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In this issue

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Articles are accepted preferably as Word documents sent electronically. Send to Shelley Reid at email:

shelleyreid2@bigpond.com

Editorial inquiries:

Shelley Reid
0428 425 022
shelleyreid2@bigpond.com
or shelley.reid@email.cs.nsw.gov.au
Postal address:
The Editor, AAIMHI Newsletter
PO Box 846
Ashfield NSW 1800

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Infant observation and ethics

Australian Association for Infant Mental Health Victoria Scientific Meeting 29 May 2010

Prof Lynn Gillam, Associate Prof Frances Thomson Salo, Associate Prof Campbell Paul

University of Melbourne, Royal Children's Hospital

Introduction and overview: aims of the meeting – Campbell Paul

Infant observation in clinical training

Esther Bick PhD, wrote that, '*Infant observation was introduced into the curriculum of the Institute of Psychoanalysis in London in 1960 as part of a course of first-year students… (It was)'Part of a training course of the child psychotherapists at the Tavistock clinic since 1948 when the course began (1963).*Piontelli commented that, '*Detailed observation and reporting to the discussion group of each student's weekly observation helped to keep interpretive impulses at bay so that the language of observation naturally remained unburdened by jargon, but rather tended towards the poetic*.'

Structure of infant observation

It is an arrangement consisting of a weekly one-hour observation of an infant in the first year of life (and subsequently) and her family, in their own home, reported to and discussed with a confidential small group seminar. It allows for systematic and thoughtful reflection, in particular about how to enter the inner world of the baby.

It is usually provided as a training experience to develop an understanding of the infant's world and development to allow improved clinical work with children. The use of the observer's own feelings are critical to this understanding (both transference and countertransference). It has also been used as a therapeutic intervention, eg, by Didier Houzel in France.

Infant observation research has been reported in a number of publications of which the most widely known are *Closely observed infants*, Lisa Miller et al. (1989), *Developments in infant observation: The Tavistock model,* Susan Reid (1997) and *Backwards in time, the study in infant observation by the method of Esther Bick,* Alessandra Piontelli (1986).

Applications of infant observation include shorter observations of infants as well as those of older children. There have been systematic observations in different settings (early childhood daycare, orphanages, hospitals, neonatal intensive care and other settings). There have been observations before birth using ultrasound (Piontelli), serial videotaping of observations (Lynn Barnett), and infant observation has also been used in other training programs of psychoanalysts and child psychiatrists.

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Infant observation: some ethical issues

First we must do no harm. We can then ask whether we provide a positive intervention, what are the ethical questions, and whether our presence is therapeutic?

Infant observation dilemma: "Should I say something?"

An infant observation dilemma involved an anxious young first time mother, an older father with other children and an observer who was an experienced clinician. The baby seemed to have an un-held experience in the family and was quiet, undemanding and sad. At 4 weeks the observer began to wonder whether the baby could see, and this was discussed in the seminar group. *What should she say?* At 6 weeks the parents reported that their anxiety had been discussed with the maternal and child health nurse and the baby was referred to the GP, to the paediatrician and to the ophthalmologist.

Ethics in infant observation

Frances Thomson Salo

Names in this article have been disguised.

I'll discuss possible gradients of harm, direct and indirect, in infant observation as taught in therapy trainings or for infant mental health clinicians. This may appear provocative as infant observation is not usually viewed in this way. However, referring to the ethical principle to do no harm may give a new way to rethink some situations met with in infant observations. This contribution should be viewed more as a work in progress rather than a finished paper. Let me make clear that I am not referring to abuse that is reportable, and I take it as the observer's responsibility, if there is danger to the baby when the mother is not present, to act to keep the baby safe.

For many of the observation seminars that I have taught, the parents are given a plain English letter of consent with a statement that the aim is to observe the infant's development in their family, and conveying that the observer's role is on a participant-observer continuum. It clarifies that the parents can withdraw from the arrangement, and contains the seminar leaders' contact details if there are issues they wish to discuss. Observers are encouraged to be transparent about their profession, student status and their notes, a summary of which can be available if the parents wish. It is helpful if someone who is known to the family makes the initial approach to the mother on the observer's behalf. Observers try as far as possible to find a 'good enough' family without obvious serious pathology as the aim is to observe more or less 'ordinary' development rather than to arrange an observation with a family that is experiencing difficulty or in a high risk situation.

