Australian Association for Infant Mental Health Inc.

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In this issue …

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

Welcome to the winter edition of the newsletter for 2015.

As an editorial team we continue to be encouraged by feedback and ideas about the newsletter as a communication resource for the membership. The current edition is leaner in content following two bumper issues, sparking us to wonder whether in fact leaner or larger editions serve a greater utility to members. The National Committee has suggested we may directly survey the membership on the topic of the newsletter to continue to grow it as a reflective written space for infant mental health conversations in Australia.

Following this theme of growing a voice for infant mental health conversations, we begin the current edition with a report from our National President, Sally Watson. She reports on the work of AAIMHI toward continuing to build a voice for infant wellbeing across Australian geographies, including online and in public policy settings. A report on AAIMHI WA's recent launch of infant mental health competency guidelines continues these ideas providing a tangible way of embedding standards for practice for helping infants and their families in the systems surrounding them.

We then turn to a review of a professional development event in Victoria exploring ways of working with infants within their family systems, integrating work with both parents together. This work seems particularly pertinent in light of AAIMHI's upcoming national conference *And father makes three: family inclusive practice* and current public conversations on the sequelae and healing opportunities amidst family breakdown and violence. In the current edition we have received our first – of what we hope will be many – 'Letters to the Editor'. The letter, written by Salo & Paul in response to the April edition article 'Work in Remote Australia' reconsiders the challenges and hopes to remediate children's fragmented care experiences.

We are delighted to conclude the edition with another first for the newsletter under the current editorial team: an artwork from an AAIMHI member, Sophia Constantinides, inviting contemplation on themes of maternal-infant experiences in a geography beyond words.

The next edition of the newsletter will be a 2015 Ann Morgan Prize special edition. This will include a section for 2016 courses and we encourage training providers to contribute. We also invite general articles from the membership for the final 2015 newsletter to be published in November.

We hope you enjoy the July edition.

Ben Goodfellow and Emma Toone

From the President

As I write this report I feel very excited about the direction that AAIMHI is taking. The National Committee recently met for our annual face-to-face planning day. At this meeting we reviewed the achievements over the past 12 months (and there have been many), and looked forward to working towards achieving our priorities over the next 12 months.

The employment of Katherine Loftus as our project officer has enabled us to 'get our house in order' so that we can more clearly communicate our message and really lift the profile of AAIMHI. One of the outcomes is the development of a new logo, which will be launched very soon. Considerable thought went into this, as to something that was simple but got out key messages around relationship and containment. In conjunction with the development of the new logo has been tireless work on developing our new website. I would like to particularly acknowledge Annie Mullan for the hours and hours and hours of work she has put into this working closely with Katherine and continuing to drive its development. As part of the website development we are looking at how we can increase membership benefits.

Our goal is that AAIMHI is a 'go to' organisation for comment and information on infant mental health. The development of the communication strategy was a key part of us moving in that direction. The website is going to be an important point of access. We want to make sure infant mental health is on the agenda, and that we 'at the table' when it is being discussed. In order to do this we will need to be active in raising our profile and making links with other key organisations. A good example of this is the Royal Commission into Family Violence. The roundtable discussions that were occurring around the country were brought to our attention by an AAIMHI member, and we then participated at roundtable events around the country, lifting up the infant's voice. In some discussions AAIMHI was the only voice speaking for the infant. Our communication strategy which outlines key messages will ensure we have consistent messages and can respond more quickly to issues as the arise, but also importantly, proactively put our message out in the community.

Since our last newsletter, there has been considerable work done on position papers. The overnight stay position paper and discussion paper has been reviewed and is now complete. Work has also begun on developing a position paper on infants in immigration detention, following a motion that was passed at the last AGM for AAIMHI to develop such a paper. A position paper on domestic violence is also being developed. These position papers while overseen by the National Committee have only developed because of members' involvement at their branch level. I thank everyone for the work they do – we are all volunteers, and much is being done.

