



Contents

Interpreting the infant transference	2
Showcasing Best Beginnings	6
Moving from place to place person to person	6
Group supervision for AAIMHI Vic branch members	9
Discussion of parents with personality dysfunction and disorder	9
Submission to the 10-year plan for mental health strategy for Victoria	12
Book review: <i>The Dark Side of the Womb: Pregnancy, Parenting and Persecutory Anxieties</i>	16
Marcé Society conference 2015	17

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.

© AAIMHI 2015. Permission for reproduction of original newsletter items is granted on the conditions that appropriate citation of source is noted and that the item is fully reproduced.

Welcome to the December 2015 edition of the AAIMHI newsletter. Reflecting on this year's contributions, we acknowledge the continued work of many members to hold steady in understanding, privileging and supporting the infant's voice in clinical and public policy settings. Indeed keeping the infant and family afloat whilst navigating the mysterious funding currents that see some services grow and others close is a dispiriting reality of the pathology in the system.

Optimism may be found in the public attention to the position of infants and young children in the context of family violence, of those seeking asylum, within Aboriginal communities and the child protection system. These groups in which infants are at their most vulnerable have been the subject of formal governmental inquiries as reflected in some of the writings in this edition. In this edition we also have a first in including links to submissions and witness transcripts from AAIMHI members advocating for infant rights in public policy settings.

Inquiry and reflection gives rise to more rigorous understandings of how we might reach the infant differently. This edition begins with two technical papers; the first from Thompson-Salo considering the concept of transference with respect to the infant and in the second Tyghe attends to infant work with disordered parents. Brown explores finding a home for the infant in the mind of their carer, and we welcome a book review from Jones covering Raphael-Leff's new book about the home of the womb.

We would like to congratulate the author of the report on the 2015 MARCE conference, Wendy Lauder, for recently receiving the Premier's Award for her work through the former Bendigo Perinatal Emotional Health Program. We also congratulate Richard Fletcher and the NSW branch for the very interesting AAIMHI 2015 conference in Sydney focusing on infant work with fathers – a conference round up will appear in the next newsletter. At the end of this rich summer edition you will also find invitations to the Master of Infant Mental Health course at Edith Cowan University and a monthly group through the Freudian School of Melbourne "Psychoanalysis and the Child."

With the National Committee, we will be surveying the membership to provide a forum for feedback on the newsletter and hear ideas for further renewal. As always we invite your submissions, letters and comments for the the first edition for next year, due 7 March 2016.

We hope you enjoy the December 2015 edition and wish you a time of rest and renewal with friends and family over Christmas and the New Year.

Ben Goodfellow and Emma Toone

Interpreting in the infant transference

Frances Thomson-Salo

I will discuss interpreting in the transference in the first half year of life, in the Royal Children's Hospital approach, which upholds the rights of infants for intervention in their own right. I think this approach includes the following four psychoanalytic elements: it aims to establish a well-thought through setting, and to take the infant's point of view and find the port of entry from the first session; the therapist is willing to reflect after the session about transference-countertransference and the unconscious, and recognises the presence of hate (Thomson Salo, 2011).

Can there be transference in a very young infant when there are fewer memories of interaction from an earlier relationship to be 'transferred' onto the therapist? Can infants be in a relationship with a clinician that is in part different to those they have with other people?

Infant developmental research has explored infants' affective experience lying beyond language. This raises issues about the way therapeutic engagement can occur in infant-parent psychoanalytic work – an engagement which is beyond interpretation and speaks to the affective language of the infant, acknowledging the infant's innate capacity for social engagement and drive towards relatedness. The infant as an active subject¹ brings her/his own specific language of emotional connectedness. Many kinds of interventions work and we need to become better at working out the mechanisms for change. I'll suggest that in an encounter with a therapist age-appropriate playfulness shaped by the therapist's thinking about the infant can be as transformational as a verbal interpretation because the infant knows it is for them, and feels affirmed and freer.

Transference

I'll consider the transferences of infants primarily in the first year and rather than describing current wider psychoanalytic views of transference in the analytic situation with adults, I'll rely on Freud's 1910 definition, "Transference arises in all human relationships (p. 51)". And I'll note a current view that in the first year the therapist is a transference object on whom the infant projects fears and hopes (Halberstadt-Freud, 2013). Infants seek to engage with others from birth, which shapes what they bring to the therapeutic encounter.

I'll draw on experience working with infants in hospitals and outpatient settings in England and Australia, and while I may mostly refer to the mother, the infant's relationship with the father is very much in mind.

I'll outline three kinds of relationships infants in the first year could make with a therapist:

1. Transfer of a current positive relationship with the parent.
2. With negative aspects in the relationship with the parent, an infant may be able to split and relate positively to the therapist.
3. Infants may transfer and maintain an aspect of a masked negative relationship with a parent in the past.

¹ The concept of the baby as subject was used at the Children's Hospital from the early 1980s, arising out of direct work with the infant and naming a number of strands in trying to articulate the infant's perspective and drawing on theorists such as Lacan, and Trevarthen's exploration of subjectivity.

We need to work particularly with the last two as being likely to affect the trajectory of development.

Responding to some discussion points before giving vignettes

What is transference in a very young infant when there are less memories of interaction from an earlier relationship to be 'transferred' onto the therapist?

An infant relates to the therapist based on thousands of interactions with the parents, and meets the therapist in the present. While for infants in the first year the past is not so very past, it is nevertheless a profound past that drives them to make a particular relationship with the therapist.

As an infant expects what has happened before, is the encounter with the therapist 'contaminated' by other encounters?

The encounter could also be seen as a novel one as an infant seeks 'the new' as a positive nutrient. An infant can see a therapist in a different sort of relationship to that which they have with other people because of the ambient expectations which the parents bring to the therapeutic encounter and what the therapist brings of him or herself to try to engage therapeutically.

While an infant may develop a strong relationship to a therapist, this is basically not independent of the mother's relationship to the therapist – or is it?

I think it may be embedded in a few seconds of experience which is independent of the mother.

In the urgent work with infants and parents should a clinician be in a more real here-and-now relationship to enable the infant to feel connected and contained rather than feeling isolated, withdrawn and needing to use massive defences?

Rather than this being a 'should', the way the therapist uses their presence would arise out of what the therapist thought that this infant in front of him or her needed.

Is it necessary for a therapist to facilitate the development of positive transference between infant and therapist?

A therapist would not need to facilitate this, but rather that if it is needed, it is likely to arise, driven by developmental forces.

Examples

1. If infants have a positive relationship with their mother, it is easy for them to see the potential of the new person in the therapist, and clinical experience suggests, especially with securely attached infants, that they are ready to engage with the therapist – as someone said, "a different dude" available for a therapeutic encounter. We perhaps might not see so much of this clinically.
2. With negative aspects in the relationship with their mother, infants might use the therapist for a positive experience. For example, infants of mothers who were experiencing postnatal depression, and who showed a rather flattened response to her, responded in a different, less depressed way to, for example, day care workers who were not depressed (Pelaez-Nogueras, 1994). As Ed Tronick has shown, babies are shocked and hurt when their mothers' positive regard is withdrawn in the Still face experience.

Vignette

A 6-month-old infant whom I had seen about six times with his mother whose severe bipolar disorder was managed with high doses of medication, seemed able to see me as a real new object. He had about him an air of acceptance of the stillness imposed on him to lie still and flat in his pusher. When I engaged with him, he would give me a wide gummy smile – and while relating to me as a new, real person, he would often give a quick checking-back look to her face.

Babies in these first two groupings usually remember their positive experience with the therapist at the next meeting. Thinking of implications for the work with these kinds of transference, a therapist would work with this but be mindful not to respond in a way that infant or parents could see as potentially seductive.

But it may take longer to bring about change.

Vignette

A seven-month-old boy, Tom, and his mother had attended a mother-infant therapy group that Campbell Paul and I ran. He was an unsmiling, passive, frozen boy, referred for various psychosomatic symptoms, who constantly held his arms rigidly at right angles to his body, glancing quickly at his mother with a frightened face. The previous year his one-year-old sister had died a cot death from Sudden Infant Death Syndrome. His mother's anger interfered with mourning; when she looked at this boy whom she had not wanted she had always seen her daughter's face superimposed on her son's. Her relationship with him was conflictual; she had never been able to play with him and said she did not like him. They had attended for five weeks with no improvement to the symptom picture for both of them, and she indicated some anger with us, believing that we had no experience of bereavement. With us, Tom had initially been as hesitant as he was with his mother and had only related to us in a blank, anxious, shut down way.

Once Campbell responded to an 'invitation' by the infant shimmying with pleasurable anticipation that he might be able to engage Campbell, and in the safe space of 10 minutes playing with him in the presence of his mother, he was able to bring his arms in and bite Campbell's hand and then relax. Campbell turned him round to face his mother as if to say "You deserve that he should face you".

With the resulting changes in the representations of both mother and infant simultaneously, she smiled at Tom for the first time and he also relaxed for the first time. I had a sense that they both had brought the problem.

Transference implications might include the importance of recognising when the infant is potentially open to a change in engagement by the therapist and titrating it to the blended needs of infant and parent.

I'll come back to this vignette again.

3. Transference of a negative aspect of the mother of the past

Example from infant observation

For the first six to eight months of a weekly infant observation, an infant seemed to be acting on his mother's unconscious hostility to the observer (she would at times forget the

observer's visits). It was not until well into the eight-month observation that he even made eye contact with the observer and this avoidance came over as very negative. As splitting in enacting what his mother felt, splitting off some negative for the observer to contain, perhaps it was not entirely the infant's transference of the mother of the past who had been negative towards him as he was born after her beloved daughter. She herself had been the first child in her family of origin followed by a second child with cerebral palsy. Unusually, she never told the observer the infant's birth story but the observer knew it had been a caesarean section birth which she was fairly sure the mother chose and she wondered whether the mother could have been depressed in her pregnancy and the infant 'sensed' hostility in utero. Transgenerational effects seemed important here.

Vignette

A mother brought her 8-month-old infant for sessions and while she appeared to have recovered from depressive feelings, her son seemed to hang on to them in connection with me. He seemed flat and to look at me in a sullen way, and I had to work very hard to feel sympathetic. It seemed he was transferring onto me, relating to me as if I was the mother of the past. This conveyed greater disturbance in that he seemed to need to maintain the negativity.

Transference implications include the countertransference work required to sense the infant's internal state beneath the presenting facade, in a process similar to parental embodied mentalizing (Shai & Belsky, 2011) and be able to respond appropriately to both layers. And it might take considerable time and need considerable attention to the infant's needs if a parent felt challenged by the intervention.

