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Contents

Guidelines for contributors

AAIMHI aims to publish three editions per year in March, July and November. Contributions to the newsletter are invited on any matter of interest to the members of AAIMHI.

Referenced works should follow the guidelines provided by the APA Publication Manual 4th Edition.

All submissions are sub-edited to newsletter standards.

Articles are accepted preferably as Word documents sent electronically to the AAIMHI Newsletter Committee.

AAIMHI Newsletter Committee

Inquiries on submitting items to the newsletter may be made to:
Ben Goodfellow at newsletter@aaimhi.org
Opinions expressed in this newsletter are not necessarily those held by AAIMHI.

Welcome to the first edition of the newsletter for 2016. This edition highlights work provided by members to at-risk infants and children in a refuge setting and in a regional mother-baby unit. It seems timely to publish this steady work against the backdrop of the recently released recommendations of the Victorian Royal Commission into Family Violence and the The COAG Advisory Panel on Reducing Violence against Women and their Children. We encourage member commentary on these important steps in public policy for future newsletter editions.

At present many infant mental health professionals striving to engage infants with their fathers after violence are trying to work out how this might best be done in a way that keeps infants safe. We are fortunate to include in this edition the reports from Victorian philanthropy recipients working in the field of family violence who consider these issues in the context of the 2015 AAIMHI National Conference held in Sydney, which focused on fathers. We continue the theme of finding ways forward on behalf of infants living amidst conflict with an inviting prelude to the 2016 WAIMH World Congress in Prague. With Australia being such a rich centre for infant mental health it is no surprise that many Australians will feature as presenters and attendees – it is a glorious city in a fascinating part of the world for those able to attend.

While resources for infant mental health work are so precarious in many regional areas, Lee's reflections on creating the Agnes parent-infant unit in Gippsland reminds us how a dedicated team can bring to bear enormous benefits for families when forging the structures needed. This sits alongside Hodges' account of how she and her colleagues are bolstered by the group-work structure of Peek-a-Boo, enabling them to hold open a space for the infant when working within impoverished systems. Continuing the theme of the embodied container for baby, we conclude the edition with Sophie Xeros-Constantinedes' artwork, part of a larger series available from the artist directly upon request.

Finally, the Winnicott lecture for 2015, delivered by Sarah Mares at the AAIMHI conference, was too useful and comprehensive a work to abridge, and too long to be included in this newsletter so a bonus edition for June 2016 will be published for this work.

Thank you to the members who completed the newsletter survey. We look forward to your feedback on how we can continue to help support louder and clearer clinical voices on behalf of babies and very young children in Australia.

Ben Goodfellow and Emma Toone

WAIMH Congress 2016

On Sunday May 29 this year hundreds of people from dozens of countries, working in every discipline relating to young children's health and well-being will converge on Prague for the 15th Biennial WAIMH World Congress. Originally scheduled to be held in Tel Aviv, but subsequently moved to Prague, this WAIMH Congress is aptly themed with its emphasis on infants in the context of conflict and natural disasters. The Pre-congress Institutes in particular will discuss the importance of infant mental health policy development both within countries where there is relative peace, and especially where there is distress and disruption.

A very large number of submissions to present were received for the general program, and we hope that in addition to the plenary, symposia, posters and workshop sessions, the Brief Oral Presentation sessions will be especially interesting. We envisage these rather like TED talks where the presenter condenses the essence of their message and delivers it in a powerful way to an audience primed to receive key information. There will be considerable discussion about the revision of the Zero to Three DC to 3R classification systems for problems in infant and early childhood. Among other eminent speakers, Prof. Charley Zeanah from New Orleans and many of the group which has been developing the new system will present during the pre-Congress Institute on Sunday. This will be an exciting opportunity to hear the latest on the understanding of the diagnostic system in relation to infants and very young children.

Prague is a wonderful city to visit; its charming historical, musical and cultural significance is worth the journey alone, so I hope that as many of you as possible are able to share your work and stories with each other and the world at this year's congress. This congress has been organized in cooperation with the Israeli Mental Health Affiliate and Palestinian Infant Mental Health Specialists. Australians are always very well represented at the Congress and contribute in a powerful way! We look forward to seeing you all there in beautiful Prague and to develop further creative ways to help troubled infants and their families!

A. Prof. Campbell Paul
Chair – Scientific Program Committee

Tasks of infancy in the first year: a reflection on the Agnes Parent and Infant Unit

Vivian Lee

Vivian is an infant, child and family psychiatrist working at the Agnes Parent and Infant Unit based in Traralgon, and in private practice in outer south-east Melbourne. She is also an adjunct senior lecturer at Monash University School of Rural Health Latrobe Valley and West Gippsland.

