Healthy Infant development

- Maternal mental health is universally acknowledged as one of the key determinants for healthy development in infants (Murray & Cooper, 2003). All aspects of infant development can be affected by maternal mental health problems including having an impact on breastfeeding, infant nutritional status and health and growth rates, as well as the social and emotional wellbeing of the infant. (Beck, 1998).
Overview of what infants need

- A child needs a relationship with someone where they can learn to reflect on their own mental state
- Delight just for who they are
- A child needs both empathy and relationship repair when difficulties arise
- The single most important factor in the infant’s and child's emotional well-being is the caregiver’s capacity to think about their own emotional responses and be able to choose to act in a way that prioritizes the needs of the infant

- Watch next clip think about shared delight. What is this infant experiencing?
Scrub (stunted tree)

If I grow bitterly,
Like a gnarled and stunted tree,
Bearing harshly of my youth
Pucker'd fruit that sears the mouth;
[This is fruit that burns and wounds.]
If I make of my drawn boughs
An inhospitable house,
Out of which I never pry
Towards the water and the sky,
Under which I stand and hide
And hear the day go by outside;
It is that a wind too strong
Bent my back when I was young,
It is that I fear the rain
Lest it blister me again.

(Edna St. Vincent Millay 1923)

Behaviors and interactions to consider when assessing infant mental health.

Parent behavior
- Quality of physical relationship (holding, face-to-face contact, eye contact, proximity, positioning)
- General mood and affect
- Expressed attitude about the baby (positive or negative)

Infant behavior
- Predominant mood
- Eye contact with parent and others
- Social initiative and responsiveness
- Attachment-seeking behaviors (seeking proximity and contact with parent, particularly when stressed)
- Ability to be comforted or soothed
- Developmental progression
- Sleep and feeding regulation
- Quality and amount of vocalizations
- Evidence of curiosity
- Range of emotions demonstrated

Parent-child interaction
- Behavioral quality of the interaction—parent’s sensitivity and responsiveness to infant cues
- Emotional tone of the dyad—feeling conveyed by this relationship (e.g., tense, withdrawn, sad)
- Parent’s interpretation of the child’s behaviour—comments made by parent about child (e.g., a mother says “he’s trying to make me angry” in reference to her 3-month-old)
Depressed mothers have been found to experience more difficulties interacting with their infants, and are typically less sensitive and responsive than non-depressed mothers (Cohn, Matias, Tronick, Connell & Lyons Ruth, 1986). These mothers may miss infant cues, appear withdrawn and disengaged, and find it hard to focus on their infants’ experiences, due to a preoccupation with their own emotions.

On the other hand, maternal mental illness is sometimes associated with intrusive and even hostile play, where the mother tries to gain the baby’s attention to distract or comfort herself. These problems with insensitivity are more common in populations of high-risk mothers with complex presentations (Field, 1992), but still occur in low-risk populations with more subtlety (Murray et al., 1996b), particularly where the depression persists over time (Campbell et al., 1995).

- Some depressed mothers are unable to recognise their importance in their baby’s life and may feel that their baby has no interest in them, thus both may withdraw from each other. Some mothers may feel the baby is rejecting them, and “does not like” them.
- Mothers with depression have been shown to be less responsive to their infants and can also be intrusive and non contingent in their care (Lyons, 1986).
- They may be withdrawn and avoid their infants’ emotional needs. Research has also been shown that mothers with depression are harsher and provide less parental warmth. (Schore, 2003).
What attachment feels like

- **Secure Attachment:**
  - Self. "I am good, wanted, worthwhile, competent, and lovable."
  - Caregivers. "They are appropriately responsive to my needs, sensitive, dependable, caring, trustworthy."
  - Life. "My world feels safe; life is worth living."

- **Compromised Attachment:**
  - Self. "I am bad, unwanted, worthless, helpless, and unlovable."
  - Caregivers. "They are unresponsive to my needs, insensitive, hurtful, and untrustworthy."
  - Life. "My world feels unsafe; life is painful and burdensome."

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**Secure Attachment**

<table>
<thead>
<tr>
<th>Child</th>
<th>Caregiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uses caregiver as a secure base for exploration. Protests caregiver’s departure and seeks proximity and is comforted on return, returning to exploration. May be comforted by the stranger but shows clear preference for the caregiver.</td>
<td>Responds appropriately, promptly and consistently to needs. Caregiver has successfully formed a secure parental attachment bond to the child.</td>
</tr>
</tbody>
</table>

Ainsworth, Blehar, Waters, & Wall (1978)
Main & Solomon (1986)
## Ambivalent/Resistant Attachment

