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## CHALLENGES WORKING WITH INFANTS AND THEIR FAMILIES: SYMPTOMS AND MEANINGS—TWO APPROACHES OF INFANT–PARENT PSYCHOTHERAPY

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**ABSTRACT:** In this article, the authors describe the rationale for the way they work with troubled infant–parent relationships. They focus on two approaches developed at the Hincks-Dellcrest Children's Mental Health Centre (Toronto, Canada), a publically funded agency where they work and teach. One approach is Watch, Wait and Wonder, and the other is Infant–Parent Psychotherapy. The authors share a common philosophy that directs the way they think about the way they work. Two clinical case studies are presented to illustrate the treatment process of each approach. The presenting symptoms in both cases are similar (sleep difficulties), but the meaning, ages, and family compositions are different. The interventions unlocked the difficulties that each relationship was experiencing in a brief period of time.

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Playing and cultural experience can be given location if one uses the concept of the potential space between the mother and the baby. . . .

(Winnicott, 1971, p. 53)

We understand potential space (Winnicott, 1971, p. 53) to be the intersubjective play space created between a mother and her infant, where creativity, thought, and imagination converge. Using Winnicott's (1971) compelling idea of "potential space" as background, we describe how we use observation, play, and reflection of play as well as the relational systems in the process of data gathering in the assessment and the treatment of infants and their families. We also describe how the clinician uses the concept of reflective potential space created between the mother, father, and infant and clinician in the presence of an observing clinical team to understand the problem and formulate the intervention strategy.<sup>1</sup>

We will focus on two approaches to deal with troubled parent–infant relationships. Both approaches—Watch, Wait and Wonder (WWW), an infant-led, infant–parent intervention, and

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<sup>1</sup>Hincks-Dellcrest Children's Mental Health Centre is a publically funded center offering services to clients and training to mental health professionals. We use a Work Discussion Seminar of observed clinical work through a two-way mirror, and the reflective observing team concept.

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Infant–Parent Psychotherapy (IPP), an infant–parent relationship-led intervention—were developed at the Hincks–Dellcrest Children’s Mental Health Centre in Toronto. Both approaches focus on the centrality of the relationship, consider reflective observation of the relational matrix, and emphasize the importance of play.

Recent infant observational and attachment research has emphasized the importance of the earliest infant–caregiver relationship for the development of optimal human functioning. The infant’s development must always be considered within the context and quality of the caregiving relationship and caregiving environment (Emde, 1987, 1991; Fraiberg, 1980; Stern, 1985, 1995, 2008).

The theoretical orientation of our work uses psychodynamic principles. We attempt to understand each infant, mother, and father in terms of the intersubjective interplay between each adult’s past enacted in the present, and each adult’s wishes, hopes, and desires for a new beginning.

We use concepts from attachment theory (Bowlby, 1979a, 1979b; Crittenden, 2006), looking at patterns of a specific relationship, patterns of information processing, and self-protective strategies. We are working with the concepts of conflictual internal representations (George, Kaplan, & Main, 1996; Sandler & Rosenblatt, 1962; Stern, 1985). We use the concepts of unconscious mental life (Freud, 1914, 1929), containment and/or failure of containment (Bion, 1962), observation and the use of play (Tuterts & Doulis, 2000), and working with the present moment (Stern, 2004). We also use the concepts of transference, meaning unresolved past relationships in the present, and countertransference, meaning to use the therapist’s feelings activated in relation to the client to inform oneself of the direction to take with the client. We understand transference and countertransference to exist within an inseparable, intersubjective matrix (Ogden, 1994), as does the potential space (Winnicott, 1971); work with disruption and repair; and the development of a reflective capacity in each parent, infant, and clinician (Fonagy, Gergely, Jurist, & Target, 2002).

We deal with essentials of intersubjectivity between the infant, mother and father, and clinician, and the clinician and the observing team. The observational stance is always one from within rather than from outside the intersubjective field, which guarantees the centrality of introspection and empathy as a method of observation. The clinician is always affected by the observed and is affecting the field of observation. We focus on the play of the infant with the others within the potential play space. We base our concept of observations on the model developed by Ester Bick. Infant Observation as a model of training is an emotional learning experience where trainees experience the impact on themselves of observing a developing infant through understanding the feelings aroused in themselves (Bick, 1964; Sternberg, 2005; Tuterts, 1988).

Each infant–parent relationship problem is assessed and formulated. To formulate the problem, the clinician must first unravel the family story, using either an unstructured approach or a more structured interview, taking a developmental history, and/or using the Adult Attachment Interview (George et al., 1996). The clinician holds the infant and parents in mind by carefully listening to every detail and affect displayed (Hirshberg, 1996). The intervention which will best address the problem is offered for a contract of 18 to 20 once-weekly sessions, each approximately 60 min in length and followed by a review. The therapeutic process is understood in terms of creating a formulation, working through the emotional problems, and planning toward a helpful termination. In the consulting room, we use a blue plastic mat to designate the play space, and toys that allow for both representational play and mastery of skills are provided

according to the developmental level (Cohen, Lojkasek, Muir, Muir, & Parker, 2002; Cohen et al., 1999).

### ONE APPROACH: WWW

WWW, an empirically based treatment, is an infant-led infant–parent intervention (Cohen et al., 2002; Cohen et al., 1999; Muir, 1992; Muir, Lojkasek, & Cohen, 1999a). This approach uses the infant’s attachment and developmental strivings.

