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:

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

President's message July 2014

This newsletter marks the start of a process of reinvigorating this publication so it can become again a regular and valued source of information and connection for AAIMHI members about our infant mental health work.

I am delighted to welcome on board a new editorial team who have volunteered to lead this process with the support of the national committee, state branches and of course you all as members. Ben Goodfellow and Emma Toone, from our Victorian Branch, will work with Shelley Reid, from the national committee, as an editorial team to source content and present it in an engaging way. They seek to both meet the needs of members to know what is happening in AAIMHI around the country, but to also spark interest and provide a forum for communicating about work in the infant mental health field. I encourage you to read, contribute to and share our newsletter.

The National committee has been very busy this year focusing both on improving AAIMHI governance and at the same time improving services we provide for members. We plan to upgrade our website in a way that will have tangible benefits for members. Some of these include developing a national calendar of events of interest to AAIMHI members and enabling registration and payment for AAIMHI events through the website. Our plan is to make it easier for state branches when they organize training and other events, but also to make booking and paying for events easier for members.

Quite a number of AAIMHI members, including me, will have attended the WAIMH world Congress in Edinburgh by the time you read this newsletter. AAIMHI is an affiliate of WAIMH and through this association we keep connected to the world of Infant Mental Health beyond our shores. Many relationships developed through these meetings underpin professional development opportunities and research connections that add to the vibrancy of our Australian association. I encourage you all, if you are not already members, to investigate what WAIMH has to offer. Being part of a much larger group of like-minded people who value relationships and keeping the infant in mind can not only reduce isolation but is important in sustaining our work.

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Within Australia, our state branches are busy with activities which develop, inspire and support us all in our work. I encourage you to find out what is happening locally, as well as nationally and internationally. This newsletter will give a forum for some of this to be shared, so I encourage you all to do just that, and contact Ben or Emma with your ideas.

The Queensland branch is working hard to organize what looks like a fantastic line-up of interesting and challenging presentations at our national conference in Brisbane from 2-4 October. I encourage you all to attend and connect with each other through AAIMHI and also with the latest in infant mental health.

I look forward to seeing many of you there.

Anna Huber

Fathers in infant-parent therapy: The widening field

Campbell Paul and Frances Thomson-Salo

In this brief communication we review the current place of fathers in infant-parent therapy, defined quite widely as clinical or therapeutic work. Under the term 'infant-parent therapy' is included individual and group work, both short term and longer term. What we emphasise here which has not been so much a feature of most father-infant therapy is the therapist working with the infant's transferences to the therapist, in addition to working with the parents' transferences to the infant.

The many roles that fathers have for their infants has long been acknowledged in the infant mental health field. But historically many services have not been father-inclusive, sometimes with 'invisible' barriers, whereas both Paul Barrows (2003) and Campbell Paul have pointed to the relative ease of including fathers, if a clinician is committed to doing so. While the many initiatives involving new fathers can be seen in Richard Fletcher's (2013) Fatherhood Bulletin, with the Neonatal Behavioural Observation (Nugent et al., 2007) aiming to develop the relationships of both father and mother with their newborn babies, here we are not able to do justice to these initiatives. In many maternal perinatal mental health services, considerable effort has been made to involve fathers, once referred to as the '(almost) forgotten' parents (Thomson-Salo et al., unpublished paper). As Campbell Paul (2010) wrote, 'Most research on parenthood and mental illness is focused on the mother-infant relationship but there always is a relationship of some kind with the father or father representation'. While the role of the father in infant-parent therapy has steadily increased so that it seems almost anomalous for the focus to remain on the mother, fathers may still be relatively left out of the picture with professionals not thinking about their internal world and emotional needs.

We acknowledge the importance of cultural factors without exploring these more widely here.

Fathers in infant-parent therapy

A survey of the literature as well as clinical experience suggests that there is increased take-up by fathers of a role in infant-parent therapy with more positive outcomes. Fathers are now also more routinely included in clinical work around the birth and early months of an infant.

We start with a clinical vignette and then outline some emerging points in therapeutic work with fathers, including fathers of very sick babies, and when a father has a serious mental health problem. These cases have been de-identified.

