Australian Association for Infant Mental Health Inc.

PO Box 39 Double Bay NSW 1360
www.aaimhi.org
ABN 93 045 030 281

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Welcome to the November 2014 edition of the national members' newsletter for the Australian Association for Infant Mental Health.

As the new editorial team, Emma Toone and Ben Goodfellow, we wish to introduce ourselves to the readership and acknowledge the work of Shelley Reid as publisher. We thank outgoing Victorian branch president Teresa Russo and past newsletter editor Sarah Jones for their mentoring and encouragement in our roles as the new editorial team. We also thank outgoing national president Anna Huber for her support to us and her work overall.

Our aim for the newsletter is to provide a forum for members to explore ideas arising from their work with infants, young children and their caregivers in an Australian context. AAIMHI members come from a diverse range of professional backgrounds and are united by the recognition of infants as subjects in their own right, requiring our support and advocacy. In this edition of the newsletter our new national president Sally Watson reminds us of the pivotal role AAIMHI can continue to play in public discourse on early intervention, calling for a movement of sustainable change for infants and their caregivers in our society.

At the WAIMH congress in Edinburgh in June 2014 it was striking how prominent the work of infant mental health in Australia is in the world at large. Clinicians from around the world spoke of their awareness of a culture of practice in Australia in which infant mental health is included broadly in the health care system in comparison to most other countries. Perhaps then it is no surprise that Australia had proportionately more delegates in attendance at the conference than any country, including the United Kingdom. We hope the newsletter can be useful to members in both describing and informing the rich clinical practice occurring here, projecting the work and the perspective of infants and their families more clearly in local and international contexts.

This edition of the newsletter covers many important themes arising in infant mental health work today. Submissions touch on the respective importance of the ghosts that haunt caregivers (Fraiberg 1975), the angels that enliven them (Lieberman 2005), the external current stressors that may disturb family relationships and the qualities and influence that the individual infant brings. Salo and Paul's article in response to Lynne

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Barnett's 'Sunday's Child', highlights the influences across a lifetime of a young man's sense of himself and of his fathering. The winning Ann Morgan Prize entry by Meehan wonders how monitoring of an infant's eating routines may inadvertently restrict space for the baby to play with mother and be seen. Milburn, Askew-Walinda & Jackson, reflecting on the WAIMH conference, touch on relational distortions babies might encounter in stressed caring milieus and the importance of scaffolding caregivers and babies in their communicative tasks with one another.

Several articles in this edition focus on the different ways that the needs of the infant may be eclipsed by debates in family and policy systems. Fletcher's commentary wonders whether definitions of family may at times detract from a focus on supporting babies and their caregivers. McIntosh, in her consideration of overnight care for infants, argues for a recovered focus on the needs of the young child amidst family conflict and gender politics. Bunston and Glennan pose a similar argument in settings of recovery after relational violence, arguing for the need to privilege the infants' needs as equal in priority to the practicalities of mother and child's family violence safety responses.

This overview gives a sense of the breadth of ideas explored in this issue and shows a spectrum of the writing we welcome for future editions. We aim to represent infant work across Australia and are heartened by the submissions received for the November edition. We are however conspicuously aware that Victorian voices may be overrepresented on the current newsletter's pages. The editorial team is Melbourne-based and there is a concentration of infant mental health work in Melbourne so some emphasis is perhaps inevitable. Members from other branches are however warmly encouraged to redress any perceived imbalance by submitting papers for the April 2015 edition by 22 February 2015.

With pleasure then we invite you to read, discuss and respond to the first full newsletter prepared under our stewardship. Comments, feedback and submissions are warmly welcomed and we wish you well in your work at this busy time of year.

Ben Goodfellow and Emma Toone

From the president

I would like to introduce myself, Sally Watson, as the incoming National President of AAIMHI.

To start, I want to acknowledge the work that Anna Huber, the outgoing National President, has done over the last three years. Anna has played a very important role in facilitating AAIMHI to move forward by advocating for the development of a Communication Strategy, which we have now developed. Anna has also highlighted and led us through addressing many procedural issues that we needed to work through. So thank you Anna for that and your tireless commitment to Infant Mental Health.

I first became involved in AAIMHI in 2002, by joining the SA Branch Committee of AAIMHI. I was relatively new to the Infant Mental Health field at that time, but the SA committee had some wonderful mentors, in particular Elizabeth Puddy and Pam Linke, from whom I learnt so much.

I became President of the SA Branch in 2008, when Pam Linke who had been the President for a number of years became National President. It was at this time that I joined the National AAIMHI committee as the SA Branch representative, and have been on the committee since. This has given me a good opportunity to see what the role of the National Committee is, and to make links with the other branches. One of AAIMHI's great strengths is the branch structure and the autonomy this allows for branches to fulfil the aims of AAIMHI in the way that fits with the branches' interests and strengths. Collectively all the branches in their own way raise the profile of Infant Mental Health across the country.

At the joint AAIMHI/ARACY conference held in Canberra last year a statement made by Frank Quinlan, the CEO of the Mental Health Council of Australia, really inspired me and was a motivating factor for deciding I would nominate for National President. He said something like "Evidence is not what informs the agenda in governments. If it did we would have different public transport policies, for example, we'd transport freight by train not road … So is using evidence the way to go alone … It is a social and political movement that we need. We have policies, and children are present in them, but still Early Intervention is not occurring – we need a movement".

AAIMHI can play a critical role in activating that movement, and is already doing so in small ways. Those small ways are the pebble that creates the ripple that can create a wave. AAIMHI, as a body made of people who are passionate about Infant Mental Health and the importance of early intervention, is well positioned to make a difference. I would encourage everyone, therefore, to think about how they do and can continue to create ripples to create a wave of a social movement that a true commitment is made to Infant Mental Health and early intervention.

So, that's my dream! Who am I?

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I graduated as a Social Worker over 30 years ago. I have worked in a range of settings including Statutory Child Protection, Hospitals, CAMHS and for the last 12 years in Infant Mental Health in early intervention and child protection. I have done considerable training in a range of Attachment measures including the Adult Attachment Interview, AMBIENCE and the Insightfulness Assessment Interview. I have also had training in a number of different interventions including Mary Dozier's ABC Intervention and am a Licensed Marte Meo Supervisor and most importantly I am passionate about Infant Mental Health

I am the mother of three children, Thomas aged 19, Alice aged 17 and James aged 14. I love to travel, read, cook and spend time with friends.

Sally Watson

Reflections on three years as President of AAIMHI

Having recently stepped down as National President of AAIMHI after three years in the role, I have been asked to reflect on my experiences. Rather than list a series of AAIMHI's achievements, I would like to offer something of what I have learned through this experience. This is not just about me, but also about our organisation and our strengths and challenges.

Leadership and trust

It has been a privilege to serve for three years as the president of AAIMHI and I have always been conscious of the trust placed in me by the national committee on behalf of all branches and members. Although being president is ostensibly a leadership role, there is no automatic power that goes with the job, except to chair meetings and exercise one vote, and at times a casting vote. Therefore, everything done on behalf of the organisation has only been achieved through the authority granted by fellow committee members, branch committees and members. Trust should not be abused, and members are entitled to call to account those in whom you have placed your trust. Many of you have done this with me and as challenging as it sometimes felt, I thank you for this. Sometimes I have had to repair ruptures in relationships that will inevitably occur. In order to keep your trust I tried to stay focused on the objects of the association while being as transparent as possible with colleagues on the national governance committee and all members.

Together we do better

The field of Infant Mental Health gives us a wonderful framework to understand how to maximize human potential. As an organisation, AAIMHI strives to support healthy social and emotional development of infants through working in relationship with caregivers and families, and building relationships with others who can support this work. We all know we cannot do this work alone, and as members of AAIMHI, we have only achieved progress with our shared goals when we have worked together on initiatives, position papers, training, conferences, and advocacy. National and branch committee members have collaborated on tasks such as updating the controlled crying position paper and our overnight shared care research review and guidelines, and finalising our child care position. We have shared the work of organizing and running national conferences and training events (as AAIMHI alone or with partners), resulting in a rich array of professional development experiences offered to members and others interested in infant mental health. Developing and maintaining a national profile has only been possible because we are a national organisation. I have seen at first-hand what has been possible because of this collective endeavour.

Strengthening our governance has been and will continue to be an important way of allowing us to operate more effectively together, provide transparency and improve our financial and legal accountability. With the help of the Associations Forum consultant, the national committee has worked hard to strengthen AAIMHI governance through the development of a dynamic strategic plan and common reporting tools. This will continue to be a work in progress.

Our strength as an organisation comes from our shared goals, but also from our diversity. This generates a range of ideas and perspectives that can be pulled together to serve our common purpose. I have come to value and respect the differing views of both 'insiders' and 'outsiders' in keeping focused on what is important. Listening to my/our detractors is just as important as listening to those who agree with us. I have learned a lot about myself/us as an organisation by hearing what critics have to say, without necessarily agreeing with their opinions. It has challenged me to clarify why AAIMHI is taking action or advancing a particular cause and to be able to communicate clearly about this both to members and others on behalf of members.

How we communicate and relate: both the medium and the message

As an organisation we are nothing without effective communication. We cannot build the relationships we need to influence outcomes for infants and their families, serve our members, or communicate our message without it.

Therefore I have put energy into leading the development of a communication strategy and also seeking appropriate outside professional help to do this.

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Working with the national committee on behalf of you all, we finalised a strategy in 2013 and are in the process of implementing it. While progress is slow because we are all volunteers, the engagement of a project officer, the upgrade of the website and the development of a calendar of training events with online registration arrangements, are all in the pipeline.

It is my hope that by communicating better both internally and externally, the objects of our association will be better served.

Finally, the way we communicate needs to include face-to-face contact. We know this from our work with infants – there is no substitute for physical contact – and that is the same with us too. While technology is enabling better 'live' connection, spending time together in the same place to get to know each other and work together is not only worthwhile but also more effective sometimes that relying on email, Skype or text messaging alone. Conferences, face-to-face meetings and events need to be valued and I hope will remain an important feature of our organizational activity.

Finally, I would like to sincerely thank all of you, my colleagues on the branch and national committees for your hard work and energy in the service of infant mental health. It has been an honour to work with you all for this cause.

Anna Huber

Clinical reflection

'Sunday's child': in becoming a father, what may be repeated?

Frances Thomson-Salo and Campbell Paul

This note is written prompted by viewing the latest film in Lynn Barnett's *Sunday's child* (1989) DVD series. These films follow the development of an infant in Britain, initially fortnightly for two years and then with follow up films until he was 21 years old, providing a longitudinal study of child development and attachment patterns. Felix, the young man in this series, is now a 31-year-old father of a four-year-old daughter and it has felt more ethical to write this as if talking with Felix. We thank Lynn Barnett for the opportunity to think again about Felix's internal world, when she showed this film at The Royal Children's Hospital Infant Mental Health group meeting on 5 May 2014.

By Felix's second year, his father was a secure attachment figure for him, although at 21 years of age Felix said that he felt he had no father, whereas now as a 31-year-old man, we see him as a good-enough father in the way that Winnicott used the term. Felix says that it is cool to be a documentary maker – is there perhaps something unconsciously that he wants 'documented' about his relationship with his father?

We make four points, as son to his father, as a father to his daughter, his daughter's relationship with him and perhaps an inner sadness in him.

