Australian Association for Infant Mental Health Inc.

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Affiliated with
WORLD ASSOCIATION FOR
INFANT MENTAL HEALTH

ISSN 1449-9509 Vol. 28 No. 1 April 2015

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A new year for the growth of infant mental health work in Australia, and the second edition of the newsletter under the new editorial team. We hope that from each edition we can learn from your feedback how we might further develop the newsletter as a lively forum for ideas and discussion within the national membership of AAIMHI. We have had much encouraging comment to date, and thank all authors for their contributions to the current April edition.

The need to provide a voice on behalf of infants *to* the adults and their systems seems to be a unifying unifying theme between the submissions in this edition. We begin with our president's surprise at the apparent dearth of the infant's perspective in public discourses around detention and violence in the home. Beulah Warren's 2014 Winnicott lecture, included in the latter section of the current newsletter, poses the question of our responsibility to support babies and their parents by improving practical supports, such as paid parental leave.

Two articles reach for ways to learn, partner and advocate within the many cultured landscape that is Australia today. Gally McKenzie finds herself advocating for the infant when she herself is dependent on multiple language interpreters, perhaps much as babies often depend on adults to interpret for them. Ben Goodfellow wonders how one new to walking alongside Indigenous Australian children and families can still draw on familiar 'expertise' to make sense of hurts past to advocate within inactions present.

Submissions also explore creativity and hope. Frances Salo and Campbell Paul wonder about the therapeutic opportunities enabled through humour in babies' communications, and amusement between parent and baby as moments for change. Amy Simpson and Yvette Mackley reflect on the AAIMHI 2014 conference in Brisbane, reminding us what breadth and richness there is in IMH in Australia and the value of the philanthropic scholarships that AAIMHI offers. We are delighted to include a press release celebrating Vibhay Raykar's recently awarded Zero-to-Three fellowship.

We also pause to recognise the contribution of the late Fiona McDonald to the field of infant mental health in Victoria, and her generative work articulating the plight of the infant in vulnerable families.

In April 2015 we are pleased to have two book reviews, a regular section now with each edition. We also have our first creative theatre review, and hope art reviews will continue to feature in editions to come. The next newsletter will also feature a selection of fine art that pertains to infant and family work to expand the modes of expression and communication. From 2015 onwards, the Winnicott lecture will feature with the Ann Morgan Prize-winning pieces in a separate stand-alone edition.

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Members who are moved and motivated by something they have read, not necessarily an academic work, might consider submitting a review for the next edition. We will have a new 'Letters to the editors' section for the August edition. Members who are moved and motivated by something they have read in these pages are encouraged to contribute to the written conversation.

Finally, we wish to make clear that for transparency any contribution from us is reviewed externally by guest editors. Thank you to Sally Watson and Meredith Banks for being guest editors for this edition.

Ben Goodfellow and Emma Toone

President's Report

As I sit here writing this report I wonder where the time has gone. Already we are in April and there has been much happening. Constantly there are events that alert us to the need for the ongoing need to advocate for infants, e.g. infants in detention or the impact of domestic violence. I am alerted to the (surprisingly) common belief that still exists in the community and even more surprisingly among professionals that infants are not impacted in the same way by traumatic events because they won't remember. I know as individuals, AAIMHI members consistently advocate for infants and as an association we can collectively be an even clearer, stronger voice. We are an organisation with a significant number of members (over 500) across all States and Territories and a very wide range of professions.

We envisage that the employment of a Project Officer for a total of 26 days to assist us with setting up structures and resources to implement the AAIMHI Communications Strategy is going to help us lift AAIMHI's presence in the public arena and therefore the voice of infants. Part of this involves developing information brochures and making our website a 'go to' place for policy writers, journalist and parents to get information. This of course all takes resources.

I am aware that many members expressed concern regarding the significant increase in membership fees for the 2014-2015 membership year. There was much discussion among the National Committee members regarding this increase but in the end the committee felt the rise in fee was needed for a number of reasons. These were:

- The redevelopment of the website;
- The employment of the project officer to help us move forward on the implementation of the Communication Strategy;
- Most significantly our depleting funds, i.e. the income from membership fees (our main source of regular income) were not meeting our running costs and financially AAIMHI was going backwards and therefore at risk.
- At the time the decision was made we were advised by the Associations Forum, of which we are a member, that it was better to make the one single increase rather that increasing every year for a few years. We envisage that there will not be another increase for some time.

So as we come close to the time of renewing our membership fees I would strongly encourage you to renew, and encourage those around you who work in Infant Mental Health to join the Association. With a strong membership base we become a stronger voice.

Sally Watson
AAIMHI National President

Clinical reflection

Why do infants laugh? A transformational moment in the therapeutic encounter?

Frances Thomson-Salo and Campbell Paul

> *... a certain kind of shining moment: when something happens that a baby finds funny. This kind of joy, which reaches into the edges of surprise, of things not being quite what was expected and yet turning out well—is often followed by the people around the baby getting it, and showing through their own laughter or joy that they get that the baby gets it. (Seligman, 2014, WAIMH conference, Edinburgh)*

In this paper we suggest speculatively that babies may see the funny side of things very early – that the capacity for humour may be there from birth, with imitation as the beginning of humour, and that as from birth onwards babies may seek humorous engagement because it is playful and hopeful, it can be part of a therapeutic encounter. We explore very early humorous engagement, to make the case that we may have underestimated babies' humour as a major therapeutic pathway, that humour may be far more than a technique for engagement, and a means of communication.

Many infants improve after a therapeutic session – do we have enough of an explanatory model for this? We see examples of humour in much of our work and we see it as a sign of progress.

Amusement between parent and baby may open some capacity for thirdness, to see the baby as different from them and how they usually see the other. With an infant's playful teasing we may infer that a greater stability of the mental self and object representations had been achieved (Galenson & Roiphe, 2015).

We can probably all think of a time when a parent found a clinician's response humorous and therapeutic. It is also easy to find examples of humour in parents' responses to their baby. For example, a baby was play-biting at the breast and his mother was angry, but was able to tell him to be gentle, that she did not have a spare breast, and with humour the tension reduced.

We are particularly interested in the infant's contribution of humour and see humour as emerging very early. Infants love the surprise that lies at the core of humour: a slight violation of expectation is a strong stimulus for laughing. Infant perception of humour is easily seen from three months onwards; three-month-old infants laugh at the absurd behaviour of others – clowning, blowing raspberries – and develop their own form of clowning (Mireault et al., 2012). Many infants make others laugh by deliberately repeating actions to elicit laughter again.

The importance of humour, playfulness and teasing with infants in therapeutic interventions

Play is woven throughout an intervention even with a baby who is sick, for example gaze play and the peek-a-boo game. An infant's capacity for humour, if treated respectfully, is a powerful way of intervening with infants and their families. Violation of intention in a gentle way is an essence of teasing. Infants can detect and disrupt adults' intentions on their own, in a humorous way. In a hospital setting, humour and teasing can become part of a therapeutic relationship with ill and traumatised infants. Gentle teasing, for example when the therapist offers a baby a toy, conceals it, offers it again and we share the joke, implies that we have faith that a baby will understand our playful intentions, and if parents participate they may see a different aspect of their troubled infant. Other examples include playing with gaze aversion and voice; a fake coughing imitating game; playing with other facial expressions with the therapist imitating in cheeky, distorted feedback; offering and withdrawing an object – but letting the infant win; or touching a hand, the infant withdrawing and the therapist touching again, gently violating expectations.

Vignette

Written in Campbell Paul's voice as the therapist. Names and details have been de-identified.

Eleven-month-old Eric had severe liver failure with no hope of surviving without a liver transplant and he needed to grow to receive that. He was the only child of an Indian couple without family support. Eric seemed very sad, miserable, and withdrawn. His sleep was broken frequently overnight and his parents who slept in shifts beside him were sleep-deprived. He had difficulty eating and needed tube feeding. When I met Eric, he was in his mother's arms, with a persistent whingeing cry. He glanced at me sideways, paused then resumed, averting his gaze. I spoke with his mother about how things were going, and he gave me a little sideways glance. We caught each other's gaze for a few moments then his gaze darted away. Before it did, I moved my hand towards him because I saw his hand move. He looked at me, turned away, glanced back and kept looking at me and I waved my hand and continued to speak with his mother while looking at Eric. He looked away, then looked back. I made a waving movement and moved my hand towards him. Eric moved his hand forward a little, then withdrew it. We continued this game for a few moments and a smile came over his face which his mother observed. We had, in the context of his profound illness, set up a humorous game with mild teasing, which required me somehow to intrude.

The second time I came, a smile developed much more quickly, as well as a softening in his mother's face. She seemed to feel that Eric could come to life despite his grave illness. Each time I came to see him, we would do the same thing and his parents were aware this was a game between us and seemed to feel more empowered to do similar slightly risk-taking things with him. It was as if my reaching out to touch him was a way of saying, "I see you there, and I realise that you don't really feel able to engage and be with people. But hopefully respectfully, I'm going to impinge on you to see if we can develop a relationship". This was not something he generally experienced as he was so ill, requiring frequently intrusive acts from staff and his parents. I thought Eric was making an embodied joke!

Reflections on a baby's humour

Freud saw humour as rebellious and 'play' as the first stage in the development of humour. Did Eric find the rebelliousness on his therapist's part contagiously enlivening and humorous, impinging on him in such a way that it nevertheless respected the infant's right to disagree?

Does this link with when an infant is amused and finds something funny, he feels more himself, she feels more her own person – in a safe and enjoyable way? An infant intuitively knows when humour is an authentic communication, intended just for him or her. When parents see their infant's humour they may recognise that, "There's my infant who is alive, I can afford to invest in his life and ongoing existence" and with it may come a major shift in the quality of their relationship, as with Eric, so that humorous action can lead to a significant 'moment of meeting', to paraphrase Stern and colleagues.

Is there a crossover of fun (or joy or delight) with humour? Does it happen earlier than three months? Within an hour of birth an infant 'knows' if we put out our tongue to get them to reciprocate. A two-day-old put his tongue out at a clinician several times and she laughed. His father had done it so often that the baby now did it to evoke an interaction with her. While that does not mean that the baby initially sought to make her laugh, the fact that he continued to tongue-protrude suggests that he was seeking to evoke that social interaction.

Could humour be there from birth?

That imitation may also be the beginning of humour was suggested by Phyllis Greenacre (Thompson, 2015) and that play is an expression of imitativeness. We see here how closely play, imitation and humour are linked in development and, we suggest, in therapeutic engagement. We know that babies seek the joy of surprise – do they from birth onwards also seek humorous engagement because it is playful and hopeful? In the first hour after birth, before attaching to the breast a baby first looks at the mother's face searching for a smile, which helps the social communicative system between them both kick in (Porges, 2011). How early might a parent smile with amusement at their baby, and is this a humorous engagement on the parent's part? With the mirror neurons in play, when a parent smiles with amusement at their baby, does the baby feel the amusement, and the beginning of seeing the humorous side of things? Does this smile open the door to the pleasure of surprise and the pleasure of humour? Is a smile a common pathway between humour and feeling safe and happy, and does an infant act in a humorous way to evoke a smile from us, and delight? Is humour part of the highway of epistemic trust, aiding secure attachment?

