



FROM THE EDITORS

In this, the first Newsletter for 1994, we have contributions from our Vice President, Bryanne Barnett about a Conference she attended while on sabbatical last year, and an account from Elizabeth Puddy from South Australia about an advocacy group for children recently formed in that State. This prompts us to think about the ways in which we promote the needs of parents and infants in our everyday work and through the various organisations with which we are associated. Accompanying this Newsletter is the flier advertising our Conference on Attachment in July. You will notice that it bears the words 'In Recognition of the International Year of the Family (1994)'. So far, there seems to have been little publicity about the importance of the family this year, but it may be that as the year gains momentum (it is already March!), there will be more in the media. However, perhaps we need to be more vocal in pointing out that a family starts with an infant, and that society's investment in ensuring the optimal conditions for the family at its beginning brings important long term benefits for the whole community.

WHAT'S HAPPENING OVERSEAS?

A Report from our Vice President, Associate Professor Bryanne Barnett.

From July to November last year I was in England on sabbatical leave from the University of New South Wales. I spent most of this time at the University of Keele in Staffordshire in the School of Postgraduate Medicine and Biological Sciences. Specifically I was working in the Department of Psychiatry with Professor John Cox (of Edinburgh Postnatal Depression Scale fame). There are a great many things about which I would like to tell you, but in this first report I thought to let you know about a meeting which I attended at Queen Charlotte's and Chelsea Hospital in London.

The meeting was held under the auspices of the Royal Postgraduate Medical School, Institute of Obstetrics and Gynaecology, of the University of London and the Marcé Society - (the society which is interested in all aspects of motherhood and mental illness). The conference was entitled Recent Developments in Understanding and Treatment of Postnatal Mental Illness. The meeting was chaired by Professor Eugene Paykel, Professor of Psychiatry at Cambridge, who is the current President of the Marcé Society. Speakers included Professor Merton Sandler, Dr Vivette Glover, Professor John Cox, Professor Channi Kumar, Dr Alan Gregoire, Dr Peter Little, Dr Barry Keverne, Dr Deborah Sharp, Dr Maureen Marks and Professor Bryce Pitt. Quite an illustrious galaxy!

Dr Glover's group from the Department of Chemical Pathology at Queen Charlotte's, spoke about mood changes in the first postpartum week and the links which this may have with later depressive illness. She described how in the first week of delivery many women experience a brief period of mild emotional lability usually beginning on the third or fourth day and often associated with crying, which has been called 'the blues'. Alternatively, about one in ten experiences a mild subclinical hypomania or 'the highs', which starts on the first postpartum day. About 25% of women who experience either severe blues or the highs in the first postpartum week go on to suffer major depression by six weeks postpartum.

Dr Glover's group examined platelet 5 H-T content, plasma beta endorphin level and plasma cortisol in samples taken from women on the third postpartum day with severe 'blues', the 'highs' or no

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psychopathology. No difference in 5 H-T or beta endorphin level was found in the three groups. Those with the blues had significantly higher levels and those with the highs significant lower levels of cortisol than either of the other two groups. This provides some evidence that the disturbance of the hypothalamic-pituitary-adrenal axis which occurs at parturition is related to mood changes in the early puerperium.

Dr Barry Keverne, Director of the Sub-Department of Animal Behaviour at the University of Cambridge, spoke about the psychopharmacology of maternal behaviour. He noted that the uncoupling of behaviour from underlying neuroendocrine mechanisms had been important in the evolution of maternal behaviour. One might, therefore, be tempted to conclude that studies on neuroendocrine mechanisms for maternal behaviour in animals had little relevance to understanding of human beings. Nevertheless, many of the neural and new chemical changes examined at parturition occur in the limbic area of the brain, which is phylogenetically old and is very similar in human and non-human primates.

The motor patterns for maternal responding in primates share much with those of importance to social cohesion. Cuddling, grooming and defending are all as much a part of the behaviour that is important to female bonded primate societies as it is to maternal behaviour. The underlying mechanisms of emotion arising from such behaviours in these situations also have a common link. In monkey social groups, huddling and grooming behaviours increase the levels of endogenous opioids released into cerebrospinal fluid, as does aggressive behaviour, while pregnancy and delivery increase opioid levels in the brain. Drugs which act on endogenous opioid receptors disrupt social behaviour in both human and monkey societies while similar drugs impair maternal behaviour in a number of species, producing for example, neglect of the infant in monkeys. Thus the neural and neurochemical basis for maternal emotion shares common mechanisms with social behaviours and may well be subject to similar disruptive influences.

