AAIMHI Newsletter

Official publication of the Australian Association for Infant Mental Health (Inc.)

AAIMHI is affiliated with the World Association for Infant Mental Health

ISSN 1449-9509 **September 2004** **Vol. 17 No. 3**

In this issue

Newsletter Guidelines

The Newsletter is published quarterly in March, June, September and December. Submissions to the Newsletter are invited on any matter of interest to the members of AAIMHI. Referenced works should follow the guidelines of the APA Publication Manual 4th Ed. All submissions are sub-edited to Newsletter standards.

Articles are accepted as hard copy or as electronic versions. Preferred method of submission is a Word document attached to e-mail. Send to:

Shelley Reid
shelley.reid@email.cs.nsw.gov.au

or Victor Evatt
vevatt@mail.tech2u.com.au

Postal address:

Newsletter Editor
PO Box 846
Ashfield NSW 1800

Editorial inquiries:
Shelley Reid (02) 9515 7845
Victor Evatt 0418 231 635

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

The newsletter and you

Welcome to another issue of the AAIMHI Newsletter. I hope you enjoy it as much as previous ones.

The newsletter forms a prominent part of the membership benefits. It brings together the reports from various state branches and publishes information on upcoming events such as seminars and conferences. It is an excellent vehicle for short articles on topics of interest to those engaged in the field of infant mental health, open letters to members that can develop into a national debate, reports on conferences for those unable to attend, updates on AAIMHI activity and the reporting of advancements in infant mental health.

Seems like a rather good deal, doesn't it? And so it is. However, the newsletter does not appear without hard work on the part of a very few people and I highly commend the people who have been involved in producing the newsletter over many years.

To ensure the newsletter continues and maintains a high standard, I would like to propose that branch participation in producing each issue be broadened. This could be accomplished by forming a newsletter committee, comprising of an executive member for every branch, who would direct contributions to the editor. All executive members can encourage submission of articles, and compile information such as conference notices. The nominated newsletter committee member would provide deadline reminders and liaise with the editor.

With this assistance I hope to be able to continue producing issues of the newsletter that will be of value to the members. The newsletter is for the members – let it also be by the members.

Shelley Reid
Editor

Learning from babies: why an individual approach works for all of us.

Tess Kingsley
Maternal and Child Health Nurse

Case studies

Note: pseudonyms have been used throughout this article.

Matthew's parents did not want him, he was not meant to happen. Having just about recovered from the experience of having had his brother Christopher, two years older, their mother had already returned to work when she found she was pregnant again with Matthew. Christopher was to have been the only child.

I met Matthew when he was two years old when his mother brought him in to the health centre. As Matthew lined up blocks on a table within earshot, she disclosed the above. There was bleakness in his expression, a hint of the disillusioned old man. He was a slim child with a complete absence of the sense of the infant. His mother was clearly frustrated; it was a frustration tempered with

Continued on page 2

concern. Matthew had terrible tantrums; there was nothing they could do with him. He would get aggressive and hit out or throw whatever came to hand. Today he had screamed to a point at which he vomited. His mother described this as 'coming out in waves'. Everything he had eaten through the day.

His mother had called the health centre when he was eighteen months old, swearing she was going to kill him. A nurse visited from an outreach program. She talked about communication, playgroups, and speech pathology. Matthew's parents, blue-collar workers, did the rounds: the hearing test, the ENT surgeon, the grommets and the speech pathologist. His hearing is normal. None of it made a difference.

His parents put Matthew into day care together with his brother, and their mother went back to work again. The woman who cares for them is reported to be very fond of Matthew.

In the last couple of months Matthew's snoring at night has got much worse. His mother says it is very loud and he makes different sorts of noises. Matthew, who has slept in his room from the time he was a baby, has the door to his bedroom shut overnight so that he cannot get out and the sound of the snoring is dulled. His brother Christopher co-sleeps with their parents. Matthew's mother said they hear him moving around at night sometimes, but he does not cry any more and they know when he is asleep because of the noise.

Matthew's mother said he spends his time at home lining up his toys, putting things in neat and exact rows. Perhaps he seeks some order in a somewhat disordered life. Matthew eventually responded to the assessment. With time he warmed, completing his tasks, responding with eye contact and a little nod of satisfaction. He didn't smile for all the time he was there.