The main idea of WWW is for the parent and infant to be in a position where together they can have an emotional experience. The parent is instructed not to intervene but to follow the infant’s lead. The parent feels held in mind by the clinician and safe to rely on his or her own feelings and not to rely on the clinician for advice or insight. The WWW intervention also puts the infant in the position where the infant can use play and activity to master difficulties in relation to the parent, and the infant may play out developmental struggles using toys. The clinician’s role is to engage in the parallel process of watching, waiting, and wondering about the interactions between the infant and the parent. The clinician provides a safe holding and containing environment in which the parent may explore feelings and memories stirred up by the experience of the infant’s spontaneous and undirected activity. The primary therapeutic action takes place in the play space (potential space) between the infant and the parent. The infant is the initiator. The material of the session is the infant’s activity and the parent’s and clinician’s reflections together.

#### *Session Structure: WWW*

*Part 1: Play and Observation of Play.* The first half of the session (10 to 30 min, depending on the development of the infant) is the infant-led activity, where the parent is asked to get down on the floor with the infant and follow the infant’s lead, and to observe the activities that the infant introduces. The parent is asked to interact only when the infant indicates to the parent to interact.

*Part 2: Discussion.* The structure of the second half of the session (30 min) leads to discussion. The discussion focuses on what the parent brings, not what the clinician may feel is important; hence, the clinician follows the parent’s lead, a parallel process. During this half of the session, the parent is asked to recall what he or she observed about the infant’s play or activity, and to talk about the experience during the session; that is, what the parent understood about the infant’s experience and how the parent experienced the session. The discussion provides an opportunity for working through difficulties that the parent has in following the infant’s lead. Some parents make links between the present experience and the past. The emphasis is on making it possible for the parent to follow the infant’s lead. Gaining insight may occur, but is not necessary for change to occur.

### CASE STUDY: MARIA (17 MONTHS) AND MOTHER

#### *WWW: First Contact*

Maria’s mother first contacted our Centre due to concerns regarding Maria’s sleep when Maria was 17 months old. She was protesting being put in her crib at night and would cry and scream

for her mother. Maria also was waking in the middle of the night and crying. Her mother stated that she could not bear to hear Maria cry and so would pick her up. Neither Maria nor her mother was getting much sleep.

My first contact with this mother–toddler dyad was several weeks later when I met with mother alone. Maria’s sleep issues had been ongoing. During her first year of life, Maria would go to sleep easily enough, but would wake up every 2 to 3 hr; recently, mother had read an article in a national Canadian parenting magazine about how to treat babies’ sleep problems. She was intrigued and hopeful.

Mother is a single, working mother. She and Maria’s father had separated shortly after Maria’s birth. Maria is her only child: “Maria is my first and last one.” Mother stated that Maria’s father has had mental health problems for years, although she was not aware of the severity of those problems until after they married. Maria’s father has been given many labels over the years from psychiatrists. At the time of the current treatment period, father lived out of the city and had no contact with Maria and her mother. Mother was afraid of her ex-husband.

Mother’s initial descriptions of Maria seemed to reflect both positive representations of her daughter as well as more negative ones. For example, she described Maria as a “good baby” who was sweet and intelligent. She felt Maria was exceptionally shy, and this concerned her. When I asked if anyone else in the family might be shy, she stated, “She is shy, like me.” During this period of assessment, mother spontaneously commented: “I just love Maria so much,” and “She’s her own person.” Mother also described Maria as a “really stubborn” child and said that she gets this from her father. “Maria wants to get her own way no matter what—like her father did.” Mother wondered why Maria did not seem to show much affection toward her; however, she felt that they had a good relationship and that Maria “trusts me.” Mother added that she did not know how to discipline a toddler and wanted help with that. Mother expressed interest and curiosity about the process of therapy, and was eager to understand the process and to get started. Mother struck me as an intelligent, attractive woman who appeared ready to begin the work.

### *Assessment Phase*

When I contacted mother to begin work, she announced that the sleeping problems had resolved. She had begun to let Maria cry a bit at night before immediately responding to her as she thought I had suggested, but in fact, I had not done so. To her surprise, Maria cried for about 5 to 10 min before going to sleep, and within a few nights, Maria was falling asleep without protest. Mother said that she was missing Maria at night, but knew it was important for Maria to learn to sleep on her own. She was, however, still very interested in therapy. I wondered if I had begun to become important to this mother in some way. Mother seemed to want to undertake the therapy to understand something about herself through the symptom her child presented. We began to meet for several sessions to gain an understanding of the family.

Mother grew up outside of Canada with both her parents and several siblings. The family was poor, but her father was an educated man who traveled a lot. As mother spoke about her father, she softened, and there was warmth in her tone. It struck me that it seemed important for her that I appreciate the fact that her father was an educated man who valued education and his daughter. She described her childhood as “very lonely.” Mother felt isolated throughout her university years. She immigrated to Canada with a university degree and worked in menial jobs while learning English. She described her mother as “extremely strict;” she disciplined them harshly, and they were often hit. Mother thought of her mother as “there but not there.” As a

young woman, she resented her mother for not caring more about her. It seemed that she was struggling to come to an understanding of her relationship with her mother, and it saddened her that they had not been close. She described her father as also “strict, but nurturing too.” She could talk to him and felt he responded to her in a caring and empathic way. As a result, her father was the one to whom she would go when she was upset and needed to talk. Her father died when she was in her 20s. “My dad is my hero.” She added that it was her father who made her who she is today, and he remains her major influence.

I know little about Maria’s father, and what information I do have was provided by Maria’s mother. The couple met online and married within a few months. Mother said it was mistake, and in hindsight, she could see that “he was what I needed him to be.” Mother said arguments began right away—he was “controlling, verbally abusive and ‘crazy.’” As I listened, I was struck by what felt like a mismatch between mother’s presentation as an intelligent, educated, and attractive woman and her error in judgment in her personal relationship.

