Our experience holding a two-day training on "Attachment and psychodynamic theory and practice: A move to representation"

Training Corner

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Following our clinical presentations at WAIMH Leipzig (June 2010), Elif Gocek, Assistant Professor of Psychology at Yeditepe University, Istanbul, and Member of the Turkish WAIMH Affiliate, invited us to offer a two-day training to mental health professionals interested in and struggling with infant-parent psychotherapy.

Elif Gocek had completed her doctoral dissertation at the University of Toronto, doing her internship at the Hincks-Dellcrest Children's Centre, focusing on maternal mentalization skills and responsiveness on the Watch, Wait and Wonder research tapes. Elif was familiar with the work of our infant and preschool training teams, which practice several approaches to Infant-Parent Psychotherapy. In 2009 she had invited Dr. Nancy Cohen (Director of Research, The Hincks-Dellcrest Centre) to offer a training in Watch, Wait and Wonder (WWW), an infant-led approach to infant-parent psychotherapy. (For more details see: Cohen et al, 1999; Cohen et al, 2002; Cohen et al, 2006; Lojkasek et al, 1994; Muir et al, 1999). Briefly, WWW psychotherapy helps the parent and infant discover for themselves a new way of relating, and aims to prevent repetition of intergenerational transmission of insecure attachment patterns. Those who attended the training were encouraged to practice the WWW approach, but some were finding it difficult and not as effective as they had hoped, and needed to have further training.

Reflecting on Elif's request, we thought those practicing were having the same difficulties we find our students have when they are first trained in either WWW or in Infant-Parent Psychotherapy (IPP). Although all the students are well trained in behavioural, physical, cognitive, social development and other theories, we find they are missing a key piece of understanding /knowledge that is essential to the work. Something happens and they see the infant and family through their theoretical lens rather than as an experiential question to try and answer – what is happening and why now?

To achieve such understanding, however, involves – for most of us – learning to see, know and feel what we have previously avoided seeing, knowing and feeling about infants' experiences in relationships (Bowlby, 1979; Tuters, 1989; Tuters et al, 1989). Our avoidance may stem from defenses of thought established in the course of our own efforts, as infants, to cope with failures in attachment relationships. Reflected in society at large, such avoidance may take the shape of training for mental health professionals that specifically excludes attention to emotional development, their own feelings /responses, or of social policies that dismiss the relationship needs of infants and young children.

We find the fulcrum of the learning experience for our students is observation – of infants and young children with their parents in a clinical setting during the process of assessment, formulation and treatment. Students experience the impact on themselves of observing the developing infant /young child in the relationship with their parents, through understanding the feelings aroused in themselves. This means becoming able to see what they have been unable to recognize; that is, the pain and distress of an infant /young child with parents who are avoiding the emotional needs of the infant /young child.

With this in mind, as well holding in mind some thoughts from Daniel Stern's article (Infant Mental Health Journal, 2008), where he mentions "good parent-infant psychotherapy has five things in common in all cultures: (a) You've got to listen; (b) You've got to take the time; (c) You've got to support them; (d) You've got to be open and welcoming; and (e) You have to have an attitude in which suffering is as important or more important than illness" (p 185).

Stern goes on to suggest that we have to look at our therapy from the perspective of, "How do we do this"? He reminds us we have a number of names for the relationship which seems to be the largest therapeutic factor to enable change to take place: the therapeutic alliance; a

Elizabeth Tuters and Susan Yabsley in the Istanbul Training (Photo: Elif Gocek).

holding environment; attachment or attachment transference; transference; and countertransference. These are key terms and concepts when talking about the therapeutic relationship. Stern tells us we need to be clearer about these notions and incorporate these five nonspecific attributes in some way (p 165).

And as well, holding in mind Patricia O'Rourke's article (Infant Mental Health Journal, 2011), where she reminds us "Parent-infant work is inherently relational and occurs in the intersubjective space between parent, infant and worker. The space can be charged with primitive, unmet needs of both parent and infant, and this in turn can trigger these same states in the worker". We could add these same states can be triggered in the students we train to do this parent-infant work.

