
THE CLINICAL RELEVANCE OF INFANCY: A PROGRESS REPORT

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ABSTRACT: In the past few decades, findings from infant observations have played a key role in the following selected areas: (a) The emphasis now is on interpersonal and intersubjective processes rather than on intrapsychic processes. This is a paradigm shift towards a two-person psychology. (b) The elaboration of the attachment domain has reoriented our views of development and treatment. (c) The success of extended home-visiting programs as a preventive measure for parents and infants at risk has brought an agonizing reappraisal of what makes prevention (and therapy) work. (d) By default, the baby's world is nonverbal. This has led to a productive reexploration of unconsciousness, especially the domain of implicit knowledge. For the future, the following are some of the areas of great promise: (a) Attachment, love and "holding" must be disentangled. (b) We must study how and when the mirror neuron system gets micro- and macroregulated. One is not always open to empathic reception. (c) The articulation between the nonverbal (implicit) with the verbal (explicit) needs far more study. (d) The nonspecific factors of psychotherapy seem to be the most important in bringing about change and prevention. We need a greater systematic study of the nonspecific. (e) The triad and quartet, and so on need further exploration. (f) There are many more, but the beauty of research is that you can't know where it will go next.

RESUMEN: En las últimas décadas, los resultados obtenidos de las observaciones a infantes han jugado un papel importante en las siguientes áreas específicas: (1) El énfasis ahora se pone en los procesos interpersonales e intersubjetivos, en vez de los procesos intrasíquicos. Esto representa un cambio de paradigma hacia una sicología de dos personas. (2) La elaboración del campo de la afectividad ha vuelto a orientar nuestras opiniones del desarrollo y el tratamiento. (3) El éxito de los programas de extendidas visitas a casa como una medida preventiva para progenitores e infantes bajo riesgo, ha resultado en una agonizante revaloración de qué es lo que hace que la prevención (y la terapia) funcione. (4) De hecho, el bebé vive en un mundo no verbal. Esto ha llevado a una productiva vuelta a explorar el concepto de inconsciencia, especialmente el territorio del conocimiento implícito.

Para el futuro, las siguientes son algunas de las áreas de gran promesa: (1) La afectividad, el amor y el apoyo se deben tratar por separado. (2) Debemos estudiar cómo y cuándo el sistema del neuro espejo es micro- y macrorregulado. Uno no está siempre dispuesto a la recepción enfática. (3) Se necesita estudiar mucho más la articulación entre lo no verbal (implícito) y lo verbal (explícito). (4) Los factores no específicos de la sicoterapia parecen ser los más importantes para lograr el cambio y la prevención. Necesitamos un mayor estudio sistemático de lo no específico. (5) La tríada y el cuarteto, etc., necesitan

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INFANT MENTAL HEALTH JOURNAL, Vol. 29(3), 177–188 (2008)

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Published online in Wiley InterScience (www.interscience.wiley.com).

DOI: 10.1002/imhj.20179

mayor exploración. (6) Hay muchos más, pero la belleza de la investigación radica en que no se puede saber a dónde se le llevará después.

RÉSUMÉ: Ces trente dernières années les résultats d'observations de nourrissons ont joué un rôle clé dans ces domaines: (1) L'accent est désormais placé sur les processus de communication et les processus intersubjectifs plutôt que sur les processus interpsychiques. C'est un glissement de paradigme vers un psychologie à deux personnes. (2) L'élaboration du domaine de l'attachement a réorienté nos perceptions du développement et du traitement. (3) Le succès de programmes de visites à domicile de longue durée en tant que mesure préventive pour les parents et les nourrissons à risques a amené un réexamen déchirant de ce qui fait marcher la prévention (et la thérapie). (4) Par défaut le monde du bébé n'est pas verbal. Ceci a mené à une réexploration fructueuse de l'inconscient, surtout le domaine de la connaissance implicite.

Quelques domaines très prometteurs pour le futur sont les suivants: (1) L'attachement, l'amour et le fait de tenir le bébé doivent être démêlés. (2) Nous devons étudier quand et la manière dont le système de neuron miroir se micro- et macro-régule. On n'est pas toujours ouvert à une réception empathique. (3) L'articulation entre le non-verbal (implicite) et le verbal (explicite) a besoin d'être plus étudié. (4) Les facteurs non-spécifiques de la psychothérapie semblent être les plus importants lorsqu'il s'agit de changement et de prévention. Nous avons besoin d'une étude systématique plus poussée sur le non-spécifique. (5) La triade et le quartet, etc, doivent être plus explorés. (6) Il existe bien d'autres domaines prometteurs, mais ce qui est beau dans la recherche, c'est qu'on ne peut pas savoir la direction qu'elle prend.

