



## FROM THE EDITORS

**O**ur first Newsletter for the year comes at a time when there a number of meetings about to be held, or being planned. In Queensland the exciting news is the inaugural meeting of the Queensland Branch of AAIMHI, with Dr Lyn Barnett, an expatriate Australian being the keynote speaker. In New South Wales we are looking forward to the visit of Patricia Crittenden who is also visiting South Australia. In Victoria, the academic year has started with the new Graduate Diploma of Infant & Parent Mental Health at the University of Melbourne, with 14 participants, an important innovation for Australian Infant Mental Health. Forthcoming meetings include the WAIMH World Congress, and a three day AAIMHI Meeting in Melbourne in December which we expect to be an exciting successor to the WAIMH Pacific Rim Meetings.

For this issue of the newsletter, we have a timely paper, reprinted from *The Signal*, the WAIMH Newsletter, by Sonya Bemporad, who pleads for prompter legal decisions in custody situations, since the attachment needs of infants cannot wait. In fact, as she points out, while legal processes are grinding away, infants who cannot obtain and keep secure attachment figures may be laying down the foundations of future and possibly life-long mental health problems. It is indeed a case where a gramme of prevention may avoid a tonne of expensive interventions in adult life.

We are also fortunate to have, in "Despairing Women", a very personal account of an experience of post-natal depression, and of various attempts by helping professionals to ameliorate things. As the author says, she was initially reluctant to think again about such a painful period of her life. Fortunately, with further reflection, she decided that it might have some place in a publication, to allow insight into the dynamic of turning absolute despair into the possibility of actually enjoying being alive. We owe Katherine Phelan a debt of gratitude for having the generosity to share her experiences with us. She has done so, because, as she says at the end of her paper, it is important "to keep looking. Never give up hope."

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## BABIES CAN'T WAIT

### Infants and Toddlers in the Child Protective Services System

by Sonya Bemporad

Babies have profound developmental challenges related to their emerging sense of self. The most profound of these challenges is the attainment of an internalized object: a permanent and reliable introject of a good enough parent that enables young children to maintain their self organization and feelings of well being out of the actual presence of the parent. This achievement brings with it the capacity for impulse control and emerging conscience as the parental object is internalized. As the toddler and young child experience the parent as an inner voice they do not have to rely on external reminders of parental prohibitions.

These achievements occur as libidinal object constancy is attained. Libidinal object constancy is distinct from perceptual object constancy. Perceptual object constancy is attained in the second half of the first year of life and indicates that baby believes in the existence of the object even when that object is not in the immediate visual field.

Libidinal object constancy is accomplished in the third year out of intimate experiences with significant objects; parents, extended family, or other caregivers. Toddlers hold their cup with milk or cocoa or whatever they drink from it, and handle it quite carefully and skillfully. But when it is empty, and if you are not very quick, they throw it away (it's very good to have plastic cups and saucers) ... Now what is the child doing there that we don't do? The child at the ripe age of eighteen months, evidently can give up his regard for the cup when the cup is empty. Then it is thrown away, it is no good; and this gives us a very good picture of what the child does with his love objects, or at least up to that age. He cannot retain his relationship to them when they are emptied of the satisfaction they could offer ... the child withdraws his libido cathexis from them, which is as good as throwing them away ... (at this stage) the relationship is inconstant and ceases with the satisfaction, and is begun again with the renewal of the need.

Then comes the next phase in the child's life, in which he behaves in relation to his cup and saucer as we do. We keep them for the next meal and handle them carefully or even cherish them whether they serve monetary satisfaction or not. Now the child begins to do the same with his mother which means, his attachment to the mother, the libidinal cathexis of her, remains constant regardless of the need. This is the phase of object constancy. (Anna Freud, 1992).

The infant has a limit to the number of relationships she can experience as intimate and meaningful. Although this capacity varies from child to child, there is a limit to both the

number of relationships and to their discontinuity within which the achievement of an internalized libidinal object can occur. This understanding of early intrapsychic development, by now widespread in infant mental health work, is what was the impetus for the formation of the "Babies Can't Wait" project in Dallas, Texas.

It has only been in recent years that we have come to understand how to diagnose and intervene in the psychological problems of infancy that underlie many of the conditions that become manifest in later life. These advances in research and understanding are slow to be translated into changes in public policy and into changes in the structure and function of service delivery systems. This is unfortunately the case in child protective services throughout the country.

Currently, our child protective service systems deal with infants with the same kinds of intervention, the same time frames for making interventions, and the same range of treatment alternatives that are used for older children and adolescents. It is equivocal whether these modes of intervention work well, even for older children. It is becoming increasingly clear that these modes of intervention can be very damaging to the development of infants and toddlers.

The "Babies Can't Wait" project attempted to deal with these issues in a collaborative effort among the Dallas County Child Protective Services agency, Dallas County Mental Health and Mental Retardation agency, and the Texas Association for Infant Mental Health. In 1987, Russ Dunckley of the Mental Health and Mental Retardation agency; Linda Fleming, then head of the Child Protective Services agency; and I, as a representative of the Texas Association for Infant Mental Health developed a proposal to the Hunt Alternatives Fund for an initiative on behalf of babies in the Child Protective Services system.

The Hunt Alternatives Fund provided funds to carry out an initiative that had three objectives: 1) to educate systems that affect infants and toddlers in child protective services; 2) to establish a demonstration project, the Infancy Project, within the Dallas Protective Services agency that would meet both the physical protection and the developmental, mental health needs of infants and toddlers; and 3) to provide support and technical assistance to the Child Protective Services agency in meeting the special needs of infants and toddlers. The "Babies Can't Wait" project attempted to put our understanding of the most critical psychological issues in infant development inside the policy and practice of child protective services in the Dallas Community.

Our approach was to assure an understanding throughout the child protective services system that by the time a child under the age of three has come to the attention of the State because of neglect or abuse, his early relationships are already highly problematic and the child's "best interests" have already been abrogated. We can no longer use a "best interest" standard in these cases. The best interest for any child includes good enough parents who do not treat them in ways that bring them to the attention of the State through its child protective agencies, i.e., their "best interests" are that we should never have had to identify them as victims of severe neglect or abuse. Their best interest also includes, perhaps even more importantly, that the State not have to be a party to their

family relationships. When this happens, when the State intrudes in the family relationships because the infant or young child is in danger within those relationships, then the issues of the impact of State intrusion on developing relationships becomes paramount.