The Agnes Parent and Infant Unit, based in Traralgon to service the infants and families of Gippsland has been open since December 2014. A year on, as I reflect on the journey of our unit, I can draw many parallels with that of infancy in the first year of life.

Pregnancy and birth

There is no infant without first the pregnancy and birth. For our unit, the gestational period was much more than the approximate nine months, and I was lucky to be around Latrobe Regional Hospital (LRH) for almost two years before we officially opened, to be part of the thinking and planning. There were so many aspects to starting this new service, and much of it I had little understanding of. However, we were given creative freedom to design the clinical aspects of the service, since it is so new and also unique even amongst the existing perinatal and infant services. Dr Julie Stone put together a 'Thinking Framework' to guide the development of our therapeutic practice within the new unit, putting together into one document ideas from Mentalization, Attachment Theory and the Solihull Approach. From there, we did some dreaming, thinking and planning on what the service could look like. As the reality of the unit soon opening drew near, we searched for the best group of people we could find to become our team. Drawing parallels with the real birth experience for many people, you can plan all you like and then on the day, things come together somehow and in December 2015 we were officially opened and we started to care for our first infants and their families.

Getting to know you

Other terms I could think of for this period are 'absolute chaos', 'we can't do this anymore' and so on but at the end, somewhat ripping off musicals and the baby DVD, I thought 'getting to know you' is a nice way to describe that first period in the life of a newborn infant, that might be days, weeks or even months for some, when the infant and their parents/carers are getting to know each other and it can all feel a bit overwhelming. Sleep deprivation is usually involved, feeding difficulties can often be implicated, and the concept of play with a newborn when you are so exhausted is unfortunately for most families the last thing they think about. There was a period when work at the Agnes Unit was a bit like this time. Infants and their parents were with us; we did our best without quite feeling like we knew what we were doing despite the depth and breadth of expertise in our team, that included nurses from maternity, paediatrics, mental health, maternal and child health, social worker and psychiatrist; adults and babies slept, fed, played, connected and got better; but it was difficult to describe exactly what we did because it was all a blur. The team was also getting to know each other and learning how to best work together.

Gaining confidence and becoming in tune

Maybe it's after the first month, or the first three months, or after their stay at Agnes Unit. Eventually, for the majority, there is a time when parents feel the worst has passed, and infants feel that we as caregivers are finally getting the hang of how to respond, and both feel that things have improved. For myself in my role as consultant psychiatrist for the unit, having my weekly therapeutic contact with the parents and infants, continually thinking about the unit and how we can best deliver our service, working with my team and as part of this supervising a number of staff, it took about six months for me to feel the initial chaotic time was over. Clinically,

what we could offer was becoming clearer: the mother and baby (interestingly, we have not yet had a father come in as the 'admitted parent' yet, though definitely more dads are becoming involved and many staying the whole time) will be welcomed to our unit on the Monday; they will have the opportunity to tell their story to one of our nurse staff members and treatment planning together will happen; they will settle into our unit and get support that is individually tailored to their needs; they will participate in the group program, which also has much flexibility depending on who are the parents and infants on the unit and what their needs are; they will see the consultant psychiatrist, who treats the usually two or three sessions she will have with the mother/baby/couple/family as therapeutic contacts and only if clinically warranted will she suggest medications; there might be individual, dyadic, couple or family sessions as needed; admissions are usually for two weeks, going home for three nights over the weekend, which is a good test of progress and coping. The infants and families give us feedback as to what works, and we over time tune our practices to their needs, while keeping integrity of our therapeutic thinking in order to be kind but also useful.

Connection

In a simplistic way I would say this is the most important task of infancy, and if you as an infant have this you will thrive in life, even if there will be stressors and difficulties. For our unit, the connections are on many levels. With each other as a team; with the community based services and professionals who refer to us and also continue the work after the infant and family leaves us (and in rural areas there is not so much choice or availability of this, despite everyone doing their best); with the community as word spreads of what we do well and how we can help often desperately suffering dyads and families. Most importantly, our philosophy is that we aim to connect with each of the mothers and fathers and infants who come to us, and in this way we are providing treatment using our Solihull Approach of 'containment' and 'reciprocity', and modelling how a safe and nurturing relationship can be for the parents so they can provide the same for their infant. Amongst all the anxieties, primitive projections and unmet needs that are inherent in perinatal and infant work, when parents say that things are feeling a bit better after their two or three weeks with us at Agnes Unit, because they feel they were supported and listened to and also that they now feel more closely connected with their infant, we know we have done enough, for now.