The National Committee is made up of a Representative from each Branch, who is elected by the local Branch Committee. Some Branches choose to have the State President as the National Committee representative, other Branches split this role. The National President position is a one-year term, with a maximum of three consecutive one-year terms. The National President must be from the previous National Committee. The National Treasurer and National Secretary positions can either be either filled by a State Representative from the National Committee, or they can be an additional position on the committee. At this stage we also have an additional role on the committee for Advocacy, which is a non-voting position. Why am I saying this? I think it is important that all members are clear how the National Committee functions and what opportunities exist for you to become involved at that level. Elections will be coming up over the next few months so if you would like to become more actively involved at a Branch or National level there are a number of options.

On another governance issue, we are excited that there is considerable interest in trying to get an AAIMHI Branch in Tasmania; an initial meeting has been held with interested people and we are looking at how the National Committee may be able to support the establishment of a branch in Tasmania.

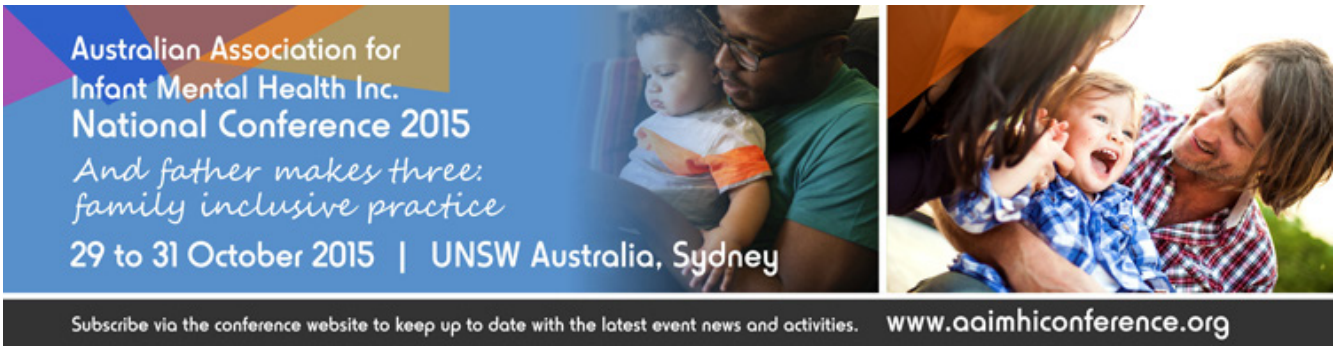
Finally, I hope you have all put the 29 – 31 October in your diaries, because that is of course the date of our next National Conference: And father makes three: family inclusive practice. We have two international speakers, Sarah Schoppe-Sullivan and Professor Kai von Klitzing, and a number of great local keynote speakers.

As I look forward to the year ahead as branches and the National Committee move forward on achieving our goals I am reminded of the statement made by Margaret Mead:

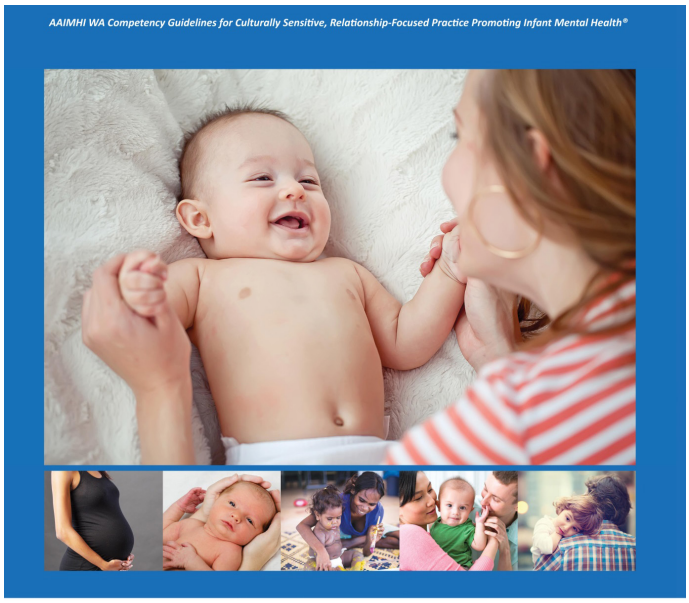
"Never doubt that a small group of thoughtful, committed people can change the world. Indeed, it is the only thing that ever has."