Mother separated from Maria’s father for the first time when she was pregnant. This separation lasted several weeks, and mother returned to her husband to try and give the marriage another chance. Mother explained how important she felt it was that Maria have her father in her life—she knew how important her own father had been for her. Maria’s birth was uneventful. She was breastfed, and her milestones unfolded normally. Maria is a healthy child who appears to be developing well. The couples’ reunion during the pregnancy lasted only months, and mother left father permanently when Maria was 3 weeks old due to his continuing controlling, destructive, and verbally abusive behavior.

### ***Formulation and Recommendations***

Maria’s mother had originally come to the Centre because of concerns regarding Maria’s sleep problems—by the time we were ready to begin service, the sleep problems seemed to have resolved. However, it became clear during our assessment that mother had deeper worries that she wished to explore in therapy and that these issues were having an impact on the developing relationship between mother and daughter. Mother clearly loved Maria very much and wanted to do the best for her daughter. Mother’s expressed concerns about Maria’s shyness and worries that Maria might have inherited her father’s mental health problems emerged as the predominant issues.

Maria’s “shyness” and “stubbornness” appeared extreme to mother and seemed to evoke anxieties in her that led mother to feeling helpless and uncertain about how to understand Maria’s personality and deal with her behavior. In particular, certain behaviors of Maria’s such as stubbornness and being “irrational” reminded mother of her ex-husband’s erratic, irrational behavior, and this frightened her. In addition, mother’s own attachment history of having a mother who was emotionally absent and harsh in her discipline seemed to lead to mother treating and disciplining Maria harshly at those times when mother became frightened and anxious. This upset mother, as this was not the kind of mother that she wished to be. Mother’s relationship with Maria’s father had led her to question her judgment and had undermined her self-confidence.

Maria herself seemed to be developing well, and yet her play did seem self-conscious and inhibited. Her shyness might be seen as temperament, but more likely her shyness, inhibition, and lack of showing of affection toward her mother was related to a fear of expressing strong emotions given the anger and anxiety she felt from her mother when she did so. Weekly sessions of the dyadic parent–child psychotherapy WWW were recommended and accepted by mother.

### *Intervention (12 Sessions)*

*Patterns of the Relationship: Self-Protective Strategies.* As always, I begin each session by giving instructions to the parent. I ask mother to get down on the floor and play with Maria. Mother is told to follow Maria's lead, letting Maria take the initiative. I suggest to mother that it is important to respond to Maria when she initiates an interaction, but I also encourage her to be guided by her understanding of what her child is wanting. I remind mother that this part can be quite difficult because adults usually have their own ideas about what should happen. Mother is told that if she is unsure of what to do, to remember the words *watch*, *wait*, and *wonder*; to *watch* Maria, *wait* before she (mother) responds, and *wonder* about what Maria might be wanting from her. I suggest that it is important mother try not to instruct, inhibit, or show displeasure with her child's activity. I explain that I will sit to the side and share in the experience, but will not intrude or interact so as not to take away from the special time they have together (Muir, Lojkasek, & Cohen, 1999b).

*Play (~20 min).* Maria, now 21 months old, is silent and looks self-conscious. She shoots me glances as I sit back, and she immediately takes her mother's hand. She brings her mother to the nearest corner of the play mat and tugs on her hand to indicate that mother should sit down. Mother also looks a bit self-conscious, but she smiles and complies. Maria sits down on her mother's lap and methodically explores each toy in the container. She is aware of me, often looks at me, and begins to smile, but then almost immediately inhibits her smile and looks away. When Maria is finished examining the toys on that corner of the play mat, she gets up, takes her mother's hand, and tugs her to another corner where there are different toys. She again tugs until her mother sits down. Maria sits close beside her mother and picks up the toys one by one. She appears interested in the toys and often makes eye contact with her mother as if asking for mother to name them, which mother does. This sequence is repeated over and over for 20 min. As I observe the play, I try to place myself in the mental frame of watching, waiting, and wondering. I try to wonder: What am I feeling as I observe? What am I thinking as I observe? What is my experience? This parallel process is similar to what I am asking mother and Maria to engage in. Various thoughts and feelings run through me. Maria seems to be clinging to her mother and allowing virtually no space between them. Is Maria feeling unsafe in this situation so she ensures she remains close to her mother, her safe base? Is Maria frightened or wary of me? I am struck by how she seems to want to smile at me, but then stops and inhibits herself. I think I need to convey with my gaze a sense of reassurance and encouragement to play and relax. I am also struck by Maria's seeming to negotiate both her attachment needs by staying close to her mother and her need to explore the toys. I observe mother. She seems to be alert to her daughter's signals and seems to easily follow Maria's lead. I feel mother is motivated by love, and her manner seems warm and available, certainly physically. I wonder about her emotional availability. As I observe, I feel that there is something missing between the two of them.

*Discussion (~30 min).* I try to place my thoughts and feelings to the side to explore with mother her thoughts, feelings, and experience. I begin by asking, "What did you observe?" Mother replies "She's kind of dominant." I ask her to tell me more about what she means. Mother reflects that Maria took her hand and led her to where she wanted her to go and where she wanted her to sit. She says that Maria does this at home as well. She said sometimes Maria plays with blocks on the floor and indicates that she wants her mother to stay with her while she plays.

