Infant Parent Psychotherapy

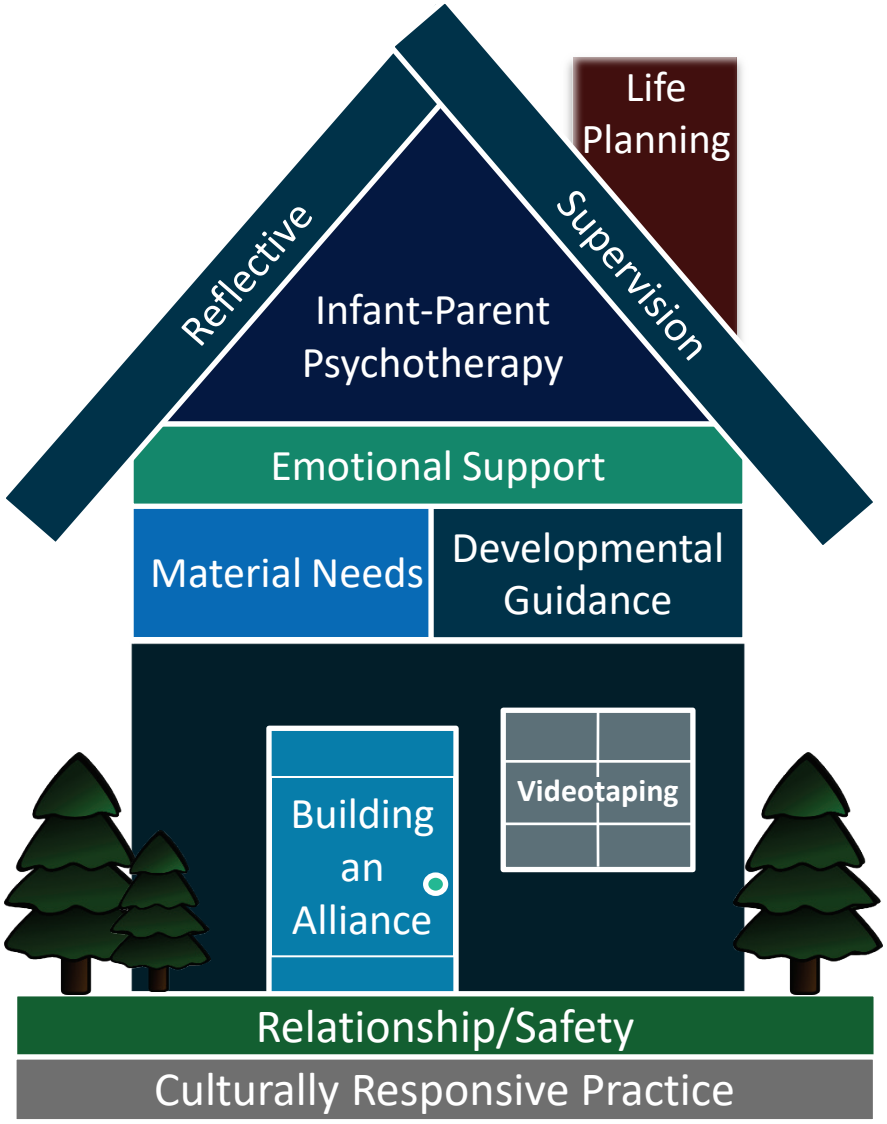
Training in Infant Mental Health-Home Visiting as an Evidence-Based Practice

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

zero TO THRIVE

Infant Mental Health Home Visiting Components

- Culturally Responsive Practice
- Building an Alliance
- Material Needs
- Developmental Guidance
- Emotional Support
- **Infant-Parent Psychotherapy**
- Life Course Planning
- Reflective Supervision
- Videotaping



Intentions for the Day

- Trainer's intentions:
  - Review the transition to parenthood and common mental health concerns in the early parenthood
  - Identify how IPP with pregnant people differs from IPP with a baby present
  - Increase participants' awareness and understanding of the concept of ghosts and angels in the nursery
  - Develop participants' capacity to therapeutically address protective factors and barriers to parent-infant relational health

Think, Pair, Share

- Take 5 minutes to reflect on and note what your hopes are for this module
- Consider your level of investment/energy and situational/contextual barriers and supports for full engagement today. What do you need and how can we as a cohort support you and each other?
- Pair up with another person and share your reflection

Relating, Tolerating, & Creating:

