

# The Signal



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## Gender POLITICS and Infant Mental Health

by Brigid Jordan

The invitation to write this paper arose from a paper I wrote several years ago when new to the field of infant mental health. At the time, I was struck by how unself-consciously the field, at least in the literature, used language and relied on concepts that had been recognized in other discourses as highly problematic. Notions of good and bad mothers, the role of fathers, the needs of infants, and "normal" mother-infant interactions continue to permeate the literature in a largely unexamined way. This paper is an attempt to reflect on our social position as therapists, question some taken for granted assumptions and think about the particular economic and historical conditions

that lead us to write and say what we do, and the social effects of what we say and don't say, ask and don't ask, in the clinical room, the academy and the research laboratory.

Infant mental health clinicians see first hand many of the material and psychological effects of current social arrangements and discourses about family life, and theoretically the field has the scope to problematise and *critically* discuss the development of infants, the formation of early relationships and the process of socialization. The study of infant attributes and infants' contributions to relationships could call into question romantic beliefs in the unity of mother and children's interests, the harmony of their relationships and the perfectibility of children. However, we tend to approach mothering and sexuality and institutions such as the family, as unproblematic except as individual instances of deviance from an achievable norm.

Sociocultural factors such as race, class, poverty tend to be treated as "white noise" or "add on" factors rather than recognized as the social and economic relations that structure the internal dynamics

of the family. In this discussion, I am suggesting that we cannot understand infants or mothers or fathers or families without taking account of the historically and culturally specific practices in which the individual subject is produced. This includes the social organization of gender -- that is -- the ways in which society places the biologically different sexes in particular positions in the social and economic order (Thorne, 1982). Gender also refers to one's sense of self acquired through the experience of one's body, as well as the social meanings given to sexual difference through culture, language and ideology (Flax, 1990).

Although "grand narratives" on how the socioeconomic and political order structures family life and linear models of relations of domination are out of favor, the questions that these grand theories sought to address remain and are insistently present in everyday clinical problems. For example, the topic of my own area of clinical research -- the treatment of persistent crying or "colic" -- traverses the domains of infants' social and emotional experience, the relation of psyche and soma, the infant's encounter with culture

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and socialization processes, power relations in families including between infant and mother, and the social expectations of mothers and mothering.

Post-modern theory has described how knowledge building has little to do with the gradual accumulation of increasingly accurate facts about "out there" external reality. Common sense views are only common sense in a particular historical and cultural moment; witness, for example, the major shifts in our thinking in the last two decades about the psychological boundary of an infant and the repudiation of previously clung to beliefs about the symbiotic phase. Theorists proposing a new paradigm sometimes have a sense of this -- Stern (1985) introduced his theory of the development of an infant's sense of self as an invention based on inference. Infant mental health's account of its history tends to be in terms of pioneers who discovered new knowledge about infants and their capacities and have faithfully mapped these findings in order to optimize the development of infants and inoculate against future psychopathology (McIntyre and Jordan, 1992). An alternative view is that this field has emerged and flourished at a time when, in western advanced capitalist societies the child has replaced participation in the community as the focus of family life (Leupnitz, 1988) and the mobility and isolation of the modern nuclear family and dissolution of community bonds has reduced access to and the status of local folk experts. It has been argued that the highly mobile and malleable (flexible) workforce required by modern capital has produced individuals and social environments characterized by uncertainty and a sense of the provisional (Richards, 1989) and that therapeutic discourses rather than overt processes are the main means of [self-] regulation of individuals by society (Rose, 1992).

In the absence of grand theory that can reveal ultimate truths it has been argued that "the ultimate test of a theory is its political consequences" (Flax, 1990). Thus, I want to raise some questions about the political and social place of infant mental health in terms of theory, research and clinical practice and to suggest that attention to gender as a fundamental category of analysis (Goldner, 1988) could lead to a deeper understanding of the context in which an infant develops and becomes a gendered subject, and allow the possibility of a theory of mothering that avoids simple mother-blaming on the one hand and the idealization of motherhood on the other.

### The Competent Infant

The premises and assumptions we make about the relationship between individuals and society are most transparent in our discussion of the mother-infant relationship but also evident in our theories about the development of infant capacities and preferences. The construction of the infant as having inbuilt social characteristics (e.g., prewired for communication and social interaction) and using these features to account for social relations implies that social arrangements are "natural" and inevitable and a consequence of individual factors (Urwin, 1986). Notions of basic motives including biologically prepared social fittedness (Emde, 1990) obscure the arbitrary nature of social arrangements and privilege an idealized view of the individual's relationship with society. There is little room in this account of the competent infant for an inner fantasy world. This over-rationalized view of a competent infant prewired for social interaction is complemented by an impoverished view of the mother-infant relationship.

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## Mother-Infant Relationship

A curious development in the infant mental health literature has been the "degendering" of mothering—the literature is full of references to infant-caregiver or infant-parent relationships. At first glance this gender neutral language might seem less discriminatory and less mother-blaming. However, the work of mothering which is done by women is done from a particular social position and the silencing of this obscures the role of gender in shaping psychological attributes and social conditions and reinforces an individualistic view of difficulties in the mother-infant relationship.

Observations from videotaped sequences of interaction between a mother and her infant have been a major source of data for infant mental health theory. This emphasis on the infant's contribution to the relationship and the construction of interactions as a "reciprocal exchange" or "dance" might seem a move away from traditional mother-blaming approaches that did not take into account the child's contribution. However, the extraction of mother-infant interaction from its context and minute measurement of behaviors can be seen as increasing the status of mothering while regulating its activities even more (Ingelby, 1986). Words like "precise adaptation," "synchrony," and "negotiation" are used, with disharmony seen as the result of individual pathology in either the infant or mother and not inherent in the human condition. The vexed question of how "accurately sensitive" a "normal mother" ordinarily can be, is rarely discussed. The relationship of the mother-infant relationship to other relations and social formations is obscured. Thus, a voluntaristic view of family life and a bias toward the need for personal individual adjustment rather than social change is reinforced (Adlam et al., 1977).

Idealized views of infant mother relationships are called into question when one considers the tenacity of infant symptoms and the enormously high rate of distress (so called "postnatal depression") in mothers of infants in western advanced capitalist societies. The name "post-natal depression" has been challenged by those who argue that it refers to timing rather than any intrinsic qualities of the distress faced by women mothering young infants. Any psychiatric condition suffered by between 10% and 20% of a given population raises questions about the emotional cost of the social conditions of mothering and the conflicts and challenges of the infant-mother relationship. In an Australian study, women saw their own depression as explicable in the context of their lives as mothers and identified salient factors as lack of support, isolation, physical fatigue or ill health, having little time or space to themselves. They also described the positive effect that the infant had on their well-being (Small, 1994). Adverse social situations and social isolation, the low esteem accorded to child rearing and the loss of identity for women who have given up paid work have been identified in the clinical literature as salient factors in addition to individual dynamics (Daws, 1989). However, the infant mental health literature and research on depression in women mothering young infants tends to pay little attention to social contradictions of mothering and the simultaneous idealization and denigration of motherhood where mothers are portrayed as Madonnas but women enjoy marginal status when pregnant and a mother, and often become financially dependent.

The field's over-reliance on attachment theory and the increasing use of the latter as a means of classification and codification obscures the fact that psychic reality is not the same as the level of reality at which a mother manages her

infant—the unconscious of the mother and infant cut across actual mother infant interactions (Adams, 1983).

The development of infant representations is increasingly portrayed as a rational cognitive process based on lived experience of actual mother infant interactions (Stern, 1996). An alternative view is that the capacity for representation is initiated by a sense of loss and absence, by the inevitable disruptions and misattunements that are part of life; "knowing people is what we do to them when they are not there" (Phillips, 1990).

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The rational, competent infant developing a coherent sense of self, from internalized interactions with a primary caregiver attuned to the infant's needs, is very different from the (infantile) infant beset by intense often intolerable anxieties whose mental growth relies on a relationship with another who works hard to contain these anxieties and help the infant to gradually tolerate the experience of psychic pain and distress (Rustin & Rustin, 1984). Psychoanalytic theory provides a richer, denser and more complex account of the development of guilt, reparation and creativity than the notions of biologically based social-fittedness. It is a theory that allows for the articulation of a connection

between internal and external experience while allowing a place for the unconscious.

