Engaging with the Baby as a Person in Their Own Right: Early Intervention with Parents and Infants

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This paper reviews and summarizes therapeutic interventions between parents and their babies by observing engagement with babies through psychological holding, communication with them as persons in their own right and pleasurable playfulness in infant-therapist interactions. In light of the fact that the increased capacity of parents in vulnerable families to think reflectively about their infant’s mind is usually a significant therapeutic method, the report suggests that engaging with the infant in the parents’ presence is usually therapeutic as well. It has been reported worldwide that the increase in interventions with infants and parents are effective, when the interactions were made: for individuals and groups; for a short and long term; in the psychodynamic and behavioral manner. Therefore, the task ahead is to further clarify the mechanisms for change. In this paper, we focused on short-term infant-parent psychotherapy by working with parents and infants in the prenatal period. Time pressure sometimes makes this no more than a relational encounter informed by psychoanalytic thinking, such as containment of feelings and thoughts incurred when unconscious conflictual or early implicit meanings distort a parent’s relationships with their baby. While there are cultural differences in views about infants, some of these ideas seem universally applicable, for instance, to the importance of sensitive parenting and attachment.

KEY WORDS: Infant-parent psychotherapy · Baby as subject · Psychotherapy groups · Perinatal psychotherapy.

Introduction

The baby as ‘subject’
I’ll begin by describing an approach of respecting the baby as subject entitled to an intervention in his or her own right, which informs the work at The Royal Children’s Hospital, Melbourne, where the paediatricians have for about 25 years referred babies with emotional and psychological difficulties to an infant mental health therapist. This follows Winnicott’s (1958) way of working in his spatula paper. The central therapeutic mechanism is thought to lie in trying to understand the infant’s experience from the infant’s point of view, and conveying to parents and infant that the infant has a mind of their own with their own history. This intervention is usually in the presence of the parents, who generally welcome this, and it aims to increase their reflectiveness as well as the infant’s - the capacity to be reflective in a thoughtful and open way to emotional communication from others and from oneself. Responding to the baby as a person shifts the view of the baby as an object - to be fed, cleaned, settled - towards that of a baby as intentional and seeking relationships. Many infants can change in a single session with an infant mental health therapist.

We generally do not find that parents resent therapists engaging with their infant. Parents usually describe it as helpful that the therapist responds to their infant as more intentional than they had seen. While therapists need to be aware of possible resentment and jealousy in parents and to protect their dignity and self-esteem, if they feel that the therapist has taken over from them as someone who could parent or play with their infant better than they could, this can usually be verbalised and worked with.

Five capacities that a baby brings to therapy
I shall now outline five capacities that I think that a baby brings to therapy (Thomson-Salo and Paul, 2008). Firstly, the wish to know and be known in a truthful experience. With a therapist who is trying to understand the infant’s experience from the infant’s point of view, and conveying to parents and infant that the infant has a mind of their own with their own history. This intervention is usually in the presence of the parents, who generally welcome this, and it aims to increase their reflectiveness as well as the infant’s - the capacity to be reflective in a thoughtful and open way to emotional communication from others and from oneself. Responding to the baby as a person shifts the view of the baby as an object - to be fed, cleaned, settled - towards that of a baby as intentional and seeking relationships. Many infants can change in a single session with an infant mental health therapist.

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seven-month-old boy did for 45 seconds the first time he met me. There are also a baby’s positive and negative emotions. Babies bring their potential for playfulness and humour, which could be included in Stern’s (1985) concept of ‘vitality affects’. They wish to be enjoyed from birth - to feel understood, meaningful and valued. Their enjoyment of interaction - of joking and teasing - is not passive, they search for it, and when they find it, they feel safe and happy, the world becomes more meaningful, and they have more sense of themselves and more hope. When playing starts, things move quickly. There are also an infant’s moral capacities which emerge quite early, such as the capacity to forgive when he or she has felt hurt or saddened by the parents’ withdrawal or sarcasm, even as early as 10 weeks of age.

Lastly, there is an infant’s drive towards being free and ‘alive’, integrated and creative. Infants bring a willingness to enter the therapeutic process and often take a risk. This links with Winnicott’s (1971) view that when things are not going well for infants, they look around for what they might be able to take in. Even infants with an insecure attachment, who might not be thought to easily trust a stranger at the first encounter, seem very prepared to take this risk and contribute to the therapy process. What is often omitted is an infant’s sensuality, their delight in extremely pleasurable sensations. Remembering this might help in interventions with infants who have had so many oral trauma that their autonomy is locked up in food refusal.