**Interpreting in the transference
With an 'unseen' infant**

I now return to the vignette of Tom given above to try to conceptualise better how we communicate beyond language. In the last session before a holiday, his mother said that all Tom did was whinge, and I talked with her about her experience of this. She began to differentiate Tom from his sister saying that his round face was not that similar to hers. His hands went to his mouth with pleasure and then downwards as his mother mentioned that he was different from his sister. There was a seemingly interminable 15 seconds when his mother left him lying face down on the floor crying as if abandoned, instructing him to lift his head up. When he then stood with her support, he watched with quiet enjoyment as Campbell attuned to his almost imperceptible hand movements with playful gestures of his own fingers. Campbell asked him, "What's going on?" Tom seemed to feel rescued. He overcame his inhibition and by shimmying, 'invited' Campbell to engage. He wiggled his fingers and Tom again shimmied with pleasure. Campbell began gently clapping.

When Tom responded with pleasure, he said "It's very exciting." Tom imitated him and moved one hand.

Campbell said encouragingly, "Do you think you can do it? ... Yeah, that's one hand, isn't it?", paused to follow Tom's lead and Tom vocalised, urging him to continue.

"He's going for the other one at the same time." Tom

shimmied and I spoke for Tom saying, “Don’t stop” and his mother said, “You’re mean if you stop, isn’t he?”

Campbell breathed a sigh, waited then said, “Yes, you do it.”

Having waited all this time, giving the infant time and space, he now moved across at the infant’s level to touch his hands and talk to him, following his actions.

“It’s a bit hard. That’s it, both at the same time.” And gradually Tom, holding Campbell’s hands, brought his hands to his mouth and mouthed Campbell’s thumb.

His mother said, of Campbell’s hands, “They’re big fat fingers, aren’t they, compared with Dad’s”. Campbell gently brought his arms together in a playful way, and then turned him to face his mother. Holding Campbell’s hands, he was able to bite his fingers.

As Tom and he mirrored chuckles, Campbell said, “I think you’re enjoying this, aren’t you?”

His mother acknowledged, “He’s had a hard life, I admit it”. He became less anxious with her and smiled. In response she smiled, tossed him in the air, kissing him and laughing and playing with him for the first time, grooming him in a bonding way, and he began vocalising. He had ‘read’ that the anger in her eyes, as well as being denied recognition, had gone. She, seeing him in a different way, claimed him immediately. Less anxiously inhibited, he no longer needed to hold his arms out and began exploring. She said she would not get pregnant just yet, which would make a space for Tom not to be blotted out by a replacement child. Follow up four years later showed that he continued to develop well.

To sum up

- Tom’s mother did not see Tom for himself, so that he was not alive for her and he felt himself not to be an alive baby and was anxiously attached.
- Our countertransference was of feeling helpless and despairing (as Tom and his mother felt), with an impending break from therapy.
- We did not consciously know it at this point but in reviewing the videos later we understood that he braced himself, frightened, sensing his mother’s anger. His positive, loving feelings for her were split off or not lived in; in this way they were unconscious.

Clinical discussion

Tom’s fearful transference was worked with in affective communication. I imagine it might feel like, “When he talks to me in my language, I feel he’s understood that I feel frightened and bad, and he accepts me as okay. He plays with me, just for me – and because of that I can let go my protection. He holds me containingly when I face my frightening mother. I can bite him – my aggression is not dangerous.” Tom had his own anxious transference relationship with us separate from his mother’s transference of masked anger with us – and Campbell worked with this.

He ascribed affect and thinking to Tom. As Shai and Belsky (2011, p. 187) write, embodied mentalizing is a “capacity to (a) implicitly conceive, comprehend, and extrapolate the infant’s mental states (such as wishes, desires, or preferences) from the infant’s whole-body kinesthetic expressions and (b) adjust one’s own kinesthetic patterns accordingly” moving towards the infant’s realm of experience – that of quality of movement, rhythms, space, time, sensations, and touch.

Implicit mentalizing is nonconscious, nonverbal’ in interpreting the infant’s movement as manifestations of mental states or in determining a therapist’s embodied responses.

Tom’s mother could not implicitly interpret changes in his movements and rhythms as expressive mentalistic signals or respond in an embodied manner; this compromised his ability to feel – at the embodied level – that he was the owner of his body and an active agent capable of influencing other people. She could not transform his movements into meaningful and intentional mental states, whereas Campbell did.

He tracked Tom’s behaviour seeing meaning in it and responded playfully in a way that elaborated Tom’s actions. His waiting when Tom cried was part of his feeling his way into the internal landscape of infant and mother rather than rushing into action. He began clapping, unconsciously aware that he was showing Tom something that Tom could mirror in his mind, if he were free to have fun; it is possible to bring hands together without hurting someone. Campbell responded to the infant’s gesture, offered by him as an invitation to join an interaction and be playful. Tom was able in playful interaction to mouth Campbell’s fingers which meant he could relax his arms. We had enjoyed his enjoyment – I laughed with Tom. Campbell built on the infant’s body movement, identified through his countertransference, and responded with attuned playfulness, which fostered the infant’s autonomy conveying that what he does is important. This interaction helped change Tom’s feelings. He was free to use his arms to find his mother. Campbell had built on a tiny positive action that Tom could do with his own hands. Nearly half of what Campbell said were gentle questions and I think this may unconsciously have matched Tom’s unspoken puzzlement.

I’ll contrast our approach with one other approach to try to isolate ‘active ingredients’. Bjorn Salomonsson (2011) also views it as feasible to approach the infant directly, with the infant able to affectively understand aspects of the therapist’s interventions and feel contained by them and thus to ‘talk’ directly with the infant, however young, in the mother’s presence. The infant-analyst dialogue becomes a major vehicle of change for the distressed infant. In 2007 Salomonsson described interpreting to a two-week-old infant, Nicholas, to whom he offered mother-infant psychoanalysis after his mother reported that he cried a lot. Salomonsson said, after Nicholas cautiously paid him some attention and then fretted, “Nicholas, I wonder what disturbs you. You have many feelings. Hunger hurts. You sense the wonderful milk. Then you recall that you didn’t like Mom’s breast and her “ouch” when it hurt her. Your feelings clash. You didn’t want the breast and throw your head back. Then you get hungry and want it anyway. And Mom gets stressed.” Salomonsson stated that Nicholas did not understand the words, but that he understood “my sincere intonation, and the rhythm and tempo following my understanding of what goes on within him when he is at his mother’s breast [and] seeks containment from the analyst”. In 2011, Salomonsson suggested the mechanism of change for the baby was the therapist processing their own anxiety in their unconscious countertransference, which contained the baby’s panic. I ask what is added with a long interpretation that seems adult, in that current views of an infant’s cognitive functioning do not support a view of an infant understanding such interpretations. This cannot therefore be interpreting to the infant, whereas embodied communication responding to the infant’s affective communication is more likely than not to be transformatively effective because the infant feels safe and

above all understood.

I now give a last example of an intervention from the Children's Hospital approach.

Vignette: A traumatised 11-week-old alone

Sometimes a therapist is called in urgently when the parents cannot be there as in the case of 11-week-old Dee who had been in hospital all her life. She was referred for feeding which was said to be 'an absolute nightmare', as she would freak out. There was no parent to take a history from as her mother could not visit from the country, although the case notes were several inches high. While the therapist held Dee preparing to feed, having seemed happy she now seemed sad, refused eye contact and she showed no signs of hunger despite being several hours since the last feed. She allowed the bottle in her mouth but cried, pleaded sadly with her eyes and refused to swallow. Seeing this, the therapist slowly asked her, 'What happened to you?' When the therapist picked up the bottle Dee looked at it, her eyes widening in terror, and the therapist again slowly asked, 'What would that be like?' The baby pushed the bottle away with her foot. The therapist spent an hour a day playfully interacting with her in ways that helped her feel safe enough to maintain eye contact and interaction. Dee became more settled and happy, and less hypervigilant. Within two days feeding volumes improved, and the nursing notes reported 'best feed ever. No crying or fussing'. The trauma that emerged was that when Dee had been oral gavage fed it took three people to hold the screaming baby down; when she was changed to naso-gastric feeds she screamed, vomited and became very distressed. Ice had been placed on her cheeks to stimulate her to suck and she had had 'suck training' when her mother had been told to put on a rubber glove, put her hand in iced water and then put a finger in Dee's mouth to stimulate her to suck. Playful interactions with her helped her regain pleasure in feeding and her autonomy.

I give this extreme example to suggest the therapeutic action does not need to include containment of the parents or verbal interpretation. I think interpretation in adult mode would not have achieved this. And I suggest that the infant reads, via the mirror neurons, some of what we are feeling, thinking and intending and this is carried through embodied mentalization, where the therapist uses their own self and body to engage the infant with gaze and touch. To quote Stern, when we watch another person act, the "visual information is mapped onto the equivalent motor representation in our own brain by the activity of the mirror neurons and we experience the other as if we're carrying out the same action, feeling the same emotion, making the same vocalization or being touched as they are being touched" (2004, p. 79).

Playful interaction, like that between the infant and Campbell, that is unique and co-created (Tronick, 2003) and sloppy (Stern, 2004) helps the infant elaborate 'a conversation', an interaction in which both people are equal but different. Campbell did this with gentleness and did not give a long interpretation to the infant which was basically intended for the mother, and his embodied responses followed the infant's need for pauses and modulated responses. The infant was not only responding to the therapist's self-containment and his containment of mother and infant, but was also responding from a position of being in the presence of another who used embodied mentalization to communicate an understanding of the predicament in which the infant had found himself.

I suggest that our approach will work not only with babies who may have eating or sleeping difficulties or irritability, but also with those who are severely injured, very disabled, dysregulated with very borderline mothers, failing to thrive to the point of dying, or actually dying, or alone – like a refugee infant, or orphan, or a baby with a substance-using mother who is about to be adopted out. With Dee, and in her mother's absence, if the therapist had only used containment and adult interpretation I want to emphasise that I do not think the change would have been as instant.

In conclusion

I suggest that interpretive play within the new relationship with the therapist offers the chance to free the infant from ongoing relationship difficulties by 'speaking' to these difficulties, as playing carries a communication by the therapist of their understanding of the infant transference that is obstructing development. The young infant does not have the capacity to process language but is organising experience around moments of emotional connectedness with the other. Campbell felt his way into the infant's mind, not assuming that he 'knew', not giving a construction as opposed to trying to feel the fear and conveying that together they will face it and playfully transform it so that the infant can take the risk of being himself and facing his mother, be playful and symbolise. I think that contingently sensitive playfulness conveys embodied mentalization very powerfully, communicating safety, pleasure and above all meaning, which the infant will understand in their own terms. As adults, we all know how freeing playing is. I think this is likely to be the main mechanism of change with young infants and to bring greater change for them than an adult interpretation.