Normal maternal ambivalence and hate (Winnicott, 1947) are written out of most infant mental health discussions of the mother-infant relationship and an idealized view of motherhood perpetuated. Elsewhere, I have argued that what is required is to theorize the connections and contradictions of infant needs and desire, actual maternal practice, maternal desire and the social context that constructs the notion of "natural" mothering (Rose, 1983).

### **Mothering and Power**

Questioning the presumed isomorphism between the infants psychic life and social experience is not to ignore or deny the infant's

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**Gender is the fundamental category of difference in our culture and society, and thus the gender of the infant is crucial to understanding the development of subjectivity and the socialization of infants.**

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helplessness and the importance of sensitive maternal care. On the contrary, a more complex theory of mothering that acknowledges power dynamics and the complicated and ambivalent feelings between mothers and infants, and allows for desire to be distinguished from need, may offer more possibilities for understanding and for thinking about the social arrangements needed to support the difficult job of mothering than romantic notions of "natural," "intuitive," "biologically based" mother-infant relationships.

The question of maternal power in patriarchal societies is difficult and vexed and prone to primitive ideological splits as Penelope Leach [1977] described in her recent discussion of childcare. A thoughtful rather than ideological approach needs to take account of the costs to mothers of isolated and economically and ideologically unsupported care of infants and the costs to infants of group care (Rustin & Rustin, 1984).

### **Gender of the Infant**

Until Alicia Lieberman's [1996] recent article, readers of our journal might be forgiven for thinking that having babies had nothing to do with sex or sexuality. Lieberman notes how the baby's body and aggressive and sexual drives have disappeared from our discussion of the infant. The place of the infant in the parent's sexuality and the relationship of this to the symptom is rarely mentioned. Although the gender of the baby does not feature in our literature, it is unlikely that the gender of the infant has no effect on our perception of the infant. In fact, its influence may be greater because it is not acknowledged and articulated. In one experiment, subjects watched a videoclip of an infant and then described the emotions they observed. Half the subjects had been told that they were viewing a boy and half were told that the infant was a girl. Subjects were more likely to describe "negative" emotion in the infant as fear if they thought they were observing a girl and anger if they thought they were observing a boy (Condry & Condry, 1976). Although the subjects were American college students rather than experienced clinicians, the findings provide food for thought. Gender is the fundamental category of difference in our culture and society, and thus the gender of the infant is crucial to understanding the development of subjectivity and the socialization of infants.

### **Cultural Differences**

It seems to me that this difficulty with gender may reflect a difficulty that the field has with difference generally. Much is made of the multidisciplinary nature of the field, and we have tended to try and be inclusive, to minimize difference, to attempt, for example, to integrate developmental psychology and psychoanalysis. This may not be as benign and straightforward as it first seems. The appeal to prewired characteristics implies a universality (and thus exportability) of our constructions of the competent infant. However, it is worth pondering the degree to which we have constructed a western, even American, infant in our own image (Cushman, 1991) motivated by curiosity, preferring novelty, keen to explore and develop mastery and to maintain self-esteem (Emde, 1990), i.e., a rational scientist in a pioneering field. Exporting this infant for overseas consumption could border on a form of cultural imperialism. Although there is an interest in cross cultural studies and individual variation there is a danger of effacing difference and viewing culture as an "add on" embellishment of an essential biological core [western] infant, for example, encouraging cross-cultural collaboration to then "strip away local language embellishments" (Emde, 1990).

As argued earlier, attempts to link or integrate developmental psychology, attachment theory and psychoanalysis in the main end up by stripping psychoanalysis of its radical content. The absence of a gender in the infant under discussion and the side-stepping of sexual difference and the social organization of this in our field reflects a more general anxiety about and repudiation of difference and avoidance of important but difficult questions about the social position of infants and their mothers and fathers and power relations between them.

## Implications for Research and Clinical Practice

A feminist approach to any field of practice is a lens rather than a set of techniques (Leupnitz, 1988). I am advocating a critical ear—to listen for social and political processes as well as the unconscious logic that resists these. Current opinion is that many different clinical models of intervention can lead to change in the mother's representations, and thus they are equally valid [Stern, 1996]. However, approaches that involve tinkering at the level of interactions or transactions between a mother and her infant, "perfecting the unexamined life" (Leupnitz, 1988) without addressing the social roots of the distress or what transpires unconsciously between mother and infant are more likely to result in mother-blaming and co-option of the therapeutic encounter into a regulatory rather than emancipatory event.

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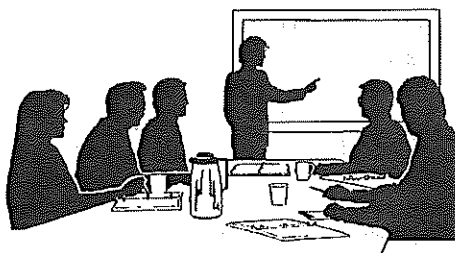
# A VIEW FROM THE CLASSROOM:

## CHANGING-----> MINDS

by Frances Stott, Ph.D.

I teach a three-course sequence on Human Development at the Erikson Institute, a graduate program in child development located in Chicago. Over the span of my career, psychodynamic thinking has strongly influenced my perspective on how people develop and negotiate their lives. This viewpoint, combined with theory and research from developmental psychology, informs my teaching. I have, however, encountered two general problems with teaching this "Infant Mental Health" perspective to non-clinical students. The first might be termed "A little learning is a dangerous thing." For example, in Human Development I, which covers the socio-emotional development of children from birth to three, I typically ask my students to observe an infant and use theory to interpret what they see. Several years ago I was disconcerted to find that after one or two observations of a mother-infant interaction, students would declare that "Amy has an insecure avoidant attachment disorder," or "Billy isn't separating or individuating," or would make some similar unwarranted judgment. I found that I had not only to tell my students that they could not make diagnoses, that these were clinical decisions, but also to make very explicit that they could not judge relationships from the outside. Finding an interpretation that corresponds with both an infant's and a parent's subjective experience is never easy, even when one has permission.

But second, just as I am troubled with the misuse of theory, some of my students are troubled with the theory itself. Sometimes students



criticize theory as being sexist, racist, or homophobic—issues which can be discussed. More disturbing to me are those students who sit with a blank face when I describe, for example, the intricately choreographed dance between mother and infant so poetically described by Stern (1985). A student may seem (perhaps pretend?) to agree with what she is learning—or at best make a valiant effort to go along with the program—and then use her own judgment and ways of doing things in the privacy of her own field setting. Sometimes, for her particular group of infants and families, the student is doing the right thing. I have thus struggled with complexity, ambiguity, and contradiction.

### New Insights

My greatest discomfort is how psychodynamic and developmental theory translates into the actual practice situations my students face. Armed with a graduate degree in child development with a specialization in infant studies, Erikson graduates work as administrators and front-line staff in the settings in which most U.S. infants and families can be found: in early intervention programs, child care centers, therapeutic programs, child life and diagnostic programs in hospitals, etc. Although their degree is not a clinical one, their work is

often informed by clinical theory. I have written elsewhere about the perils of using developmental literature as a clear guide to practice in teacher education (Stott & Bowman, 1996). There, we suggested that the changing nature of child development knowledge, the fact that it can only approximate reality, and its reflections of particular sociocultural positions make it a slippery base for practice. Our position is that child development knowledge theory and research is necessary for teacher preparation, but not sufficient. Building on those ideas, I have developed a set of new insights that help me find my footing as I teach the slippery concepts of "infant mental health."

### 1. Students' potent, enduring misconceptions.

Recent work on the acquisition of expertise in specific disciplines has established a phenomenon both unsettling and reassuring. Except for experts, most individuals continue to adhere to early misconceptions, even in the face of considerable tutelage and counter evidence (Gardner, 1991). Thus, advanced students in psychology and child development continue to adhere to the most simplistic forms of stereotypical thinking, just as college physics students often retain Aristotelian notions of force and agency. This notion is daunting when one considers the educational moves necessary to instill well-grounded, complex and comprehensive views—yet, simultaneously, it makes me more sympathetic to the misconceptions my students often have. It places the responsibility on me as an educator not to assume, for example, that one—or even a series—of lectures is going to establish fundamental understanding. It also places the onus on my



teaching practice to mediate my students' learning.

