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In this issue

Guidelines for contributors

AAIMHI aims to publish quarterly editions in March, June, September and December. Contributions to the newsletter are invited on any matter of interest to the members of AAIMHI.

Referenced works should follow the guidelines provided by the APA Publication Manual 4th Edition.

All submissions are sub-edited to newsletter standards.

Articles are accepted preferably as Word documents sent electronically.

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Opinions expressed in this newsletter are not necessarily those held by AAIMHI.

Being there: The 'something more' that the infant brings to the therapeutic process

Frances Thomson Salo and Campbell Paul

An earlier version of this paper was presented at the 2009 annual AAIMH/Marcé conference in Melbourne, and we acknowledge the contribution of the audience discussion. Identifying case material has been omitted.

Abstract

What the infant brings to therapy may not have been emphasised enough in previous writings about the Royal Children's Hospital (RCH) approach. It is sometimes hard to be specific about the infant's part in the therapeutic encounter, so that the infant's active contribution may not have been described adequately. In the RCH approach the central therapeutic mechanism is thought to lie in trying to understand with the parents the infant's experience from the infant's perspective, if appropriate through interaction with the infant, and in doing so modulating the representations of both parents and infant. Campbell Paul in 1999 described 'the infant as therapist' and we'll explore what the infant contributes to the process, even tiny infants, including those who seem to be at risk of developing an insecure attachment. We highlight six elements – a sense of immediacy that infants bring, their positive and negative emotions and moral feelings, their wish to know and be known in an experience that feels truthful and their willingness to take a risk in order to have an experience of a whole uninterrupted process.

Introduction

While we are committed to the centrality of the infant's place in the parent-infant therapeutic encounter, it is possible that we have not emphasised enough what the infant brings to therapy in previous writings about the Royal Children's Hospital approach. Much of the literature describes the infant's emotional and cognitive capacities and these are outlined particularly evocatively by Trevarthen (2001). He pointed to a number of traits in normal development such as motives for companionship, and we are interested in their role in the therapeutic encounter. We think that, particularly as it is hard for a number of reasons to be aware of and delineate the infant's contribution, the ways

Continued on page 2

in which the infant actively contributes may not have been described adequately.

Observing the infant and bringing these observations to the parents' attention can be an important component of the work. In the RCH approach, however, a central therapeutic mechanism lies in trying to understand with the parents the infant's experience from the infant's perspective and conveying to the parents and the infant something of our understanding that the infant has a mind of their own, with their own history and experience (Thomson Salo, 2007). In no way is this to disempower the parents. On the contrary we think it 'gives' them back their infant, as it were, making them more fully the parent of their infant. Engaging in interaction with the infant tries to bring about change to the parents' models more quickly, rather than showing the parents how to interact. If a mother were to say for example, "Why does my infant talk to you and not to me?", this could start a dialogue in a potentially helpful way about why her infant does this.

Campbell Paul in 1999 described the 'infant as therapist' - and we'll explore what the infant contributes, even tiny infants, and those who seem to be at risk of developing an insecure attachment. We take for granted the infant's average expectable endowment of the capacity to communicate from birth, including triadic intersubjective communication, their personality traits and resilience. And we think that the mirror neurons which may be online from birth facilitate the infant responding to the clinician's empathy and pleasure in the encounter. We highlight six elements: the sense of immediacy that the infant brings, their positive and negative emotions, their moral feelings, their wish to know and be known in a truthful experience and lastly, their wish to be creative and 'alive', to have the experience of a whole uninterrupted process, and their willingness to take a risk in order to achieve this.

We are aware that there are different cultural perspectives but in this brief paper based on observations from clinical practice, we cannot do justice to them. Our ideas link with the work of the Boston Process of Change Study Group (Stern et al. 1998) whose members suggested that much of what brings lasting therapeutic effect results from changes in the intersubjective relational procedural domain. This comprises intersubjective moments that can reorganise the patient's implicit procedural knowledge, the ways-of-being with others - that is, powerful therapeutic action occurs within implicit relational knowledge.

1. Immediacy and urgency

The infant being present in the therapy means that there is an infant who responds without too much filtering and defensiveness and who in turn expects a response from the clinician, bringing a sense of immediacy to the encounter. Not to respond is to confound the infant's expectations. *A general practitioner described her sense that even for 6-week-old infants present in a consultation, it really mattered to them how she responded to their mothers' emotions.*

There is an element of surprise in that in consultations we too do not know what will happen next or the outcome of the encounter. A 6-month-old girl, who had looked intently at a clinician as she talked, could be seen on video nodding her head after something the clinician said.

