

# Baby lead the way: Mental health group work for infants, children and mothers affected by family violence

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## ABSTRACT

*'Infant led' and 'child led' interventions designed to address the affects related to familial violence honour a 'child up', rather than a 'parent down' approach to dyadic work. The capacity to form healthy attachments is largely developed within early childhood. Relational disruption resulting from familial violence threatens to impair healthy attachments and the subsequent neurodevelopmental sequences involved in affect modulation. Two innovative mental health group work interventions within the Western Region of Metropolitan Melbourne work to enhance the attachments of infants and mothers, and children and mothers/carers affected by family violence.*

**Key words:** infant mental health; infant led; child led; family violence; group work

Much has been written about early childhood relational disruption through trauma and its capacity to compromise the development of the infant's brain. When exposed to overwhelming and ongoing trauma, the excessive secretion of potent neural chemicals intended to protect the individual in fact compromises neural development in the immature brain. Such early experiences are believed to jeopardize the devel-

opment of important neurobiological systems involved in core stress regulation up to the higher order networks involved in emotion modulation (Cozolino 2006; Perry et al 1995; Perry & Szalavitz 2006 Schore 2001; 2003a; 2003b; Siegel 2007; Streeck-Fischer & van der Kolk 2000; Teicher 2002).

We understand that affect regulation is impeded by severe and sustained relational trauma,

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particularly when this trauma is combined with neglect (Schorer 2003a, 2003b). Schorer (2001) contended that the highly distressed infant, left psychologically unattended by a mother who herself has been traumatized, will eventually move to mirror the unresponsive emotional state of the parent. How do we use this information to inform our practice? What do we do 'on the ground' when working with infants, children and mothers who have been exposed to prolonged and severe family violence?

This paper speaks to a way of working that could be best described as 'infant led' and 'child led'. It then details two mental health group work interventions that use this approach. These two child/parent programs attempt to address the relational aftermath of living with familial violence through a 'child up', rather than a 'parent down' approach to dyadic work. At their core both interventions endeavour to remain:

true to a process that is child led and not set by the compass of adult expectations. Children feel safe when they are heard, irrespective of whether their communication with us occurs verbally or non-verbally. They also feel safe when their environment can meaningfully tolerate who they are and what they have to offer, and reflects back an affirming and respectful image of self. (Bunston 2001:9)

## INFANT LED AND CHILD LED APPROACHES

Stern (2003: xiii) contended that 'self/other differentiation is in place and in process almost from the very beginning' and that one's development is 'a progressive cumulation of senses of the self, socioaffective competencies, and ways-of-being-with-others' (2003: xii). The infant, in and of itself, is a subject with its own capacity for complex representations and an ability to engage in a therapeutic relationship (Jones 2007; Thomson-Salo & Paul 2007; Thomson-Salo et al 1999).

Infant/child led work requires a shift within the mind of the therapist. It promotes a stance of

curiosity about just what the infant/child may be thinking, imagining, expressing and feeling. Infants and children are not objects that we do things to, nor are they passive participants in the therapeutic process whom we work on. Rather, they are willing, able and available unique subjects who are communicating volumes to their external world about how their internal world is faring. Winnicott (1971: 111) suggested that when the infant looks into the face of his mother, 'ordinarily what the baby sees is him or herself'. This reflection is also what he suggested psychotherapy can provide: an opportunity for reflecting back what a client, or in this case, a baby/child brings.

The infant who persistently avoids her parents gaze, the toddler who becomes rigid when a particular adult approaches, the young child who indiscriminately attaches and the youngster who throws chairs around his classroom may be telling us much about what they have seen of themselves in the faces of others. Fractured attachments as a result of exposure to violent, chaotic and terrifying dynamics between and by their primary caregivers require therapeutic responses that promote relational attunement and tackle affect dysregulation through promoting healthier patterns of attachment.

Infants suffer from depression, anxiety, attachment and sleeping/feeding difficulties, just as older children and even adults do. They are tremendously open to interactive and playful experiences with their primary caregivers, enjoying visual, sensual and auditory stimulation and are highly malleable to experience, positive or negative, due to the sequential neurodevelopment they are undergoing at this formative stage of life. Early work with infants and their caregivers can positively change neural, relational and psychological attachment patterning within infants (Thomson-Salo et al 1999; Waters 2004) and within the infant/child and parent relationship.

