

Refuge for babies in crisis



How crisis accommodation services
can assist infants and their mothers
affected by family violence

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How crisis accommodation services can assist infants and their mothers affected by family violence

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- The Sidney Myer Fund
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- Alannah and Madeline Foundation
- Magistrates' Court of Victoria
- The Royal Children's Hospital Foundation

Foreword

THIS BOOKLET IS WRITTEN SPECIFICALLY FOR WORKERS IN 'SHELTER, REFUGE AND CRISIS ACCOMMODATION' SETTINGS. Its focus is on the mental health of infants who present to these settings, generally in the company of their mothers and often after their caregiving world has been affected by significant levels of stress, trauma and upheaval. In particular, it is targeted at infants who have been exposed to significant family violence. We hope, however, that the usefulness of what it has to offer will extend to any infant who, with their mother and in many cases siblings, has had to endure the distress and uncertainty of homelessness. It is the result of a collaborative venture between McAuley Community Services for Women and the Royal Children's Hospital Melbourne's Integrated Mental Health Program — Addressing Family Violence Programs (which includes the work of the Peek-a-Boo Club™, an infant/mother family violence group work intervention). This project was made possible through the funding provided by The Australian Government Attorney-Generals Department.

Children's artwork used throughout this booklet was produced by toddlers attending a Peek-a-Boo Club™, and young children who have stayed at a women's crisis accommodation service in Melbourne. These pictures were supplied with consent from the children's parents.

Services in remote areas may not have other agencies nearby, or links with other services may not have been forged, but technology today means that we can communicate with other service providers via the internet through email, phone and video-conferencing.

A Note to Managers

THIS RESOURCE HAS BEEN WRITTEN WITH 'INFANTS IN MIND' AND ALSO WITH THE STAFF IN CRISIS ACCOMMODATION SETTINGS 'IN MIND.' Critical to the developing mind of the infant is the capacity of the caregiving adults in their world to very literally keep them 'in mind.' Keeping the infant 'in the mind' of the carer enables the infant to develop their own mind, as this process happens in tandem with their developing relationship with their caregiver/s. Traumatized parents coming into refuge because of family violence may well have a compromised capacity to keep anything in their mind other than their day-to-day survival needs. Staff within shelters/refuges can offer an enormously healing response to traumatized infants and their parents. These workers serve at the front line and are often our unsung heroes in this very complex and overwhelming area of work. This resource is intended to acknowledge, support and enhance the vital work already being done within crisis accommodation settings across Australia. It is about how the worker might be able to hold in mind the emotional and relational needs of both the infant and mother and the relationship between the two.

As important as it is to support babies and their mothers, it is equally important to support the staff members who offer these vulnerable families a place of refuge and healing. It is acknowledged that this sector is under-resourced and under-recognized. Yet despite this, shelter workers do an amazing job due to the commitment, care and passion of those who have chosen this as their work. We hope this resource will help you as a manager in the important work you do in supporting your staff. It is written in a manner which intends to be accessible and in module form so that one section at a time can be read, digested and then reflected upon. Ideally this would be in a setting where the staffing group could meet together, perhaps once a month, and talk through each module together. Each module includes a practice example taken directly from a crisis accommodation setting and has questions to assist in discussion about how the themes apply to your own unique setting.

It may well be that your staff already meet regularly and that time is set aside for professional development and debriefing. If this is the case then this resource, and the recommended further reading and resources list may be helpful to integrate into your existing structure. If a space for reflection has been somewhat eroded by the hectic, crisis-driven nature of the work, then we suggest exploring some creative ways to ensure this is reinstated. Why is this important to do? By virtue of the work your service is doing, you are dealing with families who may be reactive and crisis-driven, or experiencing situational crises, or both. It is very easy for thinking space to vanish and for these families to lunge from one crisis to the next. We can parallel this reactive, 'non-thinking' state and lunge from one urgent appointment or errand to the next, right alongside them. Slowing things down, making time to think, to feel, to talk, to respond and to reflect, can lead to vastly different outcomes. If we can't enable thinking time to

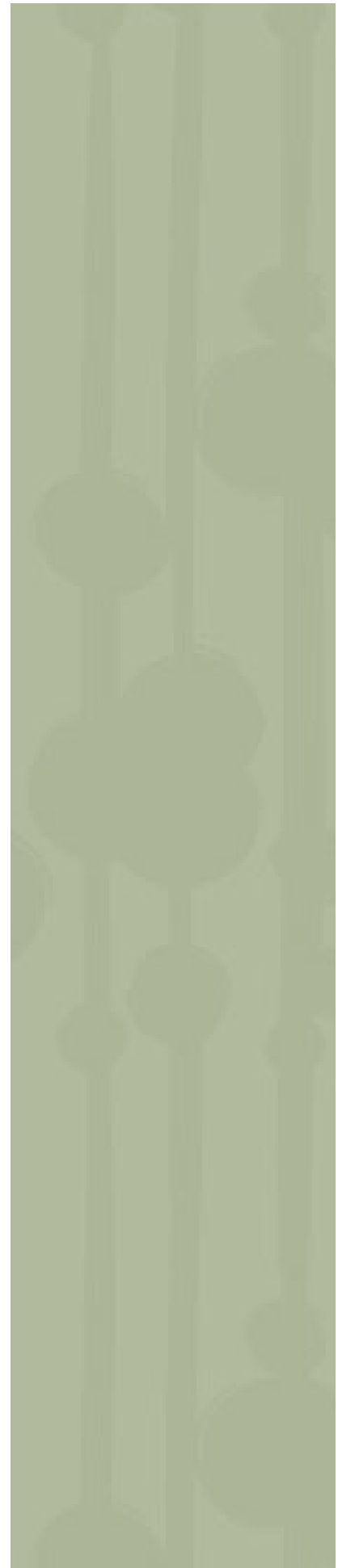
happen for ourselves, how can we expect our clients to? As a service manager noted to us when writing this resource, “their crisis is not our crisis and it helps to take a step backwards.”

Another support that may be under-utilised but available to staff is linking up with local Child and Adolescent Mental Health Services (CAMHS) or other counselling and support agencies. This resource is the product of inter-agency work between CAMHS and a number of refuges and crisis accommodation services within Victoria and beyond. The exchange of learning has been invaluable, pushing both sides outside of our comfort zones. We have learnt about the enormous load crisis accommodation services carry, the level of commitment and skill workers have in attending to damaged families, and the high levels of trauma that both infants and families carry when entering these services. Our involvement in working alongside shelter staff has enabled us to see the world outside of the safety of the ‘therapy room.’ We believe our presence as CAMHS workers has offered a reflective, thinking space to services, enabling a move towards a more ‘mindful,’ less reactive and enhanced healing space for clients.

Services in remote areas may not have other agencies nearby, or links with other services may not have been forged, but technology today means that we can communicate with other service providers via the internet through email, phone and video-conferencing.

A term popular in mental health for setting aside regular reflective time to examine one’s work is ‘supervision.’ This means ‘Super’-‘vision’ in so far as having someone else, usually more experienced and with some expertise, offering a supportive and educational space within which we can grow our thinking, explore something from a different perspective and reflect on where we fit in the picture of the work we are doing with others. Inviting service providers from other sectors, such as CAMHS, to provide regular supervision and/or consultation to your service, may be very educative for both your staff and the CAMHS worker. Mental health and the crisis accommodation sector have not traditionally had much to do with one another, but realistically we often share the same clients. An incredibly fruitful collaboration could be formed between the two services, that benefits the infants and families needing the intensive support and skill set that each service provides.

We hope this resource supports you and your staff in your day-to-day work in this vital and front line service provision. We are mindful of the enormous pressures crisis accommodation services work under, and the emotional challenges and complexities of providing for extremely vulnerable infants, children and adults affected by family violence.





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Image opposite:
"In my Mummy's tummy" by three year old

Introduction

The opportunities you and your service have to do some important repair work with infants, and the infant/mother relationship, is at the heart of this information package.

THERE ARE MANY THINGS THAT SET US APART FROM THE ANIMAL KINGDOM. These include the human's amazing capacity for insight, reflective learning, compassion, complex problem-solving and language skills. We are not born with these capacities, and more than any other living creature we are totally dependant on our caregiving environment for our emotional, physical and relational survival in the first few years of life. This high level of dependency continues well into our childhood, and to a lesser degree through to early adulthood, although some may argue it's even longer than this! We do not have inbuilt survival skills other than those that enable us to connect with other humans and enlist our caregivers to relate to us and care for our wellbeing.

The majority of infants, hard-wired from birth to communicate and connect with their caregiving environment, more or less successfully achieve this goal and form mutually satisfying and responsive relationships that adequately attend to their range of needs. Some infants, however, may be met with unpredictable and inadequate responses that harm their ability to trust and find reliable meaning as to how this new world they are born into works. Other infants suffer significant neglect and abuse at the hands of their caregivers; they are prevented from thriving in this new world and struggle to survive. Exposure to substantial and ongoing family violence inhibits infants' developmental progress. This may not always appear obvious to the outside observer, but infants give us multiple clues as to how their inside world is coping, or not coping, with their external world.

Our endeavour is to make this booklet clear, concise and informative. It is specifically written for workers within the crisis accommodation setting and we hope to offer an effective way of thinking about and working with infants — whether your contact is for six hours, six weeks or six months. We have presented five modules that cover the topics to enhance your work with infants and their families. With each module, we give examples from work in a women's refuge. We also pose some reflective questions to help you explore further what the information means for you. To facilitate clarity the male pronoun will be used when speaking of the infant (he/him), and female for the mother (she/her). The terms infant/baby are interchangeable. The terms parent/caregiver are interchangeable, and the terms refuge/shelter are interchangeable.

The information we cover may provoke anxiety in the reader by virtue of the subject matter. This may seem an odd thing to suggest to crisis workers (who are not strangers to anxiety or trauma), but the very nature of your work with some of the most disadvantaged, distressed and vulnerable members of our community may mean that you too experience their anxieties and your own, on a daily basis. However, acknowledging that you are already attentive to the infants that come into your service, and thinking about the anxiety and accumulative stress that infants experience, takes this work to another level completely.

The full implications of infants being left in a traumatised state will be discussed later. However, the opportunities you and your service have to do some important repair work with infants, and the infant/mother relationship, is at the heart of this information package. Our belief is that you can and do make a difference to the capacity for an infant and their mother to experience some recovery from the trauma (both physical and relational) that brought them to your service's doorstep. It is also our belief that your work is particularly important because you become involved in the lives of these families at such a critical time — when they are in crisis and when this 'recovery work' is so very important to the life of the developing infant and their still emerging relationship with their caregiver.

