"To seek, to strive, to find, and not to yield" Tennyson

Mental Health for the Young and their Families: Victorian Group
Emerging Minds
The Mental Health Foundation Australia
The Faculty of Child and Adolescent Psychiatry of The Royal Australian and New Zealand College of Psychiatrists
The Centre for Community Child Health, The Royal Children's Hospital, Melbourne
and The Royal Children's Hospital Mental Health Service
invite you to

THE THIRTEENTH WINSTON S. RICKARDS MEMORIAL ORATION

"CAN WE OPTIMISE MENTAL HEALTH CARE FOR OUR CHILDREN AND ADOLESCENTS?
Exploring Psychoanalytic Psychotherapy in the 21st Century"

delivered by **Ruth Wraith OAM** MCPP Dip. Occ. Ther. MCPPAA
Child and Adolescent Psychoanalytic Psychotherapist; Disaster and Trauma Clinician and Consultant;
Previous Head of Department of Child Psychotherapy, Royal Children's Hospital Melbourne
and **Jennifer Re PhD** MCPP B Ed Counselling MAPS MCPPAA FCEDP
Child and Adolescent Psychoanalytic Psychotherapist; Educational and Developmental Psychologist; Senior Lecturer & Coordinator, Master of Mental Health Science: Child Psychotherapy Studies, Monash Univ.

"Today's complex landscape of child and adolescent mental health brings a myriad of challenges such as ADHD, ASD, Anxiety Disorders and School Refusal. Contemporary psychoanalytic psychotherapy, spanning research, theory and practice, has ***significance*** *for applications in schools, specialist agencies and disaster contexts. Beyond the clinic, the untapped potential of psychoanalytic thinking embraces both individual personal development and that of families, organizations and the wider community, impacting mental health and wellbeing policy and care services across society."*

The Annual Oration honours the extensive, innovative work in infant, child, adolescent and family mental health, in Australia and internationally, of Dr Winston Rickards (1920-2007)

RUTH WRAITH OAM is an eminent Child and Adolescent Psychoanalytic Psychotherapist, coming from an initial professional background of Occupational Therapy. A mainstay within Melbourne's Royal Children's Hospital Child Psychotherapy service, Ruth served as Head of that Department for 10 years, as well as working as a Disaster and Trauma Clinician and Consultant. She is a Past President of the Child Psychoanalytic Psychotherapy Association of Australia, and of the RCH Alumni Association, and founding Chair and Past President of the Australian Society for Traumatic Stress Studies.

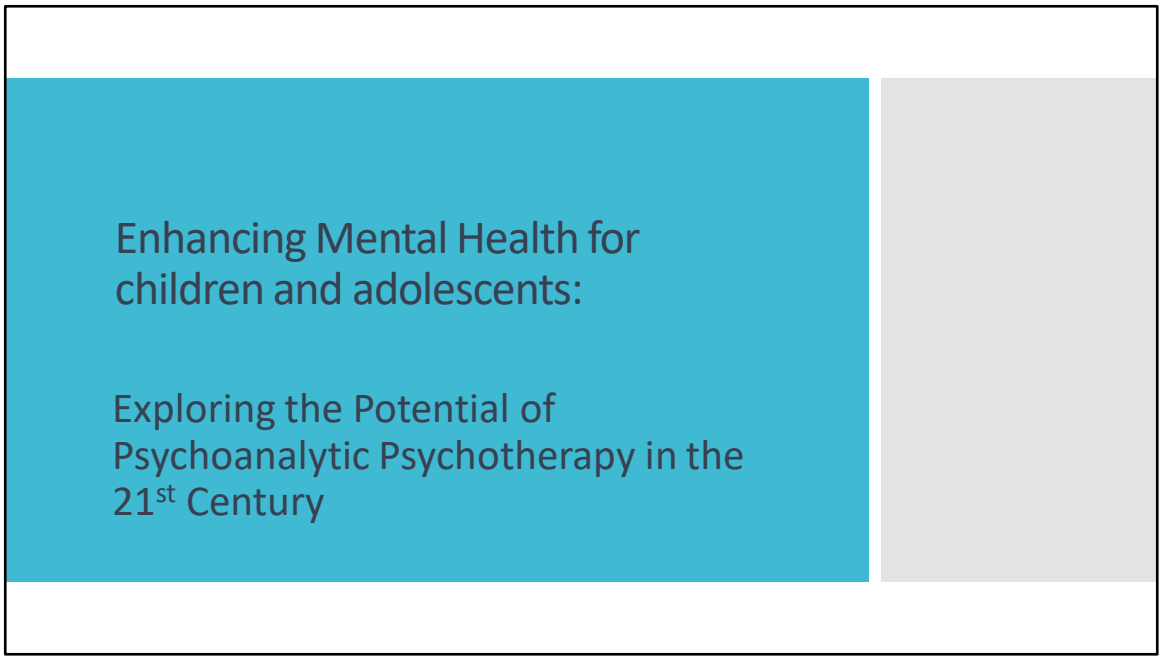
DR JENNIFER RE, Educational and Developmental Psychologist, is a lynchpin of child and adolescent psychoanalytic psychotherapy training in Australasia. Jenny worked for twenty years in the Psychotherapy Department of the Royal Children's Hospital Mental Health Service, with special interest in small children, and at the Hospital's Gatehouse Centre with abused children and adolescents of all ages, then completed doctoral research on mother-infant relationships in infants with severe congenital heart disease.
In 2012 Jenny set up training in Child and Adolescent Psychoanalytic Psychotherapy at the University of Auckland, returning to Melbourne in 2013 to coordinate Child Psychotherapy Studies in the Master of Mental Health Science

program at Monash University.

<u>INTRODUCTION</u> - Ruth

Jo thank you for your introduction and for your welcome to Dr. Re and myself.

We are especially honoured to have Dr. Rickard's family here with us including on zoom and we are delighted to welcome so many people to this Oration.



In the big picture, spanning thousands of years, this interest and concern is very recent. Percy Fitzgerald, a literary associate of Charles Dickens, wrote "it occurred to him (Dickens) 'what if he interpreted in his writings the minds and feelings of dogs, horses, birds and above all of children? No one had done so before'." - end of quote.

This was the mid 19th century, roughly only 170 years ago.

Around this time Lewis Carroll with 'Alice in Wonderland' engaged the imagination of children with his empathic style. This engagement continues powerfully today.

Prior to the 17th century in much of Europe and the UK, children had been regarded as little adults with the idea of 'childhood', as a defined entity, beginning with John Locke.

This also was the period when children from 7 or 8 years old worked in factories

for long hours in appalling conditions and were seen as inferior and indeed were powerless.

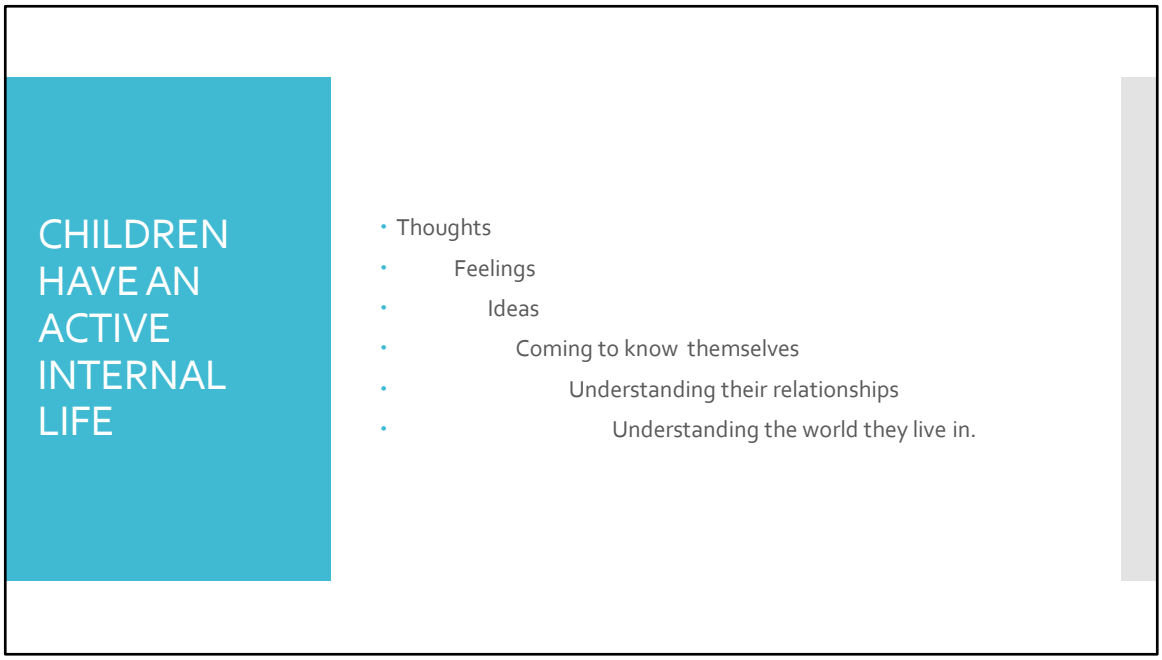
Sigmund Freud was the first person to articulate stages of psychosocial development of babies and children and as such this was the starting point for the exploration of the theories and practices that have evolved, of which child psychoanalytic therapy is one.

The application of this is what we are considering this evening.

Changes underway in our society are many and profound. They are impacting on parent/child relationships and parenting styles. These include but are not limited to the workforce gig economy, financial pressures for families, the impact of the many facets of the digital world including social media for both children and their parents and the increasing engagement of women in the workforce re-aligning family roles, expectations and functioning.

There are deep anxieties and adjustments around climate change along with community based interpersonal conflict such as bullying, increased

anger and aggression plus the conflict-ridden international environment in which we live.



Children and families, by and large, live in a hyper stimulating world of media, of expectations,

busyness and planned or incidental distractions.

As a result children may, and often do, become 'lost' in the hustle and bustle of everyday life.

Living with constant change, uncertainty and maybe fear about the future, as well as doubt about what the future holds, are the reality for many children and youth as well as adults.

Across all generations these social shifts bring with them far reaching impacts on how life is lived and experienced.

The impact is evident in the increased concern for the mental health of our young and the increase in reported mental ill health requiring clinical care.

The WHO World Mental Health Survey Initiative published last year and led by Professor McGrath from the University of Queensland with Harvard University estimated that 50% of all adult mental ill-heath has its onset before the age of 18.

To many it is apparent that an outcome of the current pressures and social changes result, in some instances, in basic psychological and developmental needs of many children and adolescents being distorted or unmet.

Psychoanalytic theory, research and practice provides valuable insights to understand and help support healthy development of children and young people.

Their thoughts, ideas, feelings and their understanding of themselves, their relationships and the world they live in all contribute to their mental health. This is a dynamic and ongoing process throughout infancy, childhood, adolescence and indeed life.
In every child there is their own infant self, in every adolescent is their own infant and child self and every parent has their infant, child and adolescent self, integral to who they are in the here and now.

Psychoanalytic theory and practice provides an under-appreciated understanding of infants, children, youth and their families and also more broadly of the communities and the organizations engaged with them where their mental health and their wellbeing needs are being addressed.

Dr Winston Rickards

This Thirteenth Winston Rickards Memorial Oration will hopefully stimulate your thinking about 'challenges and directions for the future' as the presentation proceeds.

Dr. Rickards contribution to child psychiatry commenced in the era when the mental health of infants and children was barely on the radar and in fact acknowledgement of mental ill health for infants and children was, by and large, resisted.

It was a time when mental ill health was more commonly seen through a behavioural or moral lens.

Dr Rickards was appointed Director of Psychiatry at the Royal Children's Hospital in 1955. He supported the already established work of Ruth Drake and Margaret Eriksen, then called play specialists, who were the pioneers from the 1930s and 40s, approaching 100 years ago, of what has evolved over the decades as the

profession of Child Psychoanalytic Psychotherapy in Australia.

Prior to the development of formal training which now is the Master of Child Psychotherapy Studies, Monash University he included Eileen Anderson and myself in the child psychiatry component of the Diploma of Psychological Medicine training as well as providing us with additional psycho analytically oriented child therapy supervision.

As a founding member Dr. Rickards served on the Executive Committee of the professional association, the Victorian Child Psychotherapy Association, now the Child Psychoanalytic Psychotherapy Association of Australia.

Within a multidisciplinary context a foundation philosophy of the Department of Psychiatry was psychoanalytic in its broadest and most dynamic application aiming to bring deep and informed understanding to the lives of children, their families, the context of their lives and the services with which they were engaged.

Underpinning his clinical work, teaching, consultation and guidance to many, many organizations and services was the understanding that every child, every parent and every child/parent relationship was unique.

Dr. Rickards was a visionary, a facilitator and defender of the psychoanalytic contribution to infant, child and youth mental health and he created a culture where this could evolve and be provided by skilled clinicians.

