

# Multiple Births

## The Experience of Learning in Infant-Parent Psychotherapy

**Marian Birch, DMH; Lisa Mennet, MS; Quen Zorrah, MS**

Two clinical training cases, both beginning in pregnancy, are used to illustrate how infant-parent psychotherapy can positively influence the emerging self-representations of all 3 members of the therapeutic triad: infant, new mother, and therapist-in-training. Within the training program, emphasis is placed on developing capacities for the regulation of intense emotion, integration of affects, cognitions, and memory, and increased reflective function. Supervisory support is critical as it expands these capacities in the clinician, who can in turn support the growth of the parent and the infant. **Key words:** *infant-parent psychotherapy, parenting, intervention, self-representations, supervision*

**T**HIS article will look at the first 9 months of treatment of 2 mother-infant dyads referred to the clinical service of an infant mental health training program and the experience of the trainee in each case.

Research in infant development suggests that representations of self and other are dynamically cocreated in the context of nurturing relationships (Beebe & Lachmann, 2002). Our goal is to portray the process by which new self-representations emerge as a result of the treatment relationship. We will look at emergent representations of

- self-as-mother-to-this-infant in 2 young, first-time mothers
- self-with-other in the infants of these mothers
- self-as-infant-mental-health-specialist in 2 trainees in the program

We will use clinical case material to illustrate how these emerging self-representations reciprocally influenced each other.

The training and clinical experiences described in this article took place within the Certificate Program in Infant Mental Health at the University of Washington. The Certificate Program is one of a small handful of university-based graduate-level clinical training programs in infant mental health in the United States. It offers a 21-month course of study that includes both academic preparation in current theory and research in infant mental health as well as a 1-year, intensively supervised clinical practicum doing home-based infant-parent psychotherapy. Both students and faculty come from a variety of disciplines.

Practically speaking, our home-visiting model uses a blend of concrete and emotional support, nondidactic developmental guidance, and exploration of the mother's own psychosocial development as it directly impacts her capacity to respond helpfully and happily to her infant. The model has significant advantages for training, as it is a long-term, relationship-based model that offers the trainee the opportunity to observe and experience the unfolding (and the knots and wrinkles) of both the infant-parent relationship and the therapeutic relationship. It is demanding of trainees in that it requires a sensitive attunement to the shifting—sometimes conflicting—needs of both the

---

*From the Graduate Certificate Program in Infant Mental Health (Mr Birch, Ms Mennet), University of Washington, Seattle and Jefferson County Department of Health (Ms Zorrah), Port Townsend.*

*Corresponding author: Marian Birch, DMH, Graduate Certificate Program in Infant Mental Health, University of Washington, 154 Klabbane Ridge Dr, Seattle, WA 98362 (e-mail: birchwest@olympus.net).*

baby and the parent, moment by moment. The therapist must be able to move flexibly between interpretation, empathic emotional availability, and concrete support, always keeping in mind what the mother, baby, and relationship can tolerate (Stern, 1995). It is also a flexible model, enabling the trainee to tailor interventions to fit both the dyad's unique needs and the trainee's unique skills, background, and practice setting.

Home visits afford a uniquely rich field for infant-parent intervention. Home visits provide the trainee with a depth and complexity of observational and experiential data that office practice can never offer. By being in the home, therapists are able to see "how it is" for the family much more clearly than would be the case in an office visit. Home visits also make it possible to help families whose difficulties preclude their being able to make use of center-based interventions.

The baby's presence is vital to this work, even in cases where the presenting problem appears to "reside" in the mother (eg, postpartum depression). In infant-parent psychotherapy, the therapeutic conversation is explicitly conceptualized as occurring simultaneously on a verbal and a behavioral/interactive plane. The baby's vocalizations, gestures, and facial expressions are presumed to provide an ongoing *basso continuo* to the verbal dialogue between the adults. The infant's nonverbal, presymbolic "commentaries" provide the therapist with a direct way (speaking to and for the baby) to address relational and emotional issues that may not yet be accessible to the parent verbally.

On a theoretical level, our model of infant-parent psychotherapy focuses primarily on resolving obstacles and impediments in the developing, dynamic infant-parent relationship, rather than on developmental, behavioral, or psychopathological concerns in either partner of the dyad (although all of these may inform the form and content of the intervention). The question we ask ourselves is: What gets in the way of the mother and baby responding to one another in a fashion that is optimal for this particular dyad? Per-

haps the mother and baby are temperamentally ill-matched and have trouble "reading" each other. Perhaps the baby is a poor signaler or is unusually dysregulated. Perhaps the mother's own painful early experiences—or current stresses—make it difficult for her to tolerate and respond sensitively to the powerful and primitive affect states of a vulnerable, needy infant. Whatever the original "cause" of the difficulty, we consider our client or patient to be the infant-parent *relationship* and our method to be one of understanding and responding empathically to both the mother and baby's experience of self and other within this relationship.