## **2. The critical role of context and values.**

Even more disconcerting than the notion that it takes a long time and a lot of experience to develop expertise is the idea that there is no universal truth about development. Most of us have come to agree with a perspective that considers multiple influences on development. Broadly, this perspective suggests that: 1) there is biological substratum to how children develop and that the child plays a critical role in reciprocal encounters and relationships with others; 2) the social world is of critical importance in shaping the biological and individual potential of children; 3) culture is critical in shaping the social world in which children develop; and 4) the intrapsychic life is a powerful factor in how people understand, make meaning, and respond to experience. This general framework of developmental theory is useful, but trouble often lurks in the details. For example, relationships are the crucible of development, but how many parents or caregivers, and under which circumstances, does it take to shape a child's potential? How is a child's potential defined? And whose theory do we use to make a judgment about a young child's subjective experience?

The details are so very hard to see because of our own biases and cultural values. We pay lip service to context, yet when parents, students, and others have different ideas from those suggested by formal knowledge of theory and research, they are often summarily dismissed as uninformed. As Kessler (1991) stated:

What appears to be a debate between those who are well-informed by current research in child development and those who are not is, in reality, a debate between individuals who hold different values about the purposes of schooling, what counts as

legitimate knowledge, and presumably the nature of the good life and just society. (p. 193)

Increased attention is thus being focused on ways in which historical and sociopolitical conditions provide the agendas and assumptions behind theory and research. In conceiving alternatives, our theories must now be tempered with an appreciation for the practical concerns that affect people in specific situations.

## **3. Infant mental health is not a unitary concept.**

The concept of "mental health," itself a Western construction, is undergoing some revision. There seems to be some movement from an exclusive focus on identified problems and disorder to a more inclusive consideration of how to promote health and development. Changing diagnostic classifications, confusion over what constitutes a disorder, and dissatisfaction with a disorder-deficit model as the basis for concepts about healthy development all contribute to a different, strengths-based orientation toward intervention and prevention (Emde, 1996). Emblematic of these confusions and changes, The Illinois Association for Infant Mental Health often debates the definition of mental health, and, indeed, even if the term should remain in the name of the association.

Such changes have played havoc with the mission and goals of programs in which our graduates work. Several approaches have been developed to work with young families. Clinical infant work was pioneered in the early 1970s principally by Selma Fraiberg and her colleagues. This approach remained modest in size throughout the 1970s and 1980s, found in a few clinical/academic centers in which the kind of sophisticated training needed for such work could occur. Other approaches to clinical infant work did not employ parent-infant psychotherapy but infused its principles into supportive

work with parents, often using child development specialists. Sometimes this worked very well, for example in programs where training and supervision and clear program goals were present (e.g., Provence & Naylor, 1983). Many of the early childhood intervention programs that emerged in the last two decades brought human development theory and research more directly into the world of social service (see Halpern, in press, for a review of early childhood intervention for low income families).

Tensions were created, however, in programs which are ambivalent about their mission and theoretical underpinnings. For example, in the late 1970s, family support programs were envisioned as a means of simultaneously strengthening informal support ties among families and creating a new model of helping services—one based on mutual support, family strengths, and following families' leads. While the original emphasis was on supporting all families, family support programs soon began to target poor and "at-risk" populations, often in response to funding sources. Programs therefore set out to "prevent child abuse," "prevent teen pregnancy," etc. On one hand, they were deliberately attempting to alter parenting in a significant way; on the other, many of these programs implicitly seemed to question whether they were—or should be—a formal helping service with goals of strengthening, let alone changing, parenting (Halpern, in press). Without a clear theoretical grounding and the intense training and supervision characteristic of clinical infant programs, staff in programs in which changing parents is an implicit goal cannot but feel unprepared and overwhelmed (Stott & Musick, 1994; Halpern, in press). Many of the issues of ambiguous identity and sense of purpose, and of diffuse principles and methods, also contribute to problems in other program models servicing young families.

These include early intervention programs for infants with disabilities and/or delays and their families, child care, and Early Head Start programs. Child development specialists (who have studied the clinical infant literature in order to understand development) are often in the position of working with troubled parent-child relationships. They do not have the clinical training, supervision or the mandate to attempt to effect change, yet they have difficulty promoting development in the face of family difficulties.

These three insights, among others, have helped me understand some of my discomfort in teaching Human Development. My hope is to use these insights as the basis for creating a new synthesis to better prepare my students.

### **Ways of Knowing: Theory and Practice**

However valid criticisms of theory are, they need not lead to an abandonment of human development knowledge in our educational programs. As Geertz (1973) so aptly put it, "I have never been impressed by the argument that, as complete objectivity is impossible in these matters...one might as well let one's sentiments run loose" (p.30). In order to avoid the fundamental discrepancy between formal theory and a person's experience on one hand, and theoretical nihilism on the other, I raise the following points.

First, what makes theories worth reading and discussing is not the assumption that they mirror reality but that they serve as suggestions or estimations--they help us arrange our minds. Theories are helpful in that they organize and give meaning to facts, and they guide further observation and research. In order to help students understand the importance of using theory as an aid, rather than as a straightjacket for thinking about development, I present students with

multiple theories and discuss their evolution, overlaps, and inconsistencies. I also point out that the theories are drawn from the socioeconomic-philosophical context in which they are created. Because systems of thought arise, as Nietzsche claimed, from their authors' autobiographies, it is often helpful to students to provide biographical and historical information on theorists. This often enables them to retain what is useful in a particular theory without discarding it in its entirety. Ever-changing theories present students with an ongoing challenge, the need to embed their practice in an ever-changing knowledge base. Yet the critical test of responsive practice is its flexibility. We need to temper our understanding about the source, characteristics and limitations of theories, and to subject them to the scrutiny of cultural relevance and personal reflection.

Second, there needs to be a balance in what is considered to constitute legitimate child development knowledge. Geertz's (1983) "local knowledge" suggests other ways of understanding or approaching practical wisdom than that provided by "experts." The challenge, it seems is not only to help students accept the legitimacy of individuals' personal and cultural thinking and feeling, including their own, but also to integrate these notions with their formal knowledge base. That is, we should not discount either academic or "local" knowledge.

Theories are misused when they are taken as blueprints for socialization or used to stigmatize and pathologize those who fail to conform to their model (Burman, 1994). Students need to understand that there are deep cultural differences in the goals of development, arrangement of childhood activities, and nature of communication between children and their caregivers (Rogoff et al., 1993). This raises the question of whether there are alternative pathways to developmental competence that

require different educational structures and organizations. If the answer is that there are multiple satisfactory developmental trajectories for children, how can students best learn to work with children from different cultures? Students must recognize the need to identify both their own values and those of others in order to become aware of the normal variations in development.

Theories are used well when they give students greater ability to describe, illuminate, interpret, and translate their observations of children and families. This, in turn, can help them gain some practical wisdom about children, use reasonably good judgment in their work, and engage creatively and respectfully with children, parents and colleagues.

Finally, it is important to note that most of the real learning of my students does not take place in the classroom, but rather in supervised practice. At the Erikson Institute we believe that the most important task of educational institutions is to help students begin the process of reflection, not only about their actual practice and the nature of the contexts in which it takes place, but also about themselves. We take reflective supervision so seriously that we provide two intensive forums to go along with a year-long internship experience. One forum is a weekly process seminar for 7 to 10 students led by a faculty member; the other is an individual weekly tutorial with a faculty advisor. The goals for both the group and individual meetings are to bridge theory and practice, reflect on practice, and develop self-knowledge.

