Vol. 19, No. 4 | October - December 2011

THE SIGNAL

Newsletter of the World Association for Infant Mental Health

What have we learned from cases where we felt we did not do enough or felt we failed?

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Introduction

Frances Thomson Salo

This paper is based on a Symposium presented at the 12th WAIMH Congress in Leipzig, Germany in June 2010.

The presenters of the symposium, coming from London, Paris, Capetown and Melbourne, who respectively work in an outpatient setting, a paediatric tertiary hospital and child protective services, discuss those cases where they felt that they may have missed something in the work, or failed in their intervention, in order to extrapolate further clinical learning. Difficult countertransference feelings such as anxiety, guilt and shame have also been explored.

The authors present an overview of when is a failure perhaps not a failure, or the helpfulness of rupture and repair (Benjamin, 2009). Bearing in mind Winnicott's statement about how private settings enable intensive psychotherapeutic work, in contrast with what can be achieved in public health settings, we discussed in this symposium cases where clinicians felt unsatisfied with the outcome of the treatment, , and cases where the patients expressed disappointment

Each of the authors addressed their own specific clinical domains and approaches:. Dilys Daws through her experience as a child psychotherapist, Antoine Guedeney from his experience with very difficult cases where the clinicians' countertransference and system issues are in complex interplay, Campbell Paul from his experience with the sick and dying infant and his or her family and Astrid Berg with her long term clinical work with those tragedies when a young child loses a parent The main focus of the symposium was to discuss the clinicians' part in failed cases.

For instance, how to distinguish between what is 'good enough' and what is not 'good enough, such as saying too much or too little, doing too much or waiting too long to make a diagnosis and to take action. Failures with child protection cases are often the result of the clinician's failure to keep the whole story in mind and/or to impact the system and to speak out about the infant's needs. Countertransference feelings of powerlessness and paralysis towards disorganised families may predispose to projective identification with patients or the system. There needs to be a review of the formulation so that it informs the work, and a capacity to recognise when a clinician has made too hurried a diagnosis and not fully understood the dynamics (the dialectic between knowing and not knowing) (Gold & Stricker, 2011). A major point is the clinician's capacity to view parents' lack of cooperation as a reaction to his/her failure to recognize their need for time in order to develop trust..

This symposium strengthened the need for reflective peer supervision, in order to keep the "good- enough" balance between too much frustration and too much gratification of patients. Dawson (2011) conceptualized the stuck therapeutic situations as a series of traps which are possible because 'clinicians want to maintain a view of themselves as helpful and benevolent, making experiences where they are dismissed or seen as malevolent particularly difficult to reflect upon (p. 36)

Additional issues have been addressed in this symposium, such as defining the time when the therapeutic aim has been achieved, getting feedback from the parents themselves (Birch, 2008), defining the role of the supervisor, and deciding the length and intensity of follow-up that families experiencing difficulties need.

Error and repair

Dilys Daws

Dily Daws's generation of therapists have realized today their lack of awareness of the very existence of child sexual abuse, that was in fact the explanation for their lack of improvement in spite of intensive therapy. The children would go on being restless, uncommunicative, at odds with the therapeutic relationship, or showing explicit sexual behaviour. As

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Dily Daws recalled: "Were they psychotic, we wondered? We spent hours in their company but the sad truth is that we did not ask them the most important questions that would have helped them to tell their unbearable, unthinkable story:.

> Josie, I felt fondest of, was an 8 year-old girl in care whom I saw at our Day Unit twice weekly, and then once weekly at the Clinic for 2 to 3 years. The Clinic had close contact with several children's homes in the area. The staff of the home seemed warm, caring and supportive of the therapy. Josie made a 'home' in my therapy room - on the inside of the door to her locker she stuck a list of her toys.
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> 20 years later, Josie, now with 2 children both on the child protection register, sued the local authority for thousands of pounds of compensation for sexual abuse in the children's home. The case went on for months, years, and nothing was proved. The local authority managed to lose the Clinic file with my unsuspecting notes.
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> Was this a case of abuse, accurately recalled when she had vulnerable children herself, was it opportunistic for the money, or was it a more general feeling that there should be compensation for a childhood spent in care? This wild child was felt to be unfosterable and unadoptable. If there was abuse was it current in the children's home, or earlier in her family? Her escort to therapy loved her, and so did I, but only for an hour a week. She was the one child that I had a serious fantasy of taking home and looking after properly. Perhaps I knew that I was failing in what she really needed - understanding and knowledge of her actual experiences."