Lynn Barnett's (1989) infant observation video of a mother who gave her 5 month old baby, Felix, a kitchen grater with which he played for 20 minutes has not usually provoked discussion about the ethics of the observer's role. It is not easy to think what an observer could do to intervene in that situation without impinging on the mother's responsibility for her baby. But thinking about the ethics of infant observation I wonder if a tension arises when a method that was developed to help psychotherapists learn more about child development and their own emotional responses, is used in the training of infant mental health clinicians who have become very aware of the baby's primary intersubjective communication from birth with everyone in his or her environment including the observer. With the growth in knowledge about attachment theory, intersubjectivity, the effects on the infant of maternal depression and the importance of early intervention we could think of a tilt in the field in which infant observation developed.

I'll first raise a number of general questions before turning to 4 questions that relate more directly to the baby.

1. How ethical is it to feel critical of a mother?

Some observers have felt critical of the mother, anxious that they were 'betraying the baby' as one observer wrote, who felt that the baby looked beseechingly at her to recognise her distress and do something when her mother ignored it. Many observers feel uncomfortable in a seminar if they feel that there is criticism, even if not spoken, of the parents. Some observers have said they felt guilty that they were 'stealing' from the mother; some feel that there is an undeclared agenda to observe the mother as if they had not been open about observing the baby's development in their family. Mothers often use the first year of their baby's life to

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Ethics in infant observation (cont.)

work through reawakened difficulties so that they may feel that they are dealing with hateful feelings, such as resenting their baby's 24/7 dependency needs (Griffiths, 2007). If there appears to be something negative in the mother's actions, is it unethical to 'see' and discuss it, within the overarching principle to do no harm?

2. How ethical is it to show certain infant observation videos?

There is a recognised need to publish respectful case reports to advance knowledge. The video of Felix is similarly important. It is a powerful teaching tool – he did not hurt himself with the grater which his mother had been confident about. Development over childhood can be tracked – Felix went on to study Psychology at college, specialising in attachment theory, and he described feeling that his 'absent' father had left an emptiness inside him. The fact that Lynn Barnett still had contact with the family when he was 25 years old speaks for the family's positive feelings and trust in her. One question is whether his mother gave informed consent for viewers worldwide to study her speech, tone of voice and implicit fantasy world? Another ethical question may be whether videos of Felix should be available for public viewing when he is recognisable as an adult in a way that he is not as a baby? Felix possesses copies of all the videos – but he has never looked at them.

3. How ethical is it not to be aware that observation offers an attachment relationship?

Perhaps to focus primarily on an observer's own emotional reactions can blind some infant observation participants to observation as an attachment relationship, both for mother and baby. This is something the Royal Children's Hospital clinicians have suggested for a number of years. Some babies, on waking, reach out to the observer to play with them as though they knew that while their mother would not approve of their being awake, their observer might be co-opted into being complicit as an ally.

A mother at the start of an observation experience cannot know that she is about to enter a relationship that may be very positive, and possibly therapeutic. Parents come to value the observer as an interested, empathic and non-judgemental person. They also value the opportunity to sit and watch alongside the observer – and through this may come to see increased meaning in their baby's expressions and behaviour. Parents often confide sensitive issues to the observer long before they tell others, because it feels safe.

Dimitra Bekos' (2007) research project for her Masters in Child Psychoanalytic Psychotherapy in which she interviewed three mothers in depth to explore their experience and reflections after the observation had ended found that the mothers did not understand when the observer took a strict line that the observation had to completely finish at a specific date. They felt that they had a meaningful, positive relationship with the observer, and that it was inexplicable to have no contact with her after the formal end of the observation. They felt hurt and confused, and even angry and abandoned, which suggests that this does not meet the principle of doing no harm.

4. How ethical is it for the observer to privilege using observation of the infant to develop the capacity to become more self-containing of their own emotional responses?

Some approaches seem to privilege the development of the therapist's capacity to contain their own emotional reactions above the learning objective of observing the development of a baby and thinking about the development of the baby's internal world. In a short communication to this Newsletter in 1996, I thought that this might result in the baby not being seen in his or her own right. I had misgivings about the baby potentially being used primarily to develop the observer's capacity to be self contained about their own distress and anxiety, particularly if the mother and baby were experiencing difficulty. In no other situation if a child was in distress would the clinician only observe and not act.

This leads on to four questions which focus on the baby.