We know that intervening early in the lives of infants and children promotes psychological resilience which can lead to positive changes in

developmental pathways (Australian Institute of Family Studies 2003). Early intervention is critical to disrupting the inter-generational transmission of familial violence (McGee 2000; Rossman, Hughes & Rosenberg 1999) and promoting healthier, more secure attachments (Bowlby 1988). As experts in the area of infant mental health have noted, the earlier work is undertaken with children who are experiencing difficulties, the less intensive this work needs to be (Thompson-Salo & Paul 2007).

## **INFANT LED AND CHILD LED GROUP WORK INTERVENTIONS TO ADDRESS FAMILY VIOLENCE**

### **PARKAS**

Parents Accepting Responsibility Kids Are Safe (PARKAS), for children 8 to 12 years of age and their mothers/carers, began as a collaborative Child and Adolescent Mental Health and Community Health initiative in 1996 in the outer western metropolitan suburb of Melton, Victoria (Bunston, Crean & Thompson-Salo 1999). It is informed by systemic thinking, but utilizes a strong psychotherapeutic approach, incorporating attachment theory and an awareness of current neurodevelopmental thinking while building on the existing strengths and competencies of group members (Bunston 2006a).

Many existing child/parent programs run two separately facilitated groups, one for the children and one for the mothers. Some programs run these groups parallel to one another, and then come together for conjoint work halfway through, creating one larger group. Where PARKAS differs from other existing programs is that the same facilitation team runs both the children's group and mothers/carers group.

Utilizing the same facilitation team for all components of the program is deliberate, as is having a group for the children and then a group for the mothers/carers. The toll from years of living with violence is considerable, even when the perpetrator has gone (eg the distress and disruption

around access visits, the fear of being found/re-assaulted by the perpetrator, or the re-enactment of traumatic and abusive relational styles). The attachment styles of these child/parent dyads are often deeply anxious, fragile and chaotic and move between being highly ambivalent, avoidant or disorganised. Privileging the child led content of this intervention can require on occasion a mediating buffer.

The facilitation team can act as a bridge between the children and their mother/carer, as new possibilities for hearing and digesting the experience of the other is created. This is particularly so when the meanings they have each attached to what have potentially been shared experiences are vastly different. Facilitating both groups enables the facilitators to hold the child and parent 'in mind', while integrating the rich intra-psychic material that emerges within and between each group. This can assist some mothers with finding value in, respect for and tolerance of healthy difference within their child's personality and perceptions.

It also allows the facilitation team to model attunement to the relational demands of both the child and their mother (themselves often victims of intergenerational violence) and to contain the sadness, loss, anger and shame inherent in grappling with the complexities of living with, or having lived with violence within one's most intimate and significant relationships.

Prior to the program commencing, assessment sessions are held with each individual dyad (ie child and mother/carer). They are comprehensive and engage the child around their experience of violence in the presence of their mothers/carer, often with surprising results. Time and time again we have found children willing to talk about what they think violence is and what people in their family do when they are angry. Often mothers are surprised to hear the level of detail they can recall and the fact that they recall anything at all.

Children present us with multiple entry points for discussion, interpretation or obser-

vation. When reluctant to talk they may communicate through body language, the pictures they draw or play they undertake, most often also intently listening to what their mothers are saying. We speak about our experience of running PARKAS, what are some of the things we talk about in the group and what its purpose is while making sure we make time for fun. We also clearly overt our role as mandated professionals, bound by a legislative act within the State of Victoria, to report child abuse and thus limited in our ability to provide confidentiality.

If accepted into the group, we ask both the child and mother to sign a consent form to participate and to tick boxes if they agree to: keep what others say confidential; being involved in our evaluation; their having acknowledged that they understand that we are legally required to consult with or notify child protection if any child in the group is 'at risk'; and permission to use unidentifiable materials and content from the group to assist us in training others to run the PARKAS intervention. We are as upfront, transparent and truthful as we can be about the program and see this initial meeting as critical to setting the emotional tone and psychological cornerstone for the journey that is to follow.

Our experience is that these assessment sessions can often be emotionally exhausting for both us and the child/mother dyad. Sometimes this is the first occasion where they have so fully shared their story with each other and/or others. We convey confidence about our ability to hear and hold their stories, and while able to respectfully explore the traumatic events that have been endured, also show appropriate humour and playfulness. Play is the space in which the sense of self emerges and as we develop in life, ushers in what is known as our 'introspective consciousness': that is, our ability to know that we exist as an autonomous self (Meares 1993).