Tronick (1989) talked about 'the normal, often-occurring miscoordinated interactive state as an interactive error, and the transition from this miscoordinated state to a coordinated state as an interactive repair (116)'. This concept may be valid for therapist-patient interactions, as well as for parents and infants. Feeling misunderstood may be an intrinsic part of the therapeutic work, in other words, getting it wrong may be part of the process of getting it right. How comforting that even our mistakes may turn out for the best!

Dily Daws reports her therapeutic experience with Jessica and her 4-month-old baby Thomas:

> Thomas had been born by IVF from an implanted donor egg and Jessica told me of the distress about him not being her baby genetically.
>
> In the first meeting I collected them from the Baby Clinic. Jessica was holding Thomas outwards in a sling, and both looked at me. I noticed but did not remark on their likeness. In the meeting Jessica started by telling me of the implanted donor egg and her distress about this. I said, a bit confused that I had thought how alike they were, and she agreed that people said that. I asked if Thomas looked like his father and she said he did. I asked if she looked like the father and she again said yes. We had a moment of wondering together about this likeness.
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> The next meeting was 6 weeks later after our summer holidays. Jessica talked more about her feelings about Thomas not being 'her' baby genetically and about Thomas' liveliness, which was apparent and very attractive. I then made my big mistake, and said that it was a generalisation but sometimes when mothers were depressed their babies were very lively to help cheer them up. I immediately felt I should not have said it. A theoretical point, not a timely felt one, and certainly not one discovered between us. The next week they were late. In the room Jessica

said she was angry with me for last time - what I had said about depression and liveliness. I said that I had worried that she was not coming because of that. She said, "I thought you would." We laughed a bit, but she said she was upset that I was wrong. I said perhaps it was useful that she could think I was wrong but could still come and make use of it. She was then able to talk more about the IVF; she had her own embryos, but had had a miscarriage. The doctor said she had a better chance of carrying an implanted embryo to full term – her own frozen embryos still exist. She also talked about her very difficult critical mother, and I wondered if the decision to use an implanted egg was also to disconnect from her own mother, I had just seen the film, I've Loved You so Long, where a mother adopts for this reason.

The next time she said how helpful this had been and told me how traumatic the birth had been. She had needed a caesarean, had a haemorrhage and a blood transfusion. She remembered her partner crying, thinking she was dying. After all this she could not move and they asked, "Don't you want to hold your baby?" She could not move to pick him up and no one offered to put him in her arms. She said she could not bear to look at the birth pictures because she and the baby are apart. They were being looked after separately. I said, "They were saving your life." In a later session she told me her partner was desperate for them to have another baby. I asked if that would be dangerous for her. She said, "Thank you for asking that."

My acknowledgement of how life threatening the birth was helped the work become less emergency focused and we moved on to the separateness between Thomas and herself, and to going back to work in a legal profession that she loves. The conflict between her wish to keep him close, his growing independence and indeed her own wish to separate brought back some of her agonising about whether he really was her baby. She talked about her fear of having to tell him one day and what that would do to their relationship. I said keeping him so close now was because of her fear of losing him. I said he was supposed to grow up and leave her one day. I said I wondered if it was easier that he was not a girl, and that carrying a female embryo that was not her own might have been harder. Perhaps as a boy he might care less about whose egg it was - that was women's business. She laughed and said her partner thought that, too.

There was also a long journey to the United States to see the father's parents. She began one meeting by saying how angry she was with me for the previous session when she had told me of her mother-in-law's wish for them to go straight to stay with them. I had no idea what it was like to travel overnight with a baby, be exhausted and need to recover. I said I had sided with the grandparents and we both smiled, as complices.