The Practice of Infant-Parent Psychotherapy

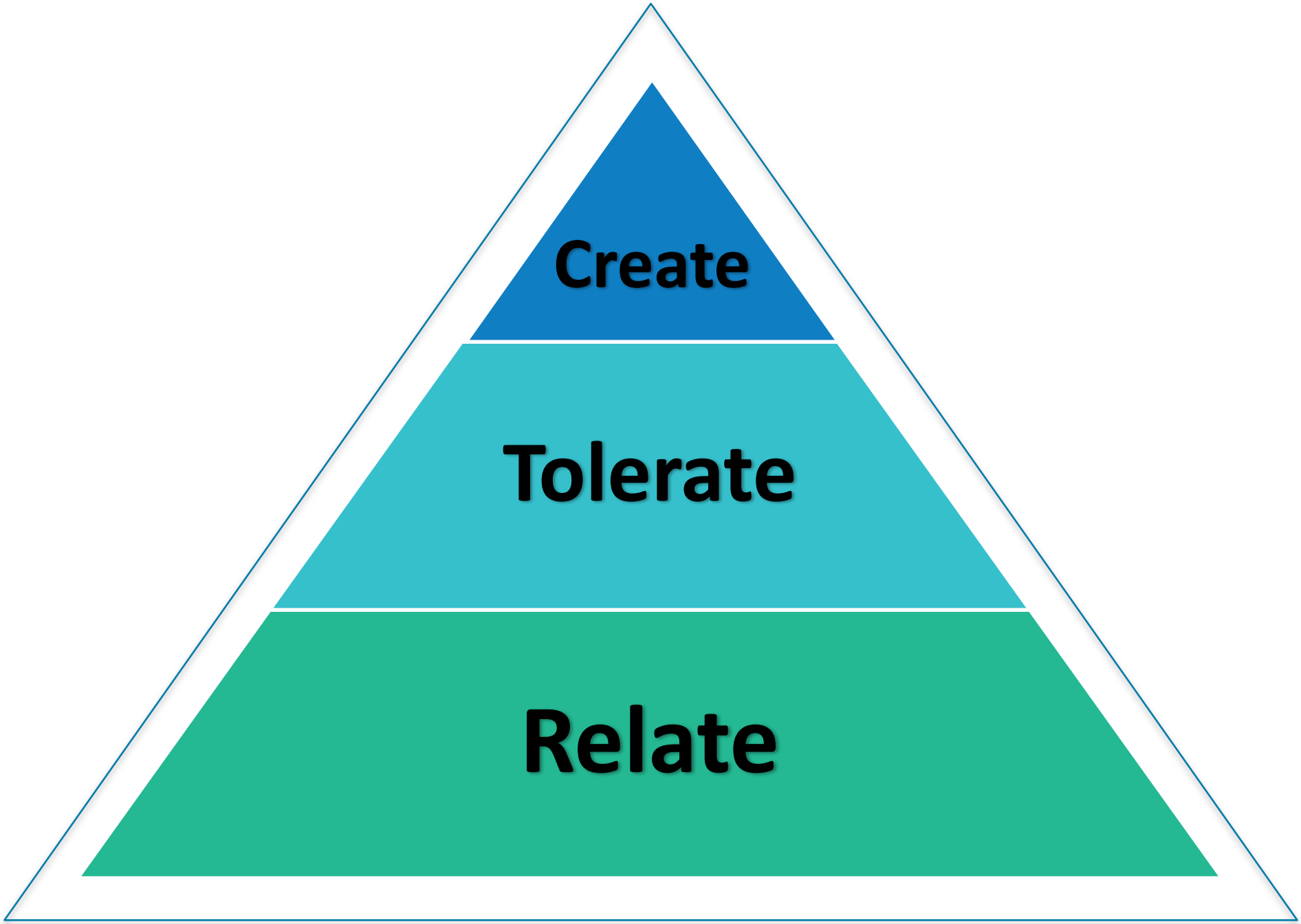
Infant-Parent Psychotherapy

OVERVIEW OF INTERVENTION STRATEGIES AND TASKS	
Strategy	**Tasks**
Building an Alliance	• Visits regularly in the home • Provides telephone support • Observes, listens, accepts and nurtures • Provides stable, consistent relationship • Identifies and meets material needs
Meeting Material Needs	• Facilitates access to community agencies • Provides transportation to services • Discusses safety issues • Uses material needs to teach problem solving
Emotional Support	• Observes, listens, feels and responds • Identifies and reinforces feelings • Sets limits for behavior • Establishes expectation for change
Developmental Guidance	Provides information about infant/toddler growth and development • Uses formal assessment to show infant/toddler's capacities and next steps • Shares literature if appropriate Encourages parents to interact positively with infant/toddler • Encourages observation and interaction • Speaks for infant/toddler • Models, reinforces or shapes appropriate interaction • Provides toys and books
Infant-Parent Psychotherapy	Observes patterns of interaction Defines issues of clinical concern Assists parent to • Identify feelings and put them into words • Understand reactions, defenses and coping strategies • Find words to understand, grieve, forgive and heal • Develop new, healthier patterns of interaction
Developing Social Support and Life Coping Skills	Helps parent to • Resolve conflicts with family members • Understand need for social support and obligations involved • Identify possible friends, community groups and services • Use anticipatory role play to rehearse use of social supports Models and teaches problem-solving and decision-making Encourages parent to plan for next birth, school completion or employment Supports parent in using new skills

Weatherston & Tableman, 2015

Infant-Parent Psychotherapy

- Strong psychodynamic/psychoanalytic history
- Focus on parents' representations about relationships
- Linking parental representation to parental behavior - understanding how underlying conflicts motivate behavior, influence the ability to read the infant cues, and to understand and empathize with the infant
- Selma Fraiberg and IMH-HV in Michigan; Alicia Lieberman & colleagues at UCSF
- The ongoing delivery and development of the "Michigan Model" of IMH-HV (Weatherston & Tableman manual)


Create
Tolerate
Relate

Infant-Parent Psychotherapy

- **Relate** – holding multiple relationships in mind
  - Relationship-focused psychotherapy (parallel process)
  - Past/present relationships and historical context
  - Between infant and parent
  - Between therapist and parent
  - Between therapist and infant
  - Between therapist and supervisor
- Tolerate
- Create

Infant-Parent Psychotherapy

- Relate
- **Tolerate** (parent and/or therapist)
  - Painful or difficult affect
  - Projections onto the infant, or onto the therapist, without rejection, abandonment, anger or withdrawal
  - Learn to regulate – tolerating expression, containing overwhelming feeling
  - Rescue fantasies and wishes/impulses (e.g., white savior complex)
- Create

Infant-Parent Psychotherapy

- Relate
- Tolerate
- **Create**
  - Capacity to mentalize
  - New meanings
  - Coherent/undistorted narratives of experience
  - Potential/Hope
  - New beginnings

Content Knowledge Necessary for Capacity to Deliver IMH-HV/IPP

- Infant-parent attachment
- Psychology of the transitions to parenthood
- Infant/child development – normal development and developmental screening/delay and referral resources
- Parent mental health- screening, assessment, treatment and/or referral resources
- Curiosity, openness to learning about *this* baby, in *this* family in *this* cultural context
- How and what to observe and listen for
- Capacity to acknowledge and reflect on one's own emotions, cognitions and behaviors

Infant-Parent Psychotherapy

- Treatment focuses on the relationship between therapist and parent as well as parent and infant
- Related to traditional psychodynamic approaches but with some differences
  - Major advance promoted by Fraiberg was an integrated model that directly included the infant in the intervention.
- Now “manualized” yet very individualized

Historical/Cultural/Race/Ethnicity Memory and Experience

Historical trauma is not just about what happened in the past.

It's about what's still happening.

We will weave this understanding throughout the training.

An Overview of The Psychology of the Transition to Parenthood

Psychology of the Transition to Parenthood

- A time of rapid transformation- in contrast to subsequent transitions in parental life
- Bio-psycho-social process
- Not “protective”– depression, trauma, anxiety all common
- Meaningful shifts in representational and meaning-making processes

Representations of Parenthood

- Who will I be as a parent?
- Exist prior to pregnancy or adoption/placement
- Related to the activation of the caregiving system
  - Unconscious motivational system that parallels the attachment system in the infant (Bowlby, 1969; George & Solomon, 1996)
- During pregnancy or during pre-placement undergo rapid change and elaboration
  - Own parents are used as a point of reference- either in terms of positive identification or feared association

Transition to Parenthood

- As we build relationships with birthing parents it is important that we attend to how we might shape expectations and meanings attributed to the baby, pregnancy, and parenthood.
- Unless the birthing parent brings up negative representations of the past, they should not be brought up
- Asking about negative representations could activate those memories that otherwise would not come up
- The negative representations become vivid and affect the way the infant is experienced
- Focus on positive parenting experiences and representations
- If negative representations are shared by the parent it is important to be responsive, acknowledge these, and be willing to explore and understand those meanings

(N. Bruschweiler Stern, 1998)

Transition to Parenthood

- Even if we are not working with expecting parents, it is important to explore what the pregnancy and transition to parenthood was like for the parent(s)
- Some questions we can ask/listen for:
  - Representation of the fetus during pregnancy/prep for adoption
  - Issues around forced pregnancy
  - How labor and delivery/placement went
  - What parents wanted to carry forth from own childhood and what they wanted to leave behind
  - Who provided guidance/wisdom/support

Representations of the Developing Embryo/Fetus

- Who will my baby be?
- Vary in terms of richness and details
- Two “represented babies”:
  - Imagined/positive fantasy→ “Wished for” baby
  - Fearful fantasy→ “Damaged” or “Dangerous” baby

Representations of the Developing Embryo/Fetus

- Representations of the fetus tend to crease in richness and elaboration up until the 7th month (end of 2nd trimester)→ then notable decrease in the quality, richness, delineation, especially about positive/hoped for expectations
- Why?
  - Intuitive protection of baby-to-be and self from discordance between 'real' baby and 'too specifically represented' baby (Stern, 1995)
  - Shift in focus to labor/delivery (Stern-Bruschweiler, 2002)
- Impact of ultrasound
- Impact of DV and other factors

Labor/Delivery

- The imagined baby meets the real baby
- Childbirth may yield positive sense of achievement, awe, wonder at her personal strength/power
  - May also be frightening, overwhelming or traumatic
- Strong desire to share personal story of birth- but often lack an audience (attention on infant)
  - Can lead to feelings of isolation/jealousy
- "Bonding period"→ feelings of intense closeness, joy may follow birth– however, also common for birthing parents to feel somewhat distant or estranged
  - Can lead to feelings of guilt, isolation

(Stern-Bruschweiler, 2002)

Pre-Placement in Adoption and/or Foster Care & the First Meeting

- Waiting period is undefined
  - May be punctuated with hopes for meeting & disappointment – thus may face the challenge of both anticipating and grieving simultaneously
- "Evaluation" by others
  - Anxiety about "passing"– Anger regarding invasion of privacy
- Negative Adoption Biases
  - Friends, family, adoption worker, cultural messages influence parents expectations
- The real baby still meets the imagined baby

Multiple Schemas/Representations Undergo Dramatic Shifts

- Schema about self (birthing parent)
  - For example-- self as a person, woman, mother, parent, romantic partner, worker, friend, daughter, granddaughter, role in society, ones' own place in the family of origin, legal status, responsible for the life of another being, 'on-call' 24-hours per day, possessor of a different body
- Schemas about own mother (grandmother)/parents
  - New-found identification with parent(s)→ negative ("I will never act as she did." or positive ("I never understood how much my mother did for me"
  - Evolutionary value in guidance from older experienced parents/mothers
  - Representation of family of origin experience predicts representation of infant (and ultimately, attachment to the baby at 1-year)
- In foster care/adoption also relevant to consider schemas about birth parents

Perinatal Depression: Understanding the Risk Factors

- Genetics/history of psychiatric illness:
  - Previous depression (30%)
  - Previous postpartum depression (50%)
  - Depressions in pregnancy (60%)