He had a natural and empathic affinity for the inner world of the child. He brought to the Royal Children's Hospital and Melbourne, leading international thinkers and practitioners, all pioneers who were working to illuminate the inner world of children and who each had a profound influence on paediatrics, psychiatry, psychotherapy, psychology and related allied health professions, to teachers and to society in general.

Early in my career I benefited from these. Dr. John Bowlby, whom many of you will know through attachment theory, Isca Wittenburg a pioneer child psychotherapist, Mildred Creak who developed an early understanding of autism, Berry Brazelton who explored mirroring of infancy and James Anthony developing an understanding of resilience and vulnerability in childhood.

It is Dr. Rickard's legacy, contextualized to the 2020s, that Dr. Re and I will briefly explore this evening. Dr. Re carries his legacy forward in her role as a child psychoanalytic psychotherapist and Coordinator of the Master of Child Psychotherapy Studies at Monash as outlined in the introduction.

Dr. Jenny Re will now outline some concepts in contemporary psychoanalytic theory and research.

I will then briefly address child psychoanalytic clinical practice followed by two examples of psychoanalytic theory applied within the community context.

In our discourse we will frequently use the word 'child' when it is appropriately inclusive of infants and youth.

There are many challenges for child and youth mental health in the current climate and we will briefly consider these and have time for questions and discussion to close…**Dr Re…**

Some Principles of psychoanalytic Theory

A developmental lens and early attachments

Intersubjective and relational

Here and now experiences: The transference Counter-transference

The mind - has an unconscious dimension and a conscious reflective capacity

The setting

When I was a new psychologist, I remember feeling I knew *nothing* about working with children and families. The psychology course did not equip me. Psychologists were trained in only one treatment mode, CBT. (Now perhaps the associated developments DBT and MBT). These treatments are not suitable for children younger than about 7 years, as they have not yet developed sufficient cognitive capacity. I was on the lookout for further clinical training.

I felt I had come home when in 1991 I discovered the child psychotherapy training which became a Masters in Child Psychoanalytic Psychotherapy during my training in 1994.

There are few specialist courses in any Allied health professions dedicated entirely to working therapeutically with children and families. It is strange really that it is so rare when the building blocks of society are our children and families.

And the Victorian Royal Commission into MH showed us how desperately we need mental health clinicians! However, it has met with a major stumbling block

in implementing! The planned one-stop service ‘hubs’ to service CAMHS (in broad sense) are foundering in the set-up because they can’t be staffed! There are burgeoning numbers looking for services and there is a critical shortage of trained MH clinicians to staff the hubs! Given the early years are so crucial to later development, this is concerning.

Principles of child psychotherapy cont.

How defenses are useful and interfering

Playing and reality

'Playing is itself a therapy' DWW

Experiencing and representing

Child psychotherapists understand a child has a mental life and a subjective way of experiencing the world *as Ruth has stated*.

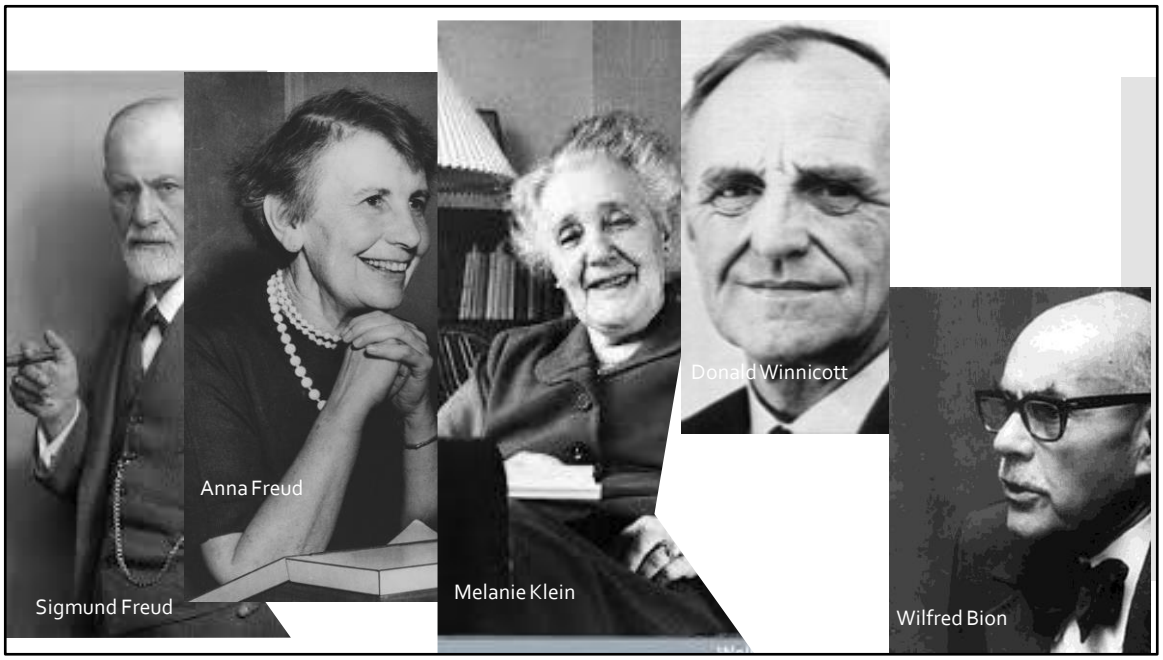
And Psychoanalytic theory provides a guiding and central framework.

We work to reduce symptoms and relieve suffering *by listening to the underlying themes and dynamics* in the child and their family relationships. Research has shown that working at a deep level can facilitate sustained change (Green, 2009; Trowell et al, 2007; Shedler, 2009).

We also have specialist training to develop observation skills.

Detailed observation facilitates an understanding of what lies beneath the child's symptoms and presenting difficulties and theory provides a coherent framework for making meaning.

So let's unpack this. *Who do we look to as our core theorists?*



Freud, Anna Freud, Melanie Klein, Winnicott and Bion. They all focus on development.

Psychoanalyst John **Bowlby (1969)** also took a developmental lens and built his theory of attachment on early experience and the opportunities for a child to develop a capacity for 'lasting and meaningful relationships'. These capacities are built around expectations of relationships and the templates developed: -ie *'internal working models'*.

Bowlby and Mary Ainsworth collaborated in developing ways **to operationalise and research attachment concepts**. This led to an enormous body of research into attachment relationships.

Eg The AAI, WMCI, Strange situation, Peter Fonagy's research team at the Anna Freud Centre have identified RF and mentalization as key variables to research and apply in clinical programs. I will return to research in child psychotherapy a little later.

Contemporary Theorists

- Dan Stern
- Beatrice Beebe
- Alessandra Lemma
- Anne Alvarez
- Graham Music
- Antonino Ferro

These are some of our contemporary theorists & therapists who have written extensively and influenced contemporary child psychotherapy practice.
Anne Alvarez, Graham Music, Alessandra Lemma, Dan Stern and Beatrice Beebe; Ferro and Field Theory- includes intersubjectivity and relational psychotherapy.
The theoretical frame in contemporary child psychotherapy practice relies on the setting.
By this I mean: the child or young person is seen in the same room, same time and day and with the same therapist each week. This regularity provides a containing structure. This in itself is very important for those who have experienced disruption and chaos in their lives. The therapist's mind is a crucial part of this setting.

Case Study

I want to take you on a journey through a therapy to explain the theory that underpins a child psychotherapist's way of working. It is from child psychotherapist Margot Waddell's book: ***Inside Lives*.**

'Sammy' was a 3 yo referred for therapy when his parents became distraught at his intense and protracted nightmares.

Sammy was a twin who had been born premature and sickly and stayed in hospital for 2 months longer than his twin sister who went home with mother. His Mother was very depressed following the twins' birth. She was convinced Sammy would die.

3yo Sammy was a happy boy during the day, and terrified and tyrannical at night. Likewise he found his mother responsive and loving during the day, but she turned frightening to him at night.

Melanie Klein wrote about the child having an inner world, or phantasy life from

birth/ before birth.

In very early infancy every discomfort is experienced as though a hostile agent has thrust something bad into the infant and they want to get rid of it. When the mother is responsive and soothing, she is felt to be a nurturing good person. When absent, as for Sammy, there is no one to soothe him. Klein saw how an infant needed to keep good and bad separate in case they contaminate each other. This is a very early protective strategy for making sense out of chaos.

I'm sure you've all felt the particular piercing quality and extreme discomfort of hearing an infant crying – it gets right under our skin. This is what I mean when the infant wants to expel the difficult feelings and the recipient wants to soothe and settle the baby asap, so all feel better. When the bad feelings are pushed into the mother, then it can appear to the infant that the mother has turned bad. This can frighten a vulnerable infant who is still developing a sense of their self; their cognitive capacities are still too undeveloped and fragile, and they can easily fragment when frightened, in pain, or fear they won't survive.

Now at night Sammy demanded his mother's presence and she felt unable to bear with him lacking the emotional resources to soothe his fear of dying because of her own fear of death.

In therapy as trust deepened Sammy felt safe to bring his nightmarish terrifying inner world. He played out violent fantasies of a 'nasty biting crocodile' who attacked his sister and others.

How do these intense fears and anxieties get sorted out and held in mind safely?

How do child psychotherapists sit with and work with these intense emotions and experiences?

Here and now experiences

The transference relationship

They work with the here-and-now of the therapy session taking note of the child's playing, relating, moods and mental states, whilst also monitoring their own responses to their experience of the child in the room.

A therapy break represents a *relational rupture* and may reflect earlier in life ruptures in the *primary attachment relationship*.

Sammy's therapist noticed his anxieties and fears increased whenever there was a break in therapy. Following one such break, Sammy was distraught building to rage. The break had triggered traces of his early experience in hospital and being left.

The therapist was actively present in the 'here-and-now' of his rage – 'what Winnicott calls -the 'white heat of the session' – ready to make meaning without being knocked off balance, being dominated by them, or driven into action herself.

Bion refers to this capacity in a therapist or mother as ‘reverie’- ie where a person opens themselves to experiencing the emotional quality present in the relationship. This is where the mother in ordinary circumstances takes in the baby’s distress and fear of dying, and ‘digests’ it returning it to the infant in a more bearable form.

The therapist was, through her training, able to sit with uncertainty, doubt and Sammy’s unbearable feelings of grief, rage and distress.

Returning to Melanie Klein, as the infant matures and has experienced many satisfying relational moments with their important others, this builds a resource the baby can draw on, and the split between good and bad of early infancy is modulated. The baby comes to feel that ‘the person whom I hated is also the one I love’.

This is a crucial developmental step, enabling a shift from the potential for feeling resentful and mistrustful to one of basic trust. With trust there is an opening to reciprocity, a capacity to make reparation, and for creativity and play. It is based in the capacity to mourn the loss of the fantasy world of omnipotence and controlling mother to one of separateness and reality.

Although *when* under stress children (and adults) can revert to early learned patterns such as seeing the world in black and white - As were Sammy’s nightmare experiences.

Recently, Child Psychotherapist **Graham Music** has written extensively about his approach to working with children and adolescents incorporating a wide base of knowledge and research to gather into, underpin and affirm the contemporary relevance of child psychotherapy.

He, and Anne Alvarez before him, show the implications for psychotherapy of new research in neurobiology, developmental psychology and attachment.

Alvarez, writes about working at different levels.

For those with the most serious disturbances, both recommend play alone and being with the child is what is needed. In fact, Winnicott stated in 1971 that '*play is the therapy itself*'. Peter Blake, Sydney child psychotherapist also wrote about play and described it as the '*dangerous edge of safety in play*' where therapeutic shifts occur- you might recall ***Campbell's presentation last year*** on this theme.

For those who cannot play Winnicott said the aim of therapy was to bring the

child to a place where they can begin to play. Play is where a child discovers a self.

Graham Music in his new book **Respark** describes children who can't play. He uses the metaphor of 'sparking' ie for types of energy. We need energy for life and too little or too much can be problematic he writes.

He has found children often fit into presentations he termed *unsparked*, *de-sparked* and *mis-sparked*.

Unsparked children and adolescents have never come to life or been 'sparked' before, eg the Romanian orphans who were cared for well enough, but were profoundly psychologically and emotionally deprived.

The therapist's job is to try to find a little bit of spark and grow it into potential by being able to tolerate this lack of aliveness and the unbearable states evoked. Knowing empathically at a deep level the child's experience and using it to connect is what is needed. Winnicott would say we have to survive their deadness without becoming dead ourselves.

Music is basically writing about defenses when he describes *desparking* and *mis-sparking*.

Desparked children are those who have suffered a trauma – either an event or developmental trauma, have often given up and their protective strategy is to shut down, numbing both body and mind. So even the capacity to think is shut down. This response of freeze/ going floppy is a highly effective defense against danger and being overwhelmed.

We need to be very careful not to push through such a defense too soon as it can re-traumatise.