The father of a boy who was about 7 months old would, as the clinician was talking, look at his infant and ask him, 'Are you listening?' and sometimes the infant took the dummy out as if to listen to the clinician.

Infants might also bring a sense of urgency.

A premature boy, 1-month corrected age, sucked on his mother's neck and blouse while she was talking to a clinician about his feeding difficulties which allowed her to see him in a new light as wanting to feed.

2. Wish to know and be known in an experience that feels truthful

We think the infant's wish to know and be known in a truthful experience is more than the infant's processing and regulatory capacities - infants wish to understand and be understood. They are primed to communicate from birth. One observer commented that a 13-week-old girl knew the observer was interested in her.

Sometimes infants lock on with their eyes, as a 7-month-old boy did for 45 seconds the first time he met Frances.

We think that when infants are in the presence of an empathic therapist who is trying to understand their experience, they sense this and it brings containment and relief. The infant looks deeply for a response from the clinician, whose reciprocal communication may be by gaze alone. We see infants looking at the clinician in such an attentive way, with a heightened intersubjective alertness, that they can only be described as being aware that an emotionally meaningful experience is taking place. We think infants are at some level aware of the resonances in the therapist's mind, however faintly they perceive this when very young. While infants sometimes gaze in a teasing or coy or self protecting way, when they gaze for a long time, we think that they want only to know whether the other is available for interaction. This might overlap with the infant's drive towards a true self (Winnicott, 1960). Dan Siegel in *The developing mind* (1999) described infants as born with 'cheater detectors (p 329)' which he felt enabled them to sense authenticity in other people's communication with them or when it was confusing or deceitful. We think that infants bring out an honest response in themselves, and in ourselves.

Continued on page 3

A clinician was recapitulating to the parents of a 15-month-old infant, 'You're doing this and the infant says no'. At one point, when the clinician repeated the word 'no', the infant echoed it saying 'no'.

A 2-year-old boy present when his mother saw Campbell pointed at pictures in a book, and when Campbell asked him, "Who is there?' tapped himself on the chest to show Campbell that he was there. Campbell felt this was a useful communication to him - and to his mother who was very anxious.

3. The infant's positive emotions

We have in mind enjoyment, playfulness and humour. Infants wish to be enjoyed from birth - then they feel understood, meaningful and valued. Their enjoyment of interaction – including joking and teasing - is not passive, they search for it in interaction, and when they achieve it, they feel safe and happy; the world takes on more meaning, they begin to feel some hope and develop more sense of themselves. As Trevarthen said (1996 pers. comm.) when play gets going, things move quickly. Infants bring their potential for playfulness and for humour to the therapeutic encounter. The infant wants fun with another and brings the wish for fun because playfulness is their language and as their sense of self increases, their anxiety decreases.

A 7-month-old boy who constantly held his arms self protectively outstretched at right angles was able in playful interaction to mouth Campbell's fingers which meant he could relax his arms. Campbell was building on a tiny positive action that the boy could do with his own hands so that his mother could see him in a different light.

Playful teasing builds the infant's sense of enjoyment. Infants know the 'rules' and vary them on their own initiative to get a rise. When they join in teasing with the clinician, their parents may 'see' a completely different infant.

A sick infant girl in hospital, when offered her bottle, would only open her mouth the fourth time it was offered - refusing the bottle was her way to see if she was alive and interacting, even while she had initially to refuse overtures.

When a 15-month-old boy presented with poor feeding, falling away on the growth percentile, appeared depressed and to have absolutely no desire to eat or be independent, the clinicians worked to rekindle his vitality affects (Stern, 1985). This led to an enlivening of his desire and he gave one clinician a kiss - hopefulness reappeared with his mother and his eating improved.

4. The infant's moral feelings

We have in mind generosity and forgiveness. Trevarthen (2004) views the development of the moral feelings of infants as starting quite early. Infants can often seem to be generous in the way they offer food to parents or clinician, sometimes seeming quite caring, even at some cost to themselves by putting the other first.

How does an infant forgive? (Perhaps if we think of the biology of attachment we may ask, can an infant not forgive?) We stress the infant's capacity to forgive and move forward when he or she has felt hurt or saddened by the parents' withdrawal or sarcasm. We see this as an active process, not the infant just forgetting - and a kind of generosity on the infant's part.