When the State becomes a part of decision making for the child, certain safeguards should prevail. They include, as Goldstein, Freud and Solnit indicate in *Before the Best Interest of the Child*:

1. respect for the child's need for continuity of relationships;
2. placement decisions that are made in accord with the child's sense of time, not the adult's - parent's, case worker's, judges, etc.; and
3. placement decisions that take into account: a) the Laws (i.e., courts and agencies who act for the court) incapacity to supervise interpersonal relationships and b) the limits of our knowledge to make long term predictions.

In addition to the three standards, these same authors propose a "least detrimental alternative" standard to replace a best interests standard.

As described above, when a child has come to the attention of the State her "best interests" have already been denied. If her best interests would have dictated that her care was good enough so that no intervention was required. Given that intervention is required, then we should develop the "least detrimental alternative" as the standard, guided by the three principles we have stated: respect for continuity of relationship, the child's sense of time, and the difficulty in making long term predictions.

As workers in the field we must not beguile ourselves with fantasies of "fixing it" or making it perfect for a child whose best interests have been compromised. Neither can be done. The reality is that the baby had a parent or parents who could not and did not care for her in a good enough way to prevent State intervention. The additional reality is that any parent, including any new, non-abusing one, has limits, i.e., will not be perfect. These are two crucial "facts": that the child's own parents were not "good enough" to prevent State intervention, and that the replacement for those parents will not be perfect. Those replacements cannot be perfect, not only because nobody is, but by the very nature of their replacement status. We cannot undo the harsh reality that this baby's own parents were destructive enough to warrant State intrusion. The State and the child will have to deal with these realities as the planning for each case proceeds.

It is clear that the State does not, for many reasons, always keep these critical considerations as primary in its decision making for babies in State care. There continue to be horror stories of young children who, having been with State-provided caregivers for a substantial part of their first three years of life, are wrenched from those relationships because of considerations other than the nature of that relationship. The grounds for removal of a child from the care of the "psychological parent" should be the same as the grounds for removal from the care of a biological parent, abuse or neglect severe enough to warrant State intrusion.

A recent case in Florida (*New York Times* 5/9/93) illustrates just how far States are from using the child's need for the

continuity of relationship with a primary caregiver as the standard for permanent placement. Baby J. had been in the continuing care of her foster mother since she was six months old. After two years in her care the State of Florida planned to place the child with a "relative." The foster mother fled with the child, was subsequently apprehended and faces up to five years in prison on a felony charge. To quote the *Time's* article, "The goal of foster care, department officials said, is to have the child reunited with the parents or at least relatives, and they said foster parents should help achieve that goal."

The goal of foster care as described above is highly questionable from an infant mental health perspective. The goal of foster care should be to provide temporary care, (temporary in a child's sense of time, not an adult's) while a permanent placement is developed within the context of "least detrimental alternative." The goal cannot be formulated on the basis of worker, or agency, or family fantasies of giving the child a real, translate biologically related family. For the child, the real family is the psychological family and that reality is the one that must be protected.

Every time a major disruption occurs in the bond between an infant and her psychological parent, we damage the foundation upon which the rest of the child's development will be built. As child protective systems are now structured, disruptions in these bonds can and do occur repeatedly for infants already at high risk because of abuse or neglect. Too often when infants are removed from the care of their parents, they then are moved through emergency shelters, and a series of foster homes, and finally after all this State designed assault on their development, are placed either back with the parents, with relatives, or with adoptive parents.

As research on infancy and child development accumulates, it is becoming increasingly clear that the first three years of a child's life are critical as the foundation of a child's personality and later functioning. In order for personality development to proceed optimally, it is essential that infants and toddlers are assured of a permanent and appropriate psychological parent so that attachment and bonding can proceed. It is becoming increasingly clear that the more frequently the bonds between an infant and the psychological parent are broken, the more likely it is that the infant will develop into an adult who has difficulty with impulse control, with the development of conscience, and with intimate relationships. These traits, impulse control, conscience and the capacity for intimacy, are the ground for constructive adult functioning.

Training has been provided to judges and attorneys on the principles of infant mental health described above and the use of those principles in child placement practice and policy. We have reviewed cases in the child protective services system in order to determine the number of times children in the child protective service system were moved, the length of time in foster care, and ultimate case resolution. We have helped the protective services agency in Dallas move toward "dual license" homes so that there can be foster homes that then become adoptive homes for a child in care, should that child's parents' rights be terminated. And, finally we have developed and made available a comprehensive training

curriculum focussed on the needs of infants for timely, permanent placement.

As part of the ongoing commitment of the Texas Association for Infant Mental Health to babies in the child protective services system, we recently sponsored along with WAIMH and the North American affiliate of WAIMH, a regional "Babies Can't Wait" conference. Several hundred people from a variety of professional backgrounds gathered in Arlington, Texas for the two day conference.

In addition, the Executive Committee of WAIMH has asked me to chair an international study group on policy and practice related to infants and toddlers in child protective services and child day care systems. If you are interested in participating in this work, please contact me:

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### **Editor's note:**

*Sonya Bemporad, in addition to being a clinician and a tireless advocate for infants, is also a member of the Executive Committee of WAIMH and the Past President of the International Association of Infant Mental Health.*

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## **DESPAIRING WOMEN**

**BY KATHERINE PHELAN**

### **INTRODUCTION**

In being asked to contribute to this book, I was hesitant and reluctant to consider this. When I saw the initial outline, I was even more overcome. It was painful to think about all I had been through.

With further reflection, I thought it might have some place, to allow insight into the dynamic of turning absolute despair into the possibility of actually enjoying being alive.

### **HISTORY**

My background was one of a dysfunctional family concurrent with emotional deprivation, with constant change in location of home and school until aged 10 ( 5 primary schools), when I was sent to boarding school until matriculation.