1. What is an ethical response to a baby who is securely attached?

A relatively common experience in infant observation is when a baby is left to go to sleep and may cry, having lost the dummy, and the mother does not respond. What is ethical? Early in an observation, responses seem to divide between continuing to observe the crying baby (who may be left to cry himself to sleep when the observer is not present) or giving the baby the dummy (which usually brings some relief but may pre-empt the baby discovering their own capacity to self regulate). Often observers do not report checking with the mother what she would like them to do, as if being with a crying baby early in an observation contributes to a difficulty in thinking. Finding the appropriate observer role may at times feel like balancing on the tightrope between doing too little or too much when it is not indicated or welcomed, while trying to remain open to the distress a mother and baby may experience as part of ordinary, manageable situations.

Often babies invite the observer to interact with them and it seems respectful to respond appropriately to the invitation, attuning to it but without escalating the response. Generally the babies I hear about or read about rarely seem adversely affected by the presence of an observer in their first year except when the observer's stance is one of non-participant observer. Let me give two examples. When a 9-month-

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Ethics in infant observation (cont.)

old baby crawled towards her observer signalling that she was available for engagement, he continued to sit still without any response. The baby then sat with her back to him and the observer thought that she felt ashamed and hurt by him and he felt very guilty.

Now a more general example. At times some observers, when a sleeping baby woke up and found them alone in their bedroom, have tried so hard to stay as neutral observers. They sometimes describe these babies as quite traumatised by their minimal engagement even if the baby already knew them well; the observers also seem upset and guilty. In infant mental health we use awareness of our emotional reactions to help understand the baby. Why is it different when as a result of the stance the observer took, the observer feels that they have been "mean" or "cruel" to the baby? Some observational approaches do not seem to include wondering whether babies feel that their expectations have been violated but rather to view it as more responsible for the observer to process their own emotional reactions and not 'contaminate' the observation by acting. But does it meet the principle of doing no harm?

In the situations just described, the observer would need to move only very slightly along the participant-observer continuum. The following examples, however, do not feature a direct invitation or appeal from the baby and may present more difficulty. What if a mother seems loving and sensitive in every way except for wiping her baby's mouth extremely roughly? What if a mother tries to trick her 10-week-old baby into breastfeeding using a supply line of supplementary milk looped over her shoulder, then notices the 'panic in the eyes' when the skin around the baby's lips turns blue? And paradoxically, what if a mother meets her baby's needs so perfectly that she could be called a 'too good mother' and perhaps fail her baby in that way? Acting ethically what position might an observer take?

2. What is an ethical response to a baby of a depressed mother?

Perhaps in the light of what is now known about infant response to maternal depression it can no longer be viewed as ethical to not intervene, however minimally. It is, however, striking how often when a mother's mild depressive feelings ease within a few months, her baby responds with a lifting of mood. It is also striking that when an observer has discussed in a seminar if they feel very anxious about for example, a gaze avoidant baby (although the situation would not be reportable to the Department of Human Services and may not qualify for services), and the observer has refrained from very actively intervening, there may be a dramatic improvement in the family the following week.

But in the 'Still Face' experiment, when a mother is asked to keep her face expressionless for 2 minutes, some babies become distressed within seconds by what they feel is a violation of what they expect to see on their mother's face. And just as the Still Face study may not be ethical in some situations because it is causes unnecessary pain to the baby who may see it as a 'threat face', I think it may not be ethical to stay in a fixed non-participant observer role with babies of depressed mothers. The observer can remain sensitive to mixed feelings the mother may have about this, while observing with an alive, empathic mirroring. Gyan Bhadra (2007) described observing twins who were born in the shadow of a dead baby and from 3 months onwards one twin was not 'seen' by her depressed mother. This contributed to considerable difficulties and the baby began compulsively stroking her bottle, and dissociating. The observer changed to a slightly more active stance in 'noticing' the baby with a successful outcome for both girls. We may need to be more mindful if the structure of observation in which the mother knows that her baby will be 'seen' by and will matter to the observer, allows some mothers to 'hand over' the noticing to the observer, while they take some time to grieve.

3. What is an ethical response to a baby of a traumatised mother?

What if the observer subjectively feels that they do harm by visiting, when for example it becomes evident that a mother is in a traumatised state but it is not the observer's role to offer therapy? In one observation, a mother who had been traumatised by her own mother's reaction to her baby sibling found this state was reawakened when she gave birth to her second baby. The hate that she experienced was transferred onto the observer, so that the mother could be 30 minutes late for the observer's visit. The baby was sensitive to his mother's feelings and refused to meet the observer's gaze for 8 months, presenting as more disturbed than babies with depressed mothers. The observer could process this as it unfolded and helped the mother by consistently and non-judgementally visiting. But despite extending the finishing period, the observer felt that the ending came before the mother had fully mastered it. So a question may be how to decide whether on balance it does less harm to continue or discontinue an observation?

