Winnicott Lecture
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Before commencing my lecture I wish to share with you an email received from a friend, 94 years of age, in response to telling him I was to present the Winnicott lecture. -Beulah's Winnicott lecture promptly brought to mind this maxim,

"There are no perfect mothers, only at best good enough mothers." How that helped my lovely wife battling to be a saint and mother of four irrepressibles all under seven. Incredibly they insist their childhood was a happy one. I cannot speak for my wife. But Winnicott was on to something, not perfect but good enough.

Winnicott was reassuring to many ordinary families.

Introduction

At the WAIMH Conference in Edinburgh this year, in conversation with Professor Louise Newman about the plight of children in Australian detention centres, I asked Louise what we could do about the situation. Louise said the first thing to do was to write to our politicians. I came home with the intention to do so.

The presentation of this lecture was my preoccupying thought but I couldn't get started. I had to write my letter to the Minister first which finally got written early August.

My message today is that we have to be the voice for infants; we are the ones who read the infants, who hear the baby's talk.

Of course last century there were many who began to speak for infants; Winnicott was one of the first to focus on the early relationship between "the ordinary devoted mother" and her baby, to be a voice for mothers and babies and to listen to the baby.

I feel a special affinity with Donald Winnicott and I will tell you why. Winnicott trained as a paediatrician and gradually changed over into being a psychoanalyst and a child psychiatrist. He spoke of how his physical training influenced his work and the accumulation of a big volume of experience due to active practice for 45 years. My own original training was as an Occupational Therapist and after working with adolescents trying to break their drug taking habits in London, I turned to psychology.

Like Winnicott I have acquired a volume of experience, not quite 45 years but many years of practice, and like him I wish to convey to you the 'strength of feeling' I have acquired over those years of working with parents and their infants and with colleagues who share the enthusiasm.

Something else I learnt of Winnicott which I will share. I quote from Sir Peter Tizard's foreword in `*Babies and their Mothers*' (Winnicott, 1988):

Dr Winnicott was a good writer, sometimes very good, occasionally rather poor, but he was a far better lecturer and conversationalist ….to express his views most clearly and vividly he needed the immediacy of an audience. (p. viii-ix)

For myself too, it is easier to speak to a receptive audience than to apply the discipline of writing a chapter or paper. I prefer to speak of my work rather than write about it. Thank you for being here today.

Two realisations came to me from working with the adolescents in London. The first was that adolescence was too late to try and bridge the gap between parents and children, early intervention was crucial. The second was that I didn't have enough knowledge of internal and interpersonal processes to adequately meet the needs of these young people.

TODAY I want to share with you my passion for infants and their families and what we can learn from observing babies and small children, what they are telling us. Also, I want to honour the place of the 'ordinary devoted mother', the importance of that role. Together let us think about how we can share that information with families. Our responsibility is to share the knowledge with families and the wider community.

A Voice for Babies

Selma Fraiberg who is credited with coining the phrase 'infant mental health' (and her colleagues), had an awareness of how important the newly acquired knowledge of infant emotional development and the role of parents in healthy development of their children was, especially to parents. To quote:

Today, we are in possession of a vast scientific treasure acquired through the study of normal and deviant infants, a treasure that should be returned to babies and their families as a gift from science. (Fraiberg, 1980, p. 3)

Beulah Warren at the WAIMH 14th World Congress Opening Ceremony. Photo by Simon Williams.

Arietta Slade (2002) said that Fraiberg demonstrated the power of a mother's discovery of her own and her baby's internal states and the link between their experiences. Fraiberg and her coworkers used straight forward techniques to bring the baby´s experience into the mother's consciousness; to help mothers accurately read their babies' signals and underlying intentions.

It was in 1978 following the birth of our third child and meeting with new parents who felt ill prepared for the task of parenting when I had my epiphany moment and changed course to work with infants and their parents. It was the year I met Dr. T Berry Brazelton on his first visit to Australia. On that occasion he trained a small number of people on the Neonatal Behavioural Assessment Scale (NBAS) who undertook to train others. I gained reliability on the scale in 1979.

Berry Brazelton awakened us to what the baby brings to the relationship with his parents. From the beginning Berry contended that "new born infants were unique, with their own individual style of responding" (Brazelton & Nugent, 2011, p. 2).

What was Berry trying to teach us?