I was never comfortable with myself. Actively disliked myself physically and emotionally. No stable core of self to fall back on. I constantly felt fragmented. I was tense, unhappy, socially awkward, frightened. Always felt I was two people - the one who could appear to cope with anything that came my way, and the child who felt lost and insecure with no one to turn to. I often had suicidal thoughts, and had at one stage requested from my G.P.(1st) a referral to a psychiatrist - I was told by this G.P. that all I needed to do was join a tennis club and I would feel better. My general mood was one of depression, with periods of intense depression. I couldn't see much point in life at all.

I managed despite this to matriculate, become a registered nurse, midwife and Clinical Nurse Specialist in Neonatal Intensive Care. I wasn't proud of any of my achievements, instead dismissing any possibility that I was a competent and caring nursing sister - anyone could do it.

I went travelling overseas alone aged 23, mainly to escape from myself. Safety of self was not an issue with me; I did not care if I was alive or dead. I believed no one else would care either. Even whilst travelling I was tempted with the

thought of suicide, as I couldn't see the point of existing. Whilst in Switzerland, I visited the Jungfrau Glacier. It was a place of amazing peace and beauty and I thought it a perfect place to die - I felt extremely calm and peaceful. I could just walk past the barriers and be done with it. Death would be swift. Not one of my family or friends knew where in Europe I was, so no one could look for me and "save" me.

Then I met the man who became my friend, lover and husband, at a party 2 weeks before I was due to return to Australia. I was astounded when he asked me for my phone number, that he would actually want to go out with me and be seen with me. I had never felt wanted before; I was always just there.

Aged 25 years had never been out alone with a male before. I had always been the one without a partner.

This relationship changed my life - I enjoyed it, anticipated doing things and being with him. I enjoyed physical pleasure for the first time ( being held, kissed, sex ) as even as a child I have no recollection of being hugged. I also experienced intense lows.

We married, overseas, and returned to Australia where we thought we'd be financially more secure. The "new" me gradually became lost, as the pressures of making a life and resettling in Australia took its toll. I had never felt at home in Australia despite it being my place of birth, never safe and felt safer living away. I could always move on if life became too difficult.

I became pregnant with our first child, and my world gradually collapsed and disintegrated around me

## **EMOTIONS AND LIFE REALITY**

### **EMOTIONS BEFORE I BECAME PREGNANT**

John was the answer to my dreams. I felt secure and safe, wanted, important, worthy of being alive. Enjoyed being with him and physical pleasure was important. Astounded that anyone so intelligent could love me and want me to be with them. Despite this I was still unsure of who I was, where I was going, what I was doing here at all. Did not know what I liked or disliked. Few opinions - not safe - the easy option and constantly feeling frustrated and angry. Social contacts were few and enjoyment limited - even with my husband - I felt threatened by my surroundings and other people when we were out. Pretence was all. Never felt as if I had any control over events. Always running away from conflict and keeping myself hidden from potential trauma in case of fragmentation. I found some comfort in swimming lengths in a pool - the water was soothing, and no one could get at me.

### **FEELINGS DURING PREGNANCY**

When I found out that I was pregnant, I was delighted with myself. Felt special. Gifted. Amazed that I could be pregnant. Maybe I could "feel normal after all". Also despair and terror - where would I get the love from? Would I find the love? John and I lost closeness during the pregnancy as I became introverted in my attempt to cope with the chaos of my emotions, and John who was also having

problems coming to terms with the pregnancy, I felt did not have much time for me. To me he wasn't interested in the pregnancy, and I felt guilty even wanting to talk about the preparations for the baby. I was working full time on rotating shifts in the NICU at the time, and completed work at 35 weeks gestation. During my maternity leave I had visitors in the house from my first day of leave to the day our son was born. I was angry and resentful of the intrusion of the space I thought John and I would have. I couldn't even get the baby's room ready before I left for hospital, as it was occupied.

### **LABOUR AND DELIVERY**

It was exciting, painful and long, but a relief to have a normal delivery of a beautiful baby boy. Proud. Perfect. I could cope with anything. Immensely proud of having produced a such a fine baby boy.

### **POSTNATALLY**

I rapidly went from an intense high to intense low three days post delivery. I felt I was fragmenting. Exhausted. Teary, but cheerful persona in company of others. I was determined to appear happy and relaxed even if I wasn't. I was depressed in hospital. I had delighted in the movement of the baby inside me, and mourned the loss. From the joy of being pregnant to the despair I felt now.

David was an unsettled, tense, unhappy, fretful baby. He didn't smell nice. He didn't sleep soundly or for any length of time. He cried when I picked him up and cuddled him, and cried when he was put down. He was very tense, and had excellent head control from birth. He was so rigid he seemed much older. There seemed no way of pacifying him. I had no idea of what to do with him. He was extremely demanding (as all babies are and should be) but I didn't seem to be able to be there for him.

### **UNREALISTIC EXPECTATIONS**

I had unrealistic expectations of myself after I came home. I had mastitis 10 days post delivery. Made no concessions for the fact we had a new baby - expected myself to cope with everything with no help at all. Had to prove to the world that all was well. I arranged a dinner party for 8 three weeks after delivery. (I remember saying that it shouldn't change your life to the extent you can't have people to dinner). The relief I had from swimming was not possible now - there was no crèche, and no one I could ask to mind the baby. There was no extended family support - the relationship I had with my parents could only be described as extremely difficult.

I wondered how I'd get through each day. The enormous demands of a new baby were totally unmanageable. I would flip through the phone book wondering who to call. What could I do? I had few close friends, and none I felt I could even open up to. My "closest" friend lived 40 minutes drive away and had very young children herself. In retrospect, I was unhappy and extremely depressed.

Did not ask my family for support. Felt I was a failure and had been most of my life. Couldn't let people see me flunk this too. Estranged from parents and my sister who lived in

Sydney. I didn't even like my mother handling my baby - it felt like she'd take him away.

Felt I was caught up in events over which I had no control, and would never do so.

Feelings of imminent fragmentation. Nothing to hold me together. Work had, but I'd lost that.