The son of his father

Felix acknowledges striking trans generational influences from his father –"I turn round too quickly and think I'm turning into my dad" and he then talks of "harrowing memories", which are actually images of death. He says, "I still think I'm probably more – this annoys me – characteristically like my dad than my mother." Similar to his father, Felix's relationship with his partner was broken off when their child was two years old. In the way that his father copes with sadness and need by minimising them, Felix does something similar too: he might make a statement and then undo it, like talking of the loss of his father as a major life event and then says that it was "not that major". But as part of those mixed feelings about him, Felix also admires him, which seems a basis for himself as a good father.

Felix as a father

Felix seems warm, more relaxed and natural; he seems to have many male friends and to be good at his work. He seems more open to admitting vulnerability than his father was: Felix says that, "There is nothing as amazing as your child smiling and telling you they love you, it changes your perception of the world – you have a vulnerability now that you always have". He says that it is "pretty rubbish" that his father has only met Audrey twice. Felix is at times quite lovely with her. However, he sometimes seems quite like his father, as when he finds her boring.

Perhaps it is hard at times for him to find a deep connection with her, that the difficult time as the child of his young parents is a ghost that sometimes visits the nursery? He says that he has always wanted to have a child – perhaps partly to get it more right for them both?

Audrey, his daughter's, relationship with him

The first words we hear Audrey say include "daddy". At times she seems a little regressed but perhaps Felix has been able to loosen the chains of the past and not have the high expectations for her that his parents had of him, and his daughter is therefore spared something. When he is able to give her time, she becomes more regulated.

Is there an inner sadness that he has struggled with?

He has talked about a gap where he feels there has been no father for him, after what he felt was ongoing rejection from the age of nine years, when it was planned that Felix would leave New Zealand to go and

live with his father, stepmother and baby half-sister. Felix had so looked forward to this move: he sang all the way over in the plane, "I'm going to live with my Daddy".

At 21 years of age, an inner sadness seemed linked with low self-esteem, when Felix said, "I don't find anything really interesting … I don't love anything except my girlfriend, I'll look after her for the rest of my life."

Then at the age of 23 he lost his mother, whom he said he would "never stop missing", feeling that she had always been there for him and had always told the truth. Much of her caring mothering seems to live on in his "fathering" of his daughter, and with Audrey he finds again the connection with his mother. He would view his feeling down or empty as linked with his mother but it followed chronologically after he talks about his father. At the end of the film, there might have been considerable sadness in his emailing Lynn Barnett, "I feel OK to get on with life without trying to appease a high power."

Could there be something he might be anxious about, in that he has not viewed the DVDs of his childhood, of which Lynn Barnett gave him copies? He says that he wants to interpolate free will between genes and environment – could it be partly to find a freedom to dispel a depression which Edna O'Shaughnessy (1989) thought was there in his first months, or a depressed father (a 'dead' father in Andre Green's (1986) terms) – to find a freedom from deadliness so that he can find more joy and liveliness in life than sadly he perhaps felt his parents had, with Lynn Barnett in part holding aspects of the good father and good mother for him?

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Commentary

The idea of a 'natural' family

Richard Fletcher

The Family Action Centre, Faculty of Health and Medicine
The University of Newcastle

Rigid rules about a 'natural' family are out of step with current thinking but we can't do without rules and if we worry too much about the words we'll miss the main event.

When 1994 was declared 'The International Year of the Family' at the Family Action Centre where I worked we debated long and hard to find a definition of the family that would suit everyone. It turned out to be more difficult than we expected.

Although the motto for the year was Building the Smallest Democracy at the Heart of Society we seemed to spend much of our time looking for words to define a family that were broad enough to avoid offending anyone. In doing so we seemed to lose the meaning and so failed to satisfy anybody. The poster we made for IYF had 18 different images trying to get across the message of diversity without pushing any particular type. The poster looked pretty but said little about building democracy.

Now, at the 20th anniversary of The Year of the Family, we don't seem to have progressed very far. The aims of the year, according to the United Nations, are to confront family poverty, ensure work-family balance and advance social integration. The main talk about family though, to judge by media reports, is whether ministers from the Abbott government should speak at The World Congress of Families.

The goals of groups like The World Congress of Families (WCF) who are met in Melbourne this year are not very different to those of the UN: giving and receiving love, ensuring the full development of children and building strong bonds between generations. The trouble is that the WCF is adamant that these goals can only be met though one type of family, a man and a woman who are married.

Extreme advocacy flows from this stance, outlawing gay relationships and criminalizing abortion. These aspects have drawn heated criticism and made good media. But will shouting down the WCF help families to do better? Is being for the rights of gays and women enough to fight poverty, balance work and family and improve social integration?

The problem with simply pushing for more liberal ideas of what a family could be was made very clear when Judge Neilson told a court that incest between a brother and sister was really OK (Hall, 2014). The reaction was fast and furious. In this case, it was clear that we need to keep some rules about who is 'family'.

It is not that these views are best ignored but the media focus on extreme definitions of family can distract us from noticing something more basic. A key aspect of family is the raising of children. Now, more than ever, we know that trauma in the early years can do harm to an infant's brain. We know that early damage to children's

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sense of trust can lead to teenage and adult problems that cost us all dearly. Yet we seem unable to make the prevention of family disruption a major issue.

Perhaps taking action as a society to ensure that families start out as safe, stable and nurturing of relationships will require facing up to the real costs of family disruption. This may mean, as Patrick Parkinson (2012) has pointed out, facing up to an 'inconvenient truth' on a par with global warming.

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WAIMH 2014 conference reflections

Learnings from the 14th Congress of the World Association of Infant Mental Health about the infant Child Protection Client

Nicole Milburn, Margaret Askew-Walinda and Annette Jackson

The World Association of Infant Mental Health (WAIMH) 14th World Congress in Edinburgh offered much for clinicians working with infant Child Protection clients and those at risk of becoming clients of Child Protection. Multiple levels of the work were addressed from the individual internal world to the relationship to the family, society and state.

Emeritus Professor Colwyn Trevarthen reminded us that the first thing we need to do is to really listen to the baby and tune in to the baby's rhythms and expressions. The close observation of infants is the cornerstone of the work, and is particularly important when something has gone awry for the baby. Emeritus Professor Trevarthen's work, and those who followed in his footsteps, shows that babies are born to communicate and to share their world. Professor Trevarthen shared that "the baby is an active participant in a narrative that has an introduction, development, climax and resolution", and that this is "a wave of vitality that has regulatory function-a motor narrative" (*WAIMH Congress, 2014). This work is fully explained in Dan Stern's book 'The Present Moment in psychotherapy and every day life' (2004). Infants therefore are story tellers as well as meaning makers from birth, and as clinicians we need to tune in to these stories and pay attention to what meaning is made if we are to help. This was the subject of a poster that Take Two authors wrote in collaboration with Associate Professor Campbell Paul, where close observation while engaging the baby in play can provide a much fuller picture of the baby's experience than file information would.

Lynne Murray reminded us that babies are extraordinarily good at working out what is real from what is not real. Her work with live versus replay TV interactions was ground-breaking. It showed how infants interact 'in the moment' with their mothers live but on computer or television screens. The mother's part is then played back and the infant was observed to find this very disconcerting indeed. This has some immediate ramifications for our work in a fresh consideration of Skype as a means of keeping some sort of familiarity in a relationship between a baby and someone far away, in that infants can manage a live video interaction but not a recorded one. It has more important considerations in terms of inter subjectivity for relationships where responses aren't quite what was expected or incongruent, such as where there is substance abuse and mental illness in a caregiver.

Lynne Murray also spoke about depressed mothers losing their musicality. Colwyn Trevathen reminded us that Lynne used this as a test of maternal sensitivity in 1975 long before Ed Tronick's still face work. Her work showed that when we observe a mother and infant interacting, the baby is not imitating the mother, it is actually that the mother carries on the conversation that the baby initiates. This is important when thinking about interactions that go awry, because it reminds us that the baby is ready and willing to interact and expects a certain response. This is innate in all of us, and perhaps goes some way to explain that crazy-making sense that the outside didn't match the inside that many people who grow up with parents with a mental illness have. They seem to know that there is something not quite right, something unexpected in the responses they receive. If it were the other way around, that babies were responding to parents' expressions and communications, this sense of confusion might not come until the baby comes more into the outside world of childcare or school. The realisation of the unthought known (Bollas, 1987) that comes from the affirmation that the world matches more of what was inside originally than the mixed up interactions can be a major part of a psychotherapeutic process. For example, a 35-year-old man in therapy for depression and anxiety was describing his early life with as a single child of a mother who had schizophrenia and frequent psychotic episodes. His therapist said "where was Child Protection?" This struck him almost visibly – he

sat up straighter and seemed to have better muscle tone. The words matched some internal sense that things weren't right in his house and that something should have been done. The work of Lynne Murray suggests that this sense was there in infancy.

There were several excellent presentations about infant observation from the traditional psychoanalytic perspective. This long and rich field of study of healthy babies helps us understand the transference and counter transferences that occur in relationships with babies, and particularly that babies can make us feel extreme emotions even when there is nothing amiss in them or their relationships. In our work with groups who provide clinical interventions for babies and their families it is always interesting to see the myriad of countertransference responses communicated in a group context, some from the baby and some from the parent, and then to put this together to think about what it means for the baby's internal world and whether they are physically and emotionally safe. The impact of the baby's primitive emotions on an organisation was the subject of a poster presented by Nicole Milburn and Jinette de Gooijer, illustrating how powerful countertransference can be picked up and acted out within an organisation. The counter transference of the infant-inside the older child and adult can be quite powerful also, and can be seen in the example above that led to the therapist's exclamation of "where was Child Protection?"

There were several presentations demonstrating the Newborn Behavioural Observation System (NBO) for use both as an assessment of a newborn and as a more structured approach for building the relationship between infants and their parents in that critical touch point of the newborn period. The Royal Children's Hospital and Royal Women's Hospitals in Melbourne have joined together with the Brazelton Institute to form NBO Australia, and Australian clinicians now have the opportunity to be trained in this very excellent procedure. For the infant Child Protection client, having an NBO performed in the newborn period could be life-changing. So many of the parents involved with Child Protection Services have a very poor sense of their own worth, and showing that they have produced a baby who already prefers them and wants to be with them above all others – and is certainly more interested in them than an expert infant mental health clinician – let alone how capable the infant is already, can be life changing.

There were numerous presentations on therapeutic approaches that provide much food for thought as we contemplate what is possible within our own context. Karl Heinz Brisch presented on the intensive inpatient treatment for children who experienced severe traumatization in Munich. The application of milieu therapy, a 'key attachment nurse' role, individual and group psychotherapy, the use of EMDR, art therapy, music therapy, movement therapy with parent and child was simultaneously comprehensive and enviable. Other presentations such as by Cristina Trentini also reported on positive findings on the use of EMDR with young children. Our own symposium in partnership with Kristie Brandt and John Hornstein presented on the application of Bruce Perry's Neurosequential Model of Therapeutics (NMT) and Brazelton's 'touch points' model to inform how we translate assessment into therapeutic interventions to bring 'therapeutic intent' into the infant and young child's day to day world through Brandt's Mobius Care approach.

One of the most helpful things about attending a congress is the opportunity to hear a presentation integrating years of work from a group of expert researchers or clinicians. We had that opportunity at the Congress on several occasions. One key finding was from the twin studies that Pasco Fearon and colleagues have conducted. These have investigated genetic components of attachment by the classic means of studying separated and non-separated monozygotic twins. They found that there is no genetic component to attachment classification in the first three years of life. This means that all babies are born with the capacity to form a good relationship with a caring and available adult and is critically important to the work with infant Child Protection clients, leading to the conclusion that we need to redouble our efforts to improve the environment for the infant-meaning, physical as well as emotional and relational.