The newborn is a social organism, predisposed to interact with her caregiver from the beginning and able to elicit the kind of caregiving necessary for her species specific survival and adaptation. (Brazelton & Nugent, 2011, p. 3)

The Brazelton Scale, as it is commonly called, is an interactive assessment where the examiner plays a role in facilitating the performance and organizational skills of the infant. Specifically we learn about the baby's autonomic stability, the competence of the reflexes, the musculature and sociability of the baby. We learn about the baby's tolerance for distress, what comforts the baby and how quickly he can be comforted. We also learn what stimulation is appealing to the infant and how much can he tolerate. What a wealth of information can be gleaned by observing the full term healthy newborn.

(I now show a film of full term healthy infant)

Baby James and Baby Patrick

Baby James

So then, what do we learn of three day old James and what did we share with his parents? James is a well rounded full term infant. He has a beautiful relaxed body with gently flexed arms and legs, a balance of flexion and extension. He has a good healthy cry when uncomfortable but he settles easily when his hands are held and he is spoken to in a quiet persistent tone. With a little help, he can self sooth. James can snuggle in when held by an adult, which of course is rewarding to the parent. When he is well fed and content he can focus on a face and a face and voice for 60 plus degrees to both sides and he can turn to the side to find a voice. We can assume his birth was not traumatic for him. James is virtually a "prototype" of the healthy newborn.

Baby Patrick

Now let me tell you of Patrick, also a healthy newborn but one who spent a lot of time crying in the first three days of his life. Patrick was born in a Maternity Hospital in Perth. Nurses who were doing training on the NBAS identified Patrick as very distressed and wondered if by doing an NBAS assessment with Patrick we might be able to give the mother some information about Patrick's needs. Mother brought Patrick into the quiet, softly lit room where the assessment was to take place. Patrick was asleep.

Patrick looked to be of average size for a healthy full term. I can't remember anything the mother said about the birth but I do remember the mother saying she had two older daughters. We began the assessment by assessing Patrick's habituation to a light across the eyes, a rattle and a bell. Patrick was able to shut out each of these stimuli and return to a deep sleep. I then rolled him onto his back and began to uncover him. The scale starts with testing gentle reflexes, glabella, rooting and sucking. The baby is then undressed to test further motor items. Once undressed Patrick had begun to fuss and very quickly went from fussing to a loud State 6 cry, I am sure you are very familiar with such a cry which demands immediate attention. On the NBAS consoling the baby is a measured incremental response. You initially show your face, then speak quietly to the baby, follow with restraining the arms(as shown with James). If that doesn't work, restrain the arms and pick up and hold, next introduce rocking and finally wrap and then give the dummy.

Patrick required the lot. Once settled, after a couple of minutes I tried to return to the reflexes; an attempt was made to lie Patrick down and un-wrap him. He remained quiet until I tried to grasp his hands or feet or move his arms and legs. He quickly began to cry again with full intensity. I went through the console procedure once more but realized we were not going to be able to continue with reflexes. Once wrapped and held firmly Patrick returned to a quiet state.

It wasn't a quiet state of sleep, but a quiet alert state so I suggested to his mother that we would try and engage with him socially. Held out in front, well supported, Patrick followed a face, face and voice, the little red ball and the rattle from side to side and around in a circle. He also turned to each side to find the enticing voice, and the rattle. It was a joy to share the experience with his mother who was delighted with his performance.

Patrick's mother and I wondered together what Patrick's behaviour might mean? She thought it was what boys did. Her girls had been quiet babies, not crying in the way Patrick was. We agreed that being unwrapped with arms flailing distressed Patrick so keeping him wrapped until he felt comfortable unwrapped was going to be important. I suggested she wrap him for sleep and also for quiet alert times in his rocker or chair for at least the first few weeks or until he had a little more control of his arms. I left my card with Patrick's mother and said she could phone me if she wanted to discuss the assessment further.

Some six months later Patrick's mother phoned me. She identified herself as Patrick's mother and said she wanted to tell me of Patrick's progress. She said she had continued to wrap Patrick for sleep and initially when he was awake. Gradually Patrick gained control of the movement of arms and legs and then it ceased to be necessary around four months. He was now a happy little fellow enjoying being on the floor unwrapped and playing with his sisters.

The physical characteristics of James and Patrick were somewhat similar. However, Patrick did not have the same regulation of motor that James had. With Patrick it was evident it was where he needed help to enable him to engage in face to face interaction with his mother.

Let me now turn to premature babies.

What do we Learn from Premature Babies?