References

- Freud S (1910). *Five lectures on psychoanalysis*, S. E., 11: 1- 55, London: Hogarth 1957.
- Halberstadt-Freud HC (2013). Emotional turmoil around birth. In: Quagliati E (Ed.). *Becoming parents and overcoming obstacles. Understanding the experience of the experience of miscarriage, premature births, infertility, and postnatal depression*. London, UK: Karnac, p. 52.
- Pelaez-Nogueras M, Field T, Cigales M, Gonzales A, Clasky S (1994). Infants of depressed mothers show less 'depressed' behaviour with their nursery teachers. *Infant Mental Health Journal* 15, 358-367.
- Salomonsson B (2007). "Talk to me baby, tell me what's the matter now": Semiotic and developmental perspectives on communication in psychoanalytic infant treatment. *International Journal of Psycho-Analysis* 88, 127-146.
- Salomonsson B (2011). The music of containment: Addressing the participants in mother-infant psychoanalytic treatment. *Infant Mental Health Journal* 32:6, 599-612.
- Shai D, Belsky J (2011). When words just won't do: Introducing parental embodied mentalizing. *Child Development Perspectives* 5, 173-180.
- Stern DN (2004). *The present moment in psychotherapy and everyday life*. New York, NY: WW Norton.
- Thomson Salo F. (2011). Does what we call 'engaging with the infant' matter? *AAIMH Newsletter* 24, 6-9.
- Tronick EZ (2003). "Of Course All Relationships Are Unique": How co-creative processes generate unique mother-infant and patient-therapist relationships and change other relationships. *Psychological Inquiry* 23:3, 473-491.

Showcasing Best Beginnings

Bendigo Health, Oct 2015 winner of the Early Years Awards in the Category of: "Improvements in parents, capacity, confidence and enjoyment of family life" and recently presented at the 2015 Marcé Society Conference in Adelaide.

Best Beginnings is an integrated response to mothers and families who are experiencing feeding issues and mental health problems in the first six weeks after a new baby is born. It is a joint initiative between Bendigo Health's Psychiatric Services, Perinatal Emotional Health Program (PEHP) and Families affected by Parental Mental Illness (FaPMI) and Maternity Services Breast Feeding Support Service (BFSS) and Maternity Support Program (MSP).

It starts out recognising the complex interplay between mental health issues and issues with feeding and in particular breast feeding. Very often the PEHP worker and the BFSS workers were being referred the same families for individual work, and very often it was unclear as to which of the two issues held the key to what was happening for this mother and baby. What both workers could see that issues with mental health often meant feeding issues and vice versa, and found that when working jointly with these women/ families they often achieved the best outcomes.

In trying to stream line appointments, make the best use of resources and offer a comprehensive intervention that addressed both issues, a new group for mothers, infants and their support network in the first six weeks was developed.

The group provides a single, supportive, two-hour group that looks at understanding infant behaviour, sleeping and feeding patterns, and looks at normalising infant behaviour through use of the Newborn Observation to understanding their individual infants better techniques (the techniques are used with parents during the group and the fathers

in particular love it as it gives them a role), through to acknowledging the changes that have taken place across the pregnancy, the impact of childbirth and making some sense of adjusting to new parenthood in the context of lack of sleep and very normal feelings of being overwhelmed by their new responsibilities and living with mental health issues and a baby.

The overarching aim of the group is to help parents understand and gain confidence in their new role, being able to prevent their anxiety from impacting on, and causing ongoing mental health issues for the infant, and giving the whole family unit the chance to enjoy the early experience of having a new baby in their lives. Evaluation of the group by participants has been overwhelmingly positive and with the \$15,000 prize money from the Early Years award we hope to further expand the group into the Special Care Baby Unit and beyond, and in 2016 we are having the Monash 4th year rural medical students (who spend time with both workers already) rostered through the group.

The group is hosted by Maternity Services in the outpatient area where many of these women have already attended to receive their ante natal care and childbirth classes and participants share in afternoon tea and socialising on top of the therapeutic element of this group.

Wendy Lauder

(newly created PEHC with Maternity Services)

Moving from place to place person to person: the emotional and relationship cost of transitioning for young children in out-of-home care

9th BASPCAN Congress Edinburgh, Scotland, 12 to 15 April 2015

Sally Brown B App Sc. (OT), OTR
Director, Allied Health
The Infants Home, Ashfield NSW

In April this year, I travelled to Scotland to present at the British Child Protection Congress in Edinburgh. This is a summary of the paper. Video clips are integral to this work and understanding. Obviously it is not possible to include these in this summary.

I would like to share with you the experiences I have had with children in an early childhood centre and the importance of transitions to the way their days unfold and progress. Specifically, the way a highly vulnerable sibling pair, who have been placed in out-of-home care in a kinship placement, respond to the many transitions that occur during their day.

The frameworks that I have used in this context are Circle of Security and Marte Meo.

At the Infants Home Child and Family Service, we have an integrated service where allied health staff and educators work together to ensure children's development and wellbeing. We have five licenced early childhood education and care centres situated on a four-acre site. The allied health team consists of occupational therapists, speech pathologists, social workers and a play therapist. Children with a diagnosed disability and/

or social disadvantage are usually referred by external agencies such as therapy services, refuges, child protection services, family support agencies as well as self-referral. We have a 30 per cent benchmark for inclusion of children with these difficulties.

Allied health team staff are involved in the daily routine of the centres. When circumstances arise where children's cues or behaviours disrupt their development – for example, poor self-regulation, aggression, withdrawal, separation anxiety, difficulty establishing relationships with educators and/ or peers – educators and allied health staff work together to support children to reach their potential. Mainstream children who have enrolled in our service and require assistance to engage in our programs are also included in this joint approach.

Of particular interest to me are the interactions and regressions that occur for children during transition periods, that is, a change of state that may be experienced internally and/or externally.

Examples of transitions include from primary carer to early

childhood care staff, from a play space to the lunch space, and from waking to sleeping. And that within these experiences, children regress and progress in their capacity to manage transitions. This is dependent on how vulnerable or robust they are on a particular day, in a particular moment, and the level of adult support they receive to manage these times/moments/transitions. Because as Winnicott said, "If you set out to describe a baby, you will find you are describing a baby and someone."

Relationships are at the core of successful transitions

Resistance to moving on to the next change may be interpreted by adults in a negative way which does not allow for enough support for children. The amount of energy used by the child to manage in these times influences their capacity to invest in their day. This is why we work with the children to give them permission to have feelings and prepare them for the next transition.

Case study

The children in this case study have experienced trauma in the form of physical and verbal abuse, emotional neglect, and the trauma of being removed.

At this point I would like to acknowledge that we are all familiar with trauma and it is unnecessary to describe it in more detail. The children referred to the Infants Home have usually experienced chronic trauma through neglect, emotional, physical and/or sexual abuse.

This sibling pair, Charlie and his younger sister Lily, were enrolled in July 2013 when they were 2- and 1-year-olds.

In January 2014, Lily was removed from our service by FACS officers. Lily had had signs of a significant physical injury, there had been insufficient explanation by her mother of the injuries and there had been several reports of risk of harm. The NSW Department of Community and Family Services Joint Investigation Response Team was involved in further investigation of the most recent incident. Charlie was removed from his mother's home later that day, taken to a children's hospital where his sister was being examined, and the two older, school-aged sisters were also removed and placed in foster care outside the metropolitan area. Charlie and Lily were in hospital for two days, transferred to a foster home for two months and finally into the care of their maternal grandmother with the two older sisters. In late March 2014 the children were re-enrolled at the Infants Home.

The initial referral to me was to assess Lily's slow progress to walking at 19 months. This was addressed; however, Charlie's struggle to transition into day care became obvious. The babies and toddlers' rooms are essentially one large area, divided by the kitchen and bathroom areas and a fence in the outdoor area. So the separation was not to another separate space, however, for Charlie, it may as well have been. His behaviour was initially interpreted as being protective of Lily, that is, fearful for her, and himself, that she may be removed from the room again. Over time, I noted that it also helped him with managing his anxiety about separating from his grandma. He felt safer in a psychologically smaller environment with more adults and younger children, who were less challenging to him than his peers.

COS road map

In the context of the Circle of Security, during the tape taken in the initial part of the intervention, Charlie uses me as a secure

base from which he explores the space. I supported his needs for exploration by delighting in him just for being him, which is the root of self-esteem; this message is conveyed through my body language, tone of voice and the quality of being present with him; the pleasure of connecting with another human being. Putting words to his experience supported his language development and gave him the sense that he is seen and that someone is with him in his world. In terms of Marte Meo, these are 'follow me' moments where waiting and naming help build connection. Without connection you cannot have development. Both frameworks encourage adults to help just enough so the child can do it for themselves.

One of the early challenging transitions was pick-up time, when grandma had the older sisters with her. The girls, particularly the younger of these two, would immerse themselves in the toddlers' room. When it came time to leave, it would take a long time with much stress to gather up the four children and make their way to the car park. The educators and I worked together to assist in this process.

Charlie's focus teacher, Traci, suggested two staff members accompanying Charlie and Lily to the car for grandma to sign them out there. Not only does this support grandma, it allows us the time and a better atmosphere in which to support Charlie in his resistance to transition.

To gain a better understanding of Charlie's struggle, I asked Belinda, his grandmother and primary carer, about transitions at home. She described the following: "It has been a long process, he is a very sensitive boy; prefers a quiet, predictable life. Prefers quiet because he has been exposed to verbal arguments."

Belinda is aware of Charlie's difficulties transitioning to the car to go home – she believes it is because he does not like the chaos created by his older sisters. He resists transitions at home – going to bed, sitting at the dinner table, getting into the bath – all transitions are resisted at home.

If anything changes in the routine at home Charlie becomes very upset. I asked about what helps him with the upset, and Belinda reported that she asks him what he would like to do. When Charlie is sad or angry, he does what the family call 'the plank', where he straightens his body and slides to the floor. Belinda waits until he's settled and can co-operate. We talked about how the resistance helps Charlie feel in control, to allay the anxiety of the unknown; that when things seem uncontrollable or chaotic, he may know cognitively what is coming next but he does not know the emotional cost involved. Charlie's passive meltdowns are a protective strategy, a collapse because it is unbearable to be misunderstood; however, his silence leads to misreading.

This made me think of how these children's lives are dominated by continuing to need to keep at bay the intolerable emotions of their past experiences of deprivation which reduces their capacity to benefit from ordinary maturational experiences. We all need to be sufficiently present and emotionally available to be receptive to the child's feelings and to 'think' about them. The thinking involves a capacity to bear experiencing the child's feelings and ones' own accompanying feelings, which need to be processed enough to allow the adult to make a response in keeping with what the child has communicated, rather than a reaction directed by the adult's own emotions. Being with deprived

children evokes strong emotions which can help but can also hinder our ability to intervene.

How waiting supports Charlie to transition

What helps Charlie with seamless transitions is providing a structure that allows the transition to happen, a Marte Meo strategy. I used two tapes to highlight what Charlie and I can achieve by waiting. The first tape is unstructured and Charlie leads, the second is structured and I lead. It showed the development of a game of peek-a-boo between Charlie and me.