Concluding reflections

The Sydney psychoanalyst, Shahid Najeeb (2014) talked of the 'magic of infancy' as including the parents' enjoyment of their infant having fun and surprise – sharing a joke, or a joking reappearance after a disappearance. Does being amused open a transitional space of safety, relief from stress, and hope for the possibility of change, so that the shoehorn of humour provides, as Burton put it, "a tiny, but not trivial instant of restoration ... (a) break with reality by what I call 'inventive absurdity' " (2014, p. 350).

Freedom in the activity of the clinician can bring novelty, courting surprise and relational curiosity. Humour connects people (Twemlow, 2014). With fun there is the potential for humour and therefore for seeing things in a new way.

Might a baby's capacity for humour, if treated respectfully, be the most powerful way of intervening with infants and their

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families? That perhaps we have all along unconsciously been aiming for humour – appropriately – in interventions. The baby in using humour is letting us know he or she is resilient. Humour is transformational in allowing hope to continue.

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AAIMHI VIC Philanthropy report

Christine Hill

In 2011 the AAIMHI (Vic) committee made a commitment to allocate, each year, up to 10 per cent of its funds to philanthropy.

In 2014, Victorian AAIMHI members were asked to nominate people who work with infants and who would benefit from attending the National Infant Mental Health Conference in Brisbane but were prevented by lack of funding. The philanthropy fund covers registration, airfares, accommodation, and a one year membership of AAIMHI.

The recipients of the 2014 sponsorship were Amy Simpson, a Registered Psychiatric Nurse currently employed with Mercy Mental Health's Wyndham Community Mental Health Team, and Yvette Mackley, a Registered Psychiatric Nurse, currently working as a senior clinician with the Community Team at Mother Baby Services.

Both were nominated by Jess Barnes (Manager of the Mother Baby Services, Mercy Mental Health) because of their commitment to developing their understanding of the infant-mother relationship and to improving their skills in supporting the mental health of infants.

Nominations for the next round of sponsorship will close on July 31, 2015.

AAIMHI Conference 2014, Brisbane

Infancy in Crisis – Rupture and Repair

Philanthropy Recipient Conference Report 1 – Yvette Mackley

The conference was held in the Gardens Campus of Queensland University of Technology with the tranquil botanical gardens on one side and the picturesque Brisbane River on the other. It is difficult to begin or explain what I gained from attending the conference but I will do my best, as on reflection it was like a feast of information. Credit should be given to the Queensland branch of AAMHI for organising an interesting and successful conference.

I was especially inspired by the lecture by Dr Anne Sved-Williams at the Marcé breakfast on the diagnosis of Borderline Personality Disorder (BPD) in mothers and the effects on the infant and mother-infant relationship. She drew our attention to the difficulties women with this diagnosis have when they become mothers and what this means for their infant, with a mother trying to manage her own emotional dysregulation. The statement "It's easy to love the baby and hate the mother" was explored further in Francis Thomson-Salo's plenary on countertransference where the difficulties of clinical work were discussed honestly. What a relief to hear of not only the rewarding work we do but to also acknowledge the sense of anxiety, indifference, anger, hate, failure and confusion that can surround our own feelings and thoughts that can overwhelm us when working with difficult dyads. Dr Sved-Williams discussed how some mothers with BPD diagnosis were initially sensitive but became less sensitive as their baby cried; further describing this occurs due to the fore-brain being in use and the cry triggering the mother to emotionally disintegrate. These theories were also supported by Dr Lane Stratham when he discussed his research focusing on the neurobiology of mother infant attachment and the relationship between levels of oxytocin and amygdala responses in the mother's ability to respond to their infants. Mothers with unresolved trauma were found to have reduced response in the amygdala when their baby cried and a decrease in oxytocin response was identified in women with addiction, postnatal depression and insecure attachments compared to women without these anomalies. I found these sessions particularly interesting and valuable as I work with so many dyads where the mother finds it distressing to be with an unsettled infant.

Throughout the conference many presenters referred to the positive outcomes of their use of Circle of Security interventions and video feedback, which I utilise in my own work. This confirmed my own experience of the possibility of improvement of emotional care and wellbeing of the infants I am privileged to work with.

Both Amy and I were inspired and encouraged by the conference to continue our work with families. We were able to collaborate about how we will use our skills to work together in our mental health service, despite having quite different positions within the organisation. Our plan is to make a proposal to our managers for a Circle of Security group intervention with case managed clients within our service.

I would like to sincerely thank the Victorian AAIMHI Committee once again for the generous financial support to enable us to attend the AAIMHI 2014 conference.

Philanthropy Recipient Conference Report 2 – Amy Simpson

This year's AAIMHI conference was so refreshing and motivating for me. The diverse range of topics offered many different insights into Infant Mental Health. Jennifer McIntosh's plenary on 'current research and theoretical perspectives on infant overnight care in parental separation: from splitting to integration' was fascinating. Jennifer's insights and special considerations for assessing the child's readiness for shared care simplified a previously confusing concept for me.

Joe Coyne's session on 'therapy with infants and their caregivers in contemporary contexts' was a wonderful transformation to watch. The amazing use of art therapy to identify and process a client's 'shark music' was powerful. I found myself becoming overwhelmed by the woman's transformation and the level of accountability she took for her shark music. Watching Joe in action on tape was a privilege to witness.

Louise Newman's plenary on 'the infant asylum seeker – impact of immigration policy and practice on infants and families seeking asylum in Australia' was heartbreaking. The fact that these human beings are being re-traumatised on a daily basis by poor conditions and inappropriate access to health and welfare is overwhelming. It left me motivated to communicate my disgust with the current policies. A child identifying themselves as a number rather than a unique human being is something that won't leave anytime soon.

Lane Strathearn's plenary on 'oxytocin, breastfeeding and the maternal brain: implications for child neglect' was an informative session – I found myself unable to turn away, from not only the content but Lane's presentation skills. The amazing protective factors of breastfeeding can't be underestimated.

Peter Carnavas's speech during the conference dinner and his reading of 'Sarah's heavy heart' was a touching insight into depression which beautifully communicated everyone's need for connection and support.

And finally Frances Thomson Salo's plenary on 'early warning signs in the countertransference in a maternity hospital setting' was a lovely reminder of the nature of the amazing work that we do and the constant need for reflection and self- care. I found it comforting to know that such an amazing clinician had similar struggles that I face in my day to day work with clients and families.

Thank you very much for sponsoring me to attend this amazing conference. I look forward to implementing some of the insights and knowledge I developed into my practice with clients and their young families as an adult community mental health clinician.

Crossing many boundaries: Working psychotherapeutically with a refugee parent infant dyad from a culturally and linguistically diverse background

C Gally McKenzie

What can we learn to guide us when working with at risk refugee infants and parents from culturally and linguistically diverse (CALD) backgrounds?

In child health clinics, general practices, hospitals, out-patient clinics, in government and non-government agencies throughout Western Australia many practitioners and students from many disciplines interact regularly with infants, parents and families for whom English is not their first language, be they Indigenous Australians or families from overseas with a CALD background.

In recent psychotherapeutic parent- infant work with such a refugee CALD family, undertaken at a metropolitan based non-government agency, I learnt to observe, to listen, to focus, to act, all the while sitting with complex and difficult emotions and narratives. I learnt that in order that this refugee infant and mother experience safety, I had to tailor my usual model of working.

The pregnancy was unplanned and unwanted. The mother, now 36 weeks gestation, with a visa and living separately from her husband, had initially requested a termination of pregnancy. She relented, fearing punishment from her god. She was despairing and suicidal.

This therapeutic undertaking involved crossing many of the more traditional clinical/therapy boundaries, all the while upholding a commitment to ethical and professional practice. The work also involved accessing the support of interpreters in the main by telephone due to the paucity of availability, as well as a number of other practitioners from myriad disciplines and services.

Selma Fraiberg in her seminal paper 'Ghosts in the Nursery' (1975) said of the infant, "this patient, who cannot talk, has awaited articulate spokesmen".

In this work, I, as interpreter for the baby, awaited articulate spokespersons, the interpreters. Fourteen sessions over eight months brought thirteen interpreters, a less than ideal structure, but the only one available. This infant and mother had their lives' narratives articulated in English to me via these interpreters. What was apparent, without a shared spoken language, was the unspoken-ness of the very great distress and difficulties that this baby and mother were experiencing, both before birth and in the immediate months after baby's arrival.

The mother had lost both parents at age two and had been raised by an older brother. Because of her ethnicity and ongoing cultural persecution in her home country, she, along

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with her fellow people, had not been allowed a school based education. While in their home country, her now ex-husband had been apprehended by the secret police. Fending for their two young children, isolated from her family of origin, she did not know if her husband was alive for several weeks. Eventually he was released. This event precipitated their leaving their country, seeking safety and refuge in Australia. The journey was hazardous. The father travelled alone ahead of the family. The mother and children followed, initially spending a difficult time in Indonesia. While at sea, their boat broke up. All feared drowning; they were rescued by an Australian vessel and taken to Christmas Island where they joined their husband and father. All suffered trauma. The mother was very angry with her husband; she said of him, he had changed and she was too angry to be with him.

Fraiberg (1975) said we are "the beneficiaries of the method which Freud developed for recovering the events of the past and undoing the morbid effects of the past in the present. The babies themselves who are often afflicted by the diseases of the parental past, have been the last to be the beneficiaries of the great discoveries of psychoanalysis and developmental psychology".

With a parent infant psychotherapy model in mind, together with interpreters, I endeavoured to benefit this baby and mother individually and together in their relationship.

What I came to learn was that many other interventions involving a number of other practitioners and services would be needed.

The World Association for Infant Mental Health (WAIMH) defines infant mental health as "the ability to develop physically, cognitively, and socially in a manner which allows them (infants) to master the primary emotional tasks of early childhood without serious disruption caused by harmful life events. Because infants grow in a context of nurturing environments, infant mental health involves the psychological balance of the infant-family system" (www.waimh.org).

Due to the serious disruptions caused by harmful life events both before and after the arrival of this new baby, this work also required a number of other articulate spokespersons. These included a child health nurse, a hospital-based social worker, a general practitioner, lawyers at both Legal Aid and the Women's Legal Service, the Coalition for Asylum Seekers, Refugees and Detainees (CARAD), staff at a multicultural centre, staff at the Department of Housing and Centrelink, the local politician's office, a specialist migrant health nurse and a school principal.

Tydeman and Sternberg (2008) state "Brief work is both compact and complicated. The clinician needs a flexibility of approach, a lightness of touch, using the minimum necessary to get a family over the present difficulty. Awareness of the brief nature of intervention means finding a few points of focus clustering around a central theme. This involves not exploring other issues that are raised by the family which might be usefully explored in longer term work but do not relate to the mutually chosen central focus".

The agency in which I worked allocated eleven therapy sessions antenatally and postnatally per mother/family.

The mother's request was for a safe home for herself and her children. She wanted a "peaceful, restful, safe place". Notwithstanding this mother's despair along with her history and lifelong need of a safe home both externally and internally, the family was living in a block of flats in which inappropriate behaviours and dynamics were well known to the police and services. The police were daily attenders, sometimes several times per day. The mother felt terrified of the drunkenness and other out of control behaviours that were frequently exhibited there.

She said she felt safer when in the two detention camps. It was at one of these detention centres that the mother had commenced antidepressant medication.