It is many years now since Dr Robyn Dolby, two physiotherapists, Dr Vickie Mead and Ms Jan Osborne, and I, carried out a research project that involved intervention with premature infants over the first year of life. We learned so much from the observation of the infants over the year. Two important pieces of learning were acquired from the project which involved meeting with the families in the hospital and in their homes four to five times over the first year.

Lesson one: Listen

Before intervening we had to listen carefully as the parents gave us their observations of their baby's behaviour and their reflections on the meaning of that behaviour.

Lesson two: We need a framework

The second lesson was the complexity of human development in the first year of life and the underpinning of the motor system and how it influenced the baby's capacity for social engagement. As psychologists we learnt from the physiotherapists the baby's motor communication. We had to be trained to know what we were looking for. *It is crucial to have a framework for what we are looking for.*

Professor Heidelise Als, who initially worked with Berry Brazelton went on to focus on the development of premature babies, especially very low birthweight babies. Dr. Als has changed the environment and ambience of Special Care Nurseries in many countries with the introduction of the Newborn individualized Developmental Care and Assessment Program, (NIDCAP) and the Scale, the Assessment of Premature Infants' Behaviour (APIB) specifically adapted from the NBAS.

Heidi Als introduced us to the "Synactive Theory of Development" in an article in the Infant Mental Health Journal (IMHJ) in 1982. Her conceptualization of infant development appear below and I quote:

Focuses on how the infant handles the experience of the world around him. The baby's functioning is perceived as continuous intra-organism, subsystem interaction and the organism in turn is seen in continuous interaction with the environment. (Als, 1982, p. 230)

Furthermore:

We have termed this view of development synactive, since at each stage in development and each moment of functioning, the various subsystems of functioning are existing side by side, often truly interactive, but often in a relative holding pattern, as if providing a steady substratum for one of the system's differentiation processes. (Als, 1982, p. 230)

The systems referred to are the:
1. Autonomic system;
2. Motor system;
3. State-organizational system;
4. The attention and interactive system and;
5. A self regulatory, balancing system.

Dr. Als maintained that the functioning of all these systems was observable; *we needed to know what we were looking for.* Thus, she identified what to look for in each system to explain the functioning:

The autonomic system
- observed via the pattern of respiration, colour changes, tremulousness, and visceral signals such as bowel movements, gagging, hiccoughing, etc.

The motor system

- was observable in the posture, tone and movements of the baby.

The state organizational system
– observable in the kind and range of states of consciousness available to the baby, from sleep to aroused states; also in how the infant transitions between states.

The attention and interactive system

– typified in the baby's ability to come to an alert, attentive state and to utilize this state to take in cognitive and social-emotional information from the environment and in turn elicit and modify the inputs from the environment.

The regulatory system

- exemplified in the observable strategies the baby utilized to maintain a balanced, relatively stable and relaxed state of subsystem integration or to return to such a state of balance and relaxation.

If the infant is unable to maintain or return to an integrated balanced subsystem state another aspect of functioning is identified. What does this baby need to return to a balanced state? What amount and what kind of facilitation is required from the environment to aid the infant's return to balance?

Let me show you some video of an assessment of a premature baby using the NBAS.

Baby Elli

At the time of filming Elli is 5 weeks corrected age, or 17 weeks chronological age. It is obvious how important it is to correct for prematurity. Where is the imbalance for Elli? In fact all of her systems are being stressed. The coughing and painful cry indicated her autonomic system was challenged in the testing of reflexes; her inability to sit without going into extension, her increased muscle tone and jerky movements demonstrated the imbalance in her motor system; while her persistent fussiness bespoke poor state control, and her inclination to hyper-alertness was an expression of her difficulty in regulating attention.

What did Elli need to return to a balanced state? Elli required loving gentle handling; to be held curled in to help her flex and reduce the increased muscle tone when being held. Also to be firmly wrapped when preparing for sleep. Her strengths were that she was responsive when cuddled and held curled, relaxing and looking into the face of the person holding her, and when lying on her side, she quietened when spoken to and stabilized. It was very apparent that to engage with her motor system required assistance and her arousal needed to be regulated.

At Elli's age of 5 weeks the parents were longing for face to face engagement with her. How patient the parents would have to be to prepare Elli for interaction and we wonder how many engaging moments she could manage in her awake times?

Parent-Infant Interactions

Parent infant dyads are the focus of many methods of intervention in the first year of life. Some are working on the mother's representations (see Beebe, 2003) while other interactional approaches attempt to intervene into specific behavioral transactions.

