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

All submissions are sub-edited to newsletter standards.

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Continuity and hope: Sustaining a valued mother-baby group within a small perinatal psychiatry service

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In this article we reflect on the organisational and clinician commitment involved in sustaining a mother-baby group for over six years, in a small perinatal psychiatry service located within a child and adolescent health service in regional New South Wales. This has been enabled through the involvement of a series of health and allied health practitioners with Kathryn Thornton (KT) since its beginning. There are challenges and rewards in regularly starting work with a new co-therapist, for both the 'anchor' therapist (KT) and the new therapist. This article describes the group itself, reflects on our experience of working together as co-therapists of the mother-baby group, and elaborates on some of the parallels we identified in the developing relationship both between ourselves and between the mothers and babies.

The importance of an infant's first relationship, which is usually with its mother, is well documented (Cozolino, 2006; Mares, Newman, Warren & Cornish, 2005; Bowlby, 1969). This relationship provides a template or working model for future relationships and the quality of the relationship can have long term implications for the infant **(**Cozolino, 2006; Liotti, 2004; Siegel, 2001). Unfortunately, for mothers who experience mental health issues and/or have a background of trauma or neglect, their capacity to be available and responsive to their infants may be compromised. This in turn impacts on the quality of their relationship with their infant. Such mothers often find community playgroups daunting. Some who attempt to attend these groups feel that all mothers, except themselves, are coping and revelling in the role of parent and they do not feel free to discuss their challenges and battles.

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The need to provide support to mother-baby dyads who are experiencing difficulty is well recognized, with a range of individual and group programs being developed (see Sameroff, McDonough & Rosenblum, 2005; Zeanah, 2009) including the PAIRS program developed in Australia (Smith, Cumming & Xeros-Constantinides, 2010). Responding to this documented and observed need, a mother-baby group was established within the Perinatal Psychiatry Service. Together the authors co-facilitated this group for one term in 2011 which led to discussion and reflection on how the group has been sustained over this time. It also led to reflections on how two clinicians who have not previously worked together can join to provide a safe and secure environment for mothers with mental illness and their infants to meet each week and explore their relationship issues.

The mother-baby group has been sustained for six years due to the support and goodwill of both management and clinicians across the CAHMS teams. The Perinatal Psychiatry Service was at the time a small service with a fulltime equivalent staff of two. The part time psychologist on the team (KT) started the group, and apart from a couple of periods of leave has been the constant facilitator of the group. Over the years she has relied on either psychiatry registrars on placement, or members of the broader CAMHS team to co-facilitate. All CAMHS staff who volunteered to participate have done so as an additional role. Staff have been motivated by their knowledge of the importance of early intervention and the sense of urgency invoked by the vulnerability of mothers with mental health issues and their infants. It was in this context that Vicki Cowling (VC) became involved.

Group purpose and structure

The primary aim of the group is to enhance the relationship between mothers with mental health issues and their infants through providing a safe environment that provides containment and support for both mother and infant. The group provides a therapeutic setting and holding environment characterized by consistency, warmth, empathy, respect and a non-judgmental stance, in which mothers are free to explore their relationship with their infant. The group is psychodynamic in nature; however educational input occurs as opportunities arise. Attachment theory provides the theoretical underpinning for the group, and behaviour is interpreted from a developmental perspective.

Potential participants are identified by staff in the Perinatal Team, mental health teams, Family Care Cottages, and private psychiatrists. The group is an ongoing group that occurs four times a year in series of 9 to10 sessions. New participants start at the beginning of each series. Infants in the group range from a few weeks of age to 12 months. Mothers initially commit to one series but are able to continue attending until their infant is 12 months old. The group is restricted to a maximum of six mother-infant dyads, runs for approximately two hours and is facilitated by two therapists. Morning tea**,** consisting of fruit juice (no hot liquids), fresh fruit and cake/muffins is provided for the mothers. Mothers cater for their infant's needs during the session, i.e. provide bottles or food. There is no charge for attending the group.

In the initial session the aim of the group is discussed, group rules formulated and issues related to confidentiality raised. Participants are encouraged to identify what they are hoping to achieve by attending the group. This is followed by parents sharing how they chose their infant's name which can lead to the ready identification of 'ghosts' or 'angels' in the mother's life. This session is devoted to forming connections between participants through discussion of the challenges that parenting presents.

At the beginning of each subsequent session each mother is invited to stand in the 'shoes' of her infant, and tell the group what the week has been like from her baby's perspective. Material for the session may arise from this introduction, from responses to the question, "How has your infant changed in the last week, and what challenges has that presented for you?", or from situations that occur during the session, such as a baby becoming distressed or a mother experiencing difficulty settling or feeding her infant.