What the therapist contributes can be conceptualised as threefold (Thomson-Salo, 2007):

1. Psychological holding
   Babies respond to the gaze of the therapist who tries to feel their way into their mind in the same way as a parent who is building up secure attachment, does. Nonverbal ways of relating contribute to an infant feeling safe in the setting. When they feel emotionally held, they sense that the therapist’s mind is available to help contain their feelings. Often in the first interview they behave differently as though they have tentatively attached to the therapist’s mind.

2. Communicating with the baby as a person in their own right
   Therapists try, above all, to understand and communicate with the infant. With younger infants, they work at making a connection with words, vocalisation, gesture and gaze. If, for example, they hold out a toy so that an infant can hold it and then gently pull on it, the infant becomes aware of someone playfully recognising their agency, which gives them the possibility to have an effect on their world. When therapists can ‘hear’ an infant’s communication they can respond in a way uniquely fitted for that infant, sometimes in ways that they could not have predicted. As Trevarthen (2011) wrote: ‘Each child’s self actively grows by sharing meaning in relationships.’

3. Pleasurable playfulness
   When infants feel enjoyed by their parents in a thoughtful way, this may be the most significant factor in developing an internal good object. Seeing enjoyment on the face of the other creates a resonant state in the self. Infants want to matter to those who look after them and above all be enthusiastically enjoyed (Trevarthen, 2001). Reflective, imitative play helps develop an infant’s sense of self and joy. And when infants do not feel this, they can feel sad and ashamed, so that when therapists relate to them, this conveys a potential for playfulness, and play can ease painful or despairing feelings.

**An Authentic Response**

Infants are able to sense authenticity when others communicate to them (Siegel, 1999), presumably also the therapist’s authenticity when they interact indirectly or directly with infants. Perhaps when making an interpretation to the infant that is really about the parent but is addressed to the infant to soften the effect on the parent, communication is confusing. (I acknowledge, however, that there are difficult clinical moments when a parent is very negative to their infant or therapist, or has serious mental illness or may become jealous and withdraw from therapy.)

An authentic response I see as interacting and talking about the present moment, about the infant’s affect and experience with the therapist. In authentic relating, the therapist talks to the infant about the experience of being that infant. Being authentic is partially surrendering to the process, not knowing what will happen. I think that the therapist would be, in the words of Paris et al. (2009) open and attuned to a small, unplanned moment of interaction as a potential arena for therapeutic action. As infants begin to monitor the attention of others, those other people at times focus on the infant herself. The infant then monitors that person’s attention to him or her in a way that was not possible previously. The infant’s face-to-face interactions with others are then radically transformed. They now know they are interacting with another intentional agent who intends things toward them. For an infant to begin to think reflectively requires a nurturing relational context conducive to exploring their mind in the mind of the other who has their mind in mind. Therapists help co-construct new representations (Allen and Fonagy, 2006). And I think that being reflective with a baby may help develop re-
reflective thinking in the parents more than teaching them to read their baby’s cues. The therapist mirroring, like the parent, may provide a stimulus that organizes a baby’s experience and provides a name for what he or she is feeling so that out of the interaction the ability to think about the mental states of others grows (Fonagy, 2002).

The core principle of infant-parent psychotherapy (Thomson-Salo and Paul, 2001) could be summarised as to ‘be with the baby’ as well as with the parents, relating to the infant as subject, so that therapist and infant begin an exploration of not-knowing, with the therapist aiming to make a connection with the infant. As part of therapeutic action how does a patient use a therapist’s authenticity? Buechler (2008) wrote that as the therapist becomes important to the patient, the patient begins to observe how the therapist functions and regains emotional balance. She asked, ‘What do we have to do to matter enough to be watched?’ And I think her answer is what a therapist is aiming for in becoming watched by the infant. She wrote, ‘I think one way is to be emotionally open, transparent and readable so that patients become interested in what they learn from how we tick (p.36).’

**Infant-Parent Psychotherapy Groups**

Turning now to infant-parent psychotherapy groups, I co-led a slow-open mother-therapy group for eight years for mothers and infants in the first year of life with psychosomatic symptoms, with my colleague Campbell Paul, and we could confirm that infants can engage with each other soon after birth and contribute enormously to the group (Paul and Thomson-Salo, 2007). Responding to the infant as ‘subject’ leads to the view of the infant as equally entitled to a therapeutic intervention in their own right in the group so that the therapist finds ways to interact that are respectful and meaningful, and not at too high a level. Infants can be therapeutic in the way that they try to engage with their parents and other adults.

