

Core concepts in infant–parent psychotherapy

By Marian Birch

From conception through the third year of life, there is, in Winnicott's (1960) pithy phrase, "no such thing as a baby." There is, rather, the dynamic, nonlinear system (Sander, 1975) of the infant-and-caregiving environment. The caregiving environment is, most immediately, in most cases, the mother; equally critically, it is the web of familial, social, and economic relationships and resources that support the mother so that she is able to find within herself the psychological and physical resources to successfully rear a healthy, happy, and competent child. A mother can no more parent successfully without such environmental support than an infant can thrive and grow without a mother (Hrды, 1999).

The tasks of the infant–parent psychotherapist include addressing internal obstacles that impede the parent from accessing the support she needs, as well as practical assistance in identifying and accessing available resources. When babies grow up and have their own babies, their capacity to find and accept the help they need from others is directly and strongly correlated with the kind of caregiving they received as infants. In terms of attachment theory, a securely attached infant grows up to become a mother who is able to use relationships with others to meet her need for support. An anxiously attached infant, barring intervening help, becomes a mother who has significant constrictions in her ability to do so. The infant with no organized attachment strategy is likely to become a mother with no organized strategy for obtaining the support she needs, and who, in powerful and automatic ways, perceives others as threatening, not helpful. Similarly, the mother's representation of her infant and her ability to be sensitively responsive to her infant are shaped to a significant degree by her own early experience and the way it is registered in her psyche (Main, Kaplan, & Cassidy, 1985).

Our intention, as infant–parent psychotherapists, is to expand the mother's range of choices in both spheres: in response to her infant, and in meeting her own psychological and practical needs.

When the infant–parent dyad is not working well, it is often because the mother has rigid defenses against being

ZERO TO THREE Corner

The following excerpt is from the first chapter of *Finding Hope in Despair: Clinical Studies in Infant Mental Health*, edited by Marian Birch (ZERO TO THREE, 2008). Therapeutic intervention with children and families is not always successful, but the professional literature does not often address treatment failures. Yet all clinicians at one time or another will face challenging cases and disappointing outcomes. To address the need for more information about how to handle challenging cases, *Finding Hope in Despair* explores the limitations of infant–parent psychotherapy by examining six different "treatment failures" using a unique format for reflective discussion. In the following excerpt, the editor describes the core concepts, techniques, and challenges of therapeutic intervention with infants and very young children and their families.

aware of and experiencing what Tronick (1998) called "a dyadic expansion of consciousness" within the dyad. On the mother's side, this dyadic expansion of consciousness, when accessible, provides her an entrance into a long-forgotten world of primitive nonverbal feeling and experience that permit her, for example, to distinguish a hungry cry from a tired cry, or, in the case of many mothers in developing countries, to unerringly hold the baby out at arm's length at the moment just before he pees.

When a mother cannot tolerate this primitive way of knowing, it is usually because she received inadequate help, when she herself was an infant, in tolerating, managing, and regulating her own primitive preverbal feelings. Thus, in her infancy, she experienced her affects as overwhelming and traumatic, not as reliable signals to herself and her caregivers about needs and wishes. Her infantile distress and arousal met with neglect, abuse, intrusion, projection, and negative attributions. Furthermore, her subsequent experiences may not have afforded her an opportunity to revise her early, infantile ways of coping with these failures of caregiving with more mature and adaptive mechanisms.

This is the help that we come, as infant–parent psychotherapists, at the 11th hour, to offer. Our objective is to exorcise the ghosts in the nursery, which cloud the mother's perception of and ability to respond to her infant. But, of course, these selfsame obstacles are the chief impediment to the mother's accepting any help we have to offer.

We cannot expect the mother to have a "realistic" view of our helpful intentions and purposes in intruding ourselves into her life, any more than she has a realistic view of her baby's motives for occupying so much of the territory formerly known as her life. We do not take her wariness, hostility, and evasive vagueness personally. We do not waste too much breath trying to persuade her that we are different from the others—the parents, teachers, doctors, social workers, and so forth—who have disappointed her in the past. Instead, we try to understand how she experienced those disappointments and how they shaped her, and in our way of doing so we try to offer a different experience of being listened to, understood, and cared about.