Recent research into the neurobiology of trauma has shown engendering safeness gives a signal to the nervous system to relax. This therapeutic focus can take time as these children are primed to be triggered by their 'internal working model' of unsafe adults and so the therapist aims to be dependably safe and non-threatening. Thus providing a safe container, so the child develops and consolidates an 'internal working model' of safeness.

Mis-sparked eg manic mental states or behaviour. Winnicott saw one form of manic defense as a way of avoiding having someone to rely on, these infants and children retreated into their head developing a hyperactive mind (intellectualisation). Underneath there might be terrible grief and pain that has never been faced.

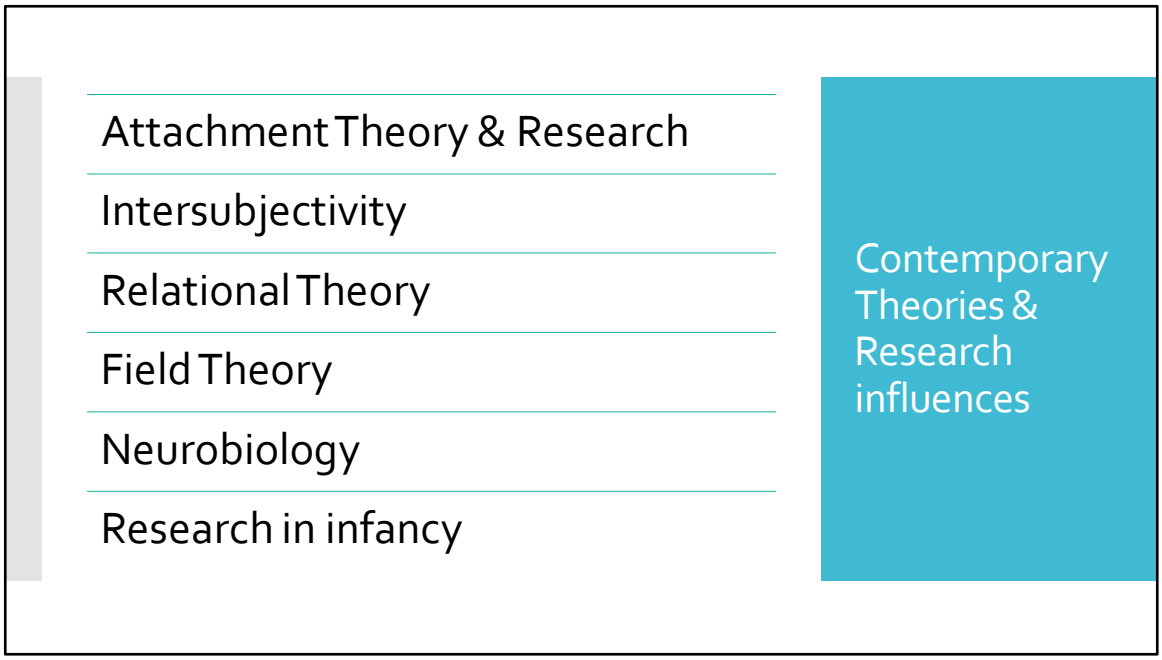
Addiction is another form of mis-sparking. Music explains that when very difficult early experiences are intolerable, addictive behaviours can be a way of holding the self together on the one hand or maybe function as respite from awful early experience.

Addictive behaviours are facilitated by the dopaminergic system which activates the reward systems, motivation and habit learning.

He tells us the dopaminergic system is being fired up deliberately by Google, Apple, Meta etc. with their digital media and games. Paediatrician Radesky researches screen use in young children and also tells us these companies design it into products to keep us online; their profit mode is for this.

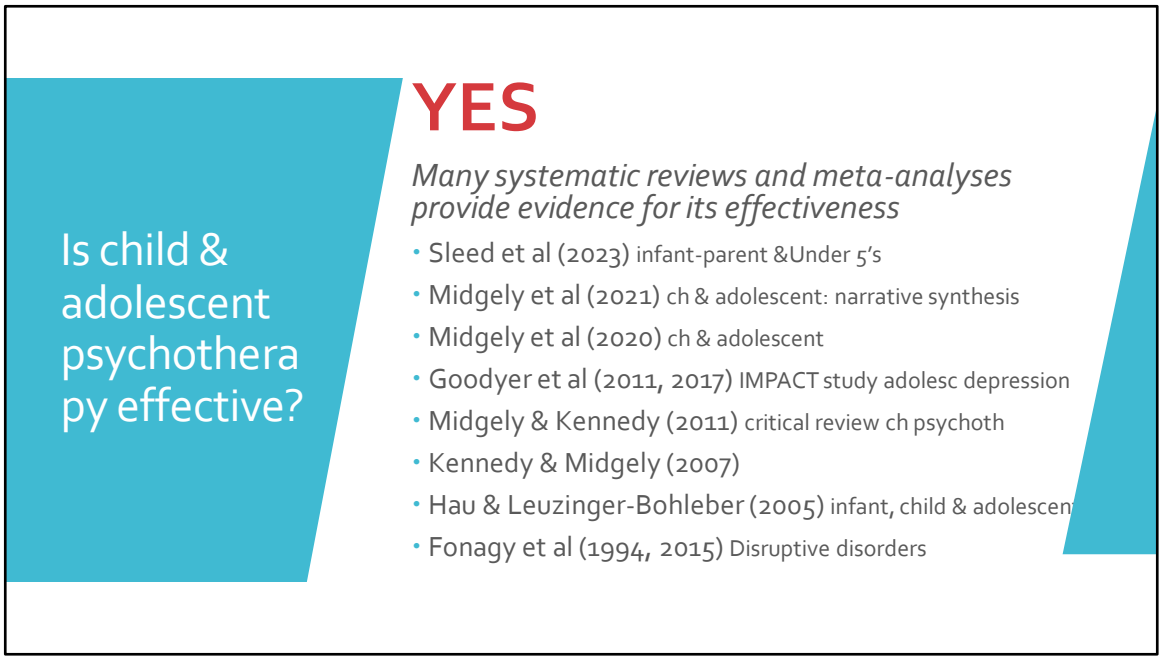
Child psychotherapists help young people to slow down and take note of and bear feelings they have long avoided. In this way a child can be supported to develop different pathways, motivations and more ordinary habits for living within a social, relational world.

So, let's look at the research:



The body of child psychotherapy research is being enriched and validated by neuroscience findings, attachment research, developmental psychology, and infant studies.

The cumulative evidence over the last 2 decades is significant, and overwhelmingly supports the effectiveness of psychoanalytic psychotherapy for parents and infants, Under 5's, children, and adolescents in a wide range of presenting problems.



Studies listed here are systematic reviews and meta-analyses, which means they review many studies. Most are outcome studies.

Eg Nick Midgley and his team (2021) at the Anna Freud National Centre, published a systematic review of 82 distinct studies from 123 papers, (22 studies were RCTs).

[RCT's are random controlled trials and they are the 'gold standard' for rigour in research].

Midgely found 'evidence of effectiveness for psychodynamic therapy in treating a wide range of mental health difficulties in children and adolescents.

Who is child psychotherapy effective for?

It is effective for some of the following:

- Depression and anxiety
- attention, behavioural and impulsivity problems e.g. ADHD
- Social communication delays/deficits e.g. ASD
- Complicated disorders that had previously been thought to be beyond treatment, eg: Severely deprived children,
- Emerging personality disorders and children who have experienced adversity. (Midgely, et al (2021).
- Fostered and adopted children, (Boston and colleagues, 1994, 2009)
- Sexually abused children (Trowell and her colleagues, 2002).

And also:

- Children under 5 years and their caregivers,
- Learning difficulties.

Child Psychotherapy research is complex

Long-term psychotherapy for severe and complex mental disorders is especially difficult to study with an RCT design.

Long-term psychotherapy for severe and complex mental disorders is especially difficult to study with the 'gold standard' RCT design, because they require a control group and large numbers of participants.

With effectiveness now clear, researchers can turn from Outcome research and focus more on process and other creative ways to explore relational qualities in therapy.

Local Studies

One of the studies included in Midgely's 2021 review referenced local researchers whose 2009 paper is based on the Time for a Future (TFFP) study.

My colleague Dr Jill Pullen ran this study for 15 years and Professor Bruce Tonge was Chief Investigator.

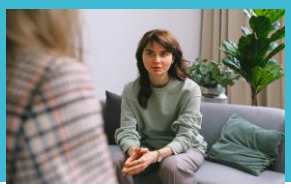
Tonge, B. T., Pullen, J. M., Hughes, G. C., and Beaufoy, J. (2009). Effectiveness of psychoanalytic psychotherapy for adolescents with serious mental illness: 12

month naturalistic study.

Their naturalistic longitudinal study examined the effectiveness of individual psychoanalytic psychotherapy in reducing symptoms and improving overall functioning for adolescents with complex, severe mental illness.

At 12 months, they found psychotherapy was associated with a greater reduction in depressive, social and attention problems than treatment as usual.

Researching child psychotherapy Adolescents



Dr Pullen's (2021) Research Key Findings:

- The relationship is central
- Building trust within a dependable relationship

Therapist qualities:

- To sit with intense emotions & difficult exps
- Trained to listen to conscious and Unc.
- Attuned to micro-shifts in mental states
- Theoretical framework & clin supervision

Jill's study : Pullen (2021) 'Experiences of psychoanalytic psychotherapy for young people with a major mental Illness, and their psychotherapists within Child and Adolescent Mental Health Services' *Unpublished manuscript.*

In Dr Pullen's PhD research, her qualitative study followed up the adolescents who had participated in the Time for a Future Study. She explored their lived experience of the psychotherapy using semi-structured in depth interviews several years following the end of their therapy.

She also interviewed the therapists and the CAMHS service Directors within which the adolescents had received psychotherapy (Therapies conducted during 2002-2012).

In the interviews, some young people went as far as saying that their psychotherapy had been fundamental in why they were now still alive!

Jill writes: 'It is critical to know what treatments best help adolescents suffering

extreme psychological disturbance, who are at risk of suicide or further deterioration. The adolescents in this study had suffered from earlier traumas and losses, and their developmental trajectory had been derailed by mental illness and developmental breakdown.'

Key findings:

- The *therapeutic relationship* was central.
- *Trust*: Building trust within an ongoing and dependable relationship.

The study identified qualities in this specialist type of relationship:

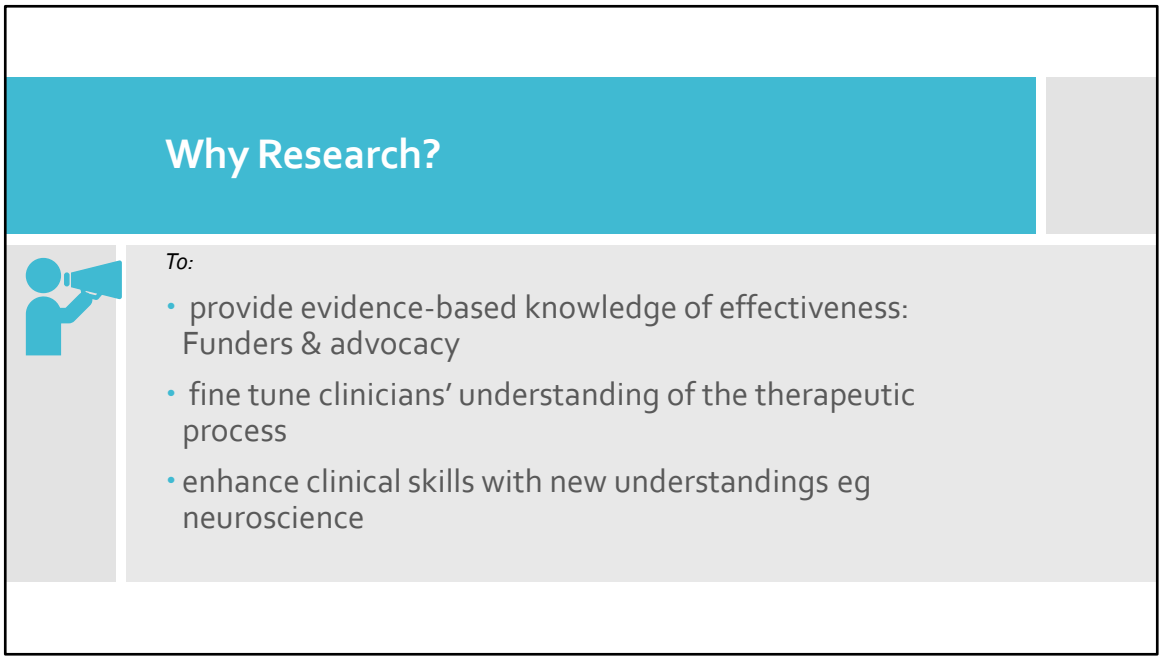
The psychotherapist

- is trained to listen to conscious and unconscious communications;
- sat with intense emotions and difficult experiences - relating to the adolescents in the here-and-now relationship between therapist and adolescent (Tx/CTx)
- were attuned to the micro-shifts in the adolescent's mood and mental states without closing off or enacting (more difficult to do than saying it!)
- relied on their theoretical framework and clinical supervision to keep them anchored (maybe like guiding beacons in turbulent waters-my image)

The service systems also provided an important supporting frame for the work.