The mother, initially antenatally, took two buses to her therapy appointments. Subsequently for her fourth session she arrived with her six-day-old baby, again having taken two buses.

In session five she said she was ambivalent about counselling and talking. On exploring, she agreed that her current feelings of hopelessness were like what she would have felt at age two when she lost her parents. In session six, she was very distressed, she felt insulted that Centrelink had enquired as to the paternity of her daughter. To have paternity questioned was a very frightening and deeply shameful experience.

Lee Mc Cullough Vaillant (1997) writes of "adaptive responsivity to experience". She writes of "harnessing the tremendous adaptive power that emotions provide" and said "the fuller one is with the joy of existence, the more generous one can be toward others". In this infant-parent dyadic work I sought to provide a space in which mother could explore her painful history of multiple losses (the Talking Therapy) in order that she could begin to free herself of emotional pain such that she could work towards having more generosity towards her baby. She sobbed and cried with me, she loudly expressed her anger and her fears. She expressed her hope that her children would have a better life, that they could have an education. She loudly expressed anger that her own hoped for education would be stymied by the arrival of a new baby. I explained to this very bright and intelligent woman that she could access the Australian system of adult education. She was learning English vicariously through listening to her sons' tutor who visited the home once per week.

Work with this mother and infant also involved collaboration with many practitioners from different disciplines, all from external agencies. Each of these contributed to the facilitation of the development of an as healthy and secure attachment as possible for this baby, mother and family. Their input constituted a nurturing environment for baby and mother. Access to the Telephone Interpreter Service together with the many external practitioners and services not only 'held' the infant and mother but me too as I sought to 'contain' this dyad. Alongside this was my regular clinical reflective supervision, a necessity when working with such complex and painful emotional material. Wilfred Bion's (1962b) concept of 'the container/contained' and Donald Winnicott's (1945) concept of 'holding' are two seminal concepts underpinning psychoanalysis and current day infant parent psychotherapy.

These concepts are also at the heart of sensitive parenting. They are necessary ingredients for attunement to and acceptance of the infant's unspoken needs and states, a parallel for the therapist's attunement to and acceptance of the patient's internal states and needs. In this case there were three patients, the infant, the mother and their relationship.

This was an accomplished mother. Despite many stresses she attended her baby with competence, along with at times a

marked irritability. I understood this to be that she had matters on her mind and wanted to be able to work on them with me. She said she wanted to commence the process of divorcing her husband.

At times, 'the baby's older brothers attended the sessions. They delighted in and played energetically with her, talking with her in English. The baby too delighted in them, following their every movement with a look of awe in her eyes. The mother delighted in her sons' capacity for engagement with their sister. The family together was unified and loving. The mother was very clearly proud of her children. After some months she said of the baby, "she misses the boys when they are at school". I said that likely she too misses her children when they were at school; she agreed. After three months, smiling, she said "I love her now, I cannot imagine life without her".

All the children saw their father on the weekends. Having had child support explained to her in therapy, the father was now contributing financially for their care.

In infant parent dyadic work, the therapist is required to attune to the parent and infant and importantly their relationship. The facilitation of a more mutually beneficial relationship, which in turn becomes the holding and containing environment for the infant, is core to infant mental health work. It is in such an environment that the infant thrives and develops a healthy sense of self, thus developing resilience for potential future vicissitudes of life.

It took the mother some time to trust the therapist, to learn that it was more than okay to express her hurts and desires, that she would not be punished for this, in other words to experience an actively secure relationship. The mother and daughter's relationship developed harmoniously over the months just as the mother came to trust that other workers in other services too were available and willing to actively support her.

Her very attractive baby developed well physically, she was engaging and was responded to actively.

Because the mother had no personal official paperwork, that is, birth or marriage certificates from her country of origin, she was given copies of all letters and emails sent and received on her behalf.

Through very active and repeated pursuit by many service providers as well as myself as psychotherapist, this family was eventually granted a single dwelling nearby to the children's school, into which they moved on the final week of their therapy sessions. The mother's despair and suicidality had lifted, she was in a much more settled and comfortable state.

"History is not destiny" wrote Selma Fraiberg in 1975. The history of our working models need neither be destiny. Like families we need to be flexible, adaptive, open, willing, curious and supportive to each other's contributions. In current day Western Australia, too few practitioners working with infants have easy access for collaboration with colleagues from other agencies. Interagency work requires much time. It is not the traditional domain of the psychotherapist. Few practitioners have access to sufficient regular reflective supervision, a core requisite for workers attending to and treating struggling infants and parents.

The Australian Association for Infant Mental Health (AAIMHI) states "infancy is a critical time for psycho-social development". (www.aaimhi.org.au)

Work with this at-risk infant, mother and family was best undertaken from an inter-disciplinary, interagency collegial model in order to undo "the morbid effects of the past in the present" (ibid).

I would argue that it too sought to minimize further morbidity via the active pursuit of a restful, safe and peaceful home for this family. This home constituted not only the house in to which they moved but the mother's now internal peaceful mind and heart, a mind and heart that could now love her baby.

Adaptation in this psychotherapy, it would seem, provided the family with an external comprehensive psycho-social system that in turn provided a safe and nurturing context, the antidote for this at risk and isolated infant, mother and family.

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Reflections on Two Short Weeks in Remote Australia

Ben Goodfellow

I suspect is impossible to work in health and children's services in Australia and not have an interest in Aboriginal affairs. Being Melbourne-based, my own experience in this area has been limited largely to what is presented in the media plus many hours of discussion with two medical colleagues who have worked in remote Australia for a number of years. An opportunity arose in 2014 to work at the CAMHS service in a remote area of the north with a large aboriginal population. It was only for two weeks, but was nevertheless enough to encounter detailed instances of the many problems we often hear about, but crucially, also enough to have a reference point for where solutions might begin, both practical and philosophical.

I make no claim to being an expert in remote Aboriginal health and welfare but I do have expertise in many cases of profound, complex psychopathology in very disturbed family and social systems which brought much to bear on my clinical encounters in the north. Nevertheless, so many aspects of Aboriginal health and welfare are deeply personal, highly political and uncertain and it would not be helpful for me to be as frank here as I might be in describing some more detailed and disturbing aspects of the problems, certain notions that underpin these nor the solutions that would follow. Instead, I will present a case (de-identified by pseudonyms), and conclude with questions and some comments that arose in discussions with professionals and non-professionals, Aboriginal and non-Aboriginal and leave readers to ponder these fragments. The purpose of this paper is to provide one brief insight and provoke discussion. Some of the clinical material may be also be of further relevance for those working more regularly in these areas.

The role

My position was as a locum child psychiatrist. There is no permanent position of child psychiatrist in this area, despite a population of around 45,000, 50 per cent of whom are Aboriginal over an area of 0.5 million square kilometres staffed by around 8.0 FTE CAMHS clinicians. By contrast, Geelong CAMHS in Victoria, my main public position, services a population of approximately 200,000, 0.8 per cent Aboriginal, in an area of 2,100 square kilometres. There we have approximately 3.0 FTE child and youth psychiatrists and around 20 EFT treating clinicians, access to the Royal Children's Hospital services and a large network of private practitioners locally and in Melbourne.

In this remote area, there is only provision for a psychiatrist for two weeks around six times a year, funded federally, not by the state hospital system despite ongoing appeals from the health service. Usually there is a different doctor (though some return each year) and many of the smaller communities only have a psychiatrist in town for one week every six months. Excellent work is undertaken by the conscientious staff there despite these limitations. My work involved direct reviews of children and families, meetings with agencies such as Aboriginal women's centres, schools, youth justice and with my background in infant psychiatry we met with paediatrics, maternity services and related agencies also. I approached the work in my usual manner formulating at a systemic and individual level, broadly from a psychoanalytically informed perspective. I chose to intervene somewhat more assertively than usual since I could only see these families once.

The case of Michael

I was asked to see four-year-old Michael and his foster mum Sandra following referral by the school psychologist to CAMHS three months earlier after several instances of high levels of aggression towards other kids and staff. I had discussions with his CAMHS therapist Lisa, also with the school and reviewed the file.

Michael was almost five years old with a complex family structure, living with his baby brother Max in a foster family of non-relatives who had agreed to permanent care of the two boys, though court proceedings were still underway with no dates or timelines known.

Sandra who was tertiary educated and in her late forties had engaged readily with CAMHS and attended the clinic an hour early for her appointment with Lisa and me. Michael was finishing a glass of milk as they came into the therapy room. I'd prepared some toys and materials in a room that contained many other distractions but Michael played quietly and hesitantly at first with those in the centre where I joined him and began the session.

Further background

Sandra spoke of Michael's family, his parents' chronic substance use in an outlying community and another sibling of his in foster care elsewhere. Michael lived amidst extreme violence between his parents and others until his removal when he was two, since which time he was in around ten different placements including group homes in different parts of the state. Sandra stated that after some initial hesitation, she and her partner accepted Michael and Max several months prior to when I met them, having been warned about ongoing disturbed behaviours and the difficult early life they'd had.

Sandra stated that at home Michael has continued to settle significantly. She spoke of having tried to be "nice but pretty firm" with a range of limits, such as acceptable behaviour and his diet, making sure he has almost "no junk food or sugary drinks". Amongst other concerns, Sandra mentioned a time when Michael said out of the blue, "my dad stabbed my mum but she's okay now", then went on playing happily, talking about some animals he'd seen hunting. She asked me what to think about something like that, a question I put back to her. After a pause she said, "I guess it's something he needs to say so he can get on with other things". I suggested to her that comments and questions regarding his mother and early events will likely come and go throughout his life, at times unhappily, though this need not necessarily haunt and dominate his childhood or how he is viewed by others. It will be just one of a range of questions and dilemmas she and her partner will face.

Present concerns

Sandra said she had no concerns at home but that she had seen him "really hit and kick other kids and even teachers". He is more settled when she is present, but just can't spend the two hours a day the school have requested her to be there. Sandra's acute anguish surrounds the decisions the courts will make in the weeks and months ahead: where the children will

live and how the relationship and contact with their parents will be managed regardless of where the boys live. She said, "but no one from child protection rings me back any more".

Sandra feels the children's relationship with their mother especially is very important despite the violence that occurred. She believes that even if the kids can't ever live with their parents again, it will be "pretty hard for them" in the long run if they don't see their mother. Sandra said she has developed a good relationship with the boys' mum who for the moment remains relatively sober and trusts Sandra with the boys' care. She feels Michael does miss his mum and enjoys the visits that occur, despite the past violence. I told her this is a common and difficult predicament.

On presentation

Michael was a skinny, healthy, well presented young Aboriginal boy with a big milk moustache. He came watchfully into the room, began with play that was quiet and wary, but engaged me steadily as the session progressed, responding to my curiosity in his work and some gentle teasing. He explored the toys I'd set out, drew a figure spontaneously that looked like a face but I couldn't prompt him to comment on it. He played keenly with toy animals, some of them fighting and biting each other, letting me join him in this. Michael smiled as this was happening and talked about hunting with an uncle.

Towards the end he was exploring more of the room, offering me toy chocolate cake, then sat on my lap and insisted I read him a pamphlet he'd found on healthy food. He offered little in the way of spontaneous speech but tolerated me gently asking about some of the "scary and angry things" in his background, and the complicated and uncertain situation his life was in now. I asked if he'd like to keep living with Sandra but still see his mum sometimes and he readily said yes. On two occasions he made the letter M with Lego and said loudly with pride to Sandra, "That's my name!" He packed up keenly at the end and agreed he might like to come back one day.

