

30

Infant–Parent Psychotherapy: Core Concepts and Current Approaches



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A father names his son Lucifer and then boasts that his now severely disturbed 2-year-old “fits his title.” A mother is convinced that her 3-month-old infant is kicking her “on purpose” when she changes the child’s diaper. Absorbed in her thoughts, another mother consistently fails to notice the crying of her 1-month old. Home alone with his 8-month-old baby, a father believes that the child’s naptime presents the ideal opportunity to go jogging. A toddler’s mother refuses his entreaties to play for fear of “spoiling” him. In each of these situations we bear witness to an infant who holds no parental focus as an individual in his or her own right but, rather, becomes the unwitting participant in a deeply conflictual aspect of the parent’s experience that impedes an empathic awareness of the baby’s own developmental and emotional needs.

Certain themes predominate, although their psychological origins and behavioral manifestations are as varied and unique as the individuals who enact them.

In these examples, the “evil” infant, the “destructive” infant, the “invisible” infant, the “independent infant,” and the “insatiable” infant represent recurrent parental constructions of what Stern (1985) called the clinical infant.

Each of these constructions, expressed in the resulting set of caregiving behaviors, stands for an important but unconscious aspect of the parent’s sense of self and other that interferes with an emotionally satisfying relationship with the child and has a negative effect on the baby’s development.

Infant–parent psychotherapy aims at protecting infant–toddler mental health by aligning the parents’ perceptions and resulting caregiving behaviors more closely with the baby’s developmental and individual needs within the cultural, socioeconomic, and interpersonal context of the family. The therapeutic process may take a variety of forms, but the core component involves the therapist’s effort to understand how the parent’s current and past experiences are shaping perceptions, feelings, and behaviors toward the infant (Fraiberg, 1980). The baby’s contribution to the interactional difficulties, for example, through physical or temperamental characteristics that hold particular meaning for the parents, has become an increasingly recognized aspect of infant–parent psychotherapy as well. The intervention focuses on what transpires between the baby and the parent, regardless of its constitutional, psychological or historical origins. The “identified patient” is the

child-parent relationship, and the therapy painstakingly examines and addresses the transactions between the partners (Lieberman & Pawl, 1993; Pawl & Lieberman, 1997).

In many cases, only one of the parents experiences conscious conflict toward the baby and is motivated to seek change through therapeutic intervention. Other times, only one parent—usually the mother—is actually present in the child's life. In these situations, infant-parent psychotherapy focuses on the dyad, although the absent parent may be actively represented in the clinical work. When both parents are physically present and willing to participate, and/or when siblings are an intrinsic part of the clinical picture involving the baby, the dyadic format is expanded to include whatever family configuration is appropriate. In these circumstances, what distinguishes infant-parent psychotherapy from family therapy is that the clinical focus remains on the baby, with the goal of achieving improvement in the baby's emotional health by enhancing the emotional quality of the relationship network in which she is embedded.

It is important to point out that this clinical focus on the baby may not always be explicitly articulated to the parents. The infant-parent psychotherapist may judge that in some circumstances the best way of helping the baby is to first help those who take care of the baby. However, infant-parent psychotherapy always involves at least a tacit expression of the baby's relevance to the treatment. This is the case even when the clinical picture of the parents prevents the therapist from pursuing an ongoing articulated focus on the baby. In this sense, the final outcome of infant-parent psychotherapy is always evaluated in terms of improvement in the *baby's* social-emotional well-being as the result of treatment.

CORE CONCEPTS

Perhaps the most succinct and enduring description of infant-parent psychotherapy was made by its originator, Selma Fraiberg (1980), when she wrote that this form of treatment is used in situations in which the baby has become

the representative of figures within the parental past, or a representative of an aspect of the parental self that 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" who have invaded the nursery, and then we must make meaningful links between the past and the present through interpretations that lead to insight. At the same time . . . we maintain the focus on the baby through the provision of developmental information and discussion. We move back and forth, between present and past, parent and baby, but we always return to the baby. (p. 61)

This passage highlights the meaning of the baby as a transference object to the parents. The transferential component obscures the baby's selfhood for the parents, so that their perceptions of the baby's personality and behavior are colored and distorted by their own experiences. Because of such perceptions, the baby's presence during the therapeutic session is a central ingredient of infant-parent psychotherapy. Parental report cannot be a substitute for direct observation of the baby and of the parent-baby interaction. The therapist's observational skills allow her to identify themes, detect defensive distortions, capture emotional nuances, and monitor infant development in ways that would not be possible in the baby's absence. Moreover, the baby's real contributions allow for therapeutic intervention in the immediacy of the moment, while affect is being keenly experienced and can be addressed most directly.

Neurotic Conflict or Character Structure?

The baby's function as a transference object for the parents stems from a particular theoretical perspective: the classical psychoanalytical concept of neurotic conflict as the interplay between an id impulse seeking discharge and an ego defense warding off or diverting the impulse's direct discharge or access to consciousness (Greenson, 1967). The metaphor of "ghosts in the nursery" illustrates the psychoanalytical concept of the struggle between an impoverished ego and forbidden, unconscious impulses that find partial expression in parental anger and ambivalence toward the baby.