The randomised control trial of intervention for Romanian orphans led by Charles Zeanah and colleagues is its fourteenth year (known as the Bucharest Early Intervention Project). It provides operational support for the research findings of Pasco Fearon and asks the question "how much recovery is possible after early adversity and deprivation"? Children in the orphanage were randomly assigned to one of three groups within Romania: care as usual in the orphanage, general foster care or foster care with carers trained in trauma and attachment. The findings are that the children in the third group have done considerably better than the other two groups. Their trained foster care intervention is somewhat similar to Victoria's Circle Program, where children who enter care are placed with carers who have been trained in trauma and attachment. This series of studies also continued to show the devastating and pervasive consequences of neglect on the developing child.

Neil Boris conducted an entertaining master class as always, running the audience through the nuts and bolts of interaction guidance as originally formulated by Susan McDonagh. Nicole saw Susan McDonagh's master class at the 13th World Congress in Cape Town, and this method, described in the second edition of the Handbook of Infant Mental Health (Zeanah, 2000), is an excellent method of therapy for the families

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involved with Child Protection. The use of video is the intervention of choice with infants and their families (Zeanah, Berlin & Boris, 2011), and is particularly useful for what McDonagh refers to as 'overburdened' parents (in Zeanah, 2000). These are families overburdened with any or all of the toxic trio (mental illness, drug addiction and family violence), as well as isolation, poverty, and low IQ (Brandon et al., 2008). Playing back the baby's interactions immediately in the session gives an opportunity, albeit sometimes painful, to really talk through what the baby is thinking and feeling and can be a fast track to change.

There were interesting discussions on the role of the legal system through the Children's Court. In particular we heard presentations by Joy Osofsky, Carla Barron, Lucy Hudson, Ann Stacks and others on different types of Baby Court Teams and some of the findings such as increased reunification of babies with parents and decreased time before other permanent care decisions are made for children. This is timely as Australia has begun its first pilot of a Family Drug Treatment Court in Melbourne for parents of infants and young children. There is the possibility of much symmetry in these therapeutic jurisprudence initiatives. The broader discussion of what could a trauma-informed legal system alongside a trauma-informed child welfare system look like is an important conversation to continue.

Professor Peter Fonagy, from the Anna Freud Centre and University College London, made a compelling and convincing argument that mentalisation is the unifying theory of psychological processes, and it is the promotion of mentalisation that underlies success in all psychotherapies. What a relief to have an answer to this vexing question of which psychotherapeutic technique is most efficacious! Fonagy used the concept of mentalisation along with communication systems to explain why psychological interventions work. He stated that no one therapy is better than another and the common factors have been researched. The research pointed to the centrality of the working alliance; the therapeutic alliance predicts symptom improvement session by session; and the therapeutic alliance can be thought about in terms of mentalising and trust. He also spoke about Epistemic Trust. Attachment to a person who responds sensitively increases trust when the person's actions are credible. Young children trust in their mother's claims. Fonagy believes the epistemic highway in insecurely attached individuals is partially closed. Thus he describes Personality Disorder as inaccessibility to cultural communication relevant to self from social context. A high level of epistemic vigilance leads to over-interpretation of motives, and so misattribution of intention is seen as malevolent.

And finally, one of the most inspiring presentations was from the Wave Trust who formulated the 1001 Critical Days campaign. The 1001 critical days are from conception to age two and the campaign is a multi-level nationwide framework for increasing support to all infants and parents. It intervenes across the universal sector to Child Protection and out of home care, aiming to both enrich the parent-child relationship and to produce healthy and happy individuals. It recognises on a national scale that intervening in the early years of life sets the infant and family on the pathway to good growth and development, strong attachment and thereby strong adult wellbeing and contentment. The program has started lectures on infant mental health and other related topics at Parliament with impressive buy in from MPs. Most of all the campaign offers much needed hope in the very difficult work with vulnerable and high risk infants with the message that change is possible. It seems to follow from Pasco Fearon's work that if attachment is entirely environmentally determined in the first three years then all we have to do is change the environment. Although this is easier said than done, the Wave Trust 1001 Critical Days Campaign is a framework for making that happen.

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**For all references from the Congress please see the Infant Mental Health Journal Supplement to Volume 35(3) (May-June) 2014.*

WAIMH 2014 - Edinburgh Enlightens

The WAIMH 2014 world congress was an enriching and successful five days thanks to the presenters and the setting. Edinburgh produced a rather uncharacteristic run of sunny days as we met and learnt and sampled the flavours of Scotland (of course) under the watch of the castle and other shadows of history that dominate this charming city. Edinburgh was a focal point of the Scottish Enlightenment, a period of profound intellectual and cultural significance that emerged during the same century as the modern nation of Australia was conceived.

The systematic study of the natural world we refer to as 'science' developed as branch of philosophy during this time in the context of the political and protestant traditions in the British Isles. Philosophers John Locke, David Hume, physician William Cullen and many others worked, drank, argued and collaborated across disciplines toward a way of thinking that underpins so much of western society that it is now almost invisible to us. Laying various foundations for the industrial revolution, to the germs of contemporary attitudes on the rights of the individual, thinkers of the time rigorously promoted an appeal to reason and evidence in achieving material and spiritual advancement of society. As clinicians, our approaches to an understanding of the infant in general, and the conditions for life and family we advocate for each child in particular owe a debt to the furnace of ideas and creativity that was lit in Scotland in 1700s and still burns around the world as we heard at this year's congress.

It isn't possible to do justice to the several hundred presentations and posters that were enjoyed by over 1500 delegates at WAIMH 2014 but I mention here several others to complement those in the paper by Milburn et al elsewhere in this newsletter.

A practical example of effective advocacy and public policy was the "1001 Critical Days Campaign." It emphasises the particular importance of a child's physical, family and emotional environment through their first 1001 days. It is a serious and detailed program driven by a clinical and intellectual understanding by infant mental health clinicians in the UK, funded in part by the Wave Trust and other philanthropy with recognition, support and - crucially - cross-party policy initiatives instituted by the government in Britain. It is perhaps a model for Australians to refine and emulate.

Frances Thompson Salo delivered a master-class derived from her work at the Women's and Royal Children's' Hospitals in Melbourne, "Intervening around a feared or traumatic birth: Antenatal and Perinatal Infant-Parent Psychotherapy," describing the preventive and early intervention work she and her team continue to develop.

Amanda Jones, psychoanalyst from London presented "Exploring the meaning expressed in psychotic material that manifests in a mother's mind in relation to her baby." Two detailed cases were presented articulating how powerful and necessary it is to endeavour to think beyond phenomenology and symptom reduction, allowing a working through of a mother's predicament even in severe mental disturbance. This was a confronting seminar for some but very powerful to those in attendance, and an impressive exposure of her own technique and process notes for comment and criticism.

Richard Fletcher from Newcastle joined with Malin Bergström from Sweden, Jenny Roberts of Perth and others in discussing not just the significance but the imperative of including fathers in infant-parent work as a matter of course. The place of fathers in the life of the infant and the work of therapy was a clear thread through many posters and presentations.

From the Royal Women's Hospital Melbourne, Susan Nicholson (a University of Edinburgh alumnus) and Campbell Paul displayed the potency and utility of the Newborn Behavioural Observation system (NBO) as an approach to aide clinicians in helping parents of any baby to experience the child's extraordinary capacity and individuality from as early as day one of life.

Recalling that the conference was held before the recent escalation in conflict in Gaza and surrounds, Miri Keren (Israel) and Ghassan Abdullah (Palestine) with others described the work and collaboration that takes place to help babies and families across borders and in spite of politics in that part of the world.

Campbell Paul, Megan Chapman and Izaak Lim spoke of infant mental health in the tertiary paediatric setting. Their presentations demonstrated not merely specific work that occurs in Australia but the sophistication in thought and integration of systems of care that are at the forefront of the clinical field worldwide, something not lost on many foreign delegates who were immediately aware (even envious!) of the opportunities we have here.

Chaired by Frances Thompson-Salo, Campbell Paul (allegedly filmed in full Scottish regalia with bagpipes primed at the closing night dinner) held a session on the use of humour in infant work. The panel illustrated among other aspects that humour is far more than merely a tool for engagement but a means of unconscious communication however indefinable that inter-subjectivity remains.

In keeping with the theme of the conference and perhaps the tradition of the humanism of the Scottish Enlightenment the conference ended with a discussion of a formal charter of rights of the infant by WAIMH, an important and complex area particularly with regard to practical outcomes of such a project.

Many important presentations have been omitted from this conference fly-over, but I hope it provides a sample of the calibre of work, and enjoyment, offered in

Cont. page 10

Edinburgh at WAIMH 2014.

The fruits of the Scottish Enlightenment are so ripe and ubiquitous that their roots are arguably taken for granted. As such we must be wary not to overlook that, for all its utility, there are clear limits to the empiricist approach that the Enlightenment thinkers developed – especially as we attempt to understand the psyche of the infant as subject. A study of the philosophies and epistemology underpinning our methods is of far more than mere historical interest. Indeed, Freud's own anticipation of the limits of his primary discipline of neurology spawned his discoveries upon which much of our field is based. Perhaps your own reflections, and those of the colleagues and families you encounter, may inspire more contributions in the Australian tradition for the WAIMH 2016 congress in Prague – not far from where Sigmund was born, as it happens.

All comments are welcomed.

Ben Goodfellow

The story of the 'Peek-a-Boo Club'™: An inspirational intervention for infants and their mothers affected by family violence.

Wendy Bunston[1], Kathy Eyre[2], Anthony Carlsson[2], Kristen Pringle[3]
[1]LaTrobe University, [2]Royal Children's Hospital, [3] Alfred CYMHS

Introduction

The Peek-a-Boo Club™ is a group work intervention within an Australian Child and Adolescent Mental Health Service (CAMHS) delivered to infants and their mothers to address the impact of significant family violence on the infant-mother relationship. Clinicians from the Addressing Family Violence Program, Royal Children's Hospital Mental Health Program, facilitated this group program across metropolitan Melbourne, Australia.

Method

133 infants, aged 0 – 48 months, with their mothers (N=105) participated in a total of 30 Peek-A-Boo Club™ groups which met weekly for 2 hours over a 6-8 week period between 2007 and 2011.
The program was evaluated utilising three measures concerned with the functioning of the infant and their attachment with their mother:
•Brief Infant Toddler Social Emotional Assessment (BITSEA)
•Maternal Postnatal Assessment Scale (MPAS)
•Parent Infant Relationship Global Assessment Scale (PIRGAS).
The evaluation was undertaken by the clinicians facilitating the program and the measures used were chosen for their reliability, ease of administration and affordability.

Results and Discussion

The table shows the outcome measures of mother's reports of infant functioning, the quality of infant maternal attachment and clinician rating of global functioning as assessed using paired t-tests.