Dr Deborah Sharp, Senior Lecturer in General Practice at the United Medical and Dental Schools of Guy's and St Thomas's Hospitals in London, spoke about the effects of maternal depression on child development. As you know there has been much material published on this vexed subject in recent years and AAIMHI reported important research findings in this field in a previous Newsletter. The objectives of Dr Sharp's current work are 1) to see if maternal depression at different times in a child's life exerts developmentally specific detrimental effects and 2) to show that different facets of cognitive and personality development are sensitive to particular clusters of adverse influences at different times in a child's life.

Dr Sharp studied 200 families from an earlier piece of research looking at emotional disorders in pregnancy and the postnatal year. The families were contacted at the time of the child's fourth birthday. Measures included mental health, IQ, child behaviour, family social milieu and child development. Debbie reported data from 172 children, 170 mothers and 105 fathers. 80% of the children were living with both biological parents. The period prevalence for depression in the mothers in the child's lifetime to date was 45% and in the fathers 17%. Dr Sharp concluded that cognitive development and behavioural adjustment of these children is adversely affected by maternal depression. In addition, the effects seem to depend on the child's gender and the timing of the depression. As has been concluded in most studies there are very important implications here for greater assistance being provided for new mothers by those in primary care situations.

Channi Kumar, Professor of Perinatal Psychiatry at The Institute of Psychiatry in London, talked about the causes and treatment of postnatal psychosis, reminding us that one in every five hundred or so recently delivered mothers experiences a psychotic illness which usually requires hospitalisation. He noted that for another 10-15% of mothers there is a non-psychotic postnatal depressive disturbance which may last a considerable period of time. For most of these mothers it is their first formal experience of mental illness and for many childbirth marks the beginning of a history of recurrent episodes of psychiatric disturbance. Hence it is important to try and identify women at high risk of puerperal breakdown and attempt to prevent or manage these illnesses.

Professor Kumar has been looking at women with a high risk of recurrence of postpartum psychosis and is currently researching the usefulness of administering high doses of oestrogen, as soon as the baby is born, to mothers with a previous history of postpartum psychosis. The protocol for this research is complex, requiring administration of anticoagulant drugs to prevent thrombosis and also requiring that the mothers do not breastfeed. Such research is extremely difficult to undertake, but promises to provide us with some very useful and very specific information about treatment of this severe mental illness.

Professor Cox talked about the identification and incidence of postnatal depression, describing the pathways to care for women with mental disorders before and after childbirth. He noted that the experience for women at this particular stage may be very different from the experience of patients who are depressed at other times. Women continue to be reluctant to seek appropriate help, for example, through fear that they will lose their infant. It is now

very clear that depression in the mother has a detrimental effect on other family members including the baby, so intervention is vital.

In North Staffordshire a very important effort has been made to train community mental health professionals in the recognition and treatment of postnatal depression. One of the interesting results of this controlled study was that women with postnatal depression were more likely to report a difficult relationship with their own mother compared with women who are depressed at other times. This is of course no surprise to those who work in the field, but it is nice to have our clinical experience validated by appropriate research.

John concluded by referring to the need to establish greater collaboration between GP's, community-based nurses and psychiatrists, especially around the time of the postnatal examination. The limitations of postnatal checkups in determining abnormal maternal mood states is recognised and a training package has been designed to alleviate this problem.

Further details of this training programme are described in a paper by Gerrard et al (1993) in the Journal of advanced Nursing, 18, 1825-1832. Jan Gerrard is the Unit Manager of the Parent and Baby Unit at Hanley in Stoke-on-Trent which is a unique programme established by John Cox and catering for parents and infants who are having a mental health problem during pregnancy and the first postnatal year. (I shall be describing this unit in more detail in a subsequent report).

Dr Gregoire, a psychiatrist from Salisbury, talked about the use of hormones in the treatment of postnatal depression (cf Dr Kumar's comments above). He noted that this is an area which has been of interest to many researchers for some time, but the only consistent positive results to emerge from studies to date indicates that there is some association between postnatal depression and thyroid abnormalities. There does not seem to be any evidence of differences in sex hormone levels between women who develop postnatal illness and those who do not. Nevertheless it may be that it is the women's individual response to such hormonal changes rather than the changes themselves which put her at risk of developing illness. He emphasised that it is essential to remember that any biological aetiology which comes to be identified cannot be considered separately from interaction with the important psychosocial factors already identified.