Much of what we explore within PARKAS is serious, but equally as important is our capacity to create a space for safe healing and safe play. Play is the language of infants and children, pro-

viding a crucial tool set for processing complex information. In particular it offers children opportunities to explore and test out their environment, problem solve, reduce and make manageable what is too overwhelming to digest from their external world as well as gain a sense of mastery, competence and control (Singer 2002; Streeck-Fischer & van der Kolk 2000). When play has become traumatic, repetitious or stuck for some children (eg we had one girl in a group who loved dolls and would, for extended periods of time, show them tender and loving care until she would eventually, methodically and violently decimate them), we may be able to join with and make sense of their play while providing some containment and together explore some restoration and resolution.

The structure purposely supports our child led ethos. We always commence with running the children's group first, usually one-and-a-half hours in duration and typically on a weekday afternoon. The following morning we run the mothers group, usually for two hours, then following lunch we go on to the facilitator's weekly supervision. This structure operates over an eight- to ten-week period with one or two joint sessions (collapsing the two groups into one joint session mid-way through the program as well as for the final session to undertake direct dyadic work). In addition we hold post-group feedback sessions for the individual mothers and sometimes the mother/child. This is followed some two months later by a group reunion.

The range of activities we undertake in the children's group (for example, this may involve drawing a picture of their family) are generally replicated in the mothers group, however always from the perspective of the child (ie draw a picture of what you imagine your child would draw if doing a family picture). We do this to encourage the mothers to shift into thinking about what might be occurring 'in the mind of', or be 'the experience of' their child. Once the mothers have completed their 'child's pictures', and only after having already first obtained the children's con-

sent to do this, we show the mothers what their child did in fact draw.

A picture tells a thousand words. It is not uncommon for a mother to leave out the child's father, or at least place him a considerable distance from the hub of family members drawn, or to include or leave out half siblings and other extended family members. It is not uncommon for children to include fathers within the family hub or include or exclude others the mother has thought of as unimportant to their child. Activities such as this and the resulting congruence or incongruence between what their children think, and what the mothers imagine they think, is at the crux of this program's effectiveness.

The distilling, the disentanglement and the heightened curiosity about what their child just might be thinking and experiencing, particularly if it is at odds with what the mother thinks, is extremely potent, confronting, illuminating and on occasion distressing for some mothers. We use our relationship with the mothers and the dynamics within the group itself to therapeutically attend to this process of reflection and digestion. At some level the children feed us what they think we can safely deliver to their mothers. We then take this one step further, and with the mother's permission, take what the mothers have produced back into the next group to show their children. Subsequently the content from each group feeds into, informs and builds on the other.

Good weekly supervision is the critical glue that holds the facilitation team together as we hold the children and their mothers. This ensures that we are held in mind of another while reflecting on the often complex and usually chaotic 'mind of the group'. It also builds in our own 'mind space', operating as a place for reflection and illuminating our capacity to offer some healthy emotional regulation and relational patterning to the group.

### **'Peek a boo' club**

Over many years our PARKAS assessments re-

vealed that the majority of children coming into the group had lived with family violence from birth and/or in utero. This led to the development of an infant/mother group work intervention, the Peek a Boo Club (Bunston 2006b). Commencing in early 2005, the premise of this intervention is to provide a therapeutic space within which the infants and mothers can safely play with alternative ways of experiencing and communicating with one another. Our focus is on the internal/external world of the infant, the internal/external world of the mother and their dyadic relationship.

The program works with infants up to age 36 months, intervening at a time when the infant is undergoing a critical period of growth neuro-psycho-physiologically. Each group aims to target a particular developmental cluster (ie 0–12, 12–24, 24–36 months). It is within the context of their relationship with their primary caregiver/s that the infant's evolving attachment repertoire is being organised. Through targeting the infant/mother relationship we are endeavouring to disrupt to the cycle of violence known to transmit from generation to generation. Additionally, the receptiveness of these new mothers, and their hopefulness in creating a different future for their baby and thus for themselves, is vividly apparent during what is a very important life stage for both.

Viewing the infant as the subject for therapeutic engagement and retaining a child led philosophy, has set the parameters for this group work intervention. Eight sessions of two hours and a very comprehensive pre-group assessment, as well post-group reunion, are involved. The assessment session combines an overview of the level, nature and perceived impact of the violence experienced by both mother and baby but also borrows what we consider to be key questions from the 'working model of the child interview' (Zeanah & Benoit 1995). This is used to elicit a sense of how the mother perceived her baby, before, during and after their birth, and how she perceives herself in relation to her baby.

Consent forms and pre-group questionnaires are also filled out in the assessment session or the beginning of the very first group session. As with PARKAS, we use this very first contact to set the infant led tone of the group, taking great care to involve the infant, through acknowledgment, observation and playful engagement.