Dily Daws goes on wondering:

"Why have I chosen this case as one to apologise for? This was a successful, indeed enjoyable piece of work although based on a mother's extreme distress that natural conception could not produce a live baby. I think that my crass mistake in the second session, of making a probably correct but completely mistimed interpretation was my defence against the distress she had come to tell me about. Perhaps also I had come up with a bit of theory to make up for my profound ignorance of the complexity of IVF. I had not previously taken in the meaning of egg donation and that there are no inherited maternal genes. Jessica's anguish included the feeling that her mother-in-law was blood-related to her baby, while she was not. A colleague pointed out to me that serum passes from mother to baby through the placenta. How much had she indeed made him her own in the womb? The fact that I could apologise and settle down to attune with her was perhaps helpful in changing her perception of her mother. As I became a therapist who could be wrong but still useful, so her mother changed into someone who offered welcome help and insights. To balance this, her mother-in-law became more infuriating. I think the separateness that my mistakes implied also allowed us to look at the separateness between her and Thomas in a less fraught way. When I said about the birth, "they were saving your life," she could give up some of her projected fury with the obstetric staff for treating Thomas and herself separately She could move on to the ordinary life process of separating.

Dily Daws felt the main mistake she had made in this case was to say too much. She reported another case, where she felt she said to little:

"I recently saw a mother Mildred and her 2-month-old baby Fraser, where I did badly miss the point. Mildred is from a war-torn country. In the UK she has been raped by more than one 'uncle' and has HIV. The conception of the baby was not from a rape, and did not cause the HIV. In our first meeting she told me a story,

not of rape but of having been defrauded of all her savings, and being further tricked into getting into debt. Listening to this story of a tragedy unfolding, my blood ran cold. I was physically affected by hearing the story and could hardly bear to listen. It actually felt as bad as many of the stories one hears of rape or near-death births. I asked about other times when she had been helplessly drawn into a sacrifice of her self and learnt of emotional abuse and denial of her identity. I learnt that the father of the baby had refused to allow the name she had chosen for her son and insisted on one that had no meaning for her. As we talked I noticed that Mildred rarely looked at the baby. His buggy was placed so that I could not see him and because of the urgency of her story, and the shame with which she told it I did not, as I usually would, pay attention to him. In the next couple of meetings she talked of her shame about losing her savings and that Fraser's buggy was second-hand. She had lost the money that would have bought him a new one, and had to pay back her debts. I was full of indignation on her behalf and told her of the government scheme to help people in debt, including condoning some debts to banks. The health centre had someone who could advise her on this. I see myself as a very sensible therapist in touch with the environment. Mildred said she preferred to pay off the debt.

In a later meeting Fraser cried and she picked him up and held him to look out of the window. This time I did comment that she did not look at him. She was surprised and said that she had a cold and she did not want him to see her looking like that. I said she was important to him and I thought he would really like her to look at him. It did not occur to me to say that she might feel that the HIV has damaged her so much that she does not want him to see that. Because of the drugs for the HIV she is unable to breast-feed him. I wondered where the outrage about this has gone? As Fraser has learnt to sit up I have asked Mildred to let him out of the buggy to sit on the floor near us both. I played with him, handing toys to him and taking them back. I invited Mildred to join in and she said how much she enjoyed it. The next time she spontaneously put him on the floor. Fraser looked at me and held out his arms. I said to Mildred that he remembered our game after a gap of two weeks. The shame of the loss of the money seemed to recede and Mildred talked about her return to work. She has a degree and has worked in an administrative job, but in the recession seems unable to get back into this. She works as a carer, and travels for up to 2 hours to do piecemeal jobs of ½ - 2 hours, travelling between clients' homes. I have said how exploited she is letting herself be, and she has started to feel this, and now refuses the ½ hour jobs.

Until writingup the case, I had not noticed how systematically I have avoided talking about the effect of the HIV on Mildred's relationship with Fraser. HIV is an exquisitely shameful state and is often kept a secret. Patients ask for it not to be in their notes. A general practitioner told me that patients treated in a specialist unit may not tell their own doctor about it. With good referrals I sometimes feel that I am supposed to know about the HIV but not to discuss it. The loss of a future that the loss of the money represented to Mildred must be much more located in the loss of a healthy body that could nurture her child; she might always feel she would be a source of contamination and danger to her child.

Lessons from foster care situations

Antoine Guedeney

As Antoine Guedeney explained, an infant in foster care and their parents evoke very complex and mixed feelings in the infant mental health team, as the situation of a neglected, sometimes abused or distressed child evokes both attachment and caregiving or internal working models (IWM) in each member of the team. In such situations, our IWM conflicts, as do those of the child and of the parents. If a baby alone does not exist, nor can an individual alone integrate such complexity: the group is needed to take up a position, after careful and independent clinical assessment. When such a position cannot be reached, then we find ourselves in a difficult position between conflicting identifications, leaving a child in a parentified position or having failed to address major safety issues with the parents.