David did not live up to my expectations, and I knew I wasn't being a good mother to him. He was an unsettled baby. Trouble with my milk supply and desperately wanted to breast feed. Feeding and expressing to boost supply. Had to "top up" with formula. Failure again. He didn't eat and sleep like I'd expected him to. Not at all like any of the babies I nursed. No idea of how to love him, care for him.. Wanted, and needed him to fit into some kind of schedule. It didn't and does not work that way. He was also sleeping poorly. John up with him until midnight then it was my turn. I gradually became resentful of his enormous burden. Mixed emotions of love and hate, constant fear of the psychological damage I was doing to David when I did so want to be a good mother. Desperately wanting to be there for him and calm and pacify him, but at the same time feeling I could handle him roughly to make him pay for all this misery.

Sadness.

Didn't take time to be with David and attempt to enjoy him, as I didn't know I could just be. Never experienced that. Always had to be doing something. Never had a sense of mother especially there for me. Didn't have any idea. Didn't understand you could just be. Could not remember cuddling my parents. Felt drained by all the extra needs placed on me.

### **CONTINUING FRAGMENTATION**

Marital difficulties as things continued to fragment. Felt a failure. Unable to relate these emotions to John. Not safe enough to do so; Felt I should cope (he was one of 7 and his mother a delightful woman). The person he had loved and married had been gradually disappearing since marriage and our return to Australia. Felt I was a fraud. I'd tricked him into marrying me.

Had lost interest in sex. Felt used. No comfort. Not comfortable with myself, let alone anyone else. Guilty feelings all the time.

Too afraid to ask for help. My whole fabric would collapse. John's image of me all important. He might reject this "new" me. I was very insecure and unsure of myself. Often appeared aggressive. Felt that I had nothing to offer John. Marriage in tatters. Isolated. Extreme difficulty in asking for help. I'd always managed without help. A failure.

### **DYNAMIC OF CHANGE**

#### **LOOKING FOR HELP**

I always presented physically very well - I took pains to do so. I'd always had problems with my body image, and if I'd let that go I doubted if I could keep myself together. So I pushed myself to shower daily, iron my clothes and put my makeup on. No one could then detect the inner turmoil.

Consequently, many people, even professionals were fooled into believing that there was basically little wrong with me. God they were wrong.

I knew I needed some help, but as an intelligent professional woman, I was so **ASHAMED** of my feelings and inability to cope. Did not consider telling my G.P.(2nd) as I'd had a previous poor experience. The care of the Tresillian Group was an option I had thought of, but was extremely reluctant to do. I eventually asked for advice on David's care - the nursing sister who visited me at home offered me time in the Residential Care Centre, which I took up after some persuading. They gave me a lot of practical advice with his care, and also looked after me. It was suggested that I might be suffering from depression, but as I had to some degree always felt like this, I refused to believe her. The help and support I received and the follow-up once discharged was excellent. I felt that things had improved slightly, and with Tresillian to fall back on I could cope.

## PREGNANT AGAIN

Just before I was due to recommence work, I found I was pregnant again. David was 5 months old. I was shocked. Couldn't believe it. Automatic pilot. Exhausted throughout the pregnancy, and no concession made for you at work if you were pregnant.

Due to financial difficulties, even though I was so tired, I once again worked to 35 weeks gestation. Emma was born at 39 weeks gestation. The labour and delivery happened so quickly I didn't really have time to psyche myself into it. Felt it was all a dream. John only stayed for a couple of hours after the birth, and I felt abandoned. Some feeling of high, but not as intense. Sheer exhaustion took over. I was so tired. Needed a private room, but couldn't get one until Day 4. Didn't really want to spend time with this new baby. Anxious about David. Emma jaundiced and that was a concern. John also overwhelmed by events.

Again attempted too much. Going was hard with 2 small children 14 months apart and minimal help. My husband busy at work, sitting his professional practice exams and trying to cope with us. I had little time for John, and was tired and resentful. Did all I could to discourage any physical contact - hugs or kisses or sex. It all became too invasive. Suicidal thoughts, but told no one. Having 2 small children 14 months apart was awful. Mood fluctuations initially from intense "high" to "low". Emma a darling and an easier child than David. Loved cuddles, smiled, calm baby, smelt right. Enjoyed time with her, especially the night feeds. Felt at one.

## THE RELIEF OF SUPPORT

Finally called Tresillian to see if I could go in for a rest. Told I'd have to confront my problems if I went there. They insisted on a home visit initially, which I resisted, and was reluctant and resentful of this. An invasion of my privacy, when all I wanted was a rest. The nursing sister who had visited me previously came, and again suggested to me that I might be depressed, and suggested I see a psychiatrist. Reluctant to do this, but agreed to see the person she suggested. It was absolutely awful trying to tell someone what was wrong with me when I had trouble pinpointing the problem myself, and I was also frightened that I'd be laughed

at and sent away. I started seeing her once a week. A bed became available in Tresillian again for me, just as my psychiatrist was going on holiday. Before admission I had to have an interview with the Social Worker ( who I knew from my previous admission ). She told me how marvellous I looked, and that I couldn't possibly be having so many problems and be so depressed. They initially wanted to put Emma in the same room as me to sleep, but I was very resistant as I wanted to just be by myself to curl up and hide. With the care I and the children received there, I lost control. A psychiatrist was called to see me, and commenced me on Ativan initially, gradually changing to Prothiaden. I was zonked out, dry mouth, floating along, not doing much with the children but trying to be there with them. Feeling guilty that I'd bought all my troubles on the children and John. My own psychiatrist was away for the first week I was in Tresillian, but came to see me there on return from her holiday. I was discharged home after 3 weeks, into the care of my own psychiatrist, and the Outreach Service of Tresillian. I had also been offered a place in a Post Natal Depression Group being run by Tresillian. The support was a relief.

Things seemed to improve for a while. Recommended work and enjoyed it. Functioned well at work and it was a relief to lose myself in it. Being on Anti-Depressants I was unable to do night duty, and the Area Supervisor made things difficult for me - I ended up resigning my position. Had 2 weeks holidays, and started work doing obs/gynae relief at a hospital much farther away from my home. It was much more stressful, and I found it difficult. They were long days, and the children were in childcare. I was exhausted again. I felt obliged to continue working as due to the Recession my husband had taken a 20% pay cut with the rest of the firm he worked for, and things were very tight.

