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New horizons for understanding the importance and challenges of working with vulnerable families and their young children.

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Shifts in the field of infant mental health

Over the last 35 years, the field of infant mental health has seen many changes and new understandings have been gained since psychoanalytic theorists first stressed the importance of the early mother and infant interactions for child development. Our knowledge has been enriched by an increasing appreciation for an intersubjective approach to conceptualizing the field of early intervention and by new knowledge of the neurobiological underpinnings and the importance of the mind-body connection for understanding behaviour and child development.

A shift to understanding the importance of an intersubjective approach

In the early years of intervening with mothers and young children clinical practice was dominated by providing individual psychoanalytic therapy with the mother in a clinic setting. Realizing that babies cannot wait for the lengthy process of such individual therapeutic work, Selma Fraiberg (1980) introduced what she called "kitchen therapy" with the mother and baby together in the home, or wherever necessary, to meet the needs of both parent and baby. Fraiberg described several cases in which she described "ghosts in the nursery" or "visitors from the unremembered past of the parents ...taking up residence in the nursery" (Fraiberg 1980). According to Fraiberg, these ghosts appear briefly, and are banished quickly, in most families. Other families, however, can be "possessed by the ghosts", leaving parents "condemned to repeat the tragedy of [their] own childhood with their infants". When this happens, caregivers may place their own babies in great emotional and developmental peril. Fraiberg and her colleagues believed that children could escape the inflicted tragedies of their caregivers if parents were helped to recall any repressed, emotional experiences of their own childhood. With this guiding principle, Fraiberg and colleagues experimented to find the best treatments to help families who were repeating negative intergenerational patterns of care with their babies (Fraiberg, Shapiro & Cherniss 1983).

A shift that has emerged from those early days has been away from a strictly *intrapsychic* approach for understanding development and psychopathology, where the emphasis is placed on interpreting the experiences of an *individual primarily as internal conflicts*, toward an *intersubjective* position, which implies understanding a person's emotional and psychological functioning as developing in the context of *relationships and experiences with others*. This new position

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sees child development as dramatically affected by interactions and relationships with primary caregivers, including the mother and other influential parenting figures (McHale 2003; McHale & Fivaz-Depeursinger 1999) and with siblings. This approach also recognizes the unique contributions that the child brings to any interaction, including temperament, genetics, and a cumulative set of experiences. The shift to the intersubjective position has been most obvious in teachings of current attachment theorists and researchers (Fonagy, Gergely, Jurist et al. 2002; Goldberg 2000; Main 1995). Such an intersubjective understanding of relationships also applies to other dyads and consequently, has significant implications for understanding the importance of the intervener-parent treatment relationship and its potential for enhancing parent-child interactions (Stern 2004).

Brain development and functioning

The last 10 years of the 20th century have been called the decade of the brain. What is clear is that brain development is affected by a number of factors including *genes* (which determine the order and schedule of neuronal growth), *genetic disorders* (such as Down syndrome and autism), *biological factors* (such as viral infections or toxemia of the mother during pregnancy, and anoxia or other birth trauma) and *early experiences* (Pliszka 2003, Shonkoff & Phillips 2000). Brain imaging techniques are making it possible to gauge the effectiveness of both psychological and pharmacologic interventions by looking at brain structure and function before and after an intervention (Bremner 2005). Exciting new findings in neuroimaging, genetics, and endocrinology have also revealed critical periods in the early years of brain development when neurons and the connections between them (synapses) are created at a rapid pace and then pruned back depending on a child's experiences (Shonkoff & Phillips 2000). Important as these new findings have

been, sometimes the media message to parents has been that the more stimulation a child is given, often seen as providing toys and special videos, the more copious those synapses will be. Less attention has been given to the more subtle needs of children for nurturing and calming when hyperaroused, and for other sensitive and attuned interactions and their importance in fostering optimal brain development (Sullivan & LeDoux 2004; Siegel 1999).