Our hope is that as a result of reading this booklet we will spark your curiosity about the mind of the infant, instil an eagerness to know more about infant development, and increase your confidence in thinking about and engaging with infants, and with the infant/mother relationship. Firstly, we have provided a module specifically for you and about you as a worker. The next two modules explore how infants develop and the impact that family violence has on the developing infant and their significant relationships. We follow on with two more modules on how we might best support infants, mothers and siblings who come into crisis accommodation services as a result of family violence. We hope that the information inspires you to think about your work in a new way, one that will hopefully enhance what you are already doing — reminding you of the great importance of the work that you do, and significant role you take, in the recovery and future of infants, children and their families.

For those keen to learn more about infant mental health, as well as family violence, we have reviewed a few articles that have guided our work and follow this with a recommended reading list and suggested web pages. The accompanying DVD complements this booklet and enriches your knowledge and understanding, with key points and examples of what can be achieved.

We hope that the information inspires you to think about your work in a new way, one that will hopefully enhance what you are already doing, reminding you of the great importance of the work that you do, and significant role you take, in the recovery and future of infants, children and their families.

Starting with you: Workers' response to the impact of family violence

WE WANT TO BE CLEAR, THAT THIS RESOURCE IS NOT TO TELL YOU 'WHAT YOU SHOULD DO,' BUT RATHER, IS SUGGESTING A WAY OF WORKING THAT ALLOWS YOU TO OBSERVE, THINK ABOUT WHAT YOU ARE SEEING AND TO WONDER ALONG WITH INFANTS AND MOTHERS ABOUT WHAT MIGHT BE HAPPENING FOR THEM. You have the power to provide a space that is about 'being with' the clients and what they bring to your service, even when what is brought to you is disturbing, frustrating or challenging. The families that come into your service have been harmed in their relationships, yet it is also within relationships that healing can occur. This is where you come in!

Let's start with you

Work within the homelessness sector is difficult and often thankless, shattering at times and even depleting at others. It can overwhelm, exhaust and demoralise because it is such a dominant fixture in the lives of this client group. As will be discussed further on, workers may often feel like they are 'left holding the baby' as the mothers may be needing shelter and food, as well as your ears to listen and sometimes your arms to hold them. All this, while you are busy making up the beds, organising referrals, interpreters, cabs, extra clothing and often attending to children's needs as well. Then add family violence issues into the mix.

Families affected by violence can be extremely challenging to work with. Many workers defend themselves from the pain of this through 'do, do, doing, all day long,' — working especially hard to 'not react' to the sadness and loss that they see in young children, and ignoring the fact that they too may have felt similar feelings or are terribly affected by what they see every day.

'Secondary' or 'vicarious trauma' are terms used to describe the negative reactions of workers specific to their work with trauma survivors. In this case, the trauma survivors are those mothers, infants and children who have experienced and witnessed family violence. The secondary trauma is the effect this work can have on us which is normal, and also familiar to the authors who have worked in infant, child and adolescent mental health and family violence for a number of years.

Often workers talk about feeling 'burnt out.' This feeling can emerge as a result of emotional exhaustion and the work you do can be both physically and emotionally exhausting. The exposure to the stories told by mothers and their children can affect the way that you view the world. What once may have felt to be a safe world, might not feel so safe anymore and the thoughts, understanding and knowledge you had about yourself and others may become distorted by the things you see and hear in your work.¹

Often it is the repetitive nature of the things we do, the things we hear and the relationship patterns that play out over time, that wear us down and leave us feeling stuck and powerless. Not only is it the work with our clients that may instigate these feelings but also our colleagues, workplaces and our service systems that may be the culprits. It is no surprise that our work culture can seem

not too far removed from our clients' stories as we deal with cutbacks, financial deprivation and policy decisions that lack compassion and do not seem connected to the day-to-day reality.

The words or themes often associated with family violence such as controlling, beaten, isolated, abused, worthless, intergenerational, hierarchical, powerless, etc., are also associated with the work itself. The words listed here are not alien to the authors in describing their experiences in attempting to have the voice of infants heard within a service sector that favours the voice of adults over infants and children. They would also be familiar words to workers within the homelessness sector who can often feel isolated from other service providers or struggle to be adequately funded and resourced to do the work they do.

This work represents the parts within society that we are loath to recognise, talk about and respond to. Whether our clients are from impoverished backgrounds or not, violence within intimate relationships exists across all sections within our community. Our shared humanity rests with the fact that we are all capable of great generosity and great cruelty. The choice to work in this sector may have something to do with wanting to help others, to help ourselves, to give, to take, to share, to learn, to find ourselves or to lose ourselves. We all have different reasons for doing this work.

We can see the people we meet as inspiring or despairing, and often as somewhere in between or even both. The most powerful gifts the 'good enough' caregiver can give her child is the belief that they, the child, is worthy, and teaching through their relationship, the ability to manage painful experiences as well as joyous experiences without feeling either experience will be so overwhelming that they become lost. Many mothers, and fathers, can often find a desire to give hope to their babies even when they may have lost this sense of hope for themselves. This is the same gift that workers can provide for mothers in crisis accommodation.

Not only can this gift give our work a greater sense of meaning and purpose, but giving something of ourselves, offering refuge to babies in crisis, is giving to both the infant, their mother and to their relationship.

Keeping ourselves safe from the fallout of family violence

After we get on a plane what is it that the flight attendant tells us during the safety talk? You might recall the announcement that if required, "the oxygen masks will fall from above your seat. If you are travelling with a small child, ensure that you place your oxygen mask on yourself first before attending to your child." They say this because we cannot put the mask on a child if we are out of breath ourselves. We cannot protect others if we are not safe to do so and safety, as we well know is not just about physical safety, but in the case of our work, it is emotional safety as well.

The most powerful gifts the 'good enough' caregiver can give her child is the belief that they, the child, is worthy, and teaching through their relationship, the ability to manage painful experiences as well as joyous experiences without feeling either experience will be so overwhelming that they become lost.

Our capacity to think about what might be going on for our clients is as important as our capacity to think about what might be going on for ourselves.

What can we do, to protect ourselves from the fallout of working with clients who have experienced family violence? How do we manage the impact of the taxing workload and emotional struggles we might experience in the work we do — the way we feel about the work we do, and the way we feel about ourselves? The following section suggests a way 'of being' with this work, with ourselves and with our clients. It focuses less on the 'to do' and more on the 'to be'.

Taking time 'to think'

We trust this booklet and DVD package will open a new and exciting way of thinking about the very important role you play. Thinking about infants and their relationships leads you to reflect on your own relationships. Whilst 'not thinking' is a very useful way to protect ourselves in the short term, troubling or traumatic experiences remain stored in our minds, bodies and souls.

Over time these traumatic memories can become toxic, overwhelming and very burdensome. They often revisit us when the work we do triggers our own past hurts and at times when we least expect it. This can make us reactive and rushing 'to do' to block overwhelming feelings of hopelessness or helplessness. Many who have suffered relational violence may deny or dismiss horrible and horrifying thoughts, events and experiences in order to survive, and in order to keep one foot moving in front of the other.

The caregiver of the infant may herself be traumatised by recent experiences, or have had an extensive history of trauma. Her capacity to think about herself let alone to think about her infant may be severely limited. Just as the infant needs his carer to think about, not just respond to him, so too does this adult/infant unit need someone to think about them; to offer a reflective capacity to give voice to their experience, validate their reactions and offer a space that can begin to give meaning to their experience.

Our capacity to think about what might be going on for our clients is as important as our capacity to think about what might be going on for ourselves.

We may reflect on why we have such a strong reaction to one family or feel so disconnected from another. We may wonder why a particular infant seeks out the company of all but his mother or why a mother chooses to only ever breast feed her infant whenever the infant shows signs of distress.

Being curious, wondering why, challenging our initial assumptions and being open to possibilities in thinking differently about ourselves and the infants, children and adults we work with, all helps to create a tolerance for discovery. Infant work is very committed to discovery; discovery of the infant, of their world and who they are yet to be.

Image opposite:
'All messed up' by two-year-old



Taking time to talk

We encourage mothers and children affected by family violence and homelessness to accept or seek out counselling services. We do this, because we know it helps. It also helps workers to talk to a counselling professional, supervisor, colleague, friends or family. This is something that the authors are well aware of: the need to talk things over, to de-brief after difficult sessions with families and to share with colleagues our concerns, experiences and insights. We need to be supported by others, just as mothers need support in order to nurture and support their children.

Talking encourages thinking and thinking facilitates talking. Talking is different to yelling, arguing or telling. It is about an exchange that occurs in relationship with another. It continues the process of discovery. We talk all the time, yet what we are proposing here is talking in an intentional way where we set aside other distractions and create a space to reflect. This might involve regular time with other staff, a more experienced colleague or a supervisor, where the agenda is to critically reflect on what we have observed in our work, both in relation to ourselves and to our clients.

This type of talking has an air of questioning and uncertainty about it where we can offer ideas rather than absolutes. It can help to create a safe, intimate space to sit and talk with clients, to reflect on what we see and how that might fit with what the infant, child and parent sees. Why? Because traumatic events often shut down talking or can do the opposite and accelerate it to such a point that it is not an exchange but a purging of all the horrible things that have happened. Creating a calm, safe, reflective space can increase the capacity to talk and to think together. On the other hand, it may also be used to provide a circuit breaker, helping slow down the rapid-fire talking, by wondering, together with a client, if it feels safer to talk rather than to stop and really think or let herself feel what has happened to her and to her baby?

This sort of interchange is intense and can be as uplifting as it can be draining. As we attempt to hold safe these very broken and traumatised families, so too we need to be held by a structure within our workplace, or with our colleagues or even outside of our workplace with another professional, who can help us talk about that which may seem unspeakable and think about what we may feel is unthinkable.

Taking time to play

In **Module 4** we discuss the need for infants 'to play' as a means of communication, expression and discovery. While we may not feel that we have the same levels of energy required for play as a small child, the importance of such an act remains. 'Playing' in our workplace, with infants, older children, mothers and colleagues can be therapeutic for all involved! We would also encourage the use of 'play' outside your workplace, whether this is in the form of exercise, relaxation,

meditation, or just plain ol' fun. Let's not deprive ourselves of joyful experiences, but embrace them as a tool for good mental health.

Many services have invested heavily in play spaces and equipment where infants and children can be spoilt for choice. Children who have fled their homes and taken little if anything at all with them, can find this sometimes overwhelming and become fixated on what 'is theirs,' perhaps refusing to share or give things back. Understanding what is symbolic play, what is imaginative, and what is traumatic play can help tell us much about the internal world of the infant.² Leaving toys or other tangible things behind for some children might feel like they have lost their sense of security, particularly when such objects may have helped them feel safer than their parents did.

For children, play with toys brings much enjoyment. Play in relationships brings about growth and discovery. Play with words, with songs, with our looks, with our presence is what infants crave and the toys that go with it are just the icing on the cake. Whilst infants need time to play alone for self-discovery, play with others is invigorating and vital to development.

What do we all need?

We have talked about being 'mindful,' thinking of others, ourselves, our environment and the impact of each on the other. Being mindful is also a way of being 'in the present' in the 'here and now' and savouring that moment. 'Being with' someone embraces a companionable space that can incorporate play, talking, thinking, silence or doing something together. We usually know when someone is 'with us' and when they are not.