### **Conclusion**

My teaching dilemma is that the nature of theories of human development and the principles of infant mental health are culture-bound and limited, and that the processes of development are too complex ever to



be completely knowable. On the other hand, as Katz (1996) points out, to teach is to act, which requires certainty and intentionality. If not certainty, both my students and I need some shared assumptions in order to do our work. I can strive to make my course work more relevant by attending to the changing nature and context of theories, the way values underlie all theory and practice, and the ways in which the purposes of programs determine the usefulness of developmental theory. I can discuss the ethics of information--how not to use formal knowledge recklessly to stigmatize and pathologize. I can reinforce the notion that you cannot deliberately set out to alter parenting without permission, without negotiating a "contract for change." Nevertheless, teaching formal theories and research--with all their richness and potential for human understanding--and critiquing them as we go is a complex and tricky business.

I can also leave the ivory tower to listen to the voices of the families my students serve. Linda Gilkerson and I are in the process of doing a participatory action research project with the staff and families of the Ounce of Prevention Fund's Early Head Start Program in an inner-city community in Chicago. Gilkerson and I are leading multi-session "Parenting Consensus Groups" to gain insight from mothers, grandparents and fathers in the community as to what they believe constitutes good parenting. The first hand knowledge we are gaining from these families' voices and perspectives about their goals for their children and their caregiving practices can not only inform Early Head Start staff, but also help me do what I expect my students to do; that is, better understand my own biases and enlarge my understanding of the parenting process.

Finally, in my classes and in my supervision of students, I can bring this same scrutiny--and some of the fundamental principles of infant

mental health--to my relationships with students, and to their relationships with the families they work with. The crux of the teaching-learning enterprise rests in how individual teachers respond to individual students. Teaching is essentially a social activity, and the ability to use relationships to stimulate development is essential. It is helpful to examine the complexity and sometimes conflicting values that underlie these relationships. By exploring differences in position and values instead of suppressing them, we are more likely to recognize other ways of knowing. By appreciating the existence of a "dark side"--that emotional experiences have a major element of pain and conflict in them--we are more likely to be empathic. This can help us connect our experiences to those of others, and through that connection, gain understanding of the feelings of others. Then we can begin to trust one another. When rooted in honesty and mutual trust, uncertainty and frustration in relationships is tolerable.

As in so many endeavors, teaching is a parallel process. We can hope that if students are embedded in honest, rewarding, and growth-producing relationships, they will respond to others with greater sensitivity and understanding. What we cannot offer them is certainty. I, as a teacher, can forge my integration of theory and practice, my own way of understanding the world. All I can really ask of my students is that they consider my theories and thoughts as they arrive at their own.

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*Editor's note: Frances Stott is Dean of Academic Programs at the Erikson Institute in Chicago, Illinois.*



## President's Perspective

Yvon Gauthier

It may seem evident that public policy is an essential part of our objectives in infant mental health; but how often do we really speak about it, in scientific meetings or in contacts with the media? Are we not mainly involved with research and intervention, concentrating our efforts on methods, positive or negative results, and leaving to others the lessons and implications of our work for public policy? We seem to think that public health decisions will happen naturally, that our results will be taken over by politicians with little effort on our part to influence their direction.

At a recent conference in Montreal organized in preparation for World Congress 2000, a whole afternoon was dedicated to public policy. Attempts were made to compare public policies concerning infant mental health in Europe, America and Canada. It was an ambitious but successful workshop. The emphasis on public policy issues was appreciated by the participants.

When we look at the situation of infants in many of our developed societies, many of us are preoccupied with issues such as the evolution of family life, the importance of poverty, and the number of children raised by single mothers in very disadvantaged conditions (even though the concept of resilience is interesting, it may easily be used as a rationalization).

Much research has been done on attempts to prevent psychopathology in such disadvantaged child-rearing conditions. Olds and colleagues have consistently reported positive results of their research in Elmira, New York

using home visits that begin before the child is born and continue over the first 2 years of the child's life. A recently published 15 year follow-up study of those families (Olds, et al, 1997) clearly shows that home visiting is a very effective intervention with single mothers from low-SES households: there is a lower incidence of abuse and neglect, later subsequent pregnancy, less utilization of welfare, less utilization of drugs and alcohol, and less involvement with the judicial system.

This important research has been replicated in Memphis, Tennessee, with similar results: less hypertension during pregnancy, fewer accidents and hospitalizations in early childhood, and a longer time span between first and second pregnancies. (Kitzman et al, 1997)

Both studies demonstrate that early care given to those mothers by a well-trained nurse and continued over two years, has beneficial and enduring effects. The concept of home visiting appears important, as well as the concept of high-risk family. Public health policies, therefore, need to reflect the effectiveness of early intervention in preventing later and more serious problems and to make resources available for home visits to vulnerable families in high-risk areas.

In France, Centres de Protection Maternelle et Infantile (PMI) have been functioning for a very long time. Despite their bureaucratic tendencies, they represent a resource which can be very helpful for early prevention. In the USA, the Early Head Start operation now being established is

based on very early home visiting in disadvantaged areas of American cities.

In Canada, I am aware of two Provinces in which important efforts are made to reach high-risk families with early intervention. In Quebec, Centres Locaux de Sante Communautaire provide for pre- and post-natal visits to young parents to make sure that basic physical and relational needs of the child are met.

Current financial constraints, however, may very well endanger such services. In Ontario, the Provincial Government has just decided to spend 10 million dollars in a new program "Healthy Babies, Healthy Children," which will use home visiting as a primary instrument for reaching families most in need. For such programs to be created and to continue their existence, on-going efforts must be aimed at convincing public policy authorities of the value of early intervention.

In spite of such small successes, I believe that we have a long way to go. Much work still needs to be done around this major problem of high-risk families. We have to be sensitized to the diversity of populations in these large cities where young immigrant families settle—families which very often have lost most of their inner security. Poverty and isolation thus become the context into which a new child is born.

Those are some of the reasons that led the Program and Local Arrangements Committees for the next congress and the WAIMH Executive Committee to choose as its main theme "Diversity: Challenges and Opportunities in Infancy." It is hoped that such a theme will stimulate research and intervention teams already involved with very diverse populations and within varied cultural milieux, to present their work in Montreal. Public policy will thus be a

*(continued on page 20)*

by Salvador Celia, M.D.

The International Congress of Mental Health was held in Canela, Rio Grande do Sol, Brasil, on May 1-4, 1997.

Canela is located about 800 meters high in the mountains in the southern part of Brazil in the state of Rio Grande do Sol. The meeting was attended by about 1000 people, coming from Brazil, Argentina, Uruguay, Chile, Paraguay and Portugal. Attendees had an opportunity to exchange experience and transcultural information with 25 invited foreign guests and 200 invited guests from Latin America. Most of the participants at the meeting were child psychiatrists, psychologists and pediatricians, in addition to educators and social workers.

In Canela, in June of 1988, we had an opportunity to host a similar kind

# WAIMH



*meets in  
Latin America*



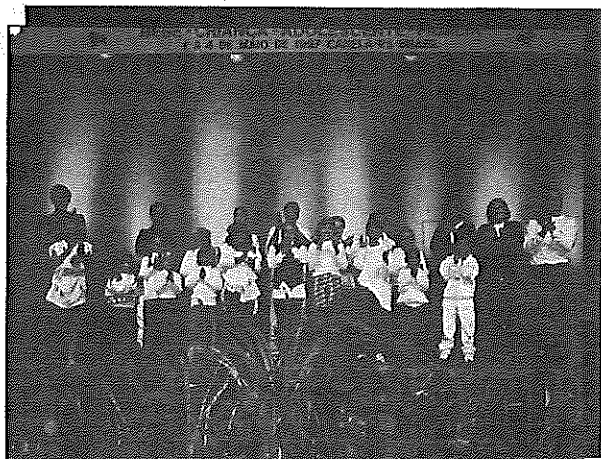
of International Meeting, with the collaboration of WAIMH (then WAIPAD) and IACAPAP. In 1997, this expanded to include the participants from ISAP (International Association of Adolescent Psychiatry), ESCAP (European Society of Child and Adolescent Psychiatry) and FLAPPIA (Latin America Association), together with two Brazilian Associations. WAIMH members attending this meeting were our President Yvon Gauthier, Joy Osofsky, Robert Emde, Bernard Golse, Charles Zeanah, Paula Zeanah, Sandra Serpa, Dora Knauer, and many others.