Trauma and brain development

Neuronal growth and synaptic connections, as well as many neurotransmitter systems and endocrine axes, are activated and interact with one another under certain circumstances (Pliszka 2003). When faced with threatening situations, relatively automatic physiological and behavioural changes occur to promote survival, including reactions in the sympathetic nervous system such as increased pulse rate, blood pressure and heart rate, sweaty palms, and feelings of panic. Our response is to fight or flee (if possible), or freeze which renders us unable to react at all. This fight, flight or freeze reaction is instinctual and occurs in animals and humans. These responses activate the release of neurotransmitters, including corticotrophin-releasing hormone, that stimulate the pituitary gland. Activation of the pituitary gland, in turn, elevates levels of the adrenocorticotropin hormone which activates the hypothalamic-pituitary-adrenal (HPA) axis resulting in the release of glucocorticoids (cortisol) from the adrenal cortex and other neurotransmitters such as noradrenaline and serotonin (De Bellis 2001; van der Kolk 1996).

If the stress is slight and the person has adequate coping strategies, the system rapidly returns to baseline with no lingering effects. Everyone experiences a certain level of stress on a daily basis; even positive events such as getting married or starting a new job can produce some worry. However,

stressful events can be traumatic when one feels threatened, overwhelmed, and that the event cannot be controlled (e.g., near loss of one's life or the death of someone close). Although the reality of the event is significant, the meaning of that event for the person experiencing it is also important. Traumatic events include a wide range of experiences such as physical and sexual abuse or rape, witnessing violence in the home or community, experiencing natural disasters such as floods, hurricanes and fires, or man-made disasters such as accidents, wars, or kidnapping (van der Kolk & McFarlane 1996). Traumatic situations can be single events or ongoing episodes over several years. What has been less acknowledged or understood is that less dramatic situations, such as chronic failure to respond to a distressed infant, can be equally traumatizing and can significantly impact on the organization of the developing brain (Feeney & Collins 2004).

Millions of children and adults across the world are exposed to trauma and may show symptoms of Post Traumatic Stress Disorder (PTSD). These symptoms include flashbacks and nightmares, chronic hyperarousal of the sympathetic nervous system, and avoidance of anything reminiscent of the trauma (McFarlane & van der Kolk 1996). Individuals with PTSD may develop chronic activation of the HPA axis resulting in an excess of various stress hormones. Trauma that occurs early in life as the brain and associated self-regulatory capacities are developing, such as the regulation of arousal, attention, and emotion, can have lifelong consequences. For example, children who have been abused or lived in orphanages where they received little adequate care show a distinct pattern of cortisol levels; an increase from the morning with mounting levels over the day, unlike the normal pattern of reduction throughout the day (Gunnar, Morrison, Chisholm et al. 2001). If

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chronic, this pattern can lead to a destruction of neurons, a reduction in their functioning, or an increase in their vulnerability to later damage. As well, synaptic branching can be decreased and cell loss can occur in certain parts of the brain. For example, reduction in size and functioning of the hippocampus (responsible for storing verbal, explicit, conscious memories), parts of the prefrontal cortex (responsible for containing emotional reactions and for planning and problem-solving) and Broca's area (responsible for speech) may occur. The brains of some seriously neglected children have actually been found to be smaller (LeDoux, 1996; Perry, 2001).

Effects of trauma on functioning and memory

Trauma such as abuse and neglect, particularly in infancy, have been linked to various kinds of compromised functioning or psychopathology such as poor academic achievement, various externalizing disorders (aggression, conduct disorder, and oppositional defiant disorder) and internalizing disorders (anxiety and depression) (Cicchetti & Olsen 1990; Trocmé & Cauce 1995). Chronic changes in neurochemistry can be associated with sleep disturbance, anxiety or panic attacks, or obsessional preoccupations about being abused or hurt again (van der Kolk 2003; van der Kolk & Fislser 1995). Some may withdraw and detach from daily activities leading to further feelings of emptiness and an inability to enjoy simple pleasures or experience small emotions. Some may use drugs, alcohol, or dissociation to ease the pain. Others may compulsively expose themselves to dangerous situations by self-cutting, or engaging in risky behaviours such as with eating disorders, presumably to escape feelings of emptiness. The very act of abuse or neglect leaves the child unable to trust. This can have a significant effect on future relationships and leave an intense need to be in control of everything (Perry 1997).