- Psychosocial Factors
  - Social support/partner support
  - Life stress
  - Childcare stress (# of children < 4 years at home)
  - Infant temperament

- Societal expectation:
  - Myths of motherhood/early parenthood
  - Work-family stress
  - Exposure to racism – allostatic load

Spectrum of Perinatal Depression

- Depression in Pregnancy — 14%[1]
- Postpartum Blues — 50%-85%[3]
- Postpartum Depression — 10%-15%, cross-culturally[2]
- Postpartum Psychosis — 1-2/1000[3]

1. Evans J, et al. *BMJ*. 2001;323:257-260; 2. O'Hara M, Swain A. *Int Rev Psychiatry.* 1996;8(1):37-54. 3.Gale & Harlow. *J Psychosom Obstet Gynaecol*. 2003;24(4):257-66

Perinatal Depression

- May have unique features
  - Excessively anxious and concerned about babies health and own performance as mother
  - Fearful of "going crazy"
  - Preoccupied with intrusive thoughts either to harm the baby or that something terrible will happen to baby

- Top three dimensions reported in screener:
  - (1) Mood swings;
  - (2) Heightened sense of confusion;
  - (3) Anxiety/Insecurity
  - NOT necessarily depressed mood, or sad (Beck & Indman, 2005)

Trauma and PTSD: How common?

- Trauma is common among women
  - 28% have been sexually abused in childhood
  - 20% experience intimate partner violence
  - 4-8% are abused during pregnancy
- Posttraumatic anxiety (PTSD) can develop after trauma
  - 10-12% (twice that of males ~6%)
  - 30% after childhood abuse
- How common is PTSD in women?
  - 4.6% - when assessed in any moment
  - 12.3% - when assessed across lifetime
  - 3-7% - when assessed during pregnancy or postpartum time

The “Background Music” of Trauma Survivors (“Ghosts”)

- Common themes
  - “The world is not a safe place.”
  - “I am helpless to protect my child.”
  - “I’m afraid I might be like my [perpetrator] or too close to my baby; but I try hard to be different.”
  - “I don’t want to think about it.”

A Therapist May...

- Help ‘turn down’ the background music
- Hold parents in nurturing, safe environment with room to share aspects of own story and feelings
- Monitor moods, sleep
- Referrals for psychiatric needs
- Attend to the representation the client has of the therapist
  - E.g., role of “wise elder,” interest in parent's experience, “hold so parent can hold”; alternatively, we may be seen as dangerous, unsafe, critical or harsh

Infant-Parent Psychotherapy
Key Concepts

Key Concepts Infant-Parent Psychotherapy

- Ghosts in Nursery
- Angels in Nursery
- Reflective Functioning
- Ports of Entry
- Transference/ counter-transference
- Attunement/mis-attunement and disrupted communication
- Projective identification
- Parallel process
- Sequencing/pacing
- Historical/race/ethnicity/culture memory/experience
- Balancing all relationships
- Reflective supervision

Ghosts in the Nursery:
Risk for Repetition of Past in Present

"Children never forget what they don't remember"

(attributed to Alice Miller)

Ghosts in the Nursery: Intergenerational Transmission

"In every nursery there are ghosts… Even among families where the love bonds are stable and strong, the intruders from the parental past may break through the magic circle in an unguarded moment...But how shall we explain another group of families who appear to be possessed by their ghosts? The intruders from the past have taken up residence in the nursery, claiming tradition and right of ownership… While no one has issued an invitation, the ghosts take up residence and conduct the rehearsal of the family tragedy from a tattered script."

-Selma Fraiberg

Fraiberg, Adelson, & Shapiro, 1975, pp. 387-88.

Ghosts in the Nursery

- We all “know” how to parent, but we “know” based on how we were parented, especially in the pre-verbal years
- Some memories or "spirits" are benevolent, some are transitory, and some are ghosts that “take up residence”
- Repetition of negative early interactions are greater when:
  - memories/experiences are repressed or denied
  - when affect is cut off from memory of earlier experience/pain or suffering
  - Ghosts of (historical and recent/current) cultural traumas
  - Enslavement, forced separation, residential schools forced upon indigenous families, impact of structural and systemic racism and oppression, loss of culture, loss of language

Ghosts Are Experiences

… and can include memories or felt experiences of relationships and "being with" people in our lives

Example of ghosts "showing up" in the relationship with the IMH-HV provider

- A parent who cancels multiple appointments with the IMH-HV provider is unconsciously protecting herself as she experienced abuse in her own childhood and feels uneasy about trusting others.

Examples of ghosts "showing up" in the relationship with the baby

- During a visit a mother tells her home visitor "See? He's already bad, beating me up," in reference to her 6 month old son pulling her hair. She has a history of physical abuse / IPV in close relationships with men across her life.
- The IMH-HV provider notices that the parent appears very anxious about anyone else holding or coming in close contact with her baby. She grew up with a substance using parent.

Parental Experiences That May Lead to Need for Infant-Parent Psychotherapy

- Parental experience of:
  - Failure to have early emotional and social needs met by primary caregivers
  - Disturbed or disordered early attachment relationships
  - Abandonment/Separation
  - Loss
  - Trauma
  - A traumatic pregnancy, labor and/or delivery
  - The birth of a sick child
  - The birth of a baby following the loss of an earlier child
  - A child diagnosis with a developmental disorder
  - The birth of an unwanted baby

Repetition of the Past in the Present

- Past experiences in relationships trigger defense mechanisms – the unconscious ways we all protect ourselves from overwhelming anxiety until we have the psychological resources to deal with the source of anxiety
- This might "show up" as distortions or projections towards infant or the self as parent. This may include malevolent attributions or unrealistic idealization of the child.
- The infant, in turn, may 'grow into' or identify with these projections or distortions
  - Ex. – A mother who was forced to be fearless and independent fails to see her own infant's vulnerability and need for protection, and thus the cycle begins again…

Repetition of the Past in Present

Fraiberg described how the risk for repetition of the past in the present increases when…

- Parents' own memories of early childhood pain or suffering are repressed or denied
- When parents cannot access affect connected to earlier experience, pain, or suffering, which can manifest as:
  - Repression – totally "forgetting"

    Ex. A mother who didn't recall her own sexual abuse until she was watching her 18-month-old child play and the sun caught his hair in a way that brought memories flooding back
  - Isolation of Affect

    Ex. Unable to mourn a personal loss but cries at funerals of distant relatives

Protective Nature of Repression

- Trauma-informed lens
  - Instead of “What is wrong with you?” we ask, “What happened to you?”
- Historical Awareness
  - For example, with a history of forced separation and threat of loss, it makes sense to not get too emotionally close to an infant
  - AND we must acknowledge the strengths of families who have thrived despite enduring racism and oppression

Aligning Affect and Experience

"Those who cannot remember the past are condemned to repeat it."

- Dissociation is ultimately a disconnect between memory and affect
- Can have memory with no affect or affect with no memory (e.g., generalized, free-floating anxiety)
- Helping parents reconnect their experiences AND the emotion is a goal of infant parent psychotherapy and helps to reduce repetition of the past in the present

Protective Processes – Remembering, Experiencing, and Tolerating

- Remembering
  - Connecting to one's own memory and history helps to make feelings and reactions in the present understandable
  - This reduces the need to reenact these experiences, and helps the parent more accurately perceive the infant as their own unique being, e.g., not as the aggressor,
- Experiencing/Tolerating
  - When parents are able to experience their own feelings, including strong or potentially conflicted feelings about the past, with acceptance and support from the home visitor, it can make these feelings more tolerable.
  - This can and help free the parent to experience more empathy and attunement with the real baby in front of them.

"… Having once been helped to recognize and recapture the feelings which she herself had as a child and to *find that they are accepted tolerantly and understandingly*, a mother will become increasingly sympathetic and tolerant toward the same things in her child." (Bowlby, 1940, p. 23)

Addressing Ghosts

- Listen, observe, and strive to understand the meaning of infant/child for the parent.
- Consider how the infant/child may serve as a "transference object", in other words, what is the parent projecting onto the child?
- The home visitor can give voice to parent and infant experiences – giving voice to the feelings that are repressed or isolated and being repeated in present
  - “Who would have soothed you when you were sad?”
  - ”What might have happened when you were angry like she was?”
  - “From what you have told me, you were often so lonely…it sounds like you don’t want that for him.”