We continue to explore these ideas for a majority of the discussion time. As the discussion is coming to a close, mother tells me that one of her main worries is that the stress in her pregnancy caused Maria to be shy. I comment that Maria did certainly seem to want to keep her close today. Mother says she realizes this; there are many days when Maria wants her to be very close. She thinks about this for a moment, and then says she thinks it is when Maria is tired that she wants to be picked up. As she is saying this, Maria is trying to crawl onto her mother's lap, and mother picks her up. I ask mother how that feels to her. Mother smiles and says warmly that she likes it. "It feels that she looks at me as her support, her protection. And I like that feeling; I want her to see me that way." She goes on to say that she associates shyness with insecurity, and she worries Maria's shyness means that she is insecure. We agree to think more about this together in upcoming sessions.

### ***Confusion in the Intersubjective Space***

The next four subsequent play portions of the sessions were very similar. As stated, Maria continued to be quiet and inhibited, and her mother began to express rather diffuse concerns that Maria was "not normal." She gave me an example: On Maria's first birthday, Maria did not want to play with any of the guests, did not want to share her toys, and just sat there and did not blow out her candles when her cake was served. I realize I too have become worried that Maria may, in fact, be behind in her development or may be depressed, something I had considered during the assessment period, but then reconsidered it as a relational problem. Now, Mother has turned to me as an "expert," and Maria seems to look to me to help her relate meaningfully to her mother. I am aware I begin to question my professional judgment. Have I missed something? I enact my confusion by suggesting to mother that we interrupt the therapy sessions, something I rarely do, and take one of our sessions to complete a developmental screening on Maria. As we are completing the screening, I realize that Maria is developmentally on track, and it is my confusion that needs clarification. Several weeks after this, mother tells me Maria's daycare teacher has completed routine developmental screens on all the children, and their results show Maria is developmentally on track.

### ***Beginning to Explore Themes of Anger/Aggression/Assertiveness***

*Maria, Age 2 Years 1 Month.*

*Play (~25 min).* Maria kneels beside the bucket of Lego toys; the bucket is between her and her mother. Maria chooses a Lego truck, a doll figure, and then a helicopter. She is silent and seems engrossed. Mother is sitting cross-legged; she appears relaxed and is leaning slightly forward watching Maria. Maria tries to place the doll figure in the truck. She tries calmly several times, but then goes to her mother arms outstretched with the truck and doll figure. She vocalizes softly, asking Mom to help. Her mother takes the toys and looks at Maria as she places the doll figure in the car as if to say "Like this?" Maria nods, looks solemn, and takes it back from her. Maria stands or kneels in front of her mother as the session continues. She chooses other vehicles from the basket and tries to place doll figures in them. She is vocal and exclaims "uh oh" when she drops a piece. She and her mother have a conversation in their language; it seems to be about Maria wanting her mother to place the doll figure in the car a certain way. They make eye contact, and mother's expression again seems to be saying "Is this how you want it?"

Maria nods, this time with a smile, and then makes the car shoot across the floor. Mother smiles and seems amused and interested in what her daughter is doing. Maria sends the car across the floor several times. Maria then shifts from placing one doll figure in the vehicles to placing two and three in each car and truck with mother's help. As I observe the play, I wonder about my experience and theirs. I am struck by how Maria no longer seems self-conscious; she appears to ignore me for the most part once I sit back, and she moves confidently around the room, occasionally catching my eye and smiling openly. I reflect how she now walks into the Centre with confidence and waves to the receptionist. I wish I could understand what mother and child are saying. Maria seems to have no hesitation in going to mother for help. However, the help is quite instrumental, and I wonder if she feels as free to go to her mother if she needs emotional comfort and support, as mother felt she could do with her own father. The vehicles and placing the doll figures in the vehicles seems to absorb Maria, and I wonder if this holds some special meaning. The dolls are held, contained in the vehicles; is Maria feeling emotionally held through these sessions with mother and me?

*Discussion (~30 min).* Mother begins the discussion by telling me of an incident at home when Maria was angry with her and swatted at mother. Mother states she cannot tolerate Maria hitting her and says she reacted harshly by yelling at Maria and putting her in her crib and refusing to hug her when Maria reached out for a hug. We explore what it is about the hitting that mother cannot tolerate. "She can be aggressive and I don't want her to be like that," she says. I ask mother if the hitting raised any particular feelings of anything that happened to her in the past or of other relationships. She thinks, but cannot identify something or someone in particular. This leads me to remember last week's session in which mother reported an incident – Maria had deliberately dumped her milk on the floor in front of her mother. Mother confessed that she became extremely angry and yelled at Maria. I become painfully aware of the rejection that Maria must have experienced. I reflect on mother's possible parental identifications at that time; an identification with a harsh internal mother seems to be in the foreground. The empathic internal father seems to be in the background of her mind. Was I experiencing her split within herself? I ask her to tell me more about the nature of these angry feelings and reactions. Mother elaborated by saying that the feeling when Maria hit her was not the same feeling that she experienced when Maria had dumped her milk. She said she interpreted Maria's hitting her as "a normal reaction of a toddler." However, when Maria dumped her milk, she thought she linked that action to Maria's father's explosions of anger and rage. Did this deliberate dumping of milk represent to mother her ex-husband and her fear of his behavior and, thus, her fear of her daughter being "crazy" like her ex-husband? I also thought of mother's own harsh mother. I wondered aloud about this to mother and said, "Looking back, you can see that Maria dumping and throwing things was directly linked to what you remember of her father's behavior and that made you frightened and angry at the same time." "Yes," said mother, "and sometimes she gets upset and stubborn, really stubborn." Mother went on to say that although she could see now that she had reacted the same angry way to Maria, she now sees that the provocation was different for her. She added that she wants to stop responding with this angry reaction. Mother had begun to explore themes of anger and aggression in both herself and Maria. I wondered if both mother and Maria were feeling contained enough by me and the therapy to begin to explore these frightening and difficult feelings.