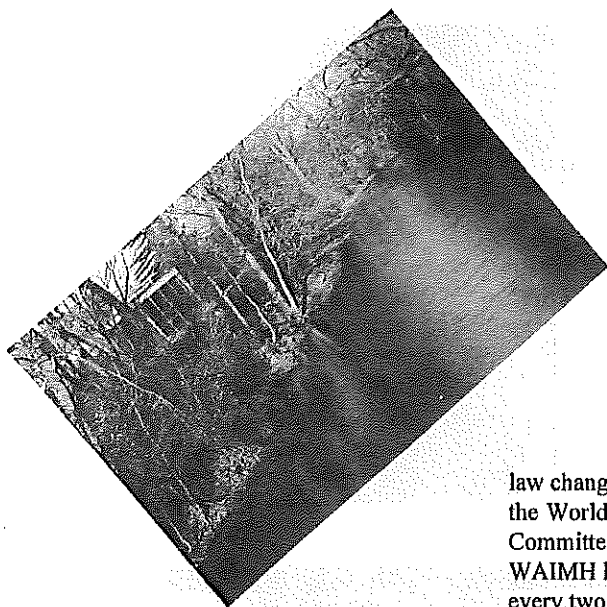
*N. Trenchi (Uruguay), R. Emde (US), M. Aguerre (Uruguay), Y. Gauthier (Canada), E. Gauthier (Canada)*



*E. Gauthier (Canada), P. Zeanah (US), J. Osofsky (US), E. Caffo, C. Zeanah (US), Y. Gauthier (Canada)*

*The children of Canela perform for the Congresso Internacional de Saude Mental*





## from the Red Cedar

### Bylaws

Recently, WAIMH members have been sent recommendations for changes in the by-laws. There are several kinds of changes being proposed. The first type are changes needed to correct typographical and other mechanical errors. The second type is to provide for changes in procedures related to elections.

In Finland we discovered a procedural error involving the timing for election of officers and election of individuals to the Board of Directors. Currently Board members are elected at the meeting of the membership at the World Congress, and officers are elected by the Board. However, because the membership meeting always occurs at the end of the Congress, we would not be able to elect a President-Elect until after the business meeting. The proposed change allows for mail ballots for election of Board members and allows for that election to take place well in advance of the World Congress. The Executive Committee believes that the proposed change will facilitate greater membership involvement in selection of individuals to the Board.

Perhaps the most fundamental by-

law change involves the frequency of the World Congresses. The By-laws Committee recommended that WAIMH hold a World Congress every two years, instead of every 4 years. There were several reasons for this recommendation: First, more frequent meetings will provide better incentive to sustain membership over the two year interval; Second, more frequent meetings mean that scientific, clinical, and policy issues raised during one congress will not die on the vine during a four-year span, but can be moved to action because of



*A working session*

more frequent meetings of committee members; Third, our field has grown so rapidly that we have far more information to exchange than can be digested in four year cycles. In Finland the program committee received over 500 abstracts, a number that seems to increase geometrically from congress to congress; Fourth, more frequent World Congresses and a more stable membership will allow

WAIMH to increase its outreach efforts with greater planning for Regional Congresses on the biennial off-years. Such regional meetings can be attempted in parts of the world yet relatively unknown to infant mental health as well as regions that have not hosted world events ever or for a long period of time.

In short, the Executive Committee believes that WAIMH is poised to move from its adolescence into full maturity as a scientific and clinical society and that as a result, it must bring its members together more frequently. I hope that you will support this proposal as well as all of the other changes offered on the ballot.

### Financial News

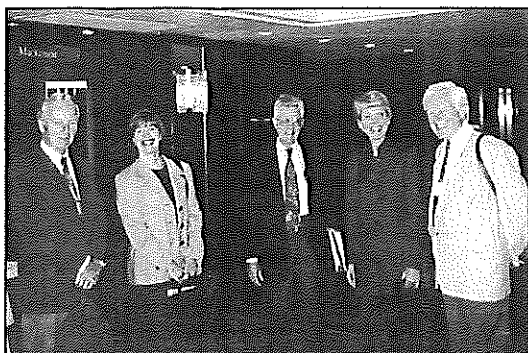
Midway through the year, WAIMH's financial status is good, in part fueled by strong yields from its investment portfolio. Projections for the year suggest that we will end 1997 within our budget. As a result, I

have not recommended any increase in dues for 1998; nor will journal subscription fees increase for members. That is the good news. On the news for concern side, it must be noted that our membership has declined slightly. Therefore, I renew my past appeal for each WAIMH member to recruit a new member for the organization. Obviously, if our membership falls below a critical mass and if our investments and other revenue sources begin to

collapse, we would have to re-examine our dues structure.

### 7<sup>th</sup> World Congress

During September, representatives of the Executive Committee met with members of the Local Arrangements Committee and the Program Committee to discuss plans



P. de Chateau (Netherlands) J. Osofsky (US),  
R. Emde, (US), S. McDonough (US),  
Y. Gauthier (Canada)

for the 7<sup>th</sup> World Congress to be held July 26-29, 2000 in Montreal.

Although great attention was given to issues related to budgets, hotels, meeting rooms, and congress events, perhaps the most significant outcome of the meeting was the selection of a theme for the congress. As President Yvon Gauthier notes in his column, the theme is *Diversity: Challenges and Opportunities in*

*Infancy*. The Program Committee (Susan McDonough, Hiram Fitzgerald, Jean Francois Saucier, Antoine Guedeney) will be responsible for developing sub-themes for each day that are consistent with the overall congress theme and these will be announced in 1998 when initial information about the congress will be distributed. If the membership approves the recommendation to move to biennial congresses, invitations to submit applications for host sites in 2002, 2004, and 2006 will be issued.

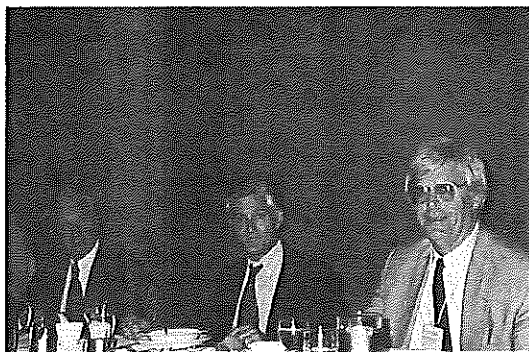
### Affiliate Developments

We have received word from colleagues in Finland that the Finnish Association for Infant Mental Health has been organized with the following individuals as members of its Board of Directors: Palvi Kaukonen (Chair),

Merja-Maaria Turunen, Kaija Puura, Piekko Niemela, Pirkko Siltala, Hannele Torronen, Merja Kumpula. Congratulations to everyone in Finland for this very special follow-up to the World Congress in Tampere. We look forward to receiving a formal application for Affiliate status in the near future.

### Suggestion BOX

A world organization with members scattered around the globe needs to have direct input from its members so that the issues, concerns, policies, and programs of the organization reflect the needs of its members. Please help to fill our Suggestion Box! Write to us, FAX us, send



P. de Chateau, R. Emde, H. Fitzgerald

email messages, or just give us a call on the telephone, in order to bring your concerns to the attention of the Executive Committee. We want WAIMH to be member-friendly and member-responsive, so please share your ideas, feelings, plans, and needs with us. Send your suggestions to the Suggestion Box at the WAIMH address, Telephone at 1-517-432-3793, Fax at 1-517-432-3694, or email: WAIMH@pilot.msu.edu

## INFANT MENTAL HEALTH JOURNAL

### CALL FOR PAPER *Fathers and Infants*

This special issue of the *Infant Mental Health Journal* will focus on studies of fathers (social and/or biological) and their infants. Studies investigating direct effects of fathers on their infants or those that consider father as a mediator of the mother-infant relationship are acceptable. Cross-cultural studies are especially invited as are those that focus on intracultural diversity. In keeping with the tradition of the Journal, studies using either quantitative or qualitative scientific methods will be considered, as will review articles, book reviews, and clinical studies. If in doubt about the link between your work and the focus of the special issue, please contact Prof. Fitzgerald (see below). All submissions will be peer reviewed. Editors for this special edition are: Hiram E. Fitzgerald, (Michigan State University), Tammy L. Mann, (Zero to Three), and Marguerite S. Barrett, (University of Wisconsin). Submit 5 hard copies (the original and 4 copies) for review and one disc copy. Disc copies must be in IBM format, and in Word or WordPerfect style. All submissions must be in English and must be in the style format used by the American Psychological Association. Submissions will not be reviewed unless the five hard copies and correct disc version are submitted. **Deadline for submissions is June 1, 1998.** The review process will be completed by December 1, 1998 and the special issue will be published in 1999.