5. The infant's negative emotions

Ben Bradley in *Visions of infancy* (1989) alerted us to an infant's negative emotions that are often not acknowledged enough. Secure infants around seven months of age can show an unconflicted expression of anger when frustrated - we can think of the infant's 'no' in communication that Spitz (1957) identified. Infants do not hide their rage and destructiveness, unless they have learnt to do so self-protectively. When the infant can harness this, it contributes to their drive towards activity and sublimation. The infant's teasing may be a safe expression of aggression and gaze aversion may be an expression of negative emotion.

We are not sure exactly what the infant's rage or destructiveness adds to the therapeutic process but the capacity to protest does seem important. The infant is asserting that something is not quite right, which means they have not given up hope. It is also very striking how the infant's protest is almost guaranteed to evoke a smile as the clinician identifies with and welcomes the infant's protest - and the infant in 'reading' this may feel a little buoyed up by a positive response from an environment that may have previously seemed somewhat negative. Perhaps the infant's negative emotions sometimes mean that he or she is not what they see in their parents' eyes. We respect when the infant turns away and we would nevertheless gently 'pursue' as we think that at some level they want to be found.

6. The infant's drive towards wholeness and creativity

This might be thought of as a higher level process. We see the infant as having the wish to be free of the inhibitions that interfere with expressing their creativity, to be 'alive' and vital. This is likely to link with Winnicott's idea of the importance for the infant of having a whole or completed process, which seems more than the concept of development unfolding in the child.

Willingness to enter the process and to take a risk

We follow Trevarthen (2001) in thinking that most infants thrive on experiencing what is new and often experiment with taking a risk. Extending this to the therapeutic situation,

Continued on page 4

we can see how often even the first time an infant meets us, there is a sense that they are open to the possibility that something might emerge from the experience. Winnicott (1971) suggested that when things are not going well for an infant, the infant looks around for what he or she might be able to take in. Even infants with an insecure attachment, whom you might think would not easily trust a stranger at the first encounter, are often courageous in being prepared in taking this risk. And those infants who are depressed and appear sullen are sometimes not so far from being able to rekindle hope if they sense someone reaching out to engage with them.

Capacity to pace his or her engagement

Sometimes, as if to allow the parent the chance to have some time with the clinician, the infant seems to become less demanding. This is similar to Winnicott's (1958) concept of the infant's capacity to play alone in the presence of the other but seems to go further.

In conclusion, another way of looking at what we have said is to see the infant and the therapist as together forming a subversive pair - and the infant might take the subversiveness back into the relationship with the parents.

With a toddler whose mother was anxious that she was autistic, Campbell pretended to take the teapot lid off which she did not want him to; he then popped something inside that did not belong - a teacup. But she coped, smiled at him for the first time making eye contact and engaged in a game.

The mother can see herself differently in the infant's eyes once the clinician has helped bring about change and the infant changes things too.

We are interested in a dialogue about what else the infant brings to therapy.

Acknowledgements

We gratefully acknowledge the contribution of our patients, and also of colleagues, particularly Kerry Connelly, Susan Davidson, Candice Franich-Ray, Brigid Jordan and Susan Morse.

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NOTICE

ACT and WA will be hosting the first trainings available outside the US for the newly developed Circle of Security Parenting (DVD based) program. The dates are May 25-28th for Perth and June 2-5th for Canberra. Full details of the training and the scope of the program and its application and how to register are available on the Circle of Security website: www.circleofsecurity.org

Registrations are done directly through Circle of Security in the US. Early Bird and group rates are available. In the ACT, Marymead Child and Family Centre will be the sponsoring organisation. Glen Cooper will be presenting the training and it is expected that the DVD will have an Australian voiceover in time for the Australian training. This is being done here in Canberra at present.

For further information re the Canberra training contact Anna.Huber@marymead.org.au

AAIMHI and Marcé Joint Conference

University of Melbourne

1 - 3 October 2009

The infant, the family, and the modern world: Intervening to promote healthy relationships

The 2009 Conference was an initiative of the Victorian branch of AAIMHI and the Australasian Marcé Society. The Conference Organiser was chosen, after a tender process, by the Organizing Committee to manage the conference. Ellen Berah, director of The Conference Organiser, kept a firm hand on time-lines and other organizational matters, and kindly provided a place for the Organizing Committee to meet.

The task for the two organizations was to devise a program that encouraged presenters to bring their research, knowledge and experience of babies, mothers, fathers and significant others together in a constructive and creative way. The Organizing Committee, with representatives from both organizations, worked hard to create a program where a range of voices could be heard. This resulted in a rich, varied, and very full three days, extended by pre and post conference workshops.