We know when we have not been heard, or when someone is distracted, thinking about something else. We know, as workers, when we have felt overlooked, unappreciated or devalued. One worker in a crisis accommodation service recently said "we all need a thank you." And yes, it is nice to hear those words, but what she was really reminding us of was the need to be acknowledged (noticed and appreciated). This need is extremely important in relationships between parents and infant or child, between partners, friends and within the workplace. How can we possibly feel motivated to do what we do, when we don't feel valued? Infants know this too. They know when a parent looks at them but there is no life in their gaze nor any interest in who they are. They know when a parent's touch is indifferent, rough or fearful.

Putting a 'safe roof' over your client's head is fundamental to your work. Fundamental to infant development is a 'safe environment' AND 'safe relationships.' These need to be not just consistent but lively, enjoyable and responsive. These earliest relationship experiences act as the foundation upon which all subsequent relational opportunities (those that are good and those that are not) will be built.

Understanding what is symbolic play, what is imaginative, and what is traumatic play can help tell us much about the internal world of the infant.

2. Symbolic play involves children using, for example, dolls and toys to represent people and events in their lives to play out, sort through and manage emotions and situations they are trying to make sense of. Imaginative play involves creating more elaborate scenarios and characters that are more explorative and magical and in some ways 'other worldly'. Traumatic play often involves repetitious or 'stuck' play that enacts events or emotions that may bring forth aggressive or violent outcomes and offers the child little relief or resolution. See 'Further Reading Resource List' on page 57 for further readings on play.

Infant inclusive practices are those that keep the infant clearly in the picture and at times make them the focal point of the work you do with a caregiver or even whole family unit.

Adopting practices that are ‘infant inclusive’ or ‘infant led’

Infant inclusive practices are those that keep the infant clearly in the picture and at times make them the focal point of the work you do with a caregiver or even the whole family unit. Infant-led work sees the infant to be as critical to the recovery of families traumatised by violence, as the adult carers are.

Infants are incredibly responsive to engagement and are in fact hard-wired to connect with others. A lifetime of abuse may have caused some caregivers to be so defeated that change seems almost unreachable. Infants, for many parents, carry the seeds of hope for a different future and may well be the catalyst or motivation for change. It is sometimes a change in the infant that can trigger a change in the parent. If the parent is so deeply stuck in their own trauma that they are unavailable to their infants, then others need to urgently step in and be a responsive, soothing and protective adult in the infant’s life. The following four modules discuss in further detail what this entails.

The need to notice and acknowledge the infant as well as the devastating impact of violence and homelessness on infant development and the importance of relationships in the healing process will be discussed. Communicating effectively with infants and their mothers and the concept of ‘holding,’ to support mothers and their children, helps in the process of making sense of their experiences.

The final part to this and every module, is the reflection exercise. Before you go on to that, we would like to say “thank you,” not only for the work that you do, but for taking the time and interest to read this booklet to enhance your work and to contribute towards the safety and wellbeing of all the infants you come into contact with, in your work.

Reflection

A mother with her 2 ½ year old toddler, 5 year old son and daughters aged 8 and 11 years entered a crisis accommodation service. The older children were furious with her leaving and taking them, demanding that they return home. The mother was very pale and thin and seemed lifeless and very fragile to the staff. A woman's support worker had been working with her for many months and the mother had revealed to her that much of what occurred happened behind the bedroom door and had done so over many years. The mother did not feel she had the words to tell her children why she had left. The children were very active and energetic and spoke of their father in glowing terms, plotting aloud to staff of their escape plan from the unit so they could return home. This particular mother was described as 'hard to like' by the staff as she spent most of her time either in bed or when present with her children, emotionally unavailable to them.

The staff felt they became the parent to the children despite attempts made to involve their mother in their care. It was observed that the toddler turned to her siblings or staff rather than to her mother on most occasions. The evening staff became particularly frustrated as they were left without a children's worker and found the behaviour of all four children became increasingly defiant. One worker in particular felt concerned that she was joining with a story about this mother that she was neglecting her children and her own growing negative feelings towards her. As the crisis unit was only short term the worker was tempted to wait out the family's stay and hope the next service could provide more structured support to all family members.

REFLECTIVE QUESTIONS

1. What do you imagine each person was feeling, from the infant though to the oldest child, the mother and the staff dealing with this family?
2. There seemed to be much talking about the family staying in this unit but less talking with them. How might a space for talking with all of the family have been created?
3. Are there any patterns that might have played out within the unit that mirrored what was happening in this family unit? What might they be and could a recognition of these have been helpful for everyone?
4. What could be learnt from the observation that the infant went to her siblings and staff rather than her mother?
5. What difference might 'thinking and talking space' for staff, the mother, children and the toddler have made for this scenario?

Why think about infants?

Infants are completely dependant on others for their survival. They are especially vulnerable and powerless because they don't yet have the language skills to request help when they feel threatened or unsafe.

BABIES ARE VULNERABLE. They are small and physically fragile. Their bodies, brains and emotional capacities are developing at the most rapid rate than at any other time throughout the lifespan. Infants are completely dependant on others for their survival. They are especially vulnerable and powerless because they don't yet have the language skills to request help when they feel threatened or unsafe.

Infants need their caregivers to help them learn to manage and tolerate strong emotions through being available to them, by giving voice to their fear, sadness or fright, as well as joyousness and even over-excitement. The caregiver helps regulate their infant's emotional world through touch, gaze, and tone of voice, and by matching, mirroring and modulating their interactions with their infants (this will be discussed more in **Module 4**). This is very important work that requires the mother (or father) 'to think' about the world of their infant and in turn, as the infant grows, helps organise their developing capacity to think for themselves.

An infant cannot use words to tell us how they feel about the horrific experiences that have brought them to the service and they can't speak of how these experiences have impacted on them and their relationships. However they do speak to us, and loudly, in other ways. Later, we will look at ways in which infants do communicate with us. We need to be prepared to listen with our eyes, mind and emotions.

As adults, it can be difficult to imagine what it is like to be so small and vulnerable and to experience such trauma at a young age. Infants who have witnessed and/or been the victim of family violence, may lose all sense of safety and ability to regulate their feeding, sleeping and general wellbeing. A mother who is the victim of abuse may not be able to attend to the immediate needs of her infant and when an infant is exposed to ongoing and frightening circumstances he learns very quickly to shut down to protect himself, especially if the caregivers around him are unavailable to provide comfort and care. In the situation of family violence, the person whom the infant normally would turn to for safety may well become a person to be feared if they themselves are not safe or struggling to cope.

The infant quickly learns to adapt to his environment, developing strategies that aid survival. Recognising that an infant has his own separate and emerging personality, and is highly sensitive to the environment around him is not commonly how we think about infants.

Infants do have a mind, which is developing and which is highly attuned to his surroundings. Babies are born with complex sensory capabilities and are highly sensitive to the harm that chaotic, unreliable and volatile relational environments can inflict, both psychologically and physically.

Do we know, dare we ask, about the circumstances in which some infants are conceived? How many infants and children (or women themselves) whom we come into contact with, were conceived as a result of rape, or 'under duress' from their partner's demands to have sex? What is the psychological impact for

the mothers, and what is the impact of this on their feelings towards their baby? How many women receive the news of their pregnancy with dread, feeling it may trap them further into a violent relationship, or perhaps may shrink from telling their partner for fear of their partner's reaction? Many mothers have told us of being forced to keep a baby they wanted to terminate. Many women have reported to us of their partner's scorn and doubt over the news, claiming that the baby is probably not theirs but another man's.

The number of women who have miscarried after being assaulted by a violent partner is not fully known. We do know that rates of intimate partner violence are significant during pregnancy³ and some women report that it is during this time that the violence first starts. In these situations, babies in-utero are at risk of harm from the physical violence inflicted upon their mothers, as well as from prolonged exposure to high cortisol levels (a chemical within the brain associated with heightened levels of stress and fear) that their mothers' experience as a result of the violence or threat of violence. Neo-natal death and premature delivery are risk factors for women and babies who are exposed to violence during pregnancy.

Studies conducted overseas and within Australia estimate that between 4-8% and up to 21% of pregnant women experience violence.⁴ A Western Australian study of adolescent pregnancy⁵ and domestic violence, showed that infants were born with low birth weight (which was linked to their continual high exposure to cortisol), significantly smaller head size and that the thymus (an important organ situated in the chest cavity that assists with developing an effective immune system) was affected reducing these infants' ability to fight infection.

National data shows that infants up to one year-old are at greatest risk of being killed, predominately at the hands of their parents or other relatives,⁶ yet one could suggest that the unborn infant is at far greater risk. More recent Australian statistics show that among children, the rate of fatal abuse was highest among 0-4 year-olds and hospitalisation for assault injuries was more common for infants than children from one year upwards.⁷

Mostly, becoming pregnant and having a baby is an exciting and beautiful experience, but in reality, we know this is not always the case. Our capacity to hold in mind other possible reactions to this news, and how a baby may have been conceived, may allow opportunities to speak about topics which many mothers may have felt were too shameful or painful to talk about. Not talking is an effective way to put the lid on things that are too painful or hard to talk about. However, this does not make it go away and as we know with toxic materials placed in landfill, they eventually make their way to the surface and can do great harm to their surrounding environment. How we might help, in some small way to de-toxify the relational environment some infants grow in, can have positive long-term benefits.

We do know that rates of intimate partner violence are significant during pregnancy and some women report that it is during this time that the violence first starts.

5. Julie Quinlivan, 'Study of Adolescent Pregnancy in Western Australia,' in Partnerships Against Domestic Violence (ed.) The Way Forward: Children, Young People and Domestic Violence: conference (Melbourne, 2000). Julie Quinlivan & S Evans, "A Prospective Cohort Study of the Impact of Domestic Violence on Young Teenage Pregnancy Outcomes," *Journal of Pediatric Adolescent Gynecology* 14 (2001):17-23.
6. The National Committee on Violence (1990). 7. Australian Institute of Health & Welfare, "A Picture of Australia's Children" (2009).

Exposure to violence, or even the perceived threat of that exposure, impacts on the developing foetus through the toxic environment created by the stress hormones secreted by the mother in her fear and anxiety.

There is no infant without mother

A famous expert in early childhood development once wrote, “there is no such thing as an infant.”⁸ By this, he meant that infants need maternal care to survive. In most instances the primary caregiver is the mother but could be the father, grandparent or some other special person in their life who feeds, protects, nurtures and bonds with the baby. In some ways this seems obvious, but much about working with infants may seem obvious until we actually ‘stop to think’ about it! So let’s think about that statement in some detail.

The embryo needs this precious incubation space to provide him with oxygen, nourishment and a healthy enough internal environment to facilitate growth and development within the womb. Medical or genetic complications, substance abuse or injuries (accidental or intentional) inflicted on the mother’s body can have disastrous effects for both mother and baby. Exposure to violence, or even the perceived threat of that exposure, impacts on the developing foetus through the toxic environment created by the stress hormones secreted by the mother in her fear and anxiety.