I am waiting, waiting ... he has an idea and peeks out. I notice and say, "There he is!" And he relaxes into delight. Waiting, naming and my tone of voice helps Charlie to build trust in himself and the joy that I see in him. Waiting also allows for the time required to hand the turn in the game back to him. The rhythm of waiting, naming, confirming and waiting is respectful and a procedure through which Charlie and I relax into delight.

The second tape highlighted the Marte Meo principles of naming and waiting in a leading moment. In this session I had been supporting Charlie in his play with others in the room and came time to pack up my toys in my bag. In this instance, waiting is about telling him how it is; his response is "I don't like this" and at one point he swiped at my face; I acknowledge his feelings, saying, "I know you don't like it."

I give time for him to work with my idea. I could have done more waiting and not mentioned lunch, (which without the benefit of seeing the video is difficult to know) however, when I do wait, he is able to pack up and move through the transition.

More positive leading: in play and for a nappy change

Another example of positive leading is a vignette from late August 2014: Charlie was settled into day care in the toddlers room today, playing at the table with Julie, a teacher. He was very settled with her and didn't need to get into my toys straight away. When he eventually did, he talked with me and at me about distress about another child, playing with the farmer he wanted for the tractor. The little girl swapped with him for a different farmer figure, then after 2-3 minutes Charlie wanted both. I said he could have both when his friend had finished. He accepted this boundary. This was a new change in his capacity to be with another.

Nappy changing has been a transition that he has struggled with at home, and with us. This transition is not always considered as a possibly uncomfortable or vulnerable time for children. For children like Charlie, it may be a disintegrating experience – the loss of the nappy and its contents; the loss, even momentarily of the physical and emotional holding a nappy provides.

Charlie had refused a nappy change by one of the teachers. I observed that she asked questions rather than made a statement for this leading moment. He was allowed further time to play. I said that when the orange hand on my watch gets to the 4, I will take you for your nappy change. The tractor and the farmer can come. When it was time I said, "Ok, orange hand is at the 4. The tractor is coming with us!" and I picked it up. "Where are your nappies? In your bag?" Charlie said "yes", I said "Ok, let's go and get your nappy from your bag." With positive leading, Charlie was an active participant, rather than a passive one. When the nappy change was finished, he left me to go and play with the others. This is a good example of a Marte Meo leading moment, and a COS filling his cup moment, where he was then able to go out on the top of the Circle to play with his friends.

In December 2104 Charlie had begun to invite other children to play with him, initiating specific play ideas with them in an open, warm way, with a sense of fun not seen since their return in March. Charlie had experienced other children as unpredictable; his level of anxiety was too high to tolerate them entering his play or sharing time with me. As his safe base became more internalised (through stable relationships with staff and at home) Charlie was able to move out on the top of the circle for longer, as well as progressing in development of his play and social skills.

In January 2015, Charlie made the transition to the preschool room with his friends. He has continued to develop his play and social skills, taking up the new routines and developing secure relationships with 'new' staff. There have been times when transitions have been overwhelming. These are often associated with stressors at home or at day care, and the internal struggles he experiences.

The final video was a narration of the apple farmer whose tractor is broken by a stick that had flown up and then down from the sky. Charlie talked of the farmer being angry, a new expression of affect. The farmer fixes the tractor because he likes fixing things, said in relaxed tones with a peaceful happy face and an air of hopefulness.

Sources

The Circle of Security Intervention by Powell, Cooper, Hoffman and Marvin, 2014

Marte Meo Basic Manual by Maria Aarts, 2000

Becoming Attached by Robert Karen, 1998



Supervision Group for Victorian AAIMH members

During the autumn term, a small number of clinicians decided to join the first Victorian Supervision Group, under the auspices of AAIMH.

The group met for six sessions over the space of three months. Based on the decision that the group wished to reconvene for a further six sessions at the end of the year, it could be viewed as a success. It was purely coincidental the composition of the group was similar to a multi-disciplinary team. We were a group with a social worker, psychologist and a perinatal psychiatrist. As there were three group members and six group supervision sessions, each clinician was able to have two sessions each to present their work. Some clinicians chose to represent the same case for a second time, others they brought an entirely new case for consideration.

Cases presented and the issues they raised reflected the range of complex work that infant-parent clinicians undertake. Being able to think about difficulties in prospective parents with an as yet unborn baby, or new mothers or fathers that present to all our work contexts means we are always trying to think both at an individual level, and the dyadic and triadic.

The supervision sessions focused on women with mental illnesses, children whose symptoms may reflect their own parents' conflicts and clients who are too young to talk, but show through play and interactions and symptoms what is going on at home. We talked about the art of engaging clients who have ambivalent attachments. This raises the enormously central quest of how to think about the ambivalence that will inevitably appear in the therapeutic relationship. How to assess for possible violence within the parental system is also crucial, and not surprising even in our small number of cases in six weeks we were left wondering how to help the clinician to think about this problem underpinning the presenting problem, in a way that she could take it in, and use it clinically with the parents directly.

We discussed whether it was always necessary to always try and meet the partner or child's father in all new referrals. This was openly debated amongst us case by case. So few cases present with all the pieces together. When arranging the first appointment we concluded it is incumbent on us to know who we might be excluding and why. If the exclusion is of our own

making, it is important we know and examine this fully. We know that clinicians practice differently, and this depends on a number of factors (not just an evidence base!). It can depend on where and how they were trained, and whether they are in an agency that supports its clinicians with good supervision. We were all impressed that if we were to identify one common theme in the cases presentations it would have been that, regardless of where a group member worked, or what the presenting problem was, it was the couple relationship that seemed to be in great disarray. This raised the question of how do clinicians assess the couple relationship and what priority is given to any identified difficulties during the assessment phase of clinical work?

Another clinical theme in the discussion was the place of 'process notes' in supervision. In this context 'process notes' are verbatim transcripts taken after a session, for the specific purpose of them being used for supervision. Some of the members had been trained in process notes during their undergraduate years, others had not.

As the supervision sessions continued, some of the members experienced with bringing in their own notes for us to use in their supervision. It is surprising what a group might find important, that a clinician might have not seen or realized as important.

Perhaps AAIMH Victorian Branch or National meetings could offer a symposium on supervision? In particular with a focus on the use of 'process notes'? This method of supervision has much to offer the infant-parent clinician. Those people who have done a formal Infant Observation might be familiar with the undertaking. Those who are more psycho-analytically trained might be very familiar regularly presenting their work to their supervisor in this form. However I think we might raise the question: are process notes a lost art? Or an art never found? We know, even if very time consuming, they are a model of case discussion which offers much richness.

Supervisor: **Sarah Jones**

Supervisees: Tamera Clancy and Fiona McGlade.

(A third supervisee member was uncontactable for consent to be included in this report.)

Discussion of parents with personality dysfunction and disorder

Wendy-Anne Tyghe, Educational Psychologist, New Zealand

Year 2 Student of the Perinatal and Infant Mental Health Program, NSWIOP

I'm selfish, impatient and a little insecure. I make mistakes, I'm out of control and at times hard to handle. But if you can't handle me at my worst, then you sure as hell don't deserve me at my best.

Marilyn Monroe

Introduction

I have chosen this topic because of an interest in attachment theory, psychoanalytic theory, and the mechanisms these theories use to describe and explain assessment, formulation, and intervention of a vulnerable population. The essay will discuss diagnosis of personality disorder; borderline personality disorder – a severe form of personality disorder; personality development; parents with borderline personality

disorder; and assessment, formulation and intervention for parents with borderline personality disorder.

Diagnosis

Personality disorder manifests as an enduring pattern of thought, affect, and behaviour, which leads to distress and impairment of functioning and is not due to substance abuse, or a medical condition. Grouped into three clusters, ten types are described in the DSM-5 (APA, 2013).

Borderline personality disorder more specifically includes instability in relationships, self-image, identity, behaviour and affects, and often leads to self-harm and impulsivity. Aspects that affect parenting are fluctuation between idealization and

Cont. page 10

devaluing of the other, difficulty with reflective functioning, and poor tolerance of negative affect. Research shows that mothers with borderline personality feel alienated, worried, overcome, and may experience anger towards their infant from birth. Their responses to their infant's needs vary, and reflecting on her infant is difficult (Newman & Stevenson, 2005; Newman, Stevenson, Bergman & Boyce, 2007). Within the mother, disturbed experience is managed by projective identification. Parts of her experience are projected and experienced as belonging to others, making the external world feel both persecutory and controlling (Fonagy, Target, Gergely, Allen, & Bateman, 2003). Mothers with a borderline personality disorder experience a fundamental difficulty in close relationships, particularly with balancing closeness and distance, resulting in oscillation between idealizing and denigrating others (Newman, Stevenson, Bergman & Boyce, 2007). There is a constant struggle to relate in the moment without intense, fluctuating hostility. An incoherent sense of identity is managed by a pretend mode, or an 'as if' mode, a primitive form of functioning that replaces reflective functioning (Stepp, Whalen, Pilkonis, Hipwell & Levine 2012; Fonagy, et al, 2003). Without reflective functioning, experience is not symbolically represented with ideas or labelled feelings. This makes experience and the sense of oneself confusing, and also confounds interpersonal interaction. Furthermore experience, which is difficult to regulate and cope with, becomes maladaptive, and can result in physical acts of violence against the person's own body or the body of another. Trauma is a substantial part of development of borderline personality disorder. Most typical of traumatization is unintegrated functioning, where the person oscillates between relatively normal functioning and extreme, primitive modes. A primitive mode of psychic equivalence happens when – just because a person thinks something, it is perceived by the person as automatically true – and the person acts on this perception. A pretend mode lacks correspondence between internal states and external reality. For example, when a woman believes that a man is infatuated with her and there is no evidence of this. Pretend mode is a mechanism to dissociate from reality (Fonagy, et al, 2003).

Personality development

Infant attachment behaviours such as smiling, crying and locomotion, establish and maintain proximity to a caregiver. Contingent sensitive caregiving responses establish a relationship that enables the infant to organise expectations that cohere, in a pattern that represents the relationship and 'what to expect' (the intentional states of others). Development of a representational system establishes psychological understanding (attributing causal motivation, intentions and beliefs) that differentiates the self from other. The relationship develops a reflective capacity for making sense of each other on the basis of an intentional stance (Fonagy, et al., 2003; Dennett, 1987). The infant internalises the mother's empathic expression (a mirror of the infant's experience – the same and not the same), as a secondary representation of his own emotional state. Awareness through representation (an image) of his affect state enables the infant to develop reflective capacity and to control affect states (Fonagy, et al., 2003). Reflective capacity requires a level of arousal to support prefrontal lobe activity in the development of cerebral structures that directly shape maturation of the infant's right-brain stress-coping system (Schore, 2001). Visual information to recognise individuals and expressive cues,

are processed in the temporal lobe, and related emotional significance in the amygdala. Extreme stress can permanently impair prefrontal lobe control to posterior lobe control, undermining reflective capacity and therefore self-regulation (Friedemann & Adshead, 2003). Failure of contingent responses from an attachment figure prevents the arousal necessary for development of cortical structures needed to regulate affect and also essential to development of symbolic representation and reflective function (Shore, 2001).