Addressing Ghosts cont'd

- Sometimes it will take a very long time for a parent to understand the split off memories or feelings of the past. This makes sense, as they have developed these defense mechanisms for a reason.
- It may also take them time to tolerate thinking about how those experiences / memories /feelings might influence feelings and experiences about the baby or themselves as a parent.
- The home visitor may find that they are gently making these connections over a long period of time before the parent consciously also makes those connections (this is the skill of 'pacing'). Sometimes this is gradual, and other times it can come in the form of an "aha!" moment.

The Process of IPP

- Identify or locate feelings associated with experiences
- Create and share words for painful feelings
- Examine conflicted feelings
- Support an understanding of why feelings exist, coping strategies and defenses that had function but may interfere with present
- Recognize these defenses are no longer needed
- Create a space to experience feelings, feel anger, hurt, sadness, loss, grieve, and put words to these experiences
- Create healthier patterns of coping, relating
- Recall the model—tolerate, relate, create

Adapted from Weatherston & Tableman, 2015

Personal Reflection
Thinking Back to Your Cultural Genogram

- What ghosts or messages do you notice in your family?
- How might these ghosts or messages show up in your work establishing relationships with parents/babies in your practice?

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“When I was a boy and I would see scary things in the news, my mother would say to me, ‘Look for the helpers. You will always find people who are helping'... Because if you look for the helpers, you'll know that there's hope.”

~ Mr. Rogers

Pair and Share

- Story in your family about something good a person did and its impact
- What message of hope comes with this story

Angels in the Nursery/"Benevolent Spirits"

- For most parents there are not only ghosts, but also angels
- Becoming a parent can bring back memories or feelings of times that we were vulnerable or felt loved and cared for
- "Angels" in the nursery are times that we felt loved, nurtured, or cared for, or memories of experiences of feeling lovable, worthy, or loving.
- As therapists our task is also to help find the angels and invite those memories or experiences as well

Example of angels "showing up" in the relationship with the IMH-HV provider

A parent accepts support from the home visitor, who happens to be an older woman, because she had a prior experience of being heard and supported by her grandmother. The therapist's offer of support evokes those benevolent memories and leads to feelings of safety and trust with the provider.

Examples of angels "showing up" in the relationship with the baby

- A parent offers his hurt child a hug and holds him close without thinking about it. The parent feels a warmth in being able to offer this nurture, unconsciously drawing on memories of being held and nurtured when hurt himself.
- A parent delights in singing familiar old songs to her baby, enacting memories and evoking positive feelings that are associated with childhood experiences of women in her community as she grew up.

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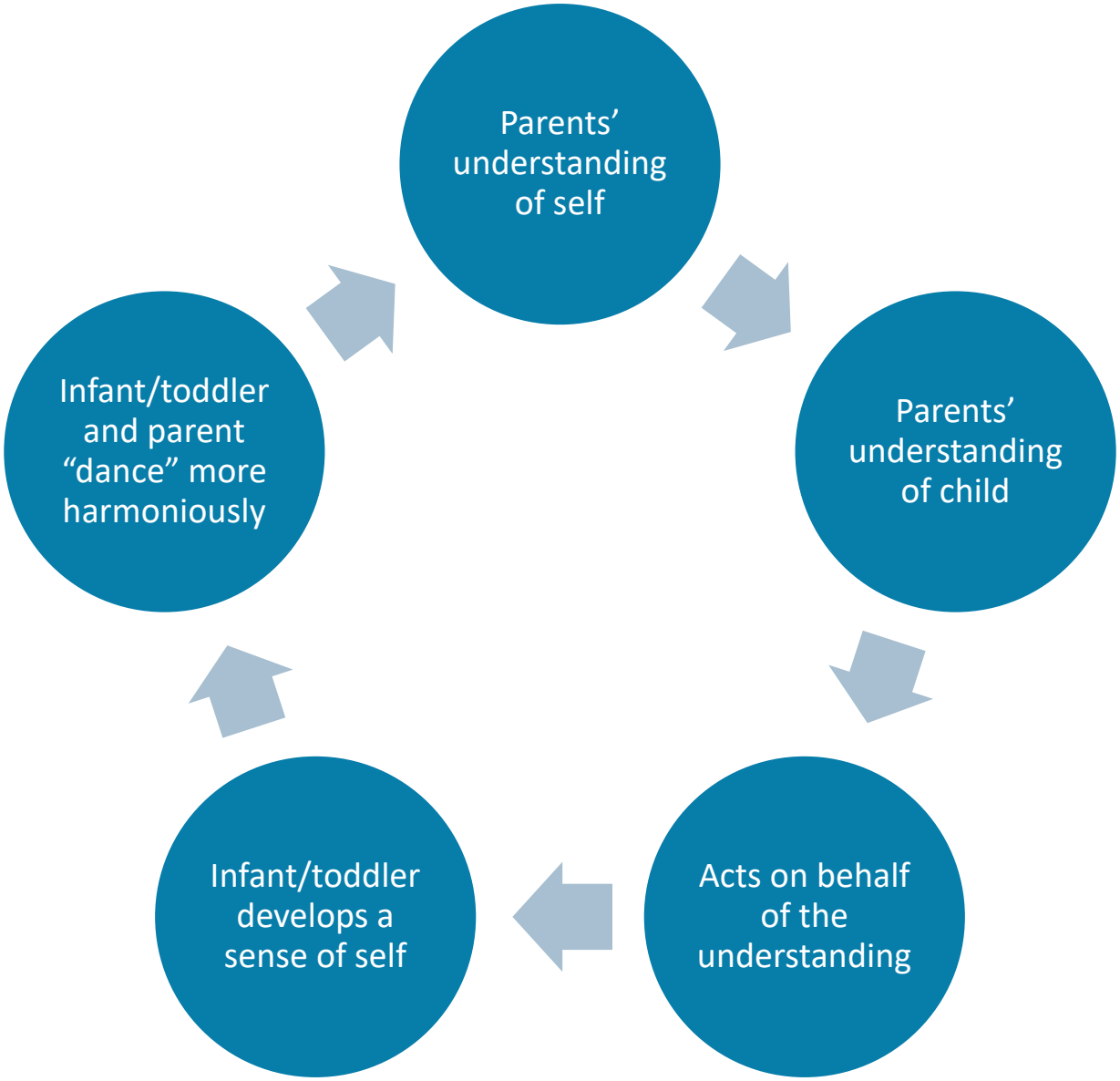
Increasing Reflective Functioning to Decrease Communication Errors

- Reflective Functioning
  - Ability to understand the behavior of others through the lens of underlying thoughts, feelings, wishes, desires and intentions that motivate the behavior

Elements of Reflective Functioning



Increasing Reflective Functioning

- Our task is to convey to the parent that their situation can be best understood if we work together to "make sense of thoughts, wishes, intentions and emotions underlying their own and others' behaviors" (Suchman, et al., 2011).
- Begin where parent is – if they believe they are in crisis, work toward helping with crisis and then to make sense of the feelings related to the crisis
- Clinicians must keep in mind that a parent's childhood interpersonal trauma often interferes with RF

Markers of Reflective Functioning

Pre RF – “How the hell am I supposed to know what he’s thinking – you’re the shrink.”

Low RF - ”He’s crying just to manipulate me.”

Moderate – “She has a hard time when I leave her in daycare after she spends the weekend with her dad. She just gets back, and I have to drop her off.”

High- “I think he feels confused and maybe a little bit frightened when I get angry with him. My upset makes him upset.”

RF	Parent Experience	Clinician Behavior
Pre-Reflective Functioning	Parent doesn't understand self. Parent doesn't understand child.	Clinician supports parent understanding of self through attuning to parent.
Low Reflective function	Parent has minimal understanding of self. Parent has minimal understanding of child	Clinician supports parent understanding of self and child through attuning to both. Makes explicit the internal experience of both and the interplay.
		Ex: You looked pretty angry just then. What was going on for you? Eventually – can add "What happens between the two of you when you get that angry?"