4. What is an ethical response to a baby in a challenging environment?

What is an ethical response when despite having tried to find a 'good-enough' family to observe, challenges for the baby emerge over time? For example when an unsupported mother was quietly sarcastic to her 10-week-old baby, saying, "You think you're so clever but mummy is the boss" and the baby lost her joyfulness and was sad for a long time. When a mother misses or ignores her baby's cues and needs for interaction and comfort. When a

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Ethics in infant observation (cont.)

mother has expectations that seem too high for example, that the baby feed him or herself too early. Or slams the pet dog across the room but is never seen to hurt the baby. Or describes accidentally killing a pet bird soon after the observer has reminded her that the visits would stop shortly.

At times, a baby in a challenging environment may reach out emotionally to the observer – a 6-month-old baby girl had been left by her busy mother to be cared for by a male stranger who was feeding her in a non-contingent way. The baby continually smiled and vocalised at the observer, who avoided being drawn in. The baby then sat up to see the observer and finally grabbed the observer's hand with both of hers and pulled it to her chest. She looked deeply into the observer's eyes, smiled and seemed delighted to have someone available to her. The baby does not know the rules!

But a baby in a challenging environment may not reach out as in the following example. While Dee, Joe's mother, never in the observer's presence hit him or held him roughly, she continually saw him in a negative way. 'You smelly, horrid thing', she would say. She often commented in the early months, "You poor, neglected little thing". When he was 4 months old she called him "stupid" because he cried every time she put him to sleep and at 5 months she said, "Children are awful and when they're sick it's even worse." At 8 months he repeatedly tried to stand up resulting in his frequently falling and hitting his head and although his mother acknowledged his distress and fragility she continued to watch him without intervening. At 10 months he was able to stand alone. As if he needed to get away, he often remained out of his mother's sight so that it was common for the observer to notice new bruises and scratches. Frequently when the observer arrived Joe shied away and seemed incapable of interacting with her. When he was younger, he would turn his head away or stare blankly at her; as he got older, he ran in the opposite direction or ran frantically and manically through the room waving his arms and tensing his body. At 15 months he entered the room on tiptoe and spun around. What might have been an ethical course of action and at which point?

When in 1997 during the visit of the psychotherapist, Suzanne Maiello, I discussed the ethics of responding - suggesting that if the observer was concerned they had to act in a way that they thought was ethical - I felt that I could be seen as having compromised a capacity to stay self-contained. I suggested that when a baby in a challenging environment reaches out to the observer, there was a responsibility to respond empathically. Staying in a traditionally less responsive observer role may leave the baby feeling alone in a despairing way, which may breach the principle to do no harm. Debbie Hindle and Trudy Klauber (2006) from the Tavistock Clinic touched on similar issues in their paper on ethical issues in infant observation when they wondered whether there might be 'a potential tension between what we as teachers want our students to learn from observing in a family, and the family's experience of the observation'. I suggest that we have reached a time when a spectrum of observer response could in therapy trainings more easily be considered to be ethical.

Let me conclude with some examples from observers that I am grateful to have permission to use, of what families get out of infant observation. Most babies seem to actively enjoy being observed, playing to the gallery, turning to check that the observer is still watching them, sometimes to the extent of ignoring being hurt by an older sibling while basking in being observed. The imitative mirroring that babies experience seems to add to their sense of self-esteem.

One mother said, "I have learnt a lot from having you here. I felt like I learnt to just look at what my son was doing and tried to see how he wanted things done. I felt it made a big difference". Another mother said, when the observer mentioned the end was coming up, that when she was first considering the observation she was hesitant as it was for such a long time. But it had been good and she said that the observer could keep coming for as long as she liked. Another mother gave feedback 22 years later, "The observer coming here once a week for a year has profoundly changed my relationship with the baby".

Ordinary infant observation can be therapeutic. One mother told the observer that her baby's sleeping difficulty was better because she did what the observer did – "I just watch her". Another observer wrote, 'When I told the mother that the observation would be over soon she was quite taken aback and said, "Who am I going to talk to if you don't come?" and talked about her husband having a fortnightly massage and this was really like a counsellor.' Another mother wrote to her observer, *For me, the presence of the observer and her involvement in our lives over the past year has been a remarkable feature. In reflecting back over the experience, I feel that this relationship between my son and I and the observer has enabled some healing of wounds from my own infancy."*

And to give the last word to a 7-year-old boy whose baby brother was being observed - 'All the children should be watched."