Sandra presented as a very caring, wise and tuned-in Aboriginal woman to these children who she says are in her care for as long as needed. She is an educated lady who engaged well and very thoughtfully in the session, and was certainly keen to continue with CAMHS.

Summary and impression

From what I heard, Michael (and his absent brother Max) are boys from a background which was chaotic, violent and deprived in many ways, despite their mother's best attempts at change. With these early circumstances and the many placements since, it is indeed significant how Michael has continued to settle and thrive so quickly with the stability he has found with Sandra and her family. Sandra's thinking and questions were those of a foster mother who has a deep care and commitment to Michael and his brother, while still being able to consider their best interests against what she recognised were her own desires in rescuing these children.

His aggressive behaviours at school are, among other things, a barrier to his learning and making friends – further therapeutic work at the school and elsewhere will be useful to help him settle as he has at home and get on with his education; his present trajectory suggests grounds for optimism that this will indeed be possible. A more detailed formulation would require further time with him and his family but he seems a bright, engagable little boy who is of course marked by his early experiences but need not be considered damaged by them indefinitely. The central importance of sensitive, stable primary carers is manifest in this case.

Recommendations

I made the following recommendations at the time, aware that my letter may be used in the ongoing custody processes:

While I noted that I only saw Michael and Sandra on one occasion, given how well things were settling, how central his placement was to his improvement, and how brittle we know children's states of mind can be after early exposure to violence (especially during the preverbal period) I was clear in stating it was in these boys' best interests that they remain with Sandra and her partner under the most permanent legal arrangement possible, unless there had been a sustained change in the parents' situation. Given also that the boys' mother is at times able to safely spend time with them, this should be facilitated at the discretion of the children themselves and Sandra, with experienced therapeutic guidance amidst the uncertainty.

Sometimes it can play out that contact with a parent who has been associated with violence (as victim or perpetrator or both) can prompt significant emotional and behavioural disturbance. In such cases contact might need to be limited or ceased with specific considerations depending on the details as they unfold. The children should be included in the discussions around any such changes, the rationale and plans – difficult as this may be given their age among other factors.

Frequently, many services cease once a child is placed in safe and permanent care, despite specialist help often being necessary through the children's lives. I wrote that I hoped this will not be the case if the children remain with Sandra.

Comments and reflections

Many questions remain with me from this one case. What was the value of this single intervention? Did Sandra find further confidence in her approach with Michael and his brother through what she saw and heard in the session and how did this translate to the aggression at school? What is to be made of Michael marking of his name with the letter 'M,' of the ease with which he and Sandra spoke about past events, mediated by me and the CAMHS worker? What did the CAMHS worker take from what she heard from me and the family? Did my comments influence the courts at all? Should they, after just one session?

Is Michael's case isolated, or representative of many? Why did Michael remain with his parents for so long despite so much documented violence occurring? I asked several groups of clinicians including Aboriginal people whether Aboriginal children in remote areas were left in situations that poor non-Aboriginal children in Perth for instance would be removed from and they said yes, quite unequivocally. I asked why. Part of their response was "there just aren't enough people working up there and because of the Stolen Generation."

Why was Michael put in 10 different placements before a permanent family was finally found? Are there simply not enough Aboriginal families like Sandra's to offer ongoing care to all the children who can't safely live with their own parents? What if there are not? Why are mining companies for example able to adequately maintain a high-quality workforce in areas even more remote and inhospitable than Aboriginal communities? Can the health and welfare sector learn from private industry, despite the obvious differences?

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Conclusion

Michael's is one of the far more encouraging cases I encountered. Remember that for direct CAMHS intervention there generally needs to be at least one adult in a child's life organised and concerned enough to bring them for treatment; this leaves very large numbers whose involvement with tertiary mental health services is via often poorly utilised secondary consultation if at all.

Whatever systemic pathology this case may expose, we should not overlook the potential value of even a single therapeutic session of this nature that can take place despite the storm.

The element of any overall solution that infant mental health clinicians can influence immediately is to support the skilled and conscientious clinicians, and the thousands of community members who work and live to help the kids, women and men in these areas. The alternative is to succumb to the nihilism that often pervades much of the discussion around Aboriginal communities whose lives have simply not improved enough for the all the time, sorrow and money that has been spent in the past 40 years. I hope this article provokes thought among readers but also comment, especially from those with more personal or professional experience in these regions, in particular if you feel my conclusions are overstated or unreasonable after such a short time in the field.

Obituary
Fiona McDonald - 1958-2015

By Lisa Bolger and Ritchie Hewett

Victoria lost a wonderful woman and passionate advocate for infants and children, when Fiona McDonald passed away on 2 January 2015 at age 56 after a short battle with cancer.

Fiona was the dearly-loved second youngest daughter of Arthur (Dasher, deceased) and Betty McDonald (Shearwater), loving wife of Ritchie Hewett and devoted mother of Adam, Amber, Beau, Sophie, Alexia and Eartha, grandmother to Jack (deceased) and Lachlan, much-loved sister of Jenny Phillips, Marguerite and Jim Murray, Denise and Dennis Waterman, Jan and Ian Evans, Trish and Eddy Hodges and their families. Fiona and her husband Ritchie met in January 1994 and married in March 1997.

Fiona had a lifelong love of learning and was conferred a Master of Social Work in 2011 as well as completing a Graduate Diploma Mental Health Science (Infant Parent Mental Health) in 2008. Fiona's work history was extensive and included many years working for the Department of Human Services, championing the rights of infants as a High Risk Infant Manager, Specialist Infant Protective Worker and Team Leader. Other positions Fiona held were as the coordinator of Parent Assessment and Skills Development Service, PASDS, for the QEC Centre, and Uniting Connections. She was Coordinator of Early Parenting Childhood Centre, Ballarat Child and Family Services. Fiona was a Case Manager for The Hotham Mission Asylum Seeker project, a role which involved providing management, consultancy and staff support to unaccompanied minors in Community Detention.

As a result of her many years of experience in her field and from her own experience as a young mum, Fiona McDonald saw a significant need for something to assist new mothers who needed assistance with their new role. To that end she created and directed her own consultancy business, Peacebaby Consulting, which saw the development and delivery of training packages for new parents. Some of the topics were 'Everything you wanted to know about babies but were afraid to ask' and 'sleep and settling: a workshop for new mothers'.

Further work included writing an illustrated children's book, Wonder Rope – a story which dealt with the anxiety around separation for young children about to start Kindergarten/ Prep and making the film, Baby Nobody. Developed from her original play, Fiona's film was ground-breaking in that it dealt with the issues surrounding high risk infants and children from the child's perspective. Fiona presented Baby Nobody at many conferences and for communities around Melbourne, Victoria and interstate. The 25-minute film is specifically developed to promote discussion and reflective practice for those working with high risk infants and their families. It follows the first 18 months of 'baby', an infant born in prison. The film is narrated by 'baby' now as a 10-year-old, as she recalls her infant experience of love, loss grieving and trauma both with her mother, and through a myriad of foster care placements. It was met with high acclaim because it provided the viewer with a complete reversal of the traditional perception of the issues confronting workers dealing with these families.

Fiona's work with The Hotham Mission Asylum Seeker project awakened her to the plight of young refugees in Australia which led her to develop her program '5 Things in my Backpack – Understanding the Unaccompanied Refugee Minor Experience'. The program sought to give understanding, particularly to students about the refugee experience. It was included in the curriculum at some schools and Fiona enjoyed the opportunity to deliver the message into those schools.

Fiona was contributing writer to a chapter on Infant development in Understanding Human Development: 2011, Dr Louise Harms.

Fiona secured a new position with St John of God in Ballarat in 2014 and was known as having a delightful sense of humour, and will be remembered with fondness and respect by her colleagues at Raphael House, Ballarat.

Fiona's colleagues and friends Associate Professor Lou Harms,

Menka Tsantefski and Winsome Roberts remember Fiona for her compassion, kindness and creativity that she combined in her work; her friendliness and sincerity; her commitment to helping women care for their infants; her intelligence and wicked sense of humour. Lou stated that Fiona was a pleasure to be around. She had a quiet modesty about her and in that modesty was an achiever and a contributor. She never sought recognition of her own work, just that lives for others were improved. Fiona introduced us to her beautiful book, 'Wonder Rope' and so we will remember her as a person who brought 'wonder rope' into so many people's lives.

Fiona was a force to be reckoned with and tackled everything in her life with passion and determination. She was passionate about her family and her home. She was a very keen renovator and competent with all tools. She was also a very keen gardener and designed and installed gardens at her homes in North Balwyn and Fryerstown.

Fiona was a wonderful determined mother, wife, daughter, sister and respected professional. Fiona's love, spirit, sense of humour, compassion and warmth will leave a lasting impact on all who knew her. She was an inspiration and will be deeply missed.

Everybody (or how the world of art can show us what is real)

A review by Christine Hill

It is 14 February and I am seduced by the Snuff Puppets marketing:

"Everybody is a live interactive art installation and performance, featuring articulated and detachable human body parts, organs, and the biggest human puppet in the World!"

The city is filled with happy young Valentines. Freshly scrubbed fellows, gelled and after-shaved join gorgeous girls in giddy heels and tiny skirts – some in gendered gangs of hopeful singles, some cosy couples – all eager to star in the fairy tale script of horse-and-carriage, red rose romance. I turn into Dodds Street and, as if by magic, they all disappear.

I find myself, Gulliver-like, in another world. An enormous puppet, 23 metres long, lies on its side, a giant, inflated arm waving in the air. I can see a puppeteer working hard as he manipulates the machinery. Awful sighing and moaning sounds become ever louder as I cautiously approach, wondering (too late as it turns out): what exactly do they mean by 'interactive'?

I soon see that the curve of the puppet's body creates a sort of amphitheatre, a semi-enclosed space that is full of young children shrieking with excitement and terror as they try to grasp the giant fingers of the inflated hand which floats almost out of their reach, at times appearing to caress the top of their heads. I am immediately absorbed by the children's behaviour. Some are curious and gentle as they stroke the big puffy fingers lovingly while others attack the hand with open aggression. One little boy is especially angry. I wonder if the material is strong enough to withstand it and decide that it must be when I see the adults seated on the ground in front and not interfering. Some in the audience sit on one large, extended, puppet leg and others on a reclining, padded arm. I stand, for a better view. The pain-filled sounds reach a crescendo and all adult eyes are drawn to the puppet's bulging, red vulva as those seated on the leg quickly move away. The children take longer to notice, busy with the playful hand, but when the vulva distends enough to show a large, round head slowly crowning, the children turn towards it, then stand quiet and still, watching, mesmerised.

When the monstrous head is born there is a pause, and then, in a remarkably life-like movement, the body quickly slithers out to lie, exhausted, on the mother's leg. No one moves for what seems like a very long time and then the children swoop. At this the baby rouses itself (its gender is not clear) and clumsily staggers all over the place. The children swiftly get out of the way but the adults are not so smart and find themselves being bowled over (literally) and sat upon by this extremely large-for-dates baby who is blissfully unaware of its effect on others. Soon the baby tires and lies down in the open space where-upon the children return to stroke its head, back, and arms. One little boy hits it. The giant hand descends to protect and caress the baby and the same little boy attacks the hand.

