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PREVENTION AND INTERVENTION IN INFANCY:

TREATMENT METHODS

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When our infant mental health program began in 1972 we described our new project to our colleagues and invited their collaboration. "A Mental Health Program for babies?" one of our friends said. "That's great...but what do you do with them?" Other responses were more forthright. When a two-line announcement appeared in our local newspaper that a professor in the Department of Psychiatry had received a grant from the National Institute of Mental Health for an infant program, an irate taxpayer wrote promptly to the editor. He demanded to know why the taxpayers should be asked to support a crazy woman professor who wanted to put babies on a couch and psychoanalyze them.

THE BABY AS PATIENT

All of this causes us to consider that the notion of a baby as a psychiatric patient is hard to assimilate. This patient has none of the conventional attributes of a patient. He can't talk about his problems. He can't form a therapeutic alliance. He has no capacity for insight. Such patients are labeled "not suitable for treatment" in the language of psychotherapy.

The forms of treatment which I will describe in these pages are also unconventional. The treatment takes place mainly in the baby's home, with one or both parents present. The baby is in the center of this treatment; and everything that transpires in the treatment is either centrally or peripherally addressed to the problems of that patient who can't talk. If treatment takes place in our offices (which also can happen) the baby is brought in for the office interview.

The parents, who are our collaborators in treatment, are also our patients, of course. These are the patients who can talk, and the family sessions will resemble in some ways conventional psychotherapy of a kind that takes place in a conventional office, except that the setting will be a family kitchen or living room, or a playroom at our office. Since the parents are talking about their baby and themselves, what is it that the baby brings to the therapeutic session? Wouldn't it be easier (and more tranquil) if the parents left the baby home and came to our office for their treatment sessions? Does it make a difference that the baby is present?

In infant psychiatry, we see that the baby as the patient who can't talk can engage in an eloquent dialogue with his family

and with us. Without words he can tell us how he is feeling about the world and himself, whether he is valued, understood, satisfied, whether he is going through a rough time, whether he is facing problems of an ordinary or extraordinary kind. And, since his parents are engaged with him -- talking, smiling, holding, feeding, bathing -- or perhaps not engaged with him -- the "dialogue" between baby and parents can be read by us as experienced observers and clinicians.

We are not observers only, in a family living room. We are therapists saying, in effect, "Tell us how it is for you and the baby." And what emerges, typically, is a dramatic "telling" and, in fact, a "showing" us, with the baby and with the family enacting their sad story in the family theatre. And it matters that the baby is there, in the center of the story. He is "telling" his own story, of course, but he is also at the crossroads of dialogue and entering into the dialogue.

For example, in the story of Jane and her mother we witness a five-month-old baby screaming disconsolately in her mother's arms. Her mother makes no move to comfort her and stares off into space, as if she has not heard her baby's cries. The mother's face reveals her own depression and hopelessness. In this interval of non-communication, mother and baby are both making an eloquent

statement. Jane is telling us that there is "no one there" to bring comfort in great need. Her mother is telling us, without words, that her own inner anguish is unbearable. She closes off the registration of her baby's anguished cries, even as she closes off the cries which rise within herself.

In moments such as these (and they proliferate in our records) we learn more by observing a baby and his parents together than we might learn through many sessions in which a parent, in conventional therapy, speaks about his child. How would Jane's mother report this to a therapist if the baby were not present in treatment? She might say, "She's a fussy baby. She cries a lot." And the magnitude of the interlocking solitude and grief of mother and baby could not be discerned in any way.

Six-month-old Billy and his schoolgirl mother must tell their story together. Kathie, his mother, is concerned about only one problem in her baby. "He spits up all the time." Billy's doctors, and our staff are gravely concerned about Billy's growth failure during the past three months. Billy, who is one of the most silent babies we have ever met, makes his own eloquent statement of the problem. He is tense, solemn, with large vacant eyes. Not once in the first five sessions does he look at his

mother, smile to his mother or vocalize to his mother. He occupies himself in solitary play. Once, when the therapist asks if Kathie would like to hold Billy and sit in our rocking chair, Kathie complies. She holds Billy limply in her arms, and rocks. And, as the rocking continues, Kathie seems oblivious to the circumstances in which she is holding a baby, and rocks slowly, rhythmically, with a distant look upon her face - the mother is a child, rocking herself.

We have seen that Billy avoids his mother. Kathie, in every observation we make, avoids physical contact with Billy. And, if we encourage her to hold Billy, we see that she creates psychological distance in the circumstance of holding him. We watch Kathie's depressed face. We watch the tense, solitary Billy and see him, at moments, on all fours mechanically rocking himself. Our fears for Billy grow with each observation.

If Kathie were in treatment for herself in a conventional psychotherapy, if we did not see Kathie and Billy together, we would see a depressed 17 year-old girl. She would speak about herself, perhaps, and speak about her unhappy marriage. She might speak about her baby who "spits up all the time," but she could not tell us that her baby was in extreme psychological peril, because she would not know that. In this hypothetical treatment,

the therapist would deal with Kathie's feelings of emptiness, isolation, inner rage, and -- if we were lucky -- within two years the depression might lift and Kathie might have resolved some of the adolescent conflicts which were impeding her growth. Her capacities to mother her baby would certainly be larger with these benefits of treatment.

But, in two years, the six-month-old baby would be two and one-half years old. Growth failure would probably have followed its typical course, with repeated hospitalizations for Billy. The cumulative severe nutritional deprivation and emotional deprivation would most likely result in a crippling of the child's potential in health and personality. The most devoted mother might not be able to undo the effects of early impoverishment in nutrition and experience for Billy.

No baby can wait for the resolution of a parental neurosis which is impeding his own development. He must have our help, too. And we have learned in our work, that it is possible to give help to the baby and help to the parents concurrently, with great benefit to both, and that the baby can be brought to adequacy even when his parents have not yet resolved their own personal conflicts. This sounds like a contradiction, but in our presentation of case reports in this volume, we will document this point

and offer our own explanations.

THE THERAPIST IN AN UNCONVENTIONAL THERAPY

There cannot be a more alien setting for psychotherapy than the one which we encounter in the story of Beth and Trudy. Beth's living room in a slum apartment is furnished with two crumbling and soiled mattresses on the floor. The therapist, Edna Adelson, sits cross-legged on one. And maintains her professional composure. Beth sits on the other. Trudy, the baby, is lying in a heap of rags beside her. The therapist is listening to the 17-year-old mother who was found as an abandoned child 15 years ago on the streets of a war-torn city. The mother is not listening to the whimpers which come from the baby beside her. The baby is in a critical nutritional state and a critical psychological state. Another "abandoned" child. Beth does not remember her early years, of course. She has only dream-like memories of a trip by plane to the U.S. and the meeting with her adoptive family. She remembers almost nothing, but she is repeating the past in the present, and the repetition -- dreadful to watch -- has caught up a baby in its morbid path.

In this alien setting, sitting cross-legged on the dirty mattresses, the work of therapy is begun and will continue for many months to come. It is a therapy which

moves from the mother's communications to the baby's from the baby to the mother. The method employed in this therapy is an adaptation of the method of psychoanalytic therapy, united with developmental guidance on behalf of the baby. The therapeutic work for the mother is one of listening, observing, giving permission to feel and to remember that which can be remembered, examining the past in the present, undoing the painful effects of that past, giving hope and the prospects of new solutions to old problems. The therapeutic work for the baby is one in which the mother is helped to recognize the baby as a symbol of her abandoned self, to find pathways to understanding the sorrows of early childhood (her own and her baby's) to find pathways of feeling which can unite the mother with her baby in hope instead of futility.

And, along with the therapy which leads to remembering and insight and positive identification between mother and baby, is a concurrent form of treatment, which we have called, "developmental guidance" in which the therapist becomes the nondidactic educator of the mother on the physical and emotional needs of her baby and the ways in which a mother can provide these needs. It is guidance in nutrition and in child development, and it is unobtrusively introduced into every session.

The therapist may also take an active role in providing concrete help. Sometimes there is no food in the house for the baby. (Management of an AFDC budget is beyond Beth in the early period of treatment). The therapist arranges for emergency food supplies... if the baby is sick and must see the doctor, the therapist offers to drive Beth and Trudy to his office.

Altogether an unconventional form of psychotherapy. In a single session the therapist is helping Beth to unravel her past and to see the past in the present, the therapist is providing nutritional guidance for a "failure to thrive" baby, the therapist is guiding the mother into new ways of nurturing a child's emotional development, and the therapist may need to provide emergency aid or transportation to a doctor. (The therapist is a clinical psychologist who once sat in her own quiet office and listened to a single patient in a single hour).

How shall we classify the treatment of Beth and Trudy? "Intensive Psychotherapy", most certainly. But "Developmental Guidance" and "Supportive Treatment" are just as central to the work. "Crisis Intervention?" just as surely if we were to read the record and witness the therapist helping the 17-year-old schoolgirl mother to cope with lost welfare checks, evictions, unpaid bills and the hazards of slum living.

✓ ✓ The admixutres of methods and services in every case are almost too numerous to catalogue and they take place in every case.

In the terms of classical psychotherapy, the therapist in such a case, has "stepped out of her role." How can the same therapist who listens to Beth and helps her disentangle the past from the present, become the active helping person in a situation like this? What happens to the transference when the therapist is both the "mother figure" in the transference of the past and a kind of "mother substitute" in a time of crisis? These are proper therapeutic concerns, and must be dealt with in the treatment process. But clearly, not to drive a sick baby and her mother to the hospital, or help to track down a lost relief check, would be the height of folly and a misguided infant-parent psychotherapy all by itself.

Yet, with all of these modifications in therapeutic role, we shall see in the clinical reports that follow that the transference to the therapist and transference as a vehicle for therapy are significant aspects of each treatment mode and are central to the work in intensive treatment cases. The therapist, it is true, is not, and cannot be the distant and neutral therapist of conventional psychotherapy, but the therapist becomes a transference figure for the adult patients, the parents, even while he

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retains his real and substantial aspect for the patient. Thus, while 16 year old Annie eventually comes to form a strong therapeutic ~~alliance~~ ^{ALLIANCE} with her therapist and the therapist is demonstrably just ~~when~~ ^{when she} Mrs. Shapiro makes her visits to Annie and her 4 month old baby in the family living room, we see many sessions in which the therapist is transformed into the "witch mother" of Annie's childhood and Annie must be helped to see the repetition of the past in this transformation (i.e., the transference).

At the same time, the positive transference, the relationship of trust which is painstakingly built with Annie, who has rarely known a trusting relationship, becomes the vehicle for the work on behalf of Greg, the baby. Annie, who has never known mother nurture herself, is initially without resources to mother her baby. Even after the first period of treatment in which her conflicted feelings toward her baby are brought to the surface and illuminated, we see that Annie is limited in her capacity to mother her baby. Annie is without stable traditions in mothering and can offer little more than mechanical care. The therapist's "psychological nurture" of Annie enables the mother to begin to respond to her baby. But Annie cannot read her baby's signals (and often misreads them as though he were an adult) and must learn through the therapist the most elementary facts about a baby's needs, how he communicates his needs, how his mother is special to him. All this is interwoven into the fabric of the sessions, as Annie and Greg are together with the therapist.

In this way, too, the transference becomes the context for offering developmental guidance. There will be many times in the course of treatment when a parent finds himself unable to use our suggestions or openly negates them. If we ask ourselves, "What is happening within the relationship between therapist and parent?" and examine the transference, we will find almost without exception that negative feelings toward the therapist are intruding. If we deal with the negative transference and bring about or restore a positive alliance, the guidance which had been spurned or hotly negated can be accepted and tried out - often before our eyes.