Analysis of a recently completed placebo-controlled double blind trial has revealed a statistically and clinically significant improvement in women with postnatal depression receiving oestradiol therapy. The study demonstrated that oestradiol has a role in treatment either as an alternative or as an adjunct to other antidepressant therapies (pharmacological or psychological). Further studies will be required to

establish dose-response relationships and the implications of possible use of oestradiol in women who are breastfeeding.

Dr Peter Liddle, Senior Lecturer in Psychological Medicine at the Hammersmith Hospital, talked about the value of a clinic dedicated to postnatal depression. Within the obstetric psychiatry clinic at Queen Charlotte's Hospital, Dr Liddle runs a clinic dedicated to PND (funded partly by the Association for Postnatal Illness) for the past two years. The specific advantages of such a clinic are:

- 1) preventative; providing simple counselling during pregnancy for those at risk, and follow-up postpartum. In these cases Dr Liddle observed a low rate of depression despite the existence of clear risk factors.
- 2) backup for health visitors community identification and treatment programme.
- 3) provision of a range of treatments embracing social support, psychological (for example, cognitive therapy) and pharmacological treatment.
- 4) opportunities for research.

Dr Maureen Marks, a research psychologist working with Professor Kumar, talked about infanticide, noting that an important aspect of the clinical management of women with severe mental illness postpartum is the concern whether the woman might harm her child. She commented that there is also a more general view that the homicide of children under one year is also associated with the mother's mental illness. She pointed out that this obscures the fact that most women who are mentally ill do not harm their children and many women who do harm their children are not mentally ill according to conventional psychiatric diagnostic criteria. Epidemiological and clinical data provide evidence that children under one year are at greater risk of becoming victims of homicide than older children or the general population, notwithstanding changes in social, economic or cultural conditions.

Some of the factors associated with infanticide in England and Wales are : a) mental illness in the mother accounts for only a minority of infant homicides and no more so than for older children; b) for infants more than 24 hours old marginally more fathers than mothers; c) younger babies are at greater risk than older babies and d) male infants are at greater risk than female.

Professor Brice Pitt, Professor of Psychiatry at St Mary's and the Royal Postgraduate School in London, talked about the Association for Postnatal Illness (APNI). This Association began in 1979, when Clare Delpech was recovering from PND. She realised that depressed mothers needed information,

empathy and support. She contacted Professor Merton Sandler of Queen Charlotte's Hospital who had just edited a book entitled 'Mental Illness in Pregnancy and the Puerperium'. They planned an organisation which would encourage mothers who had recovered from postnatal illness to support current sufferers by phone or letter, and disseminate accurate readable information to those who needed it. Professor Sandler became the President and Clare Delpech the secretary of this new organisation, and a committee was constituted with an obstetrician, a psychiatrist and a GP as medical members.

Attracted through media publicity, volunteer supporters complete questionnaires on their own wellbeing, whether they have any other illness than PND and whether they are opposed to drug treatment. Those who are accepted as volunteers are sent a guide book and given the name of a depressed mother who has contacted APNI. APNI itself ensures that the first call is made. The client returns the form after the first call to say how she felt about it and the supporter reports every 2-4 weeks unless the client asks that she does not.

The work is demanding and no volunteer is expected to support more than two clients at once. Some supporters have formed groups. Problems may arise when the client's symptoms are unfamiliar to the volunteer, when she is deteriorating despite medication, or when she is suicidal or infanticidal. Expert backup and support for volunteers is always available from headquarters and indirectly from medical members of the committee.

Information is provided in leaflets such as 'Baby Blues', 'Postnatal Depression' for mothers themselves, and 'Notes for Carers. 'Puerperal Psychosis for Relatives', and special leaflets for GP's and health visitors. APNI is very involved in lobbying and various media activities. Although it is not a research funding organisation, APNI has conducted surveys of the prevalence of migraine and response to progesterone among its members. It also funds a doctor to do a weekly clinic for women depressed before and after childbirth (see notes on Dr Peter Liddle).

APNI has provided unique peer support for depressed mothers for 14 years on a shoestring budget and Professor Pitt comments that its volunteer supporters are unsung heroines.