Sleeping and settling

More recently, as mothers who have had positive experiences with our unit spread word of us amongst the masses of struggling mothers out in the community, we have been getting more referrals requesting 'sleep school'. This is something that we as a team are continually reflecting on. What is our identity? What do we offer? Are we a mental health unit? Are we a sleep school? Where is the in-between in this spectrum of services? On a positive note, feedback and word out there that we at Agnes Unit are 'baby whisperers' (for truth, a mother called us this!) who can help infants go to sleep in their cots and stretch out feeds, are great, and help many mothers and fathers who are struggling with issues beyond this to come forward because going to a sleep school has less stigma than going to a mental health unit in most cases, but on a negative does it push the blame of the difficulties to being that of the infant? This identity issue for Agnes Unit is one we will have to continually reflect on. For myself, I am proud that around nine months ago people were reluctant to come in because they thought we were an acute psychiatric inpatient unit with babies, and now they want to come in because we are sleep school. As an infant psychiatrist, I also think that the focus on sleeping and settling is a positive one. We are not a unit solely focussed on the parent's mental health; we work with symptoms of difficulties with regulation in the infant, using sleeping and settling as the way in.

Growing and developing

So a year or so on, here we are. We have continued to use our 'Thinking Framework'. The philosophy behind our work is clear to us and also to the infants and families we serve. Whenever I am having a first session with usually the mother and infant and she lets me know that they have only been at Agnes Unit for two nights and things are already starting to improve in that baby is sleeping longer and she is also getting some sleep and hence less sad or overwhelmed, but she can't exactly describe what the team has done though she is clear that we do not leave babies to cry, I know we are still on the right track. I hope that with time our skills and confidence continue to grow, but we remain open to feedback and continue to improve. Agnes Unit is committed to making a positive and creative difference to the families in Gippsland.

Upcoming Training events - Victoria

Domestic Violence Resource Centre Victoria (DVRCV)

Infants & Toddlers: relational trauma

Presented by Wendy Bunston, Kristen Pringle, Kathy Eyre Tuesday 17 and Wednesday 18 May 2016

In this dynamic workshop you will be introduced to the principles of 'infant-led' practice, be provided with accessible and up to date information on brain development and strategies about what should guide you on how to intervene with infants and their families in the context of family violence. This training is relevant for those working as family support workers, in refuge, through to clinicians and case managers. To be held in Melbourne CBD

DVRCV **Online Registration:** dvrcv.wufoo.eu/forms/infant-toddler-relational-trauma-itrt516/ or (03) 9486 9866

Australian Association for Infant Mental Health Conference Report 2015

Funding recipient: **Bianca Morrison**
Organisation: **Emerge**

Conference Highlights

Timothy O'Leary spoke about Show and Tell – translating Infant Mental Health concepts to dads. Tim was animated and engaging in his presentation. Tim spoke of the different challenges parenthood poses for his fathers in their new role. The 2-CAN Parenting Approach educates fathers on concepts of baby basics (sleeping, feeding, and play) routines and windows of engagement within zones. These classes help equip fathers to create bonds and co-regulate their children. It also assists fathers by developing skills for successful interactions with their child and to be supportive co-parents. Key points discussed five happiness factors, and three ingredients of co-regulation. Tim uses lots of analogies "like match day" that help men interact and connect to their new roles and understanding of experiences.

In working at Emerge Women and Children's support network it was a different perspective to consider a man's needs and skill sets to equip them for successful co-parenting and partners. I have only ever experienced the trauma being expressed by infants after the experience of family violence and the loss of a father's presence, seeing the deficits that remain developmentally and emotionally for both infants and children alike. Tim really gave a good illustration of infant development and how fathers can create a secure attachment via implementing the skills taught in the sessions.

Wendy Bunston's talk on infant-lead practice for infants in refuge was very inspiring. As an art therapist working in family violence it was interesting to hear how Wendy experienced working with different refuges in Australia. Wendy spoke of how the women in refuge experience the severe end of family violence and infants exposure to this is often severe as they are dependent on mothers for care and often times in close proximity without means of escape (babies strapped in rocker, held in mother's arms, laying on floors unable to crawl or walk out of the room) to safety. Wendy discussed how refuges provide refuge to the infant and presented data from a qualitative study. Wendy views the babies' hope for intimacy and sees the compromise exhibits itself in speech and development and Lieberman concurs. Issues were discussed regarding the stability of attachment from infancy to pre-school. Wendy also got me thinking of how the infant provides refuge to the mother and how this knowledge aids us to work effectively with women within our service. In reflecting on working in the family violence sector children are often the motivating factor for change. Being able to observe these infants and put a voice to their actions helps them be present more of the time and aids the mother in shifting thinking of what an experience maybe like from an infant's point of view.