This model of infant-parent psychotherapy was originally developed by Fraiberg, Adelson, and Shapiro (1975) and further refined and expanded by her colleagues, including Lieberman and Pawl (2000) and others. Fraiberg was particularly interested in the mother's representations of her infant, that is, her understanding of the baby's personality, motivations, and needs, which are inevitably colored by her feelings and beliefs about what it means to be an infant ("abandoned," "a little dictator") or a mother ("irresponsible," "a martyr"). Fraiberg's treatment model emphasizes the importance for the clinician of understanding how distortions in these representations (the "Ghosts in the Nursery") have compromised a mother's ability to understand and respond sensitively to her child. Of course, the notion of representations is also central to attachment theory, which uses the term "working model of attachment" to denote the set of expectations one has about intimate relationships, particularly the *first* intimate relationship.

Attachment theory gives us an important foundation for understanding the experience of the infant, and how he constructs a sense of self (a self-representation) within the context of early relationships. We conceptualize social and emotional development as a process of the infant's experiencing, storing, and organizing at increasingly complex levels the myriad of emotionally laden interactions that occur moment to moment between an infant

and caregiving parents. Such interactions may be explicitly social, as in face-to-face play, or embedded in routines of physical care, like diapering, bathing, and feeding. Some may engage the attachment system, as in experiences of threat, illness, or loss, while others may not. Optimally, these interactions include often-repeated experiences of regulation—of soothing, protecting, modulating, or stimulating. Secure attachment is rooted in such experiences. These regulatory interactions also help the infant develop and expand the capacities for self-regulation and for interactive regulation (intentionally using social interaction to alter an internal state). Such regulation results in the growing capacity for maintaining calm, alert attention to the physical and social environment, and has a powerful influence on the quality and stability of the baby's mental representations of self and other (Beebe & Lachmann, 2002; Greenspan, 1997; Stern, 1995). The caregiver is experienced as trustworthy and able to soothe, while the self is experienced as soothable, and representations begin to develop that reflect these expectations.

We subscribe to the view that “reflective function” is a critical component of a parent's capacity to regulate her own affective states and those of her infant. Reflective function (Fonagy, Gergely, Jurist, & Target, 2002) is a profoundly important mental capacity, the presence of which enhances and the absence of which obstructs optimal parental responsiveness. In brief, *reflective function* is the capacity to think about and to attribute meaning to the behavior of oneself and others. It is the capacity to see behavior as motivated by internal experiences, such as beliefs, desires, intentions, and feelings. It can be negatively affected by defensive responses to painful early experience. In a nutshell, reflective function is the capacity to know that the baby who pees in your face and smiles is not “out to get you” although you, after a long day, may *feel* as if he is. Parents who are high in reflective function are better able to understand what their infant is experiencing, and they convey this understanding back

to the baby, laying the foundation for symbolic thought. High ratings in parental reflective function are positively correlated with infant secure attachment and negatively correlated with insensitive parental behaviors, like hostility, roughness, intrusiveness, and withdrawal (Grienenberger & Slade, 2002).

The focus of our training program, then, is the use of the therapeutic relationship to regulate and empathically reflect distressed and maladaptive affects as they arise between infants and parents (and, often, as well, between parents and therapists). By using the therapist's own reflective function, we hope to enhance the parents' own reflective capacity to understand and respond with sensitivity to the infant's behavior. In the process, we explore and collaborate with the family to reorganize both the parents' representations of themselves-as-parents-to-their-baby and their actual interactive behavior.

The supervisory relationship is conceptualized as paralleling the therapeutic relationship. The supervisor's task is to provide theoretical and technical guidance and emotional support to facilitate the trainee's ability to establish the optimal emotional engagement in frequently chaotic and painful family situations. The supervisory setting offers the safety and distance needed to reflect on these situations and the trainee's role within them. All of these supervisory functions can be conceptualized as components of “containment” (Bion, 1962), that is, providing the understanding, empathy, balanced hopefulness, and reassurance on the basis of experience that help the trainee tolerate and regulate her often intense affective responses to clinical encounters.

It is a central part of our model that clinicians beginning the very emotionally and intellectually challenging work of home-based infant-parent psychotherapy need a very high level of supervisory support. The home visiting psychotherapist has no external props or supports to create a “therapeutic frame,” and she is often confronted with wildly unpredictable circumstances. We offer our trainees weekly individual supervision, weekly small group supervision, and a weekly case seminar.

A trainee typically is working with 2 to 3 families.

In the pages that follow we will describe the training and treatment experience with 2 trainees and 2 families. We have adopted a multivoiced style to reflect the differing perspectives of the 2 trainees (Lisa Mennet and Quen Zorrah) and the clinical supervisor (Marian Birch). To indicate whose voice is speaking, paragraphs will be headed with the author's initials.

### **MB: OUR TRAINEES**

Quen and Lisa, my 2 coauthors, beautifully represent both the wide range and the outstanding talent of students who come to our program.