O'Rourke offers us a thoughtful quote to ponder upon:

"She was a baby once and she has in her the memories of being a baby; she also has memories of being cared for, and these memories either help or hinder her in her own experience as a mother". (D. W. Winnicott, 1987)

To return to reflecting on our planning for our two-day training, of what and how we would teach in Istanbul, and taking into consideration the challenges and difficulties inherent in doing infant clinical practice, we decided to focus our first day of training on Attachment theory and Intersubjectivity (Stern, 2004), in order to give a foundation to the students. The second day we would present two approaches to infant-parent psychotherapy (both models based in Attachment theory and Intersubjectivity) so the participants would have a common theoretical frame from which to deliberate.

We sent ahead for translation a PowerPoint presentation on Attachment theory, updated to include mentalization (Fonagy et al., 2002), and we decided, based on previous experience as trainers, it also would be crucial to include an experiential /observational component, including an interactive discussion with the group. We showed the classic films directed by Jim and Joyce Robertson (1956), "John" and "Jane".

"John" tells the story of a 17-month old boy, who experienced a nine day separation from his parents when he was placed in residential group care while mother had a baby. John had no consistent person to relate to, and he went through a process related to sudden loss – sadness, anger, protest and despair. In the reunion with his mother, John was avoidant and pulled away, a painful experience for both mother and for John.

"Jane", also 17 months, experienced a separation for nine days while mother had a baby, and was placed in planned foster care. Jane had someone who was consistent and she did not experience the devastation of the sudden loss experience; she was able to relate to the consistent caregiver and able to keep the memory of her mother alive. In the reunion behavior with mother, Jane enacted her ambivalent feelings about the separation.

Our translated PowerPoint was projected onto the screen. However, as most participants did not speak English, all the interactive dialogue we had with the participants had to be translated. This process was challenging for both of us, but as we were already familiar and comfortable in a dual teaching relationship, the process went surprisingly well. (We received an E-mail from a grateful participant to tell us how containing our style was, which enabled the group to get to the earliest difficulties some of them had experienced as babies themselves.)

Day Two focused on the two approaches of infant-parent psychotherapy we utilize most. Again, we had a PowerPoint presentation describing the approaches translated ahead of time; however, as we were also showing clinical material which could not be sent ahead, and the subtitles were in English, the text had to be translated on the spot as it appeared on the DVD clips. The translators were

Trainees in group photo (Photo: Elif Gocek).

interested in the work and were excellent.

The first case was a Watch, Wait and Wonder (WWW) case presented by Susan Yabsley, consisting of excerpts from three sessions focusing on both observation and discussion of the first, seventh and tenth sessions. This mother had sought help because she felt her two year old daughter was too shy, and reminded her of her child's father who had a diagnosed mental illness. The parents were not together after the birth of the child, and father did not see the child. Following the assessment phase of five sessions, WWW was offered. In each session, instructions were given to mother to follow her child's lead, letting her take the initiative at all times, to respond to and be accessible to her child, to pay attention to her infant's self-initiated activity and, after about 20 minutes, to stop and discuss with the therapist what mother had observed, felt and experienced during the activity.

The role of the therapist during the infant-led segment parallels what we ask of the parent, that is, to watch, wait and wonder. The therapist quietly observes the unfolding interaction and functions much like Winnicott's good enough holding mother – that is, one who is present but non-intrusive. This may appear straightforward, however it is often very difficult. As O'Rourke (2011) states, the intersubjective space between parent, infant and therapist can be charged with primitive unmet needs of the parent and infant, and can trigger these same states in the therapist. The therapist needs to be open to 'seeing, knowing and feeling' what has previously been avoided about the infant's experience in the relationship, and to be able to tolerate and process these states.