I would like to extend my sincere thanks to the committee for the opportunity to attend the AAIMHI conference via grant funding and to all the presenters at the conference who have helped me consider new possibilities and reflect on programs and the research that was presented. The opportunity to attend and engage with other professionals regarding infant mental health has been a remarkable opportunity that has facilitated much learning that I will be able to integrate into my work with both woman and children.

Australian Association for Infant Mental Health Conference, 29-31 Oct, 2015

Funding Recipient: **Emma Hodges**

Conference highlights

One of the biggest challenges I encounter in working as a Family Therapist at Emerge is not being able to work with fathers for one reason or another, the primary one being the father is more commonly a perpetrator of family violence and mothers and children are in refuge. This means the infants I see undoubtedly bring into the therapeutic space memories and representations of their father externalised through play and interactions with others, and as a ghost which haunts the dyadic relationship. As with all infants, the memories they carry relating to their father are stored implicitly, pre-verbally and pre-reflectively. Even if they had verbal language to communicate all of what the relationship with their father might mean for them, it certainly would fail to convey an infant's soupy experience of parental love, fear, rejection, unsafety, fun or abandonment. Already one of the more unique clinical challenges we have as therapists working with clients who are not able to participate in 'the talking cure', it is further complicated by the infant's mother who typically avoids exploration of the father, the relationship, the violence, and the abuse, all contaminants of their own trauma which they have survived. Consequentially, despite intellectually knowing a father's presence in terms of the infant's conception, the role of father in an infant's life is forgotten as we focus on the mother-infant relationship. The following conference presentations are the ones which I found particularly inspirational in the context of working with families fleeing violence (e.g. DV, war, trafficking etc.) as well as resonating at deeper, more personal levels.

In the context of working in a family violence service, the presentation given by Lynaire Doherty and Tawera Ormsby of Ohomairrangi Trust, New Zealand described an adaptation of the Mellow Parenting and Mellow Bumps programs to support men to become fathers and change intergenerational patterns of violence. A reflection which I have often come back to over the years in various roles with infants and women victimised by violence is the need to make fathers part of the solution. I struggle with the largely unchallenged social expectation that mothers are a child's best hope for survival, growth, healthy development and attachment when many of the mothers I work with are equally broken, having being failed by their own parent as a baby. For many of the child clients at Emerge, the abuse or neglect they experience is at the hands of their mothers or grandmothers. The attitudes which accompany this expectation are rife in the family violence service with a plethora of therapeutic services and funding only going to

women and children. It can be difficult to find space in the family violence landscape to talk about the needs of men, both for their own sakes, but also their children's. There is certainly no question about the value or necessity of services for women, but there is also an urgent need to consider the real needs of men and fathers in terms of service delivery. And this was where the Ohomairrangi Trust has been able to succeed and demonstrate true leadership. Although the presentation was brief, my sense of it is has been able to draw together community services, community development, and mental health frameworks which keeps the infant central and actively adopts a multi- and trans-discipline approach. An approach which is desperately needed in Australia.

I was deeply saddened to hear they have lost funding despite the excellent outcomes for families, but it gave me hope that infant mental health professionals from various disciplines could come together to deliver robust and efficacious programs for fathers and infants which tackle the complexities of relational trauma and family violence together.

Tim O'Leary's talk on Show and Tell was lively, energetic and dynamic! Only the inanimate objects in the room failed to be infected by his passion and enthusiasm for translating infant mental health concepts to dads. One of the presentations I took many notes on, take away points included the simple explanations of sleep and play windows used to assist fathers better understand and attune to their infant's cues and analogies to explain concepts simply. Not being a parent myself, an area of practice that I am always trying to improve and strengthen is how I talk with parents. Lacking direct practice as a parent, I often wonder if having a lived experience of parenting would help me in knowing how to explain concepts in a more straightforward manner. Possibly not, but despite my concerted efforts to describe things in lay terms with parents and even the students I teach, I don't always get it right and am often paradoxically lost for words of the non-clinical vernacular. Tim was clear, to the point and unambiguous in everything he talked about and I now have some tools to use in my own practice. Using personal narrative interwoven with clever analogies, Tim was unequivocal in his message about the vital importance of fathers being a necessary ingredient for optimal infant mental health. His voice and message are an important one in shifting attitudes around parenting and that of raising awareness and understanding around infant mental health in the public sphere.