Rex, aged 14 months, was first seen by Campbell Paul for eating difficulties. He and his parents then had joint sessions before he started individual psychotherapy at 18 months with Campbell while his parents were seen simultaneously by Frances Thomson-Salo. Rex's father asked for a list of strategies and when Campbell suggested to play with his son, he asked, "What, all the time?" as if envisaging playfulness was hard. He was extremely committed to the therapy and always attended, partly to support his wife, who had her own unresolved issues. The father always agreed with her even if it meant denying his own perception.

Finding a way to take up their difficulty functioning as a parental couple released his capacities to act more imaginatively in a paternal role. When the parents disagreed with each other, with the father saying he had seen Rex trying to take his toys back when other children snatched them and his mother categorically saying he never did this, Frances wondered aloud with them why it felt as if she was hearing two different stories. In this new space the father wondered whether Rex would eat more if he had two days of being hungry and his mother said that he would starve. When Frances tried to explore this, the mother was anxiously angry and the father said that perhaps Campbell and Frances needed to consult with some people experienced in working with children with eating disorders – he was now more able to indirectly express negative feelings. Simultaneously Rex had, partly through the work with Campbell, intuited the change that was led by his father and was unusually lively when he joined his parents at the end. He had a black eye from a fall, and his father joked that they had bashed Rex. Frances said perhaps sometimes they felt

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like bashing him and the father agreed and said, "It's all right if kept in this realm". He then made his first joke, "You can bet money on whether my wife will agree with me." She did not but was able good humouredly to join in. The father then said, "As you said last week, he's using words with the intention to communicate" and described Rex's expectant look as he waited for them to communicate. This was the first time they let us know they had taken in any reflectiveness. His father had described facilitating his son playing imaginatively with a packet of teabags, which represented a considerable shift for all. Rex's attachment changed from insecure to earned secure, with good outcomes for him and his family.

Emerging points

1. A fuller awareness of what fathers bring to their babies different from what a mother brings, and the dimensions added to the therapeutic work, provide a helpful context in the internal setting of the clinician's mind, which is conveyed to infant and family. Infants respond differentially and are likely to feel more helped with separation issues in their father's presence. Including fathers widens the portal of entry for infant-parent work compared with Stern's (1995) view of entry points in the motherhood constellation. While a father who is already engaged with his infant would likely know how to help the infant better than most, there is increasing recognition in some areas such as neonatal intensive care units, that fathers' stress in caring for their infant is different from that of mothers, and their use of coping strategies is likely to be different.

2. Involving a father in the therapeutic work co-opts them further into a therapeutic alliance and may deepen engagement and hasten improvement. There is likely to be a better outcome for an infant in feeling more contained and surrounded by the mirroring gaze of two parents, with the clinician's empathy, wish to help and sense of appropriate fun, and their input amplified in the eyes of the father and mother. Results may be more enduring with a father's support for the therapeutic work.

3. What we emphasise here which has not been so much a feature of most father-infant therapy is work with the infant's transferences to the therapist, which may be positive or negative, in addition to working with the father's (and mother's) transference to the infant rather than to the clinician.

There is the potential for the infant to feel more helped if the clinician can triangulate between infant and parents as in the following example. In a parent-toddler short term therapy group that we ran, being able to point out to a toddler that while her father had talked about her being angry with her brother, he had also just told us about being angry with the hospital security guard. Here we were saying that it is acceptable to talk about these angry feelings, that they are linked and have meaning. The work had a bi-directional effect as her father was able to mute his anger, which helped his daughter manage her anger more appropriately (Thomson-Salo & Paul, 2014).

Even in a short term intervention, if a father's response to the clinician is very negative, this may need to be worked with quickly.

4. When a father is less involved in the therapeutic work than the mother—whether he presents as being the healthier one or is more avoidant—the clinician may need to attend to what needs to be done to help him stay involved. Often fathers attend for a short time after their infant's birth but less often the longer term (Rex's father was an exception.) The clinician needs to be actively curious about the reasons for a father withdrawing or no longer attending therapy. If fathers are under-represented in a clinician's workload countertransference issues need to be considered.

5. Involving fathers, recognising them as parents, may help them become a father, to become the father they want to be. The following three vignettes of fathers with gravely ill or dying infants, and fathers with psychiatric disorders, indicate this widening scope of the work.