There are service pressures to find more short term ways of working. Our group model having been operationalised into a short term group and found to be effective with mothers with postnatal depression (Figon, 2000), we started a short-term group for parents and toddlers who were experiencing difficulties around separation or anger. The main port of entry was the child’s imaginative world - joining in their play - and trying to find a focus by the end of the first session. We interpreted to parents and children in a softer way than might be expected, hoping to shape change in their representations - making friends with the hungry dinosaur who invaded the picnic. We think that we communicate, through joining in the play, that there are additional ways of viewing experiences and internal values, and that we bring another resonance to the play. We view it as communication that is ‘intimate, intuitive and spontaneously negotiated’ (Trevathan, 2011), another layer of complexity that toddlers are able to play with and decode. The children’s Pre- and Post-Test scores improved on the Parent-Infant relationship assessment scale of the Diagnostic Classification 0-3 (PIRGAS, 2005). How does this play work towards change - is our being surprising a special kind of misattunement? ‘Toddlers take pleasure and pride in learning by imitating, cooperating to build shared beliefs and understandings. ... and are richly responsive to --- receptive adults who wish to share as companions in the child world’ (Trevathan, 2011).

**A Group for Mothers Who Have Experienced Family Violence or Non Consensual Sex**

When parenting an infant born as a result of rape or non-consensual sex, mothers experience a continuum of states of mind which affect their representations of the infant, and from the infant’s perspective, affect attachment patterns, representation of the father and development of a positive self-representation. We offered for a group for women and infants who had experienced violence in the first year of life, to help them to connect over their experience, to think what it meant that they stayed with the abuser, and to think about what was going on in their infant’s mind about the violence, and be aware of how the infant’s experiences may be seen in hypervigilant or frozen play. Being able to find appropriate words for the experience helps recovery, although sometimes therapists are anxious talking about the violence in the presence of infants [There is some evidence that dyadic work may be more effective than individual therapy in resolving feelings around traumatic experiences, as Lieberman et al. (2005) found in a Randomised Controlled Trial of therapy for traumatised preschoolers]. What seems important is to explore what the mothers feel is safe enough to voice in the group and for therapists not to over-anxiously protect the infant from the impact of these feelings. Making it possible for the mothers and babies to have experiences of joy helps the mothers see their babies in a way that they may not have done before. ‘When parents see their baby’s lively interaction with the therapist in the context of discussing their own inner and relationship problems, they can see their baby in a different light (Paul, 2009)’.

This work speaks to the infant-in-the-mother that they too are enjoyed and valued which confirms their self-esteem, acting as a protective barrier against violence. Time-limited groups of six sessions of this model can be effective. In pre- and post-test results, the mothers’ depression improved significantly and the infants who were developmentally delayed...
can be unpredictable my approach is flexible and informed by analytic thinking. I offer primarily containment in a relational experience, as this seems to make the most difference for mothers exploring difficult feelings with infants. I observe the baby to get a sense of the baby’s personality and feelings, engaging and talking to mothers, I try to involve fathers where possible. Many of the mothers with whom I work feel that their own mothers, internal and external, are not sensitively available.

Often, containment itself can lead to development of a mother’s reflectiveness. I try to accompany a mother past her ‘internal saboteurs’ to help her see her baby as a person, trying to convey a sense of enough time in my mind for her to tell her story in her own way, while intervening, as appropriate, in the first session. At the same time as trying to feel my way into the experience of baby and mother I am trying to process in the countertransference. Mothers may identify with my way-of-being, shaping their implicit memories and, through a positive transference, internalise a less severe superego, reflectiveness and playfulness. I try to help them bond by seeing the baby as a person, so that they may find the courage to imitate their baby and find moments of enjoyment. An important intervention is facilitating a mother to see how early her baby is ready for social interaction; seeing that her baby has a capacity to respond, which is enjoyable to other people, usually helps her feel that her baby is more resilient than she had thought.

Links and Interpretation

I make some links and interpretations, commenting on some things more quickly than I might otherwise, but my containment also conveys many silent interpretations. A usual transference is a positive grandmother one and I mainly intervene in a mother’s transference to her baby, trying to disconnect it from the past, like the mother whose 3-month-old baby son breastfed peacefully but she saw him as like her brother who had suffered schizophrenia and at times abusive. Parents who face less serious difficulties often talk to their baby about how the baby is coming to see me, this is the baby’s time with me and spontaneously turn their baby round to face me or hold their baby out to me. They seem to see it as positive and to be underlining the therapeutic effect of play. The most relieving interventions are around a mother’s guilt and hatred: a negative transference I would probably quickly interpret. With a mother with Borderline personality difficulties who might feel jealous if I interact too early, I try not to increase feelings of deprivation and envy. With parents with serious mental illness, many of the interventions described, appropriately modified, are helpful. With a mother recovering from a psy-