In this way the transference opens up pathways for the parent for examination of his conflicted feelings, frees the baby from the conflicted past of the parent and becomes the vehicle for the concurrent developmental guidance which we provide on behalf of the baby. This "transference cycle," to coin a phrase, will appear again and again in the course of the work with a single family.

TREATMENT METHODS

The description of our treatment methods presents us with extraordinary problems in exposition. The methods are better revealed through the clinical case reports which follow. In reading them, we see that the methods of psychotherapy and the methods of developmental guidance are interwoven through every case and, in fact, are united in any single session.

But in this presentation we want to provide an introduction to the methods, and in order to do this we have to take apart an integrated structure and examine the components. The moment we do this we are dissatisfied. How shall we show the overlap or the coalescing of the methods in a single hour? If we take apart the structure for study and exploration, will we add anything of value?

I will try.

For purposes of exposition, I will treat the methods of Developmental Guidance and the methods of Infant-Parent Psychotherapy as if they can be regarded separately. And, for fairness, I will sketch in the overlapping features in each section.

The Methods of Developmental Guidance and Supportive Treatment:

The term "developmental guidance" in our work refers to a mode of education of the parent which is integrated

with psychotherapeutic work. Since the term is widely used in infant intervention programs with various meanings, there may be some confusion about just what we mean and do not mean when we describe it as a treatment method. In many infant intervention programs it means "cognitive stimulation" or "modeling the correct behavior for the parents" or "teaching the parent about child development". And it may even mean all of these things in one program. The "intervenor" in these programs is in effect an instructor. In many such early education programs there may be an "infant curriculum", that is, a sequence of tasks which the baby and mother perform together under the guidance of the intervenor.

Our own form of developmental guidance grows out of the circumstances in which a baby and his parents are suffering with either emotional disturbances or chronic external stress, and the relationship of baby and parents is in grave danger. In our work it is a form of education which is guided by the therapist's clinical understanding every step of the way. On the one hand, we provide an ongoing, nondidactic education to facilitate the development of the parent-child relationship and to lead parents into an understanding of their baby's needs, and the ways they, as parents, can promote development. On the other hand, we also address the feelings and psychological stress

the parents may be experiencing as they attempt to respond to the infant's developmental needs.

We work in collaboration with parents to seek the reasons for troubling behavior and to find the solutions together. Where our own knowledge of babies and their needs can lead to constructive suggestions and advice, we do not hesitate to share it with our parents in the spirit of collaborators. We are not teachers, or demonstrators, and there is no curriculum. We are primarily psychotherapists who are uniting infant developmental education with the work of psychotherapy.

The differences between our methods of developmental guidance and those of other intervention programs are mainly those that reflect the extraordinary problems in infant-parent relationships which are brought to us, and the psychotherapeutic principles which guide us in our work. If, for example, the problems which came to us simply reflected the parents' innocence or ignorance of the needs of babies, an educational model might serve as well as any other. But our babies and their families come to us with disorders in the development of human attachments (or neonatal impediments to functioning), and the parents come to us with psychological conflicts which are distorting their relationship to the baby (or are immobilized with grief and anguish in reaction to a tragedy at the time of the child's birth).

It is true that many of our parents do not know the "language" of babies, have limited knowledge of normal child development, and they, too, could be called, "innocent" when they come to us, but innocence and ignorance are often compounded by the psychological impediments to parenting which we see in many of our parents, and developmental guidance for these parents must move on two tracks simultaneously: Helping the parents learn the language of babies, and finding the psychological impediments to that learning.

With our patients, then, developmental guidance must promote and enhance the parent-infant bonds and educate the parents in understanding their child and in finding new pathways in child rearing which will bring optimal development in every area of personality. The examples that follow illustrate the range of use of developmental guidance.

Nina: Guidance to Promote Mother-Infant Bonds:

Many of our parents do not come to us with the idea that babies can love, and that parents are central to the development of love. Many of our parents have not known in their own childhood the kind of love and protection which we want to help them achieve for their own children.

Karen, the sixteen year old mother of Nina, is genuinely surprised when her therapist begins to speak of the ways in which 7 month old Nina shows preference for her mother over the therapist, how "special" her mother is to her.

She's telling us, says the therapist, that her mother is the most important person in the world to her. Many months later, Karen tells the therapist what those words meant to her. It was the first time in her life that anyone had told her that she was important to someone.

At every opportunity when Nina, Karen and the therapist are together, the therapist comments on this special relationship. "That smile was special for Mom, wasn't it Nina?" "Are you tired now, Nina? Are you telling me you'd rather get into Mommy's lap?" ...Nina cries when her mother is about to leave the room for a moment. Karen thinks she is "spoiled." The therapist says, "Mommy will be right back, Nina" and to Karen, later, "when you love someone very much, it's so hard to see them go away. It will be easier when Nina is older." Karen is surprised again. (The long daily separations from mother while Nina is in the nursery are very painful to Nina.) The therapist guides the discussion into the subject of separations, how a baby of Nina's age does not yet understand that a mommy is "someplace" even when she is not present, and what ways Karen might think of to make things go better for Nina during these long separations.

In a subtle way, Nina's behavior, which Karen sees as "spoiled," is interpreted as it should be: a normal reaction in a baby to loss of a loved person. Karen's theory, "spoiling," will lead to no good solutions. The understanding of the behavior which the therapist offers can lead to new and good solutions which will be discussed.

Nina, otherwise bright, is severely retarded in language development. Karen, when we first meet her, rarely talks to Nina. The whole topic can be opened up indirectly. The therapist always talks to Nina. Karen thinks it's a little odd to talk to a baby who, after all, can't understand English. But watching the therapist, she begins to get the point. Nina obviously responds to this talking. And the pathway is opened to a discussion of "how babies learn to talk." (In a few months Nina is positively garrulous!)

Within the context of love between a baby and mother, nearly every area of infant development becomes accessible to developmental guidance. For Karen, who has not known love and understanding in her own childhood, learning to understand her baby's need for love and her baby's "language" leads her into discoveries of her own unsatisfied longings for love. When these longings can be acknowledged by Karen they are translated into new ways of mothering for Karen. Karen can read longing and grief and the wish to be understood, and she can respond with feeling.

Greg: Guidance When a Baby is Endangered by His Mother's Past:

But now, if we move to another group of examples, the work of developmental guidance becomes more complex. How shall we promote and facilitate the bonds between parents and a baby when the parent has turned away from his child, avoids his baby or is repulsed by him and cannot even minister to his physical needs? And what can we offer the baby, as patient, who avoids his mother, is fearful of her and has taken refuge in solitude?

Annie avoids Greg, her baby, and 4 month old Greg avoids his mother. He rarely looks at his mother, rarely smiles to her. He does not turn to her when he is in distress. Annie avoids touching her baby or holding him and turns over his care to Earl, her young husband. It does not help to encourage Annie to hold her baby or to provide her with techniques for engaging her baby. By the time we meet Annie and Earl and Greg, public health nurses have already acknowledged discouragement and defeat in their attempts to bring Annie closer to her baby.

In our own observations during the initial assessment period, Annie's avoidance of her baby can be pieced together through our observations and her communications to us. Annie is afraid to get close to her baby. She is afraid of her own destructive feelings toward him, afraid she might kill him. When Annie is helped to talk about herself, we learn of a childhood in which brutality, sadism and repeated abandonment constituted the largest part of what she knew of parenting. When the therapist reaches Annie through her memories of pain and intolerable fear, Annie, for the first time, reaches out to her baby and holds him.

It is at this point that developmental guidance united with psychotherapy, for Annie, can begin to foster the bonds between Annie and Greg. Annie, who had never known protective love, finds ways to give such love to her baby.

But Annie, bereft of the experiences which would lead to understanding a baby, interpreting the "language" of a baby, and unable through any tradition to confer "personhood" on a baby,

must learn all of this through the help of the therapist. Psychotherapy alone will not give Annie this knowledge. In Annie's tradition, a baby doesn't know anything and doesn't yet have feelings of his own. In Annie's tradition, a 6 month old baby who annoys his parents with his fussing is "just plain spoiled" and before the spoiling takes over and has permanent effects on personality, "you let him know who is boss" and reinforce it with a smack that he'll remember. The therapist, watching Greg with Annie, helps Annie to look for causes in the "fussing." (In the same way, the therapist is helping Annie to look for causes in her own feelings and her behavior.) The cause might be discomfort in one position, or the loss of a toy over the rim of the high chair, or just wanting some sociability. It all made sense someplace. It was a new way of looking at a baby, and it was hard work for Annie. But she trusted her therapist. And she learned a lot.

The quick smack which Annie had in her traditional repertoire had to come under scrutiny in the sessions with the therapist. The therapist, witnessing one such episode, drew Annie's attention to the fear on Greg's face. Annie saw it, as if for the first time. "Is this what we want, Annie?" the therapist asked. The words were intended to have a double meaning for Annie. Annie had been remembering her own childhood and the frightening aspects of her mother and her stepfather. And Annie said, in a low voice, "I don't want my child to be afraid of me."

Infant-Parent Psychotherapy

In infant-parent psychotherapy, the familiar methods of psychotherapy are modified to serve the unique requirements of our work. Our objectives are to identify those aspects of parental psychological conflict which are impeding the development of stable bonds between parents and baby or are impeding development in the child in other specific areas, and to resolve those conflicts through a process in which the sources of parental conflict are illuminated and interpreted. The baby is liberated, as it were, from the distortions and displaced affects which have engulfed him in the parental neurosis. This is therapeutic work which moves from the present to the past and from the past to the present.

It differs from conventional psychotherapy in its infant focus and the parental conflicts which have been visited upon the baby. This means not only that concurrent developmental guidance is part of the infant treatment but that the therapeutic work itself is, to a large extent, "selective" in its areas of work.

When we say "selective" we do not mean that we are not attentive to any and all material which the parent, as patient, brings to us. But, in analogy with "the patient's definition of the problem" in all psychotherapy, there tends to be a clustering and proliferation of patient communications in the area defined as the problem and in our cases, the problem, of course, is the baby. As therapists, we too are "selective" in highlighting and exploring those aspects of the parents' communications that

illuminate the conflict with the baby.

Our methods in this infant-parent psychotherapy are clearly indebted to psychoanalysis. The therapeutic alliance which is indispensable to all therapeutic work is given strong impetus in our work with parents by the parents' hopes for their baby. If impediments to this alliance appear either at the beginning of the work or at any point in the work, we look for causes in the relationship between parents and therapist; that is, we see the obstacle in therapeutic work as a manifestation of negative transference. The negative transference is examined as a defense against painful memories or feelings, transferred, i.e., re-experienced with the therapist. In the course of examining these transference repetitions, the disturbing memories and affects are given voice and given meaning (through the therapist's interpretation). The patient's insight gives him the possibility of finding new solutions to old conflicts.

The repetition of the past in the present becomes a key to the understanding of seemingly inexplicable attitudes and actions in the patient. (Many of our patients have lost control over their lives because the past and the present have merged, as in a nightmare.) The therapeutic work of unravelling the past becomes a form of "undoing" of the past, of diminishing or abolishing its power to invade the present.

When there is a baby at the center of such a psychotherapy, we are given extraordinary insight into the repetition of the past in the present, one in which the baby himself is endowed with attributes and qualities and sometimes malignant influence

and malevolent intention which cannot belong to a baby, and must belong to other figures in the parental past.