I went along to Elizabeth McLean's talk on her PhD research project as her discipline of Music Therapy (MT) closely relates to that of the Art Therapy (AT) program here at Emerge. There was a particular connection with some of the experiences Elizabeth shared in her work as a MT in an environment dominated by the medical model which is often at odds with the philosophical underpinnings of psychotherapy. Elizabeth's work with parents, mothers and fathers investigated the value of music therapy in the neonatal unit. Whilst the parallels in her work and what we do at Emerge are distant, it was encouraging to hear of another expressive therapy benefiting families, positively influencing healthy neuro development and promoting secure attachments in compromised circumstances. In many ways, this is similar to the value of using Arts Psychotherapy in the trauma therapy facilitated with dyads and children.

Key points were about helping parents to modulate the tone of their voice and incorporate singing into their relational exchanges as a way of establishing connection in an otherwise hostile environment. Singing is an important element of the infant-led groups we facilitate for mothers and infants living in refuge. Elizabeth was able to provide more nuanced theoretical underpinnings as to the function singing has in physical and brain development, but also in attachment. I have recently finished running another infant-led group where I was able to incorporate some of this new information in the form of psychoeducation. This seemed to have special resonance for some of the CALD families we had in the group who were dislocated from their community since moving into refuge. These mothers were able to reacquaint themselves with traditional songs their mothers and grandmothers would sing when they were babies in their home country. When English is limited, singing and song unites women, mothers together in moments of shared meaning and joyfulness. For the infants, singing goes beyond simply communicating a story conveying messages of love, hope and worthiness in a bidirectional manner. It also provides an opportunity for infants to share with their mother another aspect of their self which has been stymied or unfulfilled due to the effects of family violence.

The final presentation was that of Dr Christine Hill and Michele Meehan – Infants in Detention: What chance to play? Even though it was actually the first talk I went to, I have positioned it last as it is less relevant to my current role of Family Therapist at Emerge. Prior to joining the Emerge Art Therapy team, I spent seven years working with asylum seekers and refugees. I had decided to exit this particular field before the last federal election for my own self-preservation; not a day goes by I don't miss it deeply. It is my hope to return back to this area in the future. Compelled by the topic and being one close to my heart, I went along merely to satisfy personal reasons. I was curious to learn from Christine and Michele how they had logistically managed such a feat given the suspicious nature of the immigration department.

The stories of parents and babies brought tears to my eyes and heaviness to my heart. The presenters were profoundly honest in recounting their emotions, reflections, and insights. They told of unbearable heartbreak as parents became incapacitated in detention. I wept for parents who could not feed their child as they so desired, prohibited by draconian rules which oppressed their basic human rights in so many ways. I smiled lightly when I heard of some parents having small flickers of hope still alive in them, fathers who were committed to caring for their small child when the mother was too depressed to do so. My heart stopped hearing of the still face babies who could do nothing more than to disconnect in order to survive. I left feeling immeasurable despair and anger, but fortified in knowing that even though for a short time, these families had an opportunity to play, enjoy 'forbidden' fruit, and possibly have moments where they might forget where they were and remember who they are.

Undoubtedly a gloomy talk with little to feel optimistic about; however it was fortifying to know efforts are being made in supporting families in detention. It is of critical importance for professionals to advocate tirelessly to government for infants and parents seeking asylum ensuring the rights of the child and human rights are upheld. Christine and Michele role-modelled so many attributes of the kind of psychotherapist I hope to be, giving me courage to continue in this direction irrespective of the challenges ahead.

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AAIMHI Conference report (cont.)

Future direction

Both personally and professionally, the conference enriched me in numerous ways that I am confident will translate into becoming a more competent practitioner in the context of working in attachment trauma and family violence. Having heard from many different professionals in the field from a range of disciplines, it was encouraging to see the conference invited a broad selection of topics, locally and internationally. The inclusive nature of the conference and all who attended has moved me to author a journal article on the use of creative arts psychotherapy in the infant-led groups offered at Emerge. With Wendy Bunston as mentor, I hope to be able to have another opportunity in the near future to share more about infants in refuge with infant mental health specialists.

In closing, I would like to extend a warm and sincere thank-you to Wendy Bunston and Kathy Eyre for their nomination for this award as well as the committee in selecting us as recipients. I am deeply humbled and inspired by all of the presenters at the conference even though I have only mentioned several here. It was incredibly rewarding to have the opportunity to go along and absorb new information, learn, network, and to have the work we do at Emerge validated by the broader infant mental health community.