***Working Through While Playing in the Potential Space****Maria, Age 2 Years 3 Months.*

*Play (~30 min).* Maria has been playing with the baby dolls. She hands one to me and one to her mother. She then hands two toy baby bottles to her mother and immediately takes one back. She pauses, holds her mother's gaze for a moment, then goes to an armchair and taps the bottle lightly on the soft surface, looking at her mother expectantly. Mother smiles and seems amused. Mother smiles at me briefly and then returns her attention to Maria. I feel as if something important is happening, but I am not sure what it might be. Maria then goes to the child's wooden table and bangs twice on the hard surface, making a loud sound. Again, she pauses and looks at her mother as if waiting for a reaction. Maria's face is rather neutral. Mother again smiles and laughs softly, glancing at me as if to say "Are you seeing this too?" Maria repeats the bangs on the table and this time also looks at me in the same way. This feels quite assertive to me. Maria then shifts the play by going to the toys on the play mat. Maria kneels directly in front of her mother and tries to place a doll figure in the car. She tries once, then hands them to her mother, saying, "Mommy, in the car." Maria has her mother place several doll figures in the vehicles again and then lines them up. She then takes the rest of the doll figures and sits them down beside each other in a semicircle beside her mother. As she does this, she repeats in an assertive tone of voice to the figures, "Sit down, sit down."

*Discussion (~30 min).* I open the discussion with our usual questions: "How was the session for you today? What did you observe?" *To my surprise*, mother says "She's always testing me!" I ask mother to elaborate on what makes her say this by asking "In what way?" Mother then recounts the sequence of events at the beginning of the play. She remembers accurately that Maria had a baby bottle in her hand and went from the armchair to the table banging the bottle while looking at her. "She would look at me to see my reaction. And then she would try another place and another place and keep looking at me, and I think it was to see my reaction. That's what she does when she's upset," she adds. I move mother from recalling her observations now to exploring what Maria's experience might have been. "What do you imagine Maria might have been thinking?" I inquire. Mother responds immediately by saying that she believes Maria was teasing her and challenging her. I then ask mother how she felt as Maria did this. She responds by saying that it felt "fine" today, but that it usually worries mother because Maria is usually upset when she does that. I begin to think that mother is not upset in the here and now because she feels contained in the session. I wonder if this feeling of being held allows both her and Maria the freedom to be playful now in a way in which they could not before. I begin to consider that this might be the 'something' that was missing before when I thought about them together in the earlier sessions. This shift seems to have allowed them to begin to represent their angry and frightening feelings with each other in the presence of another in the potential play space.

Later in the discussion, we spontaneously begin to review the past sessions and the process of the therapy so far. Mother says she is beginning to understand that some of the behavior she used to think was "not normal" is, in fact, quite "normal" for a toddler. She adds that she is beginning to realize Maria's behavior is not a consequence of trauma or mental illness but that she is a "normal baby with normal behavior." Mother acknowledges that she probably will always have some worry Maria could develop a mental illness later on in her life, but it is much less of a concern for her now. I say it seems as if her perception of Maria has really changed.

“Yes” she affirms, “it has changed.” As mother is telling me this, Maria has built a tall tower using the graduated nesting cups. It is almost as tall as she is. She looks satisfied, but does not draw our attention to it and walks away seemingly content to explore another corner of the room. Mother says that being aware that she can create a good environment for her daughter and that she can be a good role model for her daughter by creating a nurturing and less stressful environment for her helps both of them. As she speaks, Maria comes back to us on the play mat and picks up a baby bottle. She places it on top of the tower and looks at us shyly with a small smile. I acknowledge this by saying, “Well done!” Maria smiles broadly, though still a bit shyly, and then runs and throws herself into her mother’s arms. Mother continues to tell me this new realization is “fantastic” because she now understands that she had been blaming Maria’s father for what she perceived as Maria’s negative and abnormal behavior, and not looking at her own emotional availability. She says now that she knows that she can take action and that she has responsibility for raising Maria. I think that mother is moving away from blaming her ex-husband and moving toward the realization that she is the most important person in developing the relationship between her and her daughter.

*Termination.* Mother, Maria, and I have two more sessions and then mother requests that we end. Mother is both enthusiastic and sad about ending, but she says she now knows that she can deal with things:

I didn’t know how to be with Maria before, how to deal with her temper tantrums, but now I can accept the reality that she can have bad days without being “ill.” It’s good because now I accept her more the way that she is instead of trying to change her because I am afraid she is going to be like her father.

Several months posttreatment, mother and Maria contacted me to share that their progress was stable.

### ***Second Approach: Infant–Parent Psychotherapy***

IPP is a relationship and infant-led therapy (Tutters & Doulis, 2002). The clinician directly approaches the infant in the presence of the parent and the parent in the presence of the infant. This approach seeks to understand how the parent’s past, activated in the present, contributes to the relational difficulties between the infant and the parent(s).