<table>
<thead>
<tr>
<th>Child</th>
<th>Caregiver</th>
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</thead>
<tbody>
<tr>
<td>Unable to use caregiver as a secure base, seeking proximity before separation occurs. Distressed on separation with ambivalence, anger, reluctance to warm to caregiver and return to play on return. Preoccupied with caregiver's availability, seeking contact but resisting angrily when it is achieved. Not easily calmed by stranger. In this relationship, the child always feels anxious because the caregiver's availability is never consistent.</td>
<td>Inconsistent between appropriate and neglectful responses. Generally will only respond after increased attachment behaviour from the infant.</td>
</tr>
</tbody>
</table>

Ainsworth, Blehar, Waters, & Wall (1978)  
Main & Solomon (1986)

## Avoidant Attachment

<table>
<thead>
<tr>
<th>Child</th>
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<tbody>
<tr>
<td>Little affective sharing in play. Little or no distress on departure, little or no visible response to return, ignoring or turning away with no effort to maintain contact if picked up. Treats the stranger similarly to the caregiver. The child has learned to disregard his/her own attachment needs and no longer seeks proximity to caregiver.</td>
<td>Little or no response to distressed child. Discourages crying and encourages independence.</td>
</tr>
</tbody>
</table>

Ainsworth, Blehar, Waters, & Wall (1978)  
Main & Solomon (1986)
Disorganized Attachment

<table>
<thead>
<tr>
<th>Child</th>
<th>Caregiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stereotyping behaviours after separation from caregiver, e.g. freezing, rocking, walking in circles. Lack of coherent attachment strategy shown by contradictory, disoriented behaviours such as approaching but with the back turned.</td>
<td>Frightened or frightening behaviour, intrusiveness, withdrawal, negativity, role confusion, affective communication errors and maltreatment. Very often associated with many forms of abuse towards the child.</td>
</tr>
</tbody>
</table>

Ainsworth, Blehar, Waters, & Wall (1978)
Main & Solomon (1986)

‘Disorganized’ infant behaviours clinical features

Lyons-Ruth

- Strong contradictory behaviour patterns. Attachment followed by avoidance, freezing, dazed look
- Simultaneous contradictory behaviours. Comes towards but then turns away... Cries as seeks a hug...
- Incomplete or interrupted sequences of behaviour... Suddenly stops or changes
- Stereotypes... Over and again... stumbles for no apparent reason
- Freezing, stilling, slowed movements
- Show fear of parent: hunched shoulders, fearful face expression... Strange, distorted facial expressions
- Disorganized... Wanders about, confused, multiple changes in mood
Early intervention

- There is increasing evidence that an insecure attachment during infancy, especially one that is “disorganized,” is an important component of the cumulative risk factors on a developmental pathway toward maladaptive child outcomes. These outcomes are related to social competence with peers and teachers, impulse control, conduct disorders, anxiety, depression, dissociative disorders, and other psychiatric and legal problems.

Descriptions of parent infant therapy

- Boston Study
- Royal children’s direct work with Infants
- Psychoanalytic Parent Infant therapy Anna Freud Centre
- Circle of security
- Interactional guidance with video (McDonough)
In a focus group study to evaluate the effectiveness of an agency-based mother-infant treatment program, nine therapists, each with 20 + years experience working with parents and babies, talked about their practices. A Boston University School of Social Work-led research team asked the participants to summarize their work, then describe what makes for therapeutic change in mother-infant therapy and how they know when it's effective. Their findings "Mother-Infant Psychotherapy: Examining the Therapeutic Process of Change," were just published in *Infant Mental Health Journal*.

"Unlike other psychotherapies, the presence and contribution of the infant are unique to mother-infant treatment and act to catalyze change throughout the therapeutic process," the study noted. "Observing and attending to the infant’s actions and communicative signals in the here and now of the session offer the therapist the opportunity to create connections between maternal experience and infant behavior.”
In examining what happens during these sessions and what makes it therapeutic, the clinicians cited a great deal of unpredictability, boundary fluidity and questions about role definition – experiences not found in mother-only office visits. Recognizing the mother's specific experiences or capacities, or interactions with her infant was central to the therapeutic change.

In analyzing the clinicians' description of their approaches to families and how they viewed the relationships between themselves and the client mothers, the study concluded that there were seven overlapping concepts to understanding the therapeutic process. All of them are interwoven in any particular clinical encounter and also serve as guidelines for ways clinicians can facilitate the therapeutic process. They are:

- Narration of the experience
- Processing the experience
- Connecting past and present
- Modeling something new within the baby
- Promoting new affective experiences
- Opening future possibilities
- Building reflective function. (Ruth Paris Boston University 2009)
Study conclusions

"Training new clinicians in mother-infant work includes, for example, prioritizing the clinical focus on the development of a relationship between clinician and mother that allows room for observation and reflection," the study concluded. "Furthermore, everyday moments among mother, baby and clinician offer powerful opportunities for problematic dynamics to develop for new interactive possibilities to emerge. Clinicians need to be open and attuned to small unplanned moments of interaction as potential arenas for therapeutic action."

RCH direct work with infants

- 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.

- 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.
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.

- 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.

- 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).