It was interesting to compare APNI with the PaNDa organisation in Victoria which is Australia's, or perhaps the southern hemisphere's, most successful postnatal support organisation.

Progesterone for PND

On the subject of hormonal treatment in the prevention of PND, Katharina Dalton, a

gynaecologist who was not an official speaker at the Queen Charlotte's meeting, reminded the audience of her interest in the use of progesterone for postpartum disorders. Although the scientific community on the whole considers her work is inadequately researched, I introduced myself and subsequently went to visit her in her Harley Street rooms. I found she was due to revisit Australia in 1994. Her particular interests are premenstrual syndrome (PMS) and postnatal depression (PND), which she treats with progesterone (not progestogens). She considers PMS to be a disease involving progesterone receptors and thus requiring treatment with progesterone and diet (small portions of starchy food eaten every 3 hours throughout the month).

Dr Dalton defines postnatal depression as the presence of psychiatric symptoms severe enough to require medical help and occurring within six months of delivery in a woman who has never previously had a psychiatric illness (including drug abuse). The illness may also start between the cessation of breastfeeding and the occurrence of the first menstruation, or on starting hormonal contraception, or after termination of pregnancy or on starting a weight reducing diet. Although Dr Dalton describes postnatal psychosis as a separate, rarer illness, she actually includes psychotic phenomena in her description of PND. She states that PND differs from the usual depressive illness in that there is a marked irritability, increased appetite, weight gain and "a constant yearning for sleep".

Katharina quotes Marcé, the French physician, as noting that the early signs of PND improving were seen after menstruation, but there tended to be deterioration before the next menstruation (stage 2). In stage 3 of PND there is PMS only - the patient being well at other times. The PMS may continue for many years.

Dr Dalton's hypothesis is as follows. Progesterone is normally absent from the blood after menstruation until ovulation occurs. The level then rises, especially if conception takes place. During pregnancy the progesterone level rises very steeply - in the second half of pregnancy the placental output results in a blood level some 30 to 50 times the usual peak (around day 21 of a 28-day cycle found in healthy, menstruating women. After delivery, the blood levels drop precipitously and some women find the altered level of progesterone hard to tolerate. This results in PND. Katharina suggests the 'baby blues' may represent a mild reaction to progesterone disappearance.

Her treatment regime has several basic rules:

a) Progesterone is best used prophylactically so treatment must begin at the completion of labour.

B) high doses will be required as the receptors will have become quite resistant during pregnancy because of the high blood levels of progesterone at that time.

C) noradrenaline inhibits receptor uptake of progesterone so low blood glucose levels must be avoided (hence the dietary injunctions).

D) progestogens and hormonal contraceptives are not utilised by the receptors and may even be counterproductive.

Details of the exact requirements are specified in Dr Dalton's various publications (ask me for the references if you are interested in these).

Other hormone levels also drop, but progesterone is the significant one. Katharina feels that oestrogen is not significant in the production of PND and that it is contraindicated during the puerperium owing to the risk of thrombosis and embolism.

(We look forward to further report from Bryanne in a future Newsletter - editors)

THE DEVELOPMENT OF A CHILD ADVOCACY GROUP

Of particular importance at times of economic stringency and in a climate where legislation is often framed pragmatically 'for the greater good' by those somewhat distant from minority populations is the need for advocacy groups who can effectively represent the needs of those who have little political clout. Dr Elizabeth Puddy, a member of AAIMHI from South Australia gives the following account of the formation of such an advocacy group.

ACTION FOR CHILDREN, INC., SOUTH AUSTRALIA.

In May, 1991, a National Conference, 'Ensuring our Future; The Fabric of Childhood in Australian Society' was held in Adelaide, South Australia under the auspices of the Child Adolescent and Family Health Service of South Australia. It was attended by representatives of Government and non-government organisations from education, health and welfare sectors, by parents, and at one stage by children. Included amongst the keynote and other speakers, as well as local authorities, were Dr Don Edgar, then the Director of the Australian Institute of Family Studies, Mrs Maalfred Flekkoy, previously Ombudsman for Children from Norway, and Dr Ian Hassall, Commissioner for Children in New Zealand.