This importantly includes acknowledging and perhaps even apologizing for the inevitably intrusive, humiliating, and insufficient aspects of our presence in her life. It also includes acknowledging that our interest, caring, and helpfulness are professional. In the brutally crude terms of one of my clients, we are paid to care. This falls far short of what our clients want—and may need.

It cannot be overemphasized how sensitive, deeply personal, and intimately tied up with self-esteem and her evil stepsisters—self-doubt and self-loathing—is the territory that we presume to enter. Often we come with only a flimsy and awkward excuse for an invitation. "Your CPS [Child Protective Services] worker, or your pediatrician thought you needed help." How special does that make a mother feel?

We, as therapists, do not like to think about this. We have our own self-esteem issues and probably would not be doing this kind of work if we did not have some fairly deeply rooted need to help. To be effective, and to survive as infant–parent psychotherapists, we have to let go of this need, or at least, loosen its grip.

The current dominant model is that we help parents become more sensitive, responsive, and protective of their babies through the therapeutic relationship itself: We have to become more sensitive, responsive, and protective of the parents. In the words of Jeree Pawl, we “do unto others as we would have others do unto others” (J. Pawl, personal communication, October 30, 2007).

This doing unto mothers what we hope mothers will do for their babies— provide sensitive, attuned, and comforting responses—has been described by Fonagy et al. (2002, p. 403) as “the creation of an interpersonal situation where the potential for reflective function could be specifically and safely exercised.” We believe that our cumulative interactive exchanges with the mother help her to think about her own and her infant’s feelings and experiences as meaningful and understandable by another and by herself. We are trying to provide an attuned, supportive relationship, a holding environment, a container within which the mother can reflect on and resolve some of the obstacles to attunement, mutuality, and growth in her relationship with her infant.

Work with infants and families is tremendously challenging. It requires us to keep a therapeutic focus and balance in the often chaotic, distracting, and disturbing settings in which our clients live. To maintain such balance, it is absolutely essential to have ongoing consultation, supervision, and training.

There must be dedicated time for the therapist to think about the system she is trying to join—time away from the infant–caregiver system and the multiple and often conflicting demands it makes for her attention and intervention. She also needs help seeing herself in the system, such as the opportunities that individual supervision and clinical case review with peers and consultants can provide.

The therapeutic challenges we face

In her radical innovation in psychoanalytic practice, what she referred to as “psychotherapy in the kitchen,” Selma Fraiberg and her colleagues (1975, p.

394) grafted a set of techniques that had long been central to the practice of nursing and social work onto an essentially classical, ego psychological model of psychotherapy. These techniques were home visiting, case management (including referral and advocacy), and educational guidance. Furthermore, Fraiberg et al. (1975) defined the patient of infant–parent psychotherapy as the dynamic relationship between an infant and his or her caregiving environment. This was a conceptualization that was far closer to family systems theory (Bateson, Jackson, Haley, & Weakland, 1956) than to the American ego psychoanalysis to which Fraiberg et al. claimed allegiance. Stern (1995) 20 years later likewise defined the patient of infant–parent psychotherapy as the infant–parent relationship.

Fraiberg et al.’s (1975) “parameters,” or special modifications of classical psychoanalytic practice, emerged in the 1970s and ‘80s, in the same historical context as other adaptations (e.g., Heinz Kohut, Kurt Eissler, and Harold Searles) to the classical mode of a rigorously “neutral” analyst who facilitated psychological change through interpreting the patient’s free associations and, in particular, “resistances” and “defenses” (Mitchell, 1988). The classical model was viewed as effective only for “neurotic” patients—those whose problems stemmed from maladaptive efforts to manage unacceptable impulses. Its practice and its failures had led to increasing awareness of different kinds of emotional problems that required different techniques (Fonagy, 2001). The rehabilitation of John Bowlby and Melanie Klein, both of whom emphasized the central motivational role of relatedness, from the status of psychoanalytic pariahs, which they had endured in the 1950s and ‘60s, also began in this period.