It seems so apt for us in AAMHI, a reasonably small group, but with so many committed people speaking for the infant, and there are certainly some changes that need to be made.

Sally Watson



Rochelle Matacz



Official launch of the AAIMHI WA Competency Guidelines for Culturally-Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®

AAIMHI WA brings internationally acclaimed professional competency guidelines promoting optimal infant mental health to Western Australia

From July 2015, the Australian Association for Infant Mental Health West Australian Branch Incorporated (AAIMHI WA) will start collaborating with organisations and agencies working with infants, young children and families to bring the AAIMHI WA Competency Guidelines for Culturally-Sensitive, Relationship-Focused Practice Promoting Infant Mental Health® (the Competency Guidelines) to their workforce.

The new Competency Guidelines identify eight areas of competency: theoretical foundations; law, regulation and agency policy; systems expertise; direct service skills; working with others; communicating; thinking; and reflection. AAIMHI WA's well-attended bi-monthly training seminars align with these areas of competency.

AAIMHI WA has received funding from the Mental Health Commission to employ a project coordinator for 12 months to promote the new Competency Guidelines and collaborate with agencies that provide training and skill development in infant mental health. The creation of this position will play an important role in developing a sustainable cohesive training framework for the state, which is aligned with the Competency Guidelines.

The Competency Guidelines were launched on 27 March 2015 in Subiaco. The successful breakfast event started with Shaun Nannup welcoming the 70 participants to Wadjak country in an engaging performance.

Guest speakers Dr Deborah Weatherston, Executive Director of the Michigan Association for Infant Mental Health (MI-AIMH) and Kate Civitella from the Mental Health Commission joined AAIMHI WA President Rochelle Matacz to introduce the new guidelines and their significance for the many professionals working with infants, young children and their families in WA. Dr Weatherston was a member of the committee that guided the development of the internationally renowned MI-AIMH Competency Guidelines for Culturally-Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®.

Rochelle Matacz said that professionals working with infants and their families before birth and in the first years of a child's life have the opportunity to promote knowledge and awareness about why a caregiver's nurturing emotional relationship with their child is of vital importance in the early years. Research has identified infancy and early childhood as a critical stage of development and demonstrated that engaging with families during this period plays a key role in building wellbeing and good mental health across the lifespan.

'We know that babies learn the emotional and social attitudes that will influence the course of their development through nurturing, stable relationships with their parents and close caregivers,' Rochelle said.

WA is leading the way internationally as the first affiliate of the World Association for Infant Mental Health outside the United States of America to have a licensing agreement to adapt and use the MI-AIMH Competency Guidelines®. The AAIMHI WA Competency Working Group worked in close collaboration with Dr Weatherston to adapt the MI-AIMH guidelines for the Western Australian workforce.

L to R: Dr Lynn Priddis, Dr Deborah Weatherston and Kate Civitella

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Guests at the launch represented a range of service levels including Senior Policy Officers from the Mental Health Commission of WA and the office of the Commissioner for Children and Young People. Also present were directors and managers from government departments in Health (Child and Adolescent Mental Health Services, Child Development Services, Princess Margaret Hospital for Children, King Edward Maternity Hospital), Education, Disability Services, Child Protection and Family Support, Local Government and Communities, and non-government organisations such as Ngala, St John of God and Raphael Centres, Ruah, Wanslea, Communicare, Australian Red Cross and Edith Cowan University.

The Competency Guidelines® have the potential to provide a framework for building long term relationships and collaboration between all those contributing to the emotional well-being of infants, young children and their families. It is hoped that implementation of the Competency Guidelines® will significantly contribute to improving the lives of all infants, young children and their families in Western Australia.

To read more and purchase the AAIMHI WA Competency Guidelines for Culturally-Sensitive, Relationship-Focused Practice Promoting Infant Mental Health® online, click on http://www.aaimhi.org/viewStory/WA+Training+and+Events

Annie Mullan and Anne Lowagie

Reflective family play

Julian Charles

On a windy autumn day in Melbourne, approximately 80 people from a variety of professional backgrounds crammed into a small room at the Royal Children's Hospital. The purpose: to spend a day with Assistant Professor Dianne Philipp, learning about a new therapeutic model she has developed called Reflective Family Play – a family based intervention with infants and young children. This essay will provide a brief summary of the workshop and the therapeutic model.