The baby starts to cry and a giant breast (there is only one) detaches itself from the puppet's torso. It rolls towards the baby as the baby reaches out. It takes some time and several attempts for them to come together. Some of the children try to help and stand back approvingly when the baby's mouth closes around the nipple and starts to suck. I am aware of a general feeling of satisfaction in the adult audience too. However, the adults' mood quickly shifts to mock fear for some and real disgust for others when, after the feed, the breast turns to attack the crowd, squirting milk indiscriminately.

As the breast rolls away to return to the mother's body, the baby does a giant puppet poo and the children have great fun poking and playing with it. This is a play space where no one says "No!" Someone puts a nappy on the baby who has developed very quickly and now plays with and teases the adults. It is very clear that the baby is in charge! While the baby plays, two headless monsters appear from the mother's mouth, causing general chaos amongst the children who alternate between fearing and loving them. I am struck by the thoughtfulness of the puppeteers (inside the monsters) as they respond sensitively to each child, playing more actively with those who are comfortable with them and very gently with those who are not so sure.

With the monsters' help, the anatomically correct, giant heart beats itself out of the mother's chest cavity to parade around the space, losing a few beats when a couple of curious children and the pursuing (but kind) security guard enter inside its deep red centre. The monsters return the heart to the mother and exit. This is the cue for a pair of giant buttocks to appear, rolling and wobbling like a jelly. The children squeal with delight as, accompanied by the appropriate sound effects and exhibiting a range of realistic colours and consistencies, giant poo after giant poo (about 6 in all) plop to the ground. These piles of poo seem to have lives of their own as they crawl and slime all over the adult audience. The effect is hilarious as some people flee, some look in disbelief, and others with

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revulsion, while one or two lovingly embrace them. I am laughing so hard that I fail to notice the slippery black stool sneaking up behind me. I feel it before I see it, and too late I realize that it is 'interacting' with me. Now it is my turn to be laughed at. Feeling embarrassed, I play the part and wipe it away. Soon after, the performance ends.

I do not wait for the late show; one can have too much of a good thing and I am not sure I am ready for the interactivity that an adults-only performance might bring! As I leave the unscripted land of giant play I see the angry little boy, all alone, still hitting and cursing the now-lifeless puppet. Sadly, I turn the corner and am transported back to Valentines land.

http://snuffpuppets.com/what-we-do/everybody/

Book review: What is a child?

Plastow, MG (2015)

Childhood, Psychoanalysis, and Discourse

Karnac Books, London

ISBN-13:978-1-78049-055-7

Reviewed by Robyn Clark

Michael Gerard Plastow's new book, What is a Child? formulates a response to this endlessly debatable question via an engagement with discourses of history, anthropology, cultural theory, literature, philosophy and psychoanalysis. Considering the dominant positioning of the child as 'minor' and diminutive, Plastow weaves his way through the work of numerous theorists and writers as well as his own clinical practice to interrogate this position and pose the possibility of a subject "able to speak in his or her own name" (Introduction p. xv) and, furthermore, a psychoanalytic subject, with whom Plastow is primarily concerned in this tome. One of his central questions is whether a child, or perhaps more properly, the category 'child', exists for psychoanalysis.

The book is divided into four parts of several chapters each, entitled The Child and the Infantile: History and Time, Psychoanalysis as a Child and its Protagonists, Discourses on Childhood, and The Child and the Subject, respectively, with a richly articulated epilogue to end.

Plastow advocates for the child as singular, critiquing the generalisation and normalisation embodied in the category 'children, saying "they make of the child a category that is subject to all the normalising tendencies of objectivising science" (xiv). He identifies the movement of "the subject as an instance of a generalised category", to "psychoanalysis as a science of the singular subject", following Freud's abandonment of the seduction hypothesis (25). This differentiation between the general and the singular is explicated and interrogated at length through the lens of multiple discourses.

Plastow's work is a huge undertaking, traversing several fields of scholarship, theory and literature. Yet the writing engages and manages clarity despite its complexity. Underpinning the work is his central thesis that the dominance of various developmental approaches on the one hand, and sentimentalism on the other, have contributed to a state of affairs whereby the place of the child in discourse inhibits the attainment of a true majority as speaking subject. He describes the mutability of the numerous discourses of childhood over the ages, and the changing cultural and legal parameters in society, which expand and contract the bounds of childhood according to which time and part of the globe one lives in, suggesting therefore that the categories of infant, child, adolescent and youth, et cetera, should not be accepted unquestioningly given their societal construction. Similarly he problematizes the term 'parents', arguing that it promotes an illusory notion of oneness between mother and father. Plastow is no fan of treatises on parenting nor the term 'parenting style' so frequently found in modern day child psychiatry parlance. For Plastow, a certain failure of the parents is both inevitable and necessary, in relation to which the child's symptom may emerge. The unassimilable surplus of the family mythology manifests in the child's symptom and for the child the symptom functions to exceed something of the family structure.

Plastow maintains that the fields of sex and death have been excluded in multiple ways from the discourse of childhood, despite Freud's discovery of the child as sexual, worked in numerous texts including the Three Essays on the Theory of Sexuality and his case study Analysis of a phobia in a five-year-old boy, and despite the incidence of child death and infanticide over many eras, which Plastow portrays as ubiquitous but repressed. Plastow traces the status of the infantile in history and in psychoanalysis: in history variously constructed according to the contingencies and mores of the day. The Middle Ages saw frequent deaths of infants and many were not expected to survive, the provisional place for the child in the world of its others then being tenuous from the outset. The period of the Enlightenment brought a whimsical rendition of the infantile as an innocent state unmarked by the sexual. The repression of sexuality and death which marks this discourse has the effect of creating an idealised place for the child, Plastow argues, something of a fetishized place forever yearned for by the world-weary adult. Only with Freud and after him Lacan, is the yearning for this imagined state of bliss posited as the search for an always lost object, theorised later by Lacan in terms of logic as the object a, apprehended in the place where "history is wanting" (p54). Plastow emphasizes that for each and every subject there is an enigma surrounding their origins, which will always be there no matter how insistent the historical attributions of cause. He states:

"…the dichotomy between the cause as unable to be grasped, and the sense that all is caused, is the very dichotomy between cause – as we understand it from psychoanalysis – and the common notion of cause which is effectively a type of determinism" (106).

The infantile factor as presented in this text, indicates an enigmatic prehistoric time, a "Once upon a time" (15). Plastow proposes the infantile as that which lacks in the chronological history, saying that it is "the accidents of history that are determining, through the weight of a particular now or event" (20). The event "pertains to that which escapes from the history" (37) – in Lacan's terms an "irruption of the real". Plastow describes the subject's invention of what Lacan called the "fantasm" (following Freud's working of unconscious fantasy), as "an invention that allows the child to overcome a logical contradiction between his or her history, and that which lies outside this history" (52). The fantasm thus provides a "discursive formula" between the history and the enigmatic real of what escapes it.

Plastow wrests child psychoanalysis from its familial beginnings, privileging the theoretical work of Hermine Hug-Hellmuth which made a separation between familial relations and the psychoanalytic relation, at a time when the practice of analysing one's own children was common and even promoted by the father of psychoanalysis. This theoretical position – despite Hug-Hellmuth's own studies of her nephew and subsequent death at his hands – remains a foundational moment in the history of psychoanalysis of the child. Plastow also argues that it was from the place of the illegitimacy which beset many aspects of Hug-Hellmuth's life, that she was able to introduce a legitimate field of psychoanalysis of the child distinct from the 'family affair' (75).

The constructions of infancy and childhood are further explicated with reference to Phillippe Ariès' book Centuries of Childhood, followed by a consideration of the work of philosophers Rousseau, Kant and Condillac posing the many dilemmas besetting the upbringing/raising of a child. The recounting of the changing constructions of the child across several societal, historical and psychoanalytic trajectories arrives at its final chapter: "From the razing of the child to the advent of the subject" – Plastow contends that the 'raising' of the child involves a 'razing' of the category 'child'. In this last chapter he theorises the enjoyment of the parents as that which both engenders and entraps the child, who must deal with the surplus therein. Plastow posits that each child must find a version of the 'child' forbidden by the parents – a 'de-formation' – and in this must give up the parents as cause of his/her suffering. "The child's symptoms or struggles cannot be continually referred back to the parents or any others, perceived as cause of one's suffering". (199). The argument has a logical coherence yet there are moments of this final chapter I struggled with. Perhaps my discomfort partially arises in response to the uncompromising ethical imperative implied here, always a difficult challenge for psychoanalysts. As well as this, the imperatives 'must', and 'cannot', in my reading come closer to a didactic style not previously present in the text. Positing what the subject must do is jarring given Plastow's cogent argument against any ideal or generalisation. However, there is more, the book has its own supplement, an epilogue, in which the writer's voice wrests the text back from its purported end, away from a teaching and towards a very different writing.

It is with Plastow's epilogue that this book marks itself as a psychoanalytic encounter. It is from the outset a psychoanalytic project, but here in the writing we encounter a demonstration of psychoanalysis "in extension" as Lacan posited it. In his manner of ending the book, Plastow formulates the trajectory of its inception/conception with his colleague Tine Norregaard, its difficult gestation and the rent with which it is pushed into the world at large. The initial drive to write this book emerged in a seminar, 'Psychoanalysis and the Child', which Plastow and Norregaard have been convening together for some years. In this epilogue, this rendering of the encounter with the surplus of writing/collaborating, the authorial voice becomes present in a manner which exceeds the scholarly. He states of his and Norregaard's work that its basis is "the residues from our lives, the remainders of our own analyses, as well as the leftovers from the work that we have pursued, both together, and of course, alone". He writes of this text he has produced as a child raised from his own surplus, having had to "face the impossibility of raising a child, the failure of never being able to produce the work one imagines", the infant produced hence bearing the mark of a "singular style".

Plastow's book offers a compelling read, and a challenge to those of us who work clinically, to consider the implications of what can be opened up beyond the well-worn categories of childhood.

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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.

Book review

Being Present for Your Nursery Age Child, Observing, Understand and Helping Children

Editors: Jeanne Magagna and Patrizia Pasquini

Published by Karnac, London, 2007

Review by Ms Sarah J Jones

Magagna and Pasquini, editors of Being Present for Your Nursery Age Child, Observing, Understanding and Helping Children have written a book about Rome's Tempo Lineare Service which has at its heart the framework of an infant observation. The book's chapters are all derived from a psychodynamic thinking and explore their application within a nursery setting. In doing so, it offers hope for all those in the field of infant mental health.

Patrizia Pasquini is described as the creator of Tempo Lineare, an Italian psychodynamic therapeutic nursery school program. Magagna will be well known to many Australian Child Psychotherapists. She has been the Head Child Psychotherapist at the Great Ormond Street Hospital in London, a prolific writer in the field of child psychotherapy and infant observation and a consultant to many services and training programs across Europe.

The introduction tells us that the basis of the nursery school work is the Tavistock Clinic's Observation Method for thinking about babies and young children. This review will describe the nursery school, and then review the contents of the book.

Tempo Lineare Service, established in 1999, is a government-funded nursery school located in Testaccio, a lively working class neighbourhood in the centre of Rome. Pasquini, its director, is also a nursery school teacher, and a child and group psychotherapist. The centre's therapeutic milieu has three main aims. First is to observe the children's interactions; all interactions between the other children, the parents and the teaching staff. Second it aims to promote capacities for containment in all three groups (children, parents, staff). The third aim is to enable the children to internalise the capacities of the adults who care for them.

