Australian Association for Infant Mental Health Inc.

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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

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

Introduction to Ann Morgan prize 2013

Speech transcript from 24 August 2013 presentation

Good morning and welcome to this the presentation of the Australian Infant Mental Health Association Victoria Branch's 4th annual Ann Morgan Prize.

AAIMHI Victoria established this prize to honour the legacy of our beloved colleague Ann Morgan's contribution to our field. Ann brought her prodigious mind, her clear thinking, her, at times acerbic, humour and her kindness and loving heart to her work. In so many ways Ann has been a pioneer in our field, and her afore-mentioned attributes together with her compassion and her generosity opened the way for those of us who followed to find our path in the often emotionally tumultuous world of working with the infant and his or her family. Thank you Ann.

My name is Julie Stone and it has been my honour and privilege to be the prize administrator since its inception. It is a role I enjoy and one which charges me with the responsibility of suggesting recommendations or changes to our committee when confusions in promoting, advertising and inviting writers come to light.

The prize is ambitious in its vision, which is to offer the opportunity for infant mental health clinicians to write about their professional work and understanding of the infant, creatively. Our wish is to offer a forum that is different from that of the usual peer reviewed journal or opinion piece or point-of-view article. So it is hybrid territory and if any of you who have been entrants, or are would-be entrants, have suggestions about ways we might be more successful in enticing you to enter or in making your task easier, then please tell or email me, or any member of the Victorian Branch committee.

In 2013 we again offered a workshop for would-be writers at the Wheeler Centre. This is the second year that Christine Hill has organised this event, thank you Christine. This year Christine invited Arnold Zable to present the workshop which was enthusiastically enjoyed by those lucky enough to be there. Arnold is a Melbourne based award-winning writer, novelist, storyteller and human rights activist. He has conducted writing workshops throughout Australia and has worked with refugees, immigrants and the homeless using story

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as a means to self understanding and healing. Arnold is currently a Vice Chancellor's Fellow at the University of Melbourne.

We are very fortunate to have stellar people to support this prize in Ann's honour. Joanna Murray-Smith, another award winning writer and Vice Chancellor's Fellow, has been one of our judges each of these last four years. As a small thank you to her for her contribution as judge we delivered a posy of flowers. She wrote this in response: "Thank you so much for the absolutely beautiful flowers. Quite unnecessary as I am very, very happy to participate (I'd do anything for Ann ... I just adore that woman)".

Those of you who were here last year may remember that Ann was a judge for the first three years. She, of course, wanted to give a prize to every entry, and so this year we relieved her from the excruciating task of having to choose a winner. She did, however, receive a blind copy of each entry, and joined the discussion at the judges' meeting.

Professor Louise Newman, known to many of you as gifted academic, teacher, clinician, human rights advocate, and also published poet and writer, kindly agreed to join Joanna Murray-Smith and Campbell Paul as a judge for the 2013 award. Louise has so much to offer and we hope that she will agree to judge the entries again in 2014. Louise, Campbell and Joanna are all exceptionally busy professionals and I cannot thank them enough for their generosity in thoughtfully reading, critiquing and discussing each entry with the care and attention they bring to the task.

If any of you would like to know more about the process or management of the prize administration, I am more than happy to tell you about it. But I have been talking long enough and you want to know who the judges chose to be 2013 Ann Morgan Prize winner. Their task was not an easy one. The field was strong with the most consistently well-written and engaging pieces we have had in any year. This year's entries took us into the world of a neonatal intensive care unit, an immigrant family, the challenges of keeping the infant in mind in a paediatric oncology ward, a family living room, an infant's cot, and the mind of a mother in those first days post-partum. Each entry was rich and engaging.

But, despite Ann's desire for every one to be given a prize, this year the judges decided on two – a winning entry and a special commendation. The winner of the 2013 Ann Morgan Prize is Margaret Dugdale for her entry title *Love in a lunchbox: A True Story*. Congratulations Margaret. The special commendation goes to Sophia Xeros-Constantinides for her poem titled *Post partum: Terra Incognita*. Congratulations Sophie.