Trauma has a significant effect on memory, both explicit (what is conscious and can be talked about and made sense of) and implicit (what is unconscious and cannot be accessed voluntarily). Implicit memories consist of olfactory, visual, auditory, kinaesthetic, and emotional experiences. According to some theorists and researchers, implicit memories of fear and panic are stored in the amygdala that functions at birth, while explicit memories are stored in the hippocampus that does not function until the child is about three years of age. This dissociation, some theorists believe, explains infantile amnesia and why trauma that occurs in the earliest years is not remembered verbally, but rather is stored and re-experienced non-verbally. Fear, terror and other bodily-sensory memories can be triggered readily if a person experiences a situation similar to those of previous trauma experiences, even if they occurred early in a child's development (Crittenden, Lang, Claussen et al. 2000; Nelson & Carver 1998). Internal bodily re-experiencing, emotions, and behaviours that are triggered may give the appearance of being unpredictable, or unintelligible to the person experiencing them, or to outside observers, because they have not been integrated into the individual's memory or conscious awareness and occur with our rational control.

Influence of trauma on parenting

The experience of becoming a parent is challenging both physically and psychologically. Early postpartum hormonal shifts, exhaustion, and the stress of separation as the baby is born can exacerbate symptoms of PTSD in new mothers who have not resolved their early experiences of loss and trauma or integrated them into a coherent narrative (Schechter 2004) Newborn babies express distress in strong, hard-to-read ways, and demand physical contact and closeness that can be difficult to tolerate. The responsibility of caring for another person can be overwhelming to mothers who have experi-

enced a past relationship of harm or fear, and can elicit memories of punitive attacks or abandonment by one's own parent. As a result trauma, if unresolved, can dramatically affect parenting (Lyons-Ruth, Yellin, Melnick & Atwood 2005; Schechter 2004). When parental mental representations of attachment relationships were explored with the Adult Attachment Interview (AAI) it was found that about 53% were in the Unresolved States of Mind classification (van IJzendoorn et al. 1999). This classification is related to the adult's signs of disorientation and even dissociation in discussing traumatic events such as loss by death, or physical or sexual abuse. More recently additional questions have been added to the AAI in order to identify traumatized adults who display what have been called Hostile/Helpless states of mind. It has been found that these Hostile/Helpless states of mind capture "indicators of a pervasively unintegrated state of mind and are linked to disorganization in the infant" (Lyons-Ruth et al. 2005, p. 39).

As many as 80% of parents in some high-risk populations, such those who abuse or neglect their children, have been found to have unresolved loss and trauma (Lyons-Ruth & Spielman 2004; Lyons-Ruth, Yellin, Melnick et al. 2005). Lyons-Ruth and colleagues have developed an observational system, called the AMBIANCE, which captures patterns of disrupted parenting behaviours that are more commonly displayed by caregivers with unresolved trauma or loss. These disrupted parenting behaviours, or "fr" behaviors, are frightening (hostile) or frightened (helpless) in quality. Frightening behaviours are rejecting of the child's bids for calming when upset. Parents with frightening behaviours can appear menacing and may threaten a child, or treat the child as an inanimate object. The frightened mother, on the other hand, often backs away from her child, may freeze or even dissociate, and

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cannot respond to her child's negative emotions without becoming overwhelmed by stored feelings and unconscious memories that are easily triggered. In either case, the child is left without a safe haven to turn to when upset, frustrated, or scared. Instead the child experiences fearful arousal without someone available to help modulate that arousal consistently. When a parent becomes a source of fear, and the parent-child emotional communication is disrupted with contradictory cues and responses, children may develop strategies to gain attention and control in the parent-child interaction (Crittenden, Lang, Claussen et al. 2000). These strategies include:

- Refusing to eat or sleep
- Whining excessively
- Reversing roles and taking care of a helpless mother
- Being excessively happy and not showing any negative emotions to ensure acceptance by the mother
- Becoming hostile, aggressive, and noncompliant in order to feel in control
- Withdrawing from the mother and other people and presenting as anxious, fearful, or depressed
- Showing disordered or disorganized behaviours or engaging in contradictory reactions to the presence of a parent.

About 85% of children whose parents interact with "fr" behaviours develop a disorganized attachment style and display rigid and exaggerated versions of the behaviours listed above. By adolescence they are at increased risk of developing psychopathology, including depression, anxiety, aggression, conduct disorder, or criminality (Cicchetti & Olsen 1990). Whether a predomi-

nantly internalizing or externalizing disorder develops may be related to the child's temperament, or arise from the strategies found to be successful in eliciting reactions from the parent. It is through these mechanisms that the trauma is believed to be passed from one generation to another (Lyons-Ruth & Spielman 2004).