A common myth is that infants are not adversely affected by bad experiences, like exposure to violence, in those early years ‘because they don’t see it or understand it.’ It is commonly accepted that mothers affected by violence are traumatised and that this trauma is experienced through all their senses; sight, smell, taste, touch and hearing.

We know, however, that infants are in fact affected by early trauma (their own and that of their mothers). Research has shown that from the first few days of life an infant recognises his own mother’s smell, and within the first few weeks can recognise faces and begin to mimic an adult poking out their tongue.⁹

The world of the infant happens within the context of his relationship with others and his very existence is not only reliant on that caregiving world but also on how it teaches him to relate within that world and the world around him.

The expression, ‘the eyes are the window to the soul’ hold great truth for the infant, and it is in the very eyes of those caring for him that the infant seeks to come to understand others as well as himself. How a mother (and father) looks at, touches and interacts with her infant imparts an information guide as to how the world works. The more patterns of information are repeated, the stronger these tracts of information are laid down in the infant’s developing brain and become the story of his world and how to navigate his relationships with others.

8. DW Winnicott was a paediatrician and child analyst. He wrote numerous papers and books on the infant-parent relationship and psycho-analytical treatment. The quote “there is no such thing as an infant” comes from “The Aims of Psycho-analytical Treatment” (originally published in 1962).

9. Daniel Stern, “The Interpersonal World of the Infant,” (Great Britain: Karnac Books, (2003).

Attachment relationships and infant development

People often talk about infants and 'attachment,' but what does that really mean? Attachment is about relationships. When working in a refuge setting you may have come across mothers who seem to be indifferent to or 'not care' about their children or babies, and toddlers who seem 'out of control' or 'blank and lifeless.' Perhaps you have heard them described by others as 'having no attachment?' There are different styles of attachment; attachment relationships can be **secure, insecure or disorganised**.

Whilst we do not expect that part of your job is to make an assessment or diagnosis on the attachment relationship between infants and their mothers, it is useful to be familiar with what attachment systems look like, so we will briefly discuss attachment styles to further develop your understanding of what you may observe.

The primary attachment figure (usually the mother) is the person who: provides the majority of care to the infant; spends the most time with the infant; has an ongoing relationship with him; and is the person to whom the infant turns as a source of safety, comfort and care. This person is, in-turn, most emotionally attuned to the infant.

Interactions within the relationship need to be nurturing, protective, secure and consistent in order for infants to feel confident to explore their environment and to have the psychological resources available for learning. Infants are vulnerable when parents and caregivers face issues that impact on their own safety and wellbeing, and reduce their ability to parent in attuned and nurturing ways.

A secure attachment relationship is built through sensitive and responsive caregiving and promotes optimal physical, behavioural, social and emotional development, including a greater capacity for emotional self-regulation, positive social interactions and better coping skills.

Over the first few months of life, infants form attachment relationships with other people with whom they have an ongoing relationship and who they experience as a provider of safety and nurture (for example, their father, grandparent, sibling, carer or babysitter). These relationships will be sought by the infant, according to their availability, when the primary caregiver is not available.¹⁰

Infants' capacities to develop new relationships are enhanced when they have a secure attachment relationship with their primary caregiver. However, we are reminded that family violence is both an assault against the mother and an assault on the infant-caregiver attachment relationship because the mother's distress can impact on her parenting.¹¹ Not surprisingly, research has demonstrated that up to 82% of maltreated infants suffer from serious disturbances of attachment with their caregivers.¹²

Infants are vulnerable when parents and caregivers face issues that impact on their own safety and wellbeing, and reduce their ability to parent in attuned and nurturing ways.

10. J Bowlby, Attachment and Loss Vol 1 (1969); Attachment and Loss Vol 3 (1980); K Brisch, Treating attachment disorders: From theory to therapy (2004).

11. K Humphreys, Talking to my mum: Strengthening relationships between mothers and children in the aftermath of family violence... (2007)

12. Carlson et al., "Disorganised/disoriented attachment relationships in maltreated infants," Developmental Psychology, 25 (1989): 525-531.

The examples given in the table below remind us of how important our earliest relationships are in shaping our behaviour, our understanding of the world and our ability to form relationships throughout life.

Table 1: Attachment relationship style

Attachment style	Caregiver responses	Infant behaviour
Secure	Sensitive, responsive, consistent, attuned, reliable (such as prompt comforting when the infant is distressed, warm interested response to the infant’s wish to communicate or play, empathy and acceptance of the infant’s point of view)	Able to regulate emotions, seek help from others when distressed, adaptable to changing circumstances and able to explore their world
Insecure (avoidant)	Connected enough to protect the infant but minimises the importance of attachment issues; can be dismissive of the infant’s attachment cues, insensitive to the infant’s signals and emotional needs	Shows little distress on separation and minimal joy when reunited with the caregiver; reduced spontaneity of emotional expression and over-controlled emotions; avoidance of affection; focus on exploration of the environment to avoid closeness
Insecure (ambivalent)	Inconsistent or unpredictable emotional availability and response to the infant’s attachment behaviours and emotional needs (for example, at times over-protective or over-stimulating and at other times rejecting or ignoring)	Overly engaged with attachment figure and may feel too anxious about the caregiver’s emotional availability to freely explore the environment
Disorganised	Unresponsive, intrusive, hostile or violent; some parents are frightening to their infants, others may be frightened due to past or continuing trauma	Responses to the caregiver look chaotic and contradictory; the infant is trying to reconcile the impulse to approach for care with their need to avoid seeing the caregiver as a source of fear; observable reactions and behaviours may include hyper-vigilance, freeze or fear when the parent appears, dissociative behaviours such as a dazed expression, appearing emotionally numb or cut off, or not crying when distressed or hurt

Table 1 gives a brief description of each attachment style, the kind of responses you might see from caregivers, and their infant’s behaviour.¹³ Take a moment to look through the table and even discuss this with your colleagues, as you may well think of many examples of these attachment styles that you have observed within your work and within your own relationships!

With all this in mind, remember that you see infants and their mothers from many different cultural backgrounds. Whilst feeling secure and loved is important for developing infants in all societies — attachment beliefs, values and practices will differ across cultures. The attachment relationship between an Aboriginal/Torres Strait Islander infant and their caregivers, for example, may be influenced by their historical, cultural and spiritual contexts.¹³

13. Sketchley & Jordan, Infants at risk of abuse and neglect: a review of literature. (Melbourne: Department of Human Services, State Government of Victoria, 2009). Online: www.dhs.vic.gov.au
 Yeo, S. S. (2003). Bonding and attachment of Australian Aboriginal children. *Child Abuse Review*, 12, 292–304

Reflection

In the quiet of the night, a six-month-old baby is feeding from his mother's breast. The milk is warm and comforting, his mother strokes his hair. Suddenly, the baby's father comes into the room and screams, "It's about time you stopped doing that and start being a wife again you stupid bitch." The mother's heart pounds fast, she knows what is coming next. "Look at me when I talk to you bitch." She removes her baby from the breast but holds him close as she stands. Her husband pushes her back down and again screams obscenities to her and adds, "Where do you think you're going? Put that kid back in the cot and get in the bedroom." He then walks out the back door to light a cigarette and as he does this, mother gets up, grabs her mobile phone and keys and runs out the front door. She runs and runs, holding her baby tightly only stopping when she gets a few blocks away. Worried that her husband has followed her in the car, she hides behind someone's front fence and calls the police on her mobile. It seems strange to her, but her baby has actually fallen asleep...

When the baby awakes a few hours later, he is in your arms in an unfamiliar room, in a women's refuge. His mother is outside the front door of the unit, smoking a cigarette and talking to another victim of family violence.

REFLECTIVE QUESTIONS

1. What do you think the baby in this scenario is experiencing and feeling:
 - when they are still in their home?
 - as their mother flees the house?
 - when they wake?
2. What do you think is going on in the mind of the mother?
3. What resources does the baby have to assist him in this situation?
4. What do you think you could do to assist when the mother and baby arrive at your service?

The impact of family violence and homelessness on infants

A LARGE AND GROWING BODY OF RESEARCH IN NEUROSCIENCE, DEVELOPMENTAL PSYCHOLOGY AND THE SOCIAL SCIENCES HAS DEMONSTRATED THE IMPACT OF TRAUMATIC EVENTS ON AN INFANT'S DEVELOPMENT. Exposure to cumulative trauma (such as abuse, neglect or exposure to violence) affects every dimension of an infant's psychological functioning, including emotional regulation, behaviour, response to stress and interaction with others.¹⁴ Experiences of neglect and abuse can undermine the infant's basic sense of trust in the world, and a basic sense of trust in their self.

The developing brain and central nervous system

From birth and beyond, the quality of care and attachments that an infant experiences have an immediate impact on his brain development and central nervous system. This occurs through what is effectively a process of shaping the brain. The developing brain sets about laying down a mass of very complex neural pathways that could be considered as the foundation upon which the rest of his development over the course of his entire life is laid. This is a period of very rapid growth and in these first few years the pathways that are laid down are highly sensitive to their relational environment.¹⁵

The brain of an infant in a constant state of fear will build restricted pathways that serve the purpose of survival. These pathways continue if the risk continues and can become so entrenched over time that the diversity and flexibility of neural pathways that his mind and brain needs to negotiate through life's many challenges can be limited. When the outside world fails to protect, the still immature infant resorts to primitive responses to seek some relief and protect his internal world. The very withdrawn, lifeless and what might seem like a constantly sleeping infant may in fact be drawing on every capacity available to him to escape the external, by disappearing as far inside himself as he can, as he has nowhere else to hide.

The brain has two hemispheres that integrate to make the whole. The right side of the brain develops first and is responsible for the 'emotional self.' It is concerned with how emotion and feeling are managed within our minds and our bodies. This is also known as 'affect regulation.' Through relationship with his caregiver an infant learns how to manage strong positive and negative emotional and physical responses, from delight and desire through to hunger and pain. The right side of the brain dominates for the first two to two and a half years, then the left side takes over for the next two years.

The left side is largely responsible for the 'verbal self' and concentrates on language skills and processing of information. Both sides continue to develop (see diagram), each dominating at different times throughout development

14. BD Perry, RA Pollard, TL Blakley, WL Baker & D Vigilante, "Childhood Trauma, the Neurobiology of Adaptation, and "Use-dependent" Development of the Brain: How "States" Become "Traits"; Infant Mental Health Journal 16(4) (1995):271-291.