It became very clear following the presentations and the discussions that children in Australia, as elsewhere, need some formal structure for advocacy for their needs, interests, welfare and rights. Reasons put forward included that they are themselves quite powerless to influence the political

agenda; they need help to have their concerns brought to the notice of legislators; they can easily have their interests sacrificed for the interests of adults e.g. a developer or a bureaucracy; they need adults to lobby for changes in health care, to monitor practices in education and to challenge a host of practices which demean children; and they need advocates to ensure continuation of services to children in economic rationalisation restructuring and other processes. In addition they do not often have a say in their family's or, indeed, any other decision making process which affects them and often need encouragement and assistance to put their point of view and to be heard. If they are consulted in these situations (which is infrequently) due weight may not be given to their opinions. And so we could go on.

At the conclusion of the Conference a recommendation was accepted as follows: "That a coalition of organisations interested in improving the social awareness of the needs of children and families be formed. The model will be that of the Women's Electoral Lobby, to challenge every Australian politician at both federal and state levels to answer a series of questions about programmes and policies affecting children and families". When the proceedings were circulated, conference members were asked to inform the organising committee if they were interested in being part of such a coalition, the names of interstate persons interested were sent to designated persons and the South Australians interested were invited to meet together. Some fifteen persons attended, a small steering group was formed the aims and objects and requirements for membership were drawn up, A constitution prepared and adopted and incorporation effected. During this time, some 8-10 months, regular meetings of those interested were held to monitor the work of the small group. A formal coordinating committee with a Chairperson, Secretary, and Treasurer was formed and the organisation was officially launched in May 1993.

In this process we were fortunate to be assisted by our Patron, Rod Sawford MHR. and other politicians from each of the major parties. The South Australian Council of Social Services provided a lawyer to help us draw up the Constitution for the princely sum of eight dollars, and we managed to obtain venues for our meetings free of charge, including for a launch which was held at the Adelaide Women's and Children's Hospital. The speaker at the launch was Mrs Irene Moss, Race Discrimination Commissioner from the Human Rights Commission, which paid all the expenses.

The aim of Action for Children, South Australia, Inc., is "To promote the status of children in Australia," and its objects are as follows:

to lobby and advocate on behalf of children on issues which affect children

to provide a mechanism for genuine government consultation on those issues which affect children

to advance the interests of children through nonparty political electoral and government lobbying

to further and heighten awareness of the principles as written in the United Nations Convention of the Rights of the Child

to liaise with organisations and associations with similar objectives

to do such other things as may be incidental to the obtainment of such objects .

The present committee is comprised of a lawyer, a lecturer in child care, a director of a Children's Centre, a research officer in haematology, a Aboriginal and Torres Islander child welfare officer, a Nunga Uniting Church welfare officer, a project officer from the state's child health organisation (C.A.F.H.S., as above) and three medical women. Apart from the patron there are no men on the committee, which is obviously something to be redressed as soon as possible. There are approximately 120 individual members, and 20 organisational. Individual membership fee is \$20.00, organisations \$50.00.

Membership of Action for Children entails a belief and commitment to the aim and objects, paying an annual membership fee, raising awareness of injustices carried out to children, the possibility of working in a special interest group, and the possibility of actively lobbying.

Very early in the process of setting up the organisation we had to face the fact that many people interested in our aim and objects belonged to government, or public service organisations and were in fact prevented either by rules of their organisation or by factors such as fear of losing their jobs, or promotion opportunities from speaking out about some of their concerns for children. During debate about an issue of grave concern to children's welfare, the Chief Executive Officer in at least one government organisation warned all employees not to speak publicly about the controversies surrounding the issue. For this reason Action for Children has become chiefly an organisation of individual members, with the potential to form coalitions mainly with non-government organisations during lobbying over issues of common concern.

Early in the life of Action for Children there was much debate about how we could best influence the political scene and a decision was made to work for

the employment of a Children's Commissioner at the Federal level, and later at State level. The purpose of such a Commissioner would be to promote children's rights throughout Australia by influencing policy makers and practitioners to take greater account of such rights and interests, promoting compliance with the minimum standards set by the United Nations Convention of the Rights of the Child and other relevant international treaties and agreements and seeking to ensure that children have effective means of redress when their rights are disregarded. In carrying out these functions the Commissioner would need to be independent in action and policy stances from Government and all other bodies, although established by Government would adopt a broad perspective cutting across departments and agencies; would constantly seek input from children and young people; and would cooperate closely with other organisations working for children and young people.