I will now hand over to Teresa Russo, our President, to award the prizes.

Thank you.

Love in a Lunch Box: A true story

Margaret Dugdale

With this story Margaret was awarded the Australian Association for Infant Mental Health Ann Morgan Prize for 2013

Opening the door to me her face is long. Her baby wrapped firmly and held to her shoulder. She is a tall, fair young woman of twenty-eight.

Three bright blue lunch boxes sit on the kitchen bench, each of their four rectangular compartments neatly filled with tiny sandwiches, cut fruit and cake. She explains, "I have to have something ready for him for every part of the day, for every possibility, every scenario".

We sit in the sunken lounge room on the mustard coloured couches, under the high vaulted ceiling and Zoe, a mild mannered, gently spoken young woman, tells me of her deep and enduring distress about the birth, not of her daughter Evie, just three weeks past, but of her son, Tim, a year ago.

"I am a trained nurse. I was strong and fit. It was the hospital I have worked in for three years in Intensive Care. I was prepared and educated about labour and birth. But I couldn't do it", she weeps. "I didn't know what was happening. They were all around me and I didn't know what was happening. I didn't know what to do; I felt lost. I'm not the person I thought I was."

These painful memories hang heavily on her face. They contort into misery as she remembers a moment just a few hours after Tim's difficult birth.

Tired and exhausted and having missed her baby's first bath and nappy change, feeling desolate and in pain, she rings the bell hoping someone will come and pass her a glass of water. The midwife, opening the door a little says, "Were you a caesar? No, then get up and get it yourself. We are busy."

"I had everything done to me except a caesarean. It was so long and hard and they didn't care." She was devastated and ashamed. A difficult start for this tiny infant and his mother: she a failure, a nuisance and an embarrassment.

Depression settled on Zoe. She spent the first six weeks on the mustard coloured couch, too sore to get up and move around and too ashamed to ask for help. She recalls the relief in hearing her parents' car coming up the driveway and each time her despair at their leaving after a quick cup of tea, a "you'll be fine" and their hasty departure. She went to the doctor who prescribed medication. She didn't take them; that would confirm her failure. She was referred to a psychologist but Zoe rejected her because of the suggestion that Steve, her husband, was not offering enough support. The months went by and Zoe became pregnant again.

But what of the baby Tim in this, what was happening for

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him?

Tim wakes in the bedroom at the other end of the house and Zoe goes to him immediately, changes his nappy silently and brings him to the lounge, gently placing him next to her on the couch. He sits blurry-eyed for a few minutes and then, still very sleepy, slides off the couch and runs. He runs, around and around and around, then back and forth, directionless and seemingly without purpose, never looking back to see if either of us has noticed him. He maintains this endless high speed activity for some time, like a blowfly trapped in a small space. I could see no delight or pleasure in his little face, just a small, thin limbed infant launched into space like a little Sputnik; wheeling and turning, no one go to, no connection, no return. Not held in body, or in mind.

His mum looks on. "I love him. I think he's wonderful and I don't want to think of him as a difficult child, like everyone else does. Everyone's saying he's a naughty boy, but he's not. He just needs a bigger space to run in, but I can't let him outside as the yard isn't fenced and it's dangerous."

Still sleepy, despite all his running, he stops for a moment, close to me but aslant, side on. He yawns and raises his little arms in a big stretch above his head. I do the same. He turns, amazed, as if seeing me for the first time. Perhaps even more surprised, at being seen. He raises his arms again, almost to see if it's true. "Yes", I say quietly and raise mine again. He is transfixed. I smile and say, very quietly, stretching my arms again, "That is a big stretch." There is a connection and my heart leaps with understanding and hope.

What has happened for this mother and infant to have them in such a void? What has prevented Zoe from seeing her first born child? Was Evie destined to the same fate?

"Will you come and see me at the clinic? "Yes, she says.

.....