## THE SLOW SLIDE INTO MY BLACK HOLE

I found out I was pregnant again. Not interested in sex, but it was part of the pretence of my existence. I fell pregnant when too tired and dispirited to bother using my diaphragm. Thought that somehow it couldn't happen to me. This pregnancy I had had confirmed at the G.P.(2nd). She knew how upset I was that pregnancy was a possibility, and yet she offered me the tester to have as a keepsake! I nearly laughed at her. No sensitivity at all. Despair. I took sick leave from my new position after 2 weeks, and never returned to work there. I decided on having the pregnancy terminated as I believed there was no way I could cope with another child. It was a very stressful experience. I felt that there was no one there for me, and as I had become so despairing and suicidal, I told my psychiatrist that I felt suicidal. ( I had expected her to laugh at me and tell me not to be so dramatic ). She immediately wanted to admit me to hospital, but as we had planned to visit friends in Canberra for the weekend and I didn't want anyone to know there was anything wrong with me, we went. She planned admission for the Monday. I had enormous difficulty telling John what was up with me. He was completely overwhelmed by the turn of events, and couldn't be much support for me. I nearly didn't go to hospital, but realised I should. The main benefit I received from being an inpatient in this hospital, was the relief I felt not to have to care for the children. There was little emotional support offered, or practical advice. The

termination was planned for the Friday. My obstetrician was wonderful - calm and non-judgmental. I walked alone to the Day Surgery from the Psychiatric Hospital. The offer of a nurse to accompany me I dismissed as unnecessary. As I had been admitted because I was suicidal, this was rather negligent. En route to the hospital, I considered either throwing myself under a truck on the highway, or to keep walking and jump in front of a train. No one to go with me, or wait with me. John had offered, but he was looking after the other two children. Felt enough of a burden. I felt as though I was existing on a different planet. Felt I was caught up in events over which I had no control. John collected me when I was able to be discharged, and I returned to the psychiatric hospital in the middle of the day. I informed them I was back. They did not inquire how I was until much later in the evening. The psychiatric hospital had no idea that I was so desperate and depressed. Felt that there was no hope for me. Would never have control. After the termination I felt even more hollow and full of hatred for myself, and delayed going home I remained suicidal. Stayed in for another week, armed with all my medication ( I had hoarded some ) and a bottle of Vodka to give it a help. Whilst in the private hospital I'd been given the Mimms to read ( on my request ) and had poured through it and decided a few drugs to get hold of. Part of the patient to patient therapy in this clinic was to discuss ways of suicide. It is easy to go from medical clinic to medical clinic and request any medication - if you know what you're looking for and you have a good story they'll give it to you. I did this whilst still an inpatient.

Psychiatrist seeing at time helpful, but I knew intrinsically she'd run out of answers with me. At the same time she did help me alot. Felt safe enough with her. Needed to see someone. Made me feel acceptable. but this only lasted re half a day, and didn't get me through the week. Assisted me to find a baby sitter and encouraged us to go out once a week. Money was short, but we saw the sense of getting out together.

I deeply resented her holidays, the fact she couldn't see me more than once weekly, when I knew for a fact that she was seeing other people twice a week. I would spend my 50 minute hour barely uttering a word, tears streaming down my face. Envious of her calm persona and what I considered good life.

Decided not to go back to work until the New Year, when I hoped to start work at the new Mater NICU.

### *IN THE DEPTHS OF DESPAIR*

Things became progressively worse. Despair and hopelessness. I was disgusted with myself and ashamed that I had had a pregnancy terminated, even though I knew I could not have coped with another baby.

Started planning my suicide. Put it off. Did not tell the psychiatrist I was seeing that I was suicidal - there seemed to be no point. Then decided that December 18 was the day. I had a job interview at the Mater in the afternoon, and I attended, so that no one suspected that I was planning suicide. Took my tablets at 8pm, and went to bed. John thought that I was just tired and going to bed early. When I

attempted suicide, I thought of killing David and Emma too. What hope was there for them with a mother like me?

Woke up in hospital ? when. Despairing that I couldn't get anything right. Still suicidal.

### **THE NIGHTMARE OF MISMANAGEMENT**

After I'd physically recovered from the overdose, I was transferred to the private psychiatric hospital I'd been in before. Left alone in my room most of the day. Desperate to talk to someone, and they finally got a Registrar to speak with me at approximately 5pm. Told him how I was feeling, but willing to take help offered. My wish to talk to someone to tell them how desperate I was feeling, ended up with me being scheduled to Macquarie Hospital, into a ward full of psychotic patients. First I knew of it was when there was a knock on the door at 11pm, and a nurse entered with 2 ambulancemen, and there were 2 policemen just outside the door. I had thought the nurse was sitting in the room with me because they knew I needed company. I was accompanied on my transfer by the ambulancemen, and two policemen sitting in the rear of the ambulance with me, followed by a police car with flashing lights. The whole episode felt like it was straight out of 'One Flew Over the Cuckoo's Nest'. It was quite unbelievable. It was extremely traumatic not only for me, but for John. Any faith I had had that I might be able to get help for my depression vanished. I felt I could trust no one. I felt that I was being punished for asking for help. I was a nuisance, and just trouble. I felt betrayed. My admission wasn't completed until after 1 am, as I had to undergo yet another physical examination and basic psychiatric history. I was terrified of what they would do to me. I was sweating profusely, hostile, angry and reluctant to co-operate. I wanted to scream and shout and run, but I realised this would not help me at all. I got no sleep. There was no privacy. The shower room had no curtains. We were herded from the locked ward to the dining room. I felt like an animal in a cage. I was given no indication of the length of time I would have to stay. The general patient area was noisy - television and/or radio on. I was touched up by one of the patients, and the staff offered me no support. I was desperate to have some fresh air - but the only outside area we were allowed was a balcony, which was used as a smoking place, and therefore offered little fresh air. We were not allowed to lie on our beds in the day. There was no relief. I was interviewed by the Registrar in the morning, whom I managed to convince I was feeling better just so that I could get out of there. I was transferred back to the Psychiatric ward of Public Hospital of my original admission in the early afternoon, as the Private Hospital refused to accept me. It was Friday afternoon, and I was given complete freedom over the weekend, and encouraged to go out. They told me I was ready for discharge home on the Monday. I found this also unbelievable - within a period of 24 hours I am initially scheduled, then told that there is nothing wrong with me! I told them I wasn't ready to go home. I appeared functional - I dressed neatly, washed, brushed my hair, went swimming. I was also desperate for help, and told them so. The shame of admitting this is feels unbearable, and is not said lightly. They did not believe my need. I was frightened of going home and being in the exact same situation I had been in. The Consultant Psychiatrist said to me on Christmas Eve that

I would only try again anyway, and that there was nothing they could do for me! They reluctantly let me stay over the Christmas New Year period, but I was constantly being told that they were only meant to have "acute" patients in during this time. If I wasn't acute, who was? My belief that I was just garbage reinforced.