The main idea for the infant is to put the infant in the position where the infant can show the clinician and parent what the problem is now (Salomonson, 2007b). The infant’s lead is followed by the clinician. The infant uses play and nonverbal and vocal communication to relate to the clinician and to the parent. The goals are for the infant to feel contained and understood, to achieve self-regulation, which involves physical, psychic, and self states. The main idea for the parent is to put the parent in the position where the parent can tell the clinician about the infant and about him- or herself. The parent can feel listened to and understood by the clinician. The goals are for the parent to begin to realize the effect of unresolved past issues affecting the present relationship with the infant. The parent is able to feel the impact of understanding, matching, and sharing the infant’s affect, which positively affects the infant’s emotional well-being (Stern, 1984). The parent feels more confident in his or her importance to the infant’s developing sense of self. The main idea for the clinician is to put the clinician in the position where he or she demonstrates attunement to the infant for the parent and to the parent for the infant. The clinician

understands what the infant communicates through play and informs the parent. The clinician is actively empathic to both the infant and the parent, and the clinician marks the importance of the relationship. The clinician helps the parent to link unresolved issues from the past (Insight may occur, but not necessarily.) The clinician helps the parent to see the infant as a separate person and enables the parent to feel important and necessary to the infant's feeling states. The clinician is aware of the transference/countertransference constellation. *The clinician always keeps the infant–parent relationship as primary.*

The primary therapeutic action takes place in the play space (potential space) between the infant, parent, and clinician. The infant is the initiator. The material of the session is the infant's, parent's, and clinician's activity as well as the parent and clinician's reflections together. The session structure (~60 min) starts with whatever the relationship brings. Everyone sits together on the floor. The clinician follows the infant's lead in the presence of the parent. The clinician focuses on the relationship between the infant and parent (potential space). The clinician is sensitive to the timing, intensity, and pace of the parent. The clinician respects the protective strategies of both the parent and the infant and offers guidance, but explores the need from within the parent and clinician relationship.

### CASE STUDY: KAY (7 MONTHS) AND MOTHER

At the time of initial contact, the infant was a 7-month-old, firstborn baby girl to parents in their early 30s. Her parents reported that they were unable to put their infant to sleep. Mother experienced anxiety throughout the pregnancy, primarily about the well-being of her infant, and she feared her infant might die. Several other family members had been diagnosed with anxiety disorder and had been treated. In the hospital, the parents were stressed by the nurses' reactions to the infant's drop in weight. The hospital staff wanted the parents to supplement with a bottle, but they refused due to a history of food allergies in both their families.

Separation anxiety issues for the mother surfaced immediately following delivery. Suddenly, mother had trouble breathing; it was the first time she and her infant had been separated in 9 months. Mother also was afraid to put her infant down because of her fear of sudden infant death syndrome. Father was with her for the duration of the hospital stay; he was calm and settling. Upon returning home, mother stayed with her infant and did not leave the house for 6 months. Upon hearing this, I was beginning to feel uneasy about the level of anxiety inside the mother.

For the first few days, the infant slept well. However, on the Day 5, an acute diaper rash appeared. Parents were instructed to wake their infant up every hour to bathe and treat her rash, as large, open sores had developed. They continued to do so for 9 weeks until the rash disappeared. I felt puzzled by the intrusive professional advice. Following this, the infant's sleeping difficulties surfaced. The rash frightened the mother, and she worried about what was best for her infant: to follow her own intuitions to let the infant sleep or the instructions of professionals to wake her and treat the rash. Both grandmothers told her that waking the infant up so often would affect her brain. Mother felt conflicted and confused. I thought that I had better take note and be careful about giving advice.

At first, Kay appeared tired, but stayed awake and fought sleep; she did not cry. Her parents tried everything to get their infant to sleep; rocking for hours worked best. Often, Kay slept in the parents' bed with mother's breast in her mouth. Mother was exhausted and exasperated. At 5½ months, they began a behavioral approach called "Ferberizing" (Ferber, 1985), to let the infant cry and not to pick her up, at the suggestion of their pediatrician.

Father took 1 month off work to relieve mother from putting the infant to sleep. The bedtime routine became a joint venture. They used the “family bed” concept in the infant’s room; they bathed her, read to her, and sang to her. By 7 months, they began to put her in her own crib and tried to leave the room. The infant woke up and screamed. Mother could not bear hearing these screams. I began to feel anxious, too. The parents were doing so much; I wondered what I could do to make a difference. I wondered what the problem was. Was it inside the infant, the mother, or something else? Would I ever know?

Mother was a professional woman on maternity leave. She had experienced job satisfaction; now, she was frustrated, tired, and sad about the struggles with her infant. She felt that their lives were controlled and that she was a failure. She lost confidence and had self-doubts. She blamed herself, especially since her own mother could put Kay to sleep by just telling her to sleep and patting her head. She felt totally inadequate. I wondered if I would be adequate to help her.

Kay, at 7 months, was healthy, petite, and attractive. She presented in a quiet, alert state, having eye contact with both me and her mother and showing intense listening and interest in me and in the toys in the room. I observed that she was using sight, hearing, touch, and movement to regulate herself. Interestingly, Kay did not show any separation anxiety in the consulting room. She used gesturing to communicate with her mother. She tried to stand on her own with help, liked to jump, and was a joy to her parents most of the time when not fighting sleep. She could play on her own with our toys. Mother told me her own mother had told her that she (Kay’s mother) had been an active child, too, who was “awful” because she refused to sleep.

Kay’s development appeared age-appropriate to precocious, except in the area of state regulation during the transition from wakefulness to sleep, when she became distressed and her ability to self-calm and relax was compromised. I wondered if Kay had to hold herself together as mother’s anxiety was disruptive to her state regulation.

### ***Psychodynamic Formulation***

Mother’s unresolved, past separation anxiety issues with her own mother affected her attitude and perception of herself as a reliable caregiver to be able to keep her infant alive, and these anxieties interfered with her establishing a confident mother–infant relationship. Mother’s anxieties over separation affected her sensitivity and responsiveness to her infant’s cues at times, thus affecting her infant’s ability to self-calm and relax into a sleep state.