Each week, before the group, we met to discuss issues arising in the group the previous week that we needed to respond to, to exchange relevant information about families that may have been received during the week, and to discuss implications for the group dynamic when one or more families had indicated that they would not be attending. Following the group we spent time reflecting on what occurred in the group, both for us and for the mothers and babies. We processed our reactions and responses to situations. We also discussed each mother and baby dyad. We noted changes that were occurring, difficulties they were experiencing, and how the group had reacted to the dyad.

The group process is powerful. The credibility of other mothers who are experiencing similar situations outweighs that of the clinicians. The empathy they are able to provide, and the understanding of each others' struggles provides hope to the participants, especially when someone with an older baby relates their struggle, what they have done, and how things have improved for them.

The group provides a time for parents, free from distractions, to be available to and focused on their infants. Hearing a range of experiences from other participants or therapists helps parents to think about what their infant

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may be experiencing, and offers other ways of understanding their baby's behaviour, which can enhance a mother's reflective functioning.

The group also provides the infant with a range of people with whom they can relate and who can show interest in them and 'delight' in them (Powell et al., 2009). Babies struggling in their relationship with their mother can often use another mother or therapist to gain validation of their worth. Babies can be seen to come alive and at times make rapid development.

Developing a working relationship

In response to an invitation from KT to CAMHS clinicians, VC volunteered to work with KT as co-therapist. While we had not previously worked together, we were familiar with and respected each other's clinical, professional and educational roles as we had for some time occupied adjoining offices and had regular exchanges. The clinical base we both brought to our relationship was an in-depth knowledge of child development and attachment theory, the completion of year-long weekly infant observations with supervision, and a shared recognition of the importance of an infant's early relationship on subsequent development. We both had a desire to lessen the adverse outcomes for infants, build each mother's capacity to meet her infant's needs, and to enhance each mother's capacity to reflect on her relationship with her baby.

For KT, the desire to sustain the group, and consequently the need to involve a number of other clinicians over the years, has brought a range of challenges including adapting to the differences in style and understandings that others bring. In addition there has been, and continues to be, the constant challenge not to view the group as 'her' group and to ensure that the co-therapist feels some ownership for the group and an equal partner in the process. The challenge for VC was joining an existing group to work with someone who had delivered the group for some years.

The therapeutic process

In a number of ways the development of our relationship paralleled that of the mothers. Just as the mothers were getting to know their infants so too were we getting to know each other. Not having worked together before we had to tolerate uncertainty, not knowing exactly what the other would bring to the group or how the other would respond in particular situations. This paralleled the space the mothers found themselves in, at times uncertain why their infants were behaving in the way they were, what was needed, or how to comfort them when distressed.

To work effectively together we needed to have a respectful relationship, one where each of our contributions was valued and where support could be offered and accepted when needed. We needed to trust each other and feel safe enough in our relationship to expose our clinical work. We needed to recognize that our different backgrounds (KT as a teacher and psychologist and VC as a social worker and psychologist) would impact on how we reacted in some situations and we needed to value this and see these differences as strengths. Our differences allowed participants the opportunity to view issues from a range of perspectives and formulate an understanding that made sense to them, and allowed them to make changes in their relationship with their infant. It was important for mothers to develop a relationship with their infant that had respect as its foundation. Their infants needed to feel safe in their relationship knowing that their distress could be tolerated, their needs responded to and their contributions to the relationship valued. They needed to know that they could be 'delighted in' and supported.

Reciprocity is also an important component of functional relationships. We needed to learn when to take the lead in the group, and when to follow the other clinician. In the same way parents needed to learn when to 'take charge' in their relationship with their infant and when to 'follow' their infant's cues (Powell et al., 2009).

Supervision

In external supervision at the end of the group we were able to reflect on our role in assisting parents to see their baby as a person, to see that the baby wants to matter as an individual, and to help them to find a way to enjoy their baby. It affirmed the importance of our role in providing to parents consistency, warmth and a non-judgmental stance, enabling mothers through reflection to step into a 'new space' in their relationship with their baby.

Conclusion

The mother-baby group is a very important part of the Perinatal Psychiatry Service within the Child and Adolescent Mental Health Service, with significant changes in the quality of relationships between mothers and babies being observed. Our experience has demonstrated that it is possible for a mother-baby group to be sustained in a small service. Essential factors that we believe contribute to this are commitment at a broader service level to the importance and value of the group and support from management which allowed CAHMS staff to devote time to the group. We believe that for facilitators to work effectively together they need to respect and trust each other in the context of providing a therapeutic group, share an in depth knowledge of early child development, attachment theory and the effects of mental illness symptoms and treatment on parenting, and believe in the power of the group process.

References

Bowlby J (1969). *Attachment and loss Volume 1*. London: Hogarth Press.

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Cozolino L (2006).*The neuroscience of human relationships: Attachment and the developing brain.* New York: W.W. Norton & Company.