The second case was an Infant-Parent Psychotherapy (IPP) case presented by Elizabeth Tuters. This approach of IPP is based on the same principles as WWW, but with an adaptation where the clinician is more active and forms a relationship with both the child and the mother, but holds the relationship between the mother and child as primary. This way of working is more visibly interactive and triadic in nature and composition.

This case was a 3.8 year old girl, who had temporarily lost her mother when she was 18 months old during the birth of her sister, and her mother had become seriously ill following and was hospitalized for seven weeks. When mother returned home she still was recovering and had to be careful, and could not physically hold her children. M became immediately upset, withdrew from mother, would not talk, and refused to take part in any activities. She clung to her mother and seemed to be more secure with her father.

We formulated this case in terms of Attachment theory, the child's traumatic loss of her mother, and their inability to regain their emotional connection. The case became a most painful situation for the mother, the clinician and the team, as we observed the emotional withdrawal of both mother from the child, and child from the mother, and the pain of the mother, who was trying to be accepted by her child. M's little sister was full of vitality. She had not suffered the loss experience the same way as M, and seemed to be securely attached to her mother and her father. Throughout the 26-session treatment, we encouraged the mother and M to play together. M symbolized the loss of her emotional connection by initiating play with train tracks and the missing pieces. M was obsessed with getting the pieces of the train track together, and we encouraged mother to participate actively. Mother became totally emotionally involved with the play.

DVD clips of the process were shown and discussed with the group, who participated actively and appeared to be affectively involved with the mother and child's process of the recovery of the relationship. They identified with the pain of both the mother and the child. We thought about the intersubjective matrix involving therapist, mother and child, to enable them to find the connection, and then to have the therapist pull back and allow mother and child to be in the recovered relationship together. The observing team members were also involved in this intersubjective matrix and experienced the pain of the mother and child and therapist. This triad experienced the team as part of their holding environment, much the same way the group participants worked with the clinical material presented in both cases.

To end, together we articulated the key principles of clinical infant-parent practice: the importance of 1) observation, 2) attachment theory and intersubjectivity, 3) developmental theory, 4) affect and regulation, 5) mentalization – finding oneself in the mind of another.

Evaluating the effectiveness of the training, we asked the participants what had worked and had not worked in what we had offered. They felt the two days were important. They felt the first day on the theory and experience of attachment had laid the foundation for them to be able to locate themselves and their reactions in the two clinical approaches and case material presented. They felt themselves able to work at understanding the material and to struggle with the pain of not seeing, knowing and feeling. This is the same struggle the therapist has in both approaches presented (WWW and IPP) – to struggle with the feeling of not really knowing what is going on and to stay with this uncertainty.

The group participants were interested, curious and affectively engaged. Some were new to the field while others had had many years of experience. Some had done training in Infant Observation and in Watch, Wait and Wonder. The group members all worked well together, with each other and with us. We were gratified by their focus, commitment and willingness to struggle to learn a new way of thinking.

We were delighted by the enthusiasm of the Turkish WAIMH Affiliate and the training group. Feedback from the participants indicated they were very impressed to hear how a "therapist felt, thought and lived when working with mother-infant dyads", noting "these kinds of sharings cannot be found in books". Dr. Gocek, who had initiated the invitation to Istanbul, commented, following the experience, "The workshop provided the participants such an important experience that in the future it will be possible for them to feel with the clients, to hold them, and to be able to stay with the uncertainty".

Postscript:

The following statement strikes me as the way we work, not only when we do therapy but also when we train others:

"Therapists are consumers of metaphors because metaphors are the links between implicit, nonverbal communication and explicit, verbal communication. They help to convey what we subconsciously perceive in a form that is communicable but that conserves some of the wealth of intuitive knowledge. Thus when we work in systems consultations we prepare ourselves to let metaphors emerge in our minds from the very beginning of the observation". (E. Fivaz-Depeursing, A. Corboz-Warney, 1999)

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