Send all submissions to: Professor Hiram E. Fitzgerald, Applied Developmental Science Graduate Programs, 6 Kellogg Center, Michigan State University, East Lansing, MI 48824-1022. Email: fitzger9@pilot.msu.edu; FAX 517 355-4565.





## Evolution of a Model

by Barry White, Ph.D.

*Re-printed from the Infant Crier, Newsletter of the Michigan Association for Infant Mental Health, nos. 78 & 79, 1997.*

### Introduction

In thinking about the evolution of the model of infant-parent psychotherapy, I am reminded of a time, 15 years ago, when I was sitting around the table at the Child Development Project in Ann Arbor as "the model" was being discussed. I recall that Bill Schafer interrupted the discussion, with some impatience, to say, "There IS no model!" I took his remark to mean that we should have been careful, even years ago, not to reify the work of Fraiberg's group into a static model; even then it was evolving and changing.

With that as a caveat, that no simple model should ever be confused with the fluidity, crosscurrents, and improvisation in any lively clinical work, it can still be helpful to talk in terms of models, to simplify and, hopefully, clarify this ungainly phenomenon we call infant-parent psychotherapy.

There have always been internal tensions and contradictions in the model. From the very beginning, it was psychotherapy for the parent and prevention for the baby; we enlisted the parents in the intervention, but the baby was the client. We tried to combine some of the more sophisticated elements of psychoanalytic psychotherapy, for example, understanding the infant as a transference object, yet working in the chaotic-

sometimes ludicrously chaotic- home settings. And to add another contradiction, we were working with a formulation based in individual psychodynamics to do a kind of family therapy. We are always working with the parent-infant relationship at the minimum, and at the maximum, bewildering, unconventional, kaleidoscopic family groupings. So contradictions and internal tensions are nothing new to this work, either in thinking about it or in the experience of doing it!

Let me begin by acknowledging the obvious fact that there are major limits to the model, ones we live with so much that we may take them for granted. I mention it because we all deal with the frustration of often feeling that we are not able to help enough, regardless of how inspired and committed we may feel as infant-parent therapists. The model, as I understand it, simply doesn't work as well, or as fast, or as consistently as I, or I imagine most of you, would like.

One of the central constraints of the intervention is that it is *only* focused on the family. I say *only* because a family centered intervention, as much as we all support it, really is NOT ecologically comprehensive. It would be very different to have infant mental health based in community centers that also offered groups, high quality child care, education and job training, or even, heaven forbid, actual jobs that paid a living wage. Then we would have a comprehensive intervention. But our current political climate will have to go through several more seasons before we as a society are ready to commit the resources to link mental

health, education, and true economic opportunity. Let me begin by acknowledging the obvious fact that there are major limits to the model, ones we live with so much that we may take them for granted. I mention it because we all deal with the frustration of often feeling that we are not able to help enough, regardless of how inspired and committed we may feel as infant-parent therapists.

My point is that *any* clinical intervention can feel absurdly small, when weighed against powerful social and economic forces. What we are trying to do is take a rather modest, I would even say tiny, intervention, typically an hour a week in the life of an infant and family, and somehow apply as much leverage as we possibly can, using whatever theoretical models, personal resources, intuition, and situational possibilities are available to us, to trigger cycles of change and growth. We can do this with the knowledge that, as powerful and as obstructive as larger social forces can be, there is also the reality of individual growth and change, driven, sometimes wonderfully, by the growth and change of a baby. So, while tempering optimism with humility, I would like to share some thoughts on the evolution of the infant mental health model. Within the context of a family focused intervention, some components are relatively straightforward, such as being home based, working directly with parent-infant interaction, trying to work preventatively, etc. But I would like to focus on two elements that may be more open to challenge and, ultimately, evolution: 1) Can we keep the baby in the center of the intervention? 2) Must we deal with the ghosts in the nursery?

### Can We Keep the Baby in the Center of the Intervention?

#### Techniques

There are a number of reasons

that this can be more easily said than done, but I wish to focus on two factors. First, a psychotherapeutic model that puts significant emphasis on the baby WITHIN the parent, working with the parent's feelings and ghosts in the parent's nursery, can easily be drawn into doing therapy with the parent rather than therapy with the infant-parent relationship. While the therapeutic rationale for this is compelling, this can also be a slippery slope toward attending to the parent at the expense of the baby. This is particularly true when the parents' legitimate needs feel all encompassing.

The second factor is that we are often working with parents who are frankly resistant to putting the baby at the center of ANYTHING, and that is the whole reason we are there in the first place. The baby may be in the other room, in the corner, or perhaps right in front of the TV, yet unseen. In saying this, I'm not being critical but realistic about the issues we are confronted with. We have lots of ways to interpret and work with these issues of avoidance; after all, this is the bulk of infant mental health work. For example, we may understand the parents reenacting their own avoidant attachment style, or recreating the abandonment they experience as an infant. The parent may be depressed, dissociated, or even avoiding the baby to protect the baby.

Traditionally we have had three basic techniques for dealing with this problem:

1. *Having the baby present*, which seems obvious to us, but was a rather radical notion at the time of Fraiberg's work. By having the baby present we are able to inquire about the parent's feelings in important interactions. Many of you have heard me describe the idealized sequence that goes from, "What just happened/ what is happening right now?" to "Where did you learn that/do you think it was like that for you as a baby?" to "What was that like for

you?" to "How would you like it to be now for you and your baby?"

This sequence begins with an intensely enacted interchange which is likely to be an expression of the parent's internalized relationships. Notice also that this sequence begins with the baby, not in some formal or didactic way about the infant's development. The focus is the baby right *now*, right this minute. We then try to go backwards to the origins of the pattern, touching of the parent's feelings (which have been defended against by the unconscious acting out of the sequence). If we can reach toward the origins of the feelings, this becomes the basis for developing true empathy. Unless the parent can touch their own feeling how can they touch their baby's? But finally, we come back to how the parent wants it to be for the baby now and in the future.

Obviously, this happens in bits and pieces over time, but it is a sequence that places the infant, now and in the future, in the center of the work.

2. *Working dynamics directly related to the baby*. Perhaps the classic example comes from "Ghosts in the Nursery", in which the mother cannot respond to her baby's cries until her own cries have been heard. The rationale here is much like what I have just mentioned, but it is more often triggered by what is NOT happening with the baby, rather than what is. The key dynamic assumption is that the baby is indirectly being responded to, with avoidance or hostility, related to the parent's issues and projections onto the baby. When these feelings can be understood and put into words, they are less likely to be acted out.

3. *Speaking for the baby*. Obviously speaking for the baby is a powerful, and concrete, way to bring the baby into the center, to give the baby and voice, and to make sure that the baby does not remain invisible.

Yet we can also supplement these techniques with some powerful

variations and alternatives.

Joy Osofsky's variation amplifies speaking for the baby and provides more structure to this idea. First, the therapist speaks for the baby as the baby interacts with the parent. Then, there is a switch in roles, so that the parent speaks for the baby who is interacting with the therapist. The therapist models for the parent and then the parent has a chance to follow up and be the competent voice for their infant. This can be a great baby game, or baby, parent and therapist game.

Susan McDonough's model of Interaction Guidance is also a powerful alternative model which puts an infant, or perhaps, the infant-parent relationship, absolutely in the center. Perhaps it puts the relationship in the center of the video screen so that the parent can actually see what is happening, being less overwhelmed by being asked to take care of the baby, respond to a therapist, and process an interaction all at the same time. Watching the interaction together, and focusing on the real, positive aspects of the interaction, are powerful tools for keeping the baby at the center of the work.

Finally, Greenspan's notion of floor time, time set aside for interaction with the infant, led by the infant, is another powerful intervention.