Managed with the help of a friend to be retransferred to the private hospital from which I'd been scheduled. There seemed no other option. I was terrified of going back there, but it would have been worse to go home. They had no idea how ill I was and I had the free run of the clinic, coming and going as I pleased. I wasn't able to tell them how I was feeling, as they would have just scheduled me again, and I would have been dosed with medication. I had no desire to see the children. On my three admissions to the one psychiatric hospital, I had been allocated on each admission to a different psychiatrist each time.

In this hospital, you were lucky if you had access to your psychiatrist ( or the registrar ) each day. Appointments could be put on the noticeboard at any time in the day - and it was very easy to miss your allotted time. The appointments were of 10 minute duration, and offered little in the way of care. There was also a policy of being moved from room to room and bed to bed at short notice, and often daily. I was told often in hospital, by the nursing staff, that I just had to put all the bad experiences behind me, and get on with my life. I shouldn't get so upset by all the moves. It was very unsettling. I had an ear infection whilst there, but decided that it would take too long to get treatment from the medical staff there, and took myself to a G.P. to get ear drops and antibiotics.

The company of the other patients was one of the few things that gave relief. I did actually discharge myself after two weeks, but after only one hour at home, requested re-admission. I did not feel safe by myself at home, and did not know how I could stand to be in the flat.

## SEARCHING AGAINST THE ODDS

Whilst still in hospital, we moved from our flat to a house. While it was a relief to have a safe garden for the children, nothing else had changed. Unable to work. Had been told in the clinic that intensive psychotherapy wasn't an option for me as it was too expensive, and to try to get on the Westmead Psychotherapy Programme. I managed to arranged an interview for myself. My original psychiatrist had agreed to see me in the interim, as my follow-up appointment at the hospital had been arranged for 6 weeks time ( the earliest possible one). My psychiatrist suggested alternative therapists who might be able to see me more frequently. On contacting one, I was told there wasn't much hope of being seen for a few months.

## A RAY OF HOPE

On contacting the other, I got the answer machine. Left no message. Tried again, and again. It then dawned on me that I would have to leave a message. She phoned back as the message said she would; I hadn't even thought that would happen. Was telling me there was no way she could see me, but I managed to talk her into at least an interview. She was my last hope, and if I had found no help, I had already

planned another suicide - and knew I would succeed. I hated this therapy, but knew I had to give it a go. Many times I wondered what I was doing there, not able to say anything, or shed any light on why I was feeling as awful as I was. Initially concurrently I was attending the Private Hospital's Day Programme; it got me out of the house twice weekly for 2 whole days. They still had no idea of how sick I was, and did not like me going off to see my own therapist.

I was still suicidal and remained so for at least one and a half years. I had psychotherapy 5 x weekly with hospital admission when my therapist was away. This hospital was the antithesis of the other, and had been found for me by my therapist after consultation with colleagues, the nursing staff and myself. I felt for the first time, as if I was being treated as a person, and not an object that was a nuisance. We had jointly decided the other hospital was detrimental to my health.

## LEARNING TO TRUST

Gradually came to rely on my therapy, and to have a degree of trust in my therapist. Kept thinking I would have a policeman knocking at my door to schedule me after some of my sessions, but this never happened. I slowly began to believe that there was some good in the world, and that I could feel differently. I had met the first "caring" professional who I felt properly understood my problems. I felt accepted. It didn't matter what kind of mood I was in. The silences were excruciatingly painful at times, but I also felt that I wasn't being judged or hurried along. I felt that what I was saying was being heard. There were no interruptions to the session once it commenced and she was always on time with her appointments, which is very important. I was greeted pleasantly even though I rarely looked at her. I became extremely dependent. Couldn't have survived without the therapy and the evening and weekend phone contact. I constantly felt I was in the black hole. A dead baby. No life.

She also instituted telephone contact each evening and weekend, as to me she didn't exist out of the therapy. It was so easy to fall into my black hole and total despair. As I got better, when she was away I was looked after by another psychiatrist I felt safe with ( on the second attempt to one) and so was contained in her absence.

I was not at all functional. It was all I could do to get to my appointments, take the children to childcare, and do the shopping and washing. It did not occur to me to do any housework or to water the garden. We had no social life. I basically locked myself away when at all possible. Listened to music. I hated the weekends and evenings when there were demands on me from the children and John. I was resentful, and hated being with them. I hated lunchtime when John came home (he worked nearby) and I know he hated it too, but was keeping an eye on me. I told him to take the children and go, so I could die and be done with it all. I was ruining his life and the lives of my children.

I remained suicidal. Felt deathly. Could hardly converse. No medication - didn't feel I could be trusted and the tricyclics and the Prothiaden had had no effect. I was driving dangerously. I often spent hours pondering different ways of dying. I made my will, and checked that the life insurance policy on me would pay if suicide was the cause of death.



Obnoxious behaviour. Hated the world and felt it hated me. Envious of any time spent away from therapist.

After a year of seeing this therapist, I commenced Prozac when it was available on the National Health. Major improvement in my mood within 6 weeks. I began to be able to talk a little. Began to function a little better. I began to be able to confront my fears and problems. I began to be able to view events with more objectivity. I began to be able to do things with the children. Initially even taking them to the park for the swings by myself was too much to contemplated. I needed someone to help me.

### *CLINGING TO A LIFELINE*

Many of my therapy sessions were spent in silence, or limited dialogue. There were weeks when it was all I could do was just "be" there, and share the pain. The inner conflict I had about my therapy would nearly tear me apart. I felt that I wasn't worth it, and often told my therapist that I was just a piece of garbage. I was often reminded that it was my time to do with as I pleased. I had never before allowed myself to experience this. The rejection I felt at the end of a session was devastating, and I hated my therapist for it.