Implementing a 5-week Peek-a-boo Club™ with mothers and infants living in refuge: Highlights, challenges and reflections

Emma Hodges

Emerge Women and Children's Support Network in Melbourne's south-east assists a growing number of women coming into refuge with their infants who have experienced Family Violence (FV) and abuse. All too often mothers arrive in a state of crisis or shock struggling to attend to the needs of their child whilst their infant tells the story of having lived in violence and experiences of a parent who is frightening, unsafe, or unavailable. Together, the mother and her infant present with compromised mental health and a bond which is formed on ambivalence, fear, and unsafety. Identified in 2013 by Emerge staff as a cohort critically in need of early intervention to repair the mother-infant relationship and interrupt intergenerational transmission of trauma and violence, the Art Therapy program adapted the Peek-a-boo Club™ developed by Wendy Bunston and the Royal Children's Hospital. To date, we have been able to offer the group four times over the past three years.

This article aims to disseminate key outcomes for dyads and findings from the program evaluation of the last iteration run over five weeks in term four, 2015 by Emerge's Family & Trauma Psychotherapist, Emma Hodges and refuge Case Worker, Micah Palmer-Cannon, as well as Art Therapist, Tania Virgona. Each practitioner has considerable experience in the community sector working with children and women who have experienced FV. This was Emma's third PAB Club™ group she had facilitated and Tania's second group.

Demographics

Each group we run attracts referrals for a broad demographic of families from different cultural backgrounds, personal histories of abuse, and FV experiences. However, this last group was unique in that the eight families, who attended the PAB™ Club, were all residing in secure housing provided by two independent women's refuges at the time of the program. Whilst we typically begin the group with a higher number of dyads to counter for dropouts, this group was unique in that all families attended.

The following points outline the main characteristics of the dyads:

- Eight dyads (N=16) comprised 8 infants aged nine months to 28 months and 8 mothers aged 21 years to 46 years
- Five mothers were born overseas: two on humanitarian visas from refugee backgrounds (Somalia and South Sudan) with beginners' English and only child; two from Pakistan on spousal visas, fluent in English, and also only children; one mother from Indonesia on a spousal visa, fluent in English and third child born at age 44. These women had limited connections to their respective communities and family-of-origin due to physical or social isolation
- Three mothers identified as Caucasian born in Australia each with multiple children except for one woman who attended with her only child
- Many of the mothers already knew each other from living in refuge together and having formed friendships
- For each woman, it was the first time they had sought refuge following FV
- Two mothers had been formally diagnosed with C-PTSD with histories of childhood abuse

Summary of results

Consistent with the PAB Club™ guidelines, both the Maternal Postnatal Attachment Scale (MPAS) (Condon & Corkindale, 1998) and the Parent Infant Relationship-Global Assessment scale (PIR-GAS) (ZERO TO THREE, 2005) were administered as the pre and post clinical assessment instruments to evaluate effectiveness of the program.

We observed a significant increase in the quality of parent-infant attachment (PIR-GAS) for 62.5% of dyads. Considering this group was time-limited, this percentage of global improvement is promising and indicates families in refuge have considerable capacity to engage in and to benefit from early intervention programs such as the PAB Club™.

Consistent with the literature, the distribution of MPAS scores are skewed heavily in the higher third percentile indicating mothers report a high quality of attachment with their infant (Condon & Corkindale, 1998) creating disparity between the clinician rated PIR-GAS with the self-report MPAS. One hypothesis to explain this phenomenon stems from anxiety in

being labelled an unfit mother. The need to present an ideal mother-infant relationship is understood as a response to the shame and guilt women often feel as mothers in staying in violent relationships.

There was minimal pre to post variance across the group for the MPAS, although there were some significant changes in particular domains for some of the dyads which are isolated in family outcomes. Ambivalence in how mothers 'should' answer were noticed when multiple boxes were marked indicating conflicting feelings for some questions.

Key outcomes for dyads

Family 1

B (26mo) overcame overwhelming activation of the parasympathetic nervous system from fear for being left alone to enjoy games and songs expressed through laughter, smiles, and high-fives. His mother, who had felt helpless in calming her son and desperately wanting him to be fine, was able to acknowledge B's fear and be empowered to respond. The smallest increase in PIR-GAS scores, emotional instability in the relationship meant both had a heightened fear of abandonment that will take time to resolve.

PIR-GAS: Pre 48 Post 50
MPAS: Pre 77 Post 75

Family 2

W (24mo) changed from being very quiet, reserved and clingy to be confident in joining in songs and moving around the space with greater confidence. His mother, concerned she had replicated the same absent relationship with her son as her older children who were subjected to severe violence and abuse, was able to identify the kind of mother she wanted to be and feel confident in making changes in their relationship.

PIR-GAS: Pre 57 Post 61
MPAS: Pre 62 Post 69

Family 3

Both J (29mo) and his mother presented in a state of fear a lot of the time, with ambivalence and avoidance defining their attachment and inability to connect emotionally or physically. By the third week, we saw shared moments of pleasure evidenced by mirrored smiles and laughs. Increased sense of safety and containment for this dyad were identified as key factors in enabling the quality of this dyad's relationship to increase by 16 points.