	Pre program		Post program		*T*
	Mean	SD	Mean	SD	
BITSEA Problem (n=38)	20.68	8.97	15.55	6.59	4.18**
BITSEA Competence (n=38)	16.47	3.65	17.42	3.49	2.05*
MPAS Global Score (n=62)	73.55	13.13	76.72	9.68	2.30*
Quality of Attachment	36.37	5.68	37.03	5.56	7.65**
Absence of Hostility	17.11	4.73	17.602	4.97	4.71**
Pleasure in Interaction	19.78	5.21	21.42	3.37	6.37**
PIRGAS (n=50)	49.62	16.60	53.25	13.88	2.05*

*p <.05 ** p < .001

In summary, the intervention outcome measure results showed that post intervention:
*Mothers reported their infants were significantly more socially competent and displayed significantly less problematic behaviours (BITSEA)
*Mothers reported a significant improvement in overall global attachment and in all subscales (MPAS)
*Clinical facilitators rated an improvement in adaptive functioning between the mother and infant (PIRGAS)
This evaluation found that the Peek-A-Boo Club™ was a successful intervention for improving: a mother's emotional response to her infant; maternal-infant interactions, the maternal-infant relationship and the quality of their attachment; the adaptive status of the infant-maternal relationship; and infant functioning. Although not unequivocal, these results are encouraging and reinforce that this work is vital in attempting to both redress and prevent future relational disruptions in a vulnerable and isolated population affected by family violence. 'Infant led' group work offers wonderful opportunities to enter often highly traumatised caregiving systems and target the point that is most responsive and available, the infant.

We are grateful to the Sidney Myer Foundation & Victorian Women's Trust for their support.

Contact details: wendy.bunston@bigpond.com

The Children's

Excellence in clinical care, research and education

The Homeless Infant.

The Infant & their Mother made Homeless Through escaping Family Violence

In 2011, there were 105,237 homeless people, an increase of 17% on 2006 figures. Australian Bureau of Statistics. (2011). Census of Population and Housing.

In 2002-03 **the annual cost of domestic violence in Australia is estimated to be $8.1 billion dollars.** Access Economics 2004

In 2012-13, adult family members and children accounted for 34% of clients (83,211 clients). Of these 82% of these clients, 61% were single parents and their children. Of these 83%, **over one-third (34%) identified 'domestic and family violence'** as one of their reasons for seeking assistance.

The majority of children and adults presenting in a family group were female (57%) Nearly half (45%) of all clients in this group were aged 0–9, and 61% of this group were aged 14 and under. In these young age groups, the numbers of boys and girls were equitable.

More than one million Australian children are affected by domestic violence. **Almost one quarter of young people have witnessed physical domestic violence** against their mother (Indermaur, 2001, Bagshaw, 2007).

There were 35,720 recorded family violence incidents in Victoria during 2009–10 (some of these incidents may have involved the same families). In 40 per cent of these cases children aged under 16 witnessed the violence (Protecting Victoria's Vulnerable Children Inquiry 2012).

The Peek a Boo Club TM

The 'Peek a Boo Club' (PABC), developed in 2005, aims to create a therapeutic arena for the infant and mother to form and consolidate a healthy attachment. This is based on the premise that exposure to intimate relational violence can prevent a mother's ability to focus on her infant's attachment needs (Bunston 2005/8).

The PABC's aim is to address the consequences of family violence and provide early intervention to disrupt the intergenerational cycles of violence known to transmit from generation to generation. It also aims to create new futures by engaging women and children early in a pathway that challenges family violence and creates links into a comprehensive service support system.

BuBs (Building up Bonds) on Board

The 'refuge based' program's aims were twofold:

To deliver an intervention which enhances the affectional bonds between infants and mothers where this has been compromised by their exposure to the trauma of severe family violence.

To provide 'hands on' training, transferable skills and cultural change to staff with regards to the mental health needs of infants affected by relational violence.

The majority of infants were observed to have considerable developmental delays, most notably in relation to language acquisition, sequential reasoning and social referencing. If left unaddressed, these relational, as well as developmental difficulties may well emerge into longstanding behavioural, emotional, psychological and learning problems.

Research shows that **infants in the first year of life are at greater risk of dying** from abuse than at any other time period in childhood and early adolescence (AIFS, 2010, 211; AIHW, 2012, 210; Brandon, 2008; Jackson, 2006 ; Zeanah, 1997) Injury is the leading cause of death amongst Australian children, with assault the third most common, additionally, **domestic and family violence, and family homelessness feature as the leading environmental risk factors contributing to child deaths** from abuse and neglect (AIHW, 2012, 201). The Australian Institute of Health and Welfare (2013) reports that the age of children where abuse and neglect is most commonly substantiated is for those under the age of one, followed closely by those aged between one to four years. Emotional abuse and neglect is the most common form of maltreatment children experience and exposure to domestic violence, included in what categorises emotional abuse by child protection, is considered to be the reason for such high substantiation rates (AIHW, 2013).

Refuge for Babies in Crisis (Bunston & Sketchley, 2012)

How crisis accommodation services can assist infants and their mothers affected by family violence

A resource guide supporting ways that allow you to observe, reflect on what you are seeing, and to wonder along with infants and mothers about what might be happening for them.

Being curious, wondering why, challenging our initial assumptions and being open to possibilities in thinking differently about ourselves and the infants, children and adults we work with creates a tolerance for discovery. Infant work is very committed to discovery, discovery of the infant, of their world and who they are yet to be.

The opportunities you and your service have to do some important repair work with infants, and the infant/mother relationship is at the heart of this package.

Downloads available on all the above:

www.dvrcv.org.au/help-advice/service-providers/practitioners-working-children

Contact details:

WENDY BUNSTON
Wendy.bunston@bigpond.com

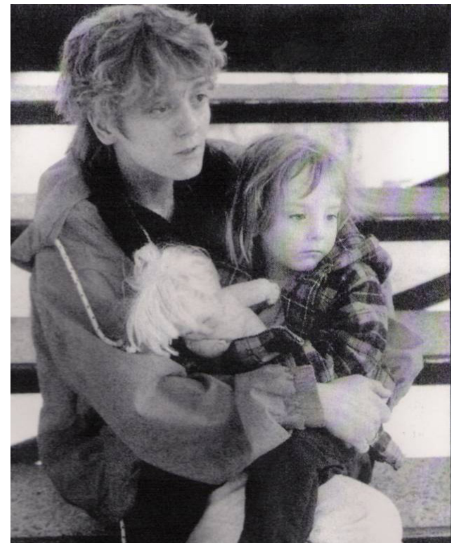
OR

KAREN GLENNEN
KGlennen@cah.vic.gov.au
emedan2@hotmail.com

Where a mother with her children leave home in order to escape family violence they are, in effect, moving away from what most would consider their 'safe haven' and into the great unknown. This is not a holiday nor an adventure, but an act of escaping. This decision reflects the opposite of what most consider the norm; that home is where you feel safe. These mothers make the difficult decision that it is safer for themselves and their children 'not to remain at home'. For some, this decision is literally in order to save their lives (Tutty, 1999).

Women who were abused were at least twice as likely to physically abuse their children; with depression playing a major role in whether they did so.

- 15% of Australian women have experienced physical or sexual violence in a relationship
- 61% of these women had children in their care during that violent relationship
- 36% of these women reported that their children had witnessed the violence



Women's shelters/refuges are often the first port of call for women and infants/children who have experienced significant trauma and/or familial violence. They offer amazing opportunities at the coalface to do urgent and important relational repair and rebuilding work for mother/infant bonds.

Creating time and space to sit with and reflect on mother/infant relationships within families displaced by violence and seeking refuge in women's shelters is vital.

Women escaping family violence are robbed of time and opportunities 'to think' and 'to reflect'. Subsequently, so too are their infants and children, and at a critical time in their formative years when skill acquisition in these areas is crucial to their ongoing development.

Shelters/refuges are, however, as susceptible as the rest of the family violence sector to adopting 'adult centric' and 'reactive cultures' that privilege the pressing demands for securing external stability over making space to attend to their clients internal landscape and the psychological avalanche set in motion for mothers and infants in attempting to escape relational violence.

These front line emergency services need support and training from early childhood specialists and child and adolescent mental health services (CAMHS) to feel confident in doing this work well and to have clear pathways for referring families in for further work.

The infants in the BuBs on Board (Bunston & Glennen, 2008) pilot presented with pressing mental health needs. Can we really afford to wait until these infants eventually come to the attention of CAMHS and other specialist services (if indeed they ever do) or should these services act now and come to them?

AAIMHI 2014 conference

Current research and theoretical perspectives on infant overnight care in parental separation: from splitting to integration

Jennifer McIntosh is a clinical psychologist, adjunct Professor at La Trobe University, Fellow of the Murdoch Children's Research Institute and Director of Family Transitions.

At the national AAIMH conference, I gave a two part keynote address:

"Current research and theoretical perspectives on infant overnight care in parental separation: from splitting to integration" and "New integrated guidelines for planning infant overnight care in separation".

The papers addressed the political and often heated nature of academic and practice debates about the care of infants after parental separation. The urge toward splitting and gender based divisive thought were considered against the need for the field to progress toward integration, on behalf of the infants who sit at the heart of family law debates. I discussed relevant research and theoretical foundations, with emphasis on their overlapping edges, and the promise these hold for progress toward higher order thinking. In the second paper, I presented "New integrated guidelines for planning infant overnight care in separation", a synopsis of two ground breaking papers by Pruett, McIntosh and Kelly (2014) that provide an integrated set of theoretical and practice assumptions about the care of infants, post separation and divorce.

Two papers that outline the above work in detail are available here:

The care of very young children after parental separation

This article has been published in *InPsych,* the bulletin of the Australian Psychological Society Limited*,* August 2014, and is available online at http://www.psychology.org.au/inpsych/2014/august/mcintosh

Beyond the Baby Wars

Toward an integrated approach to the post-separation care of very young children

Keynote Address to the Inaugural Conference of the AFCC Australian Chapter. Melbourne, August 2014. www.familytransitions.com.au

While research debates and policy wars will sadly continue to be waged on gendered lines, it is important to simply get on with the work of supporting infant mental health, and with that, effective post-separation parenting. In my pre-conference workshop, I presented a program that leaves me feeling hopeful about a way forward: "*Young Children in Divorce & Separation: A new intervention for separated parents of infants".*

The **YCIDS** program is for separated parents of infants and children 0 to5 years. YCIDS is designed to give parents a solid foundation for thinking about co-parenting their young children through and beyond separation. This five-step educational program guides parents through early development, and the creation of emotional security. It supports parents to understand why extra attention and careful thought is needed when forming overnight parenting plans for very young children. YCIDS promotes a joint basis for building emotional security, from promoting sensitive dyadic response, to the effective management of parental conflict, avoiding gate keeping, and nurturing wider relationships and cultural connections that will support the child over time.

YCIDS has been piloted as a pre mediation intervention in a random allocation study, with three-month outcomes suggesting benefits of YCIDS over the reading intervention, as reported by both mothers and fathers. It is well suited to group education settings and for use adjunct to court processes. It is also well suited to a home education format. To this end, YCIDS online will be launched late in 2014, for direct access by parents. Participants will explore the YCID materials and discuss application to their own work.

Information about the forthcoming **YCIDS** online program for parents is available at

www.familytransitions.com.au

Report: AAIMHI Victorian Branch Scientific Meeting, 28 August 2014

Emotional abuse and psychological neglect: Definition, recognition and intervention

Dr Danya Glaser MB BS, DCH, FRCPsych, Hon FRCPCH, is a Visiting Professor at UCL and honorary consultant child and adolescent psychiatrist at Great Ormond Street Hospital for Children, London.

The Victorian Branch in collaboration with the Royal Children's Hospital Infant Mental Health Program was thrilled to welcome Dr Danya Glaser who presented at the Royal children's Hospital in Melbourne. Such was the interest in her presentation that the venue was changed to accommodate the well over 100 people who attended.

In the first part of the program, the Victorian Forensic Paediatric Medical Service presented a case of very clear and devastating physical as well as emotional abuse of a young child. In focusing in on emotional abuse Dr Glaser posed the question of whether the child would have been removed if the physical harm was removed from the picture.