ZUSAMMENFASSUNG: In den vergangenen Jahrzehnten haben die Ergebnisse der Beobachtung von Kleinkindern eine bedeutende Rolle in diesen Gebieten gespielt: 1. Es wird nun mehr Wert auf die zwischenmenschlichen und intersubjektiven Prozesse gelegt, als auf die innerpsychischen. 2. Die Ausarbeitung der Bindungstheorie hat unsere Ansichten über Entwicklung und Behandlung neu orientiert. 3. Der Erfolg der ausgedehnten Hausbesuche als vorbeugende Maßnahme für Eltern und Kinder mit erhöhtem Risiko haben bestürzende Erkenntnisse zu den Fragen was Vorbeugung (und Therapie) wirklich bringen kann, gebracht. 4. Es ist einfach so, dass die Welt des Babys nicht sprachlich ist. Dies hat zu einer produktiven Neuuntersuchung des Unbewussten, besonders im Bereich des impliziten Wissens geführt.

Für die Zukunft sind dies die vielversprechenden Gebiete: 1. Bindung, Liebe und „Halten“ müssen unterschieden werden. 2. Wir müssen untersuchen, wie das Spiegelneuronensystem mikro- und makrogesteuert wird. Man ist nicht immer zu einer empathischen Reaktion im Stande. 3. Die Verbindung zwischen dem Non-verbalen (impliziten) und dem Verbalen benötigt noch mehr Studien. 4. Die nicht spezifischen Faktoren der Psychotherapie scheinen bei Veränderung und Vorbeugung die bedeutendsten zu sein. Wir brauchen größere, systematische Studien der nicht spezifischen. 5. Die Triade und das Quartett benötigen weitere Untersuchungen. 6. Es gibt noch viele andere, aber die Schönheit der Forschung bringt es mit sich, dass man nicht weiß was als nächstes kommt.

抄録：過去数十年間、乳幼児観察は、以下の選ばれた領域で重要な役割を果たして来た。(1) 強調点は、精神内界のプロセスではなく、今や人と人との間主観的なプロセスに置かれている。これは二者心理学 two person psychology へのパラダイム・シフトである。(2) 愛着の領域の精緻化は、発達と治療に関するわれわれの視点に、新しい方向を与えて来た。(3) 拡大した家庭訪問プログラムが、危険な状態にある親と乳児のための予防的手段として成功したことから、何が予防（と治療）的作業となるのかについて、苦汁の再評価がもたらされてきた。(4) 初期設定により、赤ちゃんの世界は非言語的である。これは、無意識の、特に暗黙知 implicit knowledge の領域の、創造的な再調査につながった。将来は、以下にあげる領域が、非常に有望な領域のいくつかである。(1) 愛着と、愛と「抱っこ holding」の絡まり合いは、ほ

どかれなくてはならない。(2)ミラーニューロン・システムが、どのように、そしていつマイクロとマクロに調節されるのかを、われわれは研究しなくてはならない。人にはいつも共感的な受容の余地がある訳ではない。(3)非言語的な(暗黙の implicit)ものと、言語的な(判然とした explicit)もの間を明確に表現するには、はるかに多くの研究が必要である。(4)精神療法の非特異的要因は、変化と予防をもたらす上で、最も重要と思われる。われわれには、非特異的要因について、より大きな系統的研究が必要である。(5)三者関係、四者関係などは、さらに研究が必要である。(6)もっとたくさんの領域があるが、研究のすばらしさというのは、次にどうなるかをあなたは知ることができない、ということである。

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It is a very special pleasure for me to be presenting the Serge Lebovici Distinguished Lecture. Serge Lebovici was somebody very important to me; he introduced me to French thinking in our field. I learned much from him. I respected him a great deal, and still do, and I grew very fond of him. So I want to thank the scientific committee for giving me this opportunity to honor him and to talk under his sign.