Intergenerational transmission of attachment and abuse

Over 80% of infants have been found to have an attachment classification at 12 months of age that is analogous to their mothers' own adult attachment classification (Zeanah, Benoit, Hirshberg, Barton & Regan 1994). Mothers classified during pregnancy as dismissive (of emotions and relationships) are likely to have an avoidant child who learns that cries for help will not be responded to consistently and so gives up trying. Mothers classified as preoccupied (with emotions and relationships) are likely to have an ambivalent/resistant infant who seeks out the mother at times but pushes her away at others. A mother who has unresolved loss or trauma and displays frightening or frightened parenting behaviour confuses her child. As a result, the child fails to develop an organized strategy for responding to the mother, or eliciting her attention, and is likely to present as disorganized (Fonagy, Gergely, Jurist et al. 2002).

Another dramatic example of intergenerational transmission can be seen in the way depressed mothers' interactions with their babies influence not only the infants' later regulation of their own emotions, but also the brain mechanisms underlying their behaviours. Several studies have documented that very young infants of depressed mothers exhibit reduced left frontal brain activity (associated with approach emotions such as joy and anger and with language development) and increased right frontal hemisphere activity (associated with anxiety, depression and withdrawal) (Abrams, Field, Scafidi & Prodromidis 1995;

Dawson et al. 1999a,b). Initially, the infant's neurophysiologic reactions are seen in response to their mothers' affective expression in face-to-face interactions, but not in response to interactions with an animated stranger. However, by three months of age, interactions with the mother *and* an animate stranger both elicit right frontal activity in the infant (Dawson, Frey, Panagiotides et al. 1999a). This finding suggests that emotionality and responsiveness to social exchanges can be transmitted from mother to child during interactions in which the infant's pattern of brain activity comes to mirror the mother's repeated interactional tendencies. According to this hypothesis, cross-generational transmission occurs when a mother's hyper-reactive nervous system, often established in response to how she herself was parented, reacts quickly to stress and the challenge of parenting. When a child cries, memories of fear, anger, abandonment or unbearable sadness in the mother may be transmitted to the child through "fr" behaviours. The ultimate tragedy occurs when the mother is compelled to repeat what happened to her (Kobak, Cassidy & Ziv 2004) despite wanting desperately to do better in response to her child.

Implications of the new findings for approaches to early intervention

Advances in neuroimaging techniques applied before and after therapeutic interventions suggest that there is a degree of neuroplasticity or potential for change in the human brain. Many experts now believe that current knowledge about neuroplasticity has significant implications for the field of early intervention.

Understanding the process of change

The "process of change" study group is relevant here in its examination of *intersubjective* intervention thought to promote change on a number of levels

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(Stern et al. 1998). The “process of change” study group consists of prominent attachment and infant researchers and clinicians who are using their knowledge of mother-infant interactions to shed light on what happens in psychotherapy between a therapist and client. For clinicians working with mothers, this work is particularly powerful. The process of change group highlights *moments-of-meeting* which occur in the present between mother and child, when the empathetic attunement of the mother to the infant’s cues leads to development and growth. Such moments-of-meeting, or “now” moments as the group also calls them, are also theorized to occur in psychotherapy between therapist and client, thus leading to empathetic attunement and repair, and ultimately to psychological adaptation and growth. These “now” moments exemplify the two-person or intersubjective psychology that has become essential to clinical work in infant mental health.

Beyond thinking of interactions at a purely behavioural level, there is some evidence that the actions of one person can have an impact on the neurological functioning of another. For example, an intentional action performed by another person can activate what are called mirror neurons that are situated adjacent to motor neurons in the cerebral cortex and link motor action to perception (Jacoboni 1999). A mother responding to her child, or a home visitor responding to a mother, would consistently use examples of intentional actions. The activation of mirror neurons may account for subsequent emotions and the experiencing of the actions that are activated following such actions or observed emotions in someone else. For example, such activation might explain why a state of sadness is triggered automatically and unconsciously within us when we witness another’s sorrow, or why we cry when another person cries. It may be under corrective therapeutic conditions that these significant moments of

connection can actually rewrite some devastating past memories and allow the brain to be “rewired” as neural patterns change and new connections are formed. The effect of intervention may be a bit like listening to a new song. At first, we may only be aware of pieces. When replaying the song over several sessions, a greater richness can be experienced, potentially creating a wonderful memory for the parent. This new experience can then be reactivated years later to bring back happy memories of shared interactions and being listened to (Stern 2004).