It is as if the baby has become a transference object.

The phrase, "the baby as transference object" is unsettling. How can a baby be a "transference object?" In the language of psychotherapy, we speak of the therapist as transference object, meaning that he is a screen upon which is projected the figures of the patient's past with the re-evoked attitudes and affective connotations of those past experiences. However, in life, it is not only a therapist who is capable of evoking the figures of the past. An aspect of a beloved parent can be transferred to a lover or a friend, or a teacher. A negative aspect of a parent can be transferred to a lover or a mother-in-law, or an employer, even with minimal cooperation on the part of the partner who is elected for this role.

But how can a baby become a transference object?

"The Monster"

"He is a monster!" a young mother is telling us and she has called him "a monster" in each of the sessions in which she has been invited to tell us how she sees the problem. "The monster" is 11 months old. He has the face of a cherub (in repose). "The monster" has severe temper tantrums in which he flails about, screams, and often cannot be reached either through his mother's voice or the therapist's. "The monster" also awakens several times a night, screaming in terror. "He won't leave me alone for a minute," the young mother says. "I can't

even go to the bathroom without his pestering me...he wants everything I have.. If I'm eating, he wants my toast, my coffee, or my orange...he gets into all my things, my dresser, my cupboards ...he wants his own ways all the time...he deliberately tries to get my goat."

The mother and "the monster" are in frequent contests in our playroom. In a "no-no" contest, "the monster" usually wins.

On one occasion the mother and "the monster" are quarrelling in our playroom (if a non-verbal partner can be said to quarrel). Turning to the therapist, the mothers says, "Did you see? He started it, he did it first!"

Semi colon
The therapist has the eerie feeling that she has been transformed into a mother, invited to referee a quarrel between her two children.

None of this can make sense if we look at the facts. An 11 month old baby cannot be a monster who tyrannizes a grown woman. His cognitive capabilities (even if they are good for his age) are not up to the complex mental gymnastics that are required to execute a plot against his mother or to imagine a victory in which he triumphs over her through a war of attrition.

It is no help, as the therapist finds, to offer developmental guidance only, to divest the baby of his monster attributes through tactful explanations to the mother of his actions, or to suggest alternative modes of handling everyday problems. In the last instance, this mother always reports, "I tried it and it doesn't work."

Finally, it is more profitable to ask the question, "who is the monster?" If it cannot be a baby, then the baby must

represent another figure in the mother's past.

We are struck by the phrasing of the mother's complaints. These are the phrases that a child uses in bringing a sibling dispute to a mother. "He gets into all my things. He won't leave me alone. He pesters me. Did you see? He started it! He did it first!"

As the therapist encourages the mother to talk about herself, the original monster emerges from the mother's childhood. That "monster" was the mother's brother, two years older than her. And, as the mother remembered him, he was a bully and a tyrant who reduced her to utter helplessness and inconsolable crying in her room. And that "monster" was her mother's favorite. He could do no wrong.

In the course of a few sessions, the mother's rage and heartbreak emerge as she recalls that first "monster" and the mother who gave a small girl no protection against tyranny and openly sided with her favorite child. The therapist, listening with sympathy, finds the moment after each revelation and outbreak of feeling to help the mother see the connections between the "monster" of her childhood and her own baby, and between the mother's mother who she felt could not be trusted and her fear that the therapist could not be trusted. The mother saw all this with wonderment, and the monster attributes which she had given her own baby (13 months old at that time) began to recede.

Now the mother could see her baby as a deeply troubled child. She could look at her child with the therapist and consider,

for the first time, that a small boy who flew into rages during the day was the same small boy who had night terrors, and that the two aspects of the child must be looked at together. When the monster returned to his original abode, in the remote past, we had, very clearly, a little boy who was suffering from overwhelming fears. Now we could help!

At this point the therapist offered suggestions to the mother which were always united with understanding of the meaning of the child's behavior. (Here we shift back to developmental guidance.) The child who was "understood" by his mother began to reward his mother. The no-win contests between mother and toddler came to an end. The night terrors diminished, then disappeared.

Since we are examining our psychotherapeutic methods in this section, the "monster" story serves nicely to illustrate "selection" of the areas for therapeutic work. The "monster" in this mother's past was by no means the only figure who had played a decisive role in shaping her troubled personality. There were many tragedies in that childhood, and, for that matter, many monsters. If the mother were in individual psychotherapy, the whole tangled web of childhood griefs and fears would be opened up over time. In our infant centered psychotherapy we start where baby and parents are most in need of clinical understanding. In the case cited, the problem first brought to us is "a monster" in the past who is exercising a morbid influence upon a baby and his mother. If there are other monsters or other ghosts who have invaded the baby's nursery, we will meet

them with the same thorough scrutiny in our work. But, in this monster story, we were favored by the circumstances in which only one of the many monsters in the mother's past chose to take up residence in the baby's nursery.

"The Lost Baby"

Finally, we should mention that not only the childhood conflicts of the parents may be re-enacted with the birth of a child. In our experience in brief crisis intervention we have seen how uncompleted mourning for a beloved dead person in the period before the birth of the baby can profoundly affect the parents' capacities to bind themselves to their child.

Gretchen is brought to us at four months of age because something is terribly wrong with her. "She is turning away from us. She doesn't seem to like us," the parents tell us. And Gretchen gives eloquent confirmation of one of her parents' fears. She literally turns away from her parents. Also, we learn that Gretchen is an inconsolable baby who cries for hours at a time. We hear her disconsolate wail in our office. Gretchen's cries are intolerable to her parents. The mother pleads with the baby to stop her crying.

The therapist "hears" something in the parents' story that is not communicated in their words or in their feelings. There was a first-born son who died some years before Gretchen was born. (Cause of death was Sudden Infant Death Syndrome.) The parents, in telling this tragic story, are unable to summon grief in the telling. They are sad, but detached.

In the course of three sessions, the therapist helps the parents to speak of their tragedy, to recover the memories of the first baby, to relive the moment of his death, and to feel the relief of tears at last. They had never been able to speak to each other about the dead baby; they had never, until these sessions with the therapist, allowed themselves to cry. There had been no mourning allowed until this time.

Gretchen's disconsolate wail, unendurable to the parents, represented their own inconsolable grief, which could not be endured and could not be expressed. Their fears for Gretchen, their almost obsessive concern that something would happen to her if they were not watchful, their fear that if they should become strongly attached to Gretchen, some cruel fate would intervene, could all come together now in the course of this belated but necessary mourning.

The story had a very good conclusion for Gretchen and for her parents.

The therapeutic methods in this brief form of treatment are very similar to those which we employ in the intensive treatment cases which are reported later in this volume. The therapist identifies an unresolved conflict in the parents which belongs to another time and another baby, a conflict which has re-formed itself around this baby and is endangering the infant-parent attachment. By following the affective routes which lead back to the first baby, the therapist helps the parents and the baby find new solutions.

Concluding Remarks:

When a baby is at the center of treatment something happens that has no parallel in any other form of psychotherapy. We have a consensus among our staff on this point. We often see changes in the baby and his parents as early as the first weeks and months of treatment. But if a baby's mental health status shows positive change a short time after intervention begins, we must fairly say that our therapeutic work and guidance on his behalf have been aided by the strong developmental currents which are present throughout the early months of life. Undo the impediments to forward movement, and the baby takes off! It's a little bit like having God on your side. But it's not so easy to explain the changes in his parents which have occurred during the same time. The changes are not yet fundamental changes in personality, but they represent changes in the capacity to nurture and relate to their child. (For example, four months after our work begins with Jane and her mother, Jane has reached adequacy in nearly all aspects of development, her mother has become a nurturant and caring mother, but her mother is still, clinically speaking, "depressed.")

Such changes in parenting capability within a short course of therapeutic work cannot be attributed solely to the gifts of the therapist, since in other psychotherapeutic circumstances the same therapist, with the same gifts, does not see or expect to see such radical positive shifts in any aspects of personality in a few weeks of treatment. We think another factor is present

which is facilitating this rapid development. We think it is the baby.

The baby can be a catalyst for change in his parents. He provides a powerful motive for positive change. He represents the hopes and deepest longings of his parents; he stands for renewal of the self; his birth can be experienced as a psychological rebirth for his parents.

The baby, in fact, evokes profound memories and feelings in his parents which normally lie deep in personality. This need not lead to pathological disturbance in parents. To be in touch with the deepest reservoirs of feeling in one's self can lead to a binding together of the elements of personality, a form of self healing. When the stirring of old conflicts does lead to grave disturbance in the parents (as we see in many of our patients) we find that we are still advantaged in our work. The powerful conflicts which have led to this crisis have broken through into consciousness, or near consciousness, ready as it were, for our help in resolution and healing and perhaps more ready than at any other time in adult life.

If we have already acknowledged that there are strong currents at work to bring developmental progression for the infant, there are also strong currents at work to bring developmental progression for the parents. Nearly every parent who has suffered in his own childhood wants something better for his child. Nearly every parent knows heartbreak when the baby is not doing well. So it happens that many parents who would never be "motivated" to go to a psychiatric clinic for themselves, and who may, in fact,

be initially fearful of us as "the baby specialists", or hostile towards us and all helping persons, can be brought to trust us and confide in us because we are the people who care about their baby and them. The baby becomes the bond which unites us; we are their partners and their allies in bringing their hopes for the baby to fulfillment.

~~TREATMENT METHODS IN INFANT PARENT PSYCHO~~~~TREATMENT METHODS IN INFANT PSYCHIATRY~~~~Selma Fraiberg *~~

Estimated
32 pages
gms.

When our infant mental health program began in 1972 we described our new project to our colleagues and invited their collaboration. "A Mental Health Program for babies?" one of our friends said. "That's great... but what do you do with them?" Other responses were more forthright. When a two-line announcement appeared in our local newspaper that a professor in the Dept. of Psychiatry had received a grant from the National Institute of Mental Health for an infant program, an irate taxpayer wrote promptly to the editor. He demanded to know why the taxpayers should be asked to support a crazy woman professor who wanted to put babies on a couch and psychoanalyze them.

THE BABY AS PATIENT

All of this causes us to consider that the notion of a baby as a psychiatric patient is hard to assimilate. This patient has none of the conventional attributes of

Footnote

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a patient. He can't talk about his problems. He can't form a therapeutic alliance. He has no capacity for insight. Such patients are labeled "not suitable for treatment" in the language of psychotherapy.

The forms of treatment which ^{I will} ~~we~~ describe in these pages are also unconventional. The treatment takes place mainly in the baby's home, with one or both parents present. The baby is in the center of this treatment; and everything that transpires in the treatment is either centrally or peripherally addressed to the problems of that patient who can't talk. If treatment takes place in our offices (which can also happen) the baby is brought in for the office interview.

The parents, who are our collaborators in treatment, are also our patients, of course. These are the patients who can talk, and the family sessions will resemble in some ways conventional psychotherapy of a kind that takes place in a conventional office, except that the setting will be a family kitchen or living room, or a playroom at our office. Since the parents are talking about their baby and themselves, what is it that the baby brings to the therapeutic session? Wouldn't it be easier (and more tranquil) if the parents left the baby home and came to our office for their treatment sessions? Does it make a difference that the baby is present?