Within the group itself we use playful activities, observations and discussion as a means through which to invite reflection from individual mothers and the group as a whole about what their infants might be communicating about their internal world. We spend considerable time just observing, wondering aloud and following where the infants take us through their play. In essence we encourage the mothers to see and relate to their 'baby (as) a subject' within their own right (Jones 2007; Thomson-Salo & Paul 2007).

Discussions with the mothers about violence, sadness, happiness and fear are sensitively explored and occur in the presence of the babies. Connections between how the mothers have been parented, and how they now parent often arise, as does the convergence between the hopes and dreams they have for their own lives and the hopes and dreams they have for their babies. Observing and noting the infant's responses during the group is extremely powerful. In one recent group, for example, we noticed that one very active and playful infant would suspend her exploring when her mother began to speak about her partner's violence, returning to sit with her mother and once satisfied she was okay, would wander off to play once more.

Through their non-verbal communication, proximity seeking/distancing behaviours, gaze, affect and verbal utterances the babies show us how violence has impacted on themselves and their relationships. Encouraging curiosity and mindfulness about what the babies are communicating to their mothers, to us and the group as a

whole is ultimately about encouraging healthier, more attuned responses to the babies. For example, in one group a toddler threw a toy at another child who then burst into tears. The sound of the other toddler's distress triggered a dissociative state in the first child. The mother, embarrassed by the behaviour of her toddler told him off which appeared to render him even more emotionally unavailable. The mother of the affronted infant comforted and soothed her toddler while looking with disbelief at the mother of the 'perpetrating child'. Unpacking what happened, processing the emotional responses of each infant, mother and what happens between them, as well as making connections between what is happening now and what relational patterning they have both adopted through living with violence can reveal healthier possibilities for understanding and attunement.

Seeing each baby as unique and reflecting on just some of the many influences that effect their early development can open up other possibilities of relating to their infant. The process of thinking about early influences and exploring alternative ways of relating within the group is further explored for the facilitation team through weekly supervision with experienced infant mental health specialists.

## CONCLUSION

PARKAS and the Peek a Boo Club have been well-evaluated utilizing clinically standardised quantitative as well as qualitative measures. In recent years we have introduced more targeted measures in our evaluation of PARKAS; however the longest standing instrument used since 1999 has been Goodman's (1999) *Strengths and Difficulties Questionnaire* (SDQ). 'Statistical analysis of mean SDQ scores as reported by parents and teachers before and after the AFVP<sup>1</sup> programs found an overall improvement in total difficulties' (Bunston & Dileo 2006: 158).

1. Addressing Family Violence Programs (AFVP) form part of the Victorian Royal Children's Hospital Integrated Mental Health Services; PARKAS was the predominant group-work intervention evaluated during the 2006 evaluation of the AFVP.

Since commencing, the Peek a Boo Club has utilised Condon and Corkindale's (1998) Maternal Postnatal Attachment Scale (MPAS). The data collected to date is too small to draw any significant statistical conclusions; however, indications are positive with mothers reporting improvement in the quality of attachment, reduction in hostility and increases in enjoyment of their infant (Bunston, Jones & Waters 2008).

Both the interventions described are considered pioneering group work programs within the Australian family violence prevention and treatment landscape. This is in part due to their commitment to honouring and endeavouring to afford infants and children a voice about what, how and why they are affected by family violence and using this as a platform to educate others.

Infant and child led approaches are not about overstating the importance of the child or encouraging an unhealthy power balance within the child/parent relationship. They are about reciprocity, healthy relational patterning and affect regulation. And it is fundamentally about family work, as the infant cannot exist without caregivers. This work considers an alternative entry point to most family-centered therapeutic paradigms. As noted by the Infant Mental Health Team at Melbourne's Royal Children's Hospital nearly a decade ago:

We share Winnicott's belief that if parents can help their children this is the best outcome. But in some cases the parents' thinking is stuck. It may then be that, if there is change in the infant, change can come about more quickly for the parents; when we do something relieving with her infant the mother in turn feels mothered and a good internal object can be experienced again.

(Thomson-Salo et al 1999:50)

Many of the mothers we work with have experienced immeasurable trauma and abuse, as children and as adults. They themselves have not been seen or seen themselves as subjects to be respected, valued or treasured. Exploring oppor-

tunities to delight in their own infants and children and to consider the possible complexities of their infants or child's internal world may also realign and re-attune their capacity to do this for themselves.

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