This is a unique and most important study also because its findings not only show the effectiveness of psychotherapy in the lived experience of these young people, and affirmed by the experience recalled by their psychotherapists, but also as it shined a spotlight on other issues:

- Inequity of access to services - Regional and outer-metropolitan areas struggled to recruit and retain trained clinicians, let alone specialised clinicians.
- It demonstrated that psychoanalytic psychotherapy offers effective treatment (life-changing and life-saving) for the most complex and vulnerable adolescents in our society.



*Finally, n*ew research findings in related fields such as neuroscience and attachment research provide new tools and concepts for investigating micro-shifts within the therapist-patient relationship & within and across sequences of sessions.

These findings are now being applied to study therapeutic processes.

Recently, Peter Fonagy's research team identified 'epistemic trust' as a key component in favourable therapy outcomes and are now seeking to identify the specific mechanisms underlying the relational dynamic and then what may enhance it. (Fonagy & 2014; Fonagy et al (2023).

The microscope is on the micro shifts in therapy and nuances of the patient-therapist relationship.

Summary

There is abundant high-quality research for the effectiveness of child

psychotherapy.

Narrow positivistic scientific attitudes to research have given ground and are accepting a wider interpretation of what makes up high quality research.

Qualitative methodologies have been acknowledged for contributing valuable insights in their own right, as well as complementing and enhancing quantitative research findings.

Child psychotherapy Research applications: Mothers and infants

Jenny Re Research findings (2013;2018)

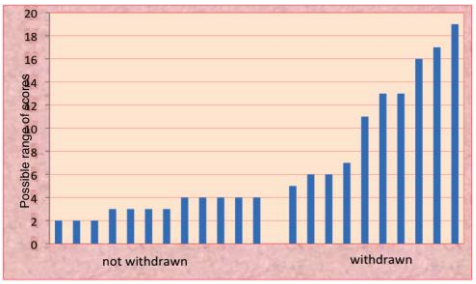


Figure 8. Range of ADBB Scores for the total sample of infants

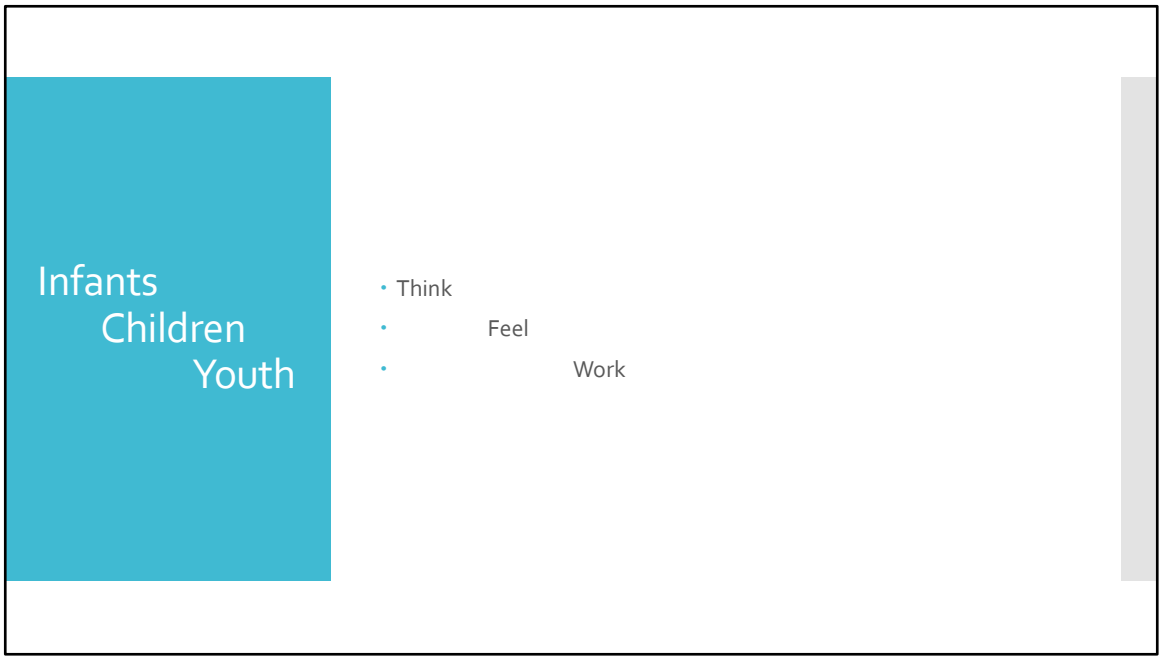
And lastly, Research is not always about the effectiveness of child psychoanalytic psychotherapy.

My research was on the developing mother and infant relationship when the infant had major surgery for severe congenital heart disease (CHD) in the 1st weeks of life.

There are a myriad ways a child psychoanalytic psychotherapist's theoretical frame may be applied to research in other fields, eg Health, education, community, etc.

There are unlimited imaginative ways to explore these domains.

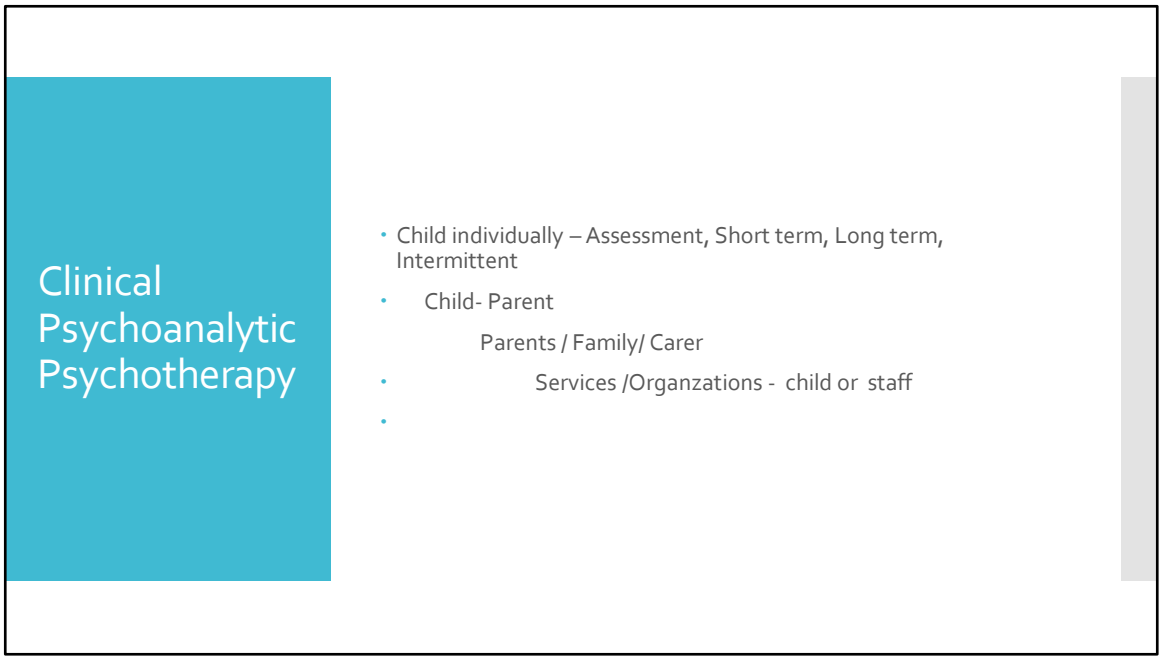
Now back to you Ruth…



Infants and children think to a degree and complexity that reflects their developmental stage. They also feel and they work to understand and to make sense of their world of relationships, of themselves in the world, how to survive and thrive in their environment.

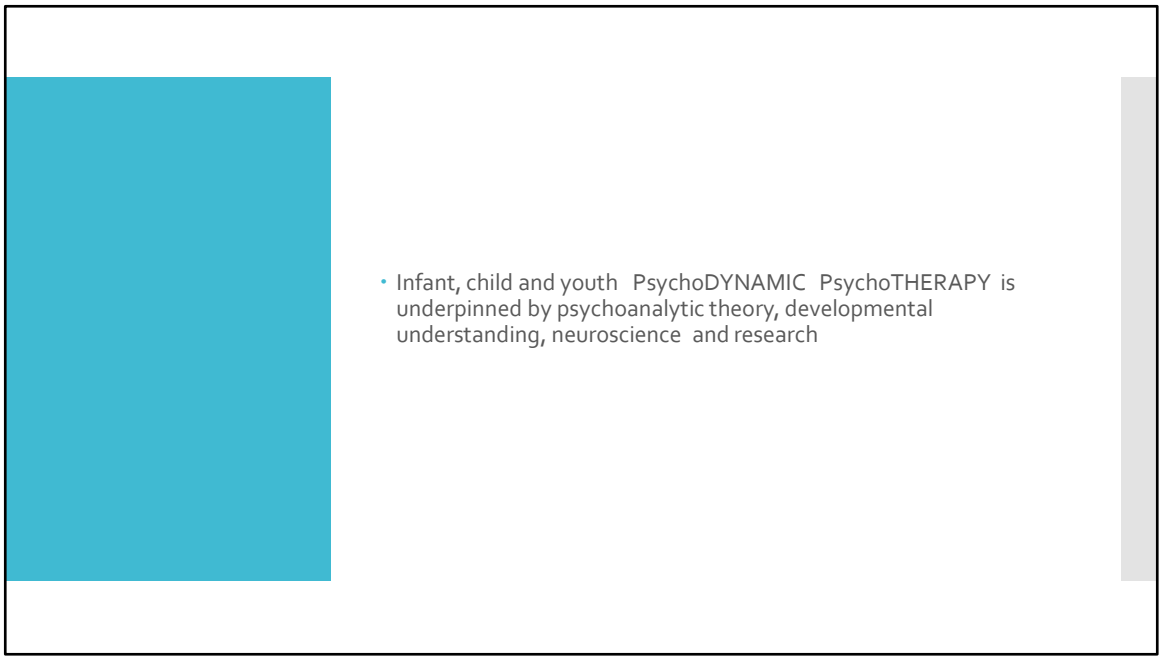
Maybe, as we sit here, you can recall such moments and experiences in your own childhood.

When children are distressed, experiencing mental health challenges, or behavioural issues clinical child psychoanalytic psychotherapy provides an entry to understanding and ameliorating a worrying situation that is concerning parents, care givers and often the child themselves.



A comprehensive assessment and short-term or long-term treatment, if needed, aims to achieve these goals.

As well as working with the child, psychotherapists also work with directly with parents, careers and services to understand their concerns, to assist them to understand and be tuned into the child, to assist them to understand more deeply their relationship with the child and to discuss supporting the child as the child moves forward.



The psychoanalytic theoretical and clinical framework works within a highly dynamic matrix to understand and assist children and their families to reduce and hopefully overcome the child's distress and enable them to continue on a healthy developmental pathway. Hence the description 'Psychodynamic Psychotherapy'. It is multi layered and complex – it is indeed DYNAMIC

The working relationship with the therapist is central and is established in a predictable setting that is child friendly but designed not to set an agenda or provide direction but to provide an environment where the child can be themselves, discover their world of thoughts and feelings, to think about these and their world and become active in understanding who they are in themselves and in their world.

This may unfold through self-directed play with toys, sand, drawing etc. as well as talking with the therapist. More frequently, especially with young children, a complex communication emerges through a mixture of multiple simultaneous or

concurrent use of these modalities.

Case Example

I would like to give you an example of how the psychoanalytic psychotherapy approach can assist young people clinically.

With respect to the privacy of the children and families with whom I have worked I am not presenting an actual case but a collation that combines common elements and themes from a number of cases.

One of the key concerns in our society today is the increase in the diagnosis of ADHD.

The parents of ''Marylou' aged 7 contacted me concerned about her disruptive behaviour, erratic moods and anxiety that escalated towards the end of the day. She had been referred by her GP for a paediatric assessment and no physical concerns were identified. Following appropriate psychometric testing an ADHD diagnosis was given and Marylou was prescribed Ritalin. Her parents were concerned about the long-term effects of medication and decided to go down the path of psychodynamic psychotherapy first.

I met with Marylou's parents to gain a developmental history, to understand the evolution of the current situation, to understand their concerns and hopes as well as Marylou's and the family's strengths, resources and any vulnerabilities.

This meeting also gave them the opportunity to ask questions, to understand the process and to be in a position to introduce the clinical context to Marylou within their style of communication.

A core principle of child psychoanalytic psychotherapy is to start where the child is at within themselves and where the parents are at with their concerns, their understanding of them and their approaches to managing the situation and also the outcomes they are seeking for their child and their family.