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We are convinced that it does make a difference, but we didn't know why until we were well into our work. The baby, physically present in the session, was not part of a "therapeutic design." While we were working out adaptations of conventional psychotherapy and developmental guidance for an infant-parent treatment program, we were open to many variants in method and explored them. But "the baby in the room" idea evolved from our earlier work, our study of the early ego development of infants blind from birth. Since infant observation and infant-parent interaction were central to that study, the baby was always in the room unless he was napping. We soon discovered that the presence of the baby was not only necessary for our study of development but the baby in the room became a partner in the ongoing dialogue. He was intensely, emotionally there and gave import to all exchanges between the parents and us. Thus, parents, discussing their baby, who happened to be napping in another room, could distance themselves in their report to us, and their communications might screen out emotion. Then, perhaps, a few moments later, when a wakeful baby was brought into the room, there was a heightened emotional climate. If there were tenderness and deep love for the baby, the presence of the baby evoked the most poignant expressions of love. If there were conflicting emotions

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toward the baby the conflict seemed to surface with the physical presence of the baby. The physically present baby touched off a chain of emotions in the parent which often led to revelations of feelings in words, or to the formulation of painful questions to us, as if the sleeping baby had aided repression or denial in the parent and the wakeful and present baby broke the barrier against feelings.

In infant psychology we see
We ~~also saw~~ that the baby, as the patient who ~~couldn't~~ *can't* talk, ~~could~~ *can* engage in an eloquent dialogue with his family and with us. Without words he ~~could~~ *can* tell us how he ~~was~~ *is* feeling about the world and himself, whether he ~~was~~ *is* valued, understood, satisfied, whether he ~~was~~ *is* going through a rough time, whether he ~~was~~ *is* facing problems of an ordinary or an extraordinary kind. And, since his parents ~~were~~ *are* engaged with him -- talking, smiling, holding, feeding, bathing--or perhaps not engaged with him--the "dialogue" between baby and parents ~~could~~ *can* be read by us as experienced observers and clinicians.

It was natural for us, then, when we began the new infant mental health program for babies who were mainly biologically intact, but suffering with emotional disorders, to follow a pattern in "interviewing" which had become congenial to us. The baby "belonged" in the interview, and has remained there in our work, except for

those times when parents have needed privacy and their own space for periods of difficult therapeutic work. (When the baby is beyond the age of 18 months, we begin to modify the pattern of visits, reserving intimate discussions with the parents for private sessions. The child who has begun to understand language may find his parents' outpourings of grief and anger confusing and disturbing.)

In our new work, the baby and his parents were patients, not research subjects, and the privilege of inquiry was given us by the nature of our work. (We must remember that our earlier work was concerned with a developmental study of blind infants, and we had no privilege to make intimate inquiries into the parent-child relationship, except under unusual circumstances. We provided developmental education in the earlier work to facilitate the blind baby's development, and this represented the decent limits of a contract with our parents in which they were permitting our visits so that we could learn and help them and other parents through what we had learned.)

As therapists, in the new Infant Mental Health program, we had another kind of understanding from the outset. There was a baby in trouble, and the family had come to us to find out what was causing the problem and asking us to bring help to that baby and his family. In order to help we needed the privilege of entering their intimate lives.

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~~With this privilege, we were no longer~~ ^{we are not} observers
only, in a family living room. We ~~were~~ ^{are} therapists saying,
in effect, "Tell us how it is for you and the baby."
And what emerged^s, typically, ^{is} was a dramatic "telling"
and, in fact, a "showing" us, with the baby and the
family enacting their sad story in the family theater.
And it mattered^s that the baby ^{is} was there, in the
center of the story. He ^{is} was "telling" his own story,
of course, but he ^{is} was also at the crossroads of dialogue
and entering into the dialogue.

For example, in the story of Jane and her mother (~~Chapter~~)
we witness a five-month-old baby screaming disconsolately
in her mother's arms. Her mother makes no move to comfort
her and stares off into space, as if she has not heard
her baby's cries. The mother's face reveals her own
depression and hopelessness. In this interval of non-
communication, mother and baby are both making an eloquent
statement. Jane is telling us that there is "no one
there" to bring comfort in great need. Her mother is
telling us, without words, that her own inner anguish
is unbearable. She closes off the registration of her
baby's anguished cries, even as she closes off the cries
which rise within herself.

In moments such as these (and they proliferate in
our records) we learn more by observing a baby and his

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parents together than we might learn through many sessions in which a parent, in conventional therapy, speaks about his child. How would Jane's mother report this to a therapist if the baby were not present in treatment?

She might say, "She's a fussy baby. She cries a lot." And the magnitude of the interlocking solitude and grief of mother and baby could not be discerned in any way.

Six month old Billy (~~Chapter~~) and his schoolgirl mother must tell their story together. Kathie, his mother, is concerned about only one problem in her baby. "He spits up all the time." Billy's doctors, and our staff are gravely concerned about Billy's growth failure during the past three months. Billy, who is one of the most silent babies we have ever met, makes his own eloquent statement of the problem. He is tense, solemn, with large vacant eyes. Not once in the first five sessions does he look at his mother, smile to his mother or vocalize to his mother. He occupies himself in solitary play. Once, when the therapist asks if Kathie would like to hold Billy and sit in our rocking chair, Kathie complies. She holds Billy limply in her arms, and rocks. And, as the rocking continues, Kathie seems oblivious to the circumstances in which she is holding a baby, and rocks slowly, rhythmically, with a distant look upon her face -- the mother is a child, rocking herself.

We have seen that Billy avoids his mother. Kathie, in every observation we make, avoids physical contact with Billy. And, if we encourage her to hold Billy, we see that she creates psychological distance in the circumstance of holding him. We watch Kathie's depressed face. We watch the tense, solitary Billy and see him, at moments, on all fours mechanically rocking himself. Our fears for Billy grow with each observation.

If Kathie were in treatment for herself in a conventional psychotherapy, if we did not see Kathie and Billy together, we would see a depressed 17 year-old girl. She would speak about herself, perhaps, and speak about her unhappy marriage. She might speak about her baby who "spits up all the time," but she could not tell us that her baby was in extreme psychological peril, because she would not know that. In this hypothetical treatment, the therapist would deal with Kathie's feelings of emptiness, isolation, inner rage and---if we were lucky---within two years the depression might lift and Kathie might have resolved some of the adolescent conflicts which were impeding her growth. Her capacities to mother her baby would certainly be larger with these benefits of treatment.

But, in two years, the six-month-old baby would be

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2 1/2 years old. Growth failure would probably have followed its typical course, with repeated hospitalizations for Billy. The cumulative severe nutritional deprivation and emotional deprivation would most likely result in a crippling of the child's potential in health and personality. The most devoted mother might not be able to undo the effects of early impoverishment in nutrition and experience for a Billy.

No baby can wait for the resolution of a parental neurosis which is impeding his own development. He must have our help, too. And we have learned in our work, that it is possible to give help to the baby and help to the parents concurrently, with great benefit to both, and that the baby can be brought to adequacy even when his parents have not yet resolved their own personal conflicts. This sounds like a contradiction, but in our presentation of case reports in this volume, we will document this point and offer our own explanations.

THE THERAPIST IN AN UNCONVENTIONAL THERAPY

There cannot be a more alien setting for psychotherapy than the one which we encounter in ~~Edna Adelson's~~^{the} story of Beth and Trudy (Chapter). Beth's living room in a slum apartment is furnished with two crumbling and soiled mattresses on the floor. The therapist, ~~sits~~^{Edna Adelson}, cross-legged on one. And maintains her professional composure. Beth sits on the other mattress. Trudy, the baby, is lying in a heap of rags beside her. The therapist is listening to the 17 year old mother who was found as an abandoned child 15 years ago on the streets of a war torn city. The mother is not listening to the whimpers which come from the baby beside her. The baby is in a critical nutritional state and a critical psychological state. Another "abandoned" child. Beth does not remember her early years, of course. She has only dream-like memories of a trip by plane to the U.S. and the meeting with her adoptive family. She remembers almost nothing, but she is repeating the past in the present, and the repetition -- dreadful to watch -- has caught up a baby in its morbid path.

In this alien setting, sitting cross legged on the dirty mattresses, the work of therapy is begun and will

continue for many months to come. It is a therapy which moves from the mother's communications to the baby's, from the baby to the mother. The method employed in this therapy is an adaptation of the method of psychoanalytic therapy, united with developmental guidance on behalf of the baby. The therapeutic work for the mother is one of listening, observing, giving permission to feel and to remember that which can be remembered, examining the past in the present, undoing the painful effects of that past, giving hope and the prospects of new solutions to old problems. The therapeutic work for the baby is one in which the mother is helped to recognize the baby as a symbol of her abandoned self, to find pathways to understanding the sorrows of early childhood (her own and her baby's) to find pathways of feeling which can unite the mother with her baby in hope instead of futility.

And, along with the therapy which leads to remembering and insight and positive identification between mother and baby, is a concurrent form of treatment, which we have called, "developmental guidance" in which the therapist becomes the non-didactic educator of the mother on the physical and emotional needs of her baby and the ways in which a mother can provide these needs. It is guidance in nutrition and in child development, and it is unobtrusively introduced

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into every session.

The therapist may also take an active role in providing concrete help. Sometimes there is no food in the house for the baby. (Management of an AFDC budget is beyond Beth in the early period of treatment). The therapist arranges for emergency food supplies....If the baby is sick and must see the doctor, the therapist offers to drive Beth and Trudy to his office.

Altogether an unconventional form of psychotherapy. In a single session the therapist is helping Beth to unravel her past and to see the past in the present, the therapist is providing nutritional guidance for a "failure to thrive" baby, the therapist is guiding the mother into new ways of nurturing a child's emotional development, and the therapist may need to provide emergency aid or transportation to a doctor. (The therapist is a clinical psychologist who once sat in her own quiet office and listened to a single patient in a single hour.)

How shall we classify the treatment of Beth and Trudy? "Intensive~~X~~Psychotherapy", most certainly. But "Developmental Guidance" and "Supportive Treatment" are just as central to the work. "Crisis Intervention?" just as surely if we were to read the record and witness the therapist helping the 17 year old schoolgirl mother to cope with lost welfare checks, evictions, unpaid bills and the hazards of slum

living.

The admixtures of methods and services in every case which we describe are almost too numerous to catalogue *and they can plan in every case.*
~~A few vignettes may enlarge the picture.~~

Vivian Shapiro arrives at the home of an 18 year old mother who has just come home from the hospital with a new baby. It is a visit to welcome the new baby and to do all those things the therapist can do to promote the bonds between the frightened adolescent and her baby. The treatment at this point can be called "developmental guidance." When the therapist arrives, she finds there is no food in the house. The relief check has not arrived. After welcoming the baby and conveying to the mother what one can do under the circumstances, the therapist goes back to her office to arrange for money from our Project's emergency fund and spends the rest of the day on the telephone tracking down the lost relief check. Today's treatment now includes "crisis intervention." It also requires "the provision of concrete services."

Dr. Carolyn Aradine, our nurse consultant, is visiting a young woman who is about to deliver her second child. The patient is in panic. She suddenly decides that she will not deliver the baby in the hospital, or if she does, she must go home the same day.

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The nurse consultant, who has been providing guidance and preparation of the mother for delivery, is confronted with a hysterical young woman who cannot be reached through reassurances or the strength of the nurse-patient relationship. Since Dr. Aradine is trained in psychotherapy, she registers the depth of the anxiety in her patient, and places this within a context which she knows. This young woman had undergone the most terrifying experiences in a hospital as a child. The nurse raises a question which is also an interpretation. "This is terribly frightening to you," she says to her patient. "Tell me, is it this hospital that frightens you, or is all this mixed up in your mind with the hospitals you knew when you were little?" Suddenly, there is a rush of tears and the patient makes a crucial link with her past. There is relief, finally, through crying and through talking. At the close of the session, the patient, with insight, says she is now ready to go to this hospital. In a single session, the nurse provided "guidance," "crisis intervention" and a form of psychotherapy which gives insight.