The school is structured so that it accepts babies to three-year- olds in one unit, and then three to six year olds in the second unit. The infant observational model is integrated at all levels of the program. Teachers are required to write daily detailed observation notes of each child's interactions with other children, parents and staff. Staff are then helped to think more deeply about what they are observing, under the supervision of Patrizia Pasquini, the head of the nursery. There are also three-hour meetings on a monthly basis for parents and teachers to discuss the children's emotional and intellectual development, including the parent's own infant observations of their own children. There is also an annual Tempo Lineare Study Day, where old and new parents, teachers and other professionals present ideas and collaborate with other contributors. Tempo Linear Conferences are open to the public; they often feature reports from parents about the central role of the nursery in their finding themselves as parents. This is one of many ways the project places partnership with parents as the strongest part of the program.

In the area for the youngest infants, babies and very young toddlers are welcomed with their parent/s. They come two or three mornings a week with either their mothers or fathers, or both. Twenty-six families are able to be enrolled; six of these are described as 'families experiencing particular interpersonal need' (p.4). The children and their families come from different economic strata, and attend for different needs. Parents are 'given dependable support and encouragement to open themselves up mentally and emotionally to the experience of motherhood and fatherhood' (p.4). Staff are provided with supervision and group discussions to further their understandings.

In 2003 a second section, for children age 3 to 6 years was initiated after parental enthusiasm for the Tempo Lineare project to continue through to school entry age. This service is open to two class groups, of fourteen children each. The service opens from eight am to 2pm, (in keeping with the Italian custom of young children not extending school beyond lunch time). Unlike the younger area which allows for children and parents to be together, as well as a space for parents and grandparents to be together and a space for private consultations, the older area promotes more separation from the parents, and more peer group experiences.

Tempo Lineare also offers a consultation service to families from nearby central Rome neighbourhoods. This service model has a child psychotherapist, who works in the nursery and who can provide brief consultations to parents and grandparents. The consultation service can offer up to five sessions. The first session is a meeting to discuss the parents' needs. The next three are observation sessions of the child and parents, to observe the child playing with her parents/father/mother. A final meeting is held to discuss the clinician's observations and attend to issues raised.

This book has five sections comprising twenty-four chapters. Of these, nineteen are written by authors Pasquini and Magagna. The book's strongest papers are those which focus on a theme, such as Magagna's chapter seven, entitled 'Primitive protections used by foster and adopted children'. Here the reader is challenged to think how children from these particular kinds of family formation may need to employ intra-psychic defence mechanisms in order to 'forget' or 'deny' their previous deprivations. Valerie Sinason's pioneering work from the 1980s is honoured and utilised. The reader is helped to understand how primitive omniscience and hyper-vigilance can be employed in the service of a child's self-protection. Vignettes are used to explore and explain children's disturbed behaviour using complex theoretical constructs. However the material here is argued so clearly that a professional new to these ideas would be engaged. For example, what might need to be considered when faced with a three-year-old who looked after a doll carefully, yet towards the end of the session threw the doll on the floor and stepped on it (p.81). Magagna identifies both the impulses behind these actions, but also the risk for a child if nursery staff feel angry towards her. The rationale for teachers and parents to be supported in the methods of infant observation is explored and emphasised.

Another theme with in the book is the importance of drawing on nursery fables. The Tempo Linear children are often read

children's fairy tales and are encouraged to create their own. The authors respect that the children's repeated request for a fairy tale to read "suggest that the imaginative portrayal of love, loss, jealousy, hate, courage and hope captures the children's emotional experiences" (p.191).

Pasquini in chapter seventeen entitled 'From tales to life and from life to tales' suggests that in the telling of a fairy tale the child goes through an experience of "emotional intensity in the experience of others". Children are then encouraged to draw from these stories and then their reflections enable them to share their emotions evoked. Throughout the book there is strong integration of psychodynamic theory with attachment theory, and trauma informed research.

Several sections incorporate detailed notes of the children's play or behaviour, the family circumstances and then the parent's own responses following being helped by Tempo Linear staff. In struggling with and learning more about themselves, the parents seem to be more available to their children.

With the utilisation of the Tempo Lineare model Australian child care centres could become more psychologically able to manage children affected by hostile parental separation, sexual abuse, or identify and work with the tiny hidden victims of domestic violence. Such improvements using this kind of therapeutic model of child care would not come easily or cheaply. However leaving the economics aside, employing child psychotherapists, or child therapists from other clinical backgrounds such as social work, occupational therapy, speech therapy in child care centres is an innovative proposal, and this book elaborates how staff could become more expert in child and family therapeutic support.

While there is a lot to commend in this book, a number of difficulties were found. For example the book would have benefitted from some more rigorous editing to reduce the amount of repetition. The Tempo Linear model is often re-described in a number of the early chapters. This is not just frustrating; it reduces the curiosity of the reader. We learn that the centre is government-funded, but not how this centre differs in funding or what the key parameters the government or agency measures. Such information might help agencies who would wish to borrow from this model of care.

While the book is around 290 pages, only three-quarters of a page is given to an evaluation of the service (p. 11). It is reported by 63 per cent of the parents that it was hard and 12 per cent reported it was very hard to comply with the demand of attending the school several days a week and 84 per cent of them were glad to have spent this time with their children. It was unclear how parents from different economic and educational backgrounds were able to write infant observation notes about their own child interacting with other children. Finally, given the difficulties all child agencies face working with Child Protection Services following the identification of child abuse, that this is not addressed is a lost an opportunity. For a book with such rich offerings, which uses both traditional and contemporary psychodynamic and related theories, a fuller exploration on some of the most awful things to think about would seem important.

Chapters of this book are relevant to all those working in the field of infant mental health. Overall this book could be useful for all child care agencies and early childhood educational professionals interested in infant mental health innovation.

Congratulations to Dr Vibhay Raykar

ZERO TO THREE Fellowship recipient for the class of 2014-2016

The 10 Fellows were selected through a rigorous selection process from a pool of 170 applicants. These experienced professionals come from a diversity of disciplines, sectors, backgrounds, and geographic locations. They bring to the fellowship the passion, will, and influence to advance change in programs, systems, and policies that positively impact the well-being of infants, toddlers, and their families. Each Fellow has a specific vision for change in their professional context that will be accomplished through innovative thinking, collaboration, and partnerships across roles, disciplines, and sectors. The fellowship experience will provide a diversity of opportunities for the Fellows to grow professionally and personally by expanding their knowledge, strengthening skills, broadening their perspective, and establishing lifelong, rewarding relationships.

Vibhay Raykar, MD, is a child and youth psychiatrist and clinical director of the Child and Youth Mental Health Service (CYMHS) program at Goulburn Valley (GV) Health, a large regional hospital, located in Shepparton, Victoria, Australia. Dr Raykar has been in this role since July 2014 and has been working as a child and youth psychiatrist at GV Health since February 2011. He is also an honorary fellow at the Rural Health Academic Centre, University of Melbourne. Dr Raykar completed his medical and basic psychiatry training at the University of Mumbai, India. He travelled to the UK to pursue specialist training in child psychiatry and obtained the Membership of the Royal College of Psychiatrists, UK. He moved to Australia in 2008 and is a member of the Faculty of Child and Adolescent Psychiatrists and a fellow of the Royal Australian and New Zealand College of Psychiatrists. He trained in infant mental health at the Royal Children's Hospital, Melbourne, and has been instrumental in setting up an infant mental health team within the CYMHS program at GV Health. He works with infants, children, adolescents, and parents with mental illnesses in a culturally diverse rural setting with considerable social disadvantage and a large immigrant population. His other interests include service and staff development, psychotherapy, and personality disorders. He brings with him a wealth of experience working in both rural and urban settings of three diverse health systems namely India, UK, and Australia. He is passionate about his work and loves travel, photography, and cycling.

For further information about the Zero to Three Fellowships, please see:
http://www.zerotothree.org/about-us/funded-projects/fellowship/class-of-2014-16.html

AAIMHI Conference Winnicott Lecture 2014

Beulah Warren

Before commencing my lecture I wish to share with you an email received from a friend, 94 years of age, in response to telling him I was to present the Winnicott lecture.

> *Beulah's Winnicott lecture promptly brought to mind his maxim there are no perfect mothers, only at best good enough mothers. How that helped my lovely wife battling to be a saint and mother of four irrepressibles all under seven. Incredibly they insist their childhood was a happy one. I cannot speak for my wife. But Winnicott was on to something, not perfect but good enough. Winnicott was reassuring to many ordinary families.*

Introduction

At the WAIMHI Conference in Edinburgh this year, in conversation with Professor Louise Newman about the plight of children in Australian detention centres, I asked Louise what we could do about the situation. Louise said the first thing to do was to write to our politicians. I came home with the intention to do so. The presentation of this lecture was my preoccupying thought but I couldn't get started. I had to write my letter to the Minister first, which finally got written in early August.

My message today is that we have to be the voice for infants; we are the ones who read the infants, who hear the baby's talk.

Of course last century there were many who began to speak for infants; Winnicott was one of the first to focus on the early relationship between "the ordinary devoted mother" and her baby, to be a voice for mothers and babies and to listen to the baby.

I feel a special affinity with Donald Winnicott and I will tell you why. Winnicott trained as a paediatrician and gradually changed over into being a psychoanalyst and a child psychiatrist. He spoke of how his physical training influenced his work and the accumulation of a big volume of experience due to active practice for 45 years. My own original training was as an Occupational Therapist and after working with adolescents trying to break their drug taking habits in London, I turned to psychology.

Like Winnicott I have acquired a volume of experience, not quite 45 years but many years of practice, and like him I wish to convey to you the 'strength of feeling' I have acquired over those years of working with parents and their infants and with colleagues who share the enthusiasm.

Something else I learnt of Winnicott which I will share here. I quote from Sir Peter Tizard's foreword to 'Babies and their Mothers' (1988 p. viii-ix):

"Dr Winnicott was a good writer, sometimes very good, occasionally rather poor, but he was a far better lecturer and conversationalist … to express his views most clearly and vividly he needed the immediacy of an audience".

For me too, it is easier to speak to a receptive audience than to apply the discipline of writing a chapter or paper. I prefer to speak of my work rather than write about it. Thank you all for being here today.

Two realisations came to me from working with the adolescents in London. The first was that adolescence was too late to try and bridge the gap between parents and children, early intervention was crucial. The second was that I didn't have enough knowledge of internal and interpersonal processes to adequately meet the needs of these young people.

Today I want to share with you my passion for infants and their families and what we can learn from observing babies and small children, what they are telling us. Also, I want to honour the place of the 'ordinary devoted mother', the importance of that role. Together let us think about how we can share that information with families. Our responsibility is to share the knowledge with families and the wider community.

A voice for babies

Selma Fraiberg, who is credited with coining the phrase 'infant mental health', and her colleagues had an awareness of how important the newly acquired knowledge of infant emotional development and the role of parents in healthy development of their children was, especially to parents. To quote, "Today, we are in possession of a vast scientific treasure acquired through the study of normal and deviant infants, a treasure that should be returned to babies and their families as a gift from science" (1980, p.3).