In its original formulations, infant-parent psychotherapy saw its goal as uncovering and making conscious the childhood sources of these unconscious impulses so that the baby would no longer serve as their representative.

However, since the inception of infant–parent psychotherapy in the mid-1970s, this theoretical core has evolved in response to three major influences: recent developments in psychoanalytical theory, the emergence of attachment theory as a clinically relevant conceptual frame, and research findings about the early affective, cognitive, and interpersonal capacities of infants (Lieberman, 1991, 1997, Lieberman & Zeanah, 1999; Pawl & St. John, 1998; Pawl & Lieberman, 1997; Seligman, 1994, 1999).

It is certainly still the case that enormous improvement in the parents' feelings toward the baby, in the infant–parent relationship and in the baby's well-being, can be accomplished when the parents are able to link their negative feelings toward the baby with their childhood experiences, gradually creating a tapestry of new meaning from initially fragmented and isolated early memories. At the same time, it is also true that retrieving the past is not necessarily or invariably the avenue to healing in the present. This is often the case, for example, when the parent does not rely on language as the primary form of self-expression, when he or she is not psychologically minded, when childhood trauma is of such magnitude that the parent's capacity for symbolization is substantially damaged, or when the parent's psychological functioning is too fragile or constricted to tolerate delving into painful early memories. In addition, some parents state forthrightly that they do not want to speak about their past. Working within these clinical constraints, it is helpful to remember that the present exists in its own right and not solely as a mirror of the past, and that childhood is not the only developmental stage when formative emotional experiences can take place. Speaking in depth about recent experiences can bring about transformative change. Moreover, in some situations the most effective interventions are not verbal but rather enacted through the therapist's empathic attitude and behavior (Lieberman & Pawl, 1993).

Infant–parent psychotherapy, as originally practiced in Ann Arbor and currently in San Francisco, is a socially minded psychological intervention. It does not require a prerequisite level of parental psychological sophistication, motivation, knowledge, or ability to pay. It does assume that all parents have the right to receive respectful, skillful, and culturally appropriate interventions to help them overcome the obstacles they face toward adequate parenting. Selma Fraiberg's training as both a social

worker and a psychoanalyst made her keenly aware of the important role of real life events and circumstances in molding psychological experience, and she appreciated the need for clinical flexibility and versatility in working with families that would not ordinarily choose to undergo psychotherapy. Infant–parent psychotherapists are trained to think carefully about therapeutic boundaries but not to be reflexively obedient to the traditional guidelines that define them. One example is the routine use of home visiting as the medium for intervention in situations in which families have difficulty with transportation, firsthand observation can provide an understanding of the conditions endured by the family and the baby, or the therapist's willingness to enter into the family's neighborhood and home can serve as an affirmation of the parent's dignity that strengthens the motivation to participate in treatment.

Mutative Factors

There is a long clinical tradition of searching for the discrete factors that promote enduring change in clinical treatment. Is it insight into the childhood origins of the patient's conflicts? Is it the novel ways of relating that are experienced in the course of a genuine, supportive relationship with an empathic therapist? Is it learning and rehearsing new ways of thinking and behaving in stressful situations? These questions apply to the mutative factors in infant–parent psychotherapy as well.

Initially, the parent's insight into the childhood conflicts that fueled the present ambivalence toward the baby was considered the pivotal factor in clinical improvement (Fraiberg, 1980). Current approaches to infant–parent psychotherapy give less primacy to conflict analysis and to clarifying links between the past and the present. Rather, similar importance as a mutative factor is attributed to the corrective attachment experiences provided by the therapeutic relationship, which becomes a vehicle for change in rigidly constricted or disorganized internal representations of the self in relation to attachment and other intimate relationships (Lieberman, 1991). Much importance is also attributed to the transformational power of learning and practicing reciprocal, mutually satisfying forms of interaction that give a positive emotional valence to the network of meanings being constructed between parent and

child (Pawl & St. John, 1998). As noted in the previous section, these developments in infant-parent psychotherapy have been spearheaded by advances in psychoanalysis, infant research, and attachment theory.

Recent Developments in Psychoanalysis

A review of this literature is beyond the scope of this chapter, but it is worthwhile to highlight Wallerstein's (1986) Psychotherapy Research Project, a seminal effort to explore the mutative effects of different therapeutic factors by comparing and contrasting the techniques of classical psychoanalysis (four to five sessions a week on the couch, with the analyst restricted to primarily interpretive interventions) with the techniques of expressive-supportive psychotherapy (involving less frequent, face-to-face sessions and a more active stance on the therapist's part). The interpretive, insight-oriented techniques were defined as those analyzing the defenses, including resistances and transference reactions, as an essential step toward the integration of id impulses and subsequent symptom reduction. In contrast, supportive techniques were described as ego supportive or ego building and included, but were not limited to, a reality-oriented position, the use of encouragement and praise, recognition of and respect for basic defenses, and occasional reeducation. All these interventions, together with allowing for a positive transference and the suspension of judgment with regard to the patient's inner life, are presumed to facilitate new emotional and relational experiences which, with repetition, can serve as the vehicle for profound and lasting change.