RF	Parent Experience	Clinician Behavior
Moderate Reflective Functioning	Parent understands self and child and the interplay between the thoughts/feelings/ behaviors of each	Clinician supports a deepened understanding of the intersection of the internal states of the parent and child.
High Reflective Functioning	Parent is attuned to how they and the child form a complex and unique dyad based on underlying thoughts, feelings, wishes, desires and intentions that motivate each's behavior	Clinician supports a deepened understanding of the intersection of the internal states of the parent and child.

Pre and Low Reflective Functioning

- Clinical conceptualization
  - Parent has not had the experience of being held in the mind of another – of feeling known, understood and accepted – and thus struggles to provide the same for the child
- Clinical intervention
  - IMH Therapist works to retain realistic goals for the parent, understanding that the parent needs a relational experience of feeling known before they can provide it for the child
  - Clinician works to give words to the parent's experiences

Intervention to Increase RF

- We work to make explicit that mentalizing (the ability to think about reasons or meaning of behavior) will help in dealing with stress
  - Aiming for accurate appraisal of one's own and other's states
- Goal: identify "distorted or denied aspects" of representation of self or others in order to promote greater "emotional balance, sensitivity and flexibility in representations"

Interventions to Increase Reflective Functioning

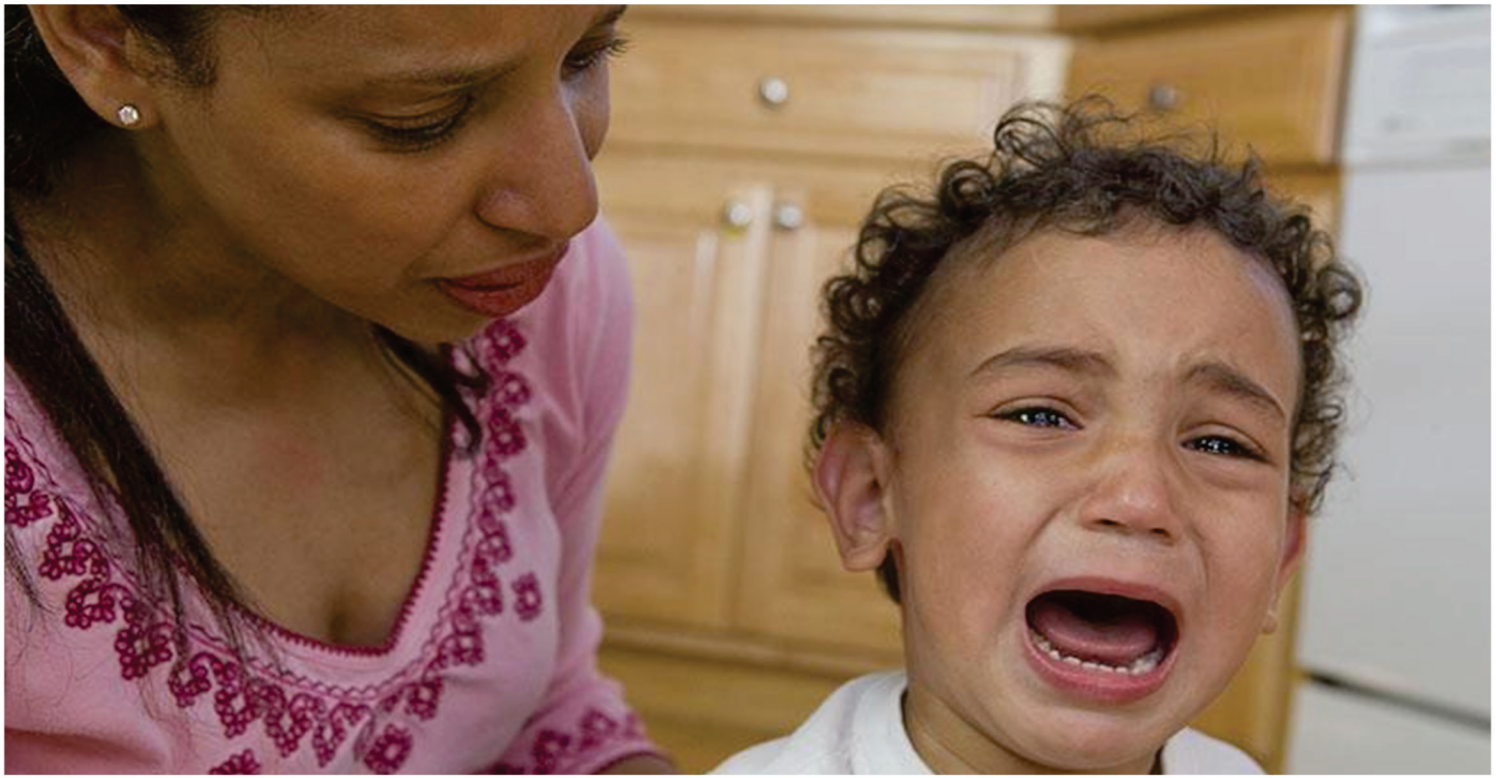
- Watch for and respond to moments of synchronicity (“You really ‘got’ what he was saying to you…what allowed you to do that/ who “taught” you to do that)
- Watch for moments they are out of sync and discuss or note for later (i.e., keep it in mind for a future point in time when the parent is in a receptive state, or the relationship is solid)

Interventions to Increase Reflective Functioning Cont.

- We can also speak for baby
  - “I didn’t like it when you walked out of the room and left me with this strange lady! I was worried you weren’t coming back!”
- What we choose to focus on depends in part on which is the best “Port of Entry”

Increasing Reflective Functioning... About the Self

Marking and Containing



Marking and Containing

"Marking": Recognizing, noting, and highlighting a feeling. Sometimes this is exaggerated

"Containing": Holding space for the feeling

"Reflecting back": The feeling state is “accurately” reflected back in a contained way – leads over time to knowing oneself

Marking and Containing

Parents "mark" "contain" and "reflect" their child's emotions. This is part of "co-regulation" and children learn to recognize and regulate their feelings through this process

Therapists also "mark" "contain" and "reflect" parent emotions.

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Ports of Entry

- Ports are a way "in" to address therapeutic goals.
- Ports are a way of addressing the question of where to place our attention and focus the intervention?
- Originally described by Stern (1995) ports included:
  - the parent's representations
  - the infant's overt behavior
  - the parent–infant interaction
  - the therapist's representations
  - and the infant's representations

Ports of Entry

- Ports reflect a clinical opportunity. We can enter through multiple ports or "doors"– our decision to enter often reflects a strategic decision.
- We might enter through different 'systems':
  - **System of Care:** Advocacy, Case management
    - e.g., if basic needs are not met, family may not be able to address infant emotional needs. Strategic decision making may lead the therapist to enter through "case management/advocacy" ports
  - **Client System:** Parent, Infant, Family System, Parent-Infant Relationship, Client-Therapist Relationship

Ports of Entry

- Chosen based on the presence, appropriateness, and modulation of infant and parent affect
  - e.g. Might begin with the parents' stated goal, but eventually that goal change
- Varies from family to family, from session to session, from one time-frame to another within a session.
- In this way IMH-HV is "needs-driven" and IPP therefore incorporates a response, versatile, flexible, and emotionally rich approach.