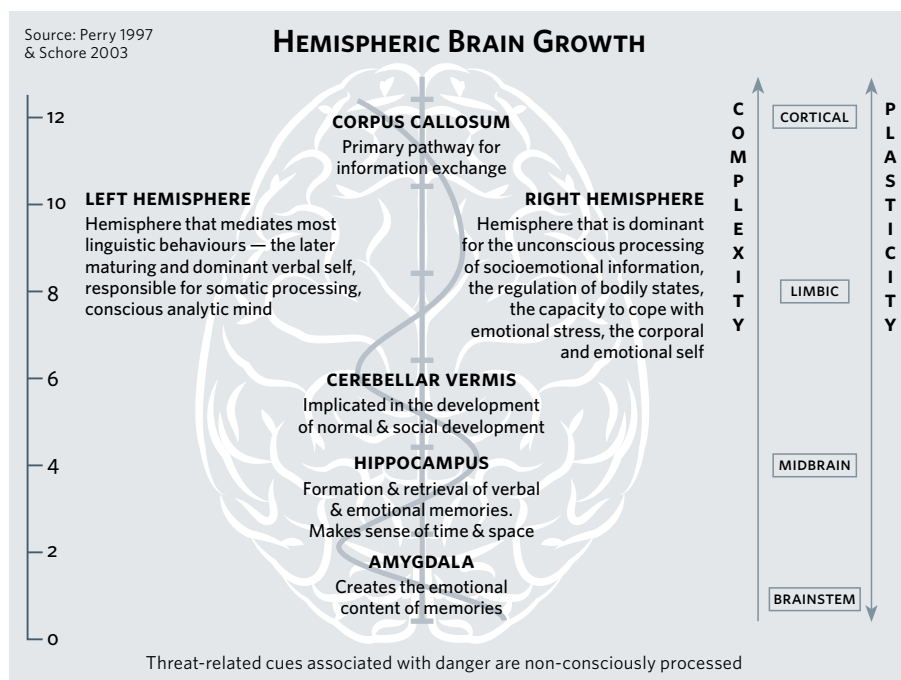
15. M Sykes Wylie, "Mindsight," Psychotherapy Networker, Sept/Oct, (2004): pp29-39. M Sykes Wylie & R Simon, "Discoveries from the Black Box," Psychotherapy Networker, Sept/Oct, (2002): pp26-37.

for the purpose of evolving our ability to integrate our neural capacities across both hemispheres and accessing higher order brain functioning. Higher brain functioning is about both emotional and intellectual intelligence and is demonstrated in our capacity for insight, problem-solving and resilience.

What is important to know about brain development is that as the emotional self develops first, trauma in the earliest years is especially harmful as we are yet to obtain adequate language skills that can help us integrate these experiences, from right brain to left. What remains are physiological memories, memories of how the body reacts to threat of danger and these can remain dominant throughout our entire life. These remain in the oldest (or first to develop) parts of the brain and thereafter will always be the first part to react, initially through feeling then followed by thinking. If our feeling (or emotional self) feels unsafe we are likely to think we are unsafe, even if we are not. This physiological response, which resides in the oldest or earliest parts of brain/body's development, is connected to the autonomic (automatic or involuntary) nervous system which is part of our central nervous system.

The central nervous system consists of the brain and spinal cord and operates as the coordination centre for how our entire body deciphers internal and external information. Our brain releases powerful hormones when faced with serious threat and it is through our autonomic nervous system that our body is placed on alert and readied for action (fight or flight). Exposure to prolonged threat or trauma can release a different hormone that overlays this earlier response and induces a state of 'tonic immobility' (to freeze).¹⁶

What is important to know about brain development is that as the emotional self develops first, trauma in the earliest years is especially harmful as we are yet to obtain adequate language skills that can help us integrate these experiences, from right brain to left.



This trauma, if left unaddressed, impacts on all levels of a child's emerging personality, belief system and sense of safety in the world.

A tiny infant who has entered into a traumatic state continues to remain in chronic arousal if there is no caregiver available to attend to and help de-escalate his emotional state. A mother who is herself traumatised may be unable to soothe her traumatised infant. Remaining in such a heightened state, for excessive amounts of time and during such a significant period in his development leaves the infant susceptible to developing a heightened sensitivity to traumatic triggers. Even as they grow older these emotional states, happening time and time again, can become so ingrained that they override the capacity to think or react differently or objectively.

Traumatic triggers or reminders can include such things as smells, images, situations, places and people (including a caregiver). In intimate partner violence, the infant witnesses the parents as victim and aggressor and is unable to rely on either parent for their own protection and comfort. Given this scenario, it is likely that specific aspects of the parents' behaviour, tone of voice and body movement and facial expressions may become traumatic reminders for the infant.

An infant living in a world that experiences chronic violence will be affected by that violence.

They may have witnessed their caregiver being assaulted and/or been directly assaulted themselves, or they may live in a fearful environment with a frightened or frightening caregiver who is not able to attend to their emotional regulation. This trauma, if left unaddressed, impacts on all levels of a child's emerging personality, belief system and sense of safety in the world. It interferes with healthy brain development, affects physiological functioning and leaves them at greater risk of developing emotional, behavioural and learning difficulties and of experiencing mental illness in adulthood.¹⁷

Homelessness as another stressor

You can provide a roof and shelter, perhaps even physical safety, but what might being homeless actually mean for this infant and their mother? Keep in mind that the mother's perspective and mental health will have an impact on that of her infant and think firstly about what 'being homeless' might mean for mothers. Some mothers may initially feel some relief, to be away from the perpetrator or the stressful home environment, but it also means that they have become dependant on others (a feeling not everyone is comfortable with). It may remind them of previous similar experiences (perhaps being kicked out of home in their adolescence), and they may not have access to their usual support system (friends and family). They may feel guilty for putting their child in this situation, or may even feel anger and lay blame on their baby/infant/child (for without them they may not be in this situation in the first place). So the mother's world has been turned upside down. This must be frightening.

Now, let us think about the infant. He too will notice that his environment has changed dramatically. He no longer has his cot, the rooms that hold familiar smells, shapes and colours and he may be without his comfort blanket or favourite toy. The presence of these physical objects and surroundings can contribute to an infant's sense of security, but that which has the capacity to really ensure or repair the safety for an infant is his primary caregiver and primary attachment figure. If that person (usually the mother) is able to continue to nurture, comfort, reassure, and think about the infant, then being 'homeless' may not be such an issue for him. The saying 'home is where the heart is' rings true for the developing infant. Unfortunately however, in this situation the capacity to provide all that is needed for her infant to feel safe may be beyond reach for a traumatised mother, who also needs care, nurturing, support and reassurance.

The concept of a 'secure base' as described in **Module 2** refers to a secure set of relationships and emotional experiences that an infant is offered by his caregiving world. These do not need to be perfect, but 'good enough' to see an infant safely throughout his development.

Both family violence and homelessness, separately and most certainly when coupled together, can pose a real threat to an infant's wellbeing, and a mother's capacity to provide a 'good enough' secure base to her infant's world.

In those instances where infants and children are left behind with the perpetrators of violence, immediate concerns for their physical and psychological safety need to be recognised and investigated through alerting the appropriate statutory bodies. When the mother and child/ren flee together, where they flee to might offer little or no relief from the trauma they have experienced. On the other hand, where these families end up might be the beginning of their entry into a world that offers an experience of what a 'secure base' looks and feels like. We can offer an experience of an alternative caregiving environment to both mother and infant. Perhaps, as seen in the reflection for this module, the alternative might be simply offering something starkly different.

The presence of these physical objects and surroundings can contribute to an infant's sense of security, but that which has the capacity to really ensure or repair the safety for an infant is his primary caregiver and primary attachment figure.



Reflection

Gillian, 18, described herself as currently homeless. She and baby Trevor (four months old) had lived the last six weeks in a shelter. They had lived the first few weeks with her mother (who attended the birth) but then stayed with different friends after this. Gillian stated she had not experienced violence, but explained her partner Frank had threatened her a lot, including threatening to stab her in the stomach when she was pregnant. She did not think he would. The pregnancy was not planned, with Trevor conceived after they had been together just three weeks. Gillian described Frank as very controlling.

During a group activity, we took a break and Gillian was struggling with all her equipment (baby bottles etc). A worker offered to help and Gillian just handed Trevor over — he was a dead weight. Gillian did not tell her baby that she was leaving the room. Trevor would not look at the worker, and moved his head about to avoid her gaze. Left by herself in the room with Trevor, the worker tried to sing and tried to give him a few things to hold but he would only hold a toy for a moment and then just drop it. The worker then found a little toy and gently tapped it on his nose, making a game that was potentially safer and he started to smile.

REFLECTIVE QUESTIONS

1. What thoughts do you have about Gillian's statement that she 'had not experienced violence?'
2. What experiences do you think have already shaped Trevor's sense of the world in his first four months of life?
3. What do you imagine it is like for Trevor to be handed over to someone he has only just met and how do you imagine he makes sense of his mother disappearing?
4. What is Trevor telling us in the scenario and just how does he tell us? What do you make of what the worker does?

Image opposite:
'My brain hurts' by three-year-old

Communicating with infants

Babies and toddlers that you see in your work setting may be overwhelmed with intense negative emotions due to their life experiences.

RIGHT FROM BIRTH, BABIES HAVE AN INNATE DESIRE AND ARE, ACCORDING TO MANY EXPERTS, HARD WIRED TO CONNECT WITH OTHERS. As mentioned in **Module 2**, this connection facilitates survival, but it is also the beginnings of the baby understanding and making sense of others, their environment and themselves. In the first few weeks of life, infants search for ways to interact with others. They seek eye contact with their caregivers even briefly, and this extends to a longer gaze as the baby and the relationship develops. Babies seem to enjoy interactions that mirror their own behaviour and expressions, such as when a baby yawns or frowns and we reply by copying these expressions. This tells the baby that you are interested in them and this type of 'mirroring' is particularly effective in sustaining babies' attention and involvement.¹⁸

Face to face play with babies is intimate and concerns nothing else but the feelings and expression between two partners. Babies are highly sensitive to the communication from others and if a response is too abrupt, babies may break contact and look away or shut down. In fact, infants often need to look away in order to avoid being overwhelmed and engage at their own pace of intimacy. This is where the game of 'Peek-a-Boo' with slightly older infants can create a great sense of fun, discovery and delight where an infant feels they can have some control over how much or how little eye contact they have with the other person.

How do infants communicate?

Even though young infants are working hard to develop their language skills, the way in which an infant communicates best is through his body and behaviour.

Babies and toddlers that you see in your work setting may be overwhelmed with intense negative emotions due to their life experiences. They might communicate this through constant crying, an inability to be soothed, feeding problems, sleep disturbances, hyper-arousal and hyper-vigilance (highly active and sensitive), or intense distress during transitions. Other infants may emotionally withdraw and 'shut down.' They may not make appropriate demands on their caregivers, for example, never crying, and avoiding initiating play or interaction. They can mistakenly be regarded as 'placid' babies.