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. Re-search has found a cascade effect of change lasting longer after psychotherapy than other modes of intervention, because of increased reflective thinking (Shedler, 2010).
Adult capacities for nurturing are embedded in an unconscious schema of a benign or damaging baby self seen through the eyes of an internalised parent. Unprocessed, this representation is acutely reawakened by caring for a real baby. Rafael-Leff

Components of good enough parenting

- Primary maternal preoccupation Winnicott 1956
- Mentalizing stance
- Mirroring and attunement
- Scaffolding the babies experience
- Interactive repair
- Tolerating mixed feelings towards the baby
- Promoting separatness
What compromises good enough parenting?

- Parents who are not able to make space in their minds to become pre occupied
- Unresolved issues from past and present
- Trauma and loss
- Mental illness
- Emotional and behavioural unpredictability
- Not supporting separateness and individuation

Aims of parent infant therapy

- For parent
- To enable parents to reflect on themselves their infant and the relationship between them
- To enable parents to regulate on their own and their infants states
- To enable parents to recognise their infant as a dependant person with a developing mind.
- To interrupt intergenerational patterns of relating, and reduce traumatic impact
- To facilitate the couples parenting of the infant
For Infant

- To promote positive attachment behaviours between the infant and his parents.
- To promote the infants sense of self
- Promote age appropriate dependency and moves towards separation and individuation
- To assess and address risk

The clinical framework

- Developmental history
- Developmental status
- Attention is given to the affective tone of the relationship, the infants attachment behaviours, self regulating behaviours, and the presence of relationship risk behaviours, such as fear and disassociation.
Key techniques

- Clarification and exploration
- Working directly with the baby
- Reflecting back the interaction
- Modelling
- Playing
- Mirroring affective states
- Representing the infants mental state (feelings) to the parents
- Reframing
- Interpretation
- Linking past with present
- Parent guidance
- reviewing

Keys to formulation

- The parents state of mind in relation to the baby
- Past experiences that are being replayed with the baby
- Current attachment experiences that impact on the parenting of this particular baby
- Unresolved trauma loss for parent
- The transference to the baby including who what the baby represents to the parent
- The baby’s developmental status and adaptive strengths
- Precocious maladaptive defensive functioning in the baby
- The capacity for interactive repair between parent and baby.
Bruce Perry describes 6 core strengths for healthy childhood development.

1/ Attachment. Making relationships. The template for future relationships the capacity to form and maintain healthy relationships.
2/ Self regulation. The capacity to regulate internally, containing impulses
3/ Affiliation. Joining in, belonging, social connectedness
4/ Attunement. Being aware of others, their thoughts, feelings and needs
5/ Tolerance. Accept difference. To learn to face the fear of difference.
6/ Respect. Finding value in differences, appreciating the worth in self and others.

Circle of security

- The Circle of Security is an early intervention program for parents and children that focuses on the relationships which give children emotional support.
- Central to the program is the Circle of Security map, which helps parents and other carers to follow children’s relationship needs and so know how to become more emotionally available to them.
**CIRCLE OF SECURITY**

*Parent attending to the child’s needs*

- Secure Base
  - Support My Exploration
  - Watch over me
  - Delight in me
  - Help me
  - Enjoy with me

- Safe Haven
  - Protect me
  - Comfort me
  - Delight in me
  - Organize my feelings

*Abilities to BE BIGGER, STRONGER, WISER, and KINDER:*
- Believe: follow my child’s lead.
- Respond: respond: make sense of the child’s words.
- Help: wherever necessary: take charge.

**CIRCLE OF DISORGANIZATION**

I need you but you are so frightened or frightening that I have no one to turn to and I don’t know what to do.

Disorganized attachment is the treacherous paradox when the parent is both the source of the child’s fear and the haven for the child’s safety. This paradox leaves a child feeling chronically afraid, on the verge of losing emotional and behavioral control with a diminished capacity to see adults as a resource.
COS aims to enhance five relationship capacities

1. Coherent understanding of children’s relationship needs
2. Observational and inferential skills
3. Reflective functioning
4. Emotional regulation
5. Empathy

CIRCLE OF REPAIR
Helping my Child Trust That Our Relationship Will (Almost) Always Get Things Right
Identify the child’s needs

- Secure base needs- for exploration
  - Watch over me moment
  - Help me moment
  - Enjoy with me moment

- Safe haven needs.
  - Protect me moments
  - Comfort me moments
  - Delight in me moments
  - Organize my feelings moment

Emotional Regulation/
COS

- Regulation of affect is not an innate capacity, but rather a capacity learned in infancy through a relationship with a primary caregiver. For many parents the idea that children need help learning to regulate their experience is new information. Through the course of the group, parents learn to identify, acknowledge, and bring language to their children’s emotional experience. This process teaches children that emotions are a useful source of information rather than something they need to hide or be punished for feeling. Through this process of working with their children’s emotional experience, parents increase their own capacity for emotion regulation.