What might a *moment-of-meeting* or “now” moment look, feel, or be like? Such moments may be verbal or non-verbal – revealed in a mutual gaze, a gesture, a facial expression, a movement, a shared joke, or a sad event. Above all, a now moment occurs when there is communication between two people that clearly demonstrates a mutual awareness of what each person is thinking and intending. Sometimes it may involve repairing a misstep in the interaction when something has been misunderstood. Such repairs can lead to a reconnection and new understanding. An illustrative moment of change from my own work occurred when a mother called me in crisis, feeling abandoned and depressed. I visited her in the evening. As she rocked back and forth in her rocking chair, she explained tearfully that she felt her baby was “leaving” her. Together, we watched her little one, newly mobile, walking across the floor away from her. Little was said, but everything was understood as tears rolled down her cheeks and she remembered other losses and people who had left her. This topic was something she had refused to talk about before. She felt something about the way I understood and connected with her, and our mutual understanding of what had occurred and she talked about it many times later. Other moments have included a mother whose stress and anxiety were apparent through panic in

her voice and a strained posture. A brief acknowledgement of her pain helped to calm her and contain her emotional responses. When a parent felt rejected following a cancelled session, or a gesture or tone of voice used in therapy, talking about the issue and showing empathy for her led to a new level understanding through a sharing of the meaning of the moment for her (Landy & Menna 2006).

Implications for the next decade

In spite of the successes of some early intervention programs and approaches to treatment, we should not ignore that there are still 25% of children entering school with an impaired capacity to function, finding it difficult to socialize with the other children, follow routines, and to concentrate in order to learn. The effect of trauma, particularly abuse on the developing child, is clear; 83% of individuals with explosive aggressive disorders are from abusive families, 75% of children receiving child protection services have clinically significant emotional and behavioural problems, and 85% of sexually and physically abused children have symptoms of PTSD, and there are many more statistics showing the dreadful effects of early trauma (De Bellis 2001).

These statistics strengthen the argument that new respect and more time must be given to building relationships with parents – both listening to them, and supporting them. We must look at what is done in intervention in new ways with less pressure to always *do* something, understanding that if past experiences or traumas are to be made less destructive they need to be rewritten, allowing a mother to be more responsive to her baby. We now know that this strategy will take time and that intersubjective approaches have the best chance of making a difference.

We also know now that certain short-term focused interventions such as *Interactional Guidance*, *Modified Interactional Guidance*, *Watch, Wait*,

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and Wonder, and Mindfulness-Based Cognitive Behavioural Therapy can improve outcomes for traumatized parents and their children. We must be bold and creative and consider these alternatives instead of resorting only to traditional parenting groups. We must strive to find approaches that reach parents who cannot see the influence of their behaviour on their children. A variety of methods are needed to increase self-reflectivity or empathy for the child and to help parents talk about feelings related to the past while reconnecting with these feelings in the present. We need to help parents learn from personal experiences with their own parents how better to parent themselves (Siegel & Hartzell 2003).

As the pendulum has swung, mistakes have been made in service delivery. We must take care not to let this happen in early intervention. For example, by integrating *all* children, regardless of their difficulty, into childcare and schools, without providing the special services they require has often left children without the support they need to manage and learn. At one time, early intervention focused on strengths and empowerment without acknowledging the equal need to attend to negative aspects of parent-child interactions. In the 1960s, mothers were blamed for everything that went wrong with a child, even autism, while the child's biology was ignored. We need to avoid thinking that trauma is responsible for everything while ignoring the individual contribution of each child. We must make sure that short-term interventions are, when necessary, embedded within a longer-term, relationship-based intervention so that parents can be helped to resolve the loss and trauma that may be preventing them from providing the nurturing and responsive interactions their children so desperately need.

We need to make prevention of mental disorders in children a public health priority. Without prevention and treatment services, stress and trauma can affect children's mental and physical

health and can lead to the development of chronic behavioural symptoms and dramatically compromised immune systems. Services are needed at all levels, both in prevention and treatment, and we must work together to reduce child and adult psychopathology. We must avoid a pendulum shift towards services dedicated only to the least at risk or to the most at risk, and establish an integrated system in which all the levels of service are equally-funded and available to all families who require them.