Liotti G (2004). Trauma, Dissociation, and Disorganized Attachment: Three Strands of a Single Braid. *Psychotherapy: Theory, research, practice, training*. 41, 472-486.

Mares S, Newman L, Warren B & Cornish K (2005). *Clinical skills in infant mental health.* Australia: ACER Press.

Powell B, Cooper G, Hoffman K & Marvin R. (2009). The Circle of Security. In: CH Zeanah, *Handbook of infant mental health* (3rd ed.) (pp. 450-467). New York: Guilford Press.

Sameroff AJ, McDonough SC & Rosenblum KL (2005).*Treating parent-infant relationship problems: Strategies for intervention.* New York: Guilford Press.

Siegel DJ (2001). Toward an interpersonal neurobiology of the developing mind: Attachment relationships, "mindsight," and neural integration. *Infant Mental Health Journal*. 22, 67-94.

Smith JC, Cumming A & Xeros-Constantinides S (2010). A decade of parent and infant relationship support group therapy programs. *International Journal of Group Psychotherapy*. 60, 59-89.

Zeanah CH (2009). *Handbook of infant mental health* (3rd Ed.).New York: Guildford Press.

Taking the time to take turns: a baby's need in interaction

Frances Thomson Salo and Campbell Paul

We want to elaborate a point in F Thomson Salo's paper (2011) about engaging with an infant, adding the importance of taking time in interaction, that a baby needs time for their response to be listened to. When we engage with an infant, it needs to be reciprocal and not an interpretation or intervention without space. For contingent reciprocating behaviours it is important that the therapist, like the parents, use language that is appropriate and allow adequate silences between interactions. Winnicott (1941 p 246) wrote, "What there is of therapeutics in this work lies, I think, in the fact that the full course of an experience is allowed."

Thomson Salo (2011) had suggested a spectrum of ways of engaging with the infant, from:

1. Less direct which largely impact on the mother's behaviour (modelling, speaking for the baby and maternal soothing gestures),

2. Interpretations to the infant at an adult level which may be to soften an interpretation meant for the mother and where the port of entry will largely be the mother's representations,

3. Respectful engagement with the infant in the parents' presence to understand the meaning of the infant's experience, where the port of entry is likely to be the baby's representations.

Salomonsson (2011, p 605) in his recent paper in the *Infant Mental Health Journal* suggested in a mother-infant therapy session that a 3- month-old girl, Frida, calmed down because, in what he called the 'infant address', she detected that he processed his anxiety in his unconscious countertransference in a way similar to the music of motherese when it 'holds' a baby - the 'music of containment' of his article as opposed to the more usual emphasis on the auditory channels of containment.

We agree that as Salomonsson became less anxious as the session proceeded and felt he had some understanding of the dynamics, Frida felt 'held'. Frida had been somewhat engaged though often looked away from him when he talked to her and then seemed to settle with the interpretive work he did with her mother. Her mother found it containing to work through her feelings of anger and revenge with Salomonsson that he had taken a phone call in her previous session, and she was relieved that these feelings could be named and known about. Frida's attention was only fully captured when she had settled and Salomonsson nodded his head slowly, imitating her.

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Salomonsson sees the elements of therapeutically engaging with an infant as i) the therapist gradually feeling more contained and then ii) a combination of adult interpretations, vocalisation and gestural language which 'carry' his containment. We would add that the 'infant address' as he conceptualises it is enhanced with a way-of-being that takes time (to take turns), as Salomonsson does when later in the session he rhythmically vocalises to her "ooohs" with his "yes...yes...". He therefore sees the mechanism of change for the baby as analyst's processing his unconscious to contain the baby's panic.

We see engagement consisting of talking, vocalising and gestural language while giving a baby enough time to digest or respond. We wonder if containment of a baby's panic is in itself enough dynamically/structurally to move the infant along.

We see the mechanism of change as fourfold. First, *changing infant representations and behaviour, s*econd, *changing parental representation* through verbal exploring and making links. This re-presents the infant to the parents. Third, *changing infant-parent interaction* with the infant taking the changed way-of-being into the relationship with the parents. Fourth, *changing parental ways-of-being with the infant*. Therapists interact in order to understand the infant and in the experience of being understood, the shape of the self representation changes a little with the possibility of other changes.

It isn't only the unconscious processing, it's also the nonverbal signs, language and the space of silence that convey acceptance and non-judgementalness in the respectful engagement with the infant in the parents' presence.

References

Salomonsson B (2011). The music of containment: Addressing the participants in mother-infant psychoanalytic treatment. *Inf Ment Health Journ*, 32: 599-612.

Thomson Salo F (2011). Does what we call 'engaging with the infant' matter? *AAIMH Newsletter,* 24: 6-9.

Winnicott DW (1941). Observation of infants in a set situation. In: *Collected Papers: Through Paediatrics to Psycho-analysis*, 1958, pp 52-69. London: Tavistock Publications.