The Psychotherapy Research Project found greater than expected success for supportive psychotherapy approaches and lesser than expected success for psychoanalytical approaches. Furthermore, the theoretical distinctions between these two groups did not hold up in practice because psychoanalysis carried more supportive elements than originally appreciated. Moreover, changes in personality structure that occurred via insight-oriented, interpretive techniques were virtually indistinguishable from those structural changes that occurred via supportive techniques.

The timing of these findings coincided with Kohut's (1966; Kohut & Wolf, 1978) writings, which emphasized the importance of explicit responsiveness, emotional attunement, atten-

tion, and respect in the treatment of narcissistic disorders. Kohut suggested that narcissistic imbalances reflected deficits in the formation of the self brought about by failures in the caregiving environment. In this paradigm, incapacity to modulate rage resulted from the infant's repeated failures in his or her efforts to have needs met and was not an expression of constitutional drive endowment, as proposed in classical psychoanalysis.

In response to Kohut's theory and its implications for treatment, proponents of classical psychoanalysis argued that an empathic and supportive stance on the therapist's part might represent little more for the patient than an experience of idealized reparenting. In their view, such a stance would inevitably fail while fostering a problematic dependence on the therapist and on the therapeutic process. The theoretical debate that ensued was characterized by an unfortunate and inaccurate binarism: the cure by empathy as opposed to the cure by interpretation, with which many practitioners are still struggling today.

Infant-parent psychotherapy relies on both interpretive and supportive techniques. It has been influenced by relational theories, such as attachment theory, American intersubjective theory, British object relations theory, self psychology, and current trends in Freudian theory. A primary characteristic of relational theories is the notion of the human subject as an open system, "always in interaction with others, always responsive to the nature of the relationship with the other . . ." (Aron, 1990, p. 481). This idea, which has been both supported and elaborated by infant research, has implications for the nature of psychopathology, transference, and change—in short, all of what constitutes psychotherapy. Aron writes: "In the relational or two-person model, the analytic relationship and the transference are always contributed to by both participants in the interaction. One can no longer think of associations as solely emerging from within the patient; all associations are responsive to the analytic interaction . . . psychological events are never just a function of inner structures and forces, but are always derivative of interaction with others" (p. 481). This construction is eminently applicable to infant-parent psychotherapy. In fact, infant research has made a significant contribution to furthering the progress of intersubjective theory, as elucidated in the section below.

The Influence of Infancy Research

In the 1970s there was a major transformation in the theoretical orientation of infant research, which evolved from a unidirectional examination of the parent's influence on the child to a bidirectional model of reciprocal influences (see Lewis & Roseblum, 1974; Sameroff & Chandler, 1975). The cumulative effect of countless studies of the sensory, perceptual, cognitive, and interpersonal capacities of infants led to the emergence of a "theoretical baby" that is not a passive recipient of the parent's ministrations but rather communicative, participatory, oriented both to relationships and to reality, and able to make various distinctions and to express preferences from the first weeks of life (for comprehensive reviews, see Stern, 1985; Beebe, Lachmann, & Jaffe, 1997; Crockenberg & Leerkes, Chapter 4, this volume). Given this early capacity for mutuality and reciprocal relationships, the baby's behavior is best understood in the context of the dyad. In this paradigm, the organizing themes for infant behavior become interpersonal rather than individual—for example, arousal and affect regulation through transactional processes, matching and mismatching of affect through facial mirroring, sequences of disruption and repair in affective matches, and the centrality of interpersonal timing in all these processes (Beebe et al., 1997). This paradigmatic change has implications not only for infant–parent psychotherapy but for adult psychotherapy as well because the central themes of treatment, such as motivation, repetition, historical significance, fantasy, perceptual processes, regulation of affect, and information processing, are viewed through a relational lens. The form of treatment most compatible with this theoretical model gives equally close attention to infant and caregiver affect, thought, and action and to the intricate interactions between them in a relational context.

Contributions from Attachment Theory

The emphasis of attachment theory (Bowlby, 1969/1982) on the importance of real-life events in shaping internal experience, on the impact of maternal sensitivity in influencing quality of attachment, and on the use of behavior as an avenue for understanding and analyzing psychological processes were incorporated into the core of infant–parent psychotherapy, although this influence was not explicitly ac-

knowledged in Fraiberg's writings (Lieberman, 1991; Lieberman & Zeanah, 1999). In addition, the construct of internal working models of attachment is compatible with the practice of infant–parent psychotherapy because it complements the emphasis on behavior with an emphasis on symbolic representation as the vehicle for the intergenerational transmission of relationship patterns (Bowlby, 1969/1982; Main, Kaplan, & Cassidy, 1985; Main & Hesse, 1990). Changes in maladaptive internal representations of the self in relation to attachment are hypothesized to occur both in the parent and in the baby through the transformational power of the therapeutic relationship, insight-oriented interpretation, and the acquisition of new interactive and caregiving behavioral patterns (Lieberman, Weston, & Pawl, 1991). Such changes go beyond circumscribed processes of conflict resolution to posit changes at the level of the person's relationship to the self and to intimate others.