PIR-GAS: Pre 25 Post 41
MPAS: Pre 64.9 Post 66.7

Family 4

P (24mo) communicated her insatiable need to connect and be reassured by her mother in quite intense ways, highlighting her mother's own insecurity to be needed and approved of. P and her mother were able to experience each other more authentically meaning P could tolerate negative mood states better.

PIR-GAS: Pre 62 Post 70
MPAS: Pre 47.9 Post 61.2

Family 5

H's (9mo) mother saw her daughter as an extension of herself intruding H's emotional and physical boundaries. Never crying in distress or protest, we wondered if H had given up on trying to be seen by her mother. With some gentle waiting and wondering, H's mother better understood her daughter's own subjectivity by the end and, in turn, H rewarded her with smiles and giggles.

This mother held an expectation the group would be a playgroup excluding herself from conversation. This could suggest psychoeducation and important feedback was not taken up or understood.

PIR-GAS: Pre 59 Post 51
MPAS: Pre 80.3 Post 80.2

Family 6

Strongly characterised by hostility, resentment, and painful memories, Z (18mo) and his mother avoided one another where possible with signs of PND a concern. Z coped with his mother's grief by moving away from her to play. By the final session, some repair in their relationship was evident by singing together, shared smiles, and softening in their interactions.

Concerns of undiagnosed postnatal depression (PND) and non-engagement with external services may have meant a continued decline in quality of attachment as seen by the PIR-GAS and MPAS score, further corroborating this. Interestingly, responses to the Absence of Hostility questions accounted for the MPAS shift.

PIR-GAS: Pre 50 Post 45
MPAS: Pre 79 Post 69.4

Family 7

Insufficient clinical observations of K (25mo) as the family only attended twice.

PIR-GAS remained unchanged having only attended two sessions and insufficient opportunity to closely observe this family. The final MPAS questionnaire was not returned.

PIR-GAS: Pre 45 Post 45
MPAS: Pre 65.6 Post - not done

Family 8

M (24mo) arrived as non-verbal and dissociative boy preoccupied by closed doors indicating issue of safety. His mother, young and from a refugee background, worried heavily about M's 'aggressive' behaviours and how they would reflect on her mothering skills; she constantly admonished any behaviour. Focus on M's strengths, as well as emphasising the need to praise M and wonder more about his behaviours helped her relax enough to be present to her son and reflect back M's needs.

PIR-GAS: Pre 35 Post 39
MPAS: not completed

Evaluation

There are many factors believed to have contributed to the success and positive outcomes of this group.

1. 1. Giving priority to dyads in refuge and maintaining working partnerships with Case Managers to assist families in coming and to help mitigate any other issues which could arise and hinder attendance.
2. 2. Every dyad reported relative stability in terms of legal and housing issues which we know is a huge determinant in attendance and non-attendance.

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Implementing a 5-week Peek-a-boo Club™ (cont.)

3. 3. Achieved 77.5% attendance and no attrition. Two families attended every session, another three families came to four sessions, two families came three times, and only one family came twice.
4. 4. It is believed that existing friendships boosted women's self-esteem and sense of safety, encouraging them to come and share. This is an important consideration for future groups as low self-esteem and a sense of unsafety are barriers in help-seeking.
5. 5. Providing transport resolved issues such as women navigating a new area of Melbourne by public transport or reluctance to take babies out in inclement weather.
6. 6. The majority of dyads were not considered to be clinically at risk and therefore maybe more amenable to engaging in early intervention in the format of a group. High risk dyads present as chaotic and disorganised often lacking the necessary internal and external resources to support and sustain engagement over numerous sessions.

Considering one of the main challenges we have faced in the past is daily crises inhibiting women from coming, the attendance for this PAB Club™ is unprecedented, but welcome. It allowed us to track dyads with greater consistency over the course of the program and provide intensive intervention meeting the core aims of the program with this cohort.

We reflected on the size of the group being too large with a central need being to hold and contain the space due to trauma responses of hyperarousal, hyperactivity, and dissociation simultaneously experienced by multiple participants. Often our attention was unequally divided between being infant-led in our approach and that of attending to the emotional needs of mothers who wanted to disclose with facilitators. Mothers would benefit from having their own one-on-one counselling as an adjunct to the group so their own 'stuff' could be bracketed out and the focus could remain on the infants.