Universal prevention services are vital. Information should be available to all parents on child development and

safety in the home. Parenting groups are needed to support parents as they deal with the stresses of raising children. When there are risks and concerns about a family, or an identified disorder in a child or a parent, intensive, specialized services are crucial. If we are to affect change, we need the expertise of all disciplines. We must also remember that many children and families are resilient and strive towards growth, although the difficulties they face may be profound. Evidence shows that with the right programming there can be hope for every child and family (Landy & Menna, 2006).

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BOOK REVIEW

Your child's emotional needs: what are they and how to meet them.

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It is always a pleasure to see another book about parenting on the bookstore shelves, and I looked forward to reviewing this publication by Dr Flory. It had glowing reviews on the back page from two of her colleagues and I hoped to glean some useful information. She was motivated to write the book to fill a perceived gap in the literature on children's emotional development.

This book is aimed at parents and begins by giving a detailed description of the role of emotions in child behaviour, making the useful point that behaviour is more often seen as the problem because it is visible, rather than the underlying emotions which are invisible. I felt this was a most useful observation to make, as many parents, and often many professionals, struggle to see anything but the undesirable behaviour shown by children who, with deeper understanding, are struggling with overwhelming emotions.

There are three sections in the book. The first is about emotions and why they are important. The second section goes on to describe the changing emotional needs of children from ages 0 to 12 years. In the final section, emotional disorders, common difficulties and their alleviation are explored.

Emotions are linked with behavioural problems that are interfering with the child's ability to fit in at home or school. Many aspects of child behaviour are explored, with each situation given an emotional context with which the parent is to empathise. The idea of emotional contagion is identified and the emotional needs of the parent are acknowledged, as well as the idea of children's emotions, being easily displayed and changeable, appearing superficial. This was useful information and would

be helpful with some parents as part of an intervention.

The concept of attachment is introduced in Chapter 2, in the context of a key element of emotional needs. It is here that the book starts to disappoint, as the idea of "the attachment relationship" seems like an add-on, without a deeper understanding of the components that enable a secure attachment for a child. This may be enough for a parent to read and benefit, but I found any reference to attachment, from this point, more confusing than enlightening and seemed extra to the text, rather than a theory that perfused the professional work. The term "attachment relationship" is generalized to describe all attachment styles and the insecure attachments are not described in detail. The obstacles to a secure attachment are listed in a sanitized way, in an effort to make it more acceptable to parents, but again falling short of greater enlightenment. Not that this should be another book on attachment, but it may have simplified some of the wordy explanations of parental empathic failure and its consequences, which became rather repetitive with each case vignette that was explored.

The subject of empathy is examined in detail from every angle, as are parental beliefs about children's behaviour, which could prove useful for parents motivated to read this book. This is interspersed with other useful ideas about unrealistic expectations and beliefs about the child, resemblance to relatives (liked and disliked), enmeshment and distance in relatedness, and is described in terms that, although making it easier for parents to comprehend, seemed to gloss over some important points.

In Part 2, the emotional needs of the age groups are explored in more detail. Here again there was a disappointing lack of information that would demonstrate a better understanding of attachment. The chapter on the first year did not mention the need for routine and lists all the physical and emotional needs rather clinically. Attachment is described in a simplistic way and detachment and intrusiveness in the parent are explored, with infant cues given some detailed outline as a guide for the parent. Some of the myths about babies are debunked, though this read like a repetition of the themes from earlier in the book.

The other age groups of One to Four and Four to Twelve are dealt with, covering tantrums and the same themes of the previous ages, which feel very familiar by now, although they are expanded for each age grouping.

Finally, in Part 3, common "emotional disorders" and their alleviation, are dealt with. Signs of emotional problems are listed for each age group, though not all of these are addressed in this section. Some more common mistakes and misunderstandings in parenting are explored, in an effort to improve self-esteem, insecure attachment, whingeing and lack of cooperation, with a few pages on soothing a child. The author ends with a brief summary pointing out the need for parents to consider their child's emotional and developmental needs, what their child needs from them and to be emotionally supportive.