Infant–parent psychotherapy has not to date made formal use of infant or adult attachment categories in devising treatment strategies. This is because attachment categories are considered useful ways of organizing information for research purposes rather than road maps for treatment, which need to be constructed jointly by the participants and the therapist and specifically tailored to the unique characteristics of the infant and the parents. However, the behavioral patterns and representational themes discovered and described in attachment theory and research (Ainsworth, Blehar, Waters, & Wall, 1978a; Main & Solomon, 1990; Main & Hesse, 1990; Main & Goldwyn, in press) enrich the vocabulary and clinical repertoire of infant–parent psychotherapy.

"Theoretical Targets" and "Ports of Entry"

In his illuminating discussion of how different clinical approaches conceptualize what needs to be changed in what he calls "the parent–infant clinical system," Stern (1995) speaks of two aspects that characterize these approaches. The "theoretical aim or target" is the basic element of the parent–infant system that the therapist ultimately wants to change. The "port of entry" is the basic element of the system that is the immediate object of clinical attention—the avenue through which the therapist enters into the clinical system.

The theoretical target of infant-parent psychotherapy is the web of mutually constructed meanings in the infant-parent relationship (Pawl & St. John, 1998). The focus here is on mutuality. Does the baby have parental permission to participate in this construction of meaning? Are her signals and behaviors accepted with an effort to incorporate them into the ongoing flow of the interaction? Or is meaning arbitrarily imposed from the outside, as the parent mandates what happens and when without using the baby's signals as a guide? Or, alternatively, is the parent so afraid of imposing meaning on a supposedly hapless infant that every signal is anxiously responded to and every initiative allowed to unfold for fear that saying "no" will bring lasting harm to the child?

Mutually constructed meanings have many components. The list of ingredients includes the most concrete daily caregiving procedures as well as the baby's emerging understanding of what is happening and his incipient theories about why an event is taking place (i.e., infantile theories of causality and the role of the self in making things happen); the parents' sometimes rigidly entrenched general ideas of who babies are and what they need; the parents' specific representations of this particular baby and his or her place in the parents' life at this point in time; and the contribution of the family's cultural, social, and economic circumstances. These individual ingredients gradually come together to form an intricate, multifaceted, and multilayered intersubjective space that for parent and baby represents the reality of their being, both individually and in relation to each other.

The infant-parent psychotherapist surveys the meanings constructed by parent and child in search of the most parsimonious or timely port of entry. The presence, appropriateness, and modulation of affect or its absence when expected are time-tested guideposts in this search. The specific port of entry selected may vary from family to family or, within a family, from session to session or from one time frame to another within a session. Commonly used ports of entry are the *child's behavior*, the *parent-child interaction*, the *child's representations of the self and of the parent*, the *parent's representations of the self and of the baby*, and the *parent-therapist relationship*. In the second year of life, toddlers' greater mastery of language and locomotion generates a more differentiated sense of personal autonomy and assertiveness

vis-à-vis the parents, at the same time heightening concerns about separation, parental disapproval, and the danger of losing the parent's love (Mahler, Pine, & Bergman, 1975; Lieberman & Pawl, 1993). The resulting increased complexity of toddlers' inner life means that they become more active participants in giving shape and content to the web of meanings between themselves and their parents. Projective identification processes take place where parental attributions are internalized by the child and become an integral part of the child's sense of self (Lieberman, 1997; Silverman & Lieberman, 1999; Seligman, 1999). When the parental attributions are negative and critical, the child finds himself in a psychological quandary because he feels compelled to accept and comply with the negative parental image while at the same time experiencing anger and fear toward the parent and anxiety about the integrity of the self. The *intertwined parent-child representations* can become a useful port of entry for therapeutic intervention as well. Clinical vignettes illustrating each of these clinical possibilities are presented below.

Child's Behavior as Port of Entry

The baby's behavior is a powerful vehicle for therapeutic intervention, whether this behavior is developmentally expected or a particular expression of the baby's individuality. The meaning attributed by the parent to the baby's behavior may be quite different than the meaning the therapist finds in it. The construction of a meaning that takes benevolent account of the baby's experience then becomes a goal of the therapeutic endeavor, as in the situation described next.

When the therapist arrived, Jason, 2 months old, was lying on his back on the mother's bed, crying hard. His 17-year-old single mother picked him up and handed him over to the therapist, saying, "Here. You take him." Without taking him, the therapist came close to mother and child and said, "Hi, Jason. Are you having a hard morning?" The mother replied, "He has a hard everything. He hollers and hollers when he's hungry. Nursing babies get hungry every 2 hours." The therapist nodded in agreement and said sympathetically, "So that makes for a lot of hollering. Not all babies are so regular either. Does he cry every two hours?" The mother answered, "Sometimes more, sometimes less." Jason was calmer now and oriented to