Three cases of 'half-failure' in foster care situations

Antoine Guedeney suggested in the vignettes that follow that the main difficulty was to accurately assess the level of disorganization in the child, probably because of countertransferential attachment issues, which are, themselves, difficult to open with the team

Case 1: The B family

The mother, Mrs B, suffered from psychosis, with Major Depressive Disorder, and had a past history of neglect and abuse in a foster family. The father was illiterate, with a low IQ, and was the unrecognized son of a German soldier. He first married Mrs. B's mother and then fathered three children with Mrs. B, a boy and

twin girls. Mrs. B was on her own with the girls soon after their birth and she asked for placement of the three children. After the children had spent one year in an institution, she asked for them to return home, which was arranged. After she experienced a long depressive episode, the second of three placements of the children in another institution took place, followed by their placement with a foster family. Mrs B claimed for the children to be returned to her full-time.

The main challenges presented by this case included acknowledging the fear roused by Mrs. B in the team members, keeping in the team's mind the clinical story as a whole, in order to make out of it an organized script, and assessing the children's status.

Case 2: The failed evaluation of the extent of disorganization of attachment in infant and mother:

M was born of an episodic encounter between his mother, Mrs E, who experienced psychotic episodes, was intelligent and well supported by her family, and his father who suffered schizophrenia and was described as isolated and aloof. M received good caregiving for 8 months until his mother had an acute psychotic episode. He was placed for 18 months in an institution, and then returned to his mother. She had several further delusional episodes but he was not placed again until Mrs. E went to the police and disclosed she had abused him. We were bothered with the fact she did not disclose this to us, the therapists…Ongoing full time foster care with mediated visits by his mother was arranged.

Case 3: Feeling helpless in front of the judge's decision:

Mrs. N is the mother of a 4-year-old girl, S, and a 2-year-old boy. She has a Borderline Personality Disorder, with a past history of foster care and abuse, and of becoming involved with men who abuse her. She was verbally abusive of her daughter S, who shows disorganized attachment and role reversal, with speech and learning difficulties and considerable agitation. The father who is drug addicted is in jail, and was only interviewed once. Effective treatment of S was delayed by her mother leaving to be close to her own mother and going back and forth between her own mother and her children. S. looked emotionally disturbed, and her brother had violent tantrums. The social worker obtained a placement order in a residential institution. The children spent 5 years in this institution and significantly improved. Unfortunately, their mother will soon regain custody, in spite of her unstable condition.

The team felt they failed at evaluating accurately the level of the girl's disorganization. They also felt surprised, depressed and powerless when the judge decided to give the children back to their dysfunctional mother, on the basis of the social workers' reports that showed an improvement in the mother's parenting skills.

These three failed cases led Antoine Guedeney's team to take several steps in the management of foster care situations, in the light of the special countertransferential processes embedded in these very complex situations:

1. Group reflective supervision: one clinician alone cannot hold in mind all the aspects of the situation.
2. Team "attachment" meetings
3. Assessment and treatment of such complicated cases should be done by two separate teams or at least by different members of team.

Lessons from working with very sick infants and their families

Campbell Paul

Campbell Paul said it can be very hard for us to think about our mistakes. For the very young infant with relationship and developmental problems the consequences of an insufficient intervention may be severe. The clinician working with very sick and hospitalised infants can at times feel very confused and overwhelmed by the intensity of issues confronting each of the child , the family and the therapist.

It may be that we feel we are not able to deliver what is the optimal service for the baby and her parents. We may feel we have not done enough to understand or ameliorate the distress experienced by the baby's parents and her carers. The acute paediatric hospital is a complex, fluid and changing human system. The stakes can be very high with disability or death as possible outcomes for sick infants. An opportunity to talk openly and reflectively with colleagues is essential. Infants with chronic illness, often have a long term relationship with a paediatric hospital. This provides an opportunity for the infant mental health clinician to monitor and evaluate the effect of their input when it occurs early in the baby's life. Parents and the child herself provide powerful feedback about how constructive or otherwise we may have been.