Quen Zorrah is a public health nurse with many years of experience working with pregnant women and new mothers, both in prevention, using David Olds' model of intensive nurse home visitation for high-risk, first-time pregnant women (Olds et al., 1997), and in an intervention program for families involved with Children's Protective Services. Quen was also enrolled in a master's program in Family and Child Nursing.

Lisa Mennet enrolled in the training program as a master's-level therapist whose previous experience in the field included several years of work with toddlers and their parents at a community mental health center and as a therapist in a pilot program for high-risk mothers that used an object relations theory focus. She was also working on an independent PhD in infant mental health.

Both trainees began their clinical work with the families discussed here following a referral from a healthcare provider who was concerned about the mother's emotional distress during the last trimester of pregnancy.

### **QZ: INTRODUCTION TO ROSE AND LILY**

Therapy began when 18-year-old Rose was entering her third trimester of pregnancy. Her motivation to participate in therapy was, "I don't want my child to have any of the feelings

that I had growing up." She had been homeless and living on the streets for some time. She said the streets were less confusing than the substance abuse at home, while at other times she claimed that her mother had kicked her out. She had a primary addiction to alcohol, but details of her use of other drugs were inconsistent. Now back living with her mother, she missed the street life and felt a strong sense of connection to the people she left behind, saying they were like a family. She did not trust mental health care providers, had not sought any help, and thought it was a normal part of her life to be victimized.

In our early sessions, her story poured out, often in an incoherent rush. She did not allow any space for reflection. If I tried to interject, she would glare at me. When speaking of her traumatic experiences, her affect remained relatively neutral. By the end of the visit she would be calmer, allowing me to respond to her. Listening to her chaotic and horrific stories was exhausting.

Rose felt overwhelmed and inadequate when anticipating the needs and fragility of her newborn. These fears were well beyond the normal anxieties of expectant mothers. For instance, she worried that the baby's head might fall off if she did not hold it properly. When Rose was 34 weeks pregnant, she recounted a very scary dream about the baby. In this dream, the baby had no face and died because she was not able to protect the baby from multiple dangers. Rose told the story of this dream with heightened affect. To her the dream vividly represented the dangers she anticipated would threaten the life of her baby after birth. Unable to look deeper into these fears, she was somewhat reassured by my suggestion that her ability to quit using substances and leave the street environment was tangible proof of her maternal commitment to her baby. However, during every session the fears would surface. She could not sustain the image of herself as competent.

Even as she worried about the vulnerability of her infant she also represented her fetus as possessing the ability to inflict great pain and damage during the birth. She was

terrified of the birth process and was certain that the intense pain would cause her to lose control. Being out of control would make her vulnerable to other people; she would incur their judgment while in need of their care. She could not see herself, her body, as capable of managing the pain of childbirth. She felt that the birth would become one more instance of her victimization. As a public health nurse, with her permission and input, I was able to work with the hospital staff to assist them in preparing for her. The labor and birth went very well. Her baby girl, Lily, was born full term and healthy. Rose described her birth as intensely painful, but she felt proud of being able to cope with her pain and emotions and could begin to consider that she might be a competent mother.

Lily seemed to recognize her mother's voice and prefer her mother's arms even on the day of birth. She was unexpectedly and extraordinarily easy to soothe and feed. She gained weight right away and was starting to develop a predictable sleep pattern at 1 week. These behaviors seem to indicate not only that the infant was sturdy and neurologically intact without extremes of temperament but also that she experienced her mother as responsive, predictable, and gentle. Rose was clearly pleased, and a little surprised, when I pointed out and admired these early successes. Although she could not hold it for very long, she started to represent herself as a good mother.

By the time Lily was 1 month of age, Rose's representations of the baby were mixed. On the one hand, Rose described her as being an easy baby because she responded to her efforts to feed and soothe her. On the other hand, she saw the baby as stubborn and smart because she knew what she wanted, she knew how to cry so as to make her mother hold her and sleep with her. Rose feared this meant Lily was "manipulative." With my help she was able to reframe these as positive attributes and similar to the good parts of herself. Being stubborn and smart had helped her survive on the streets and she was pleased her daughter was like herself. Rose responded

with pleasure when I pointed out the baby's health and competence. It seemed much easier for her to hold onto the positive representations of her baby than of herself.

She also worried that the baby was too dependent on her. Often, the baby would not stop crying when other people were holding her but would settle as soon as Rose held her. She described dependency on people as something to be avoided because people had consistently let her down. This representation of people as unreliable and unsafe had been the primary, although unspoken, focus of therapy. My presence as a consistent, calm, and resilient person (although I often did not feel calm and resilient) was a new experience for her. Several times she expressed surprise that I remembered something she had said. Several times she commented cheerfully that she knew I would respond in a certain way. She was beginning to accept the possibility that a person could be trusted.