The invited speakers included Kathryn Abel, Bryanne Barnett, Lynn Barnett, Ben Bradley, Lynn Gillam, Sarah Landy, Helen Milroy, Louise Newman, Kevin Nugent, and JoAnn Robinson. These national and international speakers were both thoughtful and thought-provoking and brought with them a generosity of spirit that permeated the rest of the conference.

The social program included a performance of "The Spare Room" written by Joanna Murray-Smith, a book launch of "Motherlode: Australian Women's Poetry, 1986-2008", edited by Jennifer Harrison and Kate Waterhouse, and a poetry reading by Jennifer Harrison and Gita Mammen. Those who attended the conference dinner were charmed by the inventive music-making of the performance group "Hark" and enlightened by the after-dinner speech by Ann Manne.

"Gestate", an exhibition of contemporary art works by Sophia Xeros-Constantinidis was on display throughout the conference, prompting us visually (and viscerally) to look and think with new eyes and new thoughts.

There were 510 registrants but, unfortunately, only about 50 completed evaluation forms. Some suggestions included: allowing more time between sessions, fewer concurrent sessions, more seating be made available at lunchtime, better sign-posting, and more international speakers.

The sponsors of the conference were: the Victorian Government Department of Health, BeyondBlue, St. John of God Health Care, and Springer Publishing. The conference budget was carefully managed resulting in a moderate profit for both organizations.

While many consider financial profit a sign of a successful conference one can also, and perhaps just as importantly, look to the less quantifiable 'felt' experience of participants. I was approached both during and after the conference by many people I did not know, spontaneously expressing their appreciation/enjoyment/surprise of various aspects of the program. Particular thanks are due to Campbell Paul and Jane Fisher who, as co-conveners, supported the Organizing Committee to contain the conference, so that participants might value experience over mere attendance.

Christine Hill

Member of the Conference Organizing Committee
AAIMH (Vic) Scientific Meeting Co-ordinator

STATE REPORT - VIC

After many years of generous service to the AAIMHI (Vic) Committee, Dr. Ann Morgan retired from her position as Honorary Vice President. The last Scientific Meeting for 2009 was held as a tribute to her and her contribution to Infant Mental Health, with case presentations reflecting the far reaching influence of her guidance and thinking over the years.

Sue Morse took us on an animated journey from memories in Wales to mealtimes in MacDonalds with her creative and thoughtful presentation of a young family's journey following trauma while Frances Thomson-Salo's vignettes raised some thought-provoking questions around the experience and ethics of Infant Observation. (This topic will be further explored later in the year at a Saturday morning

A wonderful morning of discussion and reflection concluded with the announcement of the establishment of the Ann Morgan Prize, an annual cash prize for an essay on the topic of the subjective world of the infant, with oral presentation of the winning essay at AAIMHI Victoria's AGM.

The AAIMHI/Marcé Joint conference in Melbourne in October 2009 was a very thoughtful blend of academic, social and artistic programs and was very well attended with over 500 participants. Congratulations to the organizing committee for their hard work and perseverance!

Planning is underway for the quarterly scientific meetings being held on Saturday mornings, a format which has proved very popular with members, with the first meeting to be held … date to be announced soon!

Australian Association for Infant Mental Health Inc. Victorian Branch

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WORLD ASSOCIATION FOR
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Ann Morgan Prize 2010
Invitation to Submit

As a creative pioneer in the field of infant mental health, Doctor Ann Morgan has provided immense support and leadership for those working with troubled infants and their families. She has been a passionate advocate for infants and parents, providing transformational interventions for them and inspiration for her colleagues.

In order to honour her contribution to the infant mental health field, AAIMHI Victoria has inaugurated an annual essay prize. AAIMHI Victoria seeks submissions, from any member of the Australian association for infant mental health, of an essay on the topic of the subjective worlds of the infant. The essay should make a significant contribution to our understanding of the inner world, and the relational world of the infant and very young child.

The Prize
Cash prize of AU$1000

Oral presentation of winning essay at AAIMHI Victoria's AGM on 28 August 2010

Publication in ***AAIMHI Newsletter.***

The Prize committee will facilitate publication in WAIMH's newsletter ***The Signal***

Jury
All submitted essays that qualify (see conditions) will be evaluated by a panel of at least three judges including an AAIMHI Vic committee member and a literary representative. The Jury will award the prize in the light of the contribution that the essay makes to our understanding of the social and emotional world of the infant. The decision of the Jury will be final. There is only one prize per year and the Jury reserves the right to award no prize if submitted material is not of an appropriate standard.