Personality dysfunction

Personality dysfunction develops when there is a failure of sensitive congruent and contingent responsiveness from the caregiver toward the infant. Failure of mirroring leads to deficient self-perception and control of affect. When mirroring is not congruent, infant experience is attributed to the parent. The infant's negative affect and attributed affect to the parent, escalates the baby's negative state, leading to traumatization rather than containment. Primitive modes of functioning – projective identification, psychic equivalence and pretend mode – are used to manage the negative affect. The resulting deficient affect regulation is associated with violent acts (Friedemann & Adshead, 2003; Fonagy, et al., 2003).

Parents with borderline personality disorder

Research with Borderline Personality Disordered parents has illustrated the vulnerable situation of this group when confronted with the care of an infant. Parents report feelings of dissatisfaction, incompetence and distress. Most show fear of their infant from which they withdraw (Newman, Stevenson, Bergman & Boyce, 2007). Unresolved trauma functions to directly undermine these parents' relationships with their infants. Irrational difficulty in accurately identifying, and relating to the emotional world of the infant, undermines realistic thinking about the infant (Fonagy & Target, 1997). Mothers with borderline personality have been found to be less sensitive and showed less structure in their interaction with infants. (Newman, et al., 2007). Frequently, reliable responses to their infant's requirements occur in the context of a struggle to accurately interpret affect. Research shows toddlers of these parents have shown difficulty in learning to use affect state words (Friedemann & Adshead, 2003). When infants' affects are not validated, it has been shown to correlate with neglect and abuse (Stepp, et al., 2012). Early maltreatment has been linked with disorganised attachment. Research further shows that re-experiencing trauma, and alterations in cerebral functioning, has also been linked with impaired reflective capacity in the infant (Friedemann & Adshead, 2003). Failure to gain the provision of reliable mirroring of internal states, leads to a desperation for meaning, as the self looks to find itself through the emotional responses of a consistent other. The holding function of attuned attachment is compromised, and parts of the self remain unprocessed and with a lack coherence (Fonagy, et al., 2003). Winnicott (1967) showed that without a mirrored accessible form of the infant's own experience, the infant will internalise the parent's state, which will feel foreign, as misrepresented ideas and feelings (Newman, et al., 2007).

Research with mothers with borderline personality has shown that their infants withdraw from social interaction, and develop avoidant patterns of attachment (Newman et al., 2007). Their later development revealed poor emotional regulation, increased likelihood to talk about fantasies, and stories of a traumatic nature with relationships characterised

by danger and/or unpredictability, role reversal, greater fears of abandonment, and shameful self-representations (Macfie & Swann, 2009). An incongruent sense of self has implications for a stable identity, and a fear of abandonment complicates stable and meaningful interactions. Disturbances in identity formation have been associated with self-injurious behaviour and dissociative symptoms. Difficulties with emotion regulation are associated with later internalising and externalising disorders in childhood (Stepp, et al., 2012; Friedemann & Adshead, 2003).

Assessment

Assessments of parents with personality disorder focus mainly on parenting capacity. Relevant factors for consideration are interviews from different sources to provide information that includes: a parent attachment history, mental status examination, history of violence, stability of relationships, economic stability, substance abuse and propensity for anxiety or depression. Gender plays a role in the assessment. An absent father, but who still provides for the family, will have a positive influence. If the mother has support from her parents, this will also be a protective factor. In addition, a capable father may balance the vulnerabilities of the mother (Reder, Duncan & Lucey, 2003).

While attachment status alone will not determine acceptable parenting capacity (avoidant and insecure attachment patterns are common), attachment patterns can indicate the quality of the neglected child's experience that may be 'cut off' by the parent – a form of dissociation. Mothers with borderline personality have been found to be the least sensitive in their interaction with their infants (Newman, et al., 2007). A parent who appears good enough, but who has a history of psychotic episodes, or impulsive sexual or violent actions, can be difficult to assess, however over-compliance and/or anxiety may indicate disturbance. Using a psychodynamic assessment, the structure of the self, defensive organisation and capacity for reality testing, can be useful dynamics (Reder, et al., 2003). As mothers with borderline personality have both interactional and emotional difficulties with their newborn infant, assessment of the infant's mental state can also provide information about the stability of the parent-infant relationship and the likelihood of avoidant patterns of interpersonal relating (Stepp, et al., 2012; Newman, et al., 2007). Children can show anger and anxiety towards caretakers and may become fearful, depressed and withdrawn, particularly if the parent is frightening and aggressive. They can show increased impulsivity and an inability to name and modulate affect. These infants can show a lack of an organised strategy (disorganised attachment) for relating to their caretaker, and the neurophysiological effects may suggest high risk associated with parenting (Newman & Stevenson, 2005; Perry, Pollard, Blakely & Vigilante, 1995; Schore, 2001).

Formulation

Formulation weighs up the strengths and vulnerabilities of the parent with a risk assessment. Risk assessment of infants requires information about abusive relationships, parental partners, community networks, and the child's characteristics. A diagnosis of personality disorder does not necessarily preclude 'good enough' parenting capacity, and taking children into care may have worse consequences for the child than the relative failure of parenting. Psychological neglect is also likely to be associated with increasing financial and social pressures on modern Western families where the amount of

time spent with children, by single parents and dual income families, is low (Fonagy, et al., 2003). Warmth and acceptance in parenting have been shown to be protective factors against negative parental attitudes, shown to be associated with genetic and physiological vulnerability. Certain genetic and physiological factors have also been shown to be protective factors in the face of abuse, neglect and conflict. Invalidation of children's emotions has been associated with social and emotional difficulties (Stepp, et al., 2012; Friedemann & Adshead, 2003). The possibility for change needs to be considered. In a therapeutic relationship it has been shown that change can occur with regard to traits such as impulsivity, suspiciousness and dysphoria. Cognitive behaviour therapy can assist anger management, and psychodynamic psychotherapy may reduce symptomatology of borderline and narcissistic disorders. If a therapeutic alliance is established and the countertransference of clients' projections is well managed, there is a likelihood of continued and meaningful engagement in treatment. Children may then be able to return to parental care, under supervision, while their parent continues therapy. Reducing risk can also be achieved with practical adjustments to the context of the relationship by using increased support (Reder, et al., 2003a).

Intervention

Intervention needs to promote maternal sensitivity and maternal perceptions of competence (Newman, et al., (2007). Attachment therapies are recommended during infancy and pre-school together with psycho-education. Individual psychotherapy with the mother can modify her attachment experience through interactions and experiences with the therapist (Stepp, et al., 2012). Links can be made that provide insight into the perpetuation of the mother's attachment experience. In parent-infant psychotherapy the therapist observes the interactions between the mother and the child to facilitate links with past experience and the mother's attachment style with her infant. Examples of parent-infant therapy are: Watch Wait and Wonder (Muir, Lojkasek & Cohen, 1999); Preschooler-Parent Psychotherapy (P-PP) also referred to as infant-parent psychotherapy, and toddler-parent psychotherapy (Cicchetti, Rogosh & Toth, 2000); and Circle of Security (COS: Marvin, Cooper, Hoffman & Powell, 2002). Research suggests that P-PP be used for depressed mothers and maltreated children, and that COS is beneficial for disadvantaged parent-toddler or parent-preschool dyads. Recommendations are that psycho-education and parent skills training, prior to parent-infant attachment strategies, benefit outcomes (Stepp, et al., 2012).

Psycho-education programmes include: Family Connections (FC; Fruzzetti & Hoffman, 2004), Systems Training for Emotional Predictability and Problem-Solving (STEPPS: Blum Pfohl, St John, Monahan, & Black, 2002). Multigroup Family Skills Training as part of Dialectical Behaviour Therapy for adolescents (Miller, Rathus & Linehan, 2006). Research supports Family Connections to alleviate caregiver stress, and STEPPS and multifamily skills training to improve patient outcomes. Psycho-educational approaches promote: education in developmental milestones; scheduling and providing consistent feeding and sleep-wake times; predictable transition times, e.g. play to sleep, and routines. Predictable family routines have shown fewer depressive symptoms, alcohol use, and marijuana use in adolescents. Parental monitoring of children reduces childhood injuries, substance

use, and delinquent behaviours; increases limit setting; and warmth and nurturance. Mindfulness based parenting skills training resulted in a significant reduction in internalizing and externalizing symptoms (Stepp, et al., 2012).

Conclusion

This paper has outlined the risks for infants' development in the context of caregivers with borderline personality disorder. Risk included an understanding of intergenerational transmission of disorganised attachment and the formidable

References

Blum N, Pfohl B, St John D, Monahan P, Black DW (2002). STEPPS: A cognitive –behavioural systems-based group treatment for outpatients with borderline personality disorder: A preliminary report. *Comprehensive Psychiatry* 43, 301-310.

Cicchetti D, Rogosch FA, Toth SL (2000). The efficacy of toddler-parent psychotherapy for fostering cognitive development in offspring of depressed mothers. *Journal of Abnormal Child Psychology* 28, 135-148.

Dennet D (1987). *The Intentional Stance*. Cambridge, MA: MIT Press.

Fonagy P, Target M, Gergely G, Allen JG, Bateman AW (2003). The developmental roots of borderline personality disorder in early attachment relationships: A theory and some evidence. *Psychoanalytic Inquiry: A Topical Journal for Mental Health Professionals* 23:3, 412-429.

Friedemann P, Adshead G (2003). *A Matter of Security: The Application of Attachment Theory to Forensic Psychiatry and Psychotherapy*. Kingsley: U.K.

Fruzetti AE, Hoffman PD (2004). *Family Connections workbook and training manual*. Rye, NY: National Education Alliance for Borderline Personality Disorder.

Macfie J, Swann SA (2009). Representation of the caregiver-child relationship and of the self, and emotion regulation in the narratives of young children whose mothers have borderline personality disorder. *Development and Psychopathology* 21, 933-10.

Marvin R, Cooper G, Hoffman, Powell B (2002). The circle of security project: Attachment-based intervention with caregiver-pre-school child dyads. *Attachment & Human Development* 4, 107-127.

challenges faced by parents with personality disorder, and in particular borderline personality disorder when confronted with parenting an infant. A discussion of assessment, formulation, and intervention followed, for managing the risks involved.

You are beautiful because you let yourself feel, and that is a brave thing indeed.