Supporting the father of a gravely ill baby

Bonnie was referred to the infant mental health service at 8 months of age. She was in intensive care with a drug reaction which was the probable cause of liver failure. She was thought to be so ill with severe respiratory complications that a transplant might not be possible. Campbell Paul (2013) describing her, wrote:

'But Bonnie seemed 'positive and lively'... Looking back over her 8 months extremely sick and in hospital and about to go home, I had to ask: 'How has she survived?' Bonnie had been conceived to a very young couple. At about 4 weeks, Bonnie's weight fell and she had become jaundiced due a severe liver disorder. Subsequently she spent 7 of her next 11 months in hospital. She was considered for liver transplant as the only way to survive but the difficulty was that she had to become bigger to withstand the trauma of the operation. There was to some degree a race against time. What did we find on meeting them? Both parents were present, Bonnie lying on a pillow across her father's lap, he gently holding her fingers and occasionally stroking her head. She was small – the size of a 5 week old baby and skin of a deep yellow hue, some jet black hair and deep open eyes. What was striking was her gaze. She looked, turned her head, and gazed straight into my eyes as I entered her room – she sought me out, fixed me with a powerful stare – it seemed neither fearful nor angry. It was as if she were saying to me, "Who are you? I am interested – and curious, but not too trusting. I am safe here on my father's lap – my mother also beside me."

Campbell's recognition of the infant's striking sense of self agency, here sensitively supported by her father, was

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therapeutically affirming to her extraordinary devoted father and mother in her ongoing development.

A dying baby and her father

Similarly, the following vignette emphasises the importance for a father of keeping the baby as the focus to accompany her as she is dying, and of working with the father to try to make this possible. Campbell Paul (2008) wrote:

'An overwhelmed father, John, was sitting beside his 3-month-old baby who was on the extra-corporeal membranous oxygenation machine (the artificial heart-lung system). He felt unable to touch, talk to or look at his child. He experienced severe, disabling anxiety symptoms and a recurrence of an early left arm paralysis, a conversion symptom form of severe anxiety disorder as a young man. He felt angry with himself that he could not help his daughter, and despite her being a desperately wanted baby, he felt resentful of her continued existence. She caused him so much pain. With exploration of his past mental health problems, it was possible for him to see that he did have things he could give his gravely ill daughter before she died. He was able to become a supportive father as he gently touched her, spoke with her and saw how she calmed and settled as he did so. For John being able to have a real relationship with his extremely sick infant helped release him from the mental anguish and conversion disorder from which he suffered – he could fill his role as a father albeit briefly. A relationship was there, and it persisted.'

Fathers and psychiatric disorders

For fathers with serious mental illness, their parental responsibility needs not to be dismissed because of their illness and they need to be seen as having the potential to be capable parents; work with their parenting issues is very important (Ramchandani et al., 2009; Wren, 2008). In 2010, Campbell Paul addressed this: 'The role of the father for infants whose mother has a serious mental illness may range from being totally absent or of unknown identity, to living apart with regular contact, to being the effective primary carer. Increasingly there are enduring relationships between men and women with serious mental illness. In assessing the quality of parental care experienced by an infant it is common to omit the contribution of the father who may also have a significant mental health problem ... The direct effects (upon infant care giving) and indirect effects (upon the mother's own adjustment and social circumstances) may be profound.'

6. We have not found particular technical differences in working with the father alone or with the parental couple. With two parents and an infant present a sole clinician may find it harder to work equidistant from parent and infant (Lieberman & Pawl, 1993), than when they are working with a co-therapist. In some clinicians' reports, such as those of Bertrand Cramer and Bjorn Salomonsson, the father seems to feature relatively rarely in infant-parent work, and some clinicians acknowledge that they find it harder to be in contact with an infant with both parents present and they actively exclude the father. We wonder, particularly with the widening scope of infant-parent therapy in assisting fathers to take their place in the care of their infant, why some clinicians would restrict parent-infant therapy to the mother-infant dyad and exclude the father.