Fraiberg et al. (1975) explained that their parameters, their new techniques— (a) home visits, concrete and emotional support, and developmental guidance; and (b) dyadic relationship as patient—made it possible to offer therapeutic services to families who lacked the inner and outer resources required to come to office appointments. This was initially discussed in terms of the logistical difficulties frequently facing parents with infants. It gradually became clear in practice, however, that the inability to access center-based services often reflected deep-seated distrust and disorganization in relationships. Such techniques were seen as concrete, operational statements of the therapist’s implicit and explicit offer to meet the family where and as they were. Again, the goal of this practice

was to engage distrustful caregivers in a therapeutic endeavor on behalf of the infant.

The practice of home visiting provided an incredibly rich and immediate access point or “portal of entry” (Stern, 1995) for collecting clinically relevant data. After an hour in a family’s home, the therapist often was privy to data that would take years to gather in an office setting—if, in fact, it could ever be gathered there at all.

It has seldom been acknowledged, either in infant mental health or in psychoanalysis, just how much these adaptations changed the therapeutic situation. Let us examine, then, the further implications of these innovations for the therapist’s understanding of her role and of what is supposed to be happening in therapy.

In several ways, the dominant model of infant–parent psychotherapy obscures and complicates the issues of informed consent and professional boundaries. The adaptation of home visiting forfeits one of the key features of office-based psychotherapy, namely, the patient indicates his engagement in a therapeutic endeavor by his physical presence (Clarkin, Kernberg, & Yeomans, 2006; Greenson, 1967). In addition, the formal setting of an office—often with signs, diplomas, and professional books—conveys implicitly that the therapist is offering specialized skills and services. Home visits and case management services (e.g., helping to locate housing or complete legal paperwork) make it more difficult to communicate clearly that the goal of therapy is to help the caregiver to overcome internal, mental obstacles to growth. The special quality of the patient’s transference and the therapist’s countertransference feelings and enactments (Bromberg, 1998), as a kind of “play” that occurs in the protective haven of the therapy, is easily obscured when the therapist actively seeks to engage the family in its own setting. The caregivers’ wishes that the relationship with the therapist would actually function, on a permanent basis, as a replacement for their own tormented ties to their families of origin are implicitly validated by this active, unconditionally accepting approach. Further complicating matters, our emotional availability to the caregivers is actually far from unconditional: We are motivated by a primary goal of promoting the infant’s healthy development, not the optimal future for the caregivers.

A further consequence of working in the home, with a dependent infant present, is that it is much riskier to invite and work with profoundly regressive and intense

feelings and states. An office offers the safety of a private, anonymous haven that the patient chooses to come to and that she can leave behind. Likewise, the therapist in an office can be emotionally engaged with the patient's intense and primitive material safe in the knowledge that the hour will end, there are no lethal weapons on site, and the patient is almost always able to pull himself together and leave, or at least sit in the waiting room until he can. In our work with parent–infant dyads, we are always titrating the depth to which our dialog can go against the ever-present physical and emotional need of the infant, as well as our own sense of safety (Lieberman, 2000).

The hypothesis that the therapist's provision of warm, sensitive, attuned responsiveness leads to the caregiver's enhanced capacity to provide the same to the infant has led to an emphasis on strength-based, supportive interventions (Fraiberg, 1980; McDonough, 2000; Olds, 2005; Pawl, 1995). This approach is a far cry from the often painful "interpretations of resistance" prescribed by the old classical model (Greenson, 1967). We try to find something positive and growth-promoting to admire and validate in the parent–infant relationship. Although we often observe situations and interactions that profoundly disturb us, we also often feel that we cannot address them directly lest we lose the fragile alliance with the caregiver. Finding the boundary between being supportive versus colluding with subtle forms of neglect and maltreatment can be extraordinarily difficult. If we believe in the unconscious, it is inevitable that our concealed feelings of worry, revulsion, anger, and fear have an impact even though we do not openly express them. We need better ways to think about that (displaced) impact.

Like the public health nurse, and like the social worker, the infant–parent psychotherapist may provide developmental guidance and concrete support. However, rather than being ends in themselves, these activities are understood as ways of establishing the kind of relationship with the infant and its caregivers that, because it is sensitive, nurturing, and warmly positive, facilitates the caregivers' abilities to relate to the infant in similar growth-promoting ways.

This trickle-down effect is beautifully captured in Jeree Pawl's (1995) koan-like "do unto others as you would have others do unto others." It is presumed to work by altering the caregivers' internal working model of relationship, rooted in their own infancy, so that it is more flexible, hopeful, and generous and less rigid, fearful, and

withholding (Lyons-Ruth, 1998; Main & Hesse, 1990; Slade, 1999).