A four-tier model was introduced to assist with definition and recognition.

- Tier 0: Family and social risk factors: poverty, social isolation, displacement
- Tier 1: Parental risk factors
- Including mental ill-health, domestic violence, substance misuse, history of maltreatment
- Tier 2: Parent-child interactions
- Tier 3: Child's functioning and explanations for difficulties.

The relationship between the tiers was discussed as well as the complexity and emotional toll of these cases.

Threshold definition of emotional abuse is defined as:
Parent child interactions which are
Persistent, typical of the relationship, not single event(s)*
Actually or potentially **harmful**
Include **commission & omission**
Physical contact **not** necessary

Dr Glaser pointed out that the categories of emotional abuse are applicable across cultures, that harmfulness trumps culture.

The evidence of emotional abuse and how to understand and gather evidence was discussed.

Initial observations and information about children and families of concern need to be separated into the appropriate tiers of concern:

- Tier 0 - Social and environmental Factors
- Tier 1 - Caregiver risk factors
- Tier 2 - Caregiver-child interactions
- Tier 3 - Child's functioning.

If information is lacking about one or more of the tiers, it needs to be gathered.

Assessment of parents' capacity to make sustainable change within the child's timescale.

Trial of intervention, working towards protection, time limited trial of intervention of six months.

If not achievable, early alternative placement, which can ensure continuity of care.

Dr Glaser pointed out that whatever abuse has happened, removal is further harm; it may be less harmful than leaving a child, but it is still harmful.

Some interesting discussion points around difficulties for clinicians with responding to emotional abuse included:

- Fear of treatable cause of child presentation
- Worry about splitting up family
- That there is an assumption that the parents and services have the common interests of the child
- Understanding/ compassion for family as an obstacle
- Use of strength based practice which omits the negatives
- That children can be hated by their parents.

The second part of the presentation included a case from the children's hospital, which led to a lively discussion further elucidating the points for recognising emotional abuse and neglect.

Dr Glaser pointed out that with sexual abuse, only 10 per cent of children are actually physically harmed, that the harm is emotional; that what harms children the most is psychological abuse.

The use of descriptions of persistent harmful parent child interactions are powerful and crucial.

Conclusions

- Emotional abuse and neglect is common and harmful.
- Useful to organise information in 4 tiers.
- Description of **harmful parent-child interactions** (tier 2) is the evidence.
- Categories of harmful parent-child interactions indicate how to intervene.
- Possible to intervene without invoking child protection procedures.
- *Trial* of family's capacity to change.

In her discussion, Dr Glaser often referred to the 'Clinical Guideline on When to Suspect Child Maltreatment' (2009). Danya Glaser was the Chair of the Guideline development group and the guideline can be found online via http://www.nice.org.uk/guidance/cg89/resources/cg89-when-to-suspect-child-maltreatment-full-guideline2

Reported by Lisa Bolger

Book review

Infant Observation: Creating Transformative Relationships

Editor: Dr Frances Thomson-Salo
Publisher: Karnac
Year: 2014, 298 pages

Thomson-Salo's new book, 'Infant Observation: Creating Transformative Relationships' may well become a classic in the field of IMH literature. From the moment one picks up this slightly unusually sized book, whose book-cover image has so striking a face, one wonders what else might be challenging the reader who delves inside. Before I walk you through the contents, ponder with me for a moment. The cover image is of an infant, whose colouring is slightly dark, her eyes penetrating the reader. She will be the one who gazes. She confronts me, now, as I write this review. There is no mother, no other; she is fixed in her looking at us. The poise of this naked infant is remarkable. Is the image a little play on the notion of 'Infant Observation'? That we must know that the infant will be observing! The content of the book is equally remarkable. Inside it, the papers are rich, diverse and challenging; fifteen chapters allow for a lot of ground to be covered.

In a book filled with strong articles I shall mention a few that stand out. The well-known child psychotherapist and Infant Observation teacher, Jeanne Magagna's paper on being one of the last students of a seminar with the pioneer of Infant Observation, Mrs Esther Bick. In this account she brings out the extraordinary opportunity to observe an infant for a prolonged time i.e. from birth, through the first year, the arrival of a second child and into the third year where she can observe through language acquisition, the genesis of psychic life and fantasy play. Yet her focus is not just on the emotional development of the observed infant, but also includes an account of the role of the seminar leader and seminar members in holding her with the observer's task, allowing for possibilities that the mother needs her so much she, the mother, must implement a precipitous ending. I loved reading Mrs Bick's advice to the young Ms Magagna that an observer is to 'keep a hovering attention on the whole family at home' not have her binoculars aimed only on the infant. The advice is so subtle and nuanced, yet somehow so apt for the dynamic of that family home and perhaps every family's home? It makes me wonder how many observers today have achieved a three year observation, supported by a robust group who enable steadfast reflective frame for each of its participants, and helped to keep their 'attention hovering'.

Sally Moskowitz's paper on an observation/intervention with a single gay father offers an adaptation of the place of Infant Observation in the life of the infant. Moskowitz's frame of reference allowed for the traditional model of weekly visits, then a different frequency of visits for a stretch of time, up to the child's sixth year when the paper was written. This is considerably longer than the traditional observation which often must fit into an academic calendar, sometimes only nine months, or when the infant arrives at her first birthday. This author captures something tenuously difficult to handle in her observation of the meaning of mother, lack of mother, and yet number of 'mothers' (nannies, the observer, the surrogates), and pondering the father's replacing of the work 'mother' for the word 'lady' in the children's story books? Moskowitz is clear with us that she is writing about her visits as a form of a therapeutic intervention. She is interested in exploring the place of herself, a female observer, in the life of a gay man and his daughter born by surrogacy, and a subsequent boy child being 'delivered' unto them.

The paper by Anthony Castle offers a description of a very disturbing observation he undertook in the 1980s, i.e. over two and a half decades ago. The title 'Maternal Disavowal in the Face of Abuse of an Infant by Her Sibling' is both apt and disturbing. The author very thoughtfully poses the big ethical question for Infant Observers: if one encounters something very wrong, what is the role of the observer to intervene, what is the meaning of not actively intervening? How can the observer think not only of the victimised infant, the 'perpetrator' sibling, as possibly a form of the mother's projected sadism? Castle seems fully in touch with what he is observing, an older sister engaged in child abuse towards her baby sister. The title he gives leaves us in no doubt what he was seeing. What are the ethical frames of reference used in contemporary observations? Would a contemporary seminar leader offer a different response to the one Castle took, i.e. not take any direct action in regards to the sibling abuse. I would have loved a response by one of this book's authors. Yet perhaps this is also strength of the book, there are no prescriptions, every infant observed and every observer group must grapple with the dynamics, usually disturbing, if we take an infant's experience inside us as observers. It is not central to his paper, but Castle describes the 'last visit' is in fact six months after the infant arrived at her first birthday. This model, of a 'review' at eighteen months could be a significant stage in any Infant Observation. It offers the family and infant a sense of the observer's prolonged interest in the relationship with her infant observation family, it offered Castle the observer a chance to meet the infant as a toddler. In Castle's

example it confirms her gravest concerns that the infant sisters were left to themselves to develop a disturbing feeding relationship, possibly one that augurs badly for their future object relations.

Papers by Aiveen Bharucha and Graham Music conclude the book. Both authors engage the reader in thinking more closely about cultural variations, prescriptions and dilemmas. Bharucha's account of her infant observation seems very crowded. And yet that is the matrix of the family in which the Indian child usually grows. Culture here is not seen as a 'given', Bhaucha offers us a construct which is digested also in dyadic terms of how the infant 'uses' others to remain in lively connection . She questions whether the mothers' cultural requirement to be at home for the first seven months, puts pressure on them and their infants to grow up quickly? This question allows for the cultural environments influence via the mother-child dynamic to be examined.

Music's paper 'Struggling with Cultural Prejudice While Observing Babies: Socio-centric and Ego-centric positions' candidly tackles the unpalatable notion of judgemental feelings and responses of not just group members' experience, but his own opprobrium. He argues for the usefulness for infant observers to use the participant-observer stance of the anthropologist. He writes "in both one might see practices which are hard to bear, which conflict with one's own value systems, but which one has to struggle to accept". He nimbly applies this notion to the observation seminar; where participants are also socialised into a particular cultural value system.

One of the strengths of this book is that the editor has worked hard to give us, the readers, a non-heteronormative, non-European outlook. While the book's frame of reference is psychoanalytic Infant Observation, other models of thinking about infants are included. For example ideas from neuroscience and developmental research help us to understand the dynamics of mutual regulation, which is understood to occur between people who are closely involved with each other and some acknowledgement that "it seems likely that infant's experience of being observed registers via their mirror neurons (p.286)". The strength of the book, in my view, is the achievement of incorporating a deep lens with the choice of papers and a wide lens with how the authors tackle their topics. The ideas from psychoanalysis about the psychic life of the infant are deeper when culture, different family formations and neuroscience, are included and engaged with. Thomson-Salo offers papers from some of the strongest names in the field of Infant Observation, including a paper by the 'founder' of the model of Infant Observation Mrs Esther Bick. After the editor's introduction, she gives pride of place to Mrs Bick's significant place in the history of Infant Observation and the numerous branches of this form of training. Her paper included here brings to life the unusual role of the observer, a problematic picture of an infant with a depressed mother, and how this has an impact not just on the baby but also on the seminar group. How fresh it is to read Mrs Bick's paper, written over 60 years ago, and her conclusion, "innumerable exciting questions arise showing students the vast area of the unconscious still be explored by psychoanalysis" (p.27). This book could be seen as an ongoing dialogue with those exciting innumerable questions in both psychoanalysis and the many new domains. The late Mrs Bick has an equally creative peer in the very contemporary Dr Frances Thomson-Salo.

Ms Sarah J. Jones

Ann Morgan Essay Prize 2014

Welcome – it's great to have you with us this morning for the 5th Annual Ann Morgan Prize Giving. I would particularly like to acknowledge and thank the previous winners – Fiona McGlade, Sophie Constatanides, Judy Corum, Joanne McDoland and Margaret Dugdale for their on-going support of the prize.

My name is Julie Stone and it has been my privilege and honour to be the administrator of the Ann Morgan Prize since its inception. Administrating the prize has been a joy, and this is my final year in the role.

The Ann Morgan Prize was launched in 2010 as a way of honouring our beloved colleague Ann Morgan on her retirement from the AAIMHI Victorian Branch executive committee, where she held the position of Vice-President for many years. An annual prize – to continue in perpetuity – seemed a fitting honour, echoing the on-going legacy of Ann's clinical work, supervision and teaching, which continues to enrich the thinking and the practice of so many.

For the last three years, an annual writers' workshop, held in March, has been offered to our AAIMHI Victorian Branch members to support and encourage them to write about their experience and, hopefully, to give them the confidence and encouragement to enter the Ann Morgan Prize. Lee Coffman conducted this year's workshop at the Writers' Centre in the State Library, and the participants were very enthusiastic about their experience.

The number of entries continues to grow, a trend we hope will continue. It is good to have a wide field and to attract submissions from states other than Victoria. My sense is the Prize is now firmly rooted, but it still needs tending, shaping and nurturing, something that the new administrator and the new executive committee can influence with their energy and vision for the future. And if you have ideas to share, then please do, it is your prize.