So gathering the issues raised into a question - while most mothers and babies value infant observation, are there some ethical aspects that we need to rethink?

Acknowledgments

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Address for correspondence

A/Prof. Frances Thomson Salo

Royal Children's Hospital

Flemington Rd, Parkville 3052

Email: fvtsalo@unimelb.edu.au

A framework for discussing ethical issues in infant observation

Assoc Prof Lynn Gillam

Children's Bioethics Centre
Royal Children's Hospital
Murdoch Children's Research Institute
University of Melbourne

- Basic questions to ask: a starting point for ethical analysis. The questions are generic. Here, X = infant observation for health professional training.
- What is the rationale for X? What is it supposed to be achieving, for whom, and how?
- Could X cause harms to patient /client /participant?
- Have the risk of these harms been made as low as possible?
- Does X have benefits to patient /client /participant which are commen surate with the risks?
- Do participants in X know what X is all about, and a proper opportunity to make a choice?
- Are the processes for protecting privacy in X adequate?

Some useful concepts

Standard ethical question in the context of observation: "What level of involvement (if any) is ethically appropriate?"

Engagement: participation at a minimal level, not attempting to alter what is happening.

Intervening:

- Taking action on the spot to alter what is happening
- Involving third parties with the consent of those being observation
- Involving third parties without consent, or against the express wishes of those being observed is a breach of confidentiality

Breach of confidentiality – standard ethics position

Confidentiality is not absolute in a professional setting. Under some circumstances, it is ethically appropriate to breach confidentiality, i.e. to pass on information to a third party without consent, or in the face of refusal.

Standard justifications for breaching confidentiality

- Protect other people from risk of harm
- Protect patient/client from risk of harm
- Promote broader social values

Assessing whether to breach confidentiality due to risk of harm

- Standard questions to ask:
- What is the **probability** of the harm occurring?
- What would be the **severity** of the harm, if it occurred?
- What is the **likelihood of success** ie that breach of confidentiality would achieve the aim of averting harm?

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A framework for discussing ethical issues in infant observation (cont.)

- What is the **lowest level of breach** needed to achieve the aim?
- What is the **optimal timing** for the breach?
- What is the chance that **consent** to disclosure could be obtained, if we waited longer?

Two aspects of ethics

Procedural ethics versus ethics in practice – need to attend to both

Procedural

- Ethics committee (HREC or CEC) processes
- Plain language statements, consent forms
- Protocols, risk management plans, planning for con tingencies

Ethics in practice

Responding to events and situations as they emerge in practice

Ideas from observation in anthropology

Reciprocity: you are getting something from this, what are they getting?

Respectful engagement

- Negotiating what level/kind of participation or engage ment is appropriate
- Establishing expectations
- Negotiating relationships

"Leaving the field"

Respectful disengagement

Two paradigms of ethical practice: research ethics and clinical ethics. Infant observation sits somewhat uncomfortably between them.

Clinical ethics – key features

Obligation of beneficence – to help, to make things better

Informed consent – a side-constraint: you can only help if the person is willing to agree.

Confidentiality

- Important in terms of patients' rights, and also as therapeutic device
- Recognised circumstances in which confidentiality should be breached.

Research ethics – key features

Non-maleficence – do not make people worse off than they were before the research began

Scientific merit – be rigorous, collect the best data possible

Informed consent – a side-constraint – it is unethical to use people as source of data/knowledge, unless they agree to it.

Privacy – a standard expectation on basis of human rights/ autonomy but level of protection depends on what the research participant has been told and agreed to. Again, recognised circumstances where privacy may be breached.

Major difference between the paradigms

Clinical ethics: obligation is to actively provide help or benefit to patients/ clients.

Research ethics:

- no inherent obligation to provide benefit to individual participants
- just an obligation not to harm them (more than is necessary in the pursuit of knowledge, and not be yond a certain minimal level)

Where does infant observation for professional education sit?

Done by trained health professionals – has some affinity with clinical ethics

Not done as part of treatment or therapy – has some affinity with research ethics

In some ways, a mix of the two:

- may look a bit like clinical research BUT isn't
- clinical research – participants are receiving some form of treatment or therapy, as well as participating in research
- infant observation – no therapy is being given, no scientific data is being generated
- some of the ethical issues in infant observation are very similar to those in observational research.

So a different paradigm again.

Patient or community member involvement in health professional education

What is the ethical framework for this activity?