○ major mood fluctuations. My continuing existence was very shaky at times, and I would completely withdraw into myself. Contemplate suicide. Wouldn't talk. Slam the phone down on the therapist. Not "adult" behaviour. Despite this I never missed an appointment unless it was absolutely unavoidable. It was my lifeline. The children hated leaving me, or me going out. They did not believe I would come back. I often doubted this myself.

Nothing could cheer me / please me. No interest in anything. Lifeless, but alive. I hated spending any money on myself, even when I needed some new clothes. I wasn't worth it.

My whole immediate family was depressed. John became depressed and subdued. David was especially anxious, subdued, aggressive, a bully, and not mixing well with his peers. His first smile was not at me but at a friend of mine. I was very upset by this. I didn't know that waggling a noisy blue elephant in front of him would do this to him. I had no idea. Emma was a much more contented child, although ○ ated by my illness. I shouted alot, and I hurt David a couple of times. I was filled with rage and anger. There was a gradual shift in their behaviour as I improved. David able to cope better, and relax more ( he was always a very tense child) . I had maintained going for swims 4 x weekly throughout all this time, and believe it was an important activity as it helped keep me alive. The water was soothing, and no one could get at me whilst I was swimming. I continued to have cold showers after my swims throughout summer or winter. I had to punish myself somehow.

I used to dread weekends. They were torture. School holidays, child sickness, when I had to spend time with them. They attended a childcare centre from 8.30am to 5 pm, Mondays to Friday. I could not look after them - physically or emotionally. They received love and care from this centre which they would not have received from me. Even time after childcare/school was difficult. This became so difficult for me that I finally asked my mother to assist me when possible, despite the dread and anger of someone else in the

house. John and my mother undertook their care in the evenings, whilst I hid in the bedroom.

I had always felt better in the morning than the evening. Perpetual tiredness. Extreme anger and intolerance. Not able to cope with any changes, to routine or anticipated course of events . Wanting to run away and hide constantly.

### *A SLOW RETURN OF SELF ESTEEM*

I had no desire to go nursing again, and I got the idea that I might be able to teach swimming. I did a Swim Instructors course, and got a job, initially once a week for 3 hours. Going to the course and starting work was a major trauma for me initially, but with my therapists and my husband's support and belief in me I was gradually able to live a somewhat "normal" life.

The time and effort my therapist devoted to me, along with the access I had to her or someone else in her absence, was essential. It gradually allowed me to reach a stage where the days focus shifted from revolving around my appointments, to learning to accept myself and allow normal day to day activities to become important as well. My husband was always supportive. His love and care was so important to me, but I did not often acknowledge this. Had it been withdrawn, I doubt I could have survived. The acceptance of my husband and my therapist was paramount to survival.

### *LIFE NOW - with hope for the future*

Despair, black hole, in the pit, a dead baby, fragmentation.

Integration to a whole being is possible. Psychotherapy does work - I'm living proof. Nowadays, basically I enjoy my life. I have moments of intense depression periodically, but I am able to deal with them more effectively, and I improve quickly. I know I have talents and gifts, and am a useful and necessary person. I am content. I do not envy people as I used to. I know I have alot. I have worked very hard to achieve this status quo, and treat myself with love and care. I love my husband, I love my children and enjoy being with them. I am not threatened by the company of others.

I teach swimming circa 10 hours per week now, which for me is a great way to meet people and enjoy helping people. I get alot of pleasure from this, and am confident that I teach well. Since my initial qualification, I now also am a qualified Swim Coach and Swimming Teacher for the Disabled. Most of my work is with children, whom I enjoy teaching most of all.

Now I look forward to the time I spend with my husband and children. I love weekends and holidays. I am able to do spend time with them ( didn't even want to read the children a book before - it was too much to ask of me ). I am able to treat them tenderly, love them, discipline them without physically hurting them ( smacking, or fearing I would throw them against the wall to make them shut up ). Take pleasure in their maturation, achievements and own pleasures. Want to be with them, do things with them, please them.

David now smells lovely, and is a happy and content child. He is much more flexible, and although he was unable to put his feet into his mouth as an infant, from age 5 he was able to, and still can do so). He loves his hugs and kisses, and is gentle when necessary! He is fascinated by young children. Both of my children love playing at being babies, and need to

be talked to in a baby way, stroked and kissed. I believe this is important for them and for me.

Used to scream and shout uncontrollably. Anger not able to be contained. This happens rarely now. I feel whole. We are even considering having another baby.

I always wanted to make a good family life - and feel I am doing that now. There is hope after such severe depression.

I was told once that nothing would ever change for me. I would attempt suicide again. That therapy for my needs was not available. This was said by a consultant psychiatrist a week after my suicide attempt. My advice is to keep looking.

Never give up hope.

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## BOOK REVIEW

**THE STONE DIARIES** by Carol Shields. Fourth Estate publishers, London 1994

Reviewed by Sarah Jones.

Carol Shields' novel 'The Stone Diaries' offers some big questions. What is it to be a motherless child? - is one of them. For people intrigued about infants' emotional life this novel provides us with something that research, statistics and theoretical ideas can not. It offers us the awful possibility of considering what life might be like for an infant whose mother dies in the creative act of giving birth.

Daisy Goodwill was born at a time in this century when little was known about people's "insides" - the mysterious womb, the fluids, the acts of intercourse, the desires. So Daisy was born whilst her confused and unaware mother was writhing on the stone floor of their poor workman's cottage in Manitoba, Canada in 1905. We know her mother knew not that she was labouring and we are lead to believe she had no knowledge of the pregnancy. Daisy's birth we read was a shock and a surprise to everyone. Neither her mother, nor her hard working stone-cutter father, nor the neighbour Mrs Clarentine Flett (who later steps into the mothering shoes) knew of Daisy's existence until she rudely and tragically arrived into the world.

The baby girl's response to her birth and her early infancy is not documented. From birth to 8 weeks we hear very little about her. At the end of the book we do re-visit the meaning of her birth for the unwilling participants - particularly the "old Jew" who received the dying women's final glance.