“Cascading” From One Level to Next

- Once a port is entered, other ports may then become a focus. For example:
  - Caregivers’ representation may be initial port of entry, but skill building in parent through developmental guidance becomes a later focus
  - Caregivers’ behavioral interaction in the here and now may be initial port of entry, but memories of past abuse become a later focus
  - This allows us to think about “timing” and “pacing” for each individual client

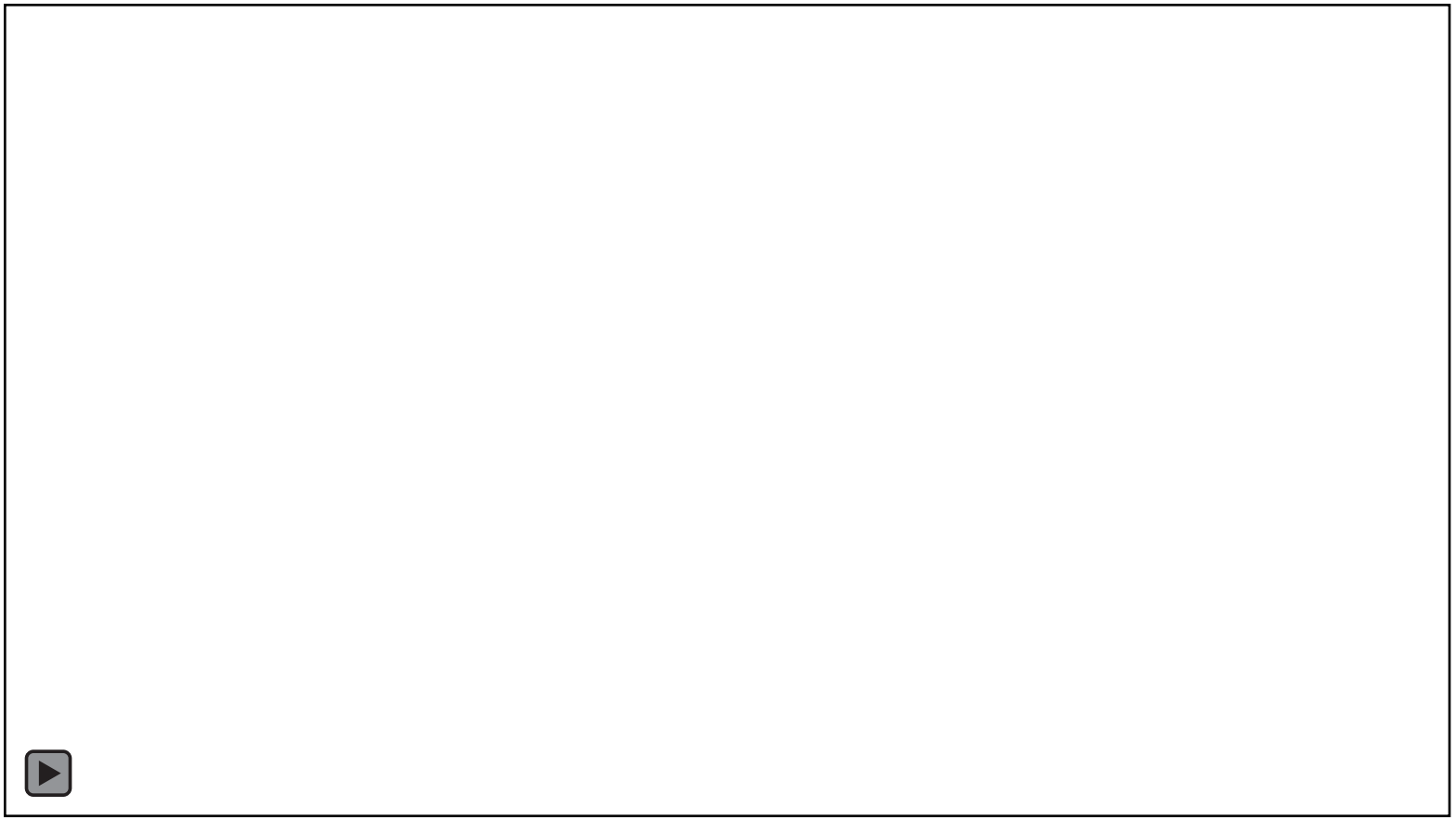
Activity: Multiple Ports

- We've described some ports- but there are many! Let's generate a list of all possible ports of entry....

Double Dutch

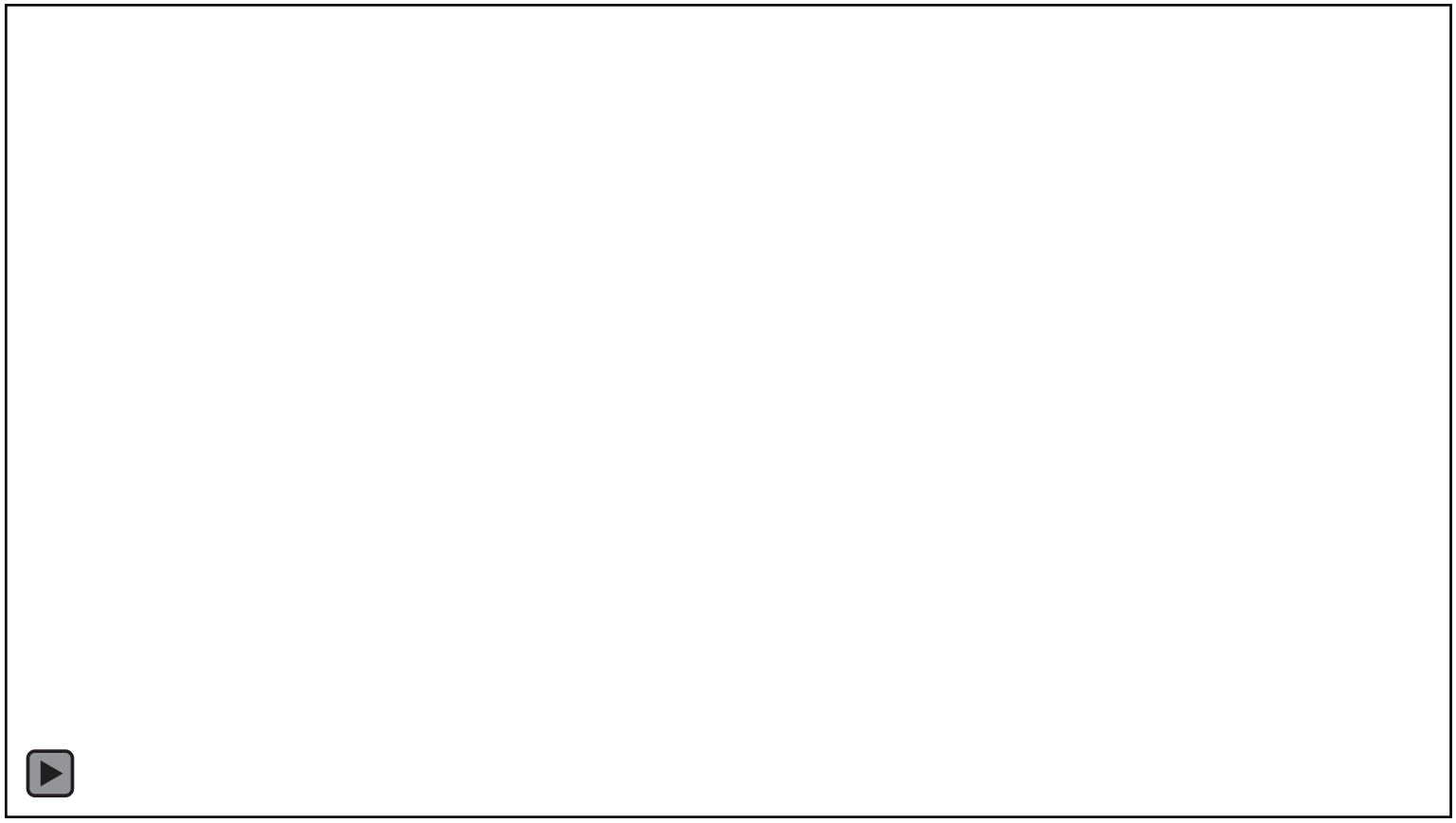
Finding the right port of entry can feel like double-dutch! You try to understand the rhythm of the environment, wait for the right moment and at some point, you just jump!

Double Dutch



https://www.youtube.com/watch?v=cAUyyUm5i14

Double Dutch



https://www.youtube.com/watch?v=u2jrJoJDZeM

Examples of Ports (adapted from Dugmore, 2014)

Parent's Representations of Self	"I am a bad mother for having so much stress during my pregnancy"
Parent's Representation of Children	"All children are manipulative and greedy."
Parent's Representations of Infant	"Our daughter is a gift from heaven."
Child's Representations of Self	A 2.5-year-old boy in foster care tosses the figure that has been representing him in play into a garbage can, saying "He's bad." Representative of self as bad and easily tossed away.

Examples of Ports (cont.)