This can work beautifully when there is a clearly identified parent or caregiver who claims the child; and when this caregiver or parent has a psychological makeup that permits him or her to alter and soften lifelong unconscious strategies for maintaining psychic coherence within the timeframe set by the infant's inexorable developmental processes.

The therapist must also be able to maintain a balance in her attention to and investment in both caregiver and infant. Therapy must focus on optimizing this relationship as opposed to the oft-wished-for happy ending for one or the other of the dyad (Seligman, 2000).

What happens if one or more of these conditions are not met?

Contemporary writing about psychoanalytic work with adults and children has been marked by a very dramatic and rich expansion of the concept of countertransference. Writers such as Stephen Mitchell (1988, 2000), Thomas Ogden (1986), and Philip Bromberg (1998), to name but a few, have vastly enlarged our understanding of the ways that, in Freud's terms, "the analyst turns his unconscious like a receptive organ to the unconscious of the patient" (1912, p. 118) and uses the behaviors, thoughts, affects, images, and impulses that are evoked in him as a rich source of "data" about the clinical situation. With these discoveries has come a profound acknowledgment of the fallible humanity of the analyst; that, in the words of Harry Stack Sullivan (1953), "We are all much more simply human than otherwise" (p. 32). Harold F. Searles, a psychoanalyst renowned for his Herculean efforts to treat schizophrenic patients psychoanalytically, has eloquently complained that the more classical view of the neutral and abstinent analyst requires the analyst to be a person who somehow transcends the ordinary human vulnerability to confusion, envy, destructiveness, and perversity, and is able to listen to extraordinarily painful and disturbing material with the serenity of a Mother Teresa.

With few exceptions, within the field of infant–parent psychotherapy, the therapist is still expected to be superhuman in this way. Yet infant–parent psychotherapy evokes what are arguably the most intense and disturbing countertransference responses imaginable.

Intimate work with an infant in distress is guaranteed to stimulate the therapist's loving and protective feelings. To a

lesser extent, the kinds of narcissistic hungers that are assuaged by producing a healthy child, the longings and impulses that Erikson (1952) so graciously called generative, are also engaged. When the child is actually in a life-threatening predicament, as may be the case in medical crises or instances of parental or institutional neglect or abuse, these countertransference feelings take on a terrifying immediacy and power.

In 1999, Arietta Slade wrote the following:

Therapy concerns itself over and over again with loss, separation, and reunion—both in its consideration of such events in patients' lives, and in the constant separations and reunions that are intrinsic to the therapeutic process. And just as losses, separations and reunions have meaning for patients, so do they have meaning for therapists. Similarly, just as being cared for may be quite evocative for patients, so may the experience of caring be evocative for therapists. Many therapists have suffered early loss and abandonment; naturally, they will vary in the degree to which they have reconciled and come to terms with these experiences. And, regardless of the degree to which a therapist has come to terms with his or her own early experiences, different patients will engage the therapist's attachment dramas in different ways. (p. 589)

When a child or infant is dangerously uncared for or maltreated in his family, finding the appropriate therapeutic stance can be very challenging. On the one hand, these situations seem to call for an intense level of therapist activity. The ethics of standing by as a child appears to slip away into physical or psychological death is tricky. On the other hand, activity may be a defense against thinking and feeling, including thinking that, in reality, the therapist's power and influence are often very limited. Sometimes it seems there is no other option than standing by; at other times, one's most sincere and strenuous efforts are unavailing. There are few things more painful and difficult in life than watching helplessly as a beloved child slips away. The feelings are not just feelings

of grief, but inevitably of failure and self-reproach.

Adults are supposed to be able to protect and care for children. Perhaps, given the actual impossibility of the task, we are supposed to have illusions that we can. Anyone whose career has involved him or her for any length of time with high-risk infants and their families has had such comforting illusions remorselessly eroded. Again and again, we have seen children we have grown to care for overwhelmed by circumstances beyond our control, and we see the window of opportunity for growth and healing in a place of safety slam shut. To continue in this work is to find a way to bear this without burning out or shutting down. This is the challenge we all face.

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