It transpired that some years previously when Marylou was 4, one night they experienced a particularly violent thunderstorm with wild wind and rain belting on the windows on the side of the house where the bedrooms were. Marylou was

asleep at the time and woke screaming. She was inconsolable for the rest of the night needing the comfort of her mother to sleep with her.

Next day, to her empathically tuned in parents, she described her experience of the storm as 'witches and ogres trying to get into my room'. Explaining the facts of thunderstorms provided the containment and assurance she needed. Marylou settled and they heard no more about it.

At the age of 4 witches, ogres, devils, 'baddies' etc are active in the imagination. We can think of the stories that engage children at this stage such as the Big Bad Wolf in Red Riding-hood, The Three Little Pigs, Billy Goat Gruff etc.

Marylou's parents recalled that some months later she started to become ratty and put it down to starting school with the associated challenges.

Very gradually and over time her behaviour evolved to the point where her parents sort assistance and she received the ADHD diagnosis.

What was the process of therapy?

As Jenny has described, the therapy room was child friendly with appropriate size table and chairs, a few familiar every day toys such as paint easel, sand tray, everyday dolls; it was low key, not cluttered, not 'setting a scene'.

For her first appointment Marylou chose to come into the room with her mother. She was curious to explore the toy cupboards, she engaged easily with me and soon said to her mother 'you can go now' and she left the room.

For the first few sessions I let Marylou set the agenda to assist me to understand her in this moment of time noting the content, style and patterns of her play and the nature and quality of her relationship and interactions with me.

Through her play, drawings and conversations with me, it gradually emerged that she was scared of going to bed because 'storms can happen' and in summary 'this scares me and I can't sleep, I try to stay awake and sometimes I know there are scary things outside my window because I see them moving on the blinds'.

Marylou was in a state of constant anxiety underpinned by worry about storms happening, with her imagination about this very active. She was constantly tired

through disrupted sleep and living with her 'reality' of scary things outside her window at night which in-fact were shadows of a tree moving in the breeze.

Marylou chose to paint - graphically painting pictures of the scary ogres and witches. She played a lot with the little grecan dolls and the doll's house - little vignettes of witches and ogres terrifying children especially if they were happily doing other things or they were asleep.

Through giving her the opportunity to communicate in her own style through a self -directed combination of toys, paintings and language, all in a multi-faceted conversation with me, Marylou responded with an emphatic 'yes' when I wondered with her if she ever felt like the dolls – 'that that happened to her, that she felt scared'?

I asked her if she would like to tell her parents about her scared feelings and she nodded with enthusiasm.

Marylou and her parents came together for a family session. They were surprised as, like Marylou, they no idea of the issues underlying her anxiety and presentation of behaviours indicative of ADHD. We all agreed to take some more time to untangle and settle the concerns and misunderstandings with the goal to relieve Marylou's anxiety.

Marylou and her parents agreed to my suggestion that I talk with her school teachers to clarify the underpinnings of Marylou's behaviours and to assist them to assist her within the classroom environment and also in her interactions with her peers.

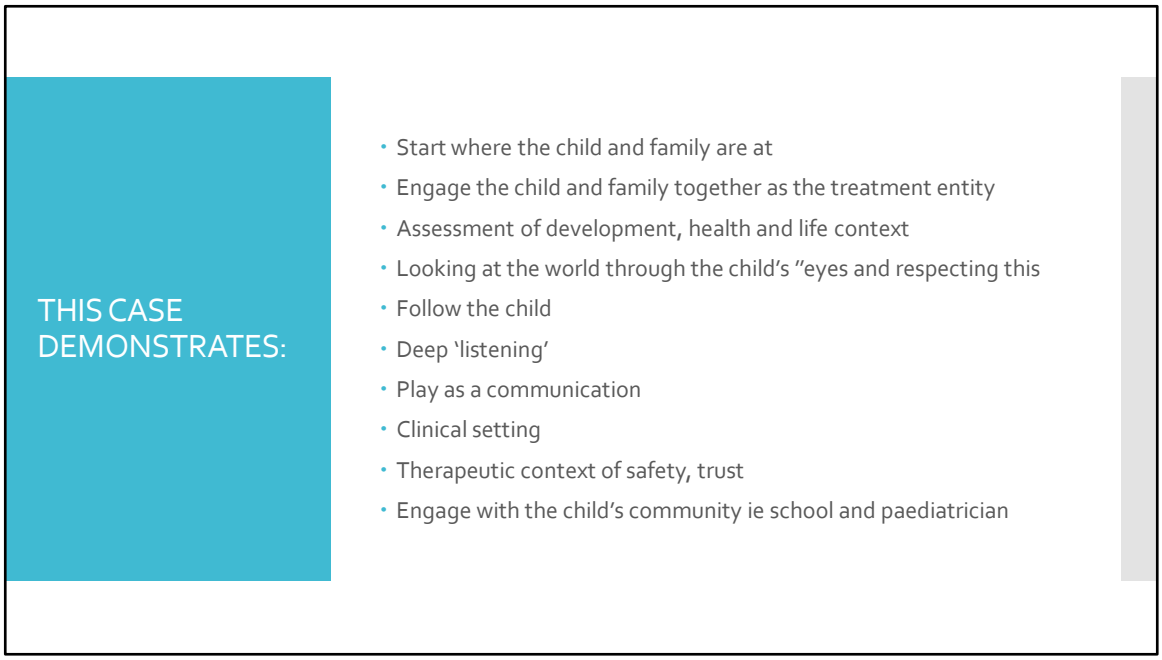
Six months after the initial appointment with me Marylou had a checkup appointment with her paediatrician who repeated the same ADHD assessment. It showed that she was now without any ADHD features and was well within the 'normal' range.

Her paediatrician and I discussed this outcome in the context of the increase in the diagnosis of ADHD in children including the importance of understanding the child's world from their perspective and the increased and nuanced insight it gives us to their presenting symptoms and general functioning.

In the context of a psychoanalytically based clinical intervention there was also some cognitive clarification which supported Marylou to reframe her worries once the underlying issues were understood.

As a post script, in another unrelated context some years later I met with one of the parents who said Marylou had grown into a fine young woman who was doing well in her chosen career but 'was still a bit of a busy bee.'

I brought to this case my training and knowledge of child development underpinned by psychodynamic theory and also as it relates to parenting.



Although I haven't been able to tease out the detail of this case it demonstrates:
Starting where the child and her family were at

Engaging the child and family together as the treatment entity

.Assessing development, health and life context

Looking at the world through the child's eyes and respecting this

.Following the child

Listening deeply

Play as a communication

The clinical setting as an element of the treatment

The therapeutic context of safety, trust,

The relationship with therapist who observes and thinks with an open curious mind

Engagement with the child's community - school and paediatrician.

Child psychoanalytic psychotherapy is different from other forms of therapy and mental health theoretical frameworks that focus on symptoms, pathology, family

structures, overt behaviours or thinking styles that initiate or maintain symptoms. It is directed to understanding the inner world of the child and how it underpins their thoughts, feelings and how these are expressed in behaviour, in their relationships and in attitudes etc..

Ruth

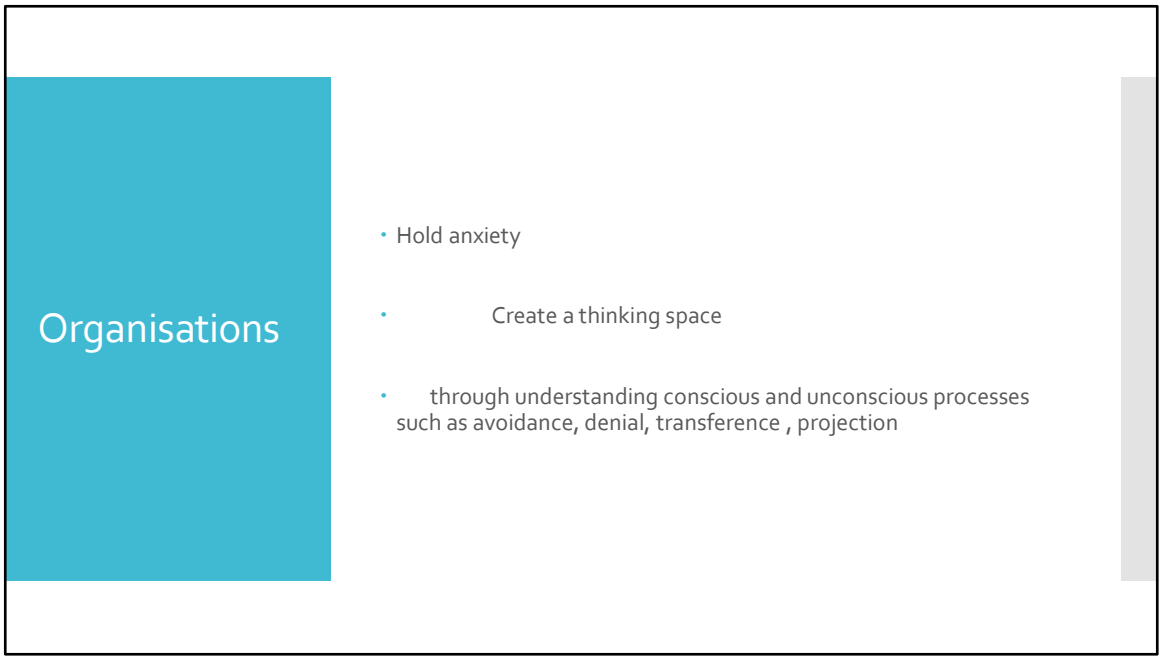
The knowledge base and principles of child psychoanalytic practice have, over recent decades, made a rich contribution beyond the formal clinical context in what I describe as Applied Child Psychoanalytic Psychotherapy.

Community application
examples:

- Early in Life Mental Health Services
- Sunbury Hub
- Take Two Berry St
- Krongold
- The Australian Childhood Foundation
- MHYFVic
- Mental Health administrative leadership
- Engaging with the Mental Health Reform process

Psychoanalytic psychotherapy informs and is practiced in a wide range of settings, for example infant mental health, foster care, child protection, children and young people with disability, refugee families, families experiencing domestic violence , children in hospital, teachers and school communities, child and maternal health care services, child care and kindergartens. In these settings it also provides opportunities for workers to better understand organizational contexts and social interactions with the young and their families. Organisations particularly appreciate the opportunity for staff to be able to discuss client or work- based stresses and dynamics in relation to issues they are dealing with, often in highly pressured circumstances.

The power of the psychodynamic approach is that it provides the opportunity to develop an understanding of the issues and processes of interaction between staff, staff and children, staff and management, and the staff policy interface.



This comes about with the psychotherapist being alert to conscious and unconscious processes that are active such as avoidance, denial, transference and projection. Holding the anxiety that is present rather than moving precipitately to actions or solutions enables clarification of issues, enables thinking which leads staff to understand what is in play and therefore develop a more nuanced grounded approach to the challenges or problems.
I will describe two very brief thumbnail sketches of markedly different child psychoanalytically informed community applications. They were in response to concerns about children and families impacted by disasters.

Community Applications: Disaster work

Indian Ocean Earthquake and Tsunami

(magnitude 9.1) December 2004

- Resulted in immense destruction and loss along the rim of the Indian Ocean. December 2004
- Indonesian Province of Aceh
- Indonesian officials estimated that the death toll there alone ultimately exceeded 200,000, particularly in northern Sumatra's Aceh province. (Source: https://www.britannica.com/event/Indian-Ocean-tsunami-of-2004)

In December 2004 the Indonesian province of Aceh was devastated by the Indian Ocean tsunami where 200 thousand people died, many were injured and all survivors were homeless and without income. More women - mothers- died than men – fathers. A very great number of children were orphaned or lost one parent, also siblings and extended family. Many of you will recall this time.

DEVASTATION

All community facilities including food supplies and sanitation, medical services and schools were destroyed or rendered immediately useless.

Living post-disaster

The countryside was inundated for large distances inland, roads were washed away and the sea, a major source of food, was polluted with chemicals and goodness knows what else as a result of the earthquake preceding the tsunami causing the ground to sink and the sea flow in.

Planning

As a result of a decades long working relationship of The Royal Children's Hospital with the University of Gadja Mada, Jogyakarta, RCH was invited to provide support to the health recovery system and process including mental health.

- The work took place within an established relationship with RCH.
- Provided support to the recovery system and process including mental health.
- Regular visits over 3 years to Psychology Department:
  - Develop and support their extensive programme
  - Provide training in MH
  - In disaster impact and in personal and community recovery.

Informal consultation

On a regular visiting basis over three years I worked with the psychology department of UGM to develop and support their extensive programme and to provide training in mental health, in disaster impact and in personal and community recovery.

It was not a training in psychodynamic theory or practice but psychodynamic theory and practice underpinned everything I did even though my colleagues were not aware of it.

School consultation

UGM Staff headed up the programme

It involved meeting and working with local community and religious leaders, and community groups, from the devastated areas….