Joshua is the first child of parents who planned to have him; he was welcomed with all the joyful anticipation of new parents. After his birth, his parents were faced with a constant barrage of advice from family, friends and health professionals – of what Joshua should be doing, and what they should be doing to achieve this. They referred to the books, which of course, Joshua was not able to read. At eight weeks of age, they took him to a day-stay facility where they were taught the method of controlled crying. From this time on, Joshua's experience of being put to bed was that of being placed in the cot on his back and the covers drawn up around him. His parents were told that under no circumstance were they to look at him or make eye contact. They were to say firmly "go to sleep" and walk out of the room.

Joshua would cry. They were to wait, at first two minutes, before going in and repeating the sequence: tuck in, offer the still face, say firmly "go to sleep" and walk out of the room. Then four minutes, then six minutes, then ten minutes, regardless of the level of distress demonstrated by Joshua. They were never to pick him up. Joshua did cry, he cried for hours but his parents did what they were told, regardless of their own pain.

Joshua and his mother were admitted to a mother-baby unit when he was six months of age. The controlled crying was not working. They were also concerned because he was different to other babies of his age. He wasn't vocalising, laughing, rolling to his side or lifting his feet up. Placed on the floor, he would lie with his legs stretched out, his gaze to the side. When approached he would regard you for a short time and with gentle coaxing would produce the ghost of a smile. However, when he was placed in the cot, he looked up at you, his gaze intense, and any motion toward disengagement, such as to arrange a blanket or to tuck him in, resulted in a crumpled expression and the beginning of a cry. As maintaining a gaze and smiling at him seemed to help him, we stayed with him, holding his gaze till he fell asleep.

On the second day, with the reassurance of the smile and gaze as he was put into the cot, Joshua sighed, moved his head to the side and allowed us to withdraw as he settled himself to sleep. On the third day his mother took over, but she was not able to immediately reverse the conditioning she had received. She had to learn to look and smile and reassure. We stayed with her and reminded her to keep looking, keep smiling and to wait for the sigh. It didn't take long.

By the fourth day Joshua was a different little boy. Although still withdrawn, he was vocalising, smiling and moving spontaneously at play. His parents would sit side by side on the couch, watching him, the trauma of the past four months reflected in their eyes. All they needed to do now was to look at him and smile when they tucked him into bed. If he were upset, they would pick him up, calm him and tuck him in again. They could leave the room and Joshua would get himself to sleep.

Dean's parents thought they had finished with babies; his sisters were in their late teens and disappointed by their parents' decision to have this baby. The increase in the family was a difficult adjustment for them.

Dean was eight months and breastfed to sleep. If he woke at night, which he did often, he needed to breastfeed to go back to sleep. As a result he was co-sleeping with his parents. In order to restore family harmony, Dean and his mother were admitted to

Continued on page 3

a mother-baby unit so that Dean could learn to fall asleep in his cot on his own and stay asleep.

The first twenty-four hours were extremely traumatic for Dean and his mother. Dean found the strange room, the separation and the loss of his mother acutely. He screamed until he vomited. He was then picked up, cleaned, held until his cot was made up again, and then put back, at which point he would scream again. After two hours or so of this his mother was called and he was breastfed to sleep. On the second morning of admission, Dean had an unfamiliar nurse put him to bed. He screamed relentlessly, moving desperately from one side of the cot to the other, his distress culminating in the vomiting up of copious amounts of his breakfast.

Another nurse, someone more familiar to him, picked him up and walked with him, taking him to a window, talking to him, allowing him to snuggle in and eventually to fall asleep in her arms. He was placed back into the cot asleep where he slept for about three hours. When he woke, his mother was there to pick him up and tend to him.

In the afternoon when Dean was obviously tired and needed to go bed, his mother was no longer prepared to hear him cry as she was hurting inside too much. As Dean was brought to his sleep room, he stiffened and began to shake. He was obviously terrified. His mother lay him in the cot, he sobbed and clung onto her. She tucked him on his side and placing her cheek against his cheek, held him. The nurse staying with them also placed one hand on his side, and patted gently with the other, observing Dean's progress in relaxing and allowing sleep to come. As Dean calmly drifted to sleep, his mother was given the cue to gently withdraw and in a matter of minutes, he was asleep. By the third day, Dean's parents were putting him to bed and he was allowing them to withdraw while he was still awake.