A small working group has been appointed to advance the establishment of a Commissioner, and this will be given a high priority. Other working groups include those concerned with child protection, the needs of rural children, disabled children, and aboriginal children, the Family Law Act, the media, and membership.

The organisation was rapidly thrust into the political scene in South Australia in July of last year, two months after the launch, by its concerns about a new Child Protection Bill being presented to Parliament. From July to November there was much activity by a small group of members preparing position papers and submissions, writing letters to, and visiting, Ministers, and other members of parliament, holding a Public Meeting, meeting with and forming a coalition with representatives of similarly concerned organisations, writing to the Press, talking over radio, attending sittings of Parliament, and of course, making literally hundreds of telephone calls and faxes. The membership was kept informed and given material to help them write letters and visit their members of parliament. Eventually a significant number of amendments which we recommended were accepted, but only after the Bill had been debated twice in the House of Assembly, once in the Legislative Council, and finally, in Committee. We were of course absolutely jubilant at the time, but that was not the end. The coalition, as mentioned above, continues to meet, and has been consulting with Government about the implementation of the new Act.

It is useful to reflect on the factors in the process which contributed to this success. Briefly they are thought to be firstly, a lot of hard work by a small committee able to make decisions and act, responding quickly, efficiently and with knowledgeablebleness not only about matters related to the act, but also about the politico-legal process.

This knowledgeableness was obtained by access to information from the network of the individual membership of the organisation. Many were prevented from contributing through their own organisations but as our individual members were able to keep us informed. We were told by one of the Ministers that the formation of the Coalition lent a lot of weight to our credibility when the names of our member organisations were read in the party room and in Parliament. Individual members of Parliament were lobbied and one of our members actually brought her member to our Public Meeting! In the last week or two some very influential persons in the community, from boards of highly respected organisations, wrote letters to key Ministers "for the sake of the children of South Australia" and finally the presence of our members in the House during the debate was certainly appreciated by those supporting our cause. All in all it was a big learning experience for most of us.

As mentioned earlier our involvement in matters relating to what is now the Child Protection Act (1993) continues. We all know that this is a difficult and complex area which cannot be managed without large input of resources and much inter-department, intersectional and interdisciplinary consultation. We are however committed to working for the rights and interests of these children who are being abused or neglected, as well as other rights and interests of the children in South Australia.

BOOK REVIEW

Your Child's Health : A Manual for Australian Parents. By Leah Kaminsky and Frank Oberklaid. Mandarin Australia.

Here is a user friendly manual in the age of a manual for most things. A sentence in 'About this book', the introduction, sums up our feelings about it. 'If you use this book in the way that we intended it to be used, we expect that very soon it will be stained with baby food, orange juice or coffee, and it will look well worn and dog-eared.' It is intended as a very personal guide to your child's health with spaces for parents to write phone numbers, emergency and useful, and spaces for parents own notes in the book.

This is a volume to pour through and become familiar with so that in moments of stress parents can easily access the information that they seek, then armed with information and understanding they are able to be involved in the decision making processes about their child's health. This empowers parents and enlists their help in getting the child to co-operate with treatment and probably improves compliance.

The book is divided into three parts, 'Practicalities', 'Everyday Life' and 'Managing your Child's Health.'

'Practicalities' has the emergency information at the front, quick to turn to but it could be enhanced by some simple diagrams. This is followed by good accident prevention. Carers, parents, grandparents and baby sitters would benefit from reading this from time to time as the child develops motor skills and takes a greater interest in their environment. The explanation of the medical system will help parents choose a doctor and also addresses the topic of changing a medical practitioner and requesting a second opinion. Having a written explanation of tests a doctor could order gives a chance to check your understanding of the information given at a consultation and what to expect when the test or procedure takes place.

'Everyday Life' acknowledges the reality, not always pleasant, of coming home with a new baby and provides practical suggestions for coping. The emphasis is well placed on parents trusting their own instincts, being guided by the baby not the clock and that infants can not be spoiled if their distress is met with comfort. Colic receives a chapter of its own which should be reassuring to the parents of unsettled children as acknowledging their plight and lends support to their efforts to live through this time.

The chapter on Sleep and Sleep Problems is a must for all ages as the principals laid down apply through childhood. This section then grows with the infant to adolescence covering the ups and downs of emotional and physical development, giving parents an idea of what it is reasonable to expect from a child.