I observed her developing a pattern of interacting with the baby that minimized the possibility of eye contact. Instead of holding Lily out in front of her so that they could enjoy mutual gazing, Rose would hold the baby on her chest snuggled up under her chin so that neither could see the other's eyes. Sometimes she would terminate a feeding before any satiation cues from Lily and quickly move the baby into this position as if to ensure that they would not accidentally make eye contact. She did not seem to be conscious of this behavior. I remembered that, during pregnancy, Rose expressed a fear of sharing the bad parts of herself with her baby. I wondered if eye contact represented an intimacy, a sharing of herself that was too frightening.

Although Rose continued to have periods of emotional instability when she would become anxious and incoherent, she seemed to be able to maintain appropriate responsiveness to Lily. It is probable that at this time the baby started having mixed representations of her mother. During several sessions I observed the baby carefully avoiding eye contact with her mother while Rose was experiencing some emotional turmoil. She

seemed to have a sense of her mother's state of mind and was unwilling to share it when it became too scary. She did not avoid her mother's body but was able to breast-feed and snuggle even when her mother was in distress. Rose's handling of Lily was always calm and firm but gentle. The baby seemed to comprehend that her mother's body was a predictably safe source of comfort and nurture but that her mother's mind was not. It was difficult to watch the baby developing this schema of being with her mother.

I continued to focus on identifying and supporting Rose's positive interactions with the baby while developing a calm, predictable, and safe therapeutic relationship within which she could express and explore her emotions and experiences. When the baby was 4 months of age, Rose was increasingly able to reflect both on how Lily might be feeling and on her own experiences. She seemed more receptive to my interpretations of her experiences and more able to hold on to the belief in the positive parts of herself. She started seeking eye contact with Lily. The baby seemed to be aware of the shift in her mother's mental state throughout the course of a session. Lily reflected her mother's state of distress by being groggy or avoidant or by spitting up. As her mother's mental state became calmer, the baby became not only receptive to eye contact but also initiated the interaction. She seemed to be able to recognize, monitor, and tolerate the distressing parts of her mother and to respond to and promote the good parts of her mother. It seemed that she was able to recognize the split in her mother and developed a flexible strategy of coping with her mother's state of mind, which allowed an increasingly satisfying and intimate interaction.

#### **LM: INTRODUCTION TO REBECCA AND JOHN**

Upon referral, Rebecca was 36 weeks pregnant with her first child. She was in her mid-20s, married, and pursuing an advanced degree in a scientific field. Her husband, also in

his 20s, was also highly educated and beginning his postgraduate career.

The pregnancy was difficult. The first trimester was characterized by severe morning sickness, requiring bed rest and visits to the hospital for rehydration, while the third trimester brought premature contractions and bed rest for the rest of the pregnancy. Rebecca was in pain much of the time and was distressed by falling behind in her work.

Rebecca was referred to our program by a perinatal social worker employed by her the clinic where she received prenatal health care. The social worker reported feeling disturbed by comments the client had made about the baby (calling him a "parasite"), and by seeing Rebecca hit her belly when the fetus moved. Rebecca freely admitted to being overwhelmed and very upset that the pregnancy was so difficult. She was anxious to be seen for treatment.

Thus, by the time treatment began (36th week gestation), a disturbingly negative representation of the baby was already well-established: Rebecca saw the baby as the cause of her physical and mental misery. If not for this pregnancy, she let me know, she would have been able to sustain both her health and her representation of herself as strong, competent, and in control. Her use of the word "parasite" eloquently conveyed her feeling (cognitively denied) that the baby intended to hurt and victimize her—that his increasing vitality sapped her own.

These feelings stood in contrast to Rebecca's attitude before the pregnancy; she had yearned to conceive, idealized motherhood, and hoped for a large family. Her fantasies revolved around a boisterous crowd of latency-aged children who enjoyed many pursuits and adored their parents. When her attempts to conceive proved successful, however, she was surprised and upset even before she began to feel ill. The prospect of an actual newborn was difficult for her—she virtually never talked about the baby as a *baby*—while the fantasized older child was longed for. She seemed to have a clear sense of what an older child could give her, and

especially how such a child would enhance her self-representation—it was this representation that appeared whenever we touched on her positive feelings and hopes for the future.

A recurring dream during the last weeks of pregnancy conveyed her conflicted feelings about her infant's dependence on her: In it, she had gone to the hospital to give birth, leaving her husband at home because the delivery would be easy. It was, and she fell asleep, then woke the next day surprised and delighted that the baby had slept through the night. She went to the crib to see an older, alert baby who smiled and said "Hi Mom" like a 3-year-old. Rebecca loved this dream but in telling it said it also made her feel sad "because he didn't need me." This comment felt hopeful to me, as it conveyed some practical knowledge that real babies do have needs, and hinted at Rebecca's growing awareness of—and desire to be needed by—this baby. It also demonstrated some capacity to tolerate mixed feelings, an important component of reflective functioning. Rebecca did not acknowledge my remark that many mothers experience mixed feelings about their baby's dependence. Yet momentarily I felt relief: so far, I had felt significant internal pressure to protect this child, in some concrete way, from his mother's most hostile thoughts and impulses (which, of course, Rebecca also wanted me to do.) This small exchange helped me reorient toward a goal of being a protector of our mutual capacity to think about her mental states, and to tolerate ambivalence.