When Edna Adelson arrives to visit Jane March and her mother, for one of their therapeutic sessions, she finds Jane feverish and crying with pain. Her mother is in a panic. Jane must get to the doctor quickly. The therapist

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drives Jane and her mother to the hospital and spends the morning with both of them, as they wait for a series of examinations and procedures.

In the terms of classical psychotherapy, the therapist *in such a case* has "stepped out of her role." How can the same therapist who listens to ~~Mrs. March~~ *Jimmy Beth* and helps her disentangle the past from the present, become the active helping person in a situation like this? What happens to the transference when the therapist is both the "mother figure" in the transference of the past and a kind of "mother substitute" in a time of crisis? These are proper therapeutic concerns, and must be dealt with in the treatment process. But clearly, not to drive a sick baby and her mother to the hospital, *is help to track down a lost relief check* would be the height of folly and a misguided *infant-parent* psychotherapy all by itself.

We appear to be "bending the rules," and since each of us at CDP conducts conventional psychotherapy as conventional psychotherapists, this bending of the rules must be explained. All the advantages in psychotherapy, we concur, come from keeping the rules. We much prefer conducting psychotherapy in our offices. We are vastly advantaged in dealing with transference issues when we can maintain our professional distance. We treasure the privacy of the office for our patients who need it for examination of their problems. And, to be

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candid, we would rather hear about a domestic crisis in our office than literally walk into one in a family living room, and witness a shrill marital fight while a hungry baby is crying for breakfast.

The unconventional therapy which we describe in these pages is addressed to the needs of a baby and his family who must be seen together, and this in itself is an unconventional circumstance. Once a therapist must visit his patients in their home, he has modified his professional role. This does not mean that he modifies his professional behavior, but in the eyes of the adult patient the therapist has become a guest in his home, whereas in conventional therapy the patient is a visitor to the therapist's office, and everything in that setting (the desk, the chairs, the couch, the books on the shelves) speaks for "the profession" and defines it.

In our offices, the professional role is defined for us. When the therapist leaves that setting to become a therapist in the family living room or kitchen, he must define himself for the patients. He is a guest, but a professional guest. The reasons for his being in this

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living room are clear to the patients from the start. Things are not going well for the baby and his parents. We are the baby and parent specialists who want to help make things go better. We do not speak about ourselves and our personal lives, which makes us a very different kind of guest from a drop-in neighbor. We address the parent as Mr., Mrs., Miss unless the parent is a teenager, in which case we follow the wishes of the teenage parent. We maintain formal address for ourselves.

But we are not distant or remote and we are not blank screens. One of the patients is a baby, and when you are talking to a baby and telling him how lovely he is and how clever his tricks are, it's preposterous to put on your professional shrink manners. The other two patients are the parents, who probably have had no experience with the arts of psychotherapy (and may have successfully dodged the practitioners of the art for years). The neutral mask of the psychotherapist would be read by them as "indifference," "coldness" and "hostility." What they need and want is a face and a voice which speaks for caring, compassion, devotion and professional wisdom.

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Yet, with all of these modifications in therapeutic role, we shall see in the clinical reports that follow that the transference to the therapist and transference as a vehicle for therapy are significant aspects of each treatment mode and are central to the work in intensive treatment cases. The therapist, it is true, is not, and cannot be the distant and neutral therapist of conventional psychotherapy, but the therapist becomes a transference figure for the adult patients, the parents, even while he retains his real and substantial aspect for the patient. Thus, while ^{16 year old} Annie, eventually comes to form a strong therapeutic alliance with Mrs. ^{her therapist} Shapiro, and Mrs. ^{the therapist} Shapiro is demonstrably ^{just} Mrs. Shapiro when she makes her visits to Annie, ^{and her 4 month old baby} Greg, and Earl in the family living room, we see many sessions in which Mrs. ^{the therapist} Shapiro is transformed into the "witch mother" of Annie's childhood and Annie must be helped to see the repetition of the past in this transformation (i.e., the transference). ^(the witch came out to Annie and Greg by later)

At the same time, the positive transference, the relationship of trust which is painstakingly built with Annie, who has rarely known a trusting relationship, becomes the vehicle for the work on behalf of Greg, the baby. Annie, who has never known mother nurture herself,

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is initially without resources to mother her baby. Even after the first period of treatment in which her conflicted feelings toward her baby are brought to the surface and illuminated, we see that Annie is limited in her capacity to mother her baby. Annie is without stable traditions in mothering and can offer little more than mechanical care. The therapist's "psychological nurture" of Annie enables ~~her~~ ^{the mother} to begin to respond to her baby. But Annie cannot read her baby's signals (and often misreads them as though he were an adult) and must learn through the therapist the most elementary facts about a baby's needs, how he communicates his needs, how his mother is special to him. All this is interwoven into the fabric of the sessions, as Annie and Greg are together with the therapist.

But none of this can be assimilated unless there is trust of the therapist. For many of our parents there will be mistrust, doubt, and even outspoken hostility in their first visits with the therapist. The label "uncooperative parent" would be unprofitable. But if we see mistrust and hostility in the context of transference there are pathways open to the therapist which can modify these attitudes and bring about a therapeutic alliance. If we speak directly to the feelings of "not being able to trust" or "anger toward people who do not help," there may be relief and readiness to begin to trust.

In this way, too, the transference becomes the context for offering developmental guidance. There will be many times in the course of treatment when a parent finds himself unable to use our suggestions or openly negates them. If we ask ourselves, "What is happening within the relationship between therapist and parent?" and examine the transference, we will find almost without exception, that negative feelings toward the therapist are intruding. If we deal with the negative transference and bring about or restore a positive alliance, the guidance which had been spurned or hotly negated, can be accepted and tried out--often before our eyes.

In this way the transference opens up pathways for the parent for examination of his conflicted feelings, frees the baby from the conflicted past of the parent, and becomes the vehicle for the concurrent ^{developmental} guidance which we provide on behalf of the baby. This "transference cycle," to coin a phrase, will appear again and again in the course of the work with a single family.

A BRIEF OVERVIEW OF TREATMENT MODES

In the presentation of treatment cases in the chapters that follow, we have grouped our cases in three sections, according to the treatment mode which was predominantly employed: Brief Crisis Intervention, Developmental Guidance, Supportive Treatment, and Infant-Parent Psychotherapy. While each of the principal types of treatment in our work can be

distinguished in terms of problems and objectives, the methods (which we will describe later) have much in common and frequently there will be overlapping aspects.

Whether a case at intake will eventually come into one or the other of these classes of treatment will depend upon our clinical assessment of the requirements to bring about the most favorable outcome for the baby and his parents. In other words, the treatment provided is, to the best of our judgment, the best alternative or "the treatment of choice," to borrow a phrase in common clinical usage. This judgment is based on an assessment of the problem in terms of its dimensions (chronic or acute, reactive to external events or intrapsychic conflicts), and of the parents' psychological capacities and needs in treatment.

In Brief Crisis Intervention the problem is brought to us as a family crisis involving the baby. This mode of treatment is chosen when in our assessment the problem is largely reactive to circumscribed external events, and when the parents' psychological capacities suggest they can make use of a brief, focused intervention. In such situations it is possible, and sometimes necessary, to accomplish a great deal in a limited time (as few as three sessions) and this, then, is our objective.

As typically happens, these situations often involve an emergency. For example, a young woman has been abandoned by her husband just prior

to their baby's birth and comes to us distraught with grief and in a precarious financial circumstance. These problems must be dealt with as quickly as possible in order to assure adequate health care, food, and shelter, and also to make possible the bonding between mother and newborn. Brief crisis work is also an important mode in somewhat different situations, where the problem is not an emergency demanding immediate action but is still acute and specific. In the case of Gretchen (Chapter) we meet two young parents who live in terror that something bad will happen to their 4 month old baby. In three sessions we learn that their fears are related to unresolved grief over the loss of their first baby. In a brief period of work the parents find the crucial connections between their fears for Gretchen and the loss of their first-born. For another mother whose baby's birth intensified the mourning of a recent death, a few sessions connecting these events alleviated the symptoms of post-partum depression for which she had been referred.

Thus, in Brief Crisis Intervention the problem may involve or directly affect the baby, but it is caused by specific situational factors. In this mode, our treatment objective is to bring about a favorable resolution of the situation within a limited time. Therefore, its choice as a treatment mode is based on an assessment of the specificity of the problem, its acuteness, and the parents' abilities to respond to brief work. When the problem is a more chronic one, and/or the causes are more diffuse and related to intrapsychic

issues rather than external events, a choice is made between the modes of Developmental Guidance-Supportive Treatment, and Infant-Parent Psychotherapy.

The choice of Developmental Guidance-Supportive Treatment is made in two kinds of situations. In one, the parents may be judged by us as having good parenting capabilities, but circumstances due to neonatal complications or the child's chronic illness may be straining parental capacities to an intolerable degree (Robbie, Chapter). In other cases there may be signs of grave emotional impairment in the baby and serious problems in the parents. However, our diagnostic appraisal of the parents' limited capacity to deal with internal conflicts leads us to choose a treatment that does not focus on these conflicts (Nina, Chapter). In both these kinds of situations our objective is to provide emotional support and to strengthen parenting capacities, while simultaneously providing developmental guidance in the form of information and discussion about the baby's needs.

Thus, both the depressed teenage mother of an FTT child and the well functioning couple with a handicapped child can benefit from this mode of treatment: While the young teenage mother cannot tolerate exploration of her intrapsychic conflicts, and the couple has no need for it, in their different ways they can both make use of information about their babies that is provided with acknowledgement of their own feelings and needs.

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In sum, the choice of Developmental Guidance and Supportive Treatment is made when a problem is seen as chronic, and interpretive work is either not possible or not indicated. In both such situations, we choose a treatment that is mainly ego supportive and ego strengthening, combining with it the provision of developmental information, discussion, and advice to facilitate healthy development in the child, and the strengthening of the parent-child bond.

In Infant-Parent Psychotherapy the problem is seen by us as a grave conflict within the parents and between the parents and their baby. It is one in which the baby has become the representative of figures within the parental past, or a representative of an aspect of the parental self which is repudiated or negated. In some cases the baby himself seems engulfed in the parental neurosis and is showing the early signs of emotional disturbance. In treatment, we examine with the parents the past and the present in order to free them and their baby from old "ghosts" which have invaded the nursery, and then, we must make meaningful links between the past and present through interpretations which will lead to insight. At the same time, in the course of

parental treatment, we maintain the focus on the baby through the provision of developmental information and discussion. Thus, we move back and forth, between present and past, parent and baby, but always return to the baby.