With an understanding of a synactive theory of the developing infant, we appreciate that at any moment of functioning the infant's various subsystems may or may not be interactive. We are better equipped, when observing parent infant interactions to understand what might be influencing the infant's contribution.

In observations of parent-infant interactions, optimally, self and interactive regulation are in dynamic balance.

Beatrice Beebe (2003) states in her outline of brief Parent Infant treatment using video feedback:

The approach of her team is based on a theory of face to face interactions developed over a number of years. Self and interactive regulation are concurrent and reciprocal processes, each affecting the success of the other. Interactive regulation is defined by bidirectional contingencies in the partnership of parent and infant, a continuous process in which each partner makes moment-to-moment adjustments to the behaviours of the other. The infant's capacity to detect and to be affected by contingent stimulation underlies all current theories of how the infant develops predictable patterns of the relatedness and their representations. (p. 27)

Beebe (2003) comments that many intervention efforts actually focus on the parent, to the point where it has been asked: "Where is the infant in infant intervention?" A unique study by Weinberg and Tronick (1998) (cited in Beebe, 2003) evaluated the outcomes of an early intervention in which only the mother was treated. They documented by microanalysis that the infants were still in distress even though the mothers reported improvement. Suggesting that the dyad should be a focus of intervention, they noted that the infant is often the "forgotten patient".

Hofacker and Papousek (1998) argue that the infant's contribution to the mother-infant interaction is still poorly understood. They wonder if this is due to our greater ease with verbal than non verbal forms of communication.

My experience is that this is so.

Introducing psychotherapy trained psychiatrists to mother-infant interactions at St. Benedict's mother- baby unit I ask the trainees to observe the interaction between mothers and their infants on video. They are asked to think what it might be like for the baby in this interaction, this situation; what is the baby's experience, how do they think the baby is feeling; are the baby's needs being met?

The participants may give one or two comments about the baby but invariably there is lively discussion about the possible diagnosis of the mother based on her facial expression, her posture, her interactions with the baby, her vocalizations, until they are directed again to the experience of the baby.

Is it that in the clinical setting we are confronted and feel helpless when we observe the pain of the baby? Often the baby is experiencing intrusion, or being ignored; sometimes the baby actively avoids the parent or is vigilant of the parent. On other occasions the baby may give furtive glances in the direction of his mother.

Beebe (2003) summarized studies of early face to face interactions which analysed second-by-second contingency behaviour of gaze, face, orientation, touch and vocalization. Some studies have linked early interaction patterns to outcome variables but the work is still in progress and reliable norms are not available. Beebe describes behaviours for each of the items but stresses they are not prescriptive nor do they assume an optimal mode of interaction: "Ranges of 'normal' interaction are more ambiguous than extremes of difficulty" (p. 28). Some of the problematic patterns observed are used by all dyads at various times and are potentially adaptive solutions to the challenges of specific interactions.

To emphasize once again it is useful for us as clinicians, when observing a baby and her mother in a clinical setting to have a framework in which to observe the infant's response in the moments of interaction. The items of gaze, face, orientation, touch and vocalization provide the immediate picture while the synactive model gives a whole of organism framework.

I recommend the article by Beebe in the *Infant Mental Health Journal* for an understanding of the more optimal and less favourable behaviours for gaze, face, vocalization, management of infant distress and self-comfort on the part of the infant and the parent and how each adapts his behaviour to the other.

The baby and infant are constantly looking for emotional expression on the face of his mother or carer which creates a resonant emotional state in the infant. The responsiveness of the adult is the food of brain development, the laying down of pathways in particular areas of the brain (Schore, 1994).

Let me illustrate with another short film of interaction between mother and infant around a breast feed.

Video of mother and 5 week old infant

When observing an infant the task is to describe as completely as possible what is seen and then to allow one's thinking to develop. It is often our capacity to observe, reflect on and try and understand the baby's behaviour which will assist the parent to understand her own and her baby's feelings as they exist both internally and externally. As a thoughtful observer I model for the mother her own reflective observation of her baby.

Arietta Slade (2002) acknowledged the reflective process of Fraiberg's approach. As Fraiberg or one of her team listened to a young mother talk about her own experience of being mothered, they wondered together about mothering her own baby, present with them in the room. Fraiberg's therapeutic successes evolved with the mother's capacity to link her baby's experience with her own, that is, reflecting on her baby needing her and her mothering, just as she had needed to be mothered as a baby; her baby was separate to her. Fraiberg's framework was psychoanalytic, dynamic psychology. It linked the present with the past, and was reflective. Slade's (2002, p.13) perspective of developing maternal reflective capacities says it is the link between mental states, and between mental states and behaviour that is at the heart of healthy mother-child relatedness. Sometimes these connections develop through an examination of past-present links; at other times they may more simply arise through the process of reflection as it pertains to daily, relational experience, the mother reflecting on how her baby might be feeling in a particular situation.