Shinji Moon

Miller AL, Rathus JH, Linehan MM (2006). *Dialectical behavior therapy for suicidal adolescents*. NY: Guilford Press.

Muir E, Lojkasek M, Cohen NJ (1999). *Watch Wait and Wonder: A manual describing an infant-led approach to problems in infancy and early childhood*. Toronto, Ont: Hincks-Dellcrest Institute.

Newman L, Stevenson C (2005). Parenting and borderline personality disorder: Ghosts in the nursery. *Clinical Child Psychology and Psychiatry* 10:3, 385-394.

Newman LK, Stevenson C, Bergman LR, Boyce P (2007). Borderline personality disorder, mother-infant interaction and parenting perceptions: preliminary findings. *Australian and New Zealand Journal of Psychiatry* 41:7, 598-605.

Perry B, Pollard R, Blakely T, Vigilante D (1995). Childhood trauma, the neurobiology of adaptation, and 'use-dependent' development of the brain: How 'states' become 'traits'. *Infant Mental Health Journal* 16:4, 271-291.

Reder P, Duncan S, Lucey C (2003a). *Studies in the Assessment of Parenting*. New York: Brunner Rutledge.

Schore AN (2001). Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal* 22, 7-66.

Stepp SD, Whalen DJ, Pilkonis PA, Hipwell AE, Levine MD (2012). Personality Disorders: Theory Research, and Treatment 3:1, 76-91.

A 10-year mental health strategy for infants and very young children

The following was a response to the call for public submissions in advance of the preparation of the Victorian state government's 10-year strategy

Who we are

We are a group of psychiatrists working in the field of infant mental health (IMH) at seven Child and Adolescent Mental Health Services (CAMHS) in metropolitan and rural Victoria, and perinatal mental health at the Royal Women's Hospital. We have come together to provide comments informed by our clinical and research experience. We offer some important additions to the background documents for the 10 year plan, plus some over-arching and specific recommendations for additional resources and service development, building on the strong networks that exist in Victoria. We would welcome ongoing involvement in the development of mental health services for young families in Victoria. We have considered the

discussion paper and technical papers carefully and chosen to respond to the many important questions posed in those documents in the following paper.

Infant Mental Health

The Perinatal Mental Health and Infant Mental Health deal with the emotional, relationship and physical needs of babies and young children from conception to approximately age three. As neonatal medicine is a sub-speciality of paediatrics, so IMH is a complex extension of child and adolescent psychiatry. With its roots in developmental paediatrics and psychoanalysis there has been a significant expansion of

work in this area over the past 20 years, and it is now a well-recognised area of professional expertise. Melbourne is in fact a world centre for clinical work and research in infant mental health and psychotherapy with young children and families, second only to London in prominence and contribution (Paul & Thomson Salo, 2014). IMH is a way of working that explicitly considers the infant as a person in their own right, and recognises the existential importance of their early life experiences within the family as the foundation for all future development: physical, intellectual, emotional, social and spiritual. Infants' suffering and well-being needs society's deliberate focus and attention, as they are our society's most vulnerable members and are not able to speak for themselves in a manner that adults readily understand. Furthermore perinatal and infant mental care is intervention at the earliest possible stage - preventive in many cases – and so, on an ethical, clinical and financial basis is a strong investment.

Epidemiology

Although not included in the National Mental Health Survey, there is a well-established evidence base that demonstrates suffering and frank mental disorders are prevalent and serious in children under four years of age. Major community epidemiological studies have demonstrated the prevalence of diagnosable mental health disorders in children under four years of age to be in order of 20 per cent (Newman, Mares & Warren, 2011). The work of Briggs, Gowan and Carter (2008) demonstrates that those infants identified as having social, emotional, developmental and behavioural problems in the age period 12-36 months also had significant problems in early and later childhood³. Early trauma and relationship disturbance has been demonstrated to have a negative impact on brain development and is linked to the entire range of mental disorders, relationship and occupational functioning throughout life.

Age-Inequity of Access

Despite increasing public and professional awareness of the needs of infants and young families, specialised mental health services are sparse and inconsistent across the state. Although CAMHS are mandated to provide assessment and care for children from birth onwards, very few resources are actually made available for infants and pre-schoolers, with resources primarily taken up with crisis work and adolescents. Some catchments in the state are provided with very good IMH services, while some areas do not even accept referrals for children under four years.

While the paediatric needs of children in Victoria are well met, the same cannot be said for their mental and emotional problems. It is perhaps no surprise that in a group who can least speak for themselves, their less visible needs most readily overlooked. It is estimated that fewer than 1 in 10 babies and toddlers receive the specialist assessment and psychotherapeutic intervention they require. Such a gap in provision is not tolerated in other areas of paediatric medicine, indeed, no expense is spared for many physical conditions. Until a child's language has developed sufficiently, much of the emotional suffering and disturbance in a child's family will present in an infant through the body, as psychosomatic in nature. Persistent sleep or feeding problems, growth delay (often life-threatening), impaired development in speech or other domains are examples of this.

Existing services

Despite the shortfalls, Victoria has a high level of expertise across disciplines that could be readily expanded to provide universal care to aid the emotional and relationship needs of infants and young children. At our respective services, we are the clinical leaders for early intervention through to high acuity care. Our work has involved forging close relationships with our colleagues across disciplines from primary care to specialist settings. For instance our liaison with maternity and maternal child health services, child protection and family services, child-care and paediatrics across metropolitan and some regional areas are a key structural mechanism through which our teams make a valuable contribution to the developmental outcomes for infants and young children.

The work of our teams is a blend of direct short and long term psychotherapy with families plus formal training, consultation and clinical supervision of the work of other clinicians and agencies who continue with the families in these varied settings of care. However, the resources presently allocated, particularly relative to the mental health care of other age groups, seriously limits our current contributions and any expansion of the clinical impact we can provide. For instance, at one regional CAMHS services with approximately 20 EFT, only 1.5 EFT is formally allocated for work with under-fours despite them constituting a quarter of the current case load.

Some principles of an ideal system

Victorian families deserve a system which provides universal access to clinicians experienced in psychotherapeutically informed work with infants and young families, direct intervention where necessary, and expert secondary consultation. In many cases the work is highly specialised and just as with cardiac surgery there is need for an adequate number of experienced senior consultants to undertake the technical tasks, and support and train other clinicians within a team.

As such, an ideal system would have a sufficient number of psychiatrists, psychotherapists and clinicians from across disciplines able then to deliver targeted, cross-disciplinary services in settings where families are already attending for care. The consultation-liaison model of psychiatry may provide a blue print that facilitates and enriches the therapeutic work to the families, supporting the clinicians who remain involved after our work is done.

Strategic planning required

It is helpful to consider several key groups of infants and young children known to be at present high risk, suffering most acutely, and who present the most complex challenges for treatment:

1) Children in the children protection, Child First systems and in out of home care

Young children in this very large group are by definition of enormous concern and yet the sophisticated treatment and family interventions they need are often not sought or are not available. Take Two is a very small therapeutic service within DHS and Infant and Perinatal psychiatrists should have a more direct role in the governance and decision-making within child protection. Mechanisms for compelling parents to engage with an IMH therapist should be explored.

In some regions of the state, IMH services are available to provide regular primary and secondary consultation to DHS and Child First agencies. Services should be expanded to all regions, plus there is capacity in the private sector to help stabilise and treat children brought into out of home care, instead of the usual pattern of referral to CAMHS occurring only when these placements are about to fail due to severe behavioural disturbance and aggression. KPIs requiring DHS and Child First agencies to take up the services offered by IMH should also be considered.

2) Children of parents with a mental illness, personality disorder or substance use.

While the symptom management of adults with serious mental illness is generally adequate, their role as parents caring for their young children usually needs the input of specialist clinicians to support them in this role.

Some regions have an IMH service that provides primary and secondary consultation to adult mental health services but this is not universal. KPIs requiring inquiry about the dependent of adult patients, and consultation with IMH services should be considered.

3) Children exposed to trauma, particularly family violence and ongoing conflictual parent relationships.

The royal commission has begun to document what we have known for some time, that conception and early childhood is the most vulnerable time for women and children living in a family where this is a history of violence. Infant mental health work has a key role in assisting women to make the difficult choices necessary to make them and their children safer, and also to help mitigate or repair the trauma that they and their children have suffered. Where no help is available, infants are at risk of assault and homicide from their mothers and fathers – conversely, IMH intervention can meaningfully reduce this risk through speaking for the baby who can't, and helping women scale the psychological cliffs they must in leaving violent partners.

Some regions have IMH services available to women and children in refuges and other family violence related centres though these are not universal and are grossly underfunded. Victoria has some world leaders in the field of IMH and family violence whose work should be supported and expanded (Bunston, accessed 2015).

4) Infants and young children in the paediatric settings, with chronic illness and disability

A large group of children includes premature babies and those born with or acquiring serious illness and disability in the first years of life. They are prone to much higher rates of major emotional disturbance and frank mental illness and their health outcomes are significantly improved, indeed, lives are saved through assertive IMH input in partnership with paediatricians. Specialists in infant mental health also have a key role in treatment choices, quality of life, pain management, ethical dilemmas and palliative care of babies and toddlers in the hospital and outpatient settings.

IMH services at the Royal Children's Hospital have developed well over 25 years, despite the closure of the psychotherapy department at RCH 10 years ago. Services there can serve as a model for other paediatric settings, especially including the large scattered network of public and private outpatient

paediatrics. Consideration should be given for re-opening the psychotherapy department perhaps under the auspices of the new Centre of Excellence in Infant, Child and Adolescent Mental Health.

Regarding disability and early intervention the signs are there is an enormous silo being built with the expansion of NDIS, indeed the pilot program in Geelong demonstrates NDIS and IMH are routinely dealing with precisely the same families in a poorly integrated, clinically unhelpful and fiscally wasteful manner; the barriers have not been erected by mental health services. Mandated collaboration beginning at the senior management level with IMH services would be of great assistance to Victorian families, their young children and the tax payer.

5) Indigenous and refugee communities

Indigenous families are significantly under-represented at IMH services compared to the level of disturbance that exists suggesting issues of access are one of many barriers to best care. We also advocate in the strongest terms to be permitted/funded for provision of care to infants from refugee families on the same basis as urgent medical care and basic safety are provided; a strong, flexible emotional environment is as essential to a baby's growth and survival as milk and shelter.

Implementing these changes – 4 pillars to implementation

1) We strongly support the re-introduction of one or more senior positions in the Department of Health with the specific portfolio for developing infant mental health services, and as a group we will happily be available for consultation and support. The systems of care pertaining to this patient group are complex and run across several government departments, so a whole-of-government approach would be useful to ensure that families receive integrated and thoughtful planning from the top down. Perhaps there could be a ministerial task force established as there was three years ago to address eating disorders, also a complex multidimensional field. Our own efforts to integrate services proceeds in spite of the institutional barriers; it is part of the pathology of the system that we are familiar with and work with.