Arietta Slade (2002) said that Fraiberg demonstrated the power of a mother's discovery of her own and her baby's internal states and the link between their experiences. Fraiberg and her co-workers used straightforward techniques to bring the babies' experience into the mothers' consciousness, to begin to help mothers accurately read their babies' signals and underlying intentions.

It was in 1978 following the birth of our third child and meeting with new parents who felt ill prepared for the task of parenting when I had my epiphany moment and changed course to work with infants and their parents. It was the year I met Dr T Berry Brazelton on his first visit to Australia. On that occasion he trained a small number of people on the Neonatal Behavioural Assessment Scale (NBAS) who undertook to train others. I gained reliability on the scale in 1979.

Berry Brazelton awakened us to what the baby brings to the relationship with his parents. From the beginning Berry's "contention was that newborn infants were unique, with their own individual style of responding" (Brazelton & Nugent, 2011, p2).

What was Berry trying to teach us? "The newborn is a social organism, predisposed to interact with her caregiver from the beginning and able to elicit the kind of caregiving necessary for her species specific survival and adaptation" (B & N p.3). The Brazelton Scale, as it is commonly called, is an interactive assessment where the examiner plays a role in facilitating the performance and organizational skills of the infant. Specifically we learn about the baby's autonomic stability, the competence of the reflexes, the musculature and sociability of the baby. We learn about the baby's tolerance for distress, what comforts the baby and how quickly he can be comforted. We also learn what stimulation is appealing to the infant and how much can he tolerate. What a wealth of information can be gleaned by observing the full term healthy newborn.

This video shown at this point is a brief segment of a NBAS assessment of baby James, three days old. So then, what do we learn of three-day-old James and what did we share with his parents? James is a well-rounded full term infant; he has a beautifully relaxed body with gently flexed arms and legs, a balance of flexion and extension, he has a good healthy cry when uncomfortable but he settles easily when his hands are held and he is spoken to in a quiet persistent tone. With a little help he can self-soothe. James can snuggle in when held by an adult, which of course is rewarding to the parent. When he is well fed and content he can focus on a face and a face and voice for 60 plus degrees to both sides and he can turn to the side to find a voice. We can assume his birth was not traumatic for him. James is virtually a 'prototype' of the healthy newborn.

Now let me tell you of Patrick, also a healthy newborn but one who spent a lot of time crying in the first three days of his life. Patrick was born in a maternity hospital in Perth. Nurses who were doing training on the NBAS identified Patrick as very distressed and wondered if by doing an NBAS assessment with Patrick we might be able to give the mother some information about Patrick's needs. Mother brought Patrick into the quiet, softly lit room where the assessment was to take place. Patrick was asleep.

Patrick looked to be of average size for a healthy full term. I can't remember anything the mother said about the birth but I do remember the mother saying she had two older daughters. We began the assessment by assessing Patrick's habituation to a light across the eyes, a rattle and a bell. Patrick was able to shut out each of these stimuli and return to a deep sleep. I then rolled him onto his back and began to uncover him. The scale starts with testing gentle reflexes, glabella, rooting, sucking; the baby is then undressed to test further motor items. Once undressed Patrick had begun to fuss and very quickly went from fussing to a loud State 6 cry, I am sure you are very familiar with such a cry which demands immediate attention. On the NBAS consoling the baby is a measured incremental response; initially you show your face, then speak quietly to the baby, follow with restraining the arms(as shown with James), if that doesn't work, restrain the arms and pick up and hold, next introduce rocking and finally wrap and then give the dummy.

Patrick required the lot. Once settled, after a couple of minutes I tried to return to the reflexes; an attempt was made to lay Patrick down and unwrap him. He remained quiet until I tried to grasp his hands or feet or move his arms and legs. He quickly began to cry again with full intensity. I went through the console procedure once more but realized we were not going to be able to continue with reflexes. Once wrapped and held firmly Patrick returned to a quiet state.

It wasn't a quiet state of sleep, but a quiet alert state so I suggested to his mother that we would try and engage with him socially. Held out in front, well supported, Patrick followed a face, face and voice, the little red ball and the rattle from side to side and around in a circle. He also turned to each side to find the enticing voice, and the rattle. It was a joy to share the experience with his mother who was delighted with his performance.

Patrick's mother and I wondered together what Patrick's behaviour might mean. She thought it was what boys did. Her girls had been quiet babies, not crying in the way Patrick was. We agreed that being unwrapped with arms flailing distressed Patrick so keeping him wrapped until he felt comfortable unwrapped was going to be important. I suggested she wrap him for sleep and also for quiet alert times in his rocker or chair for at least the first few weeks or until he had a little more control of his arms. I left my card with Patrick's mother and said she could phone me if she wanted to discuss the assessment further.

Some six months later Patrick's mother phoned me. She identified herself as Patrick's mother and said she wanted to tell me of Patrick's progress. She said she had continued to wrap Patrick for sleep and initially when he was awake. Gradually Patrick gained control of the movement of arms and legs and then it ceased to be necessary around four months. He was now a happy little fellow enjoying being on the floor unwrapped and playing with his sisters.

The physical characteristics of James and Patrick were somewhat similar. However, Patrick did not have the same regulation of motor that James had. With Patrick it was evident it was where he needed help to enable him to engage in face to face interaction with his mother.

Let me now turn to preterm babies.

What do we learn from preterm babies?

It is many years now since Dr Robyn Dolby, two physiotherapists, Dr Vickie Mead and Ms Jan Osborne, and I carried out a research project which involved intervention with preterm infants over the first year of life. We learnt so much from the observation of the infants over the year. Two important pieces of learning were acquired from the project which involved meeting with the families in the hospital and in their homes four to five times over the first year. Firstly, before intervening we had to listen carefully as the parents gave us their observations of their baby's behaviour and their reflections on the meaning of that behaviour. The second lesson was the complexity of human development in the first year of life and the underpinning of the motor system and how it influenced the baby's capacity for social engagement. As psychologists we learnt from the physiotherapists the baby's motor communication. We had to be trained to know what we were looking for. It is crucial to have a framework for what we are looking for.

Professor Heidelise Als, who initially worked with Berry Brazelton, went on to focus on the development of premature babies, especially very low birthweight babies. She has changed the environment and ambience of Special Care Nurseries in many countries with the introduction of the Newborn Individualized Developmental Care and Assessment Program, (NIDCAP) and the Scale, the Assessment of Premature Infants' Behaviour (APIB) specifically adapted from the NBAS. Als had introduced us to the Synactive Theory of Development in an article in the IMH Journal in 1982.

Heidi's conceptualization of infant development (p.230) "focuses on how the infant handles the experience of the world around him. The baby's functioning is perceived as continuous intra-organism, subsystem interaction and the organism in turn is seen in continuous interaction with the environment".

Als states, (p.230) "We have termed this view of development synactive, since at each stage in development and each moment of functioning, the various subsystems of functioning are existing side by side, often truly interactive, but often in a

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relative holding pattern, as if providing a steady substratum for one of the system's differentiation processes".

The systems referred to are the autonomic system, motor system, state-organisational system, the attention and interactive system, and a self-regulatory, balancing system.

Als maintained the functioning of all these systems was observable; we needed to know what we were looking for. Thus Heidi identified what to look for in each system to explain the functioning.

The autonomic system was observed via the pattern of respiration, colour changes, tremulousness, and visceral signals such as bowel movements, gagging, hiccoughing, *et cetera*.

The motor system was observable in the posture, tone and movements of the baby.

The state organizational system was observable in the kind and range of states of consciousness available to the baby, from sleep to aroused states; also in how the infant transitions between states.

The attention and interactive system was typified in the baby's ability to come to an alert, attentive state and to utilize this state to take in cognitive and social-emotional information from the environment and in turn elicit and modify the inputs from the environment.

The regulatory system was exemplified in the observable strategies the baby utilized to maintain a balanced, relatively stable and relaxed state of subsystem integration or to return to such a state of balance and relaxation.

If the infant is unable to maintain or return to an integrated balanced subsystem state another aspect of functioning is identified. What does this baby need to return to a balanced state? What amount and what kind of facilitation is required from the environment to aid the infant's return to balance?

Let me describe for you a brief video of an assessment of a preterm baby using the NBAS. Elli was born at 28 weeks gestational age. At the time of filming Elli is 5 weeks corrected age, or 17 weeks chronological age. It is obvious how important it is to correct for prematurity. Where is the imbalance for Elli? In fact all of her systems are being stressed. The coughing and painful cry indicated her autonomic system was challenged in the testing of reflexes; her inability to sit without going into extension, her increased muscle tone and jerky movements demonstrated the imbalance in her motor system; while her persistent fussiness bespoke poor state control, and her inclination to hyper-alertness was an expression of her difficulty in regulating attention.

What did Elli need to return to a balanced state? Elli required loving gentle handling; to be held curled in to help her flex and reduce the increased muscle tone when being held. Also to be firmly wrapped when preparing for sleep. Her strengths were that she was responsive when cuddled and held curled, relaxing and looking into the face of the person holding her, and when lying on her side, she quietened when spoken to and stabilized. It was very apparent that to engage with Elli her motor system required assistance and her arousal needed to be regulated.

At Elli's age of 5 weeks the parents were longing for face to face engagement with her. How patient the parents would have to be to prepare Elli for interaction and we wonder how many engaging moments she could manage in her awake times.

Parent-Infant interactions

Parent-infant dyads are the focus of many methods of intervention in the first year of life. Some are working on the mother's representations (see Beebe, 2003) other interactional approaches attempt to intervene into specific behavioural transactions.

With an understanding of a synactive theory of the developing infant, we appreciate that at any moment of functioning the infant's various subsystems may or may not be interactive; we are better equipped, when observing parent-infant interactions to understand what might be influencing the infant's contribution.

In observations of parent-infant interactions, optimally, self and interactive regulation are in dynamic balance.

Beatrice Beebe states in her outline of brief parent-infant treatment using video feedback "the approach of her team is based on a theory of face to face interactions developed over a number of years. Self and interactive regulation are concurrent and reciprocal processes, each affecting the success of the other. Interactive regulation is defined by bidirectional contingencies in the partnership of parent and infant, a continuous process in which each partner makes moment-to-moment adjustments to the behaviours of the other. The infant's capacity to detect and to be affected by contingent stimulation underlies all current theories of how the infant develops predictable patterns of the relatedness and their representations." (p.27)

Beebe comments (p.27) that many intervention efforts actually focus on the parent, to the point where it has been asked "Where is the infant in infant intervention?" A unique study by Weinberg and Tronick (1998 in Beebe, 2003) evaluated the outcomes of an early intervention in which only the mother was treated. They documented by microanalysis that the infants were still in distress even though the mothers reported improvement. Suggesting that the dyad should be a focus of intervention, they noted that the infant is often the "forgotten patient".

Hofacker and Papousek (1998) argue that the infant's contribution to the mother-infant interaction is still poorly understood. They wonder if this is due to our greater ease with verbal than non-verbal forms of communication. My experience is that this is so.

Introducing psychotherapy trainee psychiatrists to mother-infant interactions at St Benedict's mother-baby unit I ask the trainees to observe the interaction between mothers and their infants on video. They are asked to think what it might be like for the baby in this interaction, this situation; what is the baby's experience, how do they think the baby is feeling; are the baby's needs being met?

