.

Pre-term infants form a group with special problems. In the first place they are very poor social partners in the first 6-8 months since they sleep a lot, are not very responsive, and give no clear cues. They also experience difficulty in shifting from sleep to waking. Teaching parents to modulate the infant's state is helpful. This involves repetition such as rocking or singing to soothe, and introducing variety such as touching or repositioning to awaken. This may organise sucking bursts and improve responsiveness which in itself improves the parent-child interaction.

The attention should be focused on the parent-child relationship where the infant is pre-term, has increased medical needs, the mother is adolescent or is poorly educated. This form of intervention is more effective after the infant is born than prenatally. Video feedback is very effective. The parent-child interaction intervention should be protective, modifiable, interdisciplinary and stress the renewable, recycling resources of the dyad.

NATIONAL INQUIRY INTO SEPARATION OF ABORIGINAL AND TORRES STRAIT ISLANDER CHILDREN FROM THEIR FAMILIES

The AAIMHI Committee made the following submission to the National Inquiry on behalf of AAIMHI. Although a number of members of AAIMHI made personal submissions, the Committee felt there was some merit in producing a submission from our organisation as it would indicate that we have a major interest in contributing to the well being of infants and their families in Australia. The Committee felt there are important transgenerational issues which need addressing, and that the considering what happened in terms of attachment theory would be a helpful approach. The final submission came out of a

document prepared by a postgraduate student at the Institute of Early Childhood Studies, which was used as the basis for a paper edited by Julie Campbell with the help of a number of people on the Committee.

This submission is made on behalf of AAIMHI, the Australian Association for Infant Mental Health. Members of this Association are professionals concerned about the importance of attachment in the development of the infant, and the effects of disruption to that attachment. They may be able to offer both consultative and direct help in interventions which will minimise the adverse effects of early experience of separation from primary caregivers. While there are universal needs in early childhood, there are also particular needs which may be met in culturally specific ways. Our responses to questions based on the Terms of Reference for this inquiry address both the universal needs of young children and the culturally specific needs of young Aboriginal children who experience separation from primary caregivers and loss. The following questions relate to part (a) in the Terms of Reference, specifically the effects of past laws and practices which resulted in the separation of Aboriginal and Torres Strait Islander Children from their families.

1. What are the effects on the child of separation from a primary carer at birth, in infancy, in later childhood?

An infant does not survive without a caregiver. Communities that provide systems of care and protection for their children ensure survival. In the last 40 to 50 years much has been learned through theory and research of how such systems are constructed and continue to operate throughout the lifetime of the individual (Waters, Vaughn, Posada, & Kondo-Ikemura, 1995).

From birth, both the infant and the adult caregiver have the capacity to set up a relationship which will ensure safety for the infant; i.e. a secure base (a) from which to explore and learn about the world and (b) to which the infant can retreat when "danger" in the form of novelty, fatigue, illness or other distress threatens. Adults find it hard to ignore a crying infant and the infant gradually expands a repertoire of behaviours which elicit caregiving and ensure appropriate proximity and attentiveness of the caregiver – crying, smiling, reaching, following, and interacting. From the beginning an infant can recognise and is sensitive to the emotional state of the caregiver.

Over the first year of life, the infant gradually builds up a mental picture of the self, the caregiver and of how the caregiver usually has responded in the past and, therefore, can be expected to respond in the future in familiar situations. This picture, or attachment pattern, otherwise called an internal working model, continues to guide and interpret the individual's behaviour and expectations in important relationships. In time, it operates beyond conscious awareness, having become an intrinsic part of the personality. There will be an internal model for any relationship between the infant and someone who consistently over time interacts with that infant.

Although there is a need for consistency, there is obviously an advantage in having more than one caregiver available to the infant. Nevertheless, attachment relationships are always arranged in a hierarchy, with the one at the top being designated the primary attachment figure. The most significant model (or pattern of attachment) will be that pertaining to the mother in any culture where she is the principle caregiver,

Work in many cultures, for example, Europe, North America, Australia, Scandinavia, Japan, and Africa - indicate that, although different patterns of attachment may predominate in different communities and the behaviours of infants and caregivers may vary according to the mores of, and the prevailing potential threats in, their particular environment, infants invariably have a basic need for an attachment figure who can be trusted (Bretherton & Waters, 1985; Waters et al 1995). The more distressed the baby, the more he or she will desire contact with, and only be fully comforted by, the primary attachment figure.