Michelle was eleven months old and a small child. Her parents were of average height and both were overweight. She was breastfed and her parents said it was difficult to get her to eat solids. Michelle's experience of waking at night was that on some nights she could go to the breast and then go back to sleep; on other nights she was left to cry until her parents, who would argue between themselves as to who should see to her, would end up (in their words), "yelling at each other" in her room.

Michelle was extremely hypervigilant. In the weeks prior to an admission to a mother-baby unit, the nighttime waking and crying and the arguments that ensued were a regular feature. Michelle's father said that when he answered the phone and was told they had a place at a mother-baby unit, he walked out to the paddock and cried.

Michelle would allow you to put her to bed. She would lie, on her side, looking away from you. You could tuck her in, put the cot side up and stand for a while with a hand touching her. But she didn't trust you. At the slightest sound, inside or outside the room, she would sit bolt upright, start shaking and begin to cry. The creak of a knee, the telephone at the desk, were enough to set her off.

In the fathers group, Michelle's father disclosed his unhappiness, his feeling of being the 'bottom of the pile'. It was a regular theme in the fathers group: "Before the baby arrived, we were equal, we both worked, we shared the chores. After the baby, I don't seem to have a place."

Reversing Michelle's anxiety, re-establishing the connection between her parents and teaching Michelle to trust again were big tasks. Not achievable in five days and with limited expert knowledge all we hoped to do was to educate, give insight and the opportunity for communication. Michelle was sleeping better, eating more, but not always sleeping through the night. Her parents were discharged having recognised their value to each other, with a greater insight into Michelle's anxiety and a sense of friendship re-established. It was a start.

Occasionally, we have the privilege to accompany someone through an emotional journey. It is easy to judge, and in this instance we did. This 'bad dad' got much negative speculation. He was tall, muscular and very good looking but very, very 'bolshie'! On admission day, he sprawled on a couch, said he was there to drop his wife and son off and then go fishing. He wasn't sure about coming in, spending time with them or coming to the fathers' group. The week was his to do as he wished; to sleep and get some space.

The baby was eight months old. His wife scored high on the Edinburgh Postnatal Depression Scale and she was tearful on admission. No strategy worked with the baby: he needed his mother, he needed the breast and however tired would not sleep without the two.

His father did come into the fathers' group and was the last to be asked whether he would like to share his experience of parenting, of becoming a father. The other fathers in the group were honest and spoke with feeling about their experiences. When it came to his turn, he leaned forward with his forearms on the table and stated, quietly, "my father died when the baby was two months old, just eight weeks, you know. I was close to my father, he was sick, but it was still sudden. I spent a lot of time with him before he died. He told me, 'it will be hard, but you have to go on, just get up in the morning, go to work, just get on day by day, it will get easier'. I did not have time to grieve, what with the baby so

Continued on page 4

young and so much happening, now I can't get him out of my head, I think about him all the time".

The insight this gave us changed everything. Risking the wrath of management we kept them in until they were ready to go home. When the parents were working together again, the baby responded. His father was the best at getting him to sleep. There was an emotional moment for staff and family when they left, the sense of having shared a journey. They certainly left us with a lesson learned. There are no 'bad dads', maybe just 'sad dads'.

There were also wonderful demonstrations of resilience. Ben was ten months, breastfed to sleep, and had a capacity to roar. Ben's sequence of nighttime activity would be to wake, roll on his side, onto his knees, stand up in the cot and call out to mum. Mum arrives with the goodies and Ben goes back to sleep. On the first night that Ben experienced a failure in this system, he stood in his cot and in walked the nurse. He was appalled. As he prepared to bring the roof down, his eye caught sight of 'Pooh'. Noting the distraction, the nurse held the soft toy and spoke softly to Ben. Ben regarded the toy and looked at the nurse, he looked again at the toy, he sat down looking long and hard at the prominent black nose, his tongue moving up and down. He looked up at the nurse, his expression that of "will this do, I wonder?" The nurse laughed, Ben laughed and the moment was diffused. Ben was tucked in with 'Pooh'. After a brief kick and a grump and then a little giggle, he went back to sleep holding Pooh.

Peter was brought in to a unit two weeks following cardiac surgery, as his parents were desperate for him to learn to sleep without crying. This little boy's wonderful spirit and sense of humour allowed him to respond to a gentle approach. He did learn to sleep without crying within forty-eight hours!