The death scene consumed the neighbour, the-called-for doctor and priest, the husband just returned from the quarry. It was an "old Jew", a pedlar who looks for the baby,

"there on the kitchen table..... wrapped in a sheet. Its lips were moving, trembling, which was how he knew it was alive. No one was paying any attention to it. It was as though it wasn't there. As though it was a lump of dough left by mistake.

He reached out and touched its cheek, and felt a deep, sudden longing to give it something, a blessing of some kind. He could never understand where that

longing came from..... that he felt perfectly the infant's loneliness; it was loneliness of an extreme and incurable variety, the sort of loneliness he himself had suffered.....

But that child's sadness never left him. He swore he'd never seen a creature so alone in the world. He lived a long life..... But he grieved about that baby all his days, the curse that hung over it, its terrible anguish." (P260-1)

Daisy probably did not know much about what was happening lying on the kitchen table just after being born. If these were the thoughts of one of the observers how then would this girl have been seen, thought of, considered by those who continued to care for her? Winnicott's idea of the baby discovering herself by gazing into a mother's face and finding herself, knowing she exists through this mirroring, might not have happened. Daisy does find herself a "mother", Mrs Clarentine Flett. She is able to partially receive some of the vital nurturing required for psychic health. However Mrs Flett dies when Daisy is only 11 years of age. The emptiness, the absence of a mother, maybe even not the mother becomes a disturbingly integral part of Daisy's character.

We are reminded of this baby's loss as she develops. What is it that this girl lacked? Is it a mother, or a central constant care-giver? Is the biological mother's loss and the tragic story kept alive by those who keep her alive? Is it good-enough, that she finds security from 8 weeks until the subsequent death just a decade or so later?

Daisy's life seems good enough for 60 years. It is not till then that Daisy succumbs to depression. The novel offers us the unusual opportunity of understanding this through other people's theories. There are several short essays ascribed to the principal characters as to their hypotheses to explain the depression, friends, daughters all get their say. However the old black maid who cares for her from aged 11 starts hers with "the poor motherless thing."

Here the reader is forced again to engage with the question of a motherless child. Pondering over Daisy's debilitating depression the maid thinks to herself:

your mama's inside you. You can feel her moving and breathing and sometimes you can hear her talking to you, saying the same things over and over, like watch out now, be careful, be good, now don't get yourself hurt.

....I'm all she's got. I'm not even half a mama....How's she going to find her way? How's she going to be happy in her life? I'd stare and stare into the future and all I could see was this dark place in front of her that was black as the blackest night." (p257)

Carol Shields' fascinating story is written as if a person's life is a messy skein of wool, threads here and there, some cut, some knotted. Focusing in on one thread leaves other complicated patterns unexplored or only partially pictured. No one really ever knows all the stories, the skein begins and ends but the fragments are infinite. The metaphor that runs through the book, its title, the characters names is a metaphor

of stone. This book is so deeply personal, so touchingly about one ordinary women's life following her extra ordinary birth that cold, lifeless stone is all Daisy feels herself to be at times; never what the reader receives.

*Sarah Jones is a Social Worker who has trained in family therapy and marital therapy in England and Australia. Her fascination in Infant Mental Health was developed further whilst working with the Infant Mental Health Group at the Royal Children's Hospital, and is currently a member of this group*

## FROM THE JOURNALS

### JAMES B. WATSON

#### A Follow-up.

In the December, 1995, Newsletter, we published an excerpt from *Psychological Care of Infant and Child* by J. B. Watson, the founder of Behaviourism. One of our readers called our attention to an article written by Mufid James Hannush, entitled *John B. Watson Remembered: An Interview with James B. Watson*, which appeared in the Journal of the History of the Behavioral Sciences, Volume 23, April, 1987. James B. Watson is the younger son of the founder of Behaviourism, and was born in 1924, so that he was four years old when the book from which we quoted was published. James' recollections of his father make interesting if chilling reading. He says 'Dad followed exactly what he prescribed in his book, *Psychological Care of the Infant and Child*, and those were the procedures under which my brother and I were raised.' Both James and his brother suffered severe depressions; his brother suicided, and James sought help from his own depression through analysis. In the interview he says:

"My reason for entering psychotherapy was a very severe depression and an attempted suicide. I admit that happens to a lot of people who are not raised by behaviorists, but I strongly believe that strict adherence to the principles established in behaviorism, particularly as located in some of Dad's earlier books, tends to erode the fundamental development of the child's ego strength and to cause a great deal of difficulty in later life. Although this may be seen as a rationalization for what happened to me and my brother, I honestly believe the principles for which Dad stood as a behaviorist eroded both Bill's and my ability to deal effectively with human emotion - either to accept it or to show it - and it tended to undermine self-esteem in later life, ultimately contributing to Bill's death and to my own crisis. Tragically, that's the antithesis of what Dad expected from practicing these philosophies."

### TRAUMA AND INFANCY

The most recent issue of the Infant Mental Health Journal, Vol 16, No 4, is a Special Issue on Posttraumatic Stress Disorder in Infants and Young Children. Among the papers is one which will be of special interest to those who attended

the WAIMH Pacific Rim Meeting in 1995. At that Meeting, Mary Sue Moore in her Plenary Paper on The Complexity of Infant Trauma, made reference to the work of Bruce Perry. In this Special Issue of IMHJ, there is a paper *Childhood trauma, the neurobiology of adaptation, and "use-dependent" development of the brain: How "states" become "traits"*, of which Bruce Perry is a co-author. This paper provides a good summary of the current 'state of the art' in relation to neurobiology and infancy.

## A WOMB WITH A VIEW:

### One Day Symposium on Pre- and Peri-natal Psychology & Medicine

A few years ago, the local media carried a story about the effect of the theme music of the Australian Sitcom *Neighbours* on the foetus. The work on this was done by Prof Peter Hepper, from the UK, who is currently on a sabbatical at the Royal Hospital for Women, Paddington. Professor Hepper will be a guest speaker at this meeting, which will highlight the importance of this field of research, which has considerable implications for Infant Mental Health Workers.

Where: Royal Hospital for Women, Sydney

When: March 31, 1996.

Enquiries: Viv Wallace, School of Obstetrics and Gynaecology, UNSW, Phone(02) 339 4052

### AAIMHI Committee

Elected 25 October, 1995

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