Conclusion

In Lynn Barnett's videoing of Felix ('Sunday's child') at age 31, he says, as the father of a four-year-old daughter, "Being a father – you've got a vulnerability now (that) you've always got". He needed to find the strength in himself to be both open to his daughter and to enjoy her, whereas he had felt at 21 that he himself did not have a father available to him. Infant-parent therapy might help develop further his sense of himself as his daughter's father, a role that he may, out of the pain he has faced in the past, feel diffident about claiming.

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Report: AAIMHI Victorian Branch Scientific meeting, 24 May 2014

Refuge for Babies: Making safe the infant and mother left homeless by family violence

Presented by Wendy Bunston, PhD Candidate, La Trobe University and Consultant, WB Training and Consultancy, and a guest panel including: Kathy Eyre, Senior Clinician, RCH Mental Health Program; Meredith Banks, Clinical Nurse Consultant, Maternal & Child Health, RCH; Rosemary Barca, Manager, Emerge - Women & Children's Support Network; and Anne Dillon, Team Leader, Western Victims Assistance and Counselling Program, Cohealth.

It was a pleasure to welcome Wendy Bunston and the panel to the meeting. Wendy described the plan for the morning as an exploration into how we as a society consider how to keep infants safe. She went on to explain that she would consider both the intrapsychic understanding as well as the more practical considerations. Wendy mentioned a valuable resource, the DVRC domestic violence resource centre; in a systemic review of homicides she highlighted the vulnerability of infants and children, with 50 per cent of domestic homicides involving an infant one year or less.

Wendy generously shared an infant observation that was part of her data collection for her PhD. The mother was in a refuge with her four-month-old, having arrived that day after intervention from DHS and the police in response to family violence. The mother had been forced to enter the refuge or face losing her infant, as she had not been able to protect the infant from the abusive partner.

The reading of the observation was felt powerfully by the room and elicited much discussion. The discussion started with a reflection on the idea of refuge and linked the idea of refuge with the refuge that the eyes of caring adults provide for a distressed infant.

It was noted that the cost of family violence to the infant was high and that could be seen in the dysregulation and hypervigilence of the infant.

The unique and complex nature of an infant observation in a refuge was discussed and the importance of sensitivity, flexibility and authenticity were highlighted, as well as the difficulties of trust and maintaining an observer stance.

Ann Morgan introduced an extremely thought-provoking idea that the infant in this situation is in fact not looking for attachment but the biological experience of safety, that the observer and the refuge worker offer something vital to the infant in the looking into the infants eyes and providing a calm and safe response.

The poignancy and sadness and anger of the choice that the mother must make between her partner and her infant was reflected on and a question was raised: was it refuge from the partner or from DHS for the mother?

A final comment about transitional space and refuge was introduced. This concluded the first part of the morning.

The second part of the morning introduced the guest panel: Kathy Eyre, Meredith Banks, Rosemary Barca and Anne Dillon.

A lively discussion took place about how to give infants a voice in the child protection and family violence teams. There was a call to arms to pull together thinking about infants and family violence, to improve dialogues between the Infant mental health clinicians and refuge workers. Given all the impediments that are part of refuge, transience, et cetera, how to get services to these infants was pondered.

The difficulty of the work in this area was discussed as well as the need for good supervision to help with processing the intensity of the risk of lethal outcomes for the infants.

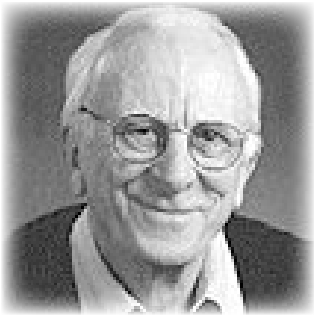
A reflection of the work to be done still to keep babies safe in our society, and the reality that it is still not mainstream to see an infant as a person, in refuges they are simply accompanying children.

Editor's note: for more information about Wendy Bunston and her work please see:

http://heresheis.org.au/youth/2013/05/wendy-bunston

Lisa Bolger

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.



HENRY GEORGE (HARRY) EDHOUSE (1924-2013)

Harry Edhouse was born and raised in country Victoria, the youngest of a family of five girls and one boy. He is reported to have been much welcomed and adored by all his sisters. His childhood was spent at Chelsea, then a small rural seaside township. Throughout his schooling at the local primary and Mordiallic High schools he was a year younger than the other students in his class and on completion too young to attend University. He then spent two years as a school teacher, the second of which he was the only teacher, in charge of a small bush school which he is said to have thoroughly enjoyed.