2) The three fellowship training positions in infant mental health for child psychiatrists have been extremely valuable in expanding specialist expertise in the field. The funding for these is under threat. We strongly advocate for the continuation of these positions.

3) The Perinatal Emotional Health Program [PEHP] is part of Victoria's response to the NPDI and has been highly successful. PEHP offers an efficient example of early intervention and specialist perinatal and infant mental health services being provided directly to the poorest and most marginalised families in rural areas directly, and through training, support and up-skilling of other clinicians such as MCHNs. Following recent federal funding cuts, some of these services have already been closed in several areas of the state and the remainder are in jeopardy. However, the PEHP is a lean, efficient, low costs program and has a great deal of intellectual capital and expertise that must be retained for the continuation of services to Victorian families.

4) More securely funded positions would allow the work to be expanded to the areas of the state that current have little or no access to specialist IMH services - these are most rural centres and large parts of metropolitan Melbourne. An 0.2 FTE

psychiatrist position and 1.0 therapist from another discipline would be sufficient to commence service which could be expanded based on demand. Current IMH services provide

State and federal resources have been targeted toward youth mental health for a range of reasons. Although this work is undoubtedly important, studies have shown that many of the challenges that services are faced with in attempting to engage and intervene with adolescents have their antecedents in early life. Effective primary consultations in maternal and child health clinics and community based mental health services, home visits with other services that are already engaged with the family and case conferences to multiple services with family members present. IMH service also conduct regular supervision and consultations as required to multiple service providers typically regarding high risk families with multiple and complex need including undertreated mental illness, substance abuse, family violence and social isolation. We also undertake parent child psychotherapy over several years as needed until the child turns four.

Intervention in the early years is a cost effective way of preventing some of these (Heckman, 2010). Additional resources would be welcomed; in the mean reallocation should be considered of resources from other areas of mental health, and also from the community services sector that would assist in developing mental health work with families with infants and young children in a more clinically effective manner.

Conclusion

We hope this overview has provided some useful understanding on the field of infant mental health, its importance to Victorian families and the needs and opportunities that exist within the system. Some changes require more resources; all changes require a shift in focus and priorities by clinicians and policy-makers alike. As senior psychiatrists with clinical experience across Victoria – urban and rural – we respectfully suggest we are well placed, and certainly interested in being consulted on future service reform and development. Our routine work in complex cases requires us to be mindful of many competing interests, resource demands, ethical dilemmas and differing political realities. These skills have been developed over many decades and we would be happy to discuss with and guide the department or others on service redesigns across, health, welfare, the courts, child protection, early education, disability and mental health.

Thank you for the opportunity to contribute and we look forward to further discussion with you.

Dr Ben Goodfellow – Infant and Child Psychiatrist Geelong CAMHS and PEHP Bendigo Health, Senior Lecturer Deakin University; Board Member Alfred Health

Prof Louise Newman – Infant Psychiatrist and Clinical Director, Centre for Women’s Mental Health The Royal Women’s Hospital and University of Melbourne

A Prof Campbell Paul – Infant Psychiatrist, Royal Children’s Hospital and Melbourne University

Dr Paul Robertson – Infant and Child Psychiatrist, Box Hill CAMHS and Director of Child and Adolescent Psychiatry Training Victoria, Melbourne University

Dr Karen Gaunson – Infant Psychiatrist Alfred Child and Youth Mental Health Service

Dr Tram Nguyen – Senior Psychiatrist, Centre for Women’s Mental Health, The Royal Women’s Hospital and University of Melbourne

Dr Vibhay Raykar – Clinical Director, Child and Youth Psychiatrist, Goulburn Valley CYMHS, Honorary Fellow University of Melbourne

Dr Julie Stone – Consultant Infant, Child and Adolescent Psychiatrist to CAMHS and PEHP, LaTrobe Valley

References

- Angold A, Egger HL (2007). Preschool psychopathology: Lessons for the lifespan. *Journal of Child Psychology and Psychiatry and Allied Disciplines* 48:10, 961-966.
- Briggs-Gowan MJ, Carter AS (2008). Social-emotional screening status in early childhood predicts elementary school outcomes. *Pediatrics* 121:5, 957-962.
- Bunston W. Refuge for Babies In Crisis – Royal Children’s Hospital Website <http://dvrcv.sites.go1.com.au/sites/thelookout.sites.go1.com.au/files/Refuge%20for%20Babies%20Manual%20FinalWEB.pdf>
- Heckman J (2010). The case for investing in disadvantaged young children – detail reference pending
- Jordan B, Sketchley R (2009). A Stitch in Time Saves Nine. Australian Institute of Family Studies.
- Newman L, Mares S, Warren B (2011). *Clinical Skills in Infant Mental Health* 2nd Ed. Australia: Acer
- Paul C, Thompson Salo F (2014). *The Baby as Subject*. Karnac.
- Heckman, J. “The Case for Investing in Disadvantaged Young Children” 2010 – detail reference pending

The Dark Side of the Womb; Pregnancy, Parenting and Persecutory anxieties

Author: Joan Raphael-Leff,

Grosvenor Group Ltd London

First published by the Anna Freud Centre, London, 2015

Book review by **Sarah J Jones**

Joan Raphael-Leff, well-known psychoanalyst in the field of motherhood, wrote over twenty years ago "Pregnancy is a blending of three intertwining systems – biological, psychological and social" (Pregnancy – the inside story, 1993). Her new book, "Dark Side of the Womb" again reflects the author's multidimensional perspectives. As a guest of AAIMH in 1996, Raphael-Leff spoke to a full audience at the Royal Women's Hospital on her views about the need for both clinicians and services to aim for greater integration.

Raphael-Leff's latest book re-introduces and summarises the notion of Maternal Orientations. It is worth either reminding of, or introducing AAIMH readers to, her concept of 'Maternal Orientations'.

In essence she proposes three modes of mothering styles.

- 'The Facilitator mother' (a mother who adapts to her baby)
- 'The Regulator mother' (a mother who expects her baby to adapt)
- 'The Reciprocator other' (a mother who negotiates).

Those familiar with Attachment Theory will know these ways of relating can also be given attachment theory nomenclature.

Explored further in this book is the vast terrain of motherhood and the infants that mothers and fathers produce or try to produce. The author interweaves these ideas with a rich infusion of literature from the biological, psychological and social. Chapter titles reflect Raphael-Leff's whimsical style, for example Chapter 3 Fruit of the Womb; In & Out, With, Without explores the transition to maternity; how a pregnant woman becomes a mother is considered through the voices of her own patients, juxtaposing them with information of infant researchers including Colwyn Trevarthen and Ed Tronic. Whilst Raphael-Leff summarises a lot of research, her dominant theme here is "how each woman tolerates the conjoint experience of pregnancy depends on her state of mind and current resilience – her 'psychic immune system'".

Chapter 5, titled 'A Meeting of Minds; Communication, Mirroring and Mentalisation' tackles some of the research about mirror neurons, that fire in the baby's brain in imitative identification, indicating that such mirroring is mediated by memory and its replication is intentional. She concludes with the importance of the father's place.

Chapter 13, titled 'Woman: the Dark Continent – Female Bodies in Social Space' delves into honour killings, female genital mutilation, underage sexual exploitation.

The unusual layout and size of this book tells us this is not a text book, nor magazine; the cover is of silhouette of a woman in the late stages of pregnancy, her body eclipses the moon, or is it mother earth? Readers can decide for themselves. This book is not an academic book, although relevant pioneers and contemporary researchers are quoted throughout. It is book full of ideas, stories and an eclectic mixture of the author's extensive and possibly unparalleled experience. The text is full of quotes from classical authors such as Dickens and Shakespeare and yet also from contemporary musicians, such as Pink Floyd whose song she borrows for the title of this book, and Bob Dylan. In line with her triadic view of the biological, psychological and social all are considered. To contextualise the social influences on the experience of motherhood, the social theorist and pioneer feminist, Gloria Steinem is quoted; "Wonder Woman symbolises many of the values of the women's culture that feminists are now trying to introduce into the mainstream; strength and self-reliance for woman, sisterhood and mutual support among women, peacefulness and esteem for human life: a diminishing both of 'masculine aggression and of the belief that violence is the only way of solving conflicts'" (Steinem, p. 201, 1972). Sadly this statement remains all too relevant, when in Australia we are reading of a pregnant asylum seeker, having been raped in a detention centre, denied the kind of care given to an Australian woman with the same traumatic experience. Is there some distorted masculine aggression at play throughout this national disgrace?

While recently retired, previously Raphael-Leff was engaged in an academic role at the Anna Freud Centre, private psychoanalytic psychotherapy and prolific writing and establishing The International Psychoanalytic Association's Committee of Women and Psychoanalysis (COWAP).

In conclusion, I think some facilitator mothers will find this book a wellspring of poignant ideas. To them there are meaningful accounts of other mothers' words, and the mystique of motherhood might be explored. 'Regulator' mothers, those more governed by needing vigilance against any sentimentality will perhaps not like this book as much. For this group of mothers, Raphael-Leff contends, "rationality triumphs" and as such the book might not offer any useful 'advice' and be too broad with which to be bothered. However the 'Facilitators' and 'Reciprocators' mothers, or mothers to be, might find it very helpful to learn that her ambivalent feelings are not just 'normal' but might also be useful, to allow exploration at her own pace, picking up and pondering on the Raphael-Leff riches.

The Marcé Society conference 2015

The Australasian Marcé 2015 conference was held in October, at the Adelaide Art Centre, overlooking the river. A beautiful venue to catch up with acquaintances, learn and enjoy the evening soirée, a relaxed evening where Graeme Simson (acclaimed author of *The Rosie Project* and husband of Anne Buist) was the guest speaker. The conference, titled SOS: Stresses, Outcomes, Solutions, featured Australian and international keynote speakers and a broad range of sessions, with topics showcasing both clinical and research in different formats.

Professor Megan Gunnar from the University of Minnesota in USA brought wisdom in stress neurobiology and hence parents' role in buffering stress in their young offspring, stressing that quality relationships are critical regulators of stress for children.

Associate Professor Ian Jones from Wales research has focused on clinical and molecular genetic studies of bipolar spectrum mood disorders and, in particular, studies of postpartum triggering of severe episodes of psychotic illnesses. He reiterated that childbirth is a potent trigger for Bipolar illness, with bipolar 1 being more severe at this time.

Mel Maginnity, an inspiring woman, presented what was both an amusing and heart tugging account of her lived experience of puerperal psychosis, begging us to both ask, how women really are following birth, and then to listen carefully to what they say!

Dr. Stephen Malloch from Sydney, psychotherapist whose well-known research with Colwyn Trewarthy on infant musicality has informed his work who talked about the love and power in a parent/infant relationship and discussed how 'in the moment of meeting' no one is leading and no one following.