During the first weeks of working together, before the baby's birth, I learned that Rebecca's parents had divorced when she was 6 and she had moved frequently between the homes of her physically abusive father and her resentful, neglecting mother. Rebecca reported these facts with little feeling or elaboration. When I sympathized with the many losses she had suffered, she responded with a dismissive "I guess so." Rebecca avoided further explorations of this painful history until we had worked together for nearly 8 months.

The baby, a healthy full-term boy, was born by C-section between our fifth and sixth ses-

sions. For the first few months of the baby's life, Rebecca's representation of a tormenting baby receded. The baby, John, was an easy, alert infant who nursed and slept well. His signals were strong, and Rebecca was very receptive to them. Rebecca was proud of John, often describing him as "perfect." In our discussions, however, the image of John as an older child predominated. This created an odd contrast between what felt like a lovely, instinctive responsiveness to this here-and-now infant and a cognitive interest in a more mature John.

Sometimes, this was expressed in her description of having discussions or disagreements with John. For instance, at 3 weeks old, she talked about "convincing" him that he needed to stop using a nipple shield. Rebecca described this negotiation, saying John had mounted a small attempt to "resist" her argument, but quickly capitulated. She was proud that he was so reasonable. When I gently challenged these representations, Rebecca offered an acknowledgment that John was "too young" to manage these complex mental tasks, only to end with a "but still . . ." It seemed that one important representation for this intellectually gifted mother was of the baby as an extension of her best, smartest self. Perhaps this was a partial explanation for the fact that, after initially introducing the baby to me, Rebecca did not use his name again with me for 6 weeks.

I imagine that John experienced his mother during this period as a dependable presence who was sensitive to his cues and responsive to his distress. His preference for her face and voice was clear from the first weeks, as was his ability to adapt gracefully when Rebecca required this (for instance, in giving up use of the nipple shield). It is satisfying to think that these are linked phenomena, that he was able to be flexible in part because she had been so gratifying to him, and I said as much to Rebecca on many occasions. I wanted to convey my real admiration for her mothering, but I also hoped to quietly remind her that John was in fact a separate person with a separate mind. Her care for him was lovely, but

her thinking about him lacked differentiation. She responded with interest and surprise to my admiring comments.

At 4 months, Rebecca's representation of John as persecutor suddenly reappeared. When I arrived for our weekly session, Rebecca was tense and tearful. She explained that John had acquired a new habit of "screeching," a sound that hurt her in a physical, even visceral, way. It did not seem to be caused by any specific event or state, but its appearance coincided with a developmental spurt that included both the difficulty of increased night wakings and the pleasure of his emerging interest in his surroundings. The session was marked by sharply contrasting representations of John as a source of joy and as a source of intense pain, the latter caused by both the vocalizations and his restlessness at the breast. Rebecca, so focused on her experience of being kicked and swiped at, struggled to take in my explanation that John's blossoming interest in the world, and in her face, made it hard for him to nurse quietly right now. This piece of developmental information, offered as a link to help her reconnect with John, must have felt puny and inadequate next to her desire to strike the baby when he "hurt" her. Rebecca responded with similar disinterest to my gentle suggestion that the intensity of her feeling might have its roots in early experiences. I tried to hope that my attempts at integration made some small, if unseen, impression, that even if the content of my comments was rejected she would feel less dysregulated and frightened by the intensity of her feelings.

Although I was not able to fully understand the "screeching" from either John or Rebecca's perspective, it was clear that John was in danger of being expelled from his safe, rather symbiotic place in her representational world and turned into an attacking "other." My job was to sympathize with her pain, be an ally of her strong protective feelings, and, as always, hint at the fact that John was neither the same as her nor attacking her. I hoped that my predictable, sturdy presence could contain her feelings while my unwavering cu-

riosity about their separate but linked experiences could increase her reflective capacity.

Subsequent sessions were marked by fluctuations in John's screeching and in the degree to which Rebecca was bothered by it. Then, when this issue seemed to resolve itself, the problem of night wakings emerged to take its place. What was most striking is that the ebb and flow of these problems (and the attendant representations of John) did not seem to persist in Rebecca's mind from session to session. When she had a good week, John was again "perfect" and no mention was made of the previous week's difficulty. When things were hard, she was not able to remember that John had so far transitioned flexibly through all the preceding challenges. Because she was not able to access an ongoing, realistic representation of John or of their strong relationship to help her through these tough times, I took on this role. I remembered and commented on the fluctuations in their moods, behaviors, and responses to each other week to week. Although my remembering was, in the moment, often met with apparent disinterest, my hope was that it also demonstrated my deep interest in holding all of both Rebecca and John in mind.