This brings me to two basic propositions for keeping the baby at the center of the intervention. Both are, on the surface simple, but could be quite different from traditional practice in application.

## **CAN WE KEEP THE BABY IN THE CENTER OF THE INTERVENTION?**

### *Changing Priorities*

1. *Play, interaction guidance, or floor time needs to be structured as a part of each and every session*. I am assuming this is easy to say but difficult to pull off. But the difficulties in pulling it off are why I am



suggesting that this must be a structured, ritualized part of each session, to make sure it happens, if only for five minutes, at each session, even if the sky is falling. Maybe the sessions in which it is most difficult to do (e.g., the parent is in crisis), will be the ones with the most payoff as the parent is reminded of their baby. Parents can see the effect of their turmoil on their baby or the way their feelings may spill over onto the baby, and, hopefully, also see how much their baby responds to them even when their life feels like it is falling apart. If this can happen, it is a very different statement of our purpose and goals- to say nothing of the fact that it makes a real and different experience for the parent and the baby, however small, from the beginning of our intervention.

2. If we want to keep the baby at the center of the interaction, it also follows that the highest priority for intakes should be those parents who are genuinely motivated for their baby! Is this heretical? It shouldn't be. If we really mean anything by saying we are client or family centered and working on the families' goals, shouldn't we seek out those parents who really want a better relationship with their baby? Shouldn't we seek out those families whose own goals match the goals of the intervention? Somehow our definition of risk has come to mean that we gravitate toward those parents who are the most deeply disturbed, with the fewest personal or family resources, and who are the least interested in their babies. I don't have a problem with those who are the most deeply disturbed, with the fewest personal or family resources, but I do have a problem with investing so heavily in those who are least interested in their babies. Obviously I'm not trying to argue that we only work with those families who are already doing fine with their babies,

but rather that we should focus on those who are in conflict about their babies versus simply showing chronic deficit. Perhaps I'm trying to describe those parents who are depressed and know they are not able to take care of their babies the way they would like versus those who are quite satisfied with their woefully inadequate parenting. Perhaps I'm describing the parents who say they want something different for their babies (and are unaware of how they are nevertheless enacting some of the old script) versus those parents who are con-

provide relatively little payoff for infants. Now you may say that your caseloads would be emptied if you gave the highest priority to families who WANT to put their babies in the center. But if this is true, then I think this is a problem with referral networks. Perhaps we need to fundamentally rethink how we present infant mental health services to the population at large, because there is no doubt in my mind that there are far more families out there than we could ever serve who are also in conflict and want help putting their infant at the center of their lives. Those are the families we should be working with



*I am suggesting that regular time set aside for parent-infant interaction in each session . . . can greatly improve our ability to keep the baby at the center of the interaction.*

vinced that they are already giving their babies what they need.

Now I understand that, in the beginning, it is can be exceedingly difficult to tell whether a parent is in conflict versus showing chronic deficit. Perhaps one way to help this differentiation would be to make a more explicit focus on parent-infant interaction from the beginning of the intervention. Some parents will be drawn into the interactional emphasis, particularly if it is positive and fun. Perhaps other parents will be clear that they have relatively little interest in structured interactional time. And that may be sad but clarifying. I know that we would all wish, on behalf of the infant, to help those families who are showing very little interest in parenting. But it also seems to me that real change is difficult, often requiring heroic effort, even for families with motivation. I rarely see it happen in families without motivation. And I seriously question the application of resources to families which drain budgets, drain staff, and

To summarize, I am suggesting that regular time set aside for parent-infant interaction in each session (whether in the model of speaking for the baby, interaction guidance, or floor time) can greatly improve our ability to keep the baby at the center of the interaction.

Such a component may also help us sort out those families who are most invested in allowing their babies to be more in the center. These are the families with whom intensive intervention will provide the most benefit for infants.

## **MUST WE DEAL WITH THE GHOSTS IN THE NURSERY?**

### *Approaches to Changing Internal Models*

I want to review this issue in light of some of the more current thinking that says that if brief therapy is brief enough, transference and countertransference don't exist. And perhaps if it is REALLY brief, one doesn't need to worry about a person's history either. So perhaps the ghosts can just stay in the closet and parents can still fundamentally change? I do not think it is that simple, but it does present a fundamental challenge to the IMH model which can be helpful dialectically.

Let me begin by ever so briefly recapitulating the basic theory as Fraiberg described it from a psychodynamic orientation.

The infant is a transference object, eliciting feelings from the parent's past that have been defended against. Consequently, the parent may defend against the reemergence of those feelings by pushing away their baby. If their baby's love and attention reminds them of their own unmet needs for love and attention from their parents, it is easiest just to push the baby away. After all, as we've all heard, anything else would just spoil the baby.

When I first got involved in infant mental health, I came with an interest in psychoanalytic object relations which fleshed out ways in which the earliest relationships are recreated. As those of you who have heard me before know, the crux of the argument is that we all internalize our earliest relationships. The emergence of those internalized relationships is triggered by the emotional power and intimacy of the birth of a baby. The internalized relationships are set into motion; they are reenacted. Sometimes the baby gets the role of the critical rejecting parent, and the parent feels rejected and powerless. Sometimes the parent assumes the critical rejecting role and simply plays it out, without any conscious awareness. And more often than not the roles are passed back and forth as the parent tries to defend against the old pain but instead reenacts it.

But the question for practitioners has always been: how can we change these internalizations so that enduring, and self-reinforcing change can occur?

Those of you who have heard Dan Stern or read his recent book, *The Motherhood Constellation*, know he makes the basic argument that there can be multiple ways ("ports") to modify a parent's internal representations. I want to take just a few minutes to recapitulate his argument and then

see if we can take it a little further into the reality of therapeutic complexity.

Stern argues that a change in parental representations can lead to a change in interaction OR a change in interaction can lead to a change in parental representation.

As an example of the first, we can use Fraiberg's example from "Ghosts in the Nursery." When the mother can feel that her pain is responded to, there is a change in her internal representations. The young part of her is no longer simply isolated, disconsolate in the face of a parental abandonment. Instead the young part of her feels empathically responded to, comforted by a parental figure, her therapist. With that change in her experience, and her internal working model, she is then able to assume the role of the empathically responsive parent who picks up and comforts her crying baby.

Although it muddles the clarity of Stern's model, in good clinical practice the baby's response to the mother would be reflected, put into words, to help crystallize this change in the mother's experience. At that moment she is an empathic mother, which is starkly different than her old working model. So in this sense the changed internal representation leads to a different interaction, which is then used to solidify the change in the mother's internal representation. So, while change is circular in good therapeutic practice, Stern appropriately uses this as an example of working on the internal representations first, with the goal of changing interaction as the outcome.

As an alternative model, in which changes in interaction drives changes in parental representations, Stern draws on Susan McDonough's Interaction Guidance. As changes or positives in the interactions are reflected to the parent, in a way that she can literally see them and hopefully internalize them, there is a change in her internal representations.

But in this case the change occurs without a direct exploration of the historical origins of the parent's internal representations.

To the extent that Stern's argument is for an ecumenical, eclectic approach, trying to use whatever ports of entry work best for a particular client, I couldn't agree more. And I assume that we all try to do this anyway, since there has never been a place in this work for orthodoxy. The work is too hard, the challenges are too great, and our clients are too complex. Ideally we are working with whatever ports are presenting themselves: we can work with interactions, with feelings from the past, we can work with what is going well as well as with what is problematic, we work with the relationship between mother and baby or between the mother and ourself.

## **MUST WE DEAL WITH GHOSTS IN THE NURSERY?**

### *Early Loss and Trauma*

Some of the newer approaches, such as Solution Focused Therapy, Interaction Guidance, or Narrative Therapy, can give us places to start that are more positive and require less initial trust and ego strength than a more purely psychodynamic model which focuses on the painful affects from the past. In that sense there is an enormous amount that is exciting about some of the newer approaches, and I encourage everyone to stay as current as possible with the evolution of these therapeutic models.