Today, we see babies and we see psychotherapy and prevention of parent–infant interactions differently than we did at the last WAIMH meeting, and certainly very differently from the way we did 10 years ago. What I would like to do is to bring up three key ideas that have played a role in this shifting perspective. I would especially like to talk about the implications of these ideas, in particular, for clinical domains.

These key ideas are not at all new; they have been around for a while. What is new is that we are starting to see their implications. What happens is that we accept these new ideas, but we do not explore them very far because in our daily lives we have many other things to do. Nevertheless, they are powerful ideas deserving fuller exploration. This is what I hope to do in this article.

KEY IDEA 1: A SHIFT FROM A ONE-PERSON PSYCHOLOGY TO A TWO-OR-MORE-PERSON PSYCHOLOGY

The first key idea or perspective has to do with the progressive shift from a one-person psychology to a two-person (or more) psychology. We all talk about it, and know about it. The question is “Do we realize its full implications?”

The traditional model in clinical psychology is to describe the therapeutic process as a largely linear, causal process. This seemed to be more compatible with a one-person psychology, especially the traditional psychoanalytic model where the therapist is assumed to be “neutral.” Yet, as we shall see, much of what happens is neither linear nor causal.

When we are in the middle of a psychotherapy session, we are often lost. We don’t know what the other person is going to say next, and we don’t know what we are going to say next until we open our mouth and say it. This is the reality of the therapeutic situation—perhaps more so when we are in a triad or quartet. In supervision, what we usually do is tell what happened in a session at the end of the session, after it happened. Then it looks linear, coherent, and all nice. The reality is that when we are in the middle of the session, we are lost. And that’s true regardless of how experienced we are. Or perhaps, if we are more experienced, we are even more lost because we are not holding onto our theory with such tenacity, and we have come to accept a degree of lostness from time to time.

A causal, linear model well describes what happens, but only for certain stretches of a session, then a nonlinear, noncausal model describes better for other stretches. They alternate as optimal descriptors. Even when considering a single individual, the variables from the past, the present, and the immediate context operating at any given moment are too vast and interacting to permit causal progression and linear coherence.

With triads and larger groups, the variables and their potential interactions are multiplied. It would appear logical that the world would become less linear, and less predictable. And what happens is more spontaneously co-created, very sloppy, full of errors and repairs, and sudden direction changes; however, this need not be so. Both individuals and groups can behave in very ritualized (even stereotyped) ways where the next sequence is highly predictable. And they can both flip into a nonlinear, noncausal mode where co-created, on-the-spot, emergent properties arise to confound prediction.

To deal with this reality, we need to be aware of the nonlinear, noncausal models that already exist, such as dynamic systems models and complexity theory models. These models have been described elsewhere (e.g., Edelman, 2000; R. Fivaz, 2000; Prigogine & Stengers, 1984; Varela, 1996). These models are now being widely used (e.g., Thelen, Smith, & Thompson, 1994). But in parent–infant clinical work, we don't use them much. This is what we have to begin to do if we are to move beyond where we are now. The beauty of these models is that they were designed specifically for situations that are complex, unpredictable, and nonlinear; more specifically, where things change suddenly and the changes are not progressive, they occur in jumps, bringing discontinuity, and where you can't explain why something changed exactly as it did or when it did. So, we need to understand and use a model for describing this kind of process because this is what we are really dealing with.

Here is another problem for us. How do we deal with the fact that these spontaneously co-created, emergent properties arise in moments of change, in turning-point moments that occur in seconds? How do we understand this? What in the world is a turning-point moment? In fact, what in the world is a moment? What is a present moment? And this poses a huge problem. It is another implication of what we have to think about in a two-person psychology or a three-person psychology. If changes are going to occur, in a moment, in a short period of time, we best understand it.

Now, a moment is a very complex thing. It has to do with how we view time. I have spent a lot of time considering this because it is so fascinating. There are probably two main ways to look at time, both of which have been coined by the ancient Greeks. The first is *chronos* that everyone knows about and that has been used by the natural sciences and most of psychology and psychiatry. In this view, you have the present instant which moves evenly, all the time. As it moves, it eats up the future as it passes and leaves the past in its wake. But it is just a point. It is very, very thin. It is so thin that nothing could happen in it before it becomes the past. There is no such thing as the present moment. But that's contrary to how we experience our lives. We experience our life as being directly lived in the here and now. The now, a present moment, has a duration. It has its own temporal unfolding. The ancient Greeks had another word for that: *kairos*. *Kairos* is the moment of opportunity. It is a moment of coming into being. It is the moment when all of a sudden, things come together, unpredictably, and we have a small window in which we can act. And if we act in that window, we can change our destiny. If we don't act in that window, our destiny changes anyway precisely because we didn't act. What I propose is that most moments of our lives when we are awake are essentially moments of *Kairos*. The consequences of any given present moment can be very great and can change our

life course, or the consequences can be very small because they only determine what we are going to say or do next, or what the mother is going to say next, or what the baby is going to do next. But these present moments determine the future in a way that cannot be predicted until it happens.