Infants are most dependent on others in the first year of life, their needs for nurturing are greatest, and they have the least well-developed resources for withstanding the effects of failure to meet those needs. Separation from the primary caregiver results in a well documented sequence of events: (1) protest (2) despair and (3) detachment (Bowlby, 1975). This behavioural sequence is actually seen throughout life when a serious separation occurs, for example, loss of a spouse in adulthood. It is particularly marked in the toddler age period when selective attachment patterns have been formed, but neurological and cognitive developments are as yet

insufficient to maintain relationships in the mind over a period of physical separation. This reaction is mitigated by siblings remaining together, contact being maintained in some way with parents, and by competent, consistent personalised caregiving being provided as a substitute by one or two adults (Rutter & Rutter, 1992).

The deficits in the experience of infants who have little mothering are reflected in the impoverishment of their relationships to others and in retardation of many aspects of their development. The symptoms increase in severity as the period of deprivation lengthens, They are more pervasive and involve more aspects of behaviour and development if they are experienced during the first year. Inadequate care at this time entails many lost opportunities for learning, doing, and experiencing warm and trusting relationships.

It has been argued (Bowlby, 1988) that early loss of a mother or prolonged separation from her before age 11 is conducive to subsequent depression, choice of an inappropriate partner, and difficulties in parenting the next generation. Anti-social activity, violence, depression and suicide have also been suggested as likely results of the severe disruption of affectional bonds (Bowlby, 1979).

The earlier a child is separated from his or her biological parents and placed in a stable alternative caring situation (adoption or long term foster placement), the more closely that situation simulates the desirable infant/caregiver relationship. However, it is not the same as that relationship. Even when a child has little opportunity to develop a relationship in reality with his or her biological parents, they are of immense significance to the psychological and social development of the individual. Indeed, where the reality is not clearly known, the missing figures assume even greater significance.

2. What are the effects on a child of institutionalisation?

Studies of infants who have been institutionalised (Provence & Lipton, 1962) have shown them to be different in many ways from babies reared in a family environment. General impairment in their relationships to others and weakness of emotional attachment have been identified as major abnormalities in their development and behaviour. The studies also found that the children rarely turned to an adult for help, comfort, or pleasure. There were no signs of a strong attachment to any one persons nor any signs of the development of a sense of trust in the adults who cared for them. The capacity to anticipate the future and defer immediate gratification of needs was impaired. The children's behaviour did not indicate the normal development of a sense of self. They seemed to have a low investment not only in all aspects of the environment, but in themselves as well.

Patterns of care provided in many institutions (Tizard & Tizard, 1971) failed to provide a psychosocial environment which could effectively meet the needs of very young children. In this situation the highest priority must be given to the child's need to be wanted and valued, and to have continuity of care within a safe environment.

Rutter (1981) addresses the issue of how early stressful events might have long term consequence for developmental processes. He lists five ways in which early experiences might be linked with subsequent disorder. Thus early stressful events might lead to :-

i. disorder at the time, but with the disorder then persisting for reasons mainly independent of the initial cause.

ii physical changes which in turn influence later functioning

iii. altered patterns of behaviour which take the form of an overt disorder some years later (experience in institutional care could be a case in point)

iv. changed family conditions which may predispose to disorder, *and*

v. alterations in sensitivity to stress or modifications of coping styles which then protect from, or predispose to, later disorder.

Of all life events associated with a difficult childhood, experiences of family troubles, the addition of a new family member, and entrances into new environments are most significantly related to children's behaviour problems (Sander & Ramsay, 1980). During adoptive placement, the older adoptive child experiences many major transitions, including the family difficulty, entrance into the new family, and entrance to a new school. and community. Each of the transitions carries tasks for the child and each transition has a compounding effect on the ability of the child to cope with any one

transition. While separation and loss may become commonplace for the child who experiences several foster placements, the multiplicity of separations does not make them any easier. Each separation and consequent readjustment affects self-expectations as well as expectations of the roles of parents and family members (Barth & Berry, 1988).

3. What are the effects on an indigenous child of socialisation in a non-indigenous family?

Within Aboriginal communities each individual has rights and responsibilities towards other family members particularly with respect to children. As a result, a child growing up in an Aboriginal community is surrounded by relatives who have designated responsibilities for that child and who play a meaningful role in child rearing (Bernt, 1981; Lawlor, 1991). There are a range of circumstances in which other members of the community would expect to contribute to the care of the child. One such circumstance would be if the primary caregiver were no longer able to do so. Adoption and fostering as legal processes imposed by external agencies are not compatible with such a community's expectations that caregiving arrangements are their responsibility.