This has been a difficult book to review as the author has made a valiant attempt to address most of the problems experienced in families in the first

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twelve years of a child's life. The result is a vast number of case vignettes that are all analysed and treated, with a re-hash of the theory for each one. It may have been clearer if the author had not tried to achieve so much, as the result is a confusing amount of advice and prescriptions with a smattering of attachment theory thrown in. I felt that a parent may need to be reading the book at the appropriate page in order to know what to do next. This must stem from the author's experience with her clients and the desperate need to effect some change in their parenting style, where many approaches to a problem are tried in the treatment.

On the whole, in some ways, this is a useful book. Some of Dr Flory's ways of conveying the emotional experience of children to their parents is helpful and would be of use to anyone who read it. It is not a book to learn more about attachment theory and a solid knowledge of this in the reader would be advised, to avoid confusion. With a stronger base (no pun intended) in attachment theory, this could have been written more succinctly and clearly for the reader to gain some real insight into the complex emotional world of children.

Martha Birch

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State Reports

NSW

In NSW we recently had a very successful conference, the first Aboriginal and Torres Strait Islander Perinatal and Infant Mental Health Conference. This was conducted under the auspices of the Sydney South Western Area Health Service – Western Zone and our thanks go to our NSW AAIMHI committee members, Trish Glossop and Charlie Griffiths who were part of the organising committee. Also on the committee were Professor Bryanne Barnett, Murray Tonkin and Gwenda Darling. The conference theme was *Old families, new beginnings – working with ghosts in the nursery*.

The conference saw over 250 delegates. Many Aboriginal health and family workers from isolated regions of Australia were encouraged to attend and many delegates were sponsored by AAIMHI NSW. Our thanks again to the organisation committee for a wonderful conference.

The executive continues to be active and our membership is growing in NSW. We have had some successful evening seminars and are currently planning more.

Ian Harrison.

South Australia

In conjunction with the National Parenting Conference held in Adelaide 25-27 May, the SA branch of AAIMHI sponsored a free public lecture by Dr James McKenna on infant sleep. We have started holding this lecture every second year in honour of Helen Mayo, one of Adelaide's early pioneers in infant welfare. The lecture theatre was overflowing and the feedback was very positive. We have video-taped the lecture and will have it available for sale in the near future.

The SA branch also sponsored two Aboriginal workers to go to the Sydney conference on indigenous infant wellbeing. Wendy Thiele and Sheryl Rothwell attended and will be presenting at our AGM on 7 August.

A plan for responding to vulnerable infants is being developed in SA and the state branch will respond to this.

Elizabeth Puddy

Our sad news is that Elizabeth Puddy will be retiring from the SA committee after the AGM. We will greatly miss her contribution, which has been inestimable over the years. Until this AGM she has been our treasurer and has steered us through the murky waters of the GST, the rise and fall of the dollar in paying international speakers, hosted most branch meetings at her home and organised the membership list and the sale of our videos.

Elizabeth's contribution to the wellbeing of Australian and particularly South Australia's children has continued over many years. Her contribution to the Mothers and Babies Health Association (MBHA) was recognised by naming of the Elizabeth Puddy building in the Child and Youth Headquarters. Elizabeth continued her interest in and contribution to infant welfare after MBHA was taken over by the government, as Chair of the Board. She was the first person in SA to start health education classes in secondary schools. She also set up and led a group of professionals from various backgrounds in delivering parent education groups in the 1960s and these continued for over 20 years until replaced by nurse-led parent education through Child and Youth Health. She was also on a number of important government early childhood advisory committees over the years. She was a founding member of AAIMHI in SA and its first president. She was involved in the setting up of a parent education course at the University of South Australia

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and lectured in this course for a number of years. On retiring from this Elizabeth was offered and took up sessional counselling in a town in Clare, in country SA, and travelled up there to parents and children for many more years. She was a founding member of Action for Children in SA and the SA branch of NIFTeY, being past president of both these organisations. For her contribution to children and the community she has been awarded an AM and a Centenary Medal.

However it is for her personal qualities that those of us who know her well most admire and respect. She has outstanding leadership qualities and as well she works hard behind the scenes. Her contributions range from advocacy and lobbying to helping with the nuts and bolts of running conferences and workshops. She is thoughtful and dedicated and has great strength of character and purpose. Her commitment is inspiring.

Over the years she has been a wonderful mentor to me so it is on a personal as well as an advocacy level that I, and our committee, will miss her from her work with AAIMHI.

Pam Linke

Branch President.



Elizabeth Puddy (front L) with husband Albert and children (back L to R) Andrew, Diana and Mark.