his mother's voice. The therapist commented, "He knows your voice and he likes listening to you." The mother smiled and fixed the blanket so that it covered the baby's toes. She said, "They told me in the breastfeeding class that it would be every 2 hours. Anyway, that class was a waste. He doesn't like nursing, so I'm gonna stop and just give him a bottle. But I could nurse him. I used to drink, but I stopped 'cause they said it was bad for him." The therapist said, "You wanted to make sure he was healthy and strong." The mother nodded in agreement. The therapist asked, "What makes you think he doesn't like nursing?" The mother rolled her eyes as if to say it was obvious, and said, "'Cuz he turns away and cries harder and harder, gets all worked up and then when he finally drinks he gets so worn out that he falls asleep at the breast." Jason was crying again and flailing in his mother's arms. The mother lifted her shirt and said, "See, I try to feed him, but he turns away." Indeed, the baby was wiggling around, keeping his head oriented toward the breast but kicking his legs and twisting. The mother tightened her hold on Jason, holding him belly to belly as Jason struggled to turn away. The therapist asked how she had decided to hold him belly to belly, and the mother replied that she was taught to do that in her nursing class. The therapist said, "You know, Jason seems to have a different idea about how he'd like to be held. Maybe we could see what position might work for the two of you." The mother loosened her hold on the baby, and as the therapist watched and made encouraging noises, she followed Jason's lead until they found a rather unique position that the baby seemed to find comfortable, "over his shoulder," as the mother came to call it. From this position, Jason nursed absorbedly. The mother was surprised and excited by this discovery, which over time proved to be the position from which Jason nursed most successfully.

In this example, the baby's fretfulness over his inability to nurse became a guideline to look for a mutually comfortable nursing position that satisfied the baby and made the mother feel confident about her competence in feeding him. Most important, the baby's emotional expressions were the guide to this accommodation. He had been heard.

Parent-Child Interaction as Port of Entry

Because harsh, punitive, or otherwise developmentally inappropriate interactions are often

the trigger for a referral to an infant mental health program, miscommunications and angry exchanges between parent and child are common during the sessions and can provide a ripe opportunity for exploring the sources of conflict and for helping in the mutual construction of meaning, as in the example that follows.

Linda, 18 months old, was eagerly trying to get a sip of orange juice from her mother's glass. The mother lifted her glass high in the air so Linda couldn't reach it, and said harshly, "You have your own glass. Go drink from it yourself." Linda cried as she reached way up in the air. She then gave up and tried to take a piece of cheese from her mother's plate. The mother took the plate away and yelled, "Stop trying to take things away from me!" She looked at the therapist and said, in exasperation, "She just started this. She won't let me eat in peace. Everything I have, she wants." The therapist asked, "Is it only food, or other things as well?" The mother says, in an angry voice, "Everything! She almost tore off my ear trying to get my earring. I found her putting my best sunglasses on—lucky I caught her before she broke them. She is always trying to take what I have for herself." The therapist said, with much feeling in her voice, "You know, I think I recognize what you are describing. She just became a toddler and toddlers are trying really hard to be like their moms and dads. She wants to be you—like you, as close as she can. She thinks you are the greatest and she copies everything you do. It can be a real pain in the neck! Can you believe that you are so important that she wants to be just like you in every way she can?" The mother's mood changed abruptly. She looked serious and surprised. There was a silence where she seemed to be trying to come to grips with the therapist's explanation. The therapist used this time to talk to Linda, saying, "You want to be just like your mom, eat just like her, look just like her." Linda had plopped herself on the floor, chewing on a piece of cheese. The mother asked, "What am I supposed to do? I hate it when my things are messed with." The therapist said, "Well, of course you have a right to keep your things safe, and she needs to learn what is OK and what is not OK for you. I wonder if there are things that you don't mind so much sharing with her, because it will make her feel so good that she has a little piece of you." The mother turned to Linda and said, "Hey, kid, what about a grape?" as she handed her one. Mother and daughter ate a few grapes looking intently at each other.

In this exchange, the therapist's tactfully phrased developmental guidance may have begun a process that could prevent the emergence of a negative maternal attribution of greediness or selfishness to her child. The therapist chose this course of action in spite of knowing that there were direct links between the mother's past experiences and her present anger at her daughter. This mother had been embroiled in a bitter and losing battle with her older sister, who constantly took things from her and interfered with her activities. She remembered her own mother as indifferent to her plight and as always taking her sister's side by telling her that she needed to learn how to share. This knowledge influenced the therapist's careful phrasing, which emphasized the mother's right to her own things and to her own experience. However, the therapist chose not to make a direct link between past and present because she believed that such an interpretation would be experienced by the mother as a repetition of earlier situations, when her frustration as a child had been belittled by her mother. Instead, the therapist anchored her approach in this mother's unfulfilled childhood wish to be recognized as important and worthy of love and admiration, and appealed to her potential to empathize with similar longings in her little girl. The coaching of the therapist's intervention in a general description of toddler development was intended to normalize Linda's behavior by making her comparable to other children her age.

Child's Representations as Port of Entry

Children's internal representations can serve as a useful therapeutic tool. Paying attention to how they feel about themselves and how they interpret the behavior of those closest to them legitimizes their experience and serves as a basis for further exploration. It can also expand the parent's appreciation for what the child thinks and feels.