If you have ideas of how we can enrich the prize and experience for entrants and the wider audience, please let us know. If you have ideas about ways to better to define the task or shape the prize let us know. Should there by a poetry prize and a prose prize? Should the prize be open to non-members? These are all questions to reflect upon and decide upon. We have developed some guidelines for writers, and these are widely interpreted by entrants, prompting reflection and lively discussion among the judges. In turn, their selection too may prompt some lively discussion among readers.

Each year all the submissions have been reviewed blind. This year Nichola Coombs, who hopefully will take up the role of administrator in 2015, assisted me in the task. She and I read the submission to ensure there was no identifying information, before copying the submissions and delivering a hard copy with a front page saying simply entry 1 or entry 2 and so on, to each of the judges. The identity of writers is not revealed to others at any point, except of course to announce the winner.

Ann was a judge in the first three years but wanted to be free from the shackles of having to choose which one was best, because she wanted to be free to delight in them all. Ann still receives a copy of the blinded entries and joins the judges' meeting. It is great to have her with us. Campbell Paul and Joanna Murray Smith have both been judges for each of the five prizes. Joanna's support of the prize has been fantastic. She continues to find the time and says it is a pleasure to be able to honour Ann, one of her favourite people, in contributing to the prize. Last year Louise Newman was a judge, but she was unable to commit to taking part in this year's prize. We are delighted that Christine Hill, who has organised and facilitated the writers' workshop and recently completed her PhD on infants and creativity, agreed to be part of the panel and Jenny Harrison, child psychiatrist and published and celebrated poet, also agreed. Good thinking and good women both, and great to have them and their thoughtful input.

I always enjoy the meetings and am impressed by how thoughtfully and respectfully each judge considers every entry. Perhaps somewhat surprisingly, along with the lively discussion there is a general unanimity of views. This year the judges agreed on a short list and then made a final decision on which entry was to win.

As was the case last year, the judges again decided to make two awards. The winning entry is Michele Meehan's entry titled "The Hall of Mirrors". Congratulations Michele on being the 2014 Ann Morgan Prize winner. The judges wished also to acknowledge Neil Underwood's creative-piece titled "A letter to two teachers", and to award him a high commendation. Congratulations Neil – our first male prize recipient. And a special thank you for making the effort to travel from Adelaide to be with us at today's prize giving Neil. It is great to have you with us.

Before handing over to the President of our Victorian Association, Teresa Russo, to give Michele and Neil their prize and to invite them to read their submissions, I would like to thank everyone who has submitted an entry over the last five years and I would like to wish all future writers and prize custodians the very best for the future of this prize which honours Ann Morgan and her contribution to our field.

Thank you.

Dr Julie Stone

The Hall of Mirrors

Michele Meehan

Looking toward the square near the cafe, it seemed strangely crowded with short fat figures, wide barrel people as well as beanpole men! What was happening to this place? As I approached the other side of the square, glancing back I saw that they had all disappeared, and in their place were five normal looking children all leaping around in front of some Fun House mirrors.

This distortion of view touched a chord when thinking about Elly and her mother Amy.

> *She looked like a little striped lanky-legged doll. Her fragile little legs covered in pink and blue stripes that made nonsense of the idea that stripes make you look fat! She sat in her pusher looking at me from the corner of her eye as I spoke to her mum.*
>
> *"You're my last resort" cried Amy and proceeded to tell the story of seeking help since Elly was 6 months. Her story was broken with tears and frenetic talk. She had documentation of foods tried, amounts eaten and weight not gained, perhaps proof, because if it was on paper it must be real and true.*

This documentation of baby's ins and outs is common today, sometimes in notebooks, or diaries, or even today's technology, the App on the iPhone.

- *Feed timer*
- *Baby Care Life*
- *Mamma baby*
- *One tap breastfeeding tracer (that one keeps track of what was the last side you fed the baby: it used to be a safety pin on the bra strap)*
- *Ins and outs by The Factory*
- *Baby Scheduler*
- *Feed me Mom.* How would you forget?

It may be easy to be cynical about these, but mothers today are a generation growing up with social media for all aspects of their lives, and this seems a reasonable extension.

But is this information highway contributing to the idea that mothers cannot trust their instincts, that others have the tools to care for the baby, not you? All of these Apps give you a reminder, a record and a summary of the day's intake and output.

In turn they give mothers a view of what a baby should be doing, looking like, or behaving. This need to measure the baby's life in micro elements is a modern development. What is this obsession with the minutiae of life? Initially, weight gain and the number and frequency of feeds and number of poos, provides a concrete record and reassurance that mum is doing it right. After all, the first question asked by almost everyone after finding the sex of the new baby is 'How much does s/he weigh?"

If the baby is gaining weight and developing then she surely is a 'good enough' mum and is reassured and knows her competence.

On the other hand in Infant Mental Health work this exploring of the finer points and details of the mother and the baby' daily events gives us a clearer picture of their interactions together, as well as demonstrate our interest in the little details that make up the family's day. Often of little interest to Uncle Bill, or childless work colleagues.

For Amy, with an anxiety dating back to the pregnancy, she has never been able to relax. While things went well she was in control, then with the unexplained cessation of weight gain following the introduction of solids, her world spun out of control resulting in postnatal depression, worry, and overwhelming anxiety.

> *Elly's weight chart showed her thriving to 6 months then a flat line to 12 months, with some weight gained in the last 2 weeks, This was evidence, and a concrete illustration of the problem, and despite mother's story of following advice and all attempts to remedy it, the weight was still just hanging in there.*

What does Amy see when she looks at Elly? Does she see the statistics and records and feel these are more real than the Elly she knows? Does the medical emphasis on her weight and failure to grow shift the image of her baby?

This may be reflected in the ambivalence of her report that it had been a bad week.

"She only gained 700 grams" in the month (last gain was 20gms) and the paediatrician had said she does not need a nasogastric tube now. This great news seems to be lost in her story of Elly refusing her cereal this morning.

Could she not see Elly as she was, but her anxiety projecting a distortion of this image?

And how true were my perceptions? What was I seeing in them? Was it the real image or one altered through the lens of my anxiety over how underweight she was, and her mother's desperation? The sense of being alone was reflected in all our discussions, and confirmed my belief that many babies who present with feeding concerns are initially fobbed off. "She looks fine, don't worry, just keep doing what you're doing" or "She'll eat when she's ready!" As Amy said, "If she thought she was alright she couldn't have been seeing her!!"

Many mothers who struggle with infant feeding problems are frustrated because what the health professional may only see is a healthy looking baby, while

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failing to see the struggle the mother is enduring to keep the baby looking this way.

How hard is it for us to see a baby, whose relationship is such that she chooses not to feed or eat? Is the baby too much a reminder of the fragility of life or the fallible nature of our work, and the great risk involved in working with mothers and babies?

In the face of a baby not eating, it can be hard to talk about the relationship between mother and baby and not be too directive in feeding advice. When trying to help the mother struggling with breastfeeding for example, it may be more helpful to emphasise the interpersonal aspects of the feed, gaze, voice, touch and motion, rather than positioning technique and milk supply.

> ***What a mess**! Rice congee and strawberries! Like blood on the snow! A strong preference displayed by refusing the congee unless it was dipped in the soup mum had made. Elly would put her skinny, E.T. like little finger into the soup and stir but not taste it, but then lean forward to drink from the container. When I tasted the soup, it was bland chicken stock, "it's nothing is it" said Amy "but she is so strong minded!" Elly took the strawberries willingly, and with spider-like fingers put it in her mouth chewed a bit then spat it out. Amy then softened the strawberry in her mouth then gave it to her, like a bird masticating for her chick. She was sitting on mum's leg as we sat on the floor and reached out willingly, opening her mouth, stirring the soup and ended up eating a bowl of chicken rice congee and 4-5 strawberries.*

Without watching Elly directly I could still see what she was doing. And while we talked above her she seemed to feel unobserved, not under scrutiny and was able to do her own feeding.

How similar to this was the feeling for Amy, of always being observed by medical people, challenging all the effort she was making to try to make Elly eat. Was our view of the couple distorted by our worry and how much do we look, but not see?

Amy felt desperate when home alone and unable to understand what Elly might be doing. Was she again only getting a distorted view of what was happening? With no buffer to her concerns, perhaps the mirror shifted and all she could see was her fear and a wraith-like baby and these images were being reflected on and on: a reflection of a reflection in the hall of mirrors.

Amy seemed more concerned with the amount eaten than the process.

> *Descending in an easy glide to the floor (I took a small chair!) she settled Elly on the floor rug she had brought and I spread the plastic mat.*

> *Amy was keen to start feeding, but Elly showed her preference for playing with the doll and the little cup, reaching out to touch the doll's eye and patting the cup.*

This determined behavioural skill of babies is a powerful manipulation of the pacing of events, and it can be hard to hold back anxiety and let the baby control the speed of events. Elly continued playing with the doll, albeit in a very tentative way, until Amy opened the bag.

> *To say she dived in would not be an exaggeration, toppling over face first onto the soft mass. Amy gently pushed her back up, but this was hampered by Elly having grabbed the plastic bag taking it with her.*

> *"She's hungry!" said Amy "and she ate breakfast too!"*

Elly's fluctuating appetite was a mystery to Amy and is hard to explain on a physical level to parents. But most parents can grasp the idea of ignoring hunger until it is below the conscious level; equating this with a headache, that if you can be distracted, you may suddenly realise it has gone. Good for the headache but not desirable for hunger.

> *Elly looked more vigorous in her eating today; opening her mouth and nudging mum if we were distracted. But a refusal (spitting the food out) seemed a body blow to Amy. But in talking to me in puzzlement, Elly herself reassured mum by grabbing the chicken nugget that was on the little bowl. Initially she took this to her mouth with two slender hands, nibbling delicately and looking at it between nibbles. Then she spat some coating out, and before Amy could comment put it back in her mouth.*

I took this opportunity to talk about what her mother's visit had meant to her.

Her mother arrived from Singapore when Amy was at the depths of her depression, helping her to start medication and offering to feed Elly. This she did by walking and rocking her and force-feeding or following her around all the time.

"But I could see this wasn't right for Elly" said Amy "so I told mum to stop".

This again was a change in perspective. Suddenly seeing her own behaviour in her mother's actions, and then being able to look at Elly and see how she was responding. Watching through the mirror, as it were, to what was actually happening.

> *"Like it must be a problem if my mum couldn't feed her, but after I saw that it wasn't just me!! And that felt like a relief."*

Depression can not only affect the mother-infant relationship in communication and responsiveness, but the actions of the baby may be distorted or blurred by the reflection of mother's sense of self-worth, or clouded as through a misted mirror; obvious in the broad view but hard to interpret accurately.

> *All through our discussion Elly was busy with the*

chicken nugget. Holding it in two hands and gnawing at it, sucking and chewing, occasionally dropping bits and ignoring them, but persevering.

As Amy turned back, she was on the last bit, and the coating fell off the remaining piece and she tossed it down with an angry exclamation. As Amy commented with a puzzled frown, Elly grabbed the second one that was nearby and started in on that.

Staying quiet was rewarded when Amy said "Oh you were just frustrated! Did you like that?"

With Amy ascribing reasonable behaviour to what Elly does, not "*Why* does she do it?" but rather "*What* is she doing?" gives a question that could be answered.

This was a clear vision of an Elly who enjoyed eating, and her mother who shared that pleasure with her.

As part of mother-infant work, it is normal to observe and be engaged with the infant, and the study of Infant Observation is vital to the training for infant mental health workers.

However it can be a challenge to be sure we are seeing what we think we are. How so for a parent, especially when one is wishing so strongly for something to happen.