The other thing about the present moment is that if we are going to move towards any kind of clinical situation which is oriented towards the subjective or the phenomenological, we have to recognize that one is only alive subjectively, “now.” Now is the only time when we are having direct, real experiences. This is the only time when we feel what is going on. A memory happens now, it doesn’t happen back then. An anticipation doesn’t happen in the future, it happens now. There is no escaping from this reality. So when we talk about the here and now, we are talking about present moments, and each of these is a moment of *kairos* (Stern, 2004).

There is another implication of a *kairos*. We, as baby watchers, are in the habit of seeing things in very short time units; taking 1 to 10 s, 3 or 4 s on average. The mother does this, the baby does that, the facial expressions form, the body goes tense or relaxes, and so on. The interaction is a fast back-and-forth. Our basic unit to understand an interaction is seconds, or even split seconds. This is not the case when we are discussing meaning. Meanings can develop and become deeper over a longer period of time.

If our basic unit is a present moment, which also is a turning point that determines the future, then we have entered into a new domain of what I will call “nanopsychology.” We are familiar with this scale of events. It is interesting that when physicists moved into nanophysics, they found that the rules of classical physics no longer held. And the basic units of the universe also changed. So as we move into nanopsychology, we are going to have to reconsider some of our basic thinking, both clinically and theoretically. This is an issue for our future.

Of course, longer periods and sequences of present moments are very important. That is where representations get accumulated and built. But what are they built of? They are built of these moments strung together, generalized, prototypicalized, and so on. So we don’t really get away from present moments.

Another shift that goes with the movement towards a two-person psychology is that more and more people look at triads and quartets and larger family groups that include infants. Here, the work of Elisabeth Fivaz, Antoinette Corboz, and their colleagues in Lausanne stands out (Fivaz-Depeursinge & Corboz-Warnery, 1999). I must say that until I met the Lausanne group, I considered a triad to be nothing more than three dyads at play at the same time. It took me a long time to realize that there is another entity called “the triad.” I think that my difficulty was not particular to me. Many of us who work with the dyad do not appreciate the systemic reality of triads, such as mother–father–baby or mother–baby–therapist. We say we know about systems theory because we are dealing with mothers and babies, and a dyad is already a system, but we don’t understand the depth of the system theory needed to fully understand the situation. We must spend a lot more time doing that.

Another implication of moving to a two-person psychology is that once you do that, you have opened up the space—in fact, the necessity—for intersubjectivity. Intersubjectivity is the means, the royal road to having two minds make any kind of contact about their shared ongoing experience. It underlines just about anything that we as clinicians hold dear, such as sympathy, identification, empathy, sensitivity, caring, and loving.

So, let’s look a little more closely at intersubjectivity. I am going to just summarize here the developmental aspects because I find them useful (Trevarthen, 1980). Probably, we are born with a capacity for intersubjectivity in some primary fashion, and it has its own developmental

course. I do not agree that all of a sudden there is “real” intersubjectivity at 5 years or 6 years because a theory of mind is accessible then. I find that unhelpful.

I think that we are born with intersubjectivity, and it then develops further in various steps over time. I think that neonatal imitation uses intersubjectivity in a primitive form (Meltzoff & Moore, 1977). Pointing at 7 months or affect attunement around 9 months could not happen unless there was some capacity for interattentionality or interaffectivity between two people, so again, intersubjectivity is clearly present (Stern, 1985). The other finding that is very convincing is the work of many people such as Meltzoff and his colleagues on the fact that what matters to infants after the first birthday is not what you do but what your intention is (Meltzoff, 1995). In other words, infants spend their lives noticing the intentions, unseen behind the acts, and not the seen actions themselves.