Slade quotes Sally Provence's directive to parents: "Don't just do something. Stand there and pay attention. Your child is trying to tell you something". Slade believes helping parents to observe their child and learn to "read" their actions and words are at the heart of the reflective model and essential for healthy mother child relationship.

Is this part of modern new mothers' repertoire, to observe, and learn to read the actions of their baby? Can we still talk of the ordinary devoted mother?

The Ordinary Devoted Mother

Reading again the lectures and talks that Winnicott gave I was warmed by his simple principles of good parenting. He believed strongly in the "ordinary devoted good enough" mother who, if supported through pregnancy will have the capacity to hold her baby. The ordinary devoted good enough mother will have an intuitive knowledge that what her baby needs "is the simplest of all experiences, that based on contact without activity,….the feeling of oneness between two people where in fact there are two" (1988, p. 7). To just be with the baby, to endorse Sally Provence's words.

So what are the essential characteristics of the mothering of the "ordinary devoted good enough mother"?

- A supportive partner or supportive community environment through pregnancy and over the early months and years.
- "Holding" of the baby, and
- "Primary maternal preoccupation" which begins in the late stages of pregnancy and continues through the early days and weeks of the baby's life.

Winnicott (1988) said that these things give the baby the opportunity "to be" from which the infant becomes the self experiencing infant. The personality develops from the simple to the complex:

"At the beginning, however, it is the physical holding of the physical frame that provides the psychology that can be good or bad. Good holding and handling facilitates the maturational process and bad holding means repeatedly interrupting those processes because of the baby's reactions to failures of adaptation" (p. 62).

That is, if the new mother is struggling to adapt to the demands of her baby to be held and responded to in a consistent way, then the baby is unable to form a pattern of response.

Is it the primary preoccupation which allows the woman to intuitively mother, to be able to "hold" her baby? Winnicott stressed that the mother has to allow herself to experience this state of oneness with the baby.

In *The Magic Years* (1959) Selma Fraiberg gives a beautiful description of what is happening in the early days and weeks of the infant-mother relationship. I quote:

These first weeks are not entirely a time of darkness and primeval chaos. An invisible web is spun around the child and his mother that emanates from the mother and through which the most subtle impressions are transmitted to the child. And while the infant doesn't know his mother, can't recognise her on sight, he is receiving an infinite number of impressions through physical contact with her that gradually lead to the formation of his image of her. (Fraiberg, 1959, p.37)

Mahler like Winnicott, sees the intense involvement of the mother in these first few weeks as crucial to the psychological birth of the infant. I quote:

"....we believe the mothering partner's 'holding behaviour', her 'primary maternal preoccupation' in Winnicott's sense (1958a) is the symbiotic organiser - the midwife of individuation, of psychological birth (Mahler, Pine & Bergman, 1975, p. 47).

Winnicott (1988) identified that many women are afraid of being absorbed in the baby:

Many women fear this state and think it will turn them into vegetables, with the consequence that they hold on to the vestiges of a career like dear life, and never give themselves over even temporarily to a total involvement. (p. 94)

The new mother has to trust that her total preoccupation with her baby will pass.

If not supported, either by a partner or by community the mother is *left holding the baby literally* and the task of being at one with her baby is virtually impossible. As a community are we supporting the new mother in her preoccupation with her baby, in holding of her baby?

If the ordinary devoted mother is consistently available to her baby, the baby begins to assume that someone is there when needed and this is foundational for the baby's ego. However, there are situations where the baby does not experience enough physical holding to allow for the development of the personality. That is, some children are let down before damage to the personality can be avoided (1988, p. 9).

Winnicott (1988) also stressed that in time the baby needs the mother to fail to adapt to the infant's needs: "there is much satisfaction to be got from anger that does not go over to despair" (p.8). The baby needs to know he can express his anger and still be accepted. And mother needs to know that the time of utter dependence will pass.

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Surely our policies of encouraging new mothers to get back into the work force as quickly as possible are not supporting the early formation of the relationship. Should we be advocating for at least six months of maternity leave for all new mothers?