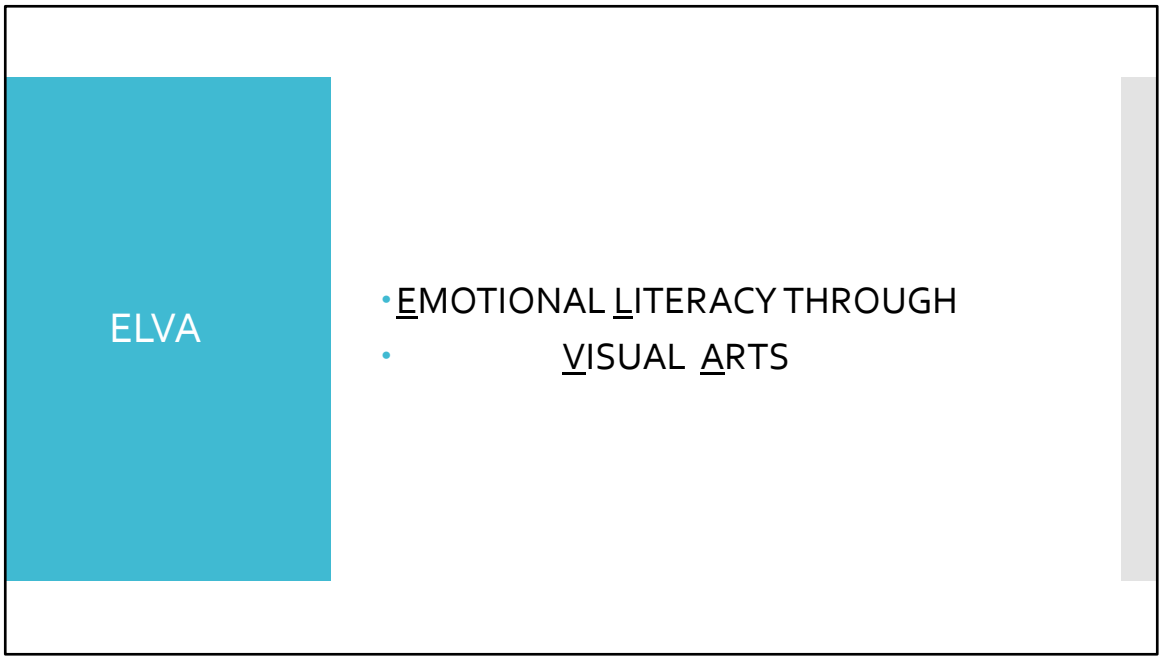
….. and also with surviving local and regional services such as health, schools and members of government and universities.

An important part of the work was meeting with the women who were caring for the surviving children, often not their own and in the face of having lost their own children and other family members.

While it was indeed multifaceted I did not provide a clinical service.

Formal Conference: Post disaster collaborative work ongoing

The work was highly valued to the extent that I continue to be invited to contribute to their online Summer School.



The second Community application is very different.

The Dax Centre here in Melbourne developed, under the leadership of Dr. Eugen Koh, a training for primary school teachers called ELVA - Emotional Literacy through Visual Arts.

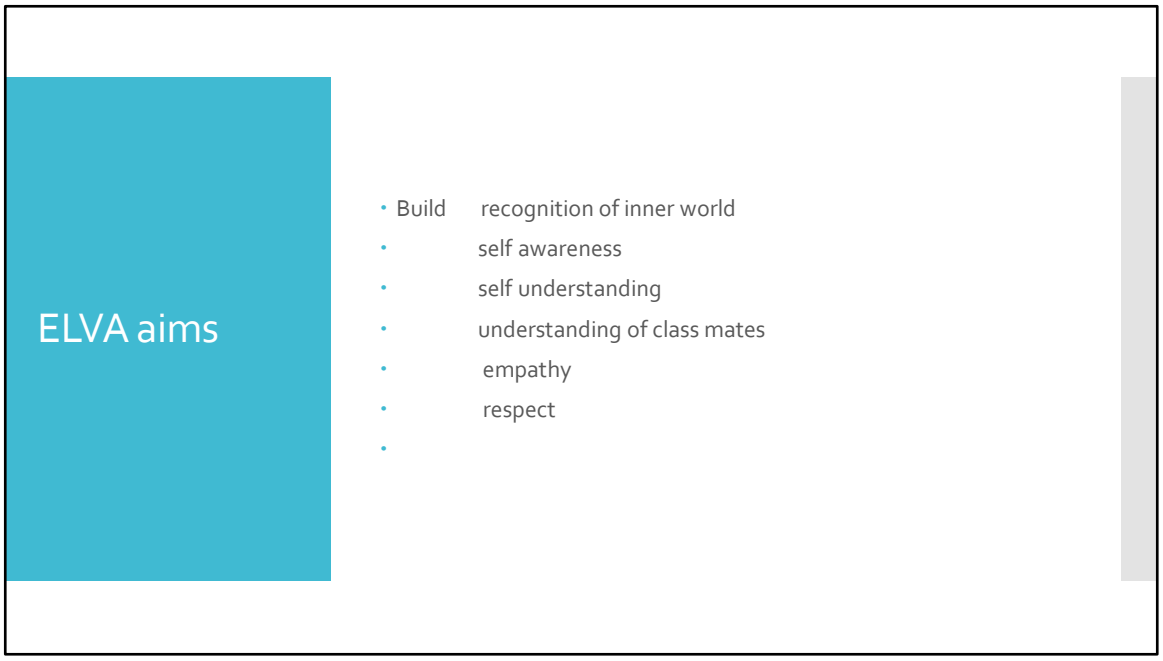
Some of you in the audience may be aware of ELVA, or may be primary school teachers who are ELVA graduates.

ELVA aimed to increase the emotional capacity of children to 'learn through their experience rather than through skills training and behaviour modification and to develop an emotionally reflective mind' which Jenny referred to in her presentation.

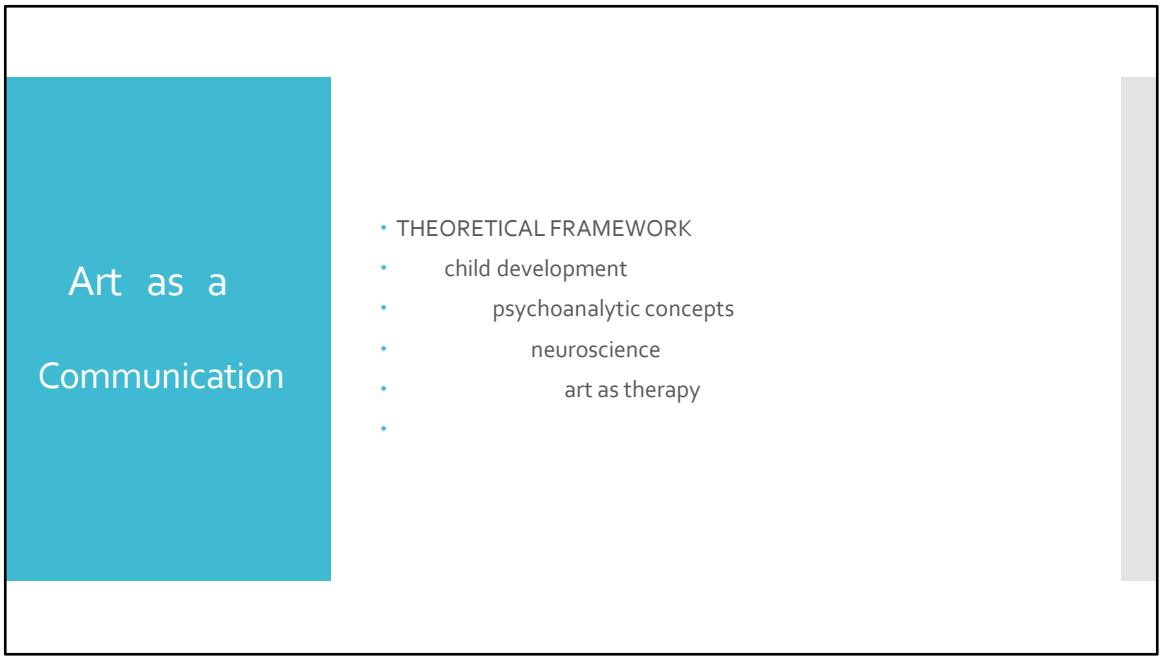
:
ELVA Schools Programme

- Introduced psychoanalytic concepts/principles to primary school teachers
- Seamlessly integrated into the curriculum goals and outcomes

ELVA was seamlessly integrated into the required curriculum goals and outcomes, aiming as a preventive approach, to support children to recognise their own inner world and appreciate that other children have inner worlds of thoughts, feelings, ideas and wishes too.

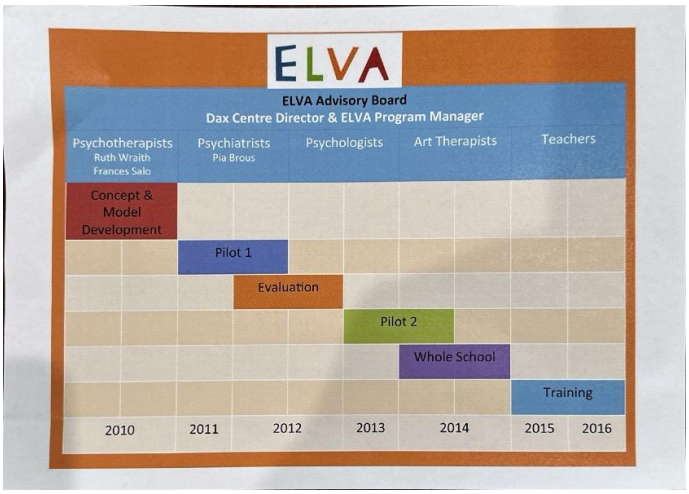


This supported the building of a basis of self- awareness, self -understanding and the building of enhanced understanding, empathy and respect for their class mates.

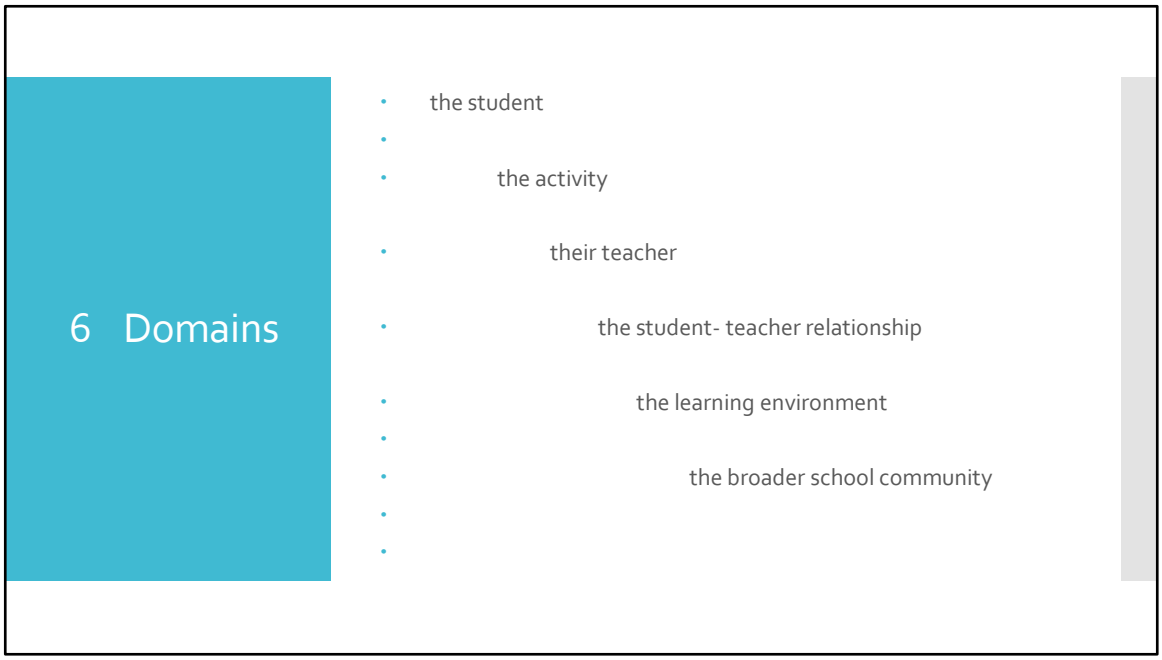


ELVA was based on the integration of psychoanalytic concepts, child development, neuroscience and art as therapy. It was presented in a way to bring this knowledge alive for the teachers and in a format that could be readily translated and be active in the classroom. It definitely was not art as therapy but was art as a communication to the self and others.

Research design for the ELVA project



It was carefully and thoughtfully designed by experienced teachers, clinicians and an art therapist.



There are 6 domains to ELVA, the student, the activity, their teacher, the student-teacher relationship, the learning environment (classroom) and the broader school environment.

Prior to training and the introduction of ELVA to a school, information meetings were held with staff and parents, along with newsletters to introduce them to ELVA. ELVA offered a whole of school training as well as selected staff training plus ongoing support as teachers applied ELVA in the classroom.