\textbf{Containment and Relational Experience as Intervention}

Usually the constraints of the work do not allow unlimited time to work with patients, so that I do what is possible in the short term and refer for longer term help. Therapists need to maximise the effectiveness of interventions particularly where there is substance use, and serious mental illness etc, and to find ways to help parents and babies with multiple difficulties or born very premature as up to 75% of those parents may experience Post Traumatic Stress. If a mother has postpartum depression, effective treatment for this is not sufficient to improve the developing mother-child relationship: the relationship and the infant both need help for continuing difficulties (Forman et al., 2007).

While how I engage with a baby and their family is shaped by the institution in which I work, my preference is to create a confidential space with a relatively unstructured approach, to try to increase reflective functioning. As work in the hospital
chotic episode I try not to contribute to her feeling persecuted by commenting too closely on what I noticed about the baby.

**Adolescent Mothers**

I’ll focus now on adolescent mothers as, while many do well, a significant proportion struggle. While parenthood can be a second chance and opens door to the past, many find it hard to use this chance and empathise with their babies as they are often hardly beyond childhood themselves. If they find it hard to empathise and think about their baby calmly, they may handle the baby roughly. The risks include a history of abuse, depression and substance use. For the infants a risk of developmental delay and later of conduct disorder, depression and suicide (Riordan et al., 2006).

Let me illustrate a way of working in 4 sessions. A 16-year-old adolescent, whom I’ll call Lee, cared for by the child protection system and living away from her home, was referred for difficulty feeling bonded to her unborn baby. She had been diagnosed as having an antisocial personality disorder and use of marijuana, ice or cocaine had increased in pregnancy. For the first postnatal visit with me, Lee arrived 2 hours late. She was said to be mechanical and not looking at baby Kay. She was a bit flat and negative about her and said she was not in love with her, was that normal? Later when I asked to hold Kay and talked to her to see if she would open her eyes and interact, she gave a few smiles and I had a sense that Lee was interested and slightly amazed at what I was doing. I talked about Kay’s crying as a strength in wanting to be close to her mother. But I felt despairing and helplessly frustrated, as she perhaps did, and wondered about referring instead for anger management.

For the second session Lee was only 15 minutes late and was slightly more talkative. I commented that Kay looked different and she wanted to know how. She said that she had got her first smile from her but interacted very little with her because she felt she needed to do housework. Kay was a good feeder and I tried exploring possible pleasure for Lee in breastfeeding so that it might become not just a functional relationship, but one open to the baby’s sensuality. Lee said that when she fed her, she looked away because her neck hurt (Lee’s mother had not been able to breastfeed Lee because of a horrific injury). Lee was becoming irritated with her partner and Kay was unsettled and I suggested that the baby was responding to her feelings but I was not sure how much Lee took in. She quickly became angry in the outside world. She felt that people reported on her negatively and she might lose the baby. She cancelled the next appointment, just before my holiday, but to my surprise I heard from Lee’s support worker that she was able to look more at her daughter since the visit to me. I thought that what was unconscious transgenerationally from her early years were terrifying feelings and conflicts that needed to be kept out of consciousness. The resistance were there in her lateness and blankness.

The third session a month later, Lee fed Kay who got extremely distressed and fixed on the light switch. Lee insisted door she could not be looking at a white wall and I said that she might be discriminating textures, implying she was not just turning away from her mother. Perhaps because I had looked for meaning Lee turned her round in such a way that I was able to talk to her and as I did so, Kay started to smile and interact vocally with me, responding and initiating. When I said, ‘You are clever’, she smiled and vocalised more. I said to Lee I thought that Kay was doing well and that she would have got that from Lee. When I talked to Kay, Lee looked interested, but told me she did not have a clue what was going on in Kay’s mind. Then perhaps jealous of my involvement, she put her on the floor the other side of the pram, and tightened the baby’s fingers round a hard rattle. Kay held on and looked fixedly in my direction, and I found it very hard to leave her there but felt that I needed to, to safeguard the therapy. I asked Lee about life being hard for her and there was a torrent of swearing about how furious she was about other workers who were stupid, and she was not allowed to do anything or go anywhere. The transference was beginning to change but it seemed appropriate at this point to work in it but not with it - and as I tried to feel what her experience would be, she brought her despair that she had lost her passion for graphic design which had been her intended career. By placing her daughter away from us, she had also been protecting her infant from her anger (What only gradually emerged was that she had about 12 other workers but only kept contact with a couple, myself included).