I wondered how John's representations of Rebecca were influenced by her strong reaction to his "screeching" and other bothersome behaviors. (Impressively, she has contained her reaction to angry or hurt facial expressions and to turning away from him—a real achievement from a mother who was physically and verbally abused herself.) At 7 months he was a content and flexible baby, with a strong capacity for focused attention. He was openly curious about strangers and seemed confident in the response he would elicit with his alert expression and wide smiles.

This "good nature" was evident even in sessions when Rebecca was experiencing distress; though she was miserable and angry, holding him turned away from her face, he seemed calm and grinned happily at me. During more upbeat sessions, John demonstrated a remarkable ability to accommodate to his mother. On several occasions she played a

looming, intense tickle game with him. He encouraged her with bright excited smiles, sobered and *subtly* turned away when he was overstimulated, then smiled when she began the sequence again. His ability to self-regulate in these moments was almost too good. I was not sure if this was evidence of the sturdiness of his positive representation (dyadically formed) of self-in-relationship, or if it was an accommodation to Rebecca's needs? Perhaps it was both, and that his easy, alert, and social temperament, combined with her usually excellent care, made it possible for him to conform with minimal visible cost to his development or his attachment to her.

### MB: SUPERVISOR'S REFLECTIONS

As the individual clinical supervisor for these 2 therapies, I was fortunate in much the same way that Rebecca and Rose were fortunate. Both mothers had healthy, alert, resilient, and responsive infants. The sturdy adaptability of both infants rewarded their mothers richly and their clear behavioral cues helped their mothers feel successful in knowing their babies.

Quen and Lisa were equally rewarding and responsive as supervisees. Both started with an exquisite ability to attune. Rebecca and Rose were both somewhat "prickly" and defensive, wanting help but quite guarded and suspicious of potential helpers. Quen and Lisa were both able to find the right emotional distance and to convey interest and concern without being intrusive or controlling. Both were able to listen patiently to often pressured, incoherent, and unreasonable maternal discourse, and offer small, modest doses of "meaning-making" nicely titrated to the mother's tolerance. Both conveyed by their own calm, steady interest, and emotional availability that they valued the well-being of mother and baby and thought that working with them was worthwhile and meaningful. Both were relatively good at letting go of their own idealized visions of what a mother and baby should look and act like, and able to fo-

cus on identifying what was the best this particular mother and baby could do today.

Furthermore, after John and Lily were born, both Quen and Lisa were quite easily able to manage the complex feat of split (or joint) attention to mother and baby, as well as graciously manage any other family member who happened to appear. This is a particular challenge in infant-parent psychotherapy, and it is often quite difficult for therapists who come from a background of individual therapy.

Supervision focused on 2 domains. First, despite their sensitive observations of mother, baby, and mother-infant relationship, both Quen and Lisa needed help to see *themselves* as part of the picture. Second, supervision served as a forum for conceptualizing and putting into words the very complex and largely nonverbal interactive processes between mother, baby, and therapist. While both Lisa and Quen seemed, more often than not, to do or say just the right thing, they often did not know that they had done so, or why it had been such a good thing to do. In this respect, my supervision of them was very much like their approach with Rebecca and Rose, who likewise often were surprised to learn that their spontaneous responses to Lily and John were so admired.

Initially, Quen's mental model of being a therapist was a very active one. That is, she imagined that doing therapy was quite different from what she usually did as a public health nurse with her clients. She believed that therapy involved a fairly constant process on the therapist's part of making sense out of the difficulties mother and baby were having and providing illuminating insights, or suggestions, to resolve them. She tended to be somewhat critical of her perceived failure to live up to this model. It was my (MB) perception however that Quen had an extraordinary sensitivity to and ability to attune to this very fragile, volatile, and guarded young woman in a way that permitted the therapeutic alliance to develop surprisingly quickly and with unexpected intensity. What Quen lacked was not so much "techniques" as a vocabulary and a conceptual framework for what she

seemed already quite skilled at doing: containment, exquisitely precise observation and mirroring, and the ability to sensitively embody the qualities of reliability, unconditional acceptance, and sturdiness. Her supervision sessions initially focused on identifying and expanding her conscious use of these skills.

As her client's growing trust in and reliance upon Quen developed and grew, Quen began to use supervision to articulate the emotional burden she felt in being the only reliable, nonreactive source of support in her client's life. At the same time, she remained realistically concerned that the client's life was never far from spinning totally out of control. Our supervisory meetings, in consequence, at times included extensive discussions of countertransference: as a source of clinical data; as a cue for self-analysis; and finally, as a reminder to be vigilant in self-care and humble in framing therapeutic goals.