What ethical principles apply?

What are the key ethical bottom lines?

AIMHI and Australasian Marcé Society Joint Conference 'The infant, the family and the modern world: Intervening to promote healthy relationships' conference review

Melbourne, 1-3 October, 2009

Joanne Garton
Health Promotion Officer - Mental Health
South West Public Health Unit
Southern Regional Services
Division of the Chief Health Officer
Queensland Health

Jo was sponsored by the Australian Association for Infant Mental Health Inc. with thanks to Victor Evatt. This article is her personal summary and not the views of Queensland Health.

The conference provided substantive evidence, support, references, networks, future directions, advocacy and efficacy for our South West Birth to Prep – Spread the Word Reading Bug project, fitting within the complex early parenting/pre-parenting and service provider environment. The South West Birth to Prep – Spread the Word Reading Bug project promotes awareness of the important contribution of sensitive interactions – reading, telling stories, play, song and rhyme – right from birth, building upon secure infant-parent relationships and foundational literacy and language skills. Other aspects of the SW Reading Bug project contribute to the promotion of early child social, emotional and physical development. I thank AAIMHI for sponsoring my attendance.

The presentations highlighted the quality and quantity of diverse programs and interventions that engage babies, parents and partnerships in caring responsive relationships and optimal early childhood developmental and family environments. The conference covered the diverse experiences of pregnancy and parenthood that lie principally within the therapeutic, clinical and parenting service realm. While this information is not the work we do ourselves, it is very important to our project rationale and efficacy. The pertinent notes also reveal solution-focussed resources and understandings around areas of influence and merge and provide a most suitable background to scrutinize and explore our early years project's validation as an appropriate Mental Health Promotion intervention in line with strategic policy.

What is it our team can gain from this myriad of information and how can we apply it to our work? Essentially it is that we do not have to accept the modern world as it is with the many forms of dysfunction and representations of ill health. But we can and must accept that the key to improved population health status rests with how well we can influence the care giving environment of our babies, to produce the environment we want for their future. This is the modern world we can hope for and achieve.

Read on to understand how we arrive at this conclusion.

What comes to mind first is to reflect on one of the important statements delivered in the conference. Let's start with the comment made in the opening presentation by Helen Milroy: "We must grow up healthy children before we fix chronic disease".

The presentation reinforced what we know, that sensitive, responsive, attuned care giving during earliest life both ante and post natally plays a critical role in guiding the newborn and infant's capacity for regulating behaviour and emotions. But just how crucial is this to people's health and wellbeing?

The following excerpts are from Peta Anderson of NGALA in the Tuned In Parenting (TIP) presentation. Daily interactions with parents form the template for future relationships and over time these become internalised and drive external behaviours of the child. The parents' own history is one of the strongest influences on the parenting the infant receives and the developing parent-child relationship. Responsive and attuned parents are sensitively aware of their infant's signals. The infant feels understood and can trust the parent to respond appropriately to his/her behaviours and feelings and be given comfort when needed. In these relationships infants learn to soothe themselves and manage their own affect.

The infant must be able to understand that parents' response is in resonance. Feeling states that are never attuned will not become part of the infant's developing repertoire (Jeanette Milgrom).

Many parents have degrees of anxiety and may have mental health and other issues and so may be under-equipped to cope as effectively as they could and go under the radar. Peta Anderson acknowledges that maternal state of mind and maternal sensitive responsiveness have both been found to act directly on infant attachment security and on healthy mental development of the infant. Healthy develop-

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Conference review (cont.)

ment occurs in the context of a supportive and attuned environment.

The supportive and attuned environment is characterised by responsive parenting. This in turn requires having the child in mind, putting the child first and recognising and responding in a timely, reflective, sensitive, predictable and appropriate way to baby/infant cues. Louise Newman summed this up by the statement "The infant only comes to think because it is thought about." A body of evidence agrees that in the world of secure infant-parent attachment, when the child feels understood he feels secure, he knows he can trust his carer and learns he is worthy of trust and that the world is trusting. Trust is foundational to (attachment) relationships across the life span.

Within a supportive and safe environment the child develops:

- the beginnings of self regulation (understanding self and managing own behaviour),
- social-emotional competence (recognising, under standing and communicating feelings and appropriate response),
- roots of empathy (an understanding that others have thoughts and needs)
- the foundations of resilience and happy, healthy relationships through life.

These points summarise a body of evidence resonated by Sarah Mares' comment that "Parenting must not be 'just good enough' – it must be good enough to support healthy development". Social and emotional competence promotes cognitive development for ongoing learning.