Mario, 3 years, 8 months old, was a child who witnessed a lot of domestic violence between his mother and father before his parents divorced. This included an incident when his mother threatened his father with a knife. In this session, Mario was playing with a kitchen set. He took a toy carving knife and excitedly said to the therapist, "This is like the knife in my dream." The mother commented that a few days earlier Mario had had a terrifying dream and could not be awakened—he

kept crying and screaming and holding on to his mother for a long time, until she finally had to lay down and sleep with him. The therapist asked Mario about his dream, and he said, with much emotion, "There was this mommy . . . no, this monster, who came up to me with a knife and cut out my heart!" The mother asked if she was in the dream, and Mario replied, "No, I wanted you to be there to help me, but you weren't." The mother turned to the therapist and said she felt guilty for making Mario feel so scared. The therapist encouraged her to speak directly to her son. The mother said to Mario, "Mario, listen to me. I know I threatened your daddy with a knife because I was very mad at him, but I am very sorry that I scared you so much and I will never do it again." Mario looked at her very seriously, came close to her, and said, "Sometimes you get very mad at me, Mommy." The mother looked helplessly at the therapist, who said, "Mario, I think you are trying to tell your mom that you are scared of what she can do to you when she gets mad." Suddenly understanding, the mother said, "Mario, I love you very much, and no matter how angry I get I will never, ever, do anything to hurt you like taking a knife at you." Mario relaxed visibly and turned to the doctor's kit. For the rest of the session he proceeded to put bandages on his mother, his baby brother, and the therapist. When his mother tried to broach the issue of the knife again, he said, "Mommy, we're done with the knife for today. Put it in the bag."

The aspect of Mario's complex representation of his mother that portrayed her as a dangerous murderer was heard and understood by his mother, who became appropriately distraught by her contribution to the child's experience. The mother's empathic response and promise to protect him from her anger were an important counterweight to Mario's fear, and enabled him to begin re-forming a more coherent representation of his mother in such a way that her protective and benign aspects began to outweigh her frightening side.

It is useful to point out that Mario's mother was not a woman who started treatment with any explicit interest in becoming more aware of her child's or her own psychological processes. When she started child-parent treatment 7 months before this session, she was an angry disciplinarian who relied on rigid standards of right and wrong to raise her child, and her stated desire for treatment was to "make Mario behave." Her ability to make use of treatment to

become more aware of psychological complexity illustrates the transformational potential of infant–parent psychotherapy when offered to parents who would not ordinarily seek conventional psychotherapy.

Parental Representations as Port of Entry

This is the best known avenue for therapeutic intervention in infant–parent psychotherapy because some of the most dramatic examples of distorted meanings in the parent–infant relationship involve parental representations of the child as willfully malevolent or as harboring adult-like motives (Fraiberg, 1980; Lieberman, 1997). In many cases, the parents' negative attributions are triggered by their subjective experience of the child's behavior, but the experience is so congruent, self-evident, and ego-syntonic and the negative attribution is so self-evident to the parent that a therapeutic effort to clarify the meaning of the behavior from the child's perspective is most often futile. Instead, the therapist tries to explore the associations to the parent's sense of being tricked, overlooked, disrespected, abused, or whatever affective experience the parent holds the child responsible for. This is sometimes done while simultaneously providing a context that suggests another meaning to the child's behavior, a meaning that is more consistent with the child's developmental stage. Pathological parental representations of a baby can occur even during pregnancy, as illustrated in the example that follows.

Eva and Sean, about 40 years old and expecting their first baby, had just found out that the baby was in a breach position and that a C-section might be necessary. Both parents were recovering drug users and had a long history of lawless and violent behavior which they were struggling to overcome. They were both quite shaken by the possibility of a C-section. Eva was trying hard to keep a positive attitude, but Sean was furious with the baby. "Who the hell does that little bastard think he is?" he bellowed, his face red with anger. "I'm gonna beat the hell out of him to teach him a lesson." Clearly embarrassed by this display, his wife tried to soothe him by assuring him that she would go for massages to turn the baby around. He calmed down a little. There was an uncomfortable silence. Looking for a way to introduce the baby's experience without sounding confrontational, the therapist said lightly, "If I were the

baby and saw how upset you were, I'd be scared stiff and wouldn't be able to turn around." Mother and father laughed. The therapist added, "Sean, I know how much you love Eva and how upset you are that she might get hurt. I think that the idea of her being cut and your not being able to protect her takes you back to the times when you were a violent man and could not control your anger." Sean said, with a muffled sob, "It took me so long to find her, and it is so hard to make a new life. I can't stand the idea of anything happening to her." The therapist pointed out that when that when people feel helpless they often try to figure out who is to blame and asked Sean whether perhaps he was blaming the baby as if the child were in breach position out of stubbornness, just to spite the parents. The remainder of the session involved Sean's recollection of his father's physical abuse, how it was often triggered by behaviors Sean had not intended to be naughty, and how Sean turned fear into aggression as a form of self protection.

Intertwined Parent–Child Representations as Port of Entry

Negative parental attributions are coercive in the sense that they are expressed through behaviors that impel the child to identify with the parent's perceptions and to internalize these attributions into the child's sense of self (Lieberman, 1997; Silverman & Lieberman, 1999). Such intertwined representations can be a starting point for therapeutic intervention, as in the example that follows.