"Sometimes understanding the past can help make sense of the present. Would you be willing to tell me what it was like when you were little?"

"It was a very happy childhood. My brother and I would play for hours out in the yard and sometimes on the street with the other kids. We were really healthy kids."

"What was it like inside?"

"I can't remember much. Our parents were wonderful—both of them teachers—very competent, both of them—we never went without—I'm pleased they were fairly strict—we learnt to behave properly—I would have stayed there—I loved the school, it was a happy place—it was a small town—we knew everyone. I was top in all my subjects too. But when I turned fourteen my parents decided we were to go to Melbourne, to a bigger, better school. Neither Michael nor I wanted to go – Mum and Dad insisted it was best for our education, and we moved. I hated it. I hated my first day at school: I didn't know anyone—they couldn't provide the subjects I wanted to do—it got worse. I felt I would never catch up—I couldn't do it—I didn't feel I was doing a good job—I felt excluded. I just didn't know what to do. I felt lost."

"Did you tell your Mum and Dad about how you felt?"

"Yes. I went home that Friday night and told Dad. I cried and cried. He said he understood. He'd had to change schools when he was young too and had felt the same. "You'll be all right", he'd said. She'd just have to get on with it. And that was that, final.

"How did you cope?"

"I spent the rest of my life swimming: seven days a week and supporting gym sessions three times a week. I became the State champion in freestyle and won places at the Nationals."

"Why swimming?"

"It was my space, stress relief I suppose. I could get way from everyone every day and no one notices when you cry under water."

Up and down, around and around, day after day.

"Zoe, in telling me about this experience of moving to a new school, you have described the same feelings as those you had around Tim's birth." I read my notes from the week before. There is silence, the silence of the inner world changing.

Each week Zoe comes with Evie. She doesn't bring Tim because her husband, Steve, has insisted that this time is for Zoe and that Tim can go to his willing paternal grandma, Steve's mum, Birgitta. Birgitta has been waiting for a year to be of help but never allowed. "She will take over and want to do it her way", had been Zoe's fear. Her own parents have gone off on a touring trip of Australia and their absence seems to have given Zoe permission to relate to her mother in law. Under duress Zoe lets Tim go, but always with two of the carefully prepared blue lunch boxes.

Each week Steve takes time off from his busy building business to meet Zoe after our sessions. He brings two falafel rolls and they go together to have lunch in the nearby park and discuss and reflect on what happened in her session. He becomes the third adult in the therapeutic process, confirming Zoe's insights and supporting her new approaches with their children.

There is another person helping too. When asked if there was anyone she went to for comfort as a child, Zoe tells me of Uma, her paternal grandma, now long gone but leaving behind memories of warm hugs and wonderful smells in her kitchen. We often call on Uma to see what she might have to say.

Evie sleeps through the first session and I wonder if she too is giving her mother time. She wakes during the

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second session. Evie cries and Zoe stiffens into an upright posture and props Evie, also upright, at arm's length at the end of her long lap, one hand around the base of her head, the other holding the bottle. Evie looks as if she is strung up; her tiny arms hanging limp and motionless beside her, her neck lengthened, her face forced to see nothing but the clinic wall. Another little Sputnik being launched into outer space.

"Oh Mummy please hold me close", I say, "I want to see your face." For a moment Zoe resists, "But I was told this was best position for their digestion." I say nothing and she draws her baby to her, awkwardly at first. As Evie responds to the warmth, Zoe's body gives way and softens. We sit in silence while she feeds. My eyes have been fixed on Evie, but as I lift my gaze I see tears flowing down her mother's face. Different tears this time, as they are flowing past a smile.

Over the next few weeks Zoe works hard at fitting together many memories that help her understand her recent experiences and present state of mind and her mood begins to lighten. She talks to her brother Michael too and he wonderfully reaches out to her with affection and understanding. He is willing to talk about their parents, how their very close marriage bond, together with their outward appearance of total competence had left very little comforting space for him or for Zoe when either felt vulnerable.