This mode is the treatment of choice for situations where the past has invaded the present and is endangering the baby's development. The choice is dependent, however, on the parents' ability to make use of this kind of focus, and it may be contraindicated in certain situations. For example, there may be ego impairment in the parents which cannot sustain inquiry into causes and motives, or the teenage mother still living in the midst of real family conflict may find it too threatening and overwhelming to engage in such inquiry. (In such cases, Developmental Guidance and Supportive Treatment is indicated.) However, our experience with a large number of gravely disturbed parents has shown us that this is a form of psychotherapy which can be used in the treatment of a broader range of cases than those described in the adult psychotherapy literature. The caveats of the textbooks, regarding interpretation and the dangers of stirring

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old memories have not always been justified in our experience. In illustrative cases in this volume, we see that adolescent patients, "acting-out patients," depressed patients, and "borderline" patients are among the patients who have profited from these methods. The level of education of the patient, the ability to verbalize, and the capacity for introspection were factors which did not impede the use of this method of psychotherapy, although they are factors often cited among psychotherapists as contraindications for the method.

This classification of our cases is useful only if we also appreciate that there are overlapping aspects. The classification is descriptive for the mode if we mean that it identifies the central focus and objectives which are implied in the mode, and which mainly discriminate this mode from another mode. But in the vignettes which we have employed earlier in this chapter, and in the case illustrations in the chapters which follow, we will see that supportive treatment and developmental guidance are incorporated into each of the treatment modes, including infant-parent psychotherapy and that crisis intervention does not restrict itself to the cases which are labeled "crisis intervention" since crises, daily or weekly, generate themselves in all of

our work.

The Treatment of Choice

Our choice of treatment mode is based in each case upon our clinical assessment of the problem as summarized in our discussion of the three primary treatment modes. It is a choice governed by no other criterion than "the best possible alternative" which our program can offer. The only external restrictions are the size of caseload and the practical limits for each staff member and trainee in taking on new cases. We do not charge fees and we do not recover costs of service from Medicaid, Blue Cross or any insurance program. This is our own wish. The costs of service were covered by the terms of our NIMH grant for a demonstration-research program and our Grant Foundation funds for training. If we had been dependent upon private fees or insurance for support, we could not have provided long term help for those children and families in need of intensive treatment. Nina, Jane, Greg and Billy, whose stories appear in later chapters, were all children of poverty. So were the largest number of children who came to us. Medicaid in Michigan would have covered a limit of ten sessions for these children. We know that in many clinics today, "the

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treatment of choice" cannot be made on the basis of clinical judgments, but on the basis of the patient's ability to pay a fee or on third party payments.

"Brief treatment" (which can produce good results when it is the treatment of clinical choice) may be prescribed in many clinics because it is the only alternative which can be offered to patients of limited means, and the criterion of patient need does not enter into the decision.

We have been greatly advantaged, then, in our program by the freedom given us to conduct treatment on the basis of need only. It was our wish, but not only our's. NIMH wanted, among other things from our work, an assessment of patient needs in this new field of infant mental health. If we burdened our study with fee and insurance requirements we could not answer the questions, "Who is out there in need of these specialized services?" and, "What kinds of service and treatment are required?".

Moreover, if we had charged fees or collected insurance, we could never have reached many of our parents and their endangered babies! Initially, many of our parents did not see that their babies were in trouble. Someone else did. And we did. Often it was necessary for us to make dozens of home calls in order

to present ourselves as decent and caring people and to invite the parents to share their concerns with us. One cannot send a bill for services that were not solicited. Often, too, in the course of treatment, there were innumerable appointments which were never kept, were rescheduled, not kept again, in a pattern that we have learned patiently to live with. If we were dependent upon fees or insurance reimbursement, approximately half of our work time would not be reimbursable. All this is the way of life in "outreach" therapy. There is no way in which a program such as ours can send a bill for services: "Outreach" 10 visits. Nobody home: \$400.00.

We record this as experience because it may be useful to our colleagues in planning other programs for infants and parents. But in the context of this discussion, it is important to note that we were uniquely advantaged in offering "the treatment of choice."

We should not close this topic without discussing a last, very important point. Sometimes the treatment of choice is not our infant mental health treatment. In certain cases foster home placement may be the recommended treatment. Thus, in the case of Sandra (Chapter II) the severe mental disorder of the mother was beyond the help of our program. Following a six-month period during

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which no progress was made, we considered that the baby and, indeed, all four children were in great danger, and we recommended placement. We have rarely needed to recommend foster home placement in our program, which is an interesting fact in itself when we consider the large number of neglect and abuse cases in our treatment caseload. But, in the case of Sandra, for example, there was no way in which we could help the mother in time to protect the baby's development and that of the other children in this family.

Today, with several years of experience behind us, we might not wish to wait six months to make the painful decision that we made for Sandra and her family. In the first years of our work we had learned that many cases described as "hopeless" could be helped through our treatment. How could we know that a Sandra and her mother could not be helped until we tried? We did, in fact, serve a protective function for the family; that is, we were standing by to see that the children would not be physically harmed, and we were providing all the help we could give to keep the family together. But the baby made no developmental progress during those six months. And a baby cannot sustain such severe emotional deprivation without great danger for further development. Today, with the wisdom of years of work,

we would probably have recommended placement after the first exploratory work with the family (including assessment) led us to identify the dangers for the baby and the severity of the mother's mental disorder.

Are there other instances in which treatment in our program should not be considered "the treatment of choice?" We can think of some. In the case of a child who is suffering from mental retardation which is not related to the quality of parenting, there are other programs in our community which can better serve the child and his family. The special education services which these programs offer and which will have continuity into the school years will better serve the child and his family than our services. In such cases we will offer an extended assessment to the family and work with another program in the community toward long range educational goals. Similarly, among handicapped children, we have expertness among us in work with blind infants, but no expertness in the field of deafness. In the second instance we might consider that other programs in our community have more to offer than we do.

In short, the "treatment of choice" in our program or any other is made on the basis both of "need" and the resources of the program.

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TREATMENT METHODS

The description of our treatment methods presents us with extraordinary problems in exposition. The methods are better revealed through the clinical case reports which follow. In reading them, we see that the methods of psychotherapy and the methods of developmental guidance are interwoven through every case and, in fact, are united in any single session.

But in this ~~chapter~~ ^{presentation} we want to provide an introduction to the methods, and in order to do this we have to take apart an integrated structure and examine the components. The moment we do this we are dissatisfied. How shall we show the overlap or the coalescing of the methods in a single hour? If we take apart the structure for study and exploration, will we add anything of value?

²
We will try.

For purposes of exposition, ² we will treat the methods of Developmental Guidance and the methods of Infant-Parent Psychotherapy as if they can be regarded separately. And, for fairness, we will sketch in the overlapping features in each section. ~~In order to keep the methods from coalescing (which is their natural tendency in practice) we will identify their characteristics~~

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through emphasis or modal characteristics, and as the exposition leads us to the margins of fusion, we will note it and quickly erect a dam before our readers (and we) slide over into the common territory. It will be a neat trick if we can do it. If we fail, the clinical reports in the following sections (which make no pretense of separating methods) may give the better picture.

The Methods of Developmental Guidance and Supportive Treatment:

The term "developmental guidance" in our work refers to a mode of education of the parent which is integrated with psychotherapeutic work. Since the term is widely used in infant intervention programs with various meanings, there may be some confusion about just what we mean and do not mean when we describe it as a treatment method. In many infant intervention programs it means "cognitive stimulation" or "modeling the correct behavior for the parents" or "teaching the parent about child development". And it may even mean all of these things in one program. The "intervenor" in these programs is in effect an instructor. In many such early education programs there may be an "infant curriculum", that is, a sequence of tasks which the baby and mother perform together under the guidance of the intervenor.

Our own form of developmental guidance grows out of the circumstances in which a baby and his parents are suffering with either emotional disturbances or chronic external stress, and the relationship of baby and parents is in grave danger.

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In our work it

It is a form of education which is guided by the therapist's clinical understanding every step of the way. On the one hand, we provide an ongoing, non-didactic education to facilitate the development of the parent-child relationship and to lead parents into an understanding of their baby's needs, and the ways they, as parents, can promote development. On the other hand, we also address the feelings and psychological stress the parents may be experiencing as they attempt to respond to the infant's developmental needs.

We work in collaboration with parents to seek the reasons for troubling behavior and to find the solutions together. Where our own knowledge of babies and their needs can lead to constructive suggestions and advice, we do not hesitate to share it with our parents in the spirit of collaborators. We are not teachers, or demonstrators, and there is no curriculum. We are primarily psychotherapists who are uniting infant developmental education with the work of psychotherapy.

The differences between our methods of developmental guidance and those of other intervention programs are mainly those that reflect the extraordinary problems in infant-parent relationships which are brought to us, and the psychotherapeutic principles which guide us in our work. If, for example, the problems which came to us simply reflected the parents' innocence or ignorance of the needs of babies, an educational model might serve as well as any other. But our babies and their families come to us with disorders in the development of human attachments (or neonatal impediments to functioning), and the parents come to us with psychological conflicts which are distorting their relationship to the baby (or are immobilized with

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grief and anguish in reaction to a tragedy at the time of the child's birth). It is true that many of our parents do not know the "language" of babies, have limited knowledge of normal child development, and that they, too, could be called, "innocent" when they come to us, but innocence and ignorance are often compounded by the psychological impediments to parenting which we see in many of our parents, and developmental guidance for these parents must move on two tracks simultaneously: helping the parents learn the language of babies, and finding the psychological impediments to that learning.

With our patients, then, developmental guidance must promote and enhance the parent-infant bonds and educate the parents in understanding their child and in finding new pathways in child rearing which will bring optimal development in every area of personality. The ~~three~~ examples that follow illustrate the range of use of developmental guidance. ~~Descriptions of two of these, Nina and Robbie, are in the section on Developmental Guidance, while Greg's story is found in Infant-Parent Psychotherapy.~~

Nina: Guidance to Promote Mother-Infant Bonds:

Many of our parents do not come to us with the idea that babies can love, and that parents are central to the development of love. Many of our parents have not known in their own childhood the kind of love and protection which we want to help them achieve for their own children.

Karen (~~Chapter~~), the sixteen year old mother of Nina, is genuinely surprised when her therapist ~~remarks~~ *begins to speak*

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~~on~~ the ways in which 7 month old Nina shows preference for her mother over the therapist, how "special" her mother is to her. She's telling us, says the therapist, that her mother is the most important person in the world to her. Many months later, Karen tells the therapist what those words meant to her. It was the first time in her life that anyone had told her that she was important to someone.

At every opportunity when Nina, Karen, and the therapist are together, the therapist comments on this special relationship. "That smile was special for Mom, wasn't it Nina?" "Are you tired now, Nina? Are you telling me you'd rather get into Mommy's lap?"

.....Nina cries when her mother is about to leave the room for a moment. Karen thinks she is "spoiled." The therapist says, "Mommy will be right back Nina," and to Karen, later, "When you love someone very much, it's so hard to see them go away. It will be easier when Nina is older." Karen is surprised again. (The long daily separations from mother while Nina is in the nursery are very painful to Nina.) The therapist guides the discussion into the subject of separations, how a baby of Nina's age does not yet understand that a mommy is "some place" even when she is not present, and what ways Karen might think of to make things go better for Nina during these long separations.

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In a subtle way, Nina's behavior, which Karen sees as "spoiled," is interpreted as it should be: a normal reaction in a baby to loss of a loved person. Karen's theory, "spoiling," will lead to no good solutions. The understanding of the behavior which the therapist offers can lead to new and good solutions which will be discussed.

Nina, otherwise bright, is severely retarded in language development. Karen, when we first meet her, rarely talks to Nina. The whole topic can be opened up indirectly. The therapist always talks to Nina. Karen thinks it's a little odd to talk to a baby who, after all, can't understand English. But watching the therapist, she begins to get the point. Nina obviously responds to this talking. And the pathway is opened to a discussion of "how babies learn to talk." (In a few months Nina is positively garrulous!)