Dr Dianne Philipp is an Assistant Professor of Psychiatry at the University of Toronto Medical School, Canada. She is a staff psychiatrist and on the faculty at the Hincks-Dellcrest Centre, Toronto. She has written extensively on working with families in the infant and preschool population and recently published, The baby and the couple: Understanding and treating young families (Fivaz-Depeursinge and Philipp, 2014; Routledge).

Dr Philipp is an articulate, warm and inspiring teacher. Following her lecture on the clinical applications of the Lausanne Family Play (LFP) paradigm the preceding night, she led us through the development of the Reflective Family Play (RFP) model and its clinical application, richly complemented by her extensive clinical experience. Under the sufferance of a cold, Dr Philipp did this with humour and flexibility, accommodating the multitude of technical difficulties and spacing issues on the day, and generously sharing her own experience and difficulties in trying to apply the model. She also responded to questions throughout, attempting to adapt the model to the various population groups and challenges raised by those present.

As stated in the forward to the manual distributed to participants on the day, the past several decades have increasingly demonstrated the importance of understanding infants in the context of the family system. Reflective Family Play (RFP) was developed in this context. It is a play-based, manualised intervention to provide brief family therapy for the very young and their families. It combines elements of an attachment-based approach (Watch, Wait and Wonder - WWW) with the assessment tool known as the LFP paradigm. RFP proposes it bridges a gap in the treatments previously available for families with infants and young children by offering a systematic way of working with one- or two-parent families and siblings of this very young population. Dr Philipp identified the key theories underpinning RFP as systems theory and attachment theory, and the key concepts of reflective function and mentalisation, along with intersubjectivity and multi-person relationships. She also highlighted the integral role of play in the therapy, emphasising its place in the title of the model is no coincidence.

In practice RFP appears like the following: From referrals to the clinic, certain families are selected to enter into RFP. Then after an approximately 3-session assessment and feedback phase the family is contracted initially for eight weekly sessions, with the possibility of extending by another 4 to 8 sessions of RFP considered at the end of treatment. Each approximately one-hour session is divided into two equal parts: 1) families being videoed playing together, and 2) a reflective discussion about the play from the first part, supported by use of the video footage. This structure is repeated for each therapy session, as is the room set up and the toys available for play. The therapist sits behind a one-way screen (or remains non-conspicuously in the room).

For the initial part (based on LFP) families are given verbal instructions on what is required. They are to negotiate a number of transitions within approximately 20 minutes including each parent individually playing with the child(ren) while the other parent is 'simply present', playing all together as a family and then the parents reflecting together on the play whilst the child(ren) is simply present. This requires the parents to coordinate with one another throughout and provides a framework for the family to work together in its various configurations. This appears as challenging as it sounds. The family signal when they are finished. In the second part, the parents are asked to reflect on the play from the first part. The therapist follows the parents' lead and explores what observations they bring up, as adapted from WWW. This exploration is supported with video footage of the moments discussed. As described in the manual, the aim of this part is to help parents become more attuned to their child (and to their partner), as well as to be more mindful of their own experience. By primarily focussing on the moment-to-moment interactions of what is said and done, there will hopefully be an enhancing of their reflective function and capacity to mentalise.

During the afternoon Dr Philipp demonstrated the model to us through video footage of cases where she was the therapist. She highlighted the difficulties in 'working by the book' and thought creatively on how it can be adapted to various clinical

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Reflective family play (cont.)

scenarios. She also emphasised this is an evolving model and encouraged feedback of people's experience who go on to use RFP.

In considering limitations, RFP is early in its use and requires further research to evaluate its effectiveness. It requires a reasonable amount of technical equipment and could potentially be logistically tricky and resource-intensive to run. It would be interesting to see how it might slot into a typical CAMHS setting, for example. It may be challenging to select which families would most likely benefit from a more insight-oriented and whole family approach as opposed to one of the already established dyadic models currently available.