I continue to welcome Evie into our conversations and occasionally, in an effort to reflect her inner world to her mum, I speak through her. Slowly, often hesitantly, Zoe too begins to see and reflect Evie's inner world. In trusting herself, warmth, playfulness, and even humour creep into her interactions with her baby. Evie responds as infants do and the two of them begin to wonder about each other.

Zoe is worried though about Tim as she has not made such progress in connecting with him. I am on the point of suggesting that she brings Tim to our sessions when, just before the sixth week, Zoe rings me to say she won't be coming in as they have all had bad gastro: she first, then Steve and now Tim. She wouldn't like to spread the germs to others. I am grateful for her consideration.

At the seventh week Zoe arrives, beaming. "I have had a second chance", she tells me. "He was so sick and I was able to be there for him. I could really be there; be with him, through it all. Something has changed and he has stopped running. I can't believe it; I think maybe he understands what has happened. He even holds my hand when we go shopping. He's happy, and he's beautiful."

We sit and talk and delight in this for a while. And then, musing, she tells me, "I think I can let him go more easily too now. He's gone off this morning in his gum boots and his dungarees to garden in the rain with Grandma Birgitta."

"And", she says, smiling at me knowingly ... "he's gone without a lunch box."

Margaret Dugdale is an Accredited Mental Health Social Worker. She is Senior Clinician in the Perinatal Emotional Health Program of Latrobe Regional Mental Health, based at the Warragul Community Mental Health Centre. Margaret is a sessional lecturer in Social Work at RMIT University and has a small private practice in mother and infant mental health in Carlton, Victoria.

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Ann Morgan Essay - specially commended

This poem ventures into the unchartered waters of the post-partum period, giving consideration to the infant's subjectivity as a function of the new mother's charity and tender-heartedness. The new infant's subjective world is inextricably bound with that of the mother - he finds himself vulnerable and dependent, waiting for the tables to turn.

I am reminded of the old-fashioned term 'foundling', defined as a young child abandoned by its parents, found and cared for by others. In this scenario there are two 'lost souls' acclimatizing, adjusting and looking for connection and care – newborn babe and 'newborn' mother. The work speaks to the vulnerability of the infant, who waits for consistent maternal care and attention, and the vulnerability of the new mother, searching for succour herself in her attempts at connection with her baby.

Sophia Xeros-Constantinidis

Post-partum: Terra incognita [1,2]

Darling Heart
this creature
part of me Yet encroaching

Puny plucked-bird foetus
besieging and besetting
Itself upon
me…
now lost in the quagmire of motherhood.

§

Angel Heart
came early
Expunged with sudden Gush-drop

Down-leg blood spurts
clots Galore
deadly fright unhinge
me…
now stuck-fast lovesick lovelorn tangle.

§

Heavy Heart
up-closeness
Stricken smothered stifling

Paralysed with love-hate
Acclimatize or lose control
this baby doesn't like
me…

§

Hardened Heart
when did you
arrive like a Wedge…

between us?

[1] Terra incognita: noun, meaning unknown territory, from the Latin 'unknown land'. Reference: Compact Oxford English Dictionary 3rd Ed (2005), Oxford University Press.

[2] Dr Vivien Gaston for her critique of *Foundling* (2009) in which she referred to "the physiognomic and psychological impact of birth on the mother, through images that depict the invasion of the mother's body by a creature that is part of that body but also an encroachment on it." Reference: essay by Gaston prepared for the 2010 Beleura National Works on Paper Exhibition at Mornington Peninsula Gallery.

Levels of feedback, levels of interaction

Frances Thomson-Salo and Campbell Paul

We'd like to share a provisional schema about levels of feedback that emerged in an Infant Mental Health Professional Development seminar offered by the Royal Children's Hospital last year when discussing how to respond when parents exert considerable pressure for feedback about their infant. The specific context had been an interaction which was difficult in the countertransference, of a parent who seemed rough in handling their infant whom they thought was misbehaving. We think that the levels described are applicable in most clinical situations, perhaps particularly when there is considerable pressure for clinician feedback and help with management. We describe the levels below in ascending complexity which is linked with the pull to not 'see' the infant.