Simon was six months old and had a terror of the cot. He discovered something so funny about a patting hand that all he needed was a gentle rhythmic pat of the cot, near his head, a sleep cue which worked for him.

Then there is the experience of the assisted fertility twins – babies with an assertive and highly organised mother and a quiet and compliant father. Their routine was established from the time they were four weeks old. Four-hourly feeds, two hours in the cot regardless of whether they slept, were awake or crying. They were five months old when admitted – their mother needed a break.

The mother was uncompromising and the routine was to be maintained regardless. The staff had to find a way of getting the twins to go to sleep without screaming. Both twins were tense and hypervigilant. They were not vocalising. The mother insisted that no one stay in with the twins when they were put to bed. They were to go into the cot, be tucked in, and left immediately regardless of level of distress.

Halfway through the program, the twins became quiet. There was an occasion, when the mother was in a group session, when the carer did not leave the room immediately. The first twin was put to bed, placed on her back. She put a thumb to her mouth and looked to the side, away from the nurse. The second twin was brought in and put to bed. She looked anxiously from side to side. After tucking her in on her back, the nurse stayed, placing a hand on her and looking at her. This twin maintained a desperate, intense gaze, her mouth wide open, but there was no sound, in what can only be described as a silent scream. A heart-wrenching sight, one that stays with you for a very long time.

There are the experiences of another three children: one in kindergarten, one at school, and one at home with mum. All of the mothers were depressed. Only one of the mothers was diagnosed with depression. One child (a boy) was unplanned, the pregnancy occurring only months after the birth of his brother. His mother's grief and sense of guilt was apparent as she spoke of her experience. She said, "I hated him when he was a baby, I didn't want to be pregnant again. He just cried and cried, I couldn't pick him up". After a highly traumatic separation and adjustment to the kindergarten, he will now go in without crying. He won't speak to anyone, won't play with any other child and if approached will move away. He is being assessed for intervention services prior to being accepted for school.

Of the other two (girls), the one in school does need extra intervention as she was diagnosed with a learning disability. Her mother disclosed her depression at a consultation related to her baby brother. She said, "That was a terrible time, when she was a baby, for most of the first year. I couldn't even look at her. Sometimes I would even feed her in her cot, so I would not have to pick her up. No one knew. The paediatrician treated her for reflux, but that didn't stop the screaming".

The third mother with the little girl still at home was abandoned by her partner while still pregnant. She was prescribed anti-depressants shortly after the baby was born. She said, and these are her words: "We couldn't do anything with her, and then when she was ten months old we took her to a parenting centre, there we did the controlled crying, took two days, she didn't sleep at all, just screamed and screamed, and then we broke her! She slept fine since then. Now they are saying she may be autistic. I don't think she's autistic, I think it's what we did to her when she was a baby".

There is a child of twelve whose mother says, "We did controlled

Continued on page 5

crying for years. All the places we took him to in Queensland did it. He still does not sleep". He has a learning disability and has an intervention aide in school.

Discussion

According to Martin Teicher (2002), stress sculpts the brain. His research shows that stressed infants are found to have a noticeably less developed left hemisphere of the brain. The left hemisphere specialises in perceiving and expressing language. Many infants who present with a history of having had the experience of controlled crying over a period of months will have delayed speech development. However, this association has not been objectively assessed.

These are here-and-now happenings and not the isolated experiences of a few infants. Also, what is described here is only a detail from a larger picture. For example, it may well be the positive experience of day care that saves Matthew from becoming unreachable. At the beginning of his assessment, it looked like he might be unreachable, but there was the capacity to connect (barely), and to engage. A referral to a sleep clinic for investigations related to sleep apnoea may help him toward quieter sleep and then maybe his parents will leave the door open. It is unlikely now that he will come looking for them at night.

Finding out if these are the experiences of a significant number of infants is not enough. We need also to ask ourselves whether this is a satisfactory state of affairs. Is the acute hypervigilance, the intense anxiety, the shaking in fear of the cot, the refusal to feed, and a delay in development acceptable because they are symptoms found in infants? Are we to say, as a society, that the experience of an infant, which results in symptoms that applied to an adult would very likely indicate medical intervention, is to be discounted, as they are only babies? Is it enough to merely provide a service, as in the case of the outreach nurse, and not ensure that the person allocated the task of assessment has the required knowledge and skills? Is it enough to provide a facility, as a mother-baby unit, and yet staff it with registered nurses with no training for that specialty? Is it enough, that infants like Peter take pot-luck, as to the knowledge and experience that would guide how they would be helped? Is it not time that children's hospitals provided an extension of care, in the form of a residential therapeutic unit attached to the department of infant psychiatry, so that more vulnerable infants in our society may benefit from the greatest expertise?