Within the context of love between a baby and mother, nearly every area of infant development becomes accessible to developmental guidance. For Karen, who has not known love and understanding in her own childhood, learning to understand her baby's need for love and her baby's "language" leads her into discoveries of her own unsatisfied longings for love. When these longings can be acknowledged by Karen they are translated into new ways of mothering for Karen. Karen can read longing and grief and the wish

to be understood , and she can respond with feeling.

Robbie: Guidance to Sustain "An Unrequited Love."

But Robbie's parents (Chapter) do know how babies learn to love. Their anguish is that the love that was in readiness for a baby has become a kind of unrequited

love. The long awaited baby was born very prematurely, with recurrent life-threatening illnesses. He remained in intensive care for the first 4 months of his life. During the first 2 months, his parents, devoted, very capable young people, could only visit him through the small glass portholes of his isolette. The heartbreak for the parents, who must have lived with constant anxiety for the life of their newborn, was compounded by the circumstances that the life-giving intensive care of the hospital had deprived them of their baby and their own parenthood. The baby "belonged" to the hospital, and not to the parents. Circumstances, beyond the control of the parents, and beyond human control, created impediments to attachment for Robbie and for his parents. If there were no help for the parents, the estrangement of the parents and baby could have later effects. The baby might go home still seeming to be a stranger when finally reunited with his parents.

The treatment methods which the therapist employed, grew out of her assessment of the impediments to attachment. The impediments were real and circumstantial. They were in no sense impediments in the personalities of the two parents. The anguish and the anxiety of the parents were the reactions of two basically healthy parents living in a nightmare. (We would have more cause

for concern if there were not pain and anxiety under these circumstances.)

The therapist, at first, became the "bridge" between the parents and their baby. She became the stable, dependable person who listened, who helped them speak of their pain and their anxiety, who visited with them in the hospital intensive care unit and became the "interpreter" for the silent, mainly unresponsive baby who lay in a glass cubicle. She helped the parents understand the hospital system. She provided the encouragement they needed to seek more information and express themselves more directly to hospital staff. The staff were thus enabled to become collaborators who helped foster the attachment between the two parents and their baby.

When Robbie was able to leave his isolette, the therapist often accompanied his mother on visits to the nursery. At each visit there were signs of response for the parents, which the therapist commented upon and wove into her own commentary upon the development of Robbie. Robbie's parents began to feel the rewards which all parents need. These were parents with large resources of love for their baby, which

had been closed off literally and metaphorically by a glass porthole. The skill of the therapist lay in freeing that love and sustaining it during a period when the premature and sick baby could not return the gift in the lavish and whole-hearted way that healthy and physiologically mature babies reward their parents. When Robbie, at last, was united with his family in his home, he was very much a person, treasured by his parents. He was not a stranger. In the many months of work that followed, the therapist brought her knowledge of nursing and infant development to the unique task of fostering the bonds between an infant and parent when the baby cannot utter sounds because the last of the life-saving measures in the hospital had been a tracheostomy.

Greg: Guidance When A Baby is Endangered by His Mother's Past

But now, if we move to another group of examples, the work of developmental guidance becomes more complex. How shall we promote and facilitate the bonds between parents and a baby when the parent has turned away from his child, avoids the baby or is repulsed by him and, cannot even minister to his physical needs? And what can we offer the baby, as patient, who avoids his mother, is fearful of her, and has taken refuge in solitude?

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Annie (~~Chapter 1~~) avoids Greg, her baby, and 4 month old Greg avoids his mother. He rarely looks at his mother, rarely smiles to her. He does not turn to her when he is in distress. Annie avoids touching her baby or holding him and turns over his care to her husband. It ~~will~~ ^{does} not help to encourage Annie to hold her baby or to provide her with techniques for engaging her baby. By the time we meet Annie and Earl and Greg, public health nurses have already acknowledged discouragement and defeat in their attempts to bring Annie closer to her baby. ^{Earl's young}

In our own observations during the initial assessment period, Annie's avoidance of her baby can be pieced together through our observations and her communications to us. Annie is afraid to get close to her baby. She is afraid of her own destructive feelings toward him; afraid she might kill him. When Annie is helped to talk about herself, we learn of a childhood in which brutality, sadism and repeated abandonment constituted the largest part of what she knew of parenting. When the therapist reaches Annie through her memories of pain and intolerable fear, Annie, for the first time, reaches out to her baby and holds him.

It is at this point that developmental guidance

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united with psychotherapy for Annie, can begin to foster the bonds between Annie and Greg. Annie, who had never known protective love, finds ways to give such love to her baby.

But Annie, bereft of the experiences which would lead to understanding a baby, interpreting the "language" of a baby, and unable through any tradition to confer "personhood" on a baby, must learn all of this through the help of the therapist. Psychotherapy alone will not give Annie this knowledge. In Annie's tradition, a baby doesn't know anything and doesn't yet have feelings of his own. In Annie's tradition, a 6 month old baby who annoys his parents with his fussing, is "just plain spoiled" and before the spoiling takes over and has permanent effects in personality, "you let him know who is boss" and reinforce it with a smack that he'll remember. The therapist, watching Greg with Annie, helps Annie to look for causes in the "fussing." (In the same way, the therapist is helping Annie to look for causes in her own feelings and her behavior.) The cause might be discomfort in one position, or the loss of a toy over the rim of the high chair, or just wanting some sociability. It all made sense some place. It was a new way of looking at a baby, and it was hard work for Annie. But she trusted her therapist. And she learned a lot.

The quick smack which Annie had in her traditional repertoire had to come under scrutiny in the sessions with the therapist. The therapist, witnessing one such episode, drew Annie's attention to the fear on Greg's face. Annie saw it, as if for the first time. "Is this what we want, Annie?" the therapist asked. The words were intended to have a double meaning for Annie. Annie had been remembering her own childhood and the frightening aspects of her mother and her stepfather. And Annie said, in a low voice, "I don't want my child to be afraid of me."

Infant-Parent Psychotherapy

In infant-parent psychotherapy, the familiar methods of psychotherapy are modified to serve the unique requirements of our work. Our objectives are to identify those aspects of parental psychological conflict which are impeding the development of stable bonds between parents and baby or are impeding development in the child in other specific areas, and to resolve those conflicts through a process in which the sources of parental conflict are illuminated and interpreted. The baby is liberated, as it were, from the distortions and displaced affects which have engulfed him in the parental neurosis. This is therapeutic work which moves from the present to the past and from the past to the present.

It differs from conventional psychotherapy in its infant focus and the parental conflicts which have been visited upon the baby. This means, not only that concurrent developmental guidance is part of the infant treatment but that the therapeutic work itself is, to a large extent "selective" in its areas of work.

When we say "selective" we do not mean that we are not attentive to any and all material which the parent, as patient, brings to us. But, in analogy with "the patient's definition of the problem" in all psychotherapy, there tends to be a clustering and proliferation of patient communications in the area defined as the problem and in our cases, the problem of course is the baby. As therapists, we, too, are "selective" in highlighting and exploring those aspects of the parents' communications that illuminate the conflict with the baby.

Our methods in this infant-parent psychotherapy are clearly indebted to psychoanalysis. The therapeutic alliance which is indispensable to all therapeutic work, is given strong impetus in our work with parents by the parents' hopes for their baby. If impediments to this alliance appear either at the beginning of the work or at any point in the work, we look for causes in the relationship between parents and therapist, that is, we see the obstacle in therapeutic work as a manifestation of

negative transference. The negative transference is examined as a defense against painful memories or feelings, transferred, i.e., re-experienced with the therapist.

In the course of examining these transference repetitions, the disturbing memories and affects are given voice and given meaning (through the therapist's interpretation). The patient's insight gives him the possibility of finding new solutions to old conflicts.

The repetition of the past in the present becomes a key to the understanding of seemingly inexplicable attitudes and actions in the patient. (Many of our patients have lost control over their lives because the past and the present have merged, as in a nightmare.) The therapeutic work of unravelling the past becomes a form of "undoing" of the past, of diminishing or abolishing its power to invade the present.

When there is a baby at the center of such a psychotherapy, we are given extraordinary insight into the repetition of the past in the present, one in which the baby himself is endowed with attributes and qualities and sometimes malignant influence and malevolent intention which cannot belong to a baby, and must belong to other figures in the parental past.

It is as if the baby has become a transference object.

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The phrase, "the baby as transference object" is unsettling. How can a baby be a "transference object?" In the language of psychotherapy, we speak of the therapist as transference object, meaning that he is a screen upon which is projected the figures of the patient's past with the re-evoked attitudes and affective connotations of those past experiences. However, in life, it is not only a therapist who is capable of evoking the figures of the past. An aspect of a beloved parent can be transferred to a lover or a friend; or a teacher. A negative aspect of a parent can be transferred to a lover or a mother-in-law, or an employer, even with minimal cooperation on the part of the partner who is elected for this role.

But how can a baby become a transference object? ~~We will have more to say about this in the chapter, "Ghosts in the Nursery", but this may be the place to introduce this alien notion.~~

"The Monster"

"He is a monster!" a young mother is telling us and she has called him "a monster" in each of the sessions in which she has been invited to tell us how she sees the

problem. "The monster" is 11 months old. He has the face of a cherub (in repose). "The monster" has severe temper tantrums in which he flails about, screams, and often cannot be reached either through his mother's voice or the therapist's. "The monster" also awakens several times a night, screaming in terror. "He won't leave me alone for a minute the young mother says. "I can't even go to the bathroom without his pestering me...he wants everything I have. If I'm eating, he wants my toast, my coffee, or my orange...He gets into all my things, my dresser, my cupboards...He wants his own way all the time...he deliberately tries to get my goat."

The mother and "the monster" are in frequent contests in our playroom. In a "no-no" contest, "the monster" usually wins.

On one occasion the mother and "the monster" are quarrelling in our playroom (if a non-verbal partner can be said to quarrel). Turning to the therapist, the mother says, "Did you see? He started it, he did it first!"

The therapist has the eerie feeling that she has been transformed into a mother, invited to referee a quarrel between her two children.

None of this can make sense if we look at the facts. An 11 month old baby cannot be a monster who tyrannizes

a grown woman. His cognitive capabilities (even if they are good for his age) are not up to the complex mental gymnastics that are required to execute a plot against his mother or to imagine a victory in which he triumphs over her through a war of attrition.

It is no help, as the therapist finds, to offer developmental guidance only, to divest the baby of his monster attributes through tactful explanations to the mother of his actions, or to suggest alternative modes of handling everyday problems. In the last instance, this mother always reports, "I tried it and it doesn't work."

Finally, it is more profitable to ask the question, "Who is the monster?" If it cannot be a baby, then the baby must represent another figure in the mother's past.

We are struck by the phrasing of the mother's complaints. ~~There~~^{These} are the phrases that a child uses in bringing a sibling dispute to a mother. "He gets into all my things. He won't leave me alone. He pesters me. Did you see? He started it! He did it first!"

As the therapist encourages the mother to talk about herself, the original monster emerges from the mother's childhood. That "monster" was the mother's brother, two years older than her. And, as the mother remembered him, he was a bully and a tyrant who reduced her to utter helplessness and inconsolable crying in her room. And

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that "monster" was her mother's favorite. He could do no wrong.