1. Feedback to parents after a session when the infant is not present

This would be giving feedback to the parents after a session that had included the infant, about the infant's behaviour, from the perspective that parent and clinician may feel this is easier to do**.** There can be considerable pressure to give feedback about the infant as if from the outside, objectifying the infant and seeming to locate the problem in him or her, rather than being able to work with parents and infant 'equidistant' as Lieberman and Pawl (1993) described, to begin to explore the parents' questions while the infant also feels that the therapist understands them and their mind, rather than only joining with the parents in discussing proposed strategies. Some clinicians feeling under pressure from the parents might say they are drawing a line at a certain point in the session in order to facilitate an encounter with the infant.

2. Strategies offered to the parents in the presence of the infant

Here the clinician observing the infant's behaviour and actions offers their thoughts to the parents as well as the often wished-for strategies to assist the infant's affect regulation.

3. Describing and observing the infant's behaviour

This would be a process intervention along family therapy lines, to try to help the parents think more reflectively. It could include a comment that the therapist noticed a sequence of behaviour, for example that after an action the infant was quiet, and offering this observation for comment and further development. Here seeing the infant as subject comes more into view.

4. Play and imitation

We saw the level of imitative and reflective play slightly differently. Campbell viewed a playful approach as representing the highest level, with play viewed as therapeutic in its own right, as an internal process without needing to be directly interpreted (as Winnicott viewed it), whereas I saw some attempt to verbalise as the highest level (see 5. below).

When the clinician is available for playful engagement and thinking reflectively about how the encounter with the infant relates to the problem, the infant often quickly 'gets' the playful intervention as embodied mentalisation (Shai & Belsky, 2011), and 'feels felt', in Dan Stern's sense, and this could be thought of as functioning as a silent interpretation. (We have previously suggested (2013) why we believe that an approach that relies significantly on verbal interpretation to a tiny baby, as Salomonsson (2011) might, is not an intervention in itself geared to that infant.)

If we think of interaction and play with a very young infant, Campbell's view that it functions as an interpretation, that it can represent the highest level without needing verbalisation, has validity. A 15-month-old girl had been withdrawn from childcare by her mother after the first two hours because she cried. She was often wary of Campbell and me, and when she tripped I thought she had cried angrily as if blaming me. After a while, she sat facing Campbell who very delicately wiped away a couple of tears with his little finger. He commented to her he was wiping a tear and followed her lead respectfully; she then drew his attention to another tear welling up indicating for him to wipe it away. He said afterwards that while unsure what was happening he thought it was in response to something in the girl. He may have been intuitively helping create a capacity to mentalise more freely and flexibly, and greater awareness of mental states in self and others, to make sense of her experience as a core way of regulating stress. In other words mentalising therapeutically, and with enactive communication, a 'being with' the infant in such a way that it confirms 'I can be with you as you are'. (The following week the mother disclosed for the first time her partner's verbal abuse, as if the experience with Campbell had 'spoken' to the dyad that their distress could be heard.)

5. Verbalising affect and intention to the infant

Here verbalisation is seen as the highest level. In the second year, parents verbalise affects with their infants who are able to spontaneously talk of their sadness and worry and the clinician builds on this in imaginative play. Further verbalisation can take place when a clinician triangulates verbally and in this way brings together the parents' and the infant's narrative: "The cross crocodile has bitey feelings and daddy has just told us about you being angry with your baby brother and how he was

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angry with the parking man." Here verbalisation acts as a total transference interpretation to everyone present.

When levels of feedback are viewed in this way, they can be seen to be levels of interaction. While verbalising with an infant would represent a higher level, it sometimes needs for the therapist to 'be with' the infant, to communicate and for the infant to feel known. We think this is a way of working that respects the rights of the infant.

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