Despite her experience and expertise, Lisa initially found it difficult to feel like a "real therapist" in her work with Rebecca. Several factors contributed to this difficulty. Most prominently, Rebecca treated her for some time as a kind of generic audience. She made frequent remarks that gave the impression that she was not sharing anything with or expecting anything from Lisa that could not be supplied by almost anyone she talked to. She also invariably ignored or actively rejected comments that Lisa intended to convey empathy or support. A typical exchange would involve Lisa saying something sympathetic about difficulties the client had just been animatedly complaining about, followed by the client's dismissing or minimizing the difficulty as it had been mirrored by Lisa. As we tracked this together in supervision, we began to think that there was a direct correlation to how kind and empathic Lisa was being and how dismissive Rebecca was in response. It was as if Rebecca experienced Lisa's empathy as an impingement. As Lisa became more aware of this, she felt less rebuffed by the behavior and more able to use it as a signal about how frightened Rebecca was of feeling vulnerable to another person.

With experience and supervisory support, Lisa became more comfortable with feeling off-balance during home visits. This very common experience in these extremely complex and multichannel clinical situations was challenging for Lisa. This was because her breadth and depth of knowledge about the field left her painfully aware, after sessions, of the 12 billion things (for instance, John's affective cues, or Rebecca's comments about her husband, in a session that ultimately focused on the issues of John going into full-time day care) she had not responded to. My job as her supervisor was to help her see herself as part of a complex and dynamic system, having normal human limits on how much she could be consciously aware of at any given time.

Another persistent theme of our supervisory meetings was finding the right balance between going along with Rebecca's difficulties in including and representing the baby's experience in sessions versus taking the initiative in trying to bring his experience into the conversation. We observed together that Rebecca had relatively little tolerance for comments about either her own or John's emotional states but was more receptive and very interested when Lisa talked to her about what was going on in John's brain and nervous system and what Rebecca's role in this was. As the therapeutic relationship deepened and consolidated, Lisa became more confident and assertive in drawing Rebecca's attention to her avoidance and resistance to thinking about John's experience when it was not entirely consonant with her own. Rebecca continued to be somewhat dismissive of these interventions at times when she was feeling in control but was increasingly able to use and expand on them at times when she felt overwhelmed and frightened by her own aggressive feelings. Although Rebecca was uncomfortable reflecting at length about her relationship with Lisa, they moved to the level of talking about that discomfort—most notably in their discussion about this article. Rebecca freely gave Lisa permission to write about her, but then laughingly commented that she thought it would be better if she did not

read what Lisa wrote! While she “didn’t want to know” what Lisa thought of her, she was increasingly able to acknowledge Lisa’s importance to her.

### **QZ: TRAINEE’S REFLECTIONS**

Reviewing my notes on these early months of therapy with Rose left me feeling quite in awe of the intensity and complexity of the work we did together. What is now revealed as a beautiful progression in relationship development looked in the beginning like utter chaos and often felt rather impossible. I would leave the early sessions feeling that I had not done anything resembling therapy but carrying the huge burden of bearing witness to the unresolved traumas hurled my way. I would come to supervision feeling shaky and unclear about a session but leave feeling competent and able to continue. After a while I realized the client was using me in the same way I was using supervision. She too would save her feelings to unload on me yet did not expect me to fix it all but just to be present and understanding.

A shift in our relationship occurred in a session just a few weeks before she gave birth. In response to her intense fear of birth, we were working on a plan designed to support her through the hospital experience. We had agreed that I would go and talk to the hospital nurses and explain her concerns. She said, “Tell them I’m a sweet pea, I’m just scared.” It was an attachment moment for me. I felt the sweetness and vulnerability that she kept hidden behind her tough and angry exterior. At that moment I knew I would be able to endure.

There was much to endure. In addition to her pressured speech and incoherence she often became angry when I tried to respond. She would dump her raw, unprocessed feelings and experiences on me but then switch to a different topic while I struggled to follow her. She canceled visits but also tried to prolong the sessions. I was reminded of the

behaviors I had seen while watching videos of children coded disorganized in the Strange Situation procedure. Like them, she had no effective strategies for dealing with attachment relationships. Working with this idea in supervision I began to see that I was providing a therapeutic experience through my ability to be consistently dependable and sturdy. I found a growing fondness for this client and a sense of hopefulness that our work together would be meaningful for her.

I found it very exciting, challenging, and important to closely observe the infant during our sessions. Her behaviors supported the theory I learned in class and in my infant observation experience. I discovered that the baby was a mirror for her mother’s internal self, reflecting what her mother could not bring to coherence. She became an active participant and guide in the therapy. When she was avoidant or spit up, I realized that the tension she experienced was unbearable. When she was open to my gaze and vocalizing, I saw that she remained intact, even if stressed. When she could seek and maintain contact with her mother, I knew the dyad was safely attuned. When I felt uncertain, her behaviors confirmed my questions and supported my approach.

Our work together helped this young mother start to be able to observe and wonder about her feelings and her mental processes and patterns. In an incredibly short period of time, she moved from an overwhelming incoherence to just beginning to be able to explore her relationship with her own mother, both from her own and her mother’s vantage point. With the baby always acting as the catalyst she was able to fully utilize the containment and reflection I offered.