In one of Meltzoff’s experiments that I love, the experimenter takes an object that is novel and passes it over the mouth of a vase as if trying to drop the object into the vase. At first pass, he drops the object short of the vase. It falls on the table. On the second pass, he drops it beyond the mouth of the vase. He never gets the object to fall into the vase. The baby is sitting there, watching. He then sends the baby home. The baby comes back the next day, and he picks up the object and puts it right into the vase, without hesitation. This is what babies do in many other experimental situations (Rochat, 1999).

Relevant to this, neuroscientific studies show that we have, and presumably babies have, “intention detector centers” (Ruby & Decety, 2001). So whenever an intention is enacted, this detection center discharges. This speaks to the profound importance of reading other peoples’ intentions, a quintessential act of intersubjectivity. Remember by intersubjectivity I mean being able to participate in and, in some way, sense or know about the other person’s experience. If the other person is experiencing an intention, you can capture it.

One of the interesting things that happens later on is when children get to be 3 to 5 years old, and they are not in the classroom and are playing freely and unsupervised with their peers. What is very clear is that they spend most of their time imitating one another, tricking one another, teasing one another, and lying to one another (Dunn, 1999; Reddy, 1991). This is what that world is all about. In the classroom, they learn about things in the world that are more orderly and nice, largely explicit knowledge, but in the playground and on the street, they learn about the reality of human social interchange. For that, you have to be able to lie and trick and cheat. To some extent, lying is one of the landmarks of development because it is proof that you know what is in another person’s mind to some extent, enough to be able to do something that the other person did not realize was going to happen. Therefore, it isn’t simply a morally bad thing, but it is a positive mark of development.

There is another interesting observation. From 6 to 12 years of age, recent studies have shown that most children in all cultures studied have imaginary companions. We thought that children let go of these earlier, but apparently, however, the growing mind seems to need this kind of intersubjective contact. This is another example of a developmental step of the intersubjective need.

The final implication of this move to a two- or three-person psychology instead of a one-person psychology has to do with a move towards the social and the cultural spheres and away from the individual. So many capacities of infants and children in development come about through dialogue with other persons. Those capacities won’t emerge if the infant is not in dialogue with other minds. Language doesn’t happen without the dialogue (That’s where language really emerges and gets hammered out.); there has to be an equipment, but there has to

be a dialogue (Tomasello, 1999). Morality is dialogic, even reflective consciousness within one person is dialogic in origin (Stern, 2004). Everything of great affective and social importance, like joy, is grown in this dialogue with other minds. Of course, this is where intersubjectivity becomes so essential. We have to identify and describe the dialogic atmosphere in which the child's mind grows because the atmosphere is a matrix of the traffic with other minds. Babies develop with the intentions, affects, beliefs, thoughts, and actions of other people impinging at every moment of their lives, except those moments when they are alone. From these interactions, their minds will form and be maintained.

KEY IDEA 2: IMPLICIT KNOWLEDGE

The second key idea has to do with the importance and the scope of implicit knowledge. This is something that has been sneaking up on us. By implicit knowledge, I refer to knowing and memory that is nonverbal, nonsymbolic, and nonconscious, as compared to explicit or declarative knowledge. Largely through the study of infant development and therapeutic process work (The Boston Change Process Study Group, 2002; Lyons-Ruth, 1998; Stern et al., 1998), what we call "implicit relational knowing," because it is about the ways of being with someone, has emerged as an important construct.

Implicit knowledge used to be what we call *sensorimotor intelligence*, or *procedural knowledge*. These are no longer adequate terms. Implicit knowledge, we realize now, includes affects, nonverbal concepts, expectations, and representations, but in a different code from the symbolic code. The concept of what is implicit has expanded enormously. We also have learned that for the most part, the baby's implicit knowledge does not turn into explicit linguistic verbal knowledge when she or he acquires language. We often describe infants as "preverbal," or "prelinguistic," but these are so often, in my mind, misused terms. While "pre" means before, it also means and carries the connotation of being an early form of, a precursor, turning into. For instance, I can see that babbling may be considered prelanguage. But what about shaking the head no? I don't see that as prelinguistic. I think that you learn to shake your head before language, and you also can shake your head when you learn to say "no." You shake your head all your life, and you shake your head when you say "no" and when you don't say "no." It is part of the repertoire which is independent, although very tied to the verbal "no." It looks like a precursor, but it is not. In addition, we don't think about walking as a prerunning event. Implicit knowledge does not disappear when we learn language, its repertoire simply becomes larger. We keep it throughout our lives, and it continually grows. My guess is that implicit knowledge of the social and emotional world is probably 80 to 90% of all such knowledge.