Child's Representations of parent(s)	Young boy: “My mother likes my sister best.”
Infant's Overt Behavior (may include play and language)	An infant persistently averts gaze when parent tries to engage
Sibling Interactions and Relationship	Sister pins younger sibling down and threatens to spit on her
Parent’s Overt Behavior (verbal and nonverbal)	Parent cries softly when recalling their lonely childhood
Therapist’s Representations (countertransference)	Therapist’s irritation at a depressed, withdrawing parent who reminds her of her own parent

Examples of Ports (cont.)

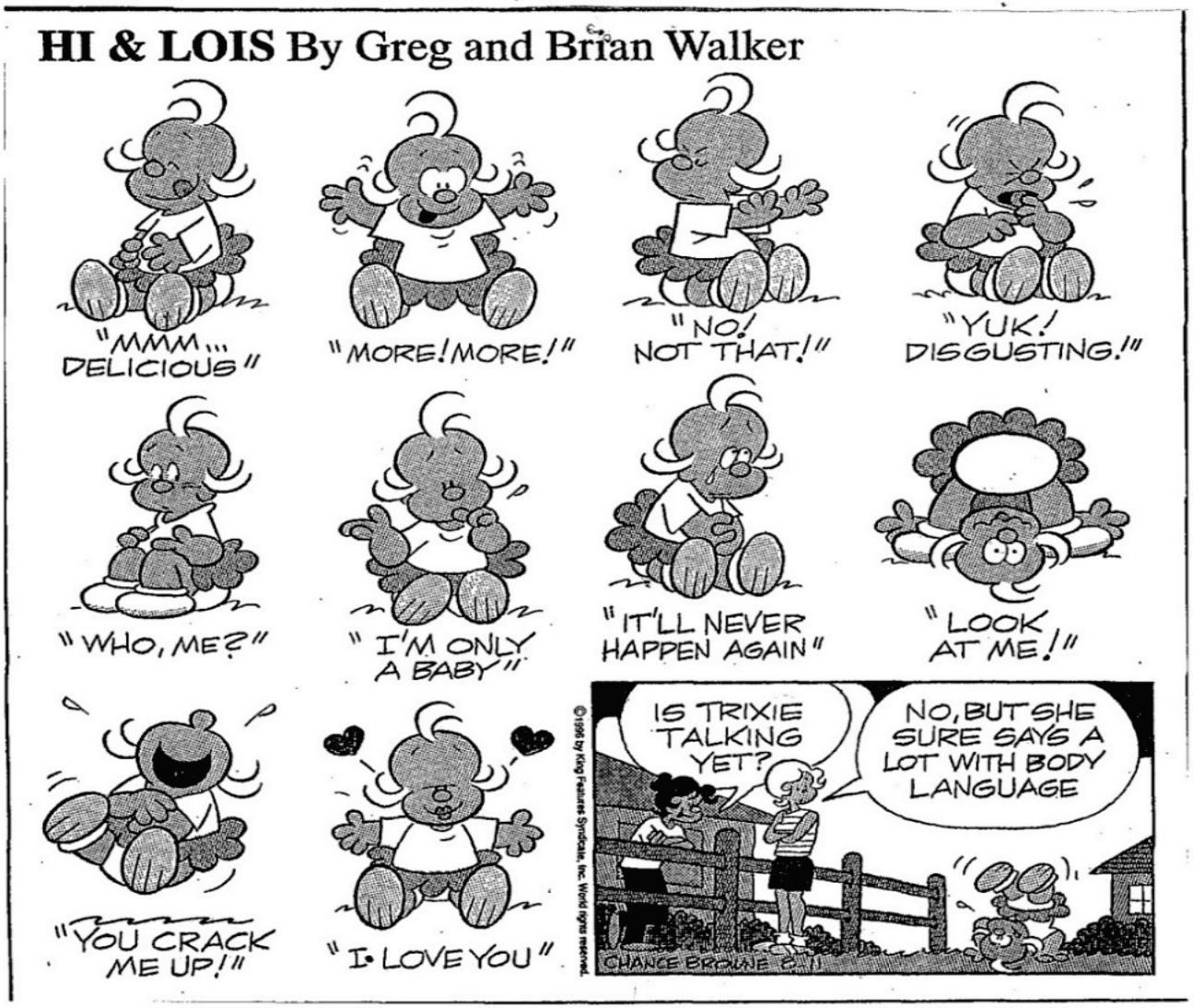
Parental Interactions and Relationship	Expression – verbal or physical - of conflict, criticism, and hostility (verbal and/or physical) between the parents (e.g., Father: “I am raising four kids, including her” referring to wife).
Toddler–Parents–Interactions (triadic)	Toddler will only allow a particular parent to perform bedtime routine
Parent–Therapist Relationship (transference)	Parent thinks therapist is always ”sticking up” for the baby
Child–Therapist Relationship (transference)	Three-year-old wants to keep a toy from the therapist’s bag, symbolically expressing a desire to keep the therapist close

Ports of Entry and Nurturing Reflective Functioning about Parent Mental State

- Exploring parent's affective state:
  - What was it like for you when…

- Progress to level of how affective state influences **behavior**, **relationships**, or **how affective states work**

Increasing Reflective Functioning... about the Baby



Ports of Entry: Nurturing Reflective Functioning about Infant Mental State

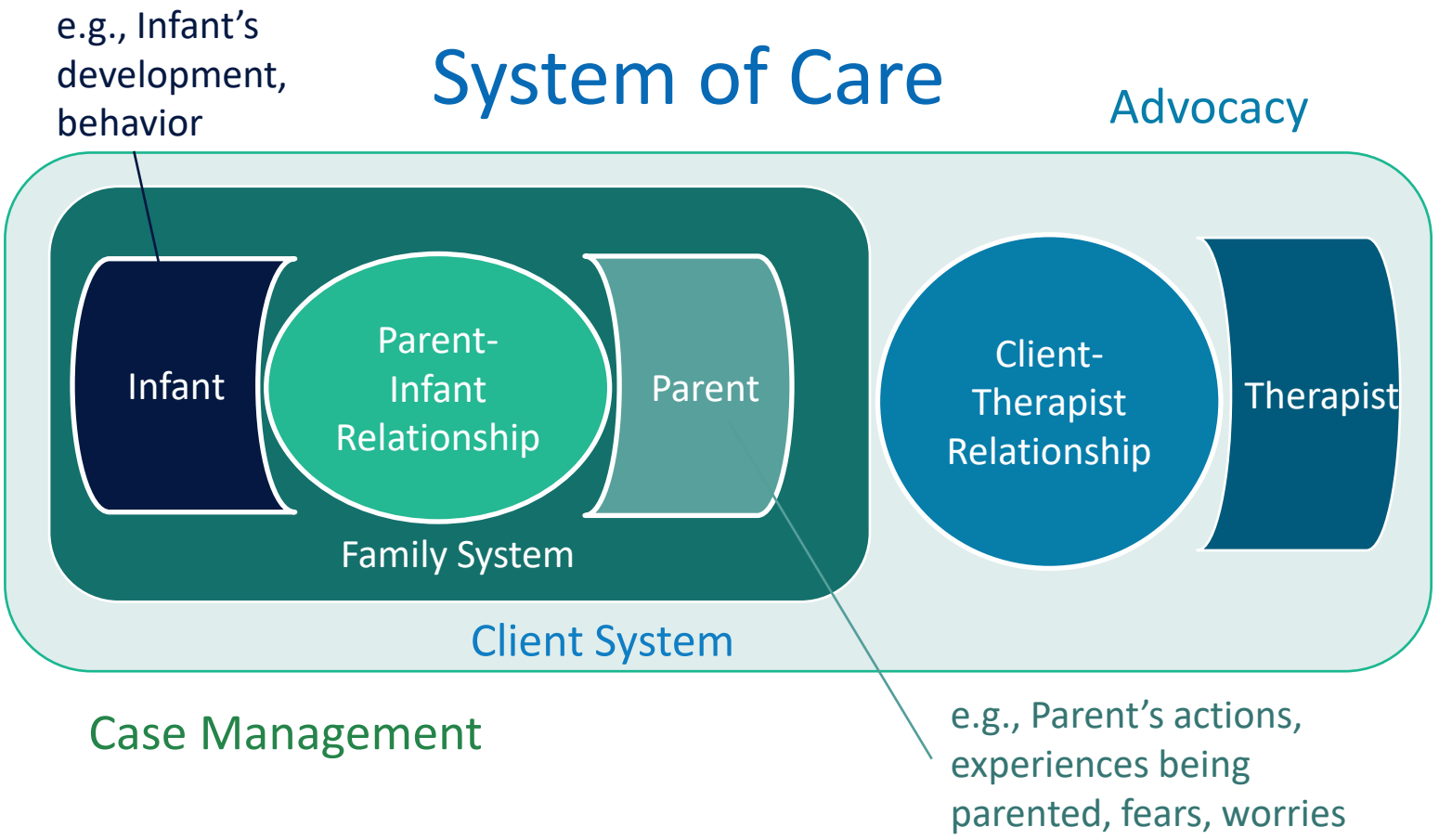
- As parent grows in trust with worker, and/or more self-reflective, then can move to the level of the infant/toddler.
- Look at infant/toddler's affective state
  - How do you think he might have felt when you told him you didn't want to play with him?
- Move to level of affective state influencing **behavior**
  - **I wonder if he could be crying because he wants more time with you?**