Some common mistakes which may occur in this clinical context include at the conceptual level:

- Letting the family feel their problem is too hard
- Idealizing the infant or the parents
- Having no feelings towards the infant or the family: disavowal of counter-transference
- Doubting our responsibility and capacity
- Losing the family who perceives the clinician as making them feel worse: how to help parents feel the gravity of the situation, yet not have them feel overwhelmed
- Being too intrusive or too avoidant of contact with the with the baby
- Talking too much with the parents, and not engaging the baby

Still, the therapeutic process involves

making mistakes: we must experience taking risks in our interactions with the baby, taking chances; this is what the ordinary parent does. The therapeutic process also involves the process of rupture and repair (Beebe, 2010; Tronick, 1989). The therapist's interactions may seem silly or may seem 'sloppy' as discussed by Stern (2010). Taking these risks is an essential part of engaging the infant with a view to therapeutic understanding.

These failures are important to be aware of, since they are especially relevant to those very young children who demonstrate autistic defences in the hospital context.

> At 3 months of age Anna was assessed for poor development and poor muscle tone. She had multiple investigations, neurology consultation and an MRI and all with normal results. At 6 months she was referred to infant mental health by a paediatrician because of possible autistic/developmental disorder and she was excessively floppy. Her mother's concern was, "She doesn't look at me and she is very alone and won't play with other children. She has no social gaze." Over time her mother reveals that she really experiences major depressive symptoms and feels alienated and distant from her husband and her family. Her daughter constitutes for her a real experience of oppression. We offer approximately second-weekly infant and psychotherapy and later time-limited infant and psychotherapy group. Anna and her mother come regularly, but we do not see Anna's father. Despite the interventions in our belief that Anna does not have an autistic disorder and mother does receive such a diagnosis from other professionals, and from a Web-based clinical service. We found the use of videotaping sessions and reviewing these afterwards to be a powerful way of trying to understand some of the issues that the child and how frequently we may miss the essence of the interaction during therapy session itself. For us as therapists it can be disturbing to see how often we appear to "miss the mark" with the child's communicative response, and misunderstanding the parents experience.
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> Paediatricians referred a 2 ½-year-old boy, Charles, who had been admitted to hospital because of severe constipation. The ward staff noticed that he appeared difficult to engage and was preoccupied with the television, his favourite show was one which featured a transparent face with only eyes and mouth. His parents related the tragic story about their prolonged infertility. Charles was conceived at the time of the distressing death of the family dog. There was a brief moment when the parents were able to relate what their son meant to them. A clearer picture of severe autism emerged. At a 15 year follow-up Charles has profound autism with minimal language and sometimes very difficult aggressive behaviour. He and his mother have remained locked in a dreadful symbiosis. Could we have done more an earlier stage? It seems in retrospect that his parents were not able to mentalize the un-mentalizable (Slade 2009). Reviewing a family video of his first bath in the maternity hospital it was clear that he was an extremely dysregulated infant whose parents were unable to read and respond to his anguish. Could we have helped his parents

Extraordinary devotion from parents is often seen among parents of very sick babies: They give up much of their life for their sick baby. Parents may feel they can not afford to let the baby out of their mind lest she die: but may not see the baby as a person. We need to allow them to express intense ambivalence at times and also to allow for hate. Parents' devotion can be a problem for the staff, who may feel intensely watched and criticized. It can make it feel uncertain as to who decides on the baby's best interests and treatment : her parents or the hospital team. The staff may feel they are in competition – raising the question 'Whose baby is it, anyway?"

What have we learned along years of work with sick infants and their parents? Generally families are available and receptive to mental health intervention: despite initial fears, they do want to know what their troubled baby is feeling and thinking. Perhaps we underestimate the resilience of parents and siblings in the face of an extremely ill infant or one who dies. This resilience may be related to what role parents have had in being with their sick or dying infant.

For the clinician, regular discussion within a team where clinicians feel respected and trusted, where playful and creative discussion may occur, around even the most distressing and grave situations, may be among the main protective factors for making fewer mistakes in these painful and distressing situations.