In reaction, the infant seemed to be adopting a premature, precocious, independent stance, as she felt that she was not held in her mother’s mind and so she had to hold herself. This also could be an early expression of the development of defensive measures against her own infantile neediness in relation to her own mother.

### ***Intervention (18 Treatment Sessions)***

*The Problem: Exploration and Clarification.* In the initial session, I suggested that mother read Daws’ (1989) book *Through the Night* to introduce her to the way we work. This book helps the parent understand how their unresolved issues can affect the developing relationship with the infant. In the second session, we all sat on the floor while Kay played on her own; she used her sounds to connect with us. Mother told me it was a horrible week because Kay screamed and mother cried, and mother felt something must be wrong with Kay. Father came home from work to help, and mother just walked out. Kay cried for over 1½ hr. Her parents decided that they

had to change tactics. Instead of breast feeding for comfort, mother introduced a soother. She put Kay in her crib, and when she woke up, mother patted her instead of picking her up. Upon reflection after reading the book, mother thought maybe she had been picking Kay up too soon. They noticed that a slight change in transition from awake to sleep was beginning. By reading the book, mother was learning that there was more to the psychological/emotional realm than she realized. She just thought it was Kay's problem; now, she realized it also was her problem.

Mother began to share her thoughts, wondering how she was communicating her anxiety to Kay when she consciously wanted her to sleep. I explained how her worried state was communicated nonverbally to her infant through her anxiety, voice tone, and handling (Stern, 1985).

While mother related her narrative, Kay crawled away from her to explore. She came and sat close to me and looked back at her mother. I felt surprised that Kay sought a connection with me and gazed back at her mother. I was holding Kay in mind while observing her reactions. Mother seemed oblivious to Kay as she was so involved in her own storytelling and upset feeling.

*Breakthrough: Linking Past to Present.* Mother, father, and infant are present. As we discussed the ongoing sleep difficulties and the parents' supreme efforts to settle Kay, mother realized there was a great part of her need in this problem, along with her anxiety. Together, we explored their difficult beginnings. Mother was particularly distressed this day, as she had to leave the infant's room last night because she could not stand to hear her infant's violent cry. Mother worried she had done something to harm her infant. In the moment, she suddenly became aware that she did not want to separate from her infant after birth. She reflected on her own early beginnings, not being an easy child; she was shy, clingy, and also needed to be close to her mother. She was colicky, had temper tantrums, did not sleep, and was a "bad baby." When she was 2 years old, she still called out at night for her mother. Mother then looked at Kay and said she saw herself in her infant. She was teary-eyed. I was acutely aware of her affect as she spoke, and I thought she was experiencing an early memory. I was excited because she was reflecting about her own experiences and seeing how her experience impacted on her relationship with her infant. I inquired, then, if she had a memory of her mother not coming to her when she was in distress. "YES" she said, emphatically and dramatically, "they would lock me in my room ... I was angry and I threw my shoes at the door." As mother related this memory, she sobbed. "Yes, I think that's why I respond the way I do to Kay's crying; I can see myself in the bedroom and I was screaming ... I was terrified ... it was not as though my mother abused me or anything like that—she was a good mother." I thought mother's insight in this session set the process of change in motion.

*The Unconscious: Link to the Present/Working Through.* Mother, father, and infant are present. The mother felt "unburdened;" there was improvement. The revelation last week was dramatic. Mother said, "I don't understand why just remembering it made it go away. I am no longer anxious being away from Kay." After the last session, I had reflected on her recovered memory making it possible for her to connect her feeling state with her memory, and therefore I could explain the process: "Before, it was unconscious and unresolved, and here, in the present moment, you connected up your past feeling memory (terror) with your current feeling state (generalized anxiety), and you understood what was driving your anxiety—your need for your own mother in infancy activated your fears of separation and aloneness ... and, you are a different mother." Then, mother shared more about her catastrophic thinking and high expectations of herself; she

had to meet a deadline to return to work; she had to be supermom; and no one in a daycare would ever be able to comfort her infant. I understood her panic and wanted to settle her by saying something that would encourage her own self-regulation. I encouraged her to trust in herself—that she, together with her infant, would know what is best for them, rather than seeking advice outside herself and turning to the “experts.”

### ***Mother's Reflective Function***

Kay is 8 months old and sleeping through the night for 10 hr, but she wakes when mother is still tired and not ready to be with her infant. Mother was stressed over her own loss of sleep, her commitments, and trying to be “supermom.” She wanted to return to work when Kay was 12 months old, but she still had no daycare in place. Mother’s capacity for reflective functioning was developing as she understood her anxiety was from unresolved past issues which were affecting her present relationship with Kay. I was feeling pleased a parallel process had developed, that what I had thought about and shared with her had enabled her to do her own thinking about herself and her relationship with her infant.

In the sessions, Kay is bright and curious, and she played with the baby dolls with me, as mother and I continued to explore her feelings from inside herself. Kay initiated a play time with her mother. Mother touched Kay when she came close, but did not follow her lead in her play. I noted this and held it in mind of work yet to be addressed. Mother related a scene when Kay had shown jealousy and had been enraged when mother held a friend’s baby in her arms. Mother was now able to think about this as Kay’s regression to needing more of her mother to respond to her baby needs; I agreed with her. I felt pleased with her ability to do reflective thinking about her infant’s behavior.