An Aboriginal child growing up in Australia today must have a strong identity as an Aboriginal. The best way to develop this is to grow up in the Aboriginal community among people who have a shared understanding of social relationships and individual roles. Aboriginal children who are separated from their primary caregivers and this community identity frequently face problems in adolescence. There is evidence (Sommerlad, 1977) that feelings of alienation from white culture and lack of identity with Aboriginal culture underlie the high incidence of criminal offending. According to Sommerlad, 90-95% of Aboriginal people requesting legal aid for criminal offences have been in foster care or institutions.

The consequences for Aboriginal children of separation from their caregivers and removal from their communities are documented in case studies and personal narratives, rather than in major studies of children similar to those carried out elsewhere (Provence & Lipton, 1962). However, the evidence from these accounts indicates that, as well as the primary alienation of children from their communities, their dispersal, and their loss to the community, the consequences of this practice have been chronic cycles of alcoholism, incarceration, and further family disintegration as ex-wards prove to be ineffective parents (Family and Children's Services (1982).

Based on this information and what is well established about the universal needs of young children and the negative effects of separation, institutionalisation, and loss of community identity, the following implications may be drawn:

* that there needs to be support for the mother and the child where needed at the community level, thus supporting early attachment patterns

* that the support systems in place in Aboriginal communities need to be acknowledged and included in any discussion of substitute care for young children

* that the community's way of coping with family breakdown and family stress be recognised

* that Aboriginal understanding of interrelatedness of care within the community be validated in the best interests of the children and in the long term interests of the community itself

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AUSTRALIAN ASSOCIATION FOR INFANT MENTAL HEALTH

ANNUAL CLINICAL MEETING AND AGM, DECEMBER, 1996

A very successful Clinical Meeting took place in Melbourne from December 6 - 8. The proceedings of this meeting will probably be reported in forthcoming Newsletters. Unfortunately, at short notice, Dr Seligman, one of the invited overseas speakers had to withdraw, and this led to a rearrangement of the programme. However, the Planning Committee, led by Campbell Paul, were able to devise an alternative program which met with considerable approval. One of the hallmarks of this changed program was presentations from the Infant Mental Health Team at The Royal Children's Hospital. Because there had been little warning, the families presented by Brigid Jordan and Sue Morse were families who had been seen very recently, and the work was 'in progress', so that the audience felt very involved in the presentations and the discussion was very lively.

The format adopted at this meeting, two overseas visitors presenting major papers, and local professionals presenting current clinical work engaged the audience well, and will probably be a format we will use again. Mary-Sue Moore and Juliet Hopkins presented major papers, and these will probably be reported on in this Newsletter next year.

The Annual General Meeting of the Association was held during the weekend of the meeting. The major topic for discussion was the question of modifications to the Rules of the association which will allow for State Branches to work semi-autonomously while a Federal Committee is responsible for the formal requirements of an incorporated organisation, for the oversight of the production and distribution of the Newsletter, and for activities which need coordination with involve all State branches, such as overseas visitors, and the Annual Clinical Meeting. The members present at the Meeting resolved that appropriate steps should be taken to prepare the necessary modifications to the Rules. It is hoped that the draft of these modifications will be circulated early in the New Year, and that a Special General Meeting will be held soon after to allow them to be implemented. In brief, the model being proposed is of a small Federal committee made up of one nominee from each sta committee.

South Australia has been asked to organise the 1997 Annual Conference, and we look forward to this meeting which will probably be in the second half of the year. More information about this will be made available in future Newsletters.

FORTHCOMING MEETINGS

Preliminary Notice

PATRICIA CRITTENDEN

will be visiting Australia in March, 1997. She will be spending two weeks in Perth, where she will conduct a workshop in the administration of the Adult Attachment Interview, and a workshop in the administration of the Child and Adult Relationsh Experiential (CARE) Index. From the 25th March she will be in Sydney where she will conduct a workshop of advanced AAI training. This workshop is for those who have attended a basic training workshop in the AAI, and is on trauma and loss in the AAI. She will also be conducting a course on Attachment and Intervention, which will be around techniques for working with infants and children with attachment disorders. Both these Sydney course will be conducted over four half days, the advanced AAI Course being in one half of the day, and the Attachment and Intervention Workshop in the other.

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