The participants may give one or two comments about the baby but invariably there is lively discussion about the possible diagnosis of the mother based on her facial expression, her posture, her interactions with the baby, her vocalizations, until they are directed again to the experience of the baby.

Is it that in the clinical setting we are confronted and feel helpless when we observe the pain of the baby? Often the baby is experiencing intrusion, or being ignored; sometimes the baby actively avoids the parent or is vigilant of the parent.

On other occasions the baby may give furtive glances in the direction of his mother.

Beebe (2003) summarised studies of early face to face interactions which analysed second-by-second contingency behaviour of gaze, face, orientation, touch and vocalization. Some studies have linked early interaction patterns to outcome variables but the work is still in progress and reliable norms are not available. Beebe describes behaviours for each of the items but stresses they are not prescriptive nor do they assume an optimal mode of interaction. "Ranges of 'normal' interaction are more ambiguous than extremes of difficulty". Some of the problematic patterns observed are used by all dyads at various times and are potentially adaptive solutions to the challenges of specific interactions.

To emphasis once again it is useful for us as clinicians, when observing a baby and her mother in a clinical setting, to have a framework in which to observe the infant's response in the moments of interaction. The items of gaze, face, orientation, touch and vocalization provide the immediate picture while the synactive model gives a whole of organism framework.

I recommend the article by Beebe in the IMHJ for an understanding of the more optimal and less favourable behaviours for gaze, face, vocalization, management of infant distress and self-comfort on the part of the infant and the parent and how each adapts his behaviour to the other.

The baby and infant are constantly looking for emotional expression on the face of his mother or carer which creates a resonant emotional state in the infant. The responsiveness of the adult is the food of brain development, the laying down of pathways in particular areas of the brain (Schore, 1994).

Let me illustrate by describing another short film of interaction between mother and infant around a breast feed. Baby Mia, a full term baby of 5 weeks is breast feeding. Mia takes a break and relaxes back on her mother's arm and looks into her mother's face. Mia and mother continue looking into each other's eyes. Mother talks quietly and asks Mia is she going to give a smile for the camera. After some seconds Mia raises her arms and her face breaks into a big smile including twinkling eyes.

When observing an infant the task is to describe as completely as possible what is seen and then to allow one's thinking to develop. It is often our capacity to observe, reflect on and try and understand the baby's behaviour which will assist the parent to understand her own and her baby's feelings as they exist both internally and externally. As a thoughtful observer I model for the mother her own reflective observation of her baby.

Arieta Slade(2002) acknowledged the reflective process of Fraiberg's approach. As Fraiberg or one of her team listened to a young mother talk about her own experience of being mothered, they wondered together about mothering her own baby, present with them in the room. Fraiberg's therapeutic successes evolved with the mother's capacity to link her baby's experience with her own, that is, reflecting on her baby needing her and her mothering, just as she had needed to be mothered as a baby; her baby was separate to her. Fraiberg's framework was psychoanalytic, dynamic psychology, the link between the present and the past and also reflective.

Slade's perspective of developing maternal reflective capacities (p13) says it is the link between mental states, and between mental states and behaviour that is at the heart of healthy mother-child relatedness. Sometimes these connections develop through an examination of past-present links; at other times they may more simply arise through the process of reflection as it pertains to daily, relational experience, the mother reflecting on how her baby might be feeling in a particular situation.

Slade quotes Sally Provence's directive to parents: "Don't just do something. Stand there and pay attention. Your child is trying to tell you something". Slade believes helping parents to observe their child and learn to 'read' their actions and words are at the heart of the reflective model and essential for healthy mother child relationship.

Is this part of modern new mothers' repertoire, to observe, and learn to read the actions of their baby? Can we still talk of the ordinary devoted mother?

The ordinary devoted mother

Reading again the lectures and talks that Winnicott gave I was warmed by his simple principles of good parenting. He believed strongly in the "ordinary devoted good enough" mother who, if supported through pregnancy will have the capacity to hold her baby. The ordinary devoted good enough mother will have an intuitive knowledge that what her baby needs is "the simplest of all experiences, contact without activity". The feeling of oneness between two people where in fact there are two (1988 p.7). To just be with the baby, to endorse Sally Provence's words.

So what are the essential characteristics of the mothering of the "ordinary devoted good enough mother"?

- A supportive partner or supportive community environment through pregnancy and over the early months and years.
- "Holding" of the baby, and
- "Primary maternal preoccupation" which begins in the late stages of pregnancy and continues through the early days and weeks of the baby's life.

Winnicott said that these things give the baby the opportunity "to be" from which the infant becomes the self-experiencing infant. The personality develops from the simple to the complex. "At the beginning, however, it is the physical holding of the physical frame that provides the psychology that can be good or bad. Good holding and handling facilitates the maturational process and bad holding means repeatedly interrupting those processes because of the baby's reactions to failures of adaptation (p.62)."

That is, if the new mother is struggling to adapt to the demands of her baby to be held and responded to in a consistent way, then the baby is unable to form a pattern of response.

Is it the primary preoccupation which allows the woman to intuitively mother, to be able to 'hold' her baby? Winnicott stressed that the mother has to allow herself to experience this state of oneness with the baby.

In The Magic Years (1959) Selma Fraiberg gives a beautiful description of what is happening in the early days and weeks of the infant-mother relationship. I quote:

"These first weeks are not entirely a time of darkness and primeval chaos. An invisible web is spun around the child and

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his mother that emanates from the mother and through which the most subtle impressions are transmitted to the child. And while the infant doesn't know his mother, can't recognise her on sight, he is receiving an infinite number of impressions through physical contact with her that gradually lead to the formation of his image of her" (p.37).

Mahler, like Winnicott, sees the intense involvement of the mother in these first few weeks as crucial to the psychological birth of the infant. I quote:

"... we believe the mothering partner's 'holding behaviour', her 'primary maternal preoccupation' in Winnicott's sense (1958a) is the symbiotic organiser – the midwife of individuation, of psychological birth" (Mahler, Pine & Bergman, 1975).

Winnicott identified that many women are afraid of being absorbed in the baby. "Many women fear this state and think it will turn them into vegetables, with the consequence that they hold on to the vestiges of a career like dear life, and never give themselves over even temporarily to a total involvement" (1988 p.94).

The new mother has to trust that her total preoccupation with her baby will pass. If not supported, either by a partner or by community, the mother is left holding the baby literally and the task of being at one with her baby is virtually impossible. As a community are we supporting the new mother in her preoccupation with her baby, in holding of her baby?

If the ordinary devoted mother is consistently available to her baby, the baby begins to assume that someone is there when needed and this is foundational for the baby's ego. However, there are situations where the baby does not experience enough physical holding to allow for the development of the personality. That is, some children are let down before damage to the personality can be avoided (1988 p.9).

Winnicott also stressed that in time the baby needs the mother to fail to adapt to the infant's needs. "There is much satisfaction to be got from anger that does not go over to despair". The baby needs to know he can express his anger and still be accepted. And mother needs to know that the time of utter dependence will pass.

Surely our policies of encouraging new mothers to get back into the work force as quickly as possible are not supporting the early formation of the relationship. Should we be advocating for at least six months of maternity leave for all new mothers?

Winnicott was the advocate of the ordinary devoted mother supported by her partner, being the crucial factor in the healthy physical and psychological development of infants. He felt this needed to be owned and spoken about, that some of the failure in development was because of absence or 'failure of the ordinary devoted mother factor' at a certain point or over a certain period. He felt we had to be able to acknowledge causal significance but not blame. His argument was that if we didn't acknowledge where the deficiency was then we can't recognize "the positive value of the ordinary devoted mother factor", the vital necessity for every baby that there is someone, some other, for the healthy development of the infant, neurologically, physically, cognitively emotionally and psychologically.

This is a very important principle for Winnicott.

"I am trying to draw attention to the immense contribution to the individual and to society which the ordinary good mother with her husband in support makes at the beginning, and which she does simply through being devoted to her infant' (Winnicott, 1964 p.10).)

Winnicott wondered if the contribution of mothers was not acknowledged because it was so immense. If we acknowledge it then it follows that we all feel a debt to our mothers – everyone who is sane, everyone who feels himself to be a person in the world and for whom the world means something, every happy person is in infinite debt to a woman. We were absolutely dependent (p.10).

Winnicott argued that with an acknowledgement of this dependence within ourselves will come a lessening of a fear which allows ease and complete health to flourish. "If there is no true recognition of the mother's part then there must remain a vague fear of dependence". He explained that the fear may take the form of fear of women in general, or a particular woman or other less recognized forms but always a fear of domination (p.10).

Let us focus on the new generation of young mothers; the young women who have been educated and expect to share the parenting role with their partners as many of them have been together for some years and have shared domestic responsibilities and work load before having a baby. When the baby comes, suddenly they are the one at home with the baby, cut off from their friends and network. They are also the ones to have the broken nights and feel exhausted. Without income there is a sense of dependence on their partner and the partner's potential domination. Do these new generation young mothers feel honoured by society in their role as ordinary devoted mothers? I think not. Society pressures them to return to work as quickly as possible and their fear of not keeping up with their peers, added to the fear of being lost in preoccupation with the baby, is a strong impetus to return to the workforce and to hand the baby over to others.

As advocates and a voice for the infants we need to speak up in support of the important work a woman is doing in being the ordinary devoted mother to her new baby.

Winnicott (1964, p 86) spoke of the ordinary mother taking care of her baby, being thoughtful of her handling of her baby because of her love; because of maternal feelings which have developed in her, and a deep understanding of baby's needs. Most women who become mothers want to be mothers, they want to be good mothers but just what does that mean to the new mother in 2014?

Here are my suggestions to "an ordinary devoted mother":

- Be sure of a supportive partner or community support through the pregnancy and early days and weeks of the baby's life.
- Tune in to your body as it prepares for the birth; the physical and hormonal changes which are happening.
- Allow yourself to be preoccupied with the potential new person in the last weeks of pregnancy and early days and weeks of baby's life, assured that this time of preoccupation will pass.
- Own the overwhelming sense of love for this new little person unashamedly whether it hits like a wave of emotion at the time of birth or creeps up slowly.
- Delight in the miracle of the birth of a human being.

As professionals let us acknowledge above all the importance

of love as the emotion which makes good enough parenting possible. We have to be more outspoken about love so women will allow themselves to be 'irrationally in love' and at home with their babies, supported by their partners for the early months. Two recent quotes on the importance of love in psychological understanding come to mind.

A listener (21.7.2014) phoned in after listening to an ABC program which acknowledged emotions as crucial in cognitive learning, and said;

"We hear about people who are good with their hands, or good with the heads, but don't hear about people who are good with their hearts."

Again, in an interview, Professor Dadds of the University of NSW, said, "In psychology we talk about teaching, rewarding, praising children, but we do not talk about love".

Finally, as advocates for babies and mothers, we have to become more politically active.

- Let us be open in our belief that love is what makes parenting possible or, as my son says when he is trying to help teachers understand children's difficult behaviour, "It is all about relationship".
- Let us be outspoken for parental leave for all mothers for at least 6 if not 12 months, with a guarantee that their employment will be there for them on their return, as happens in some European countries.
- Let us speak for babies and parents wherever we see the need and are prompted to respond.

I guess this is why, in 1988, it was so important to a little group of us to create our own Australian Association for Infant Mental Health. Thank you.

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