Infants who have experienced trauma may experience intense separation anxiety, wariness of strangers, social avoidance and withdrawal, constricted affect (facial expression of emotion) and constricted play. They may have great difficulty managing frustration and toddlers may experience problems with emotional regulation (for example, severe tantrums), rebellious behaviour and negativism. They may be aggressive and controlling. Extreme anxiety may be expressed as new fears, constricted and repetitive play, hyper-vigilance, reckless and accident-prone behaviour, and a fear of injury. Toddlers may also regress to baby-like behaviour and suffer physical complaints or illness.¹⁹

18. Lynne Murray & Liz Andrews, *Your Social Baby*, (2000) reminds us that babies have their own mind, and are actively engaged from the very beginning of life.

19. Drell, Siegel & Gaensbauer, "Post traumatic stress disorder," in C. Zeanah (Ed), *Handbook of Infant Mental Health*, (NY: Guilford Press: 1993); Zeanah & Sheeringa, "Evaluation of post traumatic symptomatology in infants and young children exposed to violence," *Zero to Three*, (Washington DC: 1996).

With all this in mind, how can we be sensitive to and effective communicators with these traumatised infants? The most important and immediate response is to view the infant as a person in and of himself, with distinct needs, and not merely an extension of the mother. We can start by acknowledging infants and being curious about what it is that infants might be trying to communicate about their world and their capacity to articulate those needs. We can let infants initiate gaze with us, being careful not to overwhelm them with too much or too little of our response. We can observe carefully their body language and listen to their verbal cues; following their lead whilst still affirming our interest in them as participants in a relationship with us. We can say their name and include them in conversations.

Play as the language of the infant

Many adults have few opportunities for play, yet play is one of the first tools through which we explore the world and understand ourselves. Getting down and playing with the infants and children we work with and including their parents, can bring about surprising results. Having a chance to sing, draw, roll a ball, make a joke, rattle a tambourine, imagine a story with plastic tigers and dinosaurs, or dance about, can all bypass one's usual patterns of responding. It can also reveal and allow opportunities to revel in, other sensory experiences and ways of communicating.

The most important and immediate response is to view the infant as a person in and of himself, with distinct needs, and not merely an extension of the mother. We can start by acknowledging infants and being curious about what it is that infants might be trying to communicate about their world and their capacity to articulate those needs.

We may not understand all that they are trying to communicate and we may not understand how they might be feeling, but it is the effort that we make to acknowledge, be with and think about these little people that can make the world of difference.

Infants communicate a great deal through play, so it is helpful when we take the opportunity to be playful and interact age-appropriately with them. It can be as simple as sitting on the floor and playing blocks with a one year old while you talk to his mother:

- Be warm, open and responsive to the infant's communication — we know that babies are interested in social interaction and curious about people from birth.
- Acknowledge the infant by speaking to him in age-appropriate language and engaging in eye contact.
- Be playful and interested in the infant's point of view — enjoy getting to know him.
- For babies, speak softly and repeat back cooing and babbling sounds.
- Sit on the floor with the primary caregiver and toddler (if it's appropriate) and respond in a calm and warm manner.
- Play alongside a toddler without expecting cooperative play. Engage the older infant or younger toddler, think of play as a window into the infant's point of view and observe sequences and repetitions.
- Talk with the toddler — perhaps gently asking about the play you observe. For example, "You are playing with the red ball," or "Can you tell me what's in your drawing?"

Remember that being over-bearing or intrusive in your interactions with an infant impinges on their personal space as well as their developing self-agency. Under-relating deprives the infant of opportunities for healthy stimulation and interaction. Learning the balance involves listening to and learning from the infant.

A depressed infant may need encouragement to become more lively, while the anxious infant may need help modulating (or managing) his emotional state. Take your lead from the infant through observing him, how he interacts with his parent and how he interacts with you. If you find engaging with him to be hard work, then that might be a clue to how hard the infant finds it himself.²⁰

Infants can understand more than they can express, so it's okay to speak to them about what they are doing, how they might be feeling or even what you might notice in the interaction between infant and mother; "It looks like you and mummy are feeling sad today." Getting it right with an infant the first time is not very realistic as infants themselves are very much exploring and trying to make sense of their world. Whatever you say or do, infants need to be noticed and kept 'in mind' (thought about and wondered about).

Image opposite:
'My three houses' by four year old



Reflection

A mother and her infant boy had been at the refuge for about two days. They were both originally from The Congo and did not speak any English. The mother chose to stay in her room for most of the morning as she was speaking with a support service via a Telephone Interpreter, trying to plan their next move to long-term safe accommodation.

When I was first introduced to the boy, he was running around the yard aimlessly. Looking at toys, touching them (not playing), then moving on. He looked lost and very sad. Clearly he could not understand what I was saying but I spoke anyway, in 'broken English' with a lot of pointing and, I guess, facial expression. I offered him a ball. He approached me, looked at the ball, touched it in my hand and then stared into my eyes. His eyes were deep dark pools, sad and searching. We held the ball together for a moment, as we both looked deeply into the other's eyes and he smiled. I copied. I said to him "shall we play?" as I tossed the ball gently in the air and he reached to try and catch it. For about 5 minutes he then played a sort of catch (or throw straight up in the air) with me, and if I missed the ball he would look at me as if to say "get it."

I remembered there were some dolls in the laundry and another worker was in there so I said to him "come," as I motioned with my index finger. He followed and his eyes opened widely as we entered the room. The laundry was a large room that also stored clothing and blankets — probably an interesting room to a small child with all the colours and soft materials about the place. As I searched for the dolls, the boy stood close by me and there was an upturned container he started to tap. I then followed his lead and began tapping it lightly. I said "drum." We took turns. It seemed that this would be much better than a doll, so I suggested we take it outside with us and he followed.

On the way through I grabbed two large pencils for drum sticks. I sat on the bench and placed the drum next to me. He stood beside it and again began tapping with his fingers as he looked up at me inviting me to follow. We continued to take turns, almost like 'duelling banjos' (but with drums!), the drumming got louder and harder. His affect was somewhat flat throughout, though it did gain some intensity when he began banging the drum hard. I followed, and copied his expression (which appeared angry). I made a "GRRRRRRRRR" sound as I did this, and he copied.

This went on for a few minutes until he began to laugh and so did I. He suddenly stopped, and stared, with his hands still placed on the drum — again, lost. My heart sank as I wondered what this boy had seen and how the laughing may have actually been painful for him or confusing for him as it was a bit for me. I knelt in front of him and caught his eyes, again deep dark (and watery) pools. I said “Oh dear, you look so sad” as I placed my hand on his. He looked down at our hands, his as black as night and my white freckled hands. He then rubbed his thumb against mine and looked again, into my eyes. I sighed, he smiled and then indicated “come” with his hands as he stepped up the stairs towards his flat — wanting me to go with him (perhaps to meet his mother). I knocked as I entered and when we got into the lounge his mother was still standing talking on the phone. She turned to me, smiled and took him to her side, stroking his hair...

REFLECTIVE QUESTIONS

1. What do you think the toddler was communicating when:
 - I first saw him running around?
 - we made eye contact?
 - playing the drum?
 - he led me into his flat at the end of the scenario?
2. What was I communicating to the boy when:
 - I first met him?
 - we began to play?
 - playing the drum?
3. Think about a current case at your service. What messages have you noticed to be communicated by the infant? Perhaps you can discuss this with your colleagues.

Helping mothers to think about their infants

The baby may be the last thing on the mother's mind and this may be because she can see that the baby is being cared for appropriately; is fed, warm and rested. It may also be that the mother is caught up in her own trauma or that she cannot bear to think about the experiences or feelings of her infant due to her own feelings of shame and guilt.

THE PHYSICAL AND PSYCHOLOGICAL IMPACTS OF VIOLENCE ON MOTHERS MAY AFFECT THEIR PARENTING CAPACITIES, PARTICULARLY THEIR EMOTIONAL AVAILABILITY AND ATTUNEMENT TO THEIR INFANT'S NEEDS. A worker in a women's refuge may at times feel as though she is 'left holding the baby' while the mother is desperately trying to find secure accommodation, make contacts with Centrelink and avoid contact from the perpetrator of violence.

Throughout this period, the baby may be the last thing on the mother's mind and this may be because she can see that the baby is being cared for appropriately; is fed, warm and rested. It may also be that the mother is caught up in her own trauma or that she cannot bear to think about the experiences or feelings of her infant due to her own feelings of shame and guilt. Thinking about the full impact of family violence on mothers, perhaps we can then imagine how it would be very difficult under the circumstances to give the full attention and care that children require, when there is so much loss, grief and uncertainty in the past, present and future.

"When a mother is unable to see their baby as a subject, or to access thinking space for their baby, we may act as the eyes, and the mind that assists them to find their baby, and even themselves, in relation to their baby. a change in the infant's internal representations may change that within their mother. Our attuning to a baby in despair may access a sense of hope."²¹

As important as being sensitive to observing and involving infants and children in this picture, is our ability to facilitate an understanding within the parent of how central they are to their infants' development and how intensely their infant yearns to be seen and understood by them. This is not as straightforward as "you need to understand that you are probably going to be the most important influence in this child's life!" For parents who have themselves experienced very poor parenting, or abuse or neglect, emphasising their importance as a parent may give rise to challenging their view of themselves as essentially unimportant. It may also evoke a powerful feeling of shame as a parent, and shame may be something they have worked very hard over many years to defend themselves against.

How we ask parents respectful questions, make subtle observations and perhaps create space to reflect on what was happening to *them* as infants/children may offer a window into their own early experiences. Allowing them to tell their stories from the past may unlock some doors that open a new picture of themselves as children — vulnerable and dependent on their parents. This family system we are working with needs to be respected, inviting infants and children into the whole story rather than ushering them out as a nuisance or burden on their exhausted parent/s.

Instead of directing all questions to mothers, it may seem appropriate to invite the infant or older child into the conversation with: "It seems like you and Mummy had a very scary night last night?" "It must be frightening to see Mummy being hit and yelled at?" or conversely to Mum, "What was your daughter doing when you were being abused?" "Do you remember what it was like witnessing the violence between your parents when you were a child?" These questions can reveal how much or how little family members know about one another. They can prompt conversations not normally had and open pathways to relating differently.

We have the capacity to contribute something towards 'holding' infants and their mothers, through how we build our relationship with the families we work with.

'Holding' means providing a space through our presence, our interactions, our manner and our thoughtfulness that allows mothers who may be highly distressed to not 'just react to their anxiety' but to begin 'to think about its meaning.'

This involves supporting their capacity to make sense of their experiences and to reflect also on how their infants may be making sense of things. Our calming presence and our 'being with' may offer a positive experience (perhaps one not provided by their own parents) and an enormous relief. When an infant or child is highly distressed, what he wants most, what he needs, is to be held by someone bigger than he is, who he trusts to take over this 'big scary stuff' that he is too small to handle, and who will affirm his right to want to feel safe and protected.

Do you see what I see?