### **LM: TRAINEE’S REFLECTIONS**

The interdisciplinary nature of the field of infant mental health has been—and continues to be—tremendously appealing to me. It is also a source of intimidation, as it is easy

to believe that one ought to be an expert in normal infant and toddler development; infant and toddler psychopathology, regulatory and other disorders considered to be more purely genetic; normal and pathological adult psychology; attachment theory and research; family and child case management, as well as (for me at least) the several, sometimes conflicting, approaches offered by psychoanalysis!

The certificate program discussed in this article has provided me with excellent training in many of the areas I mentioned above. Most important however has been how the program, especially through clinical supervision, has provided me with a cohesive, more tightly focused framework for thinking about what I am doing when I am with a mother and baby. I can—and do—draw on what I know about infant development, attachment theory, and the rest, but it is at the service of providing emotional containment and increasing reflective capacity. Rebecca was rightly afraid of the part of her that was capable of impulsive aggression, and she was visibly relieved when I was able to speak calmly and directly to her fear that she could harm her infant. My constant attempts to understand Rebecca's internal world served to contain her frightening experience of unintegrated and unregulated violence and helped her arrive at a somewhat more integrated self-representation. Her ability to nurture John's growing sense of self by helping him integrate and regulate his affective experience was, for the most part, quite impressive.

As Marian noted, Rebecca was very prone to dismiss my words, or even my presence as an individual, early in our work. It was helpful to be reminded in supervision of basic attachment strategies; the notion that Rebecca was "avoidant" in her interactions only begins to capture the complexity of her experience, but it did provide an important window into her way of relating. Thus, I was very moved when Rebecca recently let me know that I am no longer a interchangeable placeholder when she wondered if our work together had

played a part in the creation of John's easy, flexible personality. When she remembered the terror and aggression she had felt during pregnancy, it frightened her to think of what might have happened if it had not been for "the program . . . someone from the program . . . you."

## **SUMMARY**

We have presented a multilayered slice of life in a new infant mental health training program and its clinical service. Our focus has been to show the many parallels and resonances between the emerging relationships and identities of all involved within the intervention process.

As the baby finds herself in her mother's eyes, it is the baby's responsive smile, gaze, or reach that shapes the mother's growing sense of herself as a mother. As the mother sees herself reflected in the observant, supportive, and accepting eyes of the infant-parent psychotherapist, it is the struggling young mother's increasing ability to open up, to share reflective exploration, and to share her emerging joy in her baby that forms the therapist's emerging sense of a coherent professional identity. As the initially uncertain therapist, swamped by observational and emotional data, finds a coherent sense of the therapeutic process in collaboration with the containing and teaching supervisor, the supervisor learns as well from each trainee new ways of offering support and guidance.

Each of these relationships contains and is contained by the others; in each a more mature and complex organism provides scaffolding and guidance for a less mature one; in each the less mature organism brings newness and a sense of fresh possibility to the more mature one. Within each pairing, and within the greater system that contains all the pairs, emerging identity is supported and enhanced by the expanded consciousness that is possible in the context of relationship (Tronick et al., 1998).

## REFERENCES

- Beebe, B., & Lachmann, F. (2002). *Infant research and adult treatment: Co-constructing interactions*. Hillsdale, NJ: Analytic Press.
- Bion, W. (1962). *Learning from experience*. London: Heinemann.
- Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect regulation, mentalization and the development of the self*. New York: Other Press.
- Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. *Journal of the American Academy of Child Psychiatry*, 14, 387-421.
- Greenspan, S. (1997). *The growth of the mind*. Reading, MA: Addison-Wesley.
- Grienenberger, J., & Slade, A. (2002). Maternal reflective function, mother-infant affective communication and infant attachment: implications for psychodynamic treatment with children and families. *Psychologist Psychoanalyst*, 22, 20-24.
- Lieberman, A., & Pawl, J. (2000). Infant-parent psychotherapy: Core concepts and current techniques. In C. Zeanah (Ed.), *The handbook of infant mental health* (2nd ed.). New York: Guilford.
- Olds, D. L., Eckenrode, J., Henderson, C. R., Kitzman, H., Powers, J., Cole, R., et al. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect. *JAMA*, 278(8), 637-643.
- Stern, D. (1995). *The motherhood constellation*. New York: Basic Books.
- Tronick, E. Z., Brushweiller-Stern, N., Harrison, A. M., Lyons-Ruth, K., Morgan, A. C., Nahum, J. P., et al. (1998). Dyadically expanded states of consciousness and the process of therapeutic change. *Infant Mental Health Journal*, 19, 290-299.

Current articles- [http://depts.washington.edu/isei/iyc/iyc\\_comments.html](http://depts.washington.edu/isei/iyc/iyc_comments.html)

Back to lists of previous articles: [http://depts.washington.edu/isei/iyc/iyc\\_previous.html](http://depts.washington.edu/isei/iyc/iyc_previous.html)