### ***Importance of Relationship***

On the weekend, at a large family gathering, Kay was passed around among many guests. Kay did not react at the time, but her sleep progress was derailed, and she was irritable throughout the week. However, mother was able to think about Kay’s behavior as Kay’s delayed reaction to strangers and not feeling secure enough with her mother. Again, I agreed and supported mother to value her own thinking to enable her to feel important and necessary to her infant.

Kay’s sleep patterns improved. Mother lies with Kay in the mornings and breastfeeds, and is comfortable with this routine. Mother noted that a big change was occurring inside her. She felt more confident as a mother, and that was being conveyed to Kay through her interaction in their relationship.

### ***Regression***

Kay’s sleep had deteriorated during the week. Mother’s anxieties about returning to work had exacerbated her fears of not being able to separate from her infant; as well, her husband was less available to them due to his work pressures, and she was feeling the loss of his presence and support. I suggested the possibility that mother, unaware, might be forcing a separation from Kay and that Kay was reacting to her perceived fear of loss. I suggested the book *The Birth of a Mother* (Stern & Bruschweiler-Stern, 1998) to help her think more about the mutuality in their relationship. Mother was grateful. I felt that I was fortunate to be working with such a responsive young lady.

### *Disruption and Repair/Strengthening the Self*

Mother arrived feeling depressed; she felt they were back to where they were in the beginning. Mother related her high expectations of herself, and said “Last night Kay threw herself into my husband’s arms. . . I don’t know how to help her ... she doesn’t sleep.” I felt upset to hear her say this after all the progress she had made. I said, in a firm tone, “Yes she does, you are not sleeping; you need to pay attention to your own intuition—about how much is the right amount of sleep for you both.” Mother burst into tears and appeared hurt. I immediately realized my own anger had affected my empathic stance, creating a disruption in our relationship. I asked mother if she felt criticized by me; she said yes. Mother had heard me say she was expecting too much by expecting her infant to sleep. I tried to repair the injury by using a softer tone and restating my intention by saying that mother needed to believe in herself and what she intuitively knew was best for her and for her infant, instead of deferring to “the expert.” Mother accepted my repair. When mother suddenly cried, Kay crawled away from mother toward and past me, and I reached out toward Kay, touched her shoulder, and looked at her, saying, “It’s okay for your mommy to cry, she will feel better; you don’t know too much about crying.” Then, I spoke empathically to mother to explain my intention. When mother felt settled, Kay crawled back to mother and onto her lap, and mother snuggled her. Kay smiled happily. Following this, all three of us played and talked together while we rolled a ball back and forth to Kay, to mother, to me. The connections between mother and Kay, mother and me, Kay and me, were restored. I encouraged mother to focus on present moments instead of on future deadlines and expectations which were distressing her, to allow herself to enjoy the last few months she had with her infant, together, just she and Kay. Mother smiled warmly. I felt relieved. In this session, I felt intensely what it was like to be emotionally connected to another person who in turn was learning to be emotionally connected with her infant.

### *Process of Change Continues*

Kay’s sleeping patterns at 11 months continued to improve. Mother was feeling encouraged. Kay played with the dolls in the doll bed, feeding and putting them to sleep as if she had understood our very words. Mother was more interactive and emotionally attuned to Kay, following her lead in the play. Mother noted how much Kay’s imaginative play had increased in the last few weeks.

Throughout these last sessions, all three of us played together. I marked and demonstrated responsiveness by being responsive to both mother and infant, and gradually, I was able to take a less active role as mother and Kay were increasingly more affectively attuned to each other.

Kay transitioned well to part-time daycare, and weaning had begun. Mother gradually returned to work. The family was ready to take a long vacation.

### *Termination*

After the extended break of 2 months due to their holidays, mother and infant continued to enjoy the progress that they made. Mother said, “I feel we are cured. Thank you for all you have done for us.” I felt pleased with our work together, yet sad to say goodbye.

### *Follow-Up*

About 1 year later, when Kay was 2 years old, mother again contacted the clinic. She was pregnant with her second child. She wanted to discuss relationship issues that she was having

with her daughter, who was now exhibiting typical toddler behavior, and Kay already was aware of the baby inside her mother. I thought that Kay's attachment needs were being activated. Mother wanted to ensure that she was appropriately responding to her daughter. In addition, mother related ongoing fears of her daughter dying. This fear sometimes prevented mother from allowing her daughter to be involved in independent activities. I met with mother and daughter a few times, and then suggested a brief individual therapy with me for mother to address unresolved, past traumas, and anxieties which continued to frighten her. The issues related to traumas when mother was a young girl. Mother's reflective capacity which she had gained in our earlier work enabled her to quickly resolve the earlier traumas. In our last session, she reported that her death dreams, negative thoughts, and anxieties had disappeared. Mother continued to occasionally meet with me over the next 2 years to discuss issues with her children as they arose. The earlier traumas resolved and did not reappear.

Our last follow-up contact was when Kay was 5 years old. Kay already had taught herself to read, and she could regulate herself well, even in an unpredictable situation. Mother reported that the children occasionally engaged in the usual misbehaviors, but they had settled into a stable routine and got along well together.

## CONCLUSION

We have presented two approaches of IPP developed by the Infant and Family Assessment and Treatment Teams of the Hincks-Dellcrest Children's Mental Health Centre, Toronto, Canada. We have described how the clinician uses the concept of reflective potential space (play space) created between the mother and infant and oneself and in the presence of the observing clinical team to understand the problem and formulate intervention strategies. We attend to the inner experience of all participants as we explore, gather data, and reflect on the material as it unfolds in a creative way in our presence. We have illustrated through the two case studies the importance of observation, reflection, and understanding the importance of play in the treatment of infants and their families.

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