Brian, 3 years old, sat on the floor near his mother as she listed her complaints about him. She said, in a harsh voice, "People don't want to be around him. He hit another kid in school today. He gets everyone mad at him, so they don't like him. He's just like his father, and I worry that he'll grow up to hit women just like his father hit me." Without looking up or acknowledging in any direct way that he heard what his mother was saying, Brian began twisting the heads and mangling the limbs on the human figures he was playing with. The therapist said, "You have a lot of complaints for someone as little as Brian." The mother continued, "He doesn't listen; he has tantrums if he doesn't get his way. I don't know what to do with him anymore." Brian stood up, walked across the room and yanked a toy from his 12-month old sister's hands. The mother yelled at him, saying, "Give it back to her! I will kill you before I let you terrorize my family!" Brian went back to the doll he had

been playing with and stomped on it repeatedly. The mother yelled at him not to break the therapist's toys. The therapist said, "The toys are not breakable. Brian, what is happening with the doll?" Brian answered, "It's a bad, bad baby and I'm gonna kill it." The mother looked at the therapist and said, "I just said that about Brian, didn't I?" The therapist answered, "That is what Brian heard and what I heard." Brian stopped stomping on the doll and looked at his mother, who began to cry and said, "I'm so mean to him, I get convinced that he's my enemy and I have to protect myself from him. In my mind I know that he's just a little boy and that this is crazy." This was the beginning of a long therapeutic process where the mother's attributions of badness and dangerousness to Brian and Brian's internalization and enactment of this attribution were examined and corrected again and again.

Parent-Therapist Relationship as a Port of Entry

Transference phenomena are as ubiquitous in infant-parent psychotherapy as in other forms of clinical intervention. The same emotional impediments that parents face in forming solid relationships with their children are also at work as impediments to the formation of a working alliance. This is even more apparent when the client belongs to a disadvantaged social group in which powerlessness and discrimination are rampant, creating a perceptual filter that makes it difficult for the parent to trust the therapist's competence and good intentions (Fraiberg, 1980; Seligman & Pawl, 1984). As a result, the parent's motivation to participate in infant-parent psychotherapy often needs to be patiently fostered. This process involves the therapist's ability to engage in a genuinely felt human connection with the parents, which often involves surmounting biases and preconceptions. The following vignette illustrates how the therapist's ability to repair an empathic break in nondefensive ways can provide the basis for a parallel process where the therapist's acknowledgement of his or her mistakes can soften the parent's angry stance toward the child.

The therapist arrived to meet with this 22-year-old mother and her daughter, Isabella. It was their seventh meeting, and the therapist was surprised to find that the mother, who had been resentful of the child protective services (CPS) referral to the

infant mental health program, was waiting eagerly to see her. The mother ran out to meet the therapist while holding the child in her arms. The therapist commented that it was nice to see them. The mother sighed heavily and said that it had been a hard day because a child protective services worker had come to see her. She was interrupted by Isabella, who jumped into the therapist's arms. As they walked into the house, Isabella chattered away with the therapist, who answered her playfully. The mother started speaking again, "CPS did a surprise visit today. My ex called them. . . ." Isabella took the therapist's hand smilingly and said, "Go." For the next 10 minutes, therapist and child played together while the mother looked at them from a distance. Suddenly, while Isabella was jumping on the bed, the mother yelled, "Stop jumping! This house is a mess! All I do is clean all day long, and it is never clean! Get off the bed right now, Isabella!" As the mother started cleaning up, she spoke harshly to the child, telling her to move out of the way. It took the therapist several moments of feeling confused and rejected to realize her series of errors. She gently said to the mother, "Jenny, you met me at the door and told me that this had been a hard day, and I'm afraid I made it even worse. I think you wanted to talk to me about the CPS visit and I ignored you. I only paid attention to Isabella. I treated Isabella like her feelings were really important and I treated you like your feelings weren't important at all." The mother continued cleaning while ignoring the therapist. After a few minutes she yelled, "Isabella, you better start cleaning up. We have to go and I don't want this house to be a mess when we come back." The therapist took the dust pan and said casually, "Is it okay if I help?" The mother nodded unenthusiastically. The therapist took the dustpan and held it on the floor for the mother to sweep into it. After a few minutes of silence, the therapist added, "I am afraid I made you hurt and angry, but it's hard for you to tell me. I mean, you know, I was insensitive from the start today, and I think it might be easier for you to get mad at Isabella than to get mad at me, especially on a day when a CPS worker dropped in unexpectedly." The mother nodded, then she said with some embarrassment, "Both Isabella and I were a little sick, and the house was such a mess." The therapist said, "It is a small place, just a few things lying around can make it feel that way." The mother shook her head and said, in a resigned voice, "No, it was a mess. I have been sick and tired lately and just don't feel like keeping up with things." Isabella pulled on her mother's leg and asked for

some juice. Her mother put down the broom and in a nice voice said, "I have to make some, Isabella, it will take a minute." The therapist followed mother and child into the kitchen and sat at the table while the mother made juice. "So," she asked, "why did CPS drop by today?" Jenny gave the child her juice, pulled Isabella on her lap, and explained that her ex-husband had reported a diaper rash on Isabella that did not exist. She added that the CPS worker had asked a few questions, checked Isabella, and left. The therapist said sympathetically, "It's very stressful even if nothing came of it." Jenny nodded vigorously and answered, "And it's not like I don't have enough to worry about already, like how I'm gonna get me and my kid out of this hellhole." Once her relationship to the mother was back on track, the therapist was able to move her attention back to a consideration of the stresses that interfered with this young mother's ability to be emotionally responsive to her child. The therapist's willingness to speak openly about her mistakes and to apologize for the distress she caused were a turning point in this mother's attitude toward herself, her child, and the therapeutic endeavor. The therapist was, in effect, showing the mother a new way to be, quite different from the critical and dismissive responses the mother had encountered from her parents.