The act of NOT being observed seemed to allow Elly to get on with her own plan about food, and her mother, distracted by our interaction, turned a fresh face to the activity and made a positive interpretation of what she saw this time.

Many things may get in the way of a single clear view of the situation. Not just the family but our own feelings or distractions of the day. Focusing and remaining intent in the situation is important and frequently tiring, but being sure we are seeing the family and not a reflection of events, or a distorted view as through a smoky mirror, is our challenge.

Elly decided she did not want food but to practice her new walking skill. Her mother put the food away and said she would give it later and encouraged Elly to walk, and a game began with Elly walking away and then turning back to laugh at us. Her mother clapped and laughed back and this sharing seemed to be a glowing reflection of a new relationship that was not distorted by the pressure to eat. Elly suddenly crawled rapidly back and grabbed a strawberry left on the plate and rushed off with it, held triumphantly high in her hand!

Michele Meehan is the winner of the 2014 Ann Morgan Prize with her entry titled *The Hall of Mirrors*.

Michele is a Maternal and Child Health Nurse who has been a member of the Australian Association for Infant mental Health since the early 80s. She has served as State and National President and is currently on the Victorian Branch committee.

Michele has post graduate qualifications in Community Health Nursing, Health Education, and Counselling. In 2008 she completed her Masters in Health Science (Parent & Infant Mental Health) in 2008 with her minor thesis entitled "He won't eat! Developing a model for treatment of infant feeding refusal."

After 30 years at the Royal Children's Hospital, in July 2013 Michele resigned to pursue a quieter pace in her private practice, Parenting Matters, which is mainly referrals for feeding problems.

She enjoys travel, especially to the WAIMH Congresses in exciting places, and in her leisure time sails and is Vice Commodore at Port Melbourne Yacht Club.

A letter to two teachers

By Neil Underwood

If you are honest, I'm sure that you could tell of a time – at least once – like I am having; looking over a cliff and wondering when to jump. I bet you wouldn't be doing what I am doing now though – writing letters at the same time on the back of a used meat pie bag.

The cliff is a personal one – a parole board hearing in a few minutes, actually. But don't for a moment allow yourself think that I am in any less danger though. This is my last chance. One of a string of them, and I can tell you, there is only one thing more shit-scary than falling down a hole, its being in one with no ladder. Worse, one where the things that once intruded on your brain now are so familiar they are comforting. The jail smells – stale white bread, stress, and another that surely can only belong to this kind of place – a mix of dust, damp and cheap toilet disinfectant. Faint sounds – a whining voice in a cell somewhere, talk-back radio. All have been enough to make me chew my nails until they bleed in the years past. Now I don't know what a world would be like without them.

I'm guessing also that your educated self finds it hard to believe that I have these words – I know your types. The manual might mention that all of us have ability in us somewhere, but I would bet money that you would see me differently. Bean-thin, worn out at 40, and an un-feminine face that would haunt your dreams; and all around me is a 'fuck-off' air. No, I'm pretty sure you wouldn't expect punctuation, let alone stories that are knit together well.

Another chance, whatever. Isn't that the script that runs in our heads from the day we have words? I reckon I'm right that we all have a voice from the time we first can remember – "get it right get it right get it right, just a little further and there is safety just over the hill." Trouble is, for me, that voice has been with me every day and sometimes all night. Dreams too. Let's leave those alone for a bit, right.

Dear Mr Addison

This is to you from my prison cell, writing with a pen like you taught me.

I sit here. Waiting for a key to turn. Today is not like the other days, and for some reason you seem to have found your way into my thoughts. Actually that's horseshit. Has there ever been a day when you haven't been there in some way? You are a thorn, a tone, a tincture. You are the window that I've always looked out of, and I never knew that it was cracked because it's always been there.

Maybe this poor troubled brain tries to make connections between then and now – then, a skinny and freckled girl from the 'burbs with a fresh face and a wish to be an astronaut; now, a person of interest, a headline, a token of a broken society.

You taught me not to trust my teachers, because the bigger and smarter ones are those that will put one over. Kind words lost their power first, then I lost all recognition of them. Be good to me now and I wouldn't know. You taught me that I owed you my silence, that I should be grateful for the favours of a man who is bigger and more powerful than me. It wouldn't be so bad if you didn't make me think that the silence is trust, protection, an elevated position. Only you and I knew, and only you and I know now.

It would be easier now if you had done standard stuff- hands up skirts, special anatomy lessons ... the things that the ladies tell me about their stories. But that would be too simple, and even now you screw with my head about what the hell is right and wrong.

Mr Addison, you were there from the early times and you never let me forget that. A seven-year-old girl, fresh from the boat, is hungry to know there is a place away from mum's Valium-induced holiday and her dangerous dad. Somewhere, anywhere.

Because of your smile, I distrust those that are evidently light hearted, and gravitate naturally to those who look like darkness is their companion. Because of you, the night time is the only place that really makes sense – inside or out of me.

Mate – you were a good teacher, obviously.

And this you will never know, wherever you are, that the rock-like bed I sit on now was made by you.

Most sincerely, V.

Dear Aunty Kat,

You never knew it, maybe, but you were my one true teacher. Even though you never went to university – or even school, as far as I may know – your simple and loving presence in the house next door was all I needed as a teacher.

Baked bread and buttons, digging a hole to hide things for the future ... those things that were "only you and me" but the difference, as big as a universe, was that our secret was for me ... not for him.

I don't know what it was after school afternoons that would lead me to knock at your flaky green door – and now I wonder if you sometimes sighed when the odd little Greek girl with the scabs on her knees rocked up yet again. But then, there was a wave of warmth that would catch my stomach knowing that when the door opened – and it always did – then your arms would be there behind it. That sweet sour smell – some outdated cologne that your husband had given her

years ago perhaps – mixed with musty frock, honey, flour. Something comes of seeing someone so long that you don't remember a time before them – knowing that you had a routine as worn as the beige cracks in your linoleum floors. Left, right, sit on the stool, tell you something- anything about the day.

How did you bring out the chatty nonsense in me? The story always ended up in those loose and light places in my imagination; and your face would somehow make it flow. It was – is – our story; I don't think that you would understand. Or anyone. And that's OK.

Aunty Kat ... you taught me that I have something, anything, that I take into the world, and I don't know how or even why you did it. I don't know if it was just for me or was it something that you gave to the world, to your sons and daughter.

Don't get all heroic on me, I don't trust your memory fully. Trust is a gift, not a choice. But I mistrust you less than anyone I have known. What you have given me is an invisible hand pushing me towards the possibility of good stuff, maybe somewhere.

And this you will never know.

I think of you lots. From V.

There are others who helped – jeepers, do I sound self-pitying? Telling this story I find my back straighten though.

And so now, in this space, I sit, but soon I will leave for the begging room. Never quite know which voice, Mr Anderson's or Aunty Kat's, will be loudest when I again sit on the beige plastic chair of scrutiny. Don't know if I will do what I'm meant to do, say what I'm meant to say. Gollum I am, forever to be pulled into light or dark, never able to be in between.

I'm guessing there will be Mr Phillips, the bent old guy who thinks his tinted glasses stop me from knowing he's trying to see up my skirt. And maybe there might be that youngish type, Marissa I think her name is. Boring as hell, it's not worth stirring her up as she doesn't click that it's happening. So to give in to the red dog and offer to make the old man feel better and screw him for setting me free? To keep the paintball stashed in my pocket and not chuck it at that bitch with the pencil skirt and perfect skin? Who knows – I don't have the luxury of good choices. I'm hoping though that I can maybe keep a lid on the shit. I wish I had a picture of aunty Kat to take in my pocket. Ah, they're here.

Neil Underwood is Clinical Practice Consultant, Perinatal and Infant Mental Health Services, Women's and Children's Hospital, South Australia. Neil's background includes training in mental health nursing, couple therapy, and infant mental health.

In 1997 Neil was awarded 'Mental Health Nurse of the Year' by the South Australian Mental Health Nursing Research and Education Centre, and in 2012 he won the South Australian excellence in clinical practice award.

Neil's passion in clinical work is in the therapeutic use of musicality and movement. In 2011 he was part of a successful grant application under the National Perinatal Depression Initiative to further develop a program reflecting this. He co-composed a suite of music specifically for use with pre-verbal infants in group therapy; this is currently being taken up as part of a state-wide expansion of community-based therapeutic groups.

Neil is on the Faculty of the Certificates of Perinatal and Infant Mental Health (run through Women and Children's Hospital) and is associate clinical lecturer at the University of Adelaide, where he teaches in nursing as well as the Masters program in counselling and psychotherapy.

Contributors for November 2014

Margaret Askew-Walinda is an Adult Psychoanalytic Psychotherapist in Private Practice; a Child Psychologist and Infant Mental Health Clinician also working as an Area Manager with Take Two, Berry Street.

Wendy Bunston is a senior clinical social worker, family therapist and infant mental health worker. She is undertaking her PhD at La Trobe University and researching how Refuge provides 'refuge' to infants.

Lisa Bolger is a Parent, Infant Mental Health Clinician in private practice and is the Senior Clinician with the Perinatal and Infant Mental Health Initiative at Austin Health.

Anthony Carlsson is a Researcher with the CASEA Program within Mental Health at Melbourne's Royal Children's Hospital. He is a D Psychology (Clinical) at Swinburne University of Technology.

Kathy Eyre is senior Occupational Therapist and an infant mental health worker within Melbourne's RCH Mental Health Program. Kathy previously worked as a facilitator within the "Peek-a-Boo Club" program.

Dr Richard Fletcher is the Leader, Fathers & Families Research Program at The Family Action Centre, Faculty of Health and Medicine, The University of Newcastle and is the Convenor of the ARACY Fatherhood Research Network.

Karen Glennen is Children's Coordinator, Barwon & Western District Areas Children's Resource Program. Karen was involved in piloting "BuBs on Board" in Tasmanian women's refuges in 2008 and has written about the 'homeless infant'.

Ben Goodfellow is an infant, child and family psychiatrist working at Geelong CAMHS on the infant program and paediatric consultation liaison service, perinatal psychiatrist at Bendigo Health, in private practice in Melbourne and is a senior lecturer at Deakin University.

Associate Professor Annette Jackson is a Social Worker and the Director of Take Two, which is the Victorian mental health service for child protection clients.

Sarah J. Jones is a Mental Health Social Worker/ Psychotherapist, Supervisor and Trainer in Private Practice; with a special interest in couple psychotherapy and its clinical relationship with infant mental health.

Jennifer McIntosh is a clinical psychologist, adjunct Professor at La Trobe University, Fellow of the Murdoch Children's Research Institute and Director of Family Transitions.

Dr Nicole Milburn is a Clinical Psychologist in private practice and the Infant Mental Health Consultant at Take Two.

Associate Prof Campbell Paul is an infant psychiatrist who has worked with infants and their families at the Royal Children's Hospital Melbourne for over three decades. He is involved in teaching infant mental health at the University of Melbourne and the Newborn Behavioural Observation through the Royal Women's Hospital.

Kristen Pringle is an Occupational Therapist/Senior Clinician with Avenues Education within Alfred CYMHS and is a clinical consultant in private practice. Kristen was previously a facilitator in the RCH "Peek-a-Boo Club" program.

Shelley Reid is a nurse-midwife and freelance professional editor working as a research coordinator in the RPA Newborn Care unit at Royal Prince Alfred Hospital, Sydney.

Julie Stone is an Infant, Child and Family Psychiatrist. Julie consults with a number of CAMHS and perinatal teams in rural Victoria and has a small private supervision practice in Melbourne.