When a mother is struggling to 'see' her infant (by that we mean to think about, acknowledge and appreciate the infant's own experience of violence), we can assist by being the eyes and mind that see and think about the infant and by sharing this vision with the mother. We can ask such questions as: "What do you imagine your baby is thinking or feeling about coming into this new and strange place?" or "Can you tell me what you have noticed your baby doing if he becomes distressed, frightened, feels happy or lonely?" Maybe even asking, "And what are the things that may make your baby feel like this?" Just introducing the idea of the baby having emotions or feelings can be astounding for some parents. Even more surprising for some is the notion that how she, the mother, is feeling, directly affects how the infant is feeling.

Whether as a worker in a refuge setting, a worker from a support service or the case manager, the impact of how we are 'in relationship with our clients' can be startling. How we look at, engage with and interact with caregivers, infants or children is important. Our bending down to introduce ourselves to children or directly addressing an infant to explain who we are and what we do is observed by the parent. Our articulating what we see, say for instance if we notice that the

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little boy in this family “look’s really sad when I talk about having to find you all a new place to live,” gives voice to the possibilities of experience this child might have, and brings his presence into the picture. It treats him as an important and worthy recipient of attention and reminds his mother of this.

We cannot know all that is in the mind of another human being, and how well we manage our anxiety about ‘not knowing’ can reassure anxious parents who may feel like failures if they don’t get it right. Like a new mother and baby, we want to explore, keep an open mind and be prepared to make mistakes.

As an adult-centric society we can, without thinking, automatically defer all things (including asking a parent how a child is when the child is sitting right there with you) to the adults in the room. These adults may well be so caught up in their own trauma history and experiences of damaging relationships, that shifts in thinking are difficult to achieve.

While not in every case, most parents hold a hope for their infant’s future that is far more enlivened than for their own. A desire to be a different kind of parent or to provide a different future for their offspring is a powerful motivator. In other instances, ones capacity to simply see, engage with and delight in their children can offer parents a new and intriguing insight into what ‘might be’ for their infant and within their relationship.

Reflection

A woman and her three year old daughter had come to the refuge during the night. They had fled their home and both had arrived at the refuge in a traumatised state. The mother was, however, generally attentive and engaged with her toddler the following morning, when I arrived. I invited them into the playroom, where the young girl wanted to draw and her mother sat with us telling me the story that led to them coming to the refuge. Her husband had been violent for as long as she had known him, he was an older man who controlled everything she did. She had never left him before, but had planned her escape for a month or so and said she was relieved to be 'out.' She asked about the impact of violence on her little one...

A refuge worker came into the playroom and said she was passing on a message to the mother to say that a taxi had arrived to take them to a long-term refuge. At that point, the mother went into a terrible panic and said to her daughter "come on, we have to go NOW. I have to gather up our things, you have to come with me NOW." I noticed the response from the girl was both panic and confusion as she was being told to leave an activity she was not only enjoying, but was focused on her and her mother's wellbeing. I said to her mother, "You know, the taxi driver will wait, just take your time there is no rush." Her daughter began to cry hysterically. I said "Oh you are frightened. You can hear that Mummy is in a panic and it scares you. Did this happen to you last night?" As I said that, the little girl stopped, looked me in the eye and nodded, her mother then hugged her and began to cry. "I'm so sorry," she said. "This is exactly what happened last night. I rushed her out of the house and she was crying for her Daddy." She then looked at her daughter, "I didn't mean to frighten you. Sorry sweetheart." I told them I would speak to the taxi driver and ask him to wait. As I was leaving the playroom, another refuge worker asked "What's wrong in there?" After I explained what had happened and that I was going to speak to the taxi driver, the worker said "No, the taxi isn't here yet, the other worker was just supposed to tell you that it was on its way...!"

REFLECTIVE QUESTIONS

1. What are the benefits of a worker inviting both mother and infant to sit together, playing/drawing and talking?
2. This particular mother seems quite responsive to her daughter. At what point did she 'drop' her daughter from her mind and why?
3. How could the workers in the refuge have better communicated with this dyad (mother & child)?
4. What could be learnt from the above exchange by the worker and the mother?
5. What do we understand about the daughter's experience and relationships through her communication?

When infants are at risk of further abuse or neglect

We don't have all the answers, but we do know that we all need to think and act protectively when it comes to the most valuable members of society and the most vulnerable victims of family violence.

IT MAY WELL BE THAT YOU HAVE TRIED TO ASSIST A MOTHER AND HER INFANT, BUT YOU HAVE REAL CONCERNS FOR THE INFANT'S SAFETY. This may be because a mother has decided to go back home to a violent partner or that you sense she herself is violent. You may be concerned about a mother's capacity to care for her infant and to keep that child safe from violence, or you may be worried that the infant is being seriously neglected.

We have all seen the cases where a mother may say all the 'right things' about her infant yet she demonstrates quite the opposite behaviour. This may of course be because she is so traumatised by violence she is struggling to care for her child.

However, as we have spoken about throughout this booklet, infants do not have a voice, and need us to sometimes be their voice or at least to advocate for their wellbeing. If you have concerns, there should be policies in place that will guide you to act in a protective manner and if we are not legally bound then we are professionally and ethically bound to the reporting of abuse or neglect of infants and children.

Infants who are at risk of abuse and or neglect require a timely response from workers as they can not afford to wait for things to improve. Hopefully, you have support within your service, perhaps a Manager you can consult with, who will assist you with the process of action. While making a notification to a child protection service is not a pleasant part of our job, we must consider the vulnerability of infants and the risk factors involved.

We do understand the complexities of this matter, and have experienced working with infants and their mothers where we have felt that the issue of abuse and neglect is unclear and we are unsure how to act on these appropriately. Again, we suggest discussing your concerns within a supportive and consultative workplace 'culture.' Creating a space for yourself and/or other workers to discuss these concerns can assist to create better outcomes for infants at risk. Through the support of managers or other workers it may be that there is an opportunity to work more closely with the family if one worker is identified as having established a 'therapeutic relationship' with the infant and mother. Perhaps someone in your team can help to come up with an appropriate solution or referral?

We don't have all the answers, but we do know that we all need to think and act protectively when it comes to the most valuable members of society and the most vulnerable victims of family violence.

Image opposite: 'Where I live' by three-year-old



Reflection

Sarah (23) and her three month old daughter Emily entered the crisis service late in the afternoon. Sarah was talking quite fast and constantly moving around, often jiggling Emily in her arms. Sarah had stated from the moment that she arrived that she was not sure what to do and was considering going home to her partner and his family. Sarah was happy to talk through her options with workers and Emily was always present. Sarah would also ask if it was okay for workers to hold or mind Emily 'quickly' while she did things and was quick to offer Emily to workers. Emily would make sounds and hold eye contact with workers but as soon as Sarah was out of sight, she became distressed and inconsolable. Sarah stated that this was a normal occurrence whenever she was out of sight.

Workers were struck by the large circles under Emily's eyes and her constant sleepy gaze. Sarah stated that Emily 'was not sleeping properly and did not have a regular sleep pattern.' Workers observed Sarah trying constantly to put Emily to sleep, feeding her a bottle, rocking, soothing. But Emily would not sleep. On one occasion Emily did fall asleep but woke only 20 minutes later. On another occasion a worker offered to take Emily from Sarah's arms and sit quietly with her (aware of all the talking and constant movement Emily was surrounded by) and Emily did fall asleep, though woke 15 minutes later, startled and distressed.

Sarah stated to workers that her partner was a 'good Dad' and adored Emily and that he did not and would not ever hurt Emily. When asked where Emily was when her father had smashed Sarah's head down onto the concrete path, Sarah stated she was inside the house and did not see and was often asleep when they would argue. Sarah also stated that she had a very short temper and would often 'fly off the handle' and 'start' the arguments with her partner. She also stated tension was high in the house as she and her partner lived with his parents and sister and Sarah was constantly being over ruled or ignored by his family when it came to raising Emily. Her sister-in-law referred to Emily as 'it' and never once called her by her name, which upset Sarah.

Sarah stated she would like to get an Intervention Order to protect her and her daughter when she went home as she had decided to give her partner a second chance at being a family together. Sarah and Emily left the service, returning home to her partner after staying only one night.

REFLECTIVE QUESTIONS:

1. How do you feel after reading this?
2. What is your immediate concern for Emily and Sarah?
3. How might you respond to your concerns?
4. What are the policies/procedures around managing this situation in your service?
5. When notifying to Child Protection Services, do you discuss this with the family involved? Why/why not?



Conclusion

WE HAVE EXPLORED AT GREAT LENGTH, THE IMPORTANCE OF WORKING DIRECTLY 'WITH INFANTS' WHO HAVE BEEN A WITNESS AND/OR VICTIM OF FAMILY VIOLENCE.

This booklet has discussed the fragility of infants, both physically and emotionally and the need for the infant to engage with others to make sense of their world. We have provided you with some useful information and hopefully inspiration to not only continue the amazing work that you do, but to try to see things from the infant's perspective, from the moment they enter your service. In writing this, we have attempted to see things from your perspective as well and to acknowledge that this work is often chaotic, unpredictable and emotionally draining.

Through the authors' collective experience in working in a women's refuge (McAuley) directly with infants and their mothers and working with and learning from the workers within that refuge, we have been privileged to bear witness to some incredible changes within infant-mother relationships, within the workers themselves and within the organisational culture.

Ultimately, our aim is to encourage a shift within all women's refuges across Australia that will assist to minimize the negative impacts of family violence and facilitate the best possible outcomes and future opportunities for infants. We hope that this resource encourages you to become a voice for those infants who find themselves in your service due to being the otherwise voiceless victims of family violence.

And finally, again we say "**Thank you**" for the incredibly valuable work that you do.

Image opposite:
'My recurring nightmare' by eight year old who
had witnessed family violence since infancy

Article Reviews

Below are reviews of some of the articles that have helped to guide our work and we would highly recommend you read the originals of these articles as well. We also have a list of recommended reading, if you have any spare time!

GHOSTS IN THE NURSERY: A PSYCHOANALYTIC APPROACH TO THE PROBLEMS OF IMPAIRED INFANT-MOTHER RELATIONSHIPS by Selma, Fraiberg, Edna Adelson and Vivian Shapiro published in the 1975 *Journal of American Academy of Child Psychiatry* (14) pp 387-412.

Whilst this article is now decades old and the work being undertaken considered revolutionary (in its time) as it took place in the home, the ideas it concerns itself with have certainly stood the test of time. The authors were undertaking work with very damaged families and had the luxury back then to be able to stay working with families for years rather than our time limited 'weeks' or if we are lucky 'months.' It is well worth (and we highly recommend) reading the original article if you can and be prepared to read it over a number of times because the ideas being expressed are complex but very important and very valuable to consider.

The essential idea they are discussing is that we all have 'ghosts' from our early childhood experiences where "intruders from the parental past may break through the magic circle in an unguarded moment, and a parent and his child may find themselves re-enacting a moment or a scene from another time with another set of characters" (p. 387).