A primary strength of RFP is its capacity to work with infants and very young children within the whole family context. It is systematic, structured and adaptable. It focusses on the parental subsystem and reflective function. It can accommodate various family configurations in the sessions, for example, single child, multiple children, single parent and multiple care-givers, such as grandparents who provide key support to the parent(s). It insists all family members be present where possible, assertively including fathers and/or other parental figures. The structure of the session shifts focus from presenting problem and symptoms to the family dynamic, the live interactions being a window into this, with video footage supporting rich reflections. It thereby also includes all members in thinking about and working through their concerns. It models many aspects of family life that can be pursued at home, particularly play, reflection and 'holding others in mind'. The family playing together in session can also be therapeutic in and of itself. The aspect of following the child(ren)'s play means it has a large component which is non-directive and child focused. The video feedback potentially accelerates parents' reflections on what is said and done in a way that differs from relying on recollection (also potentially shortening treatment time).

Dr Philipp's enthusiasm for working with very young children within the family context was inspiring and a reminder to consider who is, and who is not, in the room when working with this population, and the impact this may have. It would be very interesting to follow in subsequent newsletters the experience of those who are brave enough to trial RFP in their clinical setting.

References

Philipp DA (2012). Reflective Family Play: A model for whole family intervention in the infant and preschool clinical population. Infant Mental Health Journal 33:6, 599-608.

Philipp DA, Hayos C (2015). Reflective Family Play: A manual for family based intervention with infants and young children. Toronto, Canada: Hincks-Dellcrest Centre/Gail Appel Institute.

Letter to the editors

Dear Ben,

Thanks for your article about the rural work you did in which you present an encounter with a 5-year-old boy, Michael, and his foster mother after early exposure to extreme violence and multiple short disruptive placements, and we'll respond to a couple of points.

We thought your account illustrated the potential impact of a single session in the context of a system receptive to input as well as validation through the child's play and behavioural response to the thoughtful reaching out of a therapist to the troubled child and his carers. It reminded us of Winnicott's engagement on one occasion with a boy with syndactyly in a children's hospital in Kuopio, Finland, where the consultation was observed by the ward staff and he later spoke with the boy's mother about her sexuality and guilt about passing on her disability (Winnicott, 1971, pp 12-27). Despite not speaking the boy's language Winnicott using play engaged with him straight away with the Squiggle game, anticipating what may have been his trauma and worry.

About Michael saying the letter 'M' was his name

This may point to his experience; he had so many placements he did not always know who or what he is or has. (Saying 'M' was his name may also stand for 'Mum', especially if he said it after you asked about him occasionally seeing his mother.)

'Beyond' the best interests of the child

You wondered about Michael being put in ten different placements before a permanent family was found. This reminded us of the then controversial position of Anna Freud, Alf Solnit and Joe Goldstein in the late 1960s, that when family breakdown has resulted in involvement with the legal system it is already 'beyond the best interests of the child' (Goldstein, Freud & Solnit, 1973). They argued for an early finality in decision-making about placement rather than, for example, after a number of trials of reunification. Whatever strong reasons exist for trying to delay finalising an alternative placement very quickly, however compelling reasons such as cultural ones that might view a child as needing to stay with their family, children need for physical and psychological reasons to attach to whoever is looking after them and suffer further detriment with every change. We know that they are likely to do best when there's a sense of permanence about placement, even if there's sadness about loss of some contact with the biological family.

If we put the best interests of the child first, we have to be serious about trying to find the next best placement rather than wait for a return to the family of origin which may never materialise or take too long, as the end effect of this may be to privilege the interests of adults over those of the child.

What 'Michael' said

You wondered what to make of the ease with which 4-year-old Michael said out of the blue, "My dad stabbed my mum". Any

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child wants the meaning of what he said to be acknowledged, and needs some sense made of it, if it's about an event that has forever changed his life. Even if he didn't see the event, but only heard people talking about it.

You clearly tried to explore scary and angry things, and for a child to feel that even just one adult had understood what they feel should never be underestimated.