The third section 'Managing your child's health' accounts for half the book. The medical information is presented in alphabetical order with different chapters covering different topics. The subjects are described in a general introduction followed by cause, clinical features, investigations and treatment. Most importantly 'when to see your doctor' and prevention follow this. There are cross references to other sections and the index as back up. It includes the normal as well as the abnormal conditions that can occur in childhood. This allows parents to accept the normal as a phase in development and to seek help with the abnormal. We would be happy to recommend this book to our friends and clients and hope that it is put in many nappy bags and consulted at the playgroup as subjects come up in discussion.

Reviewed by Dr Debby Perkins and Marianne Nicholson.

CONFERENCES, WORKSHOPS AND SEMINARS

Post Natal Depression Workshop

Dr Frances Salo, a clinician with a special interest in Post Natal Depression is conducting an afternoon workshop on her and Dr Campbell Paul's work with groups of mothers with postnatal depression using a dynamic model. Dr Salo worked in London for many years, and is now at the Royal Children's Hospital, Melbourne. Early Childhood Nurses are particularly welcomed.

Date: Monday, May 9

Time: 2-5 pm

Venue: Rozelle Conference Centre

Enquiries: Monica Fritchley (02) 804 6889

Cost: \$30-00

Preschool Attachment "Strange Situation" Scoring Workshop

Dr Robert Marvin from the University of Virginia is conducting a ten day workshop in the use of the 'Strange Situation' with preschool children. This is a return visit from Dr Marvin who conducted a workshop on this technique in infancy in January, 1993.

Date: July 11 - 22, 1994

Venue: Macquarie University

Cost: Approx \$1350-00

Enquiries: Dr Judy Ungerer, (02) 805 8045 (direct); (02) 805 8063 (messages); (02) 805 8062 (fax).

AAIMHI

Principles of Attachment Theory: Relevance to Intervention with Infants and Caregivers.

This Conference should interest a wide group of professionals who work with children, and their caregivers or who are interested in recent findings in child development research and their application to the understanding of adult emotional disorders. Papers will be given by Bob Marvin, Lynne Murray, Peter Cooper and Mary Sue Moore.

Date: Friday & Saturday, 29th & 30th July, 1994

Venue: Auditorium, Westmead Hospital, NSW

Cost: \$70-00/day or \$120 for both (AAIMHI members)

Information: Margaret Burton, phone (02) 827 8011

Faculty of Child Psychiatry, Royal Australian and New Zealand College of Psychiatrists. 7th Annual Meeting. 'Families under Pressure: The Changing Face of the Family in the 1990's.

Date: October 6-9, 1994.

Venue: Glenelg, South Australia.

Closing Date for papers: April 30, 1994.

Enquiries: Dr Graham Martin, Phone (08) 204 4556

KARITANE INTERNATIONAL CONFERENCE FAMILY REALITIES IN THE STRESSFUL NINETIES

Date: November 2-4, 1994

Venue: Sydney.

Enquiries: Karitane International Conference, P.O.Box 79, Turramurra NSW 2074.

Phone (02) 449 5279, Fax (02) 988 3856

Call for Papers. Abstracts must be received by **Friday, March 31st, 1994.** (Please contact Ms Faye Cameron on the above phone number before this date if you wish to submit an abstract).

OVERSEAS MEETINGS

World Association for Infant Mental Health.
Regional Meetings.

Riga, Latvia, June, 1994

San Francisco, July, 1994 - in association with IACAPAP World Congress (see below).

Enquiries: David Lonie, phone (02) 817 5223, fax (02) 879 7305.

International Society for Infant Studies. IXth Biennial International Conference for Infant Studies.

Date: June 2-5, 1994.

Venue: Paris, France

Enquiries: Dr H. Bloch, Laboratoire de Psychobiologie du Développement, EPHE-CNRS U.R.A. 315, 41 rue Gay-Lussac, 7500 Paris France.

International Association for Child and Adolescent Psychiatry and Allied Professions. 13th International Congress, 'Violence and the Vulnerable Child'. This meeting will include an invited Symposium on Infant Psychiatry, and either a pre or post Regional WAIMH Meeting.

Date: July 24-28, 1994.

Venue: San Francisco, USA.

Enquiries: Office of Continuing Medical Education, Room LS 105, University of California, San Francisco, CA 94143 - 0742; FAX (415) 476-0318

Deadline for next AAIMHI Newsletter May 15, 1994

Please send letters to the Editors, newsletters, announcements, short articles etc to

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