Most parents can push these unwelcome intruders aside or may seek professional help to help rid themselves of these ghosts quickly enough. There is then another group of parent who seem to in fact be "possessed" by past 'ghosts' or past traumas that and "while no one has issued an invitation, the ghosts take up residence and conduct the rehearsal of the family tragedy from a tattered script" (p. 388).

The idea of the transmission of family violence from one generation to the next is not a new idea to many of you. What might be helpful to consider is how the parents of the infants and toddlers we work with may be re-enacting the past (and how they were treated) as a way to protect themselves from it. This may sound funny, but in order to protect oneself from the enormous emotional blow that your parent may leave you in harms way or at least fail to protect you from it, that they may feel murderous feelings towards you or may deliberately hurt you, is just too overwhelming, too frightening and too sickening that you push it away and emotionally disconnect. This is done in order to survive, to keep up that idea we have discussed previously of just keeping going, of doing what you have to, to keep 'one foot in front of the other.' When the child becomes the parent and their child is emotionally asking from them what they were never given it is just too much and they again 'emotionally disconnect.'

How can we as workers open up opportunities for a parent to revisit their past? Not just as a hollow 'retelling' of their story, but as one that enables them to be safely supported by us whilst they take a risk. This risk involves allowing themselves to emotionally reconnect with their feelings of abandonment, anger, shame, guilt or whatever it is that they have held at bay for so long and with such a force of strength. For example, we can reflect with them on how frightened they must have been when no one came to answer their calls for help, or how ashamed, guilty, confused they may have felt when they were forced to watch things between their parents they did not understand and did not want to see. With each unique story comes our capacity to respectfully hear their story and offer bridges for a connection between what happened and how they felt about what happened. We can affirm their right as a child to have felt sad, disappointed, angry or whatever they felt whilst empathically registering how terrifying and difficult that such big events were happening to so little a child. The purpose is to facilitate an ability for the parent to feel some empathy for themselves as a child as a step towards reflecting (with their head and their heart) on what it might feel like when their child looks to them for comfort, support or protection and finds they may not be there for them, either in body or in spirit.

Why is this article complex? Because the work they are talking about is complex and rarely happens quickly but it is worth taking the risk in attempting (slow and gentle steps to start) as this type of bridge building can open up marvellous and very healing pathways for both parent and child.

ANGELS IN THE NURSERY: THE INTERGENERATIONAL TRANSMISSION OF BENEVOLENT PARENTAL INFLUENCES by Alicia Lieberman, Elena Padrón, Patricia Van Horn and William Harris published in 2005 *Infant Mental Health Journal*, (26,6) pp 504-520.

This much more recent article (again we highly recommend reading the original) is in some ways a direct tribute to the original 'Ghosts in the Nursery' article but paints a very different colour scheme where the authors talk equally about the importance of capturing the 'Angels' who have occupied the nursery of parents' pasts. Experiences of being loved, cared for and understood must also be recognised and built upon. The authors "argue that uncovering angels as growth-promoting forces in the lives of traumatised parents is as vital to the work of psychotherapy as is the interpretation and exorcising of ghosts" (p. 504). This approach fits much more readily with a 'strengths based' approach to honouring and further growing the positives that may exist in the background but have been eclipsed by so much trauma and tragedy.

These angels may have visited in the form of the parent or in other adults/carers as they were growing up such as aunts, uncles, grandparents or others. The ideas in this article encourages workers to help make visible relationship experiences that were positive and protective and exploring how these felt and might now be re-created for their infant in the way they now relate to them. This work, just as in the previous article, is about bringing to the surface these early childhood memories and emotionally connecting with them. In fact, they suggest that by

doing both (recovering the 'ghosts' as well as the 'angels') we will more likely speed up the recovery from trauma and enable parents to more successfully handle both the 'good' and 'bad' stuff (which in reality we are made up of both) instead of seeing things as 'all good' or 'all bad.' Identifying the 'good stuff' and for parents re-connecting with how that felt is just as powerful, they argue, in enabling a "maltreating parent to find empathy with their children's vulnerability and to discover their crucial role as their child's protectors" (p. 508).

Both this and the previous article are written for those workers who have an understanding of psychotherapeutic ideas. We are not suggesting you should go out and get yourself a degree! We do think, however, that these two complementary ideas about understanding how trauma in early childhood does play out in later life are very useful and that there will be times when it feels comfortable to apply them to how you think about and work with the parents in your refuge.

WATCHING, WAITING, AND WONDERING: APPLYING PSYCHOANALYTIC PRINCIPLES TO MOTHER-INFANT INTERVENTION Infant Mental Health Journal, E. Muir, (1992) Vol 13, No. 4.

If we think about the concept of 'the ghosts in the nursery' and how a mother might, unaware, re-enact the relational patterns that she has experienced, it makes sense to work on these unresolved conflicts of the past in order to assist an infant and mother to focus on their relationship in the present. 'Watch, Wait and Wonder' is an infant led approach that specifically and directly uses play where "the infant takes the initiative in changing interactions that can potentially change the relational system." (p. 320) The approach provides space for the infant and parent to work through developmental and relational struggles through play.

Muir introduced a simple set of instructions to mothers: to become a non intrusive observer of their infant, to only interact when invited by the infant, and to allow the infant to initiate the play/interaction. The role of the therapist is to provide the 'safe space' for this to happen and to contain the sessions by engaging the parent to be reflective about the child's inner feelings, thoughts and desires. Through this, the mother can recognize the separate self of the infant and develop an understanding of her own emotional responses to her child.

Watching, waiting and wondering can allow us all the space to think and to be curious. In our work with infants and their mothers, we can model this curiosity by asking mothers questions like "what do you think he is wanting from you?" or "what do you imagine he is feeling?" We can also reflect on our own feelings while talking to a mother about her experience of herself and her infant.

In our work, the authors often do this watch, wait and wondering quite automatically and we know the benefits in not 'diving in' to try to change things but to rather be able to observe and think about the infants and their mothers, especially if the mothers thinking is 'stuck'. The real 'work' in this type of intervention, takes place between the infant and mother, while the worker is providing the safe, holding and containing setting for exploration of feelings/memories that are stirred up by the mother's experience with the infant.

Of course, in working with infants we are well aware that there are times when we need to be more direct and take action, because an infant who is in dire need cannot wait. However, we can always be watching and wondering with our clients, as we can provide a thinking mind for mothers that may otherwise be lost due to the trauma associated with family violence.

'FREE TO BE PLAYFUL': THERAPEUTIC WORK WITH INFANTS (1999). Thomson-Salo, Paul, Morgan, Jones, Jordan, Morse & Walker.

Members of the Royal Children's Hospital Melbourne (RCH) Infant Mental Health Team have compiled a number of examples of their therapeutic work with infants and their parents with the emphasis of that work being the direct and playful approach with the infant as subject of intervention. The teams' work is informed by Winnicott's observation that "Children play more easily when the other person is able and free to be playful" (Winnicott, 1971).

They argue, that whilst observation and waiting, wondering or working with the infants' parents around the 'ghosts in the nursery' or what the infant represents to her parents are all useful therapeutic tools, that the direct work with an infant (especially one who is seen to be very unwell) can bring about change in the infant that then creates change in the parent and their relationship.

When we think about working with infants in a crisis accommodation setting, we do not have much time at all to assist with this relationship, so what can we achieve in this small window? Thinking of some of the vignettes offered to you throughout this booklet, you may see that in fact the direct work with an infant can facilitate change and even if that is to assist a mother to identify that her infant is an individual who too has experienced the violence, may be all the infant requires from you-for then there is opportunity for further work or support that a mother may seek on behalf of her infant. Often in Peek-a-Boo Club™ groups a mother will state that she continues to come to the group because she sees that it is 'good for her baby' and that she enjoys seeing her baby in a different light. Perhaps this is because the baby is being enjoyed by staff, when we try to communicate with the infant we are telling them and their parent that they are worthy of a relationship/playmate and that their experiences and feelings are valid.

The clinicians at RCH are genuinely interested in the infants they work with and acknowledge that the infant has a story of their own to tell. This article highlights what can be achieved for an infant in a very short time (often in one session) and reminds us that infants cannot wait. When we as workers can allow ourselves to be playful and open to actively engage with an infant who has experienced trauma, then we make it possible to allow the opening up of a whole world of communication that is vital to the infants' survival. As discussed in **Modules 1 and 4**, we do have time for this play in our work and this type of work is indeed that which is most beneficial to infants.

Again, we highly recommend that you read the original paper for a better understanding of the possibilities of this work.



Further Reading Resource List

PLAY

Russel Meares, *The Metaphor of Play: Disruption & Restoration in the Borderline Experience*, (USA: Jason Aronson Inc, 1993).

DW Winnicott, "*Mirror-Role of Mother and Family in Child Development*" (chapter 9) in *Playing and Reality*, (London & NY: Routledge, 1971).

IMPACT OF VIOLENCE

Alicia F. Lieberman and Patricia Van Horn, *Don't Hit Mommy: A Manual for Child-Parent Psychotherapy with Young Witnesses of Family Violence*, (Washington DC: Zero to Three Press, 2005).

Frances Thomson Salo and Campbell Paul (eds), *The Baby as Subject* (Melbourne, Stonnington Press, 2007).

BODY AND BRAIN

Daniel J Siegel, *The Developing Mind: How relationships and the brain interact to shape who we are*, (USA: Guilford, 1998).

AN Schore, "*The Effects of Early Relational Trauma on the Right Brain Development, Affect Regulation, and Infant Mental Health*," *Infant Mental Health Journal*, 22:1-2, (2001):201-269.

AN Schore, "*Attachment, Affect Regulation, and the Developing Right Brain: Linking Developmental Neuroscience to Pediatrics*," *Pediatrics in Review* (2005).

ATTACHMENT THEORY

Jeremy Holmes, *John Bowlby and Attachment Theory*, (London: Routledge, 1993).

Colin Murray Parkes, Joan Stevenson Hinde & Peter Morris (eds), *Attachment Across the Life Cycle*, (London: Routledge, 1991).

Frances Thomson-Salo, Ruth Wraith, Jenny Re, *Fractured Attachments: The Foundation of Longterm Difficulties*, (Parkville, Melbourne: Department of Child Psychotherapy, Royal Children's Hospital, 2002).

Yeo, S. S. (2006). *Bonding and attachment of Australian Aboriginal children*. *Child Abuse Review*, 12, 292-304

Useful Web Pages

The Australian Institute of Family Studies National Child Protection Clearinghouse: www.aifs.gov.au/nch/resources/links/links.html

The Australian Association for Infant Mental Health Inc.
www.aaimhi.org

The Alannah and Madeline Foundation
www.amf.org.au

Child Trauma Academy
www.childtrauma.org

Child Abuse Prevention Service
www.childabuseprevention.com.au

Domestic Violence Resource Centre Victoria:
www.dvirc.org.au

Zero to Three National Centre for Infants, Toddlers and Families
www.zerotothree.org

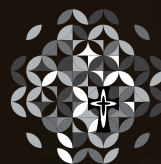




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