Winnicott was the advocate of the ordinary devoted mother supported by her partner, being the crucial factor in the healthy physical and psychological development of infants. He felt this needed to be owned and spoken about, that some of the failure in development was because of absence or 'failure of the ordinary devoted mother factor' at a certain point or over a certain period. He felt we had to be able to acknowledge causal significance but not blame.

Winnicott (1988) argued, if we don't acknowledge where the deficiency is, then we can't recognize "the positive value of the orginary devoted mother factor" (p.9). That is, it is of vital necessity, for every baby, that there is someone, some other, for the healthy development of the infant, neurologically, physically, cognitively, emotionally and psychologically.

This is a very important principle for Winnicott (1964):

I am trying to draw attention to the immense contribution to the individual and to society which the ordinary good mother with her husband in support makes at the beginning, and which she does simply through being devoted to her infant. (p.10)

Winnicott wondered if the contribution of mothers was not acknowledged, because it was so immense? If we acknowledge it, "it follows that we all feel a debt to our mothers – everyone who is sane, everyone who feels himself to be a person in the world and for whom the world means something, every happy person is in infinite devt to a woman…in our infancy we were absolutely dependent (p. 10). Winnicott (1964) argued that with an acknowledgement of this dependence within ourselves will come a lessening of a fear which allows ease and complete health to flourish: "If there is no true recognition of the mother's part then there must remain a vague fear of dependence" (p.10). He explained that the fear may take

the form of fear of women in general, or a particular woman or other less recognized forms but always a fear of domination (p.10).

Let us focus on the new generation of young mothers; the young women who have been educated and expect to share the parenting role with their partners as many of them have been together for some years and have shared domestic responsibilities and work load before having a baby. When the baby comes, suddenly they are the one at home with the baby, cut off from their friends and network. They are also the ones to have the broken nights and feel exhausted. Without income there is a sense of dependence on their partner and the partner's potential domination. Do these new generation young mothers feel honoured by society in their role as ordinary devoted mothers? I think not. Society pressures them to return to work as quickly as possible and their fear of not keeping up with their peers, added to the fear of being lost in preoccupation with the baby, is a strong impetus to return to the workforce and to hand the baby over to others.

As advocates and a voice for the infants we need to speak up in support of the important work a woman is doing in being the ordinary devoted mother to her new baby.

Winnicott (1964, p. 86) spoke of the ordinary mother taking care of her baby, being thoughtful of her handling of her baby because of her love; because of maternal feelings which have developed in her, and a deep understanding of baby's needs. Most women who become mothers, want to be mothers, they want to be good mothers but just what does that mean to the new mother in 2014.

Here are my suggestions to "an ordinary devoted mother":

- Be sure of a supportive partner or community support through the pregnancy and early days and weeks of the baby's life.

- Tune in to your body as it prepares for the birth; the physical and hormonal changes which are happening.

- Allow yourself to be preoccupied with the potential new person in the last weeks of pregnancy and early days and weeks of baby's life, assured that this time of preoccupation will pass.

- Own the overwhelming sense of love for this new little person unashamedly whether it hits like a wave of emotion at the time of birth or creeps up slowly.

- Delight in the miracle of the birth of a human being.

As professionals let us acknowledge above all the importance of love as the emotion which makes good enough parenting possible.

We have to be more outspoken about love so women will allow themselves to be 'irrationally in love" and at home with their babies, supported by their partners for the early months. Two recent quotes on the importance of love in psychological understanding come to mind.

A listener (21.7.2014) phoned in after listening to an ABC program which acknowledged emotions as crucial in cognitive learning, said;

"We hear about people who are good with their hands, or good with the heads, but don't hear about people who are good with their hearts."

Again, (5.5.2014) in an interview on the ABC Radio National program, 'All in the Mind,' Professor Dadds of the University of New South Wales, said, "In Psychology we talk about teaching, rewarding, praising children, but we do not talk about Love".

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Finally, as advocates for babies and mothers, we have to become more politically active.

- Let us be open in our belief that love is what makes parenting possible or, as my son says when he is trying to help teachers understand children's difficult behaviour, 'It is all about relationship".

- Let us be outspoken for parental leave for all mothers for at least 6 if not 12 months, with a guarantee that their employment will be there for them on their return, as happens in some European countries.

- Let us speak for babies and parents wherever we see the need and are prompted to respond.

I guess this is why, in 1988, it was so important to a little group of us to create our own Australian Association for Infant Mental Health. Thank you.

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