But the question I want to pursue is what we can do if the ghosts don't go away? What can we do if there is a "stickiness" to the negative feelings and interactions that a focus on solutions, or an amplification of positive interactions doesn't really budge? I've heard too many clients say, even among bright motivated clients with whom I sometimes have the privilege to work with in private

practice, "I know how I should be with my kids, I know what works, I can even see that things go better when I do it the right way but I STILL don't do it." In these situations there is a solution, the client understands it, knows that it works, feels better when it is used, but the client often doesn't do it! This is what I mean about "stickiness;" the ghosts are still driving the reenactment.

How do we make sense of this and are there things we can learn from some of the contemporary currents in psychotherapy to expand our repertoire?

One of the first things that my IMH clients taught me, years ago, was NOT to go straight for the ghosts, not to go straight for the negative affect when I would ask them about their parents. I used to think of this in terms of the splitting they had had to maintain in experiencing their parents. The positive experiences with their parents were so weak that they had to split off and deny the negative internal representations to avoid overpowering the positives. Consequently, the positive feelings often needed to be affirmed before exploring the negative.

I think this is still true, but I tend to think of it in slightly different ways. I want to draw on two lines of thinking:

- grief processes for children, since so many of the parents we see have sustained enormous losses in early childhood.
- our growing understanding of the sequelae of trauma, which obviously is the other major life theme in most IMH cases.

With respect to the first, the process of grief and loss in young children, we find that there is a central paradox: children have to have their parent internally before they can let go. Consequently, much of the internal grief work with young

children is about CONSOLIDATING their internal images, their memories, thus, about holding onto rather than simply letting go. Given how early the initial losses are for so many of these parents, might the same approach to the past work as well, working on consolidating what was positive before grieving the losses?

Sometimes the positive descriptions that our clients tell us about their parents strike our ears as wildly unrealistic, split, or showing denial that is stunning in its magnitude. But even if there is a major element of denial, it nevertheless deserves our respect. Even as a partial truth it must be honored for what it consolidates



... there is an enormous amount that is exciting about some of the newer approaches, and I encourage everyone to stay as current as possible with the evolution of these therapeutic models.

rather than seen simply as a defense against the ghosts. *Consolidation must precede grieving or differentiation from the lost object. And it is that intertwined process of internalization and differentiation which we are ultimately trying to support.*

The second line of thinking comes from the work that has emerged in recent years on the effects of trauma. Trauma profoundly sensitizes the survivor neuro-psychologically, leaving the person caught between affective constriction and flooding. Thus, what we are often seeing in a client who finds it difficult to talk about painful feelings from the past is a person not simply showing resistance in the normal, everyday sense. Rather, the traumatized client is often maintaining a constricted stance to avoid being flooded by affect, present and past. To do otherwise is to risk retraumatization.

In spite of these difficulties, there is a general consensus among those working with trauma that, at least when post traumatic stress syndrome is manifest, that the trauma *must* be approached. Behavioralists may approach it explicitly, systematically desensitizing, re-evoking the old trauma to desensitize. Psychodynamic therapists will put more emphasis on helping the client put words on the trauma, and speaking what has, until that point, been unspoken. And while there are a whole range of techniques for working directly with traumatic material, they all share the explicit assumption that the original material must be revisited, perhaps now in

smaller steps or with the therapist as a witness, or perhaps with the client empowered through imagery or self-comforting techniques. But the trauma cannot simply be avoided or classified as "problem talk."

What is tricky here, however, is that most of the people we see are not floridly demonstrating PTSD, and they

typically are not asking for help with the old trauma. Instead they are enacting the old traumas. This is particularly difficult to get a handle on when the parent is reenacting the parental position of "not seeing": not seeing the violence, or not seeing the dangers of indiscriminate sexual liaisons, or not seeing the impact of shaming, punitive interactions with their children. Yet the trauma of the parent is being revisited on the children.

Thus, the task becomes one of talking about the past, approaching the ghosts, without devastating the client with a sense of loss or recreating the trauma psychologically, that is, retraumatizing the parent. And this must be done with what is often a fairly tenuous contract. What avenues are open to us?

## MUST WE DEAL WITH THE GHOSTS IN THE NURSERY?

### *Approaching the Past Constructively*

One avenue is narrative therapy, which contains elements of solution focused therapy, but also incorporates approaches to the past that may be particularly helpful for parents and infants. The general notion of the approach is that in the process of therapy we are helping people develop a narrative of their life. If the therapy is healing, the narrative sense of self becomes reworked in important ways; the person becomes less passive and more active, less a victim and more a hero, less caught in the past and more able to live in the present. Pain *can* be transformed and integrated in a generative fashion which, in the work we do, typically means that the parent is more conscious and motivated to make life better for their children.

At the level of technique, narrative therapists might start with what Solution Focused therapists would call exceptions and then go two steps farther. The first is to explicitly explore the MEANING of this event (e.g., "What did you make of that? What does that tell you about your relationship?"). These questions imply the plasticity of constructions, which is a step to helping the client move from an "exception" to a rewriting the narrative of their life, as a parent in relationship with their baby, with more positive and constructive themes. Thus, to use different language, the old internal working models can be rewritten.

But the second step is even more germane to our discussion today. Combs and Freedman (1996) suggest that, "*Until such stories are linked into narratives with a past, present, and future, they are in danger of easily being overshadowed by old, dominant stories.*"

They suggest asking such questions as, "Was there another time, farther in the past, that this (positive)

incident reminds you of." Another question could be to reflect, "this is a wonderful/important quality you are rediscovering in yourself. Can you think back to previous times you were aware of that in yourself?"

In a case example Combs and Freedman describe how the pivotal work in the treatment of an abuse survivor was helping her link back to a sense of being loved by her grandmother as a very young child. This is a situation we often encounter in infant mental health work, but it may also begin to suggest a variety of ways that this approach can be used.

It is possible to take ANYTHING positive in the present and ask about precursors. It is also possible to frame this in several ways. For example, we could focus on the strengths within the person (e.g., previous times they were this patient or this resourceful). At other times, it may be more important to go back to relationships in which attachment was secure, asking about those in which the person felt loved- and lovable.

Just as we have often used the phrase, "I wonder where you would have learned this" to ask about precursors to problematic feelings or behaviors, it is also possible to ask the same questions about strengths.

This brings us back to the argument that narratives need to be anchored not only in the past, but also in the present and future. And this is precisely where we can link very directly to our work on behalf of the infant. When we have worked in the present, and perhaps been able to help the client discover precursors in their history, we can also ask what this means to them now as they are raising their baby. So the linkages are:

- finding the strengths in the present,
- linking them to the past,
- and then linking to the baby.

This is an exact parallel to the sequence that I was describing before (what happened, was it like that for you as a child, how did it feel, and how would you like it to be with your

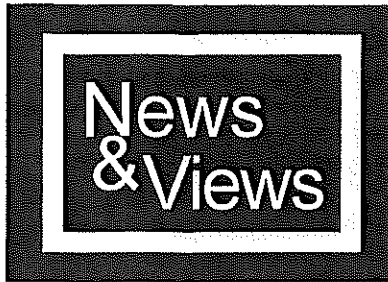
baby). Except that in this approach, it is built around a strength rather than a problem, something that feels positive rather than painful.

Starting with the positive typically seems like a "no lose" approach. Particularly for those clients who are not able to touch what was painful, this provides an approach to genuinely consolidate what was positive for them in the past. If, having done this, they feel impelled to tell you that this isn't the whole story, that there were some major problems in the past, this discussion can happen within the context of the client knowing, and knowing that we know, that there was also positive. At that point, the ghosts can be revisited even more safely and effectively.

This then helps with the integrative work: knowing that they were loved, but often hurt; there were attachments, as well as losses. Similarly, they can integrate that while they may have angry and rejecting feelings toward their babies, they also love them and want the best for them. Developing this more compassionate understanding of themselves and their parents allows them to extend the same compassion to their infants. At this point, in more analytic terms, the splitting is healed, and the projections have lost their power.

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November 20-23, New Orleans, Louisiana, *International Early Childhood Conference on Children with Special Needs*. For information call 1-(407) 628-3602.

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*(President's Perspective, continued from page 10)*

strong component of this international congress: research and intervention must lead to decisions which reach entire populations not just the privileged ones.

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