Entry
Dr Julie Stone will administrate the 2010 Ann Morgan Prize. Papers must be submitted by e-mail to **prize@jolpet.com**. Please write *Ann Morgan Prize* in the subject line. Essay should be in the form of a double spaced word document attached to the email and modified for blind review (title and essay only with no name or identifying information). Please include in the body of your email your name, phone number, email, and the title of your essay. The winner of the prize will be announced on the ***AAIMHI*** website (www.aaimhi.org) and contacted personally.

Terms and conditions of entry:

1. Entries must be current financial AAIMHI members
2. An original single-authored essay in English with a maximum of 3000 words.
3. Entries must not be previously published or be on offer to any other publication or prize.
4. The name or work place of the essayist must not appear on the essay.
5. Essays will be judged anonymously.
6. Entries must be non-defamatory and must not infringe people's privacy or intellectual property.
7. The judges' decision will be final. No correspondence will be entered into.
8. **The closing date will be 30 June 2010** and late entries will not be accepted.
9. AAIMHI Victoria will announce the result in August 2010.
10. The winning author will read his/her essay at AAIMHI Victoria's 2010 AGM on 28 August 2010.
11. The winning author will be expected to self-fund his/her travel to the Victorian AGM.
12. AAIMHI will publish the winning essay in the September newsletter.
13. AAIMHI Victorian committee will assist winner to offer the essay for publication in the Signal.
14. AAIMHI Victoria intends to periodically publish a collection of winning and highly recommended essays in a stand alone publication.
15. Entrants receiving Highly Commended may be asked to read his/her essay at the AAIMHI Vic AGM in addition to possible publication.

FUTURE EVENTS

Please reserve the following dates for your diaries!

PERTH: **May 11-14, 2011**

Advance notice of combined AAIMHI/ Faculty of Child & Adolescent Psychiatry Conference 2011

'Growing up solid: Integrating emotional and mental health throughout infancy, childhood and adolescence'

Confirmed speakers:

Dr Karlen Lyons-Ruth is the author of more than 70 research articles and book chapters on infant development, maternal depression, the early attachment relationship, and, more recently, the interplay between genetic and environmental factors in young adult psychopathology. Her work has focused on the assessment of attachment relationships in high-risk environments over the infancy, childhood, and adolescent periods. A **pre-conference workshop** will be held, providing training in the attachment-focused AMBIANCE coding system developed in Dr Lyons–Ruth's lab which qualifies atypical parent-infant interaction.

Dr Astrid Berg works as a Child Psychiatrist at the Red Cross Children's Hospital in Cape Town and is a senior consultant in the Department of Psychiatry at the University of Cape Town. Her main interest is in Infant Mental Health, and she has established a Parent-Infant Mental Health Service under the auspices of the University of Cape Town. Dr Berg is very active in promoting the mental health needs of infants from different cultures and brings a Jungian perspective to her work in creating intervention programs.

Dr Michelle Sleed is a Senior Researcher at the Anna Freud Centre, collaborating with Peter Fonagy, Mary Target, Tessa Baradon, and is involved in multiple research projects on the effectiveness of parent-infant psychotherapy. Dr Sleed works closely with Arietta Slade in the use of the Parent Development Interview (PDI), and will provide training in the PDI in a **post-conference** workshop.

Professor Robin Murray is professor of psychiatry at the Institute of Psychiatry at Maudsley Hospital, Kings College, and University of London; and consultant psychiatrist at the Maudsley. Murray's research interests range widely, but he is perhaps best known for helping establish the neurodevelopmental hypothesis of schizophrenia and for identifying environmental risk factors for schizophrenia such as obstetric events and cannabis use. At the Psychosis Research Group, the largest of its kind at any center outside the U.S., Murray oversees a group of more than 100 researchers working in epidemiology, molecular genetics, neuropsychiatry, neuroimaging, neurodevelopment, neuropharmacology and related fields.

Shaun Tan, a local illustrator and author of award winning children's books, will be speaking about his creative process. Read the "The Red Tree", "The lost thing" and "The arrival" to appreciate his wonderful talent and capacity to convey the inner world in his work.

The conveners look forward to seeing you all in Perth in May 2011. As places for the following workshops are very limited, please register your interest for these by contacting Caroline Goossens (Caroline.Goossens@health.wa.gov.au) or Lynn Priddis (l.priddis@curtin.edu.au).