These examples, taken together, illustrate the readiness of the infant-parent psychotherapist to make use of whatever promising entry he or she encounters to change the infant-parent relationship for the better, moving seamlessly (or trying to) between behavior and internal representation, between individual, dyadic, and family issues, and between the past and the present to construct a rich joint narrative between parent and child.

This variety of therapeutic approaches and modalities can be bewildering to a therapist used to working within a different clinical tradition. Therapists who were trained in an individual psychotherapy model can find it difficult to attend to the partners in a dyadic or triadic therapeutic format. Therapists who work with adults and rely on words as the carriers of meaning may not attend to the nonverbal signals of a baby or to the unspoken exchanges between parent and child. These difficulties can lead to serious therapeutic mistakes. Among the most common of these mistakes are the following: The therapist becomes so involved in the parental experience that he or she does not include the baby in the evolving understanding of

the situation; the therapist is too timid or unsure of his or her knowledge about babies and does not introduce the baby's experience into the therapeutic process; the therapist colludes with the parent in the maltreatment of the child; or, alternatively, the therapist is so identified with the infant that he or she cannot be empathically attuned to the parent's experience (Lieberman & Pawl, 1993). The ability to be evenly attuned to the individual needs of the partners while remaining keenly devoted to their interpersonal experience with each other is a hallmark of the seasoned and skillful infant-parent psychotherapist.

THE EFFECTIVENESS OF INFANT-PARENT PSYCHOTHERAPY: RESEARCH EVIDENCE

The conceptual compatibility of infant-parent psychotherapy with attachment theory (Lieberman, 1991) was used for measure selection. Difficulties in the infant-mother relationship was assessed using the Strange Situation procedure (Ainsworth, Blehar, Waters, & Wall, 1978b). Anxiously attached infants were randomly assigned to an intervention or a control group. Securely attached dyads comprised a second control group.

At outcome, the intervention group performed significantly better than anxious controls in measures of goal-corrected partnership, child avoidance, resistance and anger at mother, and maternal empathic responsiveness to the child. The intervention group did not differ from the securely attached comparison group at outcome.

Within the intervention group, mothers who formed a strong positive relationship with the intervenor tended to be more empathic to their infants and to have less avoidant babies at outcome. However, the mother's ability to use infant-parent psychotherapy to explore her feelings about herself and her child had the most positive outcomes. This measure was significantly correlated in the expected directions with maternal empathy, child anger and avoidance, security of attachment, and goal-corrected partnership in the negotiation of conflict. These findings indicate that the human quality of the therapeutic relationship has significant repercussions on both mother and child behavior, but that the most powerful results emerged

from the mother's capacity to make use of the therapeutic relationship as a "secure base" to increase her self-knowledge and understanding of her child.

Many of the parameters of infant-parent psychotherapy are currently being applied with preschoolers who witnessed severe domestic violence (Lieberman, Van Horn, Grandison, & Pekarsky, 1997; Lieberman & Van Horn, 1998). The basic format of intervention in the child-parent relationship is being employed in family situations in which the abuser (most commonly the child's father) has left the home, and in which the child and the mother are reenacting with each other the patterns of abuse and victimization that previously were played out between the adult partners. Outcome evaluation does not yet incorporate a randomized control design, but preliminary analyses of maternal and child behavior before and after intervention using standardized measures show significant statistical differences pointing to improvement in quality of the child-mother interaction as well as in child cognitive performance, decreases in child behavioral problems, and decreases in and maternal posttraumatic stress disorder symptomatology. Although preliminary, these findings echo the more systematic research findings that intervening in the child-parent relationship can lead to beneficial individual effects in both partners.

CONCLUSION

Infant-parent psychotherapy is a multimodal method of intervention that uses joint work with parents, infants, toddlers, and, more recently, preschoolers with the ultimate goal of improving the parent-child relationship and the children's socioemotional functioning. The therapist strives to create a therapeutic relationship characterized by flexibility and receptiveness to the parents' and the child's needs. This therapeutic relationship is a basic catalyst for change, and it becomes the vehicle for utilizing a combination of intervention modalities that include insight-oriented psychotherapy, unstructured developmental guidance, emotional support, and concrete assistance as well as crisis intervention when needed. The underlying assumption is that the corrective experience of the therapeutic relationship (a "corrective attachment relationship"), generated through the therapist's supportive and empathic stance, co-

alesces with the new knowledge, self-understanding, and behaviors fostered and practiced through the different therapeutic modalities. It is these processes, created jointly by parent, child, and therapist, that can lead to enduring changes in the parent's and child's experiences of each other, the meanings they construct together, and their sense of themselves both individually and in relation to each other.

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Parent-Infant Psychotherapy: Using Groups to Strengthen Parent-Infant Relationships: A Training Workshop. Parent-Infant Relational Assessment Tool - PIRAT Global Scales Training. Reflective Functioning Training on the Parent Development Interview.Â The depth of the presentations and case examples was very helpful in understanding the core concepts and techniques in Parent Infant Psychotherapy. All the therapists were very generous in showing their own work, highlighting the individuality of each therapist's style. Participant, February 2017.