Training was conducted by an experienced school teacher and a clinician (myself). Care was taken to ensure that appropriate channels and services were in place should concerns arise about the well- being of any child or teacher.

The training included the psychodynamic understanding of boundaries and containment to assist the teachers to provide a culture where the children felt subjectively safe and secure.

The pilot training was evaluated by the University of Melbourne Centre for Programme Evaluation. In their report of the implementation phase teachers reported the following:

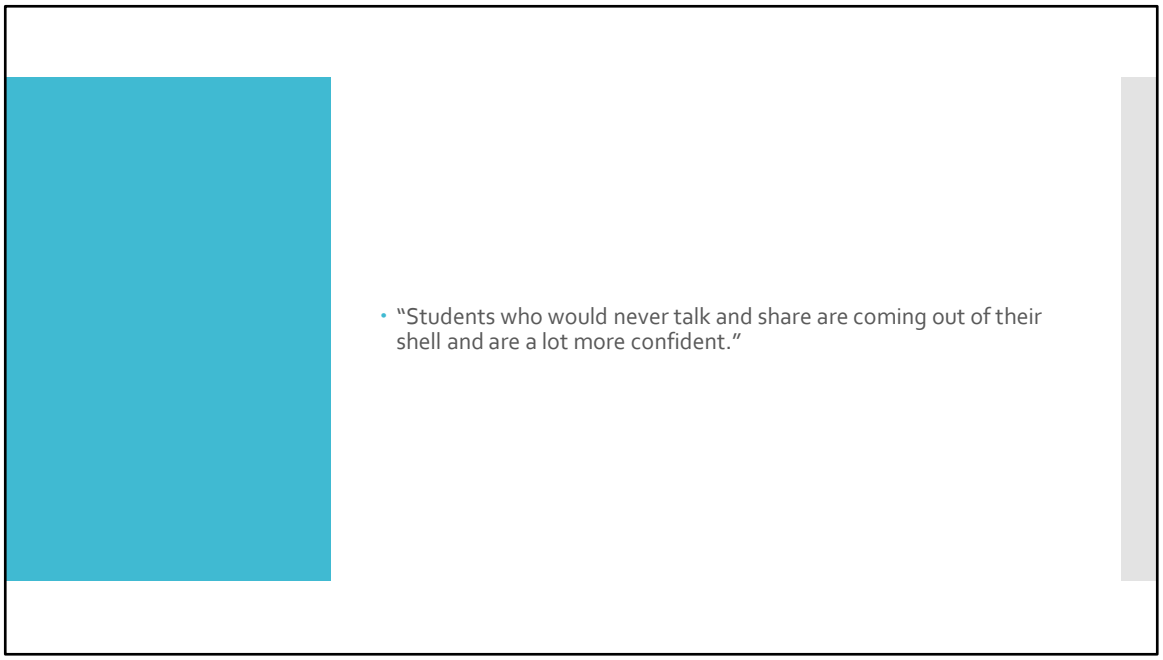
. they had developed greater emotional self -awareness and had a greater understanding of how their thoughts and emotions could impact on their students

. being more reflective, empathic and mindful

. a greater awareness of creating a caring and supportive environment when encouraging children to express their emotions

. that… the training "had changed the way they teach and think about teaching,'

A 2017 ELVA trainee said: "ELVA training has changed the way I do everything. It's changed the way I work with my students and the way I relate to and understand my co-workers… and it's even improved the way I communicate with my partner."



Another 2017 trainee reported: "Students who would never talk and share are coming out of their shell and are a lot more confident."

Children reported that 'ELVA teaches me about myself', and other similar comments.

The setting

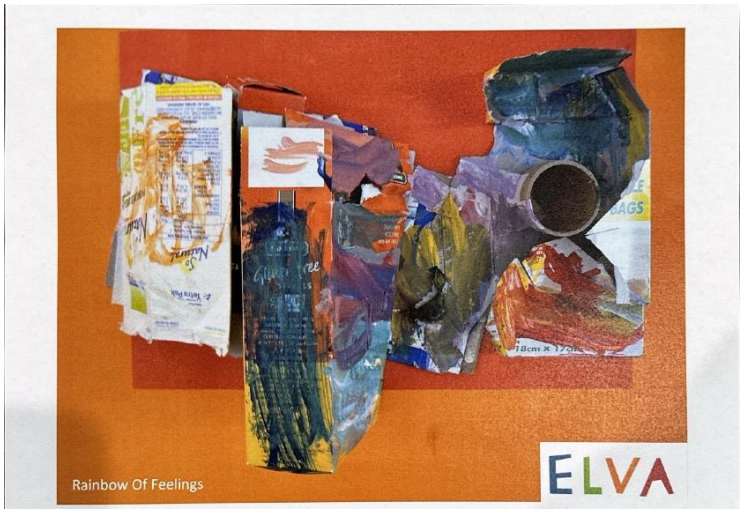
A consistent therapy setting

- The therapist's mind: reverie
- Relational and intersubjective
- The transference relationship
- Therapy room
- Play/art materials (suited to symbolic expression of inner world)
- Time: frequency and duration (Same day, time, and session length)
- Agreements eg confidentiality

The next 2 slides show the individual representation of the theme ‘Dreaming Over Time’

..and are representations of ‘Rainbow of Feelings’

Rainbow of Feelings



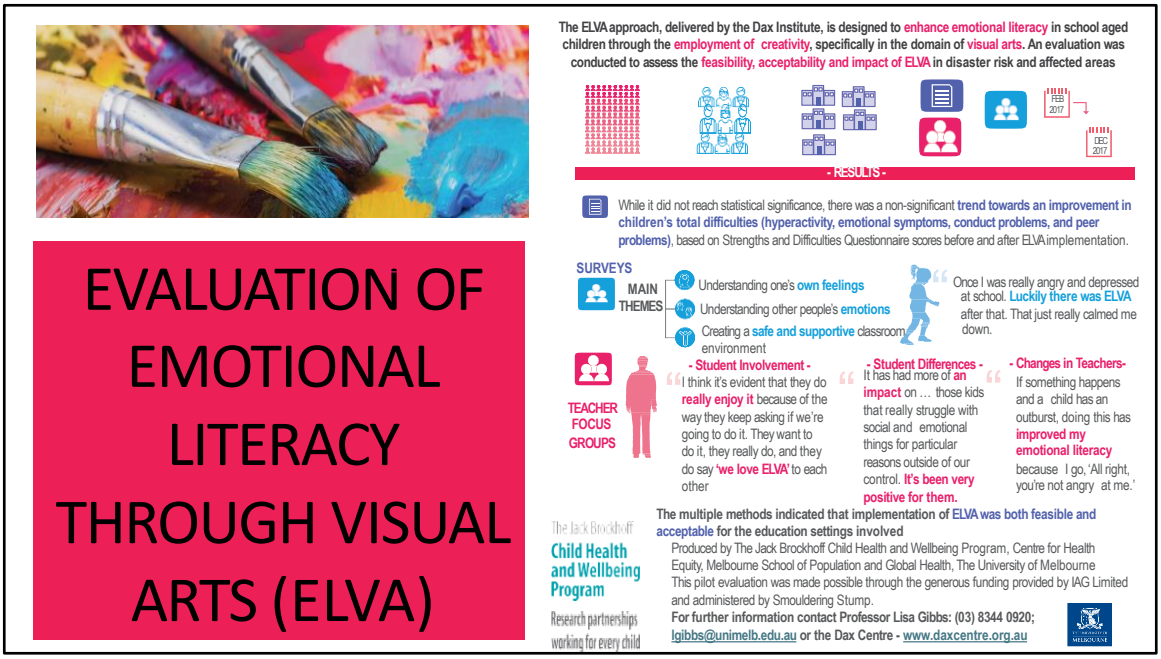
…with another class theme of 'Inside/Outside Feelings', using boxes, children represented these feelings in their own style.

The children and their families have given permission for these photos to be shown in the public domain

Rainbow of Feelings

Training findings were replicated when ELVA training was provided to and adapted for teachers from schools impacted by the Black Saturday 2009 bushfires in Victoria.

I

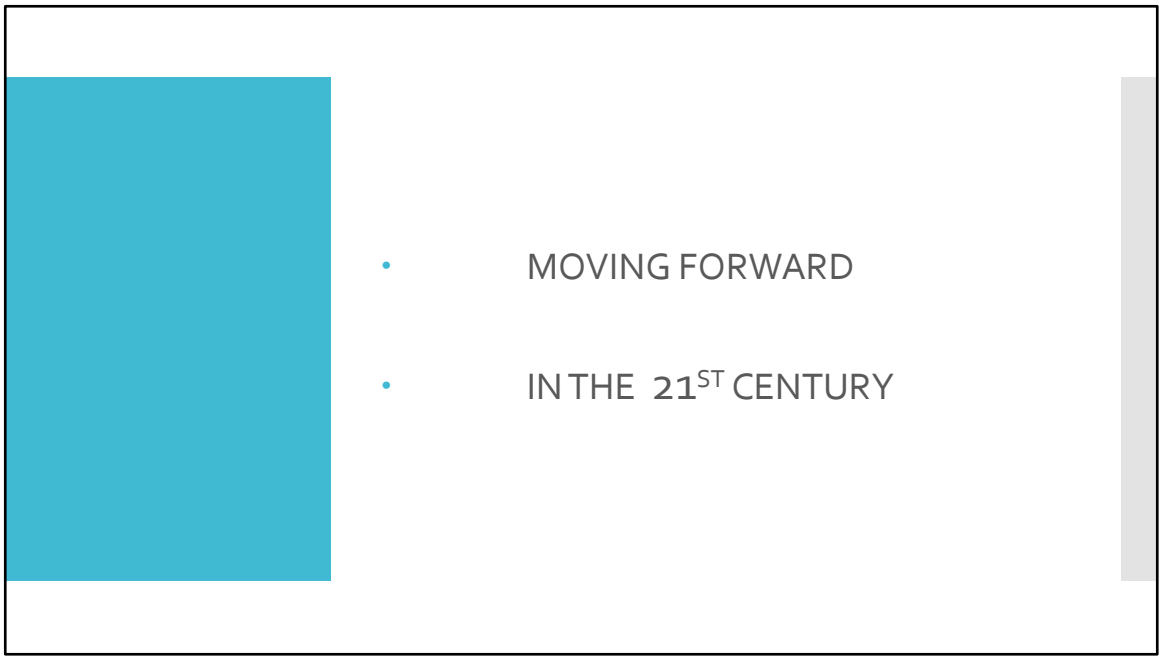


In 2017 ELVA was a VicHealth Award finalist in the category of 'Building Health Through Art'.

The training requires resourcing over 18 months to enable teachers to absorb their learnings and apply them while receiving ELVA support through the process.

When the Dax Centre became part of the Sane Australia Group in 2012 and focus consolidated around adolescents and adults, funding became an issue. Consequently ELVA training is no longer available.

This leads us to consider how the knowledge and expertise of child psychoanalytic psychotherapy can be made available to contribute to the mental health and wellbeing of our children and young people.

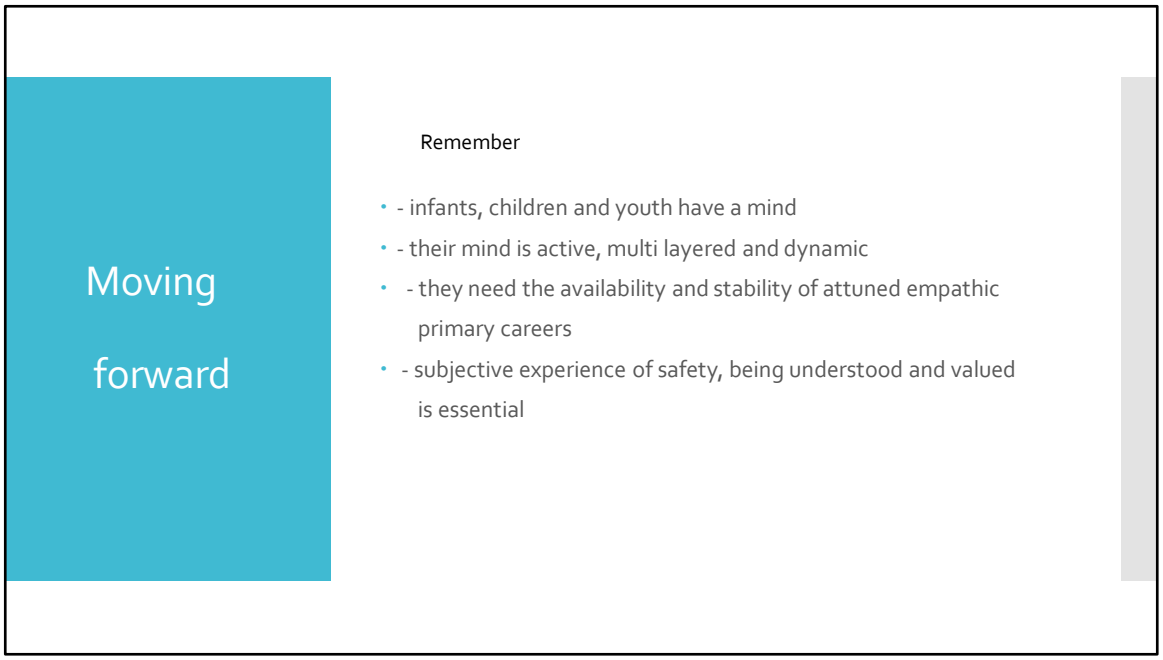


As Jenny outlined in her presentation, many of the concepts that underpin psychoanalytic therapy are embedded in the thinking and the every-day conversational discourse in our society.