From June 1944 until December 1946 Harry served in the Australian Army at Moratai as a signalman, and after demobilisation attended the University of Melbourne from 1947 until 1954, qualifying in medicine. He then studied psychiatry, his first postgraduate appointment being at Royal Park Hospital (Victoria) during 1961 and 1962. Following this he trained as a child psychiatrist in Perth, Western Australia from 1962 until 1964, during which time he also obtained a Diploma in Psychological Medicine.

He was then appointed the first Director, Department of Psychiatry, Adelaide Children's Hospital in Adelaide, South Australia, a position he held until 1971. He quickly made a name for himself, especially as a clinician, and as a teacher, specialising in child development from infancy. It was his deep concern for better practice in this area that led him to the position of Medical Director of the then Mothers and Babies Health Association which was responsible for training, accrediting and employing the infant welfare sisters and mothercraft nurses throughout the State. He held this position in 1975 and 1976, and then returned to full-time psychiatry practice in both Adelaide and Melbourne, finally retiring in 2009.

Harry worked from approximately 1961 until 2009, as a clinician, teacher, and administrator. However there is much more, particularly in relation to his work in educating key people in the community to do a better job when advising parents on matters related to child development. Two major projects come to mind, presented below.

He was instrumental in setting up a Graduate Diploma in Parent Education and Counselling Course in 1975 at the then Kindergarten Teacher Training College, later to become part of the University of South Australia. This postgraduate course was multi-disciplinary, and in much demand. Harry was also co-founder of Marbury School, a small independent, non profit making, non competitive, non authoritarian, progressive coeducational school at Aldgate in the Adelaide Hills which existed from 1972 until 2004.

Harry's interests were widespread, first and foremost to quote him, "all matters psychological and philosophical especially those of clinical application". He was involved in fiction writing, music making, drawing, and was an avid reader. He had a great love of the seaside, and of the outdoors, and enjoyed bush-walking, country camping, and safaris. He belonged to a gold prospecting club (his father was born and raised on the goldfields in Castlemaine, Victoria).

Finally, an important part of Harry's life was his membership of several professional groups and associations, one of which, notably, was as Chairman from 1968 until 1976 of the Section of Child Psychiatry of the Association of Psychiatrists in South Australia (this Association became part of the Royal Australian College of Psychiatrists in 1970).

Harry Edhouse was generous with his time and clear and imaginative in his teaching. He was criticized by some as being too idealistic in his approach to child rearing to which it would be expected he would answer something like " What is more important than ensuring that our babies and young children are set in the right direction towards building healthy relationships as they proceed through life?" It is difficult to calculate or fully comprehend the enormous contribution he made to tens of thousands of Australian families and individuals who went to him for treatment or counselling or who were affected by his administrative changes, or indeed the large number who would be affected through his influence on the other professionals taught by him.

Written by Dr Elizabeth Puddy with information provided by Dr Edhouse's family and colleagues.

Hisorical article: Controlled Crying

Harry Edhouse (written sometime in the 1980s)

Briefly, controlled crying is a behaviour modification routine, aimed at training babies to not expect attention to their cry, by means of gradually increasing the amount of time they are left to cry before they are attended to. Carefully done, it can succeed in reducing the readiness of babies to signal their need state in this way. The problem is that this procedure disturbs the natural development of cooperative mother-child interaction, and is imposed upon babies before they are ready to tolerate delay in need satisfaction. The pity is that tolerance will happen naturally in due course anyway. Child and Family therapy clinical practice sees the results of such rushing of the maturation program, and they are not good.

The following is a short observation I wrote down, a few years ago, away from my clinical work simply observing a young family.

There is a young family with a baby living near and they nurse their baby on the porch. We hear how often the baby cries and for how long. I listen to the note in the baby's voice. I hear it change after ten minutes of crying from that of discomfort, to that of alarm, to that of a sad low grade sobbing. It is at the latter stage that the mother attends to the baby. I think to myself that this conditioning, repeated several times each day, is surely guiding this babe along the path towards sadness as a character trait, towards not expecting his needs to be read or responded to, and towards not remaining in touch with his own needs.