Doing too much: When does infant-parent psychotherapeutic work end? When life starts with a trauma – implications for the therapeutic relationship

Astrid Berg

According to Astrid Berg, having a baby constitutes probably the most highly charged time in the life of parents:

We know that pregnancy and the perinatal period are often accompanied by an 'affective upheaval' (p.25) even in the most normal and stable women (Slade, Cohen, Sadler & Miller, 2009). This emotional time is also felt by the rest of the family such as father and grandparents. If during this already tumultuous time, an unexpected event, a crisis, a trauma occurs, it is superimposed on this already unstable system. Engaging in a therapeutic relationship at such a moment is thus one fraught with intense emotions on both sides – that is, the collective transference from the patient and family as well as the countertransference coming from the therapist. Astrid Berg elaborates on these countertransferential processes:

The countertransference – doing too much and assuming too much

The tragedy of many family's situations are deeply moving. The death of the mother during the early phases of the child's life constitutes a crisis of unequalled intensity. The grief over the loss is compounded and amplified by who is left behind: namely, a human being in its most vulnerable phase of life. The birth right for 'absolute dependence' on 'the live mother and her womb or infant care' (p84) (Winnicott, 1990) is suddenly and irretrievably taken away. In cases of parental suicide or violent death this level of crisis often precipitates immediate and unusual intervention on the part of the therapist.

The therapist who comes in from the outside gets pulled in, and is often compelled into action that he or she may, under less fraught circumstances have resisted. Who gets seen when may become muddled because of the sense of collective urgency and distress. So it may happen that the first consultation takes place not at the clinic or consulting room, but at infant's home. For example, following the murder of his wife a distraught father calls on a therapist, requesting the presence of a professional when he tells his pre-school and toddler boys about their mother's death. How can one insist on an office interview in the heat of this moment?

Similarly, who gets seen and consulted may be wider than would usually be the case and include extended family and house-help, nannies or au pairs. Because of the desperateness that this primal loss evokes the usual protective boundaries of the therapeutic frame may momentarily be broken.

The loss of a mother of a young child is traumatic, traumatic in the sense that it causes upheaval in the psychical organization of those who are left behind. The upheaval is more than in other phases of the life cycle because of what this loss represents to the child and family: namely the violation of an inherent human birth right to be cared for.

The devastation that this reality brings to the surface is a compensatory impulse of rescue, of wanting to save. This 'saviour complex' reaches into deep levels of the psyche, layers which can be called archetypal in the sense that they are universal human impulses. Jung described a complex as being a feeling-toned 'image of a certain psychic situation which is strongly accentuated emotionally…this image has a powerful inner coherence… [and]…a relatively high degree of autonomy.' (p96) (Jung, 1969) The complex is something that 'can have us' (ibid); in other words, we are not always conscious of it and certainly not in control of it. This urge to help an 'abandoned' infant can pull us into the realm of these powerful affects and resultant urges to go along with these and 'act out'.

Psychoanalytic writers do mention the 'saviour complex' in terms of idealizing the analyst and seeing him/her as the saviour (Steinberg, 1988) and, in a similar vein where mirror self-object countertransferences may be at play (Köhler, 1984), that is, the idealizing is mutual and comes from both the patient as well as the analyst. These situations are often precipitated by the psychopathology within the patient which in turn finds a 'hook' within the analyst. However, the argument brought forth here is that the saviour complex that is constellated because of a tragic human situation – that is, an actual traumatic loss during infancy - reaches realms which lie beyond personal psychopathology. The 'image of a certain psychic situation' is that of an infant out in the cold, so to speak. It would evoke a response of urgency and action in most human beings – in this sense it is dimensions which are transpersonal or archetypal.

In the beginning this urge is of benefit to the child and the family – they do indeed need someone who is committed, who will walk the extra mile in the sense of being flexible, available and reliably present. It may lead to an ongoing, long therapeutic relationship which initially is stabilizing and containing. The family and child find comfort in going back to the 'original object' as it were, because of the strong affective ties that have been built around the initial trauma. And thus the cycle of what could be called 'benign mutual' projective identification of 'saviour and being saved' continues.

But, families and children heal with time, the helpless infant becomes an active pre-school child, the surviving parent may find a new partner and life becomes normal again. Are we as therapists always sufficiently aware of these positive developments that are occurring with our patients?

Or, put in another way: are we as therapists sufficiently in touch with our own saviour complex and the family's development to know when the time has come that they are no longer needed in the same way as before? When is it time to stop and to let go?