Frances Thomson-Salo is a psychoanalyst, Honorary Principal Fellow the Department of Psychiatry, University of Melbourne, and Honorary Fellow the Murdoch Children's Research Institute.

Emma Toone is a child psychotherapist in private practice; senior clinician with the Infant, Child & Parent Program at Berry Street Family Violence Service; and lecturer at Monash University.

Perinatal and Infant Mental Health (PIMH) Program of Study

The NSW Institute of Psychiatry (NSWIOP)

The perinatal, infancy and early childhood periods are a time of enormous developmental and relational change for all family members. Early development occurs in the context of relationships, past and present, which act as risk and protective factors during this period. Knowledge of early development, skills and confidence in infant and relational assessment and intervention are central to competent perinatal and infant mental health practice. Professionals with these skills are therefore essential to comprehensive service delivery. Programs are offered in distance education mode with teleconference supervision.

Graduate Diploma of Mental Health (Perinatal and Infant) (48 Units)

A 4 semester course providing theoretical and practical knowledge and skills for therapeutic work using a relationship based approach with infants, care-givers and families in a variety of settings, and for roles in service and policy development and delivery.

Year 1

Semester 1: Core Infancy Studies I (6 Units), Infant Observation I (6 Units)
Semester 2: Core Infancy Studies II (6 Units), Infant Observation II (6Units)

Year 2

Semester 1: Clinical Infancy Studies I (6 Units), Clinical Supervision (6 Units)
Semester 2: Clinical Infancy Studies II (6 Units), Clinical Supervision (6 Units)

Master of Mental Health (Perinatal and Infant) (Clinical/Research) (24 Units)

The 2 semester Coursework stream program is designed to equip professionals working in the area of infant mental health with appropriate, comprehensive, skills for providing leadership within the discipline. There is an emphasis on developing students' critical thinking, analysis and awareness of current debates within the area.

Completion of Graduate Diploma of Mental Health (Perinatal and Infant)

Semester 1: Advanced Clinical Practice I (6 Units), Current Debates in PIMH/Elective Unit (6 Units)
Semester 2: Advanced Clinical Practice II (6 Units), Current Debates in PIMH/Elective Unit (6 Units)
A Research stream is also available on achievement of a satisfactory pass in the Graduate Diploma and Research Methods. By application (12 Units)

Infant Observation

A 2 or 4 Unit Infant Observation, with entry in Semester I or II, provides 12 units toward the Graduate Diploma. Infant Observation augments psychotherapy training and clinical knowledge by observation and discussion of the emotional development of an infant, within the context of the family. Small group supervision is provided by teleconference.

NSWIOP Locked Bag 7118, Parramatta BC NSW 2124 Australia
02 9840 3833 **www.nswiop.nsw.edu.au**
Course Director: Dr Nick Kowalenko
Enquiries: Martha.Birch@nswiop.nsw.edu.au
ESO: Luisa.Mulholland@nswiop.nsw.edu.au

INTRODUCTORY CERTIFICATE COURSES IN PERINATAL AND INFANT MENTAL HEALTH, SOUTH AUSTRALIA

Two Introductory Certificate courses are run annually from the Women's and Children's Network (WCHN) in South Australia, mainly by staff of the Perinatal and Infant Mental Health Services and Department of Psychological Medicine. Students receive an introductory certificate from the WCHN.

The intent of each course is to provide basic knowledge and some skills in the relevant area, with one course focusing on infant mental health (IMH) and the other on perinatal mental health (PMH). There is a mixture of didactic input with one or two lectures per week providing relevant information which will supplement students' reading. In addition, there is a significant focus on self-reflection and the impactful nature of the work, with the Certificate of Infant mental health using infant observation which is supervised in small groups and the perinatal mental health course using reflective case supervision.

Each course usually takes up to 35 students from a wide range of disciplines and agencies including social work, psychology, general practice and psychiatry, mental health nursing, midwifery, childcare, NGOs, private practice, child protection services, education and more. During each run, at least 3 remote sites can be accommodated via tele health, with at least 6 people required to ensure viability of small group work at that site. Many South Australian country towns have used this facility and several remote sites from other States of Australia.

The courses each run for 10 consecutive weeks on Wednesday afternoons from 3-6 pm and are run face to face at Glenside Hospital in Adelaide. The Introductory Certificate in IMH will run from January 28, 2015 to April 1, 2015. The Introductory Certificate in PIMH will run from April 29 to July 1, 2015.

The cost is $500 per student. Enquiries from Rochelle Brown at Rochelle.brown@health.sa.gov.au or Anne.SvedWilliams@health.sa.gov.au

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POSTGRADUATE ONLINE COURSES ON *FATHER-INFANT ATTACHMENT* AND *WORKING WITH VULNERABLE FATHERS*

How does father-infant bonding take place and how do couples co-parent? How do we engage with fathers when partner violence or abuse may be present? How do we achieve a balance between enthusiasm for fathers' involvement and mothers' need for support? These two online courses provide answers.

Father-Infant Attachment and Co-Parenting: Theory and Intervention
http://www.newcastle.edu.au/course/HLSC6112.html

Students in this course develop a thorough understanding of the formation of father-infant relationships. Fathers' interactions with their infants are now the subject of increasing interest to researchers and their patterns of play, nurturing and care are now being linked to long term child outcomes. At the same time, a father's relationship with the mother is also identified as an independent factor in plotting children's development. How couples negotiate and develop a sense of comfort with their roles as 'mother of new baby' and 'father of new baby' is an emerging are of research. Both the role of fathers in co-parenting with mothers and the development of the father-infant bond have important implications for therapy and support of fathers and their families. Examples of effective practice wi new fathers and their families will be described and discussed in order to develop the skills to engage with fathers while delivering effective programs and services for families with infants.

Working with Fathers in Vulnerable Families
http://www.newcastle.edu.au/course/HLSC6126.html

This course will provide an evidence-based, practical understanding of how to include men (fathers, uncles, boyfriends) in the services and programs aiming to support vulnerable families. The course uses motivational interviewing and Alan Jenkins' restorative approach to assist fathers to find an ethical basis and the means to develop new ways of relating. The video and written materials identify and clarify the competencies needed to promote reclamation of a sense of integrity for fathers who have been distant, controlling, violent or abusive. Successful (and promising) interventions with fathers will be examined and practical exercises including specific, brief research projects connected to students' work environment ensure that the course is relevant to practice.

These online courses will be available in 2015 as stand-alone courses or through enrolment in the postgraduate programs in Family Studies at The University of Newcastle.

Website: http://www.gradschool.com.au/ Phone 1800 88 21 21

MASTER of MENTAL HEALTH SCIENCE (INFANT STREAM)   The University of Melbourne

The University of Melbourne **Master of Mental Health Science** programs are recognised professional development for a wide variety of mental health and associated vocations and provide a solid grounding in selected areas of mental health practice. A Graduate Certificate, Graduate Diploma or Master degree in Mental Health Science will be viewed positively by employers and may lead to advancement within a mental health related career. The research year at Masters level provides graduates with the experience for those who may wish to pursue a PhD course.

The focus of the **Infant Stream** is primarily on the baby and the infant/parent relationship. We provide an interdisciplinary training in skilled assessment and intervention with families.

The **Infant Stream of the Master of Mental Health Science** builds upon the former University of Melbourne *Graduate Diploma and Masters courses in Infant and Parent Mental Health* (est. 1996) and was developed out of the clinical, teaching and research work of the Infant Mental Health Group at the Royal Children's Hospital Melbourne and other infant mental health programs in Australia and world-wide. The course draws broadly on the disciplines of psychiatry, developmental psychology, attachment theory and psychoanalysis for the theoretical basis to provide a sound practical basis for working with infants and families experiencing mental health problems.

The Student Experience: What can you expect in this stream?
Students are drawn from a wide range of health and welfare professions, and a strength of the course is a rich interdisciplinary experience.

The Infant Stream is taught at the *Health Education Learning Precinct* located at the Royal Children's Hospital Academic Centre. It is delivered as a part-time course with on-campus teaching one afternoon per week over two twelve-week semesters each year. **Distance students** attend using video conferencing facilities and obtain reading material supported by the University ePortal.

The Infant Stream is coordinated by Associate Prof Campbell Paul and subject coordinators are Associate Professors Brigid Jordan and Frances Thomson Salo. Additional teaching faculty are drawn from the staff of the Infant Mental Health Group, Royal Children's Hospital, and other clinical infant and parent mental health programs.

Infant Course Stream Structure

YEAR 1: Graduate Certificate: 1 YEAR PART-TIME- 50 Credit Points
2 Infancy theoretical units
1 clinical and 1 observation units

YEAR 2: Graduate Diploma: 2 YEARS PART-TIME - 100 CP
2 Infant observation seminar units
1 clinical infant mental health theory unit
1 Research prep (if continuing to masters level) or 1 Selective subject

YEAR 3: Master: 3 YEARS PART-TIME - 150 CP
2 Research Units (completion of a research thesis)

Now accepting applications for 2015 entry

Applicants must meet all entry relevant requirements to complete any part of this course.

The **Masters of Mental Health Science** is now open for applications through this website: http://medicine.unimelb.edu.au/study-here/postgraduate_coursework_programs/master_of_mental_health_science

MDHS Student Centre t: +61 3 8344 5890 e: mdhs-sc@unimelb.edu.au ; www.sc.mdhs.unimelb.edu.au ; http://medicine.unimelb.edu.au/MC-MHSC

The Academic Programs Administrator: Ms Aris Cologon
Department of Psychiatry, University Of Melbourne
Phone: 8344 8975 (Office) Fax: 03 9035 8842 E-mail: acologon@unimelb.edu.au

Other course enquiries: Course Coordinator (Infant Stream)
Assoc. Prof Campbell Paul
Phone: 03 9345 5502; Fax: 03 9345 6002 E-mail: cwp@unimelb.edu.au

MASTER OF MENTAL HEALTH SCIENCE (MMHSCI) – CHILD PSYCHOTHERAPY STREAM

The Master of Mental Health Science is available by coursework or minor thesis and provides the opportunity to exit the course at Graduate Certificate or Graduate Diploma levels as long as requirements for that alternative exit have been met. The program offers specialisation in Child Psychotherapy.

This three-year, part-time degree is taught off campus by some of Australia's most experienced mental health professionals and researchers, allowing you to apply the latest thinking to your workplace as you study. The course also includes an on-campus workshop.

The child psychotherapy pathway gives you a deep understanding of psychoanalytic and developmental theory and how it can help children and adolescents with emotional and behavioural problems.

Students seeking to be considered eligible for professional recognition at graduate diploma level in the child psychotherapy specialisation need to complete all core and elective units in that specialisation. Successful completion fulfils one of the criteria for professionals to be employed under the Child Psychotherapists Award and to be eligible for membership of the Victorian Child Psychotherapists' Association

Further Information: Monash School of Clinical Sciences
Course Administrator: Ciara Boyd Ph: 9594 4789
Child Psychotherapy Stream: Dr Jennifer Re Ph: 9371 0205
Email: mmhs.psych@monash.edu
http://www.monash.edu.au/study/coursefinder/course/4508/?courseview=domestic

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Guidelines for contributors

AAIMHI aims to publish three editions per year in March, July and November. 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 to the AAIMHI Newsletter Committee.

AAIMHI Newsletter Committee

Inquiries on submitting items to the newsletter may be made to:
Ben Goodfellow at newsletter@aaimhi.org
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