There are some research implications of this that are quite interesting. The first implication has to do with this extraordinary, fascinating movement from verbal to nonverbal and back and forth because the two have an awful lot of traffic between them. We are beginning to realize the existence and importance of nonverbal concepts in providing a base for linguistic concepts and meanings. Here, I am thinking of the works of Lakoff and Johnson (1999) and of McNeill (2005). They talk about "primary metaphors." These primary metaphors are not linguistic inventions or conventions. These are body concepts. They are implicit. And they are nonverbal and nonconscious. An example of a primary metaphor would be as you move through space, even if you are crawling like a baby, and you go from one place to another place and then you stop, and then you start again and change the direction of where you go and the place at which you arrive. All of that is known in experience, implicitly. So now, if I say "Well, in

the relationship that I had with her, we only *went so far*, then *we stopped*, *we stopped moving*, and . . . we got stuck there for a while, and then we both *went in our different directions*.” Where do the italicized words or phrases come from? “We only went so far.” Where is far? “We stopped.” Where is “there?” The point is that the verbally transmitted knowledge rests upon body knowledge of movement and time and space—upon the implicit knowledge of the body in the world. There are a multitude of these primary metaphors that are nonverbal concepts that language can use and build upon. This is a very promising area for looking for the relationship between the verbal and the nonverbal.

The most interesting thing about implicit knowledge with regard to clinical application is that implicit knowledge contains representations, affects and memories, and nonverbal concepts. This begins to have important clinical implications. How much of what we usually think of as the dynamics of past experience will get subsumed by our notions of implicit knowledge? Are we in the process of rewriting psychodynamic theory? Let me explain.

Will implicit knowing and its subcategories start to absorb concepts such as transference, countertransference, primary fantasies, or relational past experiences that bear on what happens now? Are these not all implicit relational knowings? Trauma might be a separate entity, but we don’t know that yet. What I am saying is that there is a crisis now going on about what we are going to do with the past, with fixations, trauma—all of the past that impinges on the present. As we start thinking about the past differently by virtue of this expansion of the concept of implicit knowing, the dynamic unconscious of classical psychoanalysis, that which is under repression, gets relegated to a very small part of everything that is not consciously available. So we have to think more about this constructive crisis, and we have to figure out to what extent this particular key idea and its implications are going to alter our research strategies and our clinical practice because it seems to me that the implications are very far reaching for the future.

KEY IDEA 3: NONSPECIFIC FACTORS IN THERAPY

The final idea that I want to mention has to do with the nonspecific factors in treatment that, once again, we all know about. Most of us have been dragged kicking and screaming to the realization that what really works in psychotherapy is the relationship between the therapist and the client. That’s what does the work. We are all devastated by this reality because we spent years and a lot of money learning a particular technique and theory, and it is very disheartening to realize that what we have learned is only the vehicle or springboard to create a relationship—which is where the real work happens. But that is where it is, from my point of view. We need to have a technique, and we cannot have a technique without a theory. We have to do something and act like we know what we are doing in a therapy session, otherwise we cannot create a relationship. The relationship, of course, is not symmetrical, but we need not delude ourselves that the technique is what achieves most of the results.

The reason I say this is the following: Outcome studies, which are always painful to clinicians, show that it doesn’t matter too much which technique we apply. If we have been well trained, we believe in the technique, and we have some experience, all of our techniques cure roughly equally (Frank & Frank, 1991; Parloff, 1988; in parent–infant psychotherapy: Stern, 1995). And if we combine treatments, our effectiveness might improve a bit. If we add drugs, that also may increase efficacy. But basically, there is something at work that is common to every therapeutic approach: the nonspecific factors built into the relationship. This realization greatly upsets therapists with strong beliefs in their approach.

People who do brief psychotherapy with parents and infants find that one can achieve results quickly, but are they lasting? In some cases they are, but in most cases they are not lasting. What really happens is that the parents need to reapply some kind of therapeutic maneuver—1 month, 3 months, 6 months later, whatever—to bring therapeutic attention to the new situation that they find themselves in with the baby, who is developing so rapidly. Now the baby no longer has a feeding problem but does have a problem with aggression or anxiety. Brief psychotherapy, most often, is a first step in a series of follow-ups of one kind or another.