For her fourth session Lee was on time. 3-month-old Kay worked so hard to connect with me, smiling at me, like a light bulb lighting up. Lee unselfconsciously began talking motherese very easily to her, so we had reached some good implicit memories behind the difficulties. When I talked about Kay’s responsiveness with Lee, Lee said ‘OK’ a number of times as though she was open to the ideas, interested and accepting of the positive. She told me that she had got her first laugh from Kay and had telephoned her own mother to share this. She echoed a phrase that I had used, ‘She’ll do it again’. For the first time Lee talked freely. She had had a bad week, been in a fight with a foreigner who said she was disgusting being a teenage mother, and accused her of wielding a knife. But she also told me about another baby empathically understanding Kay’s crying and I wondered about a beginning empathic state of mind oscillating with the more usual out-of-touch one.

There were many issues I did not explore. In four hours of
work it would have been difficult to have an effect on the depression or personality disorder underlying the addiction but the mother-infant relating was improved. The infant did her bit, trying so hard to respond to me, then allowing her mother to have time with me and continuing to be responsive at home. Lee was clean of drugs. She seemed to feel that I could help with something that she wanted help with and to be thinking that her baby might have a mind that she could be curious about. She wore makeup and new clothes on this visit.

With S Nicolson, PhD student, I have trialled an intervention with pregnant adolescents, to fit in with routine care, aimed at increasing attachment and mind mindedness (Meins et al., 1998). It comprised group discussion of a brief composite DVD of infant social capacities, and an infant mental health intervention at the momentous time around birth to meet the baby as a person, focussing on their capacity for gaze, interaction and consolability, and above all their feelings and personality. I thought that if a mother could see her baby as a person from the beginning the projections onto the baby as being inexplicable, random or bad might be lessened. Most of the mothers who were followed up when their babies were 4 months of age felt that the intervention had helped them be more confident and to enjoy the baby in a way that they had thought unimaginable. They were also significantly less likely to show hostility and intrusive behaviour towards them, which is an important intervention as intrusive behaviour is difficult to shift and being able to do so this early is likely to have a positive cascade effect.

Promoting Reflective Thinking in the Face of Attachment Difficulties

When therapists work with vulnerable families it seems likely that they need to help them see how crucially important it is to think about what might be their infant’s experience. There is a consensus that reflective thinking promotes secure attachment. When therapists point out what an infant is doing or asking questions about what they think an infant means, and about the meaning of behaviour they are functioning as another pair of observing eyes and promoting reflective thinking (Fonagy, 2002). Or in video feedback with parents, parents may feel more empowered to think about what their infant might be experiencing and perhaps begin to withdraw some projections.

How does interacting with the baby help reflective thinking develop? It seems to have a fourfold action (Thomson-Salo, 2007). Firstly, changing infant representations and behaviour. When infants experience their mind as existing in the therapist’s mind, and are responded to in a new way, this offers the possibility for responding differently. Being with a therapist who is interested in understanding the meaning of an infant’s experience, infants get this mirrored back in a way which they feel bodily with changes in behaviour and representations. Second, changing parental representation through exploring and making links, concurrent with seeing their infant differently. This re-presents the infant to the parents who have the possibility to see their infant as more robust than they had thought, the infant whom they had at some level hated for making them feel ‘bad’ parents. Third, changing infant-parent interaction with the infant taking the changed way-of-being into the relationship with the parents, increasing their sense of having regained their infant. Fourth, changing parental ways-of-being with the infant. When the therapist interacts with an infant from a position of finding the infant intentional, understandable and potentially enjoyable, the parents are likely to have mirrored in themselves a similar experience. The therapist-infant interaction can begin shaping the parents’ representations, as well as implicit memories of relational behaviours. It seems possible that in the relational encounter with the infant these could be modified faster than at other times. Pally (2005) agrees that neuroscience supports the idea that the therapeutic action may begin nonverbally, at an implicit level. Interacting with the infant in the parents’ presence may do more to rework implicit relational knowing than working only with the parents.

Conclusion

When the focus is on helping new parents and infants who are experiencing difficulty, it is probably most helpful if the infant is included in the work as a way of contributing to increased reflective thinking. Infant-parent psychotherapy offers an infant an experience of being understood and communicated with in their own right. As the therapist becomes important, the patient extrapolates the ‘rules’ of this relationship, modifying their early ways-of-being from a predominance of insecure attachments towards more secure ones. Research has found a cascade effect of change lasting longer after psychotherapy than other modes of intervention, because of increased reflective thinking (Shedler, 2010).

Conflicts of Interest

The author has no financial conflicts of interest.

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