When I see them in the street, the mother seems to interact closely with him, and you would think them an ideal couple. But, once again, I hear him cry for prolonged periods when they are in the house alone. My impression is that the mother is meeting her needs of the baby, but not the baby's needs of her. Over the six months of his life, his crying has become less and less. I worry that he has given up. I think that I am witnessing the making of a man who will neither weep socially nor relate sensitively in a sharing sort of way, and who may have a reservoir of intense rage directed at females and mother figures.

All organisms sleep according to their needs and according to the conditions to which they are exposed. Babies who are content in themselves, physically and mentally, will sleep contentedly according to their needs. Sleep is determined by the circadian rhythms which have been set by Mother Nature and Father Time and are built-in to the genes and chromosomes. It is not possible for any one set of earthly parents to improve on this system. It is possible however for the prevailing condition affecting the nursing couple to inactivate, disrupt or distort this system. For the record, and excluding passing illness and indispositions, there are physical organic conditions which disrupt these patterns, but they are few, and they are usually identifiable, and are usually treatable on organic grounds. The pregnancy itself, the gestation events, the parturition experiences and all of the factors which could have affected the mother during these times are all variables that can weigh. The babe is not a standard product, nor is the mother, nor the family circumstance in all its possible manifestations.

The touted notion of "sleep resistance" is a patently ridiculous one as sleep will ensue if the conditions are suitable. The term "sleep resistance" implies that babies are at fault, and are perverse and malign toward the people on whom their lives depend, which does not make sense. A term like "sleep pattern disruption" or even "nursing couple dysfunction" would be the more accurate and would direct attention to the conditions the two persons involved are having difficulty with. Sleeping, as a rhythmic biological function, like breathing, will occur dependably if the biologic state is not thrown out by the physical, social and emotional surroundings.

In the ideal background the mother has wanted the baby, has had a good pregnancy and confinement, and is well supported by husband and family of origin in her mothering preoccupation in the early months of parenting. If to this person is born a normal child who is in a normal state of health, then I would expect there to be no problem produced if the nurturing is geared to the needs of the infant. Saturating each need as it arises enables the infant to progress steadily through the need calendar without interruption or deviation. This is the situation which prevails during intra-uterine life and which proceeds reliably and optimally, (excepting the exceptions,) producing normal full-term babies.

In contrast to chicken and turtle hatchlings which are ready for independent living once out of the shell, human children need months and some years of nurturing in their post uterine life while they piece together a mature format for social living.

With regard to corrective management, I am realist enough to know that many of the parenting situations existing in the community are far from this ideal. For many parents, parenting is not the main priority, and closer attention is paid to matters other than parenting. It can be a nuisance for them when the parenting needs begin to demand higher priority. They then seek a remedy for the nuisance of parenting. Controlled crying seems like a remedy for this nuisance factor. It takes no account of the causes or consequences. It is a procedure for disengaging the infant from the parent against the infant's wishes. It is likely to be resorted to in situations where there is already a degree of disharmony. Usually

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the situation has gotten out of hand because the parents have been following a course of handling of the baby that the baby can't yet adapt to, such that its rhythms are thrown out, or the parents are not willing to modify their own patterns for this period of time.

The central issue for the advising clinician is that of helping the parents manage the situation so as to not allow the sleep experience to become coloured with separation anxieties as this leads to many later adjustment and behaviour problems.

This can be done by the parent:

(1) Stage setting of the end-of-day routines (reduce light, sound, physical activities; see to appetite satisfaction, bodily comfort etc.) to induce in the infant a total mental set towards withdrawing attention from the surroundings and becoming absorbed in the infant's own inner state.

(2) Taking the child to the sleeping situation, settling down there with the child, gently pat or sing or read the child into a sleepy state.

(3) Engage upon some activity of interest to yourself (reading, knitting, pencil and paper work etc.) to be there if the child should rouse until the child is well asleep.

(4) When this routine is well established, the whole process will become more efficient until the child is more and more able to be left and get to sleep quickly and contentedly.

(5) Seek out a parenting therapist to obtain individualised guidance back to harmony and progression.