The third observation is the success of home-visiting intervention programs. I think this is very important, and it speaks very loudly to us. I am talking here about the work of many here at the Congress (Ammaniti et al., 2006; Boris et al., 2006; Lyons-Ruth, Connell, Gruenebaum, & Bostein, 1990; Olds et al., 1997; Zeanah, Boris, & Larrieu, 1997; Zeanah, Larrieu, & Naggle, 1998) who have all shown in one form or another that some kind of home visiting seems to be extraordinarily useful prevention for people who are at risk for one reason or another. What is interesting about these programs is that they are often conducted by non-mental-health professionals. Most of the people who are doing home visiting have not been trained extensively to do it. Instead, they are highly selected for being experienced mothers and generally kind with people. They receive supervision and support, but basically they are improvising. They do establish important relationships with the people at home with whom they visit. The results of these studies are fascinating because they show in large part that this kind of intervention has superior results to other methods that have tried to prevent adverse long-term outcomes.

There is a caveat to this general assertion: The home visitor must visit the home over a long time and frequently. Most of the programs provide once-a-week visits for a minimum of 12 months, optimally 18 months according to some studies. Each of the studies is slightly different, but the basic story is: You get a non-mental-health professional who goes to the home, and without specific training establishes a relationship, deepens the relationship—once a week over 12 to 18 months—and the families fare far better than those with similar risk status who do not receive the intervention. Given this situation, we must reexamine what we are doing and what our therapy is really about, how we train people, and how we select them. This requires an agonizing reappraisal of what we consider to be the work of child psychology and psychiatry in the clinical sense. I am not sure how we are going to resolve this because it is not an easy challenge.

What then are the nonspecific factors that make these relationships so successful therapeutically? We are beginning to pay more attention to these factors that we call by different names. One of the heads of the World Health Organization, an extraordinary man named Benedetto Saracena (personal communication), mentioned a study on parent–infant psychotherapies drawn from all around the world. He said that all of the good programs have five things in common: (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. He went on to say that if you look at any society, what they do is that they all arrive at these same five principles, and they do these five things, but they all do it differently. The exact form depends upon the culture, the time, the place, resources available, the education system, but they all end up with the same five principles. They manage to put them into a system that is compatible with their cultural reality, which determines the technique, the theory, and the special conditions under which this goes on.

We have to look at our therapy from this perspective. How do we do this? We do have a number of names for the relationship which seems to be the largest therapeutic factor: the therapeutic

alliance, the holding environment, attachment or an attachment transference, transference and countertransference. These are our key terms and concepts when talking about the therapeutic relationship. We have to be clearer about these notions and incorporate the five nonspecific attributes in some way.

All of these terms and concepts are hugely overlapping, and to make any clarity here, we have to disentangle them. We also must make it clear what we mean by this or that term. No one from a particular school of thought can talk to someone from another school without a great deal of clearing away. We have to sit down and draw where the boundaries are to have clarity in the clinical situation and in the theoretical situation. For instance, I have a very hard time knowing where attachment leaves off and love begins, and where love leaves off and dependency begins, and how is that related to caring? The same applies to the boundaries of intersubjectivity. Now there are certain problems. People who do attachment research have what sometimes looks like an imperialistic view in which they incorporate “love,” “caring,” and “intersubjectivity” into the construct of attachment. People who study intersubjectivity appear equally imperialistic, and they tend to subsume everything into that construct.

For too long, we have avoided paying the necessary attention required to unpack the nonspecific factors in therapies and act on them. For instance, the selection process for most home visitors is to pick an older woman who has had a family and some experience. That is not crazy. The good business schools around the world won't take any student without experience, preferring 5 or more years out in the marketplace. I wish they would do that for doctors and lawyers, but that's a long way off. But it is as important for therapists.

In conclusion, we are clearly in a new phase and a new place here at the 10th meeting of WAIMH, and if we are going to lay the groundwork for different experiences between the 10th and 11th and 12th meetings, I think that we are going to have to take such key concepts and study much more their implications. We need to see, in fact, how and where they fit with what we really do. This, I think, will assure us a much clearer path into the future that we are all going to share.

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