So reading to babies every day nurtures brain circuit development for the foundations of literacy and learning and social/emotional wellbeing. When protective, attuned relationships are not provided, levels of stress hormones increase, impairing cell growth, interfering with healthy neural circuit formation and disrupting brain architecture and impacting upon other body processes, ushering in a myriad of health consequences for life (CDC, 2009). To establish and sustain healthy environments, it is imperative that health systems and policy model behaviour desired for optimal early child development by providing sensitive, attuned and timely response to the needs of future parents, babies, infants and young children.

The book *Why Love Matters – How Affection Shapes a Baby's Brain* by Sue Gerhardt (2004) is an excellent reference to substantiate the impact of secure infant-parent attachment upon earliest brain development, health outcomes and the role of our Birth to Prep – Spread the Word Reading Bug project. Excerpts relating to these are noted in the paragraphs which follow.

Expectations of other people and how they will behave are inscribed in the brain in infancy and underpin our behaviour throughout life. Being able to identify feelings and label them clearly is essential for social and emotional competence. Parental attunement is the basis of emotional regulation – the attachment figure is the source of social learning. Early secure relationships facilitate resonance with other people's feeling; the capacity to empathise.

The brain's orbito-frontal cortex is considered most responsible for 'emotional intelligence' (Goleman 1996, cited Gerhardt 2004) and develops almost entirely post natally, beginning to mature in toddlerhood. Our brains develop in response to social experience – an evolutionary explanation moulding each human to the environmental niche in which he finds himself.

If we want optimal development for optimal health and wellbeing outcomes we must educate early and support parents to achieve optimal environments for real behavioural and social change to occur.

Positive looks stimulate growth of the social/emotional brain and help neurons to grow by regulating glucose and insulin (Schore 1994, cited Gerhardt 2004). These are natural opioids and make you feel good; the neurotransmitter dopamine is released enhancing the uptake of glucose in the prefrontal cortex helping tissue to grow in the pre-frontal brain. We have all our neurons at birth but lots of early positive experiences mean more richly connected brains, with better performance and a greater ability to use particular areas of the brain.

Development of the dorsolateral pre-frontal cortex, the area where we think about our feelings, is the site of working memory (Gerhardt, 2004). The capacity to hold things in mind is a key aspect of our ability to plan, to evaluate experience and to make choices.

Healthy lifestyles are about making healthy choices. We cannot expect this ability to emerge when needed if the connections in brain development have not been optimal.

Also in the second year the linguistic ability develops in the left brain and emotions can be communicated verbally as well as through touch and body language (Gerhardt, 2004). Caregivers can now acknowledge the child's emotional state in words. This allows the child to build an emotional vocabulary, identify feelings and differentiate between feelings. Parents can now teach social rules more explicitly. Reading aloud, talking and stories provide opportunity to discuss expressions and feelings of book characters and others, facilitating this process. Not only do safe and relationship-based activities encourage the development of thinking

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about and concern for others (empathy) but also help with the child's own literacy and language development, complementing expression, communication and relationships.

By age three the hippocampus develops and with that the ability to synthesise information and remember sequences of events (Gerhardt, 2004). There is a before, during and after and the child can commence a personal narrative; parents can now talk to their child about the future.

We can see now how reading aloud with children, story sharing and listening can facilitate this process, but also how important this is right through life. This has meaningful implications for linking Aboriginal learning with oral language culture. Stories have a place in helping to close the gap.

The process of putting feelings into words enables the left and right brains to become integrated. Information can flow freely; the brain can use all its resources, particularly those of the left brain to regulate feelings. When words flow out of a feeling they can be the ones that say 'so that's what it is all about' producing a body shift that feels good (Gendlin 1978, cited Gerhardt 2004).

So, this is what the Birth to Prep – Spread the Word Reading Bug project is about; it makes children and communities feel good.

The way we manage stress is at the heart of our mental health. The stress response is a cascade of chemical reactions triggered by the hypothalamus in the centre of the brain (Gerhardt, 2004). The stress response is known as the HPA axis (hypothalamus triggers the pituitary gland which triggers the adrenal glands to generate extra cortisol). As soon as the level rises there are brakes put on the immune system and capacity to learn and ability to relax. While this can be useful in the short term, prolonged cortisol production can damage the hippocampus which is central to learning and memory. Dopamine and serotonin levels can also fall.