Recommendations

- Resume a 6-week program as per the format of the PAB Club™ which balances the needs of families living in crisis as well as families living in the community with greater level of stability. Women commented that they would have liked another couple of weeks as it ended when they had just started to notice positive changes.
- Close the gaps between community and public health to ensure vulnerable dyads are supported holistically. Establishing stronger links with specialist infant teams in public hospitals would assist with secondary consultation and formal assessment, two areas currently outside Emerge's capabilities.

Summary

Overall, this PAB Club™ was the most successful group to date since its implementation at Emerge. With each group, actions are taken on the back of the recommendations in a concerted effort to meet the needs of families and ensure the group is delivering its key objective and outcomes. This last group highlights much of the tireless efforts gone into making this program a success. The influx of referrals sometimes months in advance indicates the real need for early intervention for infants impacted by FV. The positive outcomes for the dyads and feedback by mothers is testament of the PAB Club™ model offering mothers and infants an essential opportunity to repair the attachment style to be one of safety, respect, and trust.

References

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Contributor biographies

Ben Goodfellow is an infant, child and family psychiatrist working at Geelong CAMHS on the infant program and paediatric consultation liaison service, perinatal psychiatrist at Bendigo Health, in private practice in Melbourne and is a senior lecturer at Deakin University.

Emma Hodges is a psychotherapist in private practice with a specialty in trauma, children and families. She is Emerge's Family Psychotherapist in the Art Therapy program, and completing her doctorate in Arts Therapy.

Vivian Lee is an infant, child and family psychiatrist working at the Agnes Parent and Infant Unit based in Traralgon, and in private practice in outer south-east Melbourne.

Bianca Morrison works at Emerge Women's and Children's Refuge.

Emma Toone is a child psychotherapist in private practice; senior clinician with the Turtle Program in the Berry Street Family Violence Service; and lecturer at Monash University.

SOPHIE X: A Self-portrait by Sophie Xeros and Konrad Winkler

In this collaboration, between artist/clinician Sophie Xeros and photographer Konrad Winkler, Xeros explores 'maternal infant space' through imaginative play, as mother in relation to her own daughter's doll as baby. Her journey is captured on photographic film by Winkler in the setting of Xeros' studio.

In her performative role, Xeros is both the subject and author, giving expression to her own, ambivalent feelings as mother and as daughter. She also draws upon the truths communicated to her as a therapist by women suffering post-natal distress.

The works explore boundaries between self and other, and what it is to be woman, mother, daughter and subject behind the lens. And they explore the range of feelings that emerge in relation to an-other, including repressed, hostile and negative feelings that are evoked between mothers (and partners) and their offspring.

Drawing upon photography's inherent performative capacity, the artists invite the viewer into an internal world to witness the ambivalence and paradox in which the reality captured by the camera reverberates as reminder of our own mothers' heimlich-unheimlich. Together the works offer powerful commentary on the influence of interpersonal relationships to self-expression and creativity and the role of the camera in bringing to vision a particular synthesis of these relationships unique to their own time and place.

The photographs are black and white, archival inkjet prints, 58 x 90cm and colour archival inkjet prints 40x 28cm.

The series has 15 images.

Sophia Xeros-Constantinides is an artist and clinician working with perinatal mother-infant distress. She is currently undertaking research for a PhD in Fine Art at Monash University, exploring the visualisation of women's reproductive experiences and the maternal-infant relationship.

Xeros-Constantinides works in a variety of media, including drawing, printmaking, digital photography and collage. Whilst acknowledging and celebrating the wonders of procreation, she is aware of the enormous risk and cost falling to women in their reproductive lives, not least in terms of mental health and well-being. She uses collage as metaphor for the schisms and disruptions which confront women in their reproductive quest.

In the catalogue to her recent exhibition 'Bedlam: The bitter-sweet embrace of motherhood' (2010), curator Dr. Wendy Garden commented: "In the work of Xeros-Constantinides the body is not so much an inscriptive surface upon which meaning is mapped out but rather a container of hidden interiorities and cavernous depths ... she unhinges the maternal body to lay bare the anguish and dread that lies at the heart of many women's experiences of maternity and early motherhood ... she explores the invisible mechanisms of alienation and the ambivalence women have with their changing bodies as a result of reproduction. By bringing to visibility deeply interred fears Xeros-Constantinides' monstrous montages reclaim the maternal body, intervening in the knowledge-struggles over early mothering and validating women's private experiences."

Xeros-Constantinides' work has been exhibited nationally in the Fremantle Print Prize (2010), in the 2010 Swan Hill Print & Drawing Prize exhibition, and in the 2010 Beleura National Works on Paper exhibition at the Mornington Peninsula Regional Gallery. Her work has been acquired by the Dax Centre in Melbourne, a National collection of art pertaining to mental health and psychological trauma.