There is no clear cut-off age and it is an individual case-by-case decision. One of the difficulties of many cases is that the contact may be intermittent and in different modalities. The fluidity which was necessary in the beginning may eventually lead to an ongoing blurring of boundaries of therapeutic spaces. But sometimes there are signs within the therapeutic system that evolve and that could serve to alert the therapist.

Family relationships may have stabilized, and 'the infant' has become a pre-schooler, needing to enter the stage where work takes over from play. This may be the point when a hand-over should occur, when, if necessary, one should let an 'outsider' do a fresh assessment of the child. 'Hanging on' to the child may not be of help – the original therapist may not have the objectivity to look at the child in a sufficiently dispassionate way.

Beginnings in infancy are powerful and they evoke 'wildness within and between', to quote Joan Raphael-Leff (2003). In these cases of early trauma the 'wildness' has to do with a prevailing need to help, to be a continuous, consistent, good-mothering presence for the baby who had lost a parent in a tragic manner. This attempt at compensation may work for the first few years, but then it can become corrupted: the growing child needs more than a nurturing therapist – she or he may need an educational assessment and a more objective psychological evaluation. The original therapist may not be the appropriate person to give this. The 'wild' beginning of our young patients' lives and its effect on us as therapists may be one of the explanations of why we may realize this too late and end up doing too much.

To conclude, talking and thinking about failed cases and repressed difficult issues at each WAIMH conference, could be a very beneficial experience for trained and experienced clinicians, as well as for the younger ones. We all remember how, as trainees, the lessons we most remembered were those of a senior clinician talking about his/her failures (eg. do not initiate discussion of drugs on the phone with patients; take a break when you begin to raise your voice with patients; be careful when you get angry about a case, etc.)

References

Beebe, B. , Jaffe, J, . Markese, S. , Buck, K., Chen, H. , Cohen, P., Bahrick, L. , Andrews, H. & Feldstein, S. (2010). The origins of 12-month attachment:

A microanalysis of 4-month mother-infant interaction. Attachment & Human Development, 12: 1, 3 — 141.

Benjamin, J. (2009). A relational psychoanalysis perspective on the necessity of acknowledging failure in order to restore the facilitating and containing features of the intersubjective relationship (the shared third). Int Journ Psycho-anal: 90: 441-450.

Birch, M. (ed). (2008) Finding Hope in Despair: clinical studies in infant mental health. Zero to Three Press.

Dawson, A. (2011). Stark cases: Understanding the experience of children, families and clinicians in a child and adolescent mental health setting when the helping relationship becomes stuck. Unpublished thesis reported in The Bulletin of the Association of Child Psychotherapists, March 2011.

Gold J. & Stricker, G. (2011). Failures in psychodynamic psychotherapy. Journal of Clinical Psychology: In session, 67: 1096-1105.

Jung, C.G. (1969). The Structure and Dynamics of the Psyche. (Second Edition ed.) (vols. 8) London: Routledge.

Köhler, L. (1984). On Selfobject Countertransference. Annual of Psychoanalysis 12, 39-56.

Raphael-Leff, J. (2003). Parent-Infant Psychodynamics - Wild things, mirrors and ghosts. London and Philadelphia: Whurr Publishers.

Slade, A. (2009). Mentalizing the un-mentalizable. Parenting children on the spectrum. Journal of Infant, Child, and Adolescent Psychotherapy; Jan-Mar 2009; 8, 7-21.

Slade A., Cohen L. J., Sadler S.S., & Miller M. (2009). The Psychology and Psychopathology of Pregnancy. In Zeanah C. H. (Ed.), Handbook of Infant Mental Health (Third ed., pp. 22-39). New York, London: The Guilford Press.

Steinberg, W. (1988). The Evolution of Jung's Ideas on the Transference. Journal of Analytical Psychology 33, 21-37.

Stern, D. N. (2010). Forms of Vitality: Exploring Dynamic Experience in Psychology and the Arts. Oxford University Press.

Tronick, E. Z. (1989). Emotions and emotional communication in infants. American Psychologist, Vol 44: 112-9.

Winnicott, D. W. (1965). The Maturational Processes and the facilitating environment. London: The Hogarth Press and the Institute of Psycho-Analysis.

Winnicott, D.W. (1990). The Maturational Process and the Facilitating Environment. London: Karnac.

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