Early care shapes the developing nervous system and determines how stress is interpreted and responded to in the future. Stress in infancy can affect the development of other neurotransmitter systems whose pathways are still being established. Too much cortisol can affect the orbito-frontal pre-frontal cortex (Lyons et al. 2000a, cited Gerhardt 2004) responsible for reading social cues and adapting behaviour to social norms.

Interestingly, the more social power you have then the less stress you have. Persistent powerlessness equates to unrelieved chronic stress, anxiety and helplessness, unable to do anything about it. Seligman called this 'learned helplessness' (Seligman and Beagley 1975, cited Gerhardt 2004) and in this state of powerlessness and stress, high levels of cortisol are produced. Solutions can be made by finding an alternative sense of value and power by building on elements of lives that give hope and connect the person back to people. An important for consideration of Aboriginal people's health and closing the gap.

Children with secure attachments do not release high levels of cortisol under stress but there is a strong link between emotional insecurity and cortisol dysfunction (Gerhardt, 2004). For children who have had their needs ignored and feelings not regulated there is abundant evidence that the stress response underlies an astonishing array of disorders: chronic depression, compromised immune system, muscle mass and osteoporosis; diabetes and hypertension.

Those who have adapted to stress early in life through suppression of feelings and have a low cortisol defence are vulnerable to post traumatic stress disorder, chronic disease, asthma, allergies, arthritis; a lack of positive feeling, flattened emotional life, and 'alexithymia' – a difficulty in putting emotions into words most probably originating in early parent-baby communication (Gerhardt, 2004). Also the earlier anti-social behaviour develops in boys the more it is likely to be associated with low cortisol (McBurnett et al. 2000, cited Gerhardt 2004). Aggression and antisocial behaviour, and personality disorders are linked to adult criminology, drug abuse and violence. Good emotional immunity comes from the feeling of being safely held, touched, seen and helped to recover from stress. The baby's feelings have been identified and responded to in a contingent way. Feelings do not have to be blocked, ignored or numbed – they can take their place as the core of the self, a self that can be elaborated in words.

This explains why foundational literacy and language is and needs to be a real part of mental health promotion.

So much depends on one central caregiver and her state of mind to create a safe world or a fearful world for her child. There is a continuum between milder forms of neglect and emotional abuse and more intense forms but essentially they are the same thing, a problem with emotional regulation within the parent-child relationship (Gerhardt, 2004). Children develop working models of relationships based on their own experiences. The stress response is set early and various systems are influenced by pre natal and post natal environments. Of note, babies whose systems are sensitised because of conditions they experienced in utero are much more vulnerable to insensitive parenting.

Conclusion

There are many excellent programs designed to support parents but for optimal contribution to future infant, family and community mental/physical health and wellbeing (including influencing precursors to chronic disease), those that substantially invest in the universal provision of suitable psycho-educational pre-parenting/antenatal courses matched to the need of all parents and parents-to-be are

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best. The primary goal must be to enhance parenting confidence and competence by increasing the caretakers' awareness of the importance and nature of sensitive attunement to infant signals and skills to achieve optimal responsiveness to the baby's/infant's cues.

A supportive community of this nature would carry and sustain that support throughout the critical earliest years of life on one hand and through generations on the other. And this is the environment which will support all parents in reading aloud with their children. This is how our Mental Health Promotion services and our project can work together. The Reading Bug project can play an exceptional role in contributing to the quality of child-parent interactions and relationships, social-emotional competence development as well as preparing children and parents for school participation, enjoyment and longer term school and community belonging and functioning.

Giving children the best start in life means more than adapting to the modern world, it is the epicentre of the modern new world. Why should we accept the world the press so eagerly portrays, with violence and destruction key marketing strategies? This is not the world our brains are designed for from birth; we exist within relationships and all we do or should do is relationship based (and why they take time). Social environments must improve or they will deteriorate. Love and secure relationships really do matter and impact across the board in families, workplaces and communities.

If our government accepts this achievable challenge, the nature of such universal parallel prevention and early intervention provision will equate to the healthy supportive environment required for health and wellbeing and will establish Queensland and/or Australia as leaders in preventative health care, caring for and respecting Queenslanders/Australians right from the start. Building strong foundations to life through the universal application of this strategy makes sense of best practice and it must be affordable or we inevitably pay later.

Growing up healthy children must come first. Advocacy for universal provision of suitable psycho-educational pre-parenting courses matched to the need of all parents and parents-to-be aligns with the objectives and strategic background of our South West Birth to Prep – Spread the Word Reading Bug Project.

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