If we are to say that it is not enough, not good enough to place any infant in a situation that may risk his potential, then whose task is it to regulate the system? We readily acknowledge that infants and children have become a commodity. Are we as ready to acknowledge that infant distress has also become a commodity? After all, as Martin Teicher says, "Society reaps what it sows in the way it nurtures its children" (2002, p.71). Are we to look forward to a whole cohort of leaning disabled children?

Let us ask these questions and persist in finding answers.

Reference

Teicher M (2002). Scars that won't heal. *Scientific American* 286:3, 68-75.

State News Update

SA News

We have had/are having some educational sessions, which are going well. At the last one Mary Hood presented the STEEP training and at our AGM on the 5th October, Mary Houlihan (who has just come back from Seattle) will present Katherine Barnard's infant assessment scales. Mary is now an accredited trainer. We are also sponsoring a workshop by Meredith Small who is here for the national Parenting Conference on infant crying and sleep. Meredith wrote the book *Our Babies, Ourselves*. We will have the session video-taped so interested people will be able to buy it.

Our videos of the sessions by Bruce Perry and Martha Erickson are still attracting some interest and it is a way of keeping people who can't attend workshops in touch with what is happening. Anyone who is interested in any of the videos should contact Elizabeth Puddy on 82722039

Pam Linke

SA Branch President

Victoria

The State and National AGM were held on the same evening in August, with an impressive turn out. Reports were given from committee members and elections were held for the committee of 2004-2005. So far the members are Michele Meehan, Campbell Paul, Rosalie Birkin, Brigid Jordan, Kerry Judd, Jennifer Jackson and Frances Salo.

The video, 'A Simple Gift. Comforting your Baby' from the Infant Mental Health Promotion Project at The Hospital for Sick Children in Toronto, Canada, was screened also.

Jennifer Jackson

continued on page 6

State News Update (cont.)

New Sout Wales

Fresh from a recent NSW committee meeting, this president's zestful enthusiasm has been fuelled (sounds dangerous!) by the numerous inspiring forthcoming scientific and clinical events. We are looking forward to the 5th of October when we will have three exciting hours with Dr Lyn Murray and her re-presentation of the plenary session along with some evocative videos from the recent Queen Elizabeth conference in Melbourne. Heartfelt thanks to Trish Glossop and Ian Harrison for making this possible. Get in early as seats are limited.

Soon AAIMHI NSW will be holding its inaugural film festival with the NSW premiere of Sara Murphy's documentary on the life and illusions of Hermine Hug-Hellmuth. This evening will be catapulted into a psychoanalytical abyss by Dr Isla Lonie who will launch the proceedings. Again reserve your place early, as this is one night not to be missed!

Tuseday the 9th of November will see the continued ambition of AAIMHI to embrace those in the field of Early Childhood Education and Early Intervention, with a special evening focusing on the relationship between sleep, settling and the day-to-day experiences of the Early Childhood Educator. The four-member panel will offer their perspective on the effect of emergent sleep patterns of infants and the response of all associated with this development. This will be a joint effort between AAIMHI and Learning Links.

Did I mention the birth of my second daughter, Lucinda? Born on the 19th of July at 3.55am, weighing 3.815kgs.

Our membership has had a small reduction, which we feel is the result of poor communication through the changes to the Newsletter distribution. We anticipate this will correct in the near future as things become more predictable.

Victor Evatt

International Association of Infant Massage

National Conference

Nurturing our future society

19-20 March 2005

Sydney

Call for abstracts

IAIM would like to invite members of AIMHI to submit an abstract for either a paper presentation or poster. Abstracts are to be no more than 350 words, in Arial font size 12 including Title, Author/s and institution if applicable. They may be submitted electronically (preferred) as MS Word for PC to:

margtanner@iinet.net.au

Or mail to:

IAIM Conference

17 Yallambee Road

Lane Cove NSW 2066

For more information see www.iaim-oz.org

or email to above address.