Professor Jenny Gamble, a nurse and midwife from Griffith University shared current research interests including counselling women who have experienced distressing births and interventions after caesarean section to improve women's perinatal mental health.

Professor Jayashri Kulkarni from Monash University, shared her extensive knowledge and expertise on women's mental health

through the life span, and the effects of hormones on mood, and implored us all to work hard as Women's mental health is still not a priority, and that is just not good enough.

Ass Prof Felice Jacka shared the latest knowledge on a rapidly developing front of understanding the effects of nutrition in pregnancy and early life on the mental health of infants as they grow. Both a lack of healthy diet and an unhealthy diet are risk factors for mental health disorders, and discussed how maternal diet is important to outcomes in offspring of mental and physical health, and early life nutrition is very important for later mental health.

Anne Buist, winner of the Marcé Medal for 2015 presented the Marcé lecture, a clinician's response after 25 years research. She asked us why are we still repeating the same studies and finding the same things? She said we know that we need to target early to make a difference and then she asked why aren't we? She said that parenting is the key modifiable pathway and asked us to make the hard decisions in the best interests of the child.

Professor Marie-Paule Austin, recipient of the Jon Rampono medal talked about the change in paradigm shift in the last 15 years from Post Natal Depression to Perinatal Mental Health, and that the next change should be the addition of the word Infant to this title. She also asked is there life after the National Perinatal Depression initiative, a question close to my heart given without this and the funding my role as perinatal emotional health worker for the areas of Bendigo and Swan Hill ended last month.

Overall a great few days of informative research based and clinical interventions, hosted beautifully by the Adelaide members headed up by the outgoing president Anne Sved Williams, and for those who left early and missed her final closing talk, you missed a highlight as she talked us through the themes of the conference accompanied by footage of three of her grandchildren. We were also given a taster for next year's International Marcé conference to be held in Melbourne 26 to 28 September with the theme of 'Frontiers in Perinatal Mental Health- looking to the future'.

Wendy Lauder

Public Policy Advocacy for Infant Mental Health - Links of interest

Victorian Royal Commission into Family Violence

Various members of the Australian Association for Infant Mental Health provided written submissions and participated in the public hearings of the Victorian Royal Commission into Family Violence. The two days of the public hearings set aside to consider children focused almost exclusively on infants and young children:

<http://www.rcfv.com.au/Public-Hearings>

Children's Rights Report 2015

Nationally, members of AAIMHI also provided written submissions and participated at roundtable consultations held by the National Children's Commissioner to assist with her focus on prioritizing children's experiences in the context of family violence. Chapter 4 of the Commissioner's final report quotes AAIMHI submissions and Chapter 2 focuses on children's rights in the court system:

<https://www.humanrights.gov.au/our-work/childrens-rights/projects/childrens-rights-report-2015>



Master of Infant Mental Health – Edith Cowan University

Edith Cowan University is delighted to announce that the first Postgraduate Infant Mental Health course in Western Australia is taking enrolments now for 2016. This two year university based postgraduate course will provide students with knowledge and skills that have evidence-based theoretical underpinnings from developmental psychology, attachment theory, psychodynamic literature and relationally based models of assessment and intervention.

The course is designed for those who have a relevant undergraduate degree and who are already working or planning to work to improve the emotional and social mental health and well-being of infants, young children and their families. It is taught on the ECU Joondalup campus with classes for the first unit running over an intensive one week block and subsequent units typically after regular work hours one evening per week. The course has a practical work-place based research component as well as two consecutive applied units in reflective practice and a traditional infant observation. Students may exit the course after the first year and take out a Post Graduate Diploma or continue through to complete the second year for the award of a Master Degree.

A significant bonus for students of this course is that it is designed to align with the recently launched AAIMHI WA Competency Guidelines and Endorsement®. Upon completion of the course students will be eligible for endorsement at level 3 as an 'Infant Mental Health Specialist'. The AAIMHI WA competency guidelines and endorsement® are both a first for Australia and provide practitioners with a recognised level of international standing in the field. All indications are that the course is likely to be viewed positively by employers from a range of services and that the qualifications will give graduates an edge in workforce labour markets.

The course is coordinated by Associate Professor Lynn Priddis, a previous National President of AAIMHI and of AAIMHI WA; units are coordinated by Joanne MacDonald and Dr Raffaella Salvo who are both experienced practitioners with long histories of working and teaching in infant mental health. The course also draws substantially upon perinatal and infant mental health expertise of current local practitioners from a variety of disciplines and professional backgrounds. There is also provision for new staff to be appointed as the course proceeds.

Master of Infant Mental Health Course Structure

YEAR 1	SEMESTER ONE
IMH5001	Foundations of Infant Mental Health
IMH5002	Infant Observation 1
IMH5004	Theoretical Frameworks of IMH
YEAR 1	SEMESTER TWO
IMH5005	Assessment & Formulation in IMH
IMH5003	Infant Observation 2
IMH5006	Principles of IMH Intervention 1
YEAR 2	SEMESTER ONE
IMH6001	Reflective Practice in IMH 1
IMH6003	Principles of IMH Intervention 2
IMH6005	Report Planning
YEAR 2	SEMESTER TWO
IMH6002	Reflective Practice in IMH 2
IMH6004	Current Issues & Global Perspectives
IMH6006	Research Project

A range of experts from different professions teach in the course to reflect the interdisciplinary nature of the field.

Master of Infant Mental Health Course Admission Requirements

Students are required to have an undergraduate Bachelor degree in a related field; working with children and young families in health, education or social science. Entry processes will include an interview.

ACCREDITATION INFORMATION

The course meets all the requirements for the Australian Qualifications Framework (AQF) levels 8 (Post Graduate Diploma) and level 9 (Masters Coursework Degree).

CONTACT INFORMATION

The Master of Infant Mental Health is now accepting applications for 2016:

<http://www.ecu.edu.au/degrees/courses/master-of-infant-mental-health>

The Academic Course Coordinator: Associate Professor Lynn Priddis

Phone: +618 6304 5692 Email: l.priddis@ecu.edu.au Mob: +61 417986710

Student Recruitment

Edith Cowan University

270 Joondalup Drive

JOONDALUP WA 6027

Telephone: 134 ECU (134 328)

Email: futurestudy@ecu.edu.au

Pregnancy to Parenthood Clinic, Edith Cowan University

A further innovative West Australian training initiative in perinatal and infant mental health is the ECU Pregnancy to Parenthood Clinic in the Psychological Services Centre. The P2P clinic as it has become known is a free Perinatal and Infant Mental Health service provision that offers a range of therapeutic programs. It provides an early identification and early intervention service aiming to ensure optimal psychological, emotional and social wellbeing of mothers, fathers, infants, young children and family from pregnancy through to 3 years.

This clinic offers placements for students in their second year of the ECU Master of Psychology course using an infant mental health reflective supervision model as a core component of building professional competencies. Students work alongside an experienced clinical psychologist and infant mental health practitioner to build skills in relationally based psychotherapy with antenatal and perinatal clients to facilitate the best start possible for the young families. Staffing of the clinic comprises Associate Professor Lynn Priddis as coordinator of the Master of Psychology Programme, and Ms Rochelle Matacz with consultancy and support from Ms Elizabeth Oxnam.

The placement is aligned with level 3 of the AAIMHI WA Competency Guidelines and Endorsement®. Students develop skills in evidence based and relational approaches to parent-infant observations, assessments, formulations, interventions as well expertise in report writing, community liaison and collaboration with local hospitals, government agencies and services that refer to the clinic.

Taken together with the new Master of Infant Mental Health Course, Edith Cowan University is proud of its commitment to building workforce capacity in infant mental health in Western Australia and bridging the gap between perinatal and infant mental health.



THE FREUDIAN SCHOOL OF MELBOURNE
 School of Lacanian Psychoanalysis
 Inc. A0037619V

Directors: David Pereira,
 Rodney Kleiman
 PO Box 12, Hawthorn,
 Victoria, 3122 Australia

Seminar: Psychoanalysis and the Child

First Tuesday of each month 8-9.30pm, reconvening Tuesday, 2 February 2016

Convenors

Michael Plastow MBBS, FRANZCP, MMed (Psych), Cert Child Psych

Analyst of the School, The Freudian School of Melbourne.

Tel. 9347 1486

Tine Nørregaard MA, MAPS (Clinical College)

Analyst Member, The Freudian School of Melbourne.

Tel. 9690 9597

The seminar *Psychoanalysis and the Child* has taken place for the past seven years and we are opening it up for new participants. Although it specifically addresses questions pertaining to the child, it is pertinent to anyone with an interest in psychoanalysis, and we welcome those at any stage of their professional formation. Participants are encouraged to actively participate in the seminar by presenting their own accounts and readings on the topic.

In 2016 we will directly take up questions relating to the transference. Sabina Spielrein was still a teenager when admitted to the Burghölzli asylum in Zürich and treated by a young Carl Jung. Each addressed—to Sigmund Freud—the difficulties that arose in their transference to the other. Freud, though, resisted the demands to take up the position of “third person” [*dritte Personen*]. His response, in part, was to write his series of *Papers on Technique*, including “Observations on Transference Love”. We will begin to study these papers in reference to this early history of psychoanalysis. We will also do so by reference to Lacan’s first seminar, *Freud’s Papers on Technique 1953-1954*, where he embarked upon a detailed commentary on these, and which also contains many references to the treatment of the child.

Contributor biographies

Sally Brown is a paediatric occupational therapist 30 years’ experience working with children and families. She is trained in COS and Marte Meo and is currently the Director of Allied Health at The Infants Home Ashfield.

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.

Sarah J Jones is a Mental Health Social Worker/Psychotherapist, Supervisor and Trainer in Private Practice; with a special interest in couple psychotherapy and its clinical relationship with infant mental health.

Associate Prof Campbell Paul is an infant psychiatrist who has worked with infants and their families at the Royal Children’s Hospital Melbourne for over three decades. He is involved in teaching infant mental health at the University of Melbourne and the Newborn Behavioural Observation through the Royal Women’s Hospital.

Frances Thomson-Salo, psychoanalyst, Honorary Principal Fellow the Department of Psychiatry, University of Melbourne, and Honorary Fellow the Murdoch Children’s Research Institute.

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

Wendy Tyghe is a parent, grandparent and full-time Infant Mental Health psychologist in a district health board infant child and adolescent mental health service in New Zealand.

Wendy Lauder is a credentialed Mental Health Nurse who has worked for 16 years in the field of perinatal emotional health. She has a Graduate Diploma in Infant Parent Mental Health, and has done extensive work in Infant Attachment (including advanced Circle of Security training) and Newborn Behaviour Observation.

Lynn Priddis is a clinical and counselling psychologist and infant mental health clinician. She is in private practice and also Associate Professor Psychology at Edith Cowan University in the Master of Psychology and Master of IMH programmes.