In the course of a few sessions, the mother's rage and heartbreak emerge as she recalls that first "monster" and the mother who gave a small girl no protection against tyranny and openly sided with her favorite child. The therapist, listening with sympathy, finds the moment after each revelation and outbreak of feeling to help the mother see the connections between the "monster" of her childhood and her own baby, and between the mother's mother who she felt could not be trusted and her fear that the therapist could not be trusted. The mother saw all this with wonderment, and the monster attributes which she had given her own baby (13 months old at that time) began to recede.

Now the mother could see her baby as a deeply troubled child. She could look at her child with the therapist and consider, for the first time, that a small boy who flew into rages during the day was the same small boy who had night terrors, and that the two aspects of the child must be looked at together. When the monster returned to his original abode, in the remote past, we had, very clearly, a little boy who was suffering from overwhelming fears. Now we could help!

At this point the therapist offered suggestions to the mother which were always united with understanding

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of the meaning of the child's behavior. (Here we shift back to developmental guidance.) The child who was "understood" by his mother began to reward his mother. The no-win contests between mother and toddler came to an end. The night terrors diminished, then disappeared.

Since we are examining our psychotherapeutic methods in this section, the "monster" story serves nicely to illustrate "selection" of the areas for therapeutic work. The "monster" in this mother's past was by no means the only figure who had played a decisive role in shaping her troubled personality. There were many tragedies in that childhood and, for that matter, many monsters. If the mother were in individual psychotherapy, the whole tangled web of childhood griefs and fears would be opened up over time. In our infant centered psychotherapy we start where baby and parents are most in need of clinical understanding. In the case cited, the ~~probe~~ problem first brought to us is "a monster" and we conduct a search with the mother to find that "monster" in the past who is exercising a morbid influence upon a baby and his mother. If there are other monsters or other ghosts who have invaded the baby's nursery, we will meet them with the same thorough scrutiny in our work. But, in this monster story, we were favored by the circumstances in which only one of the many monsters in the mother's past chose to take up residence in the baby's nursery.

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"The Intruder"

The baby as "transference object" can be explored in the clinical studies presented in this volume. Billy (Chapter) is another baby who, at 5 months, is the unhappy victim of an unsettled quarrel in his mother's childhood. The baby is starving, and the 17 year old mother cannot feed him. Nor can she love him! Billy has turned away from his mother and his father. The baby's life is in danger, and the therapist, in almost daily visits, is doing two things at once in every session. She is present at feedings to give practical help in establishing adequate food intake, and she is trying to understand the mother who can only give mechanical compliance with the good advice and often forgets it.

There is a litany of complaints against the baby. "Whenever we are eating, he pesters us for food," says the mother. The therapist says, "Could he be hungry?" and the schoolgirl mother says, "How could he be? He just ate!" The therapist asks, "How much could he eat if we gave him all he wants?" The mother says, fighting angry tears, "If we gave him everything he wants, he'd eat us out of house and home!"

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The mother is hungry. The father is hungry. They are living in poverty. Billy, we learn, has "spoiled everything." If all the lamentations could be compressed in a single sentence it would come out like this: "He has taken everything away from me, all the good things I wanted for myself."

How can a 6 month old baby "eat us out of house and home?" Even in desperate hunger themselves, few parents could say this -- and mean it.

The irrational fear must be understood. And, while the therapist is keeping her watchful eyes on food, (for the baby and the parents) and giving emotional support to this child mother, her eyes and her ears are searching for a clue to the mystery.

In the full clinical report, (Chapter) we see a rapid unravelling of the love-hate conflicts in the mother which have been visited on her baby.

There was another baby in this mother's life who took all the good things away from her, another intruder who "spoiled everything." It was a baby sister, and in the language of childhood, that baby had stolen food (love) from her "hungry" sister.

When the young mother makes the astonishing

connection between past and present, Billy becomes her baby and the first intruder and despoiler moves back to the mother's childhood, where she can safely "pester," and carry on old quarrels, (and she does for awhile) but she can no longer invade this baby's life with his mother.

And Billy begins to thrive!

Not the end of the story, of course. From time to time old ghosts appear in new disguise, but now the therapeutic work can move freely between developmental guidance and parent psychotherapy.

Re-enactment of Tyranny

In the case of Annie and Greg (Chapter) we see another form of transference in which the baby is caught up in the morbid past of his mother. We have touched on this story at several points in this chapter.

Annie, the mother, as we have seen, avoids her baby because she is afraid she will harm him. And this is not an unrealistic fear. Her rage, indiscriminately directed toward everyone (including the therapist) could result in physical harm to Greg, as we see when it breaks

through from time to time.

Annie herself, we learn, had experienced terrible brutality in her childhood and repeated abandonment by her mother. She is now a mother who is driven by forces beyond her control to re-enact her own tragic childhood.

What is repeated is the tragedy of a helpless child (her baby now) and a dangerous parent (herself). What is transferred to the baby is one part of herself, the helpless and crying child, and this aspect of her childhood self she does not remember at all at the beginning of treatment. She only remembers herself as tough. How Annie took over and identified with the dangerous and brutal aspects of her parents is a part of the story that is better told in the clinical narrative in this volume.

We hypothesized that if Annie could remember her childhood terror and helplessness, she could move protectively toward her baby. But it is just this, the overwhelming anxiety of her own childhood that has undergone repression.

The therapeutic work in Annie's case must help Annie recover the emotional experience of childhood helplessness and terror in the safety of the therapeutic relationship. When Annie remembers and re-experiences the anxiety, she begins to move protectively toward her baby.

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Abandonment Re-enacted

In two other cases, "Jane" and "Trudy" (Chapters and), two mothers who had experienced abandonment in early childhood, have psychologically abandoned their babies. In each case, the baby has become the representative of a childhood self which is not remembered. "The abandoned child," long buried in memory, is revived, re-born, given another name. And, as if a diabolical stage manager had contrived this hideous drama, there is now another abandoned child and the old one is now the abandoner, watching like the observer in a nightmare, as a distantly familiar horror story is re-enacted and the observer is helpless to stop it from happening.

In each of these cases the therapist becomes the awakener from the nightmare so to speak. We won't let it happen! When we join with the mother to protect the baby from abandonment, we reach out in the same moment to the other abandoned child; the mother as child. We speak directly to the heartbreak for each. Long before the mother is helped to remember her own childhood terror at abandonment, we help her to name it, and the awakening from the nightmare occurs at just the moment when the therapist names it, and does what no one had done in the first abandonment: offers human sympathy, lets the tears come, helps to find the words, and stands

by as symbolic protector for that lost child as well as the new baby.

When the nightmare ends, the therapeutic work has only begun. But the mother has already joined us in an alliance to protect the baby from the old nightmare. And then we see, in each of these cases, that the mother (still not understanding all that she will need to free herself and her baby from the past) turns to her baby and returns the gift which she has received from the therapist. She can find sympathy and understanding for her baby, can find words for the child who has no words, and can become the protector of her child.

"The Lost Baby"

Finally, we should mention that not only the childhood conflicts of the parents may be re-enacted with the birth of a child. In our ^{experience in brief} crisis intervention ^{have seen} ~~papers~~ we see how uncompleted mourning for a beloved dead person in the period before the birth of the baby, can profoundly affect the parents' capacities to bind themselves to their child.

Gretchen (~~Chapter~~) is brought to us at four months of age because something is terribly wrong with her. "She is turning away from us. She doesn't seem to like us," the parents tell us. And Gretchen gives

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eloquent confirmation of one of her parents' fears. She literally turns away from her parents. Also, we learn that Gretchen is an inconsolable baby who cries for hours at a time. We hear her disconsolate wail in our office. Gretchen's cries are intolerable to her parents. The mother pleads with the baby to stop her crying.

The therapist "hears" something in the parents' story that is not communicated in their words or in their feelings. There was a first-born son who died some years before Gretchen was born. (Cause of death was Sudden Infant Death Syndrome.) The parents, in telling this tragic story, are unable to summon grief in the telling. They are sad, but detached.

In the course of three sessions, the therapist helps the parents to speak of their tragedy, to recover the memories of the first baby, to relive the moment of his death, and to feel the relief of tears at last. They had never been able to speak to each other about the dead baby; they had never, until these sessions with the therapist, allowed themselves to cry. There had been no mourning allowed until this time.

Gretchen's disconsolate wail, unendurable to the parents, represented their own inconsolable grief, which could not be endured and could not be expressed. Their

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fears for Gretchen, their almost obsessive concern that something would happen to her if they were not watchful, their fear that if they should become strongly attached to Gretchen, some cruel fate would intervene, could all come together now in the course of this belated but necessary mourning.

The story, ~~as we will later see,~~ ^{had} has a very good conclusion for Gretchen and for her parents.

The therapeutic methods in this brief form of treatment are very similar to those which we employ in the intensive treatment cases which are reported later in this volume. The therapist identifies an unresolved conflict in the parents which belongs to another time and another baby, a conflict which has re-formed itself around this baby and is endangering the infant-parent attachment. By following the affective routes which lead back to the first baby, the therapist helps the parents and the baby find new solutions.

Concluding Remarks.

When a baby is at the center of treatment something happens that has no parallel in any other form of psychotherapy. We have a consensus among our staff on this point. We often see changes in the baby and his parents as early as the first weeks and months of treatment. But if a baby's mental health status shows positive change a

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short time after intervention begins, we must fairly say that our therapeutic work and guidance on his behalf have been aided by the strong developmental currents which are present throughout the early months of life. Undo the impediments to forward movement, and the baby takes off! It's a little bit like having God on your side. But it's not so easy to explain the changes in his parents which have occurred during the same time. The changes are not yet fundamental changes in personality, but they represent changes in the capacity to nurture and relate to their child. (For example, four months after our work begins with Jane and her mother, Jane has reached adequacy in nearly all aspects of development, her mother has become a nurturant and caring mother, but her mother is still, clinically speaking, "depressed.")

Such changes in parenting capability within a short course of therapeutic work cannot be attributed solely to the gifts of the therapist, since in other psychotherapeutic circumstances the same therapist, with the same gifts, does not see, or expect to see, such radical positive shifts in any aspect of personality in a few weeks of treatment. We think another factor is present which is facilitating this rapid development. We think it is the baby.

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The baby can be a catalyst for change in his parents. He provides a powerful motive for positive change. He represents the hopes and deepest longings of his parents; he stands for renewal of the self; his birth can be experienced as a psychological rebirth for his parents.

The baby, in fact, evokes profound memories and feelings in his parents which normally lie deep in personality. This need not lead to pathological disturbance in parents. To be in touch with the deepest reservoirs of feeling in one's self can lead to a binding together of the elements of personality, a form of self healing. When the stirring of old conflicts does lead to grave disturbance in the parents (as we see in many of our patients), we find that we are still advantaged in our work. The powerful conflicts which have led to this crisis have broken through into consciousness, or near consciousness, ready as it were, for our help in resolution and healing and perhaps more ready than at any other time in adult life.

If we have already acknowledged that there are strong currents at work to bring developmental

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progression for the infant, there are also strong currents at work to bring developmental progression for the parents. Nearly every parent who has suffered in his own childhood wants something better for his child. Nearly every parent knows heartbreak when the baby is not doing well. So it happens, that many parents who would never be "motivated" to go to a psychiatric clinic for themselves, and who may, in fact, be initially fearful of us ^{as "the baby specialists"} at the Child Development Project, or hostile toward us and all helping persons, can be brought to trust us and confide in us, because we are the people who care about their baby and them. The baby becomes the bond which unites us; we are their partners and their allies in bringing their hopes for the baby to fulfillment.