However to a large extent they remain outside or are indeed resisted in considerations of mental health and mental well- being.

In the context of the increasing prevalence of mental ill health in our young this presentation aimed to provide an opportunity to consider current psychoanalytic theory and practice and what it can offer to clinical understanding and wider community considerations such as policy, service options and resource allocations to clinical practice and service delivery.

Holding in mind what we have presented this evening I would like to focus on summarizing some central themes.



Infants, children and youth have a mind. Their mind is in a constant state of dynamic, multilayered activity.

'Good enough 'attachment relationships are core and they need to be experienced by the child in 'the here and now', not at a prescribed or delayed time.

Healthy individuation and separation occurs as a developmental process when these needs are met.

The adult mind assists the infant, child and adolescent to think, to understand and also to regulate their emotions. These learnings, or skills, gradually become internalised and become the child's own. The external world of the child is important too including relationships beyond the family plus organisations and services. Being able to reflect on the interaction of oneself, or the service, with the child/ youth and /or their family, as demonstrated by the ELVA teachers, contributes to the well-being and mental health of the child.

Turning our focus to today's world we can ask, from a psychodynamic perspective, if the way our lives are lived is working to undermine the mental health and wellbeing of our infants, children and adolescents.

If the answer is Yes, what can we do about it?

Psychoanalytic theory would argue that for some infants and children experiencing multiple care givers with subtle but different communication styles, expectations and relationship patterns can be confusing to children and work against them feeling safe and secure in a predictable world of trusted relationships and expectations. This has the potential to lead to an unstable inner world resulting in susceptibility to or actual anxiety or other signs of mental stress.
In so many instances across the board in society, assistance is needed to develop an appreciation of the importance of primary carers being available, tuned in and responsive to children when the child needs it.

Similarly, the impact of the gig economy, of financial stress and social disruption

on the security, safety and stability of parents undermines their capacity to provide this for their children.

The ever- pervasive digital world …. the evidence is clear and abundant that, as currently engaged in by so many infants, children and adolescents, many aspects of it are damaging our young.

When infants, children and adolescents experience mental health challenges, services and highly trained, highly competent, well mentored and supervised clinicians are needed. And they need to be enabled to function to the same standards required for physical health.

The political emphasis on funding for wellness programmes and short -term mental health treatment is important. Currently the health needs of serious mental illness in children and youth who require highly skilled and long- term treatment and care are to the sideline.

This situation is so different from the clinical, research and financial resources available for physical health.

Aligning mental and physical health policy, practice and funding would have significant positive outcomes for infant, child and adolescent mental health.

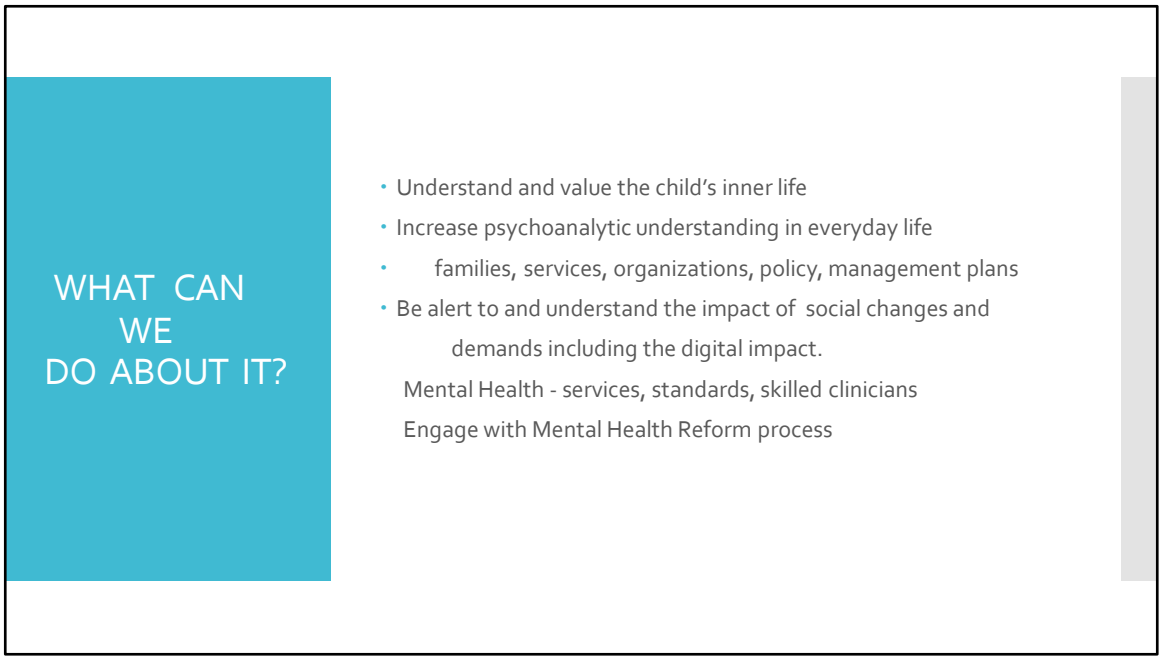
MHYFVic and the CPPAA are working together to engage with the Mental Health Reform process currently underway to emphasize this, but wider community support is needed as well.

At this point I would like to briefly draw your attention to the specialist level of child psychoanalytically trained clinicians here in Victoria and the need to, once again, recognise the profession in its own right.

While Government Mental Health policy and management recognises the competence and contribution of child psychoanalytically trained clinicians to the public health system, it is a 'hidden' profession. Generally child psychoanalytic psychotherapists are employed according their original profession such as psychologist, occupational therapist, social worker for example. This makes it difficult for services to identify, engage and benefit from their additional

specialist skills.

In closing, we would like to share with you a quotation from an article in the Sunday Age in December last year when Trent Dalton author of 'Boy Swallows Universe', and father of two teenage girls, was interviewed about his forthcoming book 'Lola in the Mirror'….

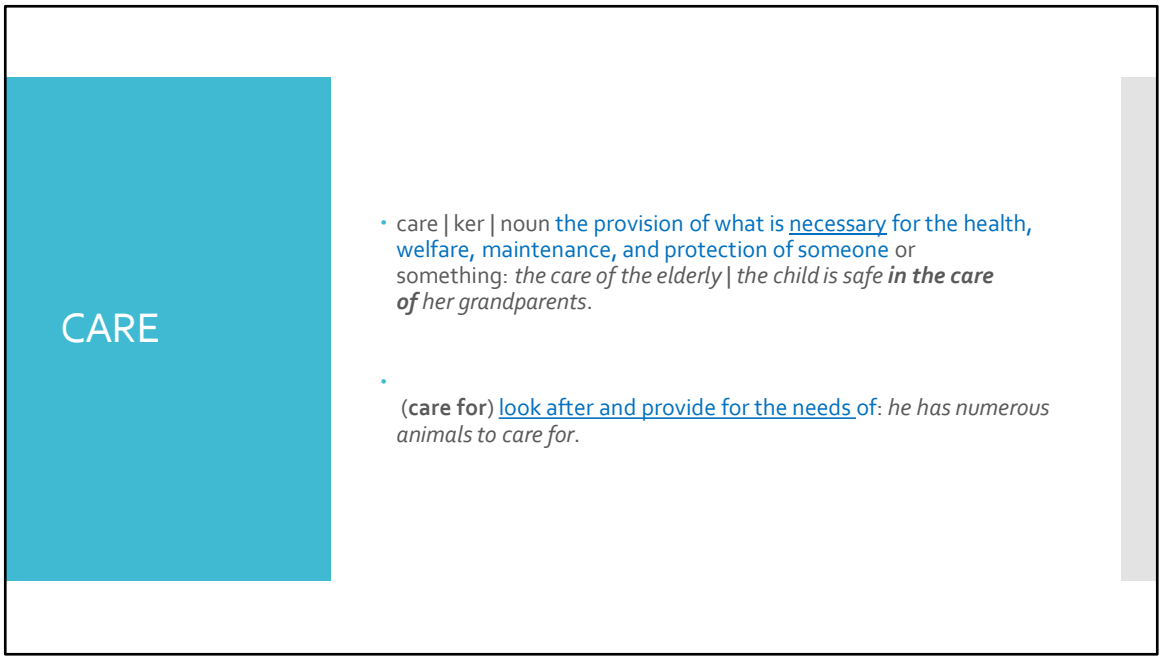


Understand the child's inner world, especially when they are distressed or experiencing mental health issues, before a diagnosis is formulated.

Continue to be open to bringing psychoanalytic understanding into everyday life.

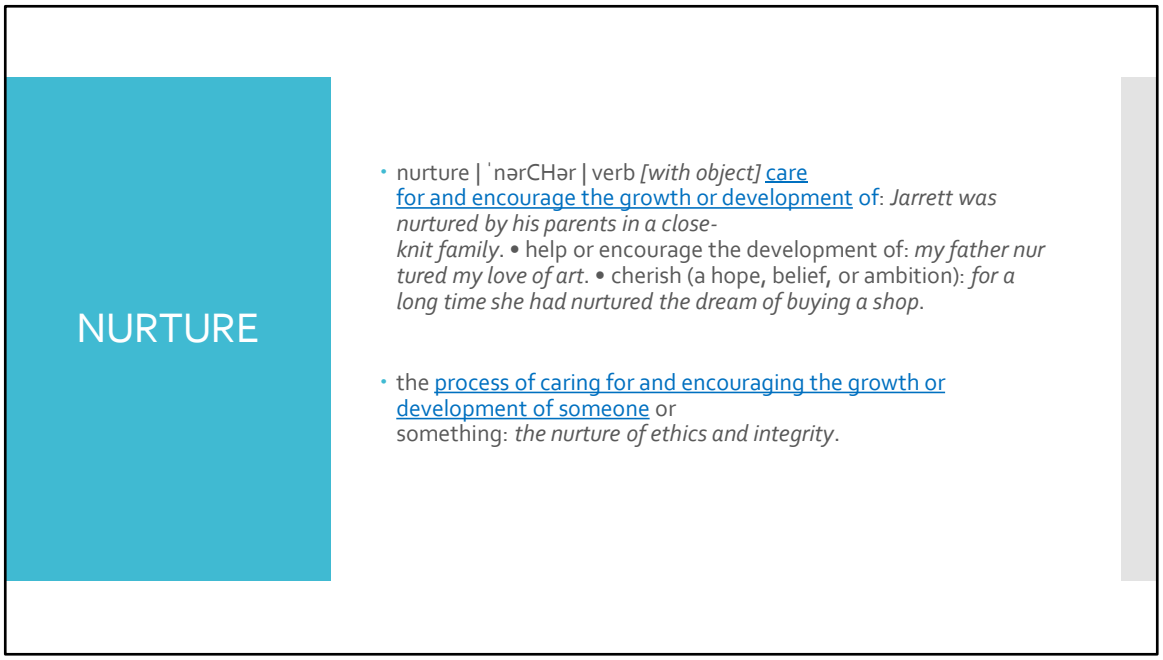
Bring psychodynamic knowledge to family stress, and to organisations and services working with troubled children and also to communities as they deal with complex issues and situations.

Bring the wellbeing of infants, children and youth to the fore in policy development and management plans, including the psychodynamic lens.



An example of where this is needed is the current economic push to bring women, most often the initial and ongoing primary caregiver, into the workforce by expanding the availability of child care.

While we acknowledge the importance and benefits of child care in the lives of many children and families, child care as it stands in many situations today is not necessarily appropriate for all infants and children or in all children's best interest.



The New Oxford American dictionary defines an important difference between Child CARE and Child NURTURING. The child psychoanalytic position is that in all situations, relationships and experiences should be nurturing of the child as we have discussed this evening, with care as an important part of that.

He said:

> "The thing I have learnt about teenage girls is to approach them like anyone you care about - from the inside out.
>
> Find out what is in their heart, their brain, what they're scared of and care about.
>
> See what they see. When you've done that, open your ears."

Jenny and I hope that our time together this evening has given you some ideas for your way forward with the young people in your orbit and the services engaged with them.

THANK YOU

FIN

PART 5: RESPONSE TO ORATION by Assoc Prof Campbell Paul, RCH

Part 6: GENERAL DISCUSSION