It is always difficult meeting a child the first (and only) time, to know how direct to be. We might try to explore what Michael said about his dad stabbing his mother (thinking that his statement contains many unasked questions) and might say something along the lines of it being scary. We might add, "You wanted me to know about that", and "It shouldn't have happened, it was very, very wrong", and we might add something like "Daddy needed help and he didn't get it."

Michael's aggressiveness presumably often comes about when he is anxious and tries to be big – and frightening (as perhaps he had seen his father be). If talking about his father's action is partly an attempt at an explanation for the ruptures in care, those looking after Michael might need to be aware of helping him keep what good he can, at least in an internal father-object relationship, so that he does not have to check himself from identifying with an object seen as totally bad.

We wonder whether above all what Michael hoped for was acknowledgement.

We guess the central message is that children will be kept safe. What comes over is that you tried to prevent the effects of further negative projections onto this child and not only to keep the doors of communication open for him and for those looking after him, but to engage the child's capacity for repair.

Thank you for the opportunity to go on thinking about these things,

Frances and Campbell

References

Goldstein J, Freud A, Solnit AJ (1973). Beyond the best interest of the child Vol 1. New York: The Free Press.

Winnicott DW (1971). Therapeutic consultations in child psychiatry. London: Hogarth.

Contributors for July 2015

Dr Julian Charles is an advanced trainee in child and adolescent psychiatry based at Geelong and Box Hill Victoria. He will soon undertake the infant mental health fellowship at the Royal Children's Hospital Melbourne.

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.

Annie Mullan is a clinical psychologist working in a child development service in Perth. She is an executive board member for AAIMH; immediate past president of AAIMHI WA; and a member of the AAIMHI WA Infant Mental Health Competency Working Group.

Anne Lowagie manages a Child and Parent Centre in Balga and is a member of the AAIMHI WA Infant Mental Health Competency Working Group. She recently worked with the Australian Research Alliance for Children and Youth as project manager for five years.

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

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.

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.

La Figura nella Veduta #2. © Sophia Xeros-Constantinides

'In this series 'La Figura nell a Veduta', I have extended my visual exploration of the world around me with an intergenerational and cross-cultural collage 'play'. The series was conceived in 2011, whilst on a trip to Italy with fellow artists where I happened upon a second-hand set of reproduction prints depicting antique views of Tuscany, Viaggio Pittorico della Toscana ('Pictorial Journey of Tuscany'). The reproduction bi-fold pages were exquisite in their detail, encased in battered cardboard bindings, and blemished with age. It felt like I had uncovered a treasure trove buried in time.

My impulse has been to work from each bi-fold in turn, using the material as a source of compositional inspiration for collage. I have chosen to extend the 'veduta' (the 'view' or 'vista') provided by male artists of the past, so as to include evidence of the experiences of women. I have therefore inserted into the landscape visual references to women and infants and transformed the vista into a 'maternal-infant space' for consideration by the contemporary viewer.

I have incorporated some of my own etching print-work in the form of collage fragments, as well as found imagery from magazines, books and reproduction medical texts. I am proposing alternative pictorial journeys for the viewer, seen through the lens of my own gender and culture – that of a twenty-first century feminist Australian artist and clinician, with a Mediterranean heritage.'

ARTIST STATEMENT

The art Sophia Xeros-Constantinides explores the female form and questions what it is to be human. Her art-practice is characterized by appropriation and juxtaposition, which manifest in her collage works on paper and in her prints and drawings. These works challenge integrity and identity, recall surrealistic and uncanny forces and give expression to alternative realities.

She was a selected exhibitor in the 2010 Swan Hill Print & Drawing Prize, in the 2010 Beleura National Works on Paper Exhibition at the Mornington Peninsula Regional Gallery, and in the 2010 Fremantle Print Prize.

Sophia Xeros-Constantinides is a Postgraduate PhD student with the Faculty of Art & Design at Monash University, Caulfield. She has exhibited prints at the Impact-7 International Printmaking Conference at Monash University in September 2011, and presented a conference paper entitled Fertile Bodies: Fearsome space, collage and the maternal print archive. She is currently completing her PhD exploring the visualization of maternal-infant 'space'.