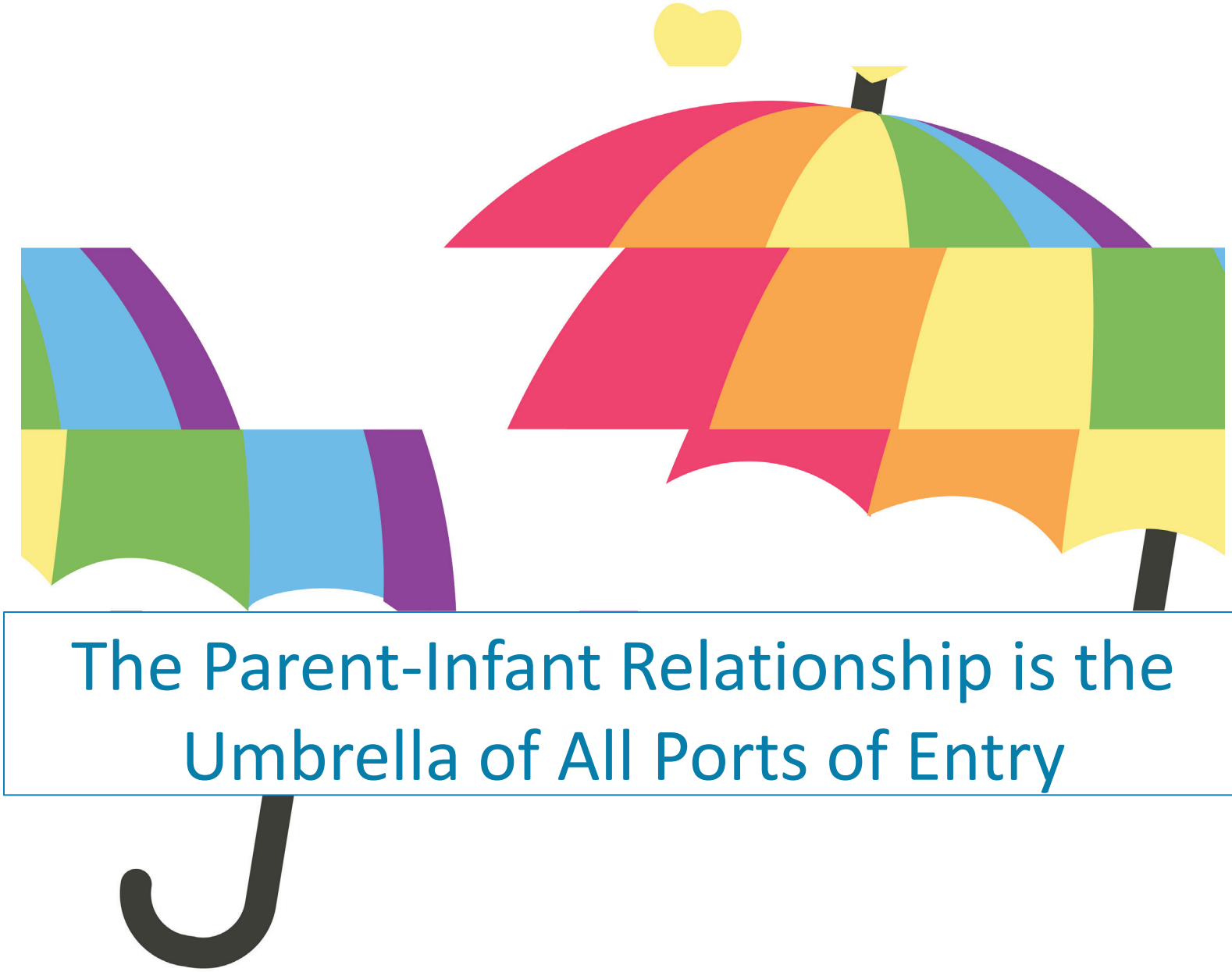
Ports of Entry/Infant Mental State cont'd

- Or influence of affective state on **relationship**
  - **"I wonder if he senses your frustration with him and then gets overwhelmed?"**

- Or influence of how **affective states work**:
  - **"He was smiling but could he be disguising the fact that it scares him when you are frustrated and angry with him?"**

Multiple Possible Ports of Entry





The Parent-Infant Relationship is the Umbrella of All Ports of Entry

Key Concepts Infant-Parent Psychotherapy

- Ghosts in nursery
- Angels in nursery
- Reflective Functioning
- Ports of Entry
- Transference/ counter-transference
- Attunement/mis-attunement and disrupted communication
- Projective identification
- Parallel process
- Sequencing/pacing
- Historical/race/ethnicity/culture memory/experience
- Balancing all relationships
- Reflective supervision

Transference/Countertransference

- Transference: "Transferring" past feelings, experiences, attitudes to current situations and present relationships– in particular, unresolved conflicts and past unsatisfactory relationships
- We are never who we think we are to a family – we are who *they think* we are! Developing the relationship so they can experience our care/intent takes time!! We don't always know who we represent to them.
- Countertransference: Clinicians' reactions, thoughts, feelings in response to or 'induced by' client
- Transference is a key therapeutic agent—it allows us to understand their experiences and create new ones

Illustrating Transference

- Ways in which clients/families approach us through the lens of their past experiences and their expectations of how relationships go
  - A parent who expects when you go on vacation that you won't come back because others have abandoned in past
  - A parent who is angry and hostile with you before they even know you
  - A client who assumes you are angry at them
  - A child who doesn't approach you when he needs help because he assumes you will reject him if he does

Countertransference

- Two ways this shows up in our work: Induced Countertransference and "Our Own Stuff" (which we all have!)
- Induced
  - Ways in which we “feel” what the client is feeling
    - e.g., as you leave a home where a baby is failing to thrive, you feel ravenously hungry
    - as you play with a child who is immersed in reenacting a trauma, you find yourself confused, anxious and tense

Countertransference Cont'd

- Our own “stuff” being evoked
  - Ex.: You feel angry at a parent who is abdicating or passive with her child without quite realizing that she reminds you of your own depressed mother who often left you to care for younger siblings
  - bias, racism, unacknowledged power

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What is attunement and how do we see lapses in attunement between parent and child?

Ruptures & Repairs: The Infant

- Ruptures and repairs are key concept (Winnicott D. W., 1973: *The Child, the Family, and the Outside World,* p. 10). A good enough parent cannot meet every need of their baby
- Parent must learn to step in to repair the rupture in the relationship. When done too late or too little, the baby or toddler may feel overwhelmed by distress

Ruptures & Repairs: The Infant Cont'd

- No parent is able to "get it right" every time. These can be smaller ruptures or bigger ruptures.
- Allan Schore: resilience is built on tolerance of negative experiences. However, the quicker a parent can notice the rupture and skillfully repair it, the better a child will learn to self-regulate (Schore, 2003)
- The child learns to trust that even though it is an imperfect world, their parents are there for them and will not abandon them. Our mental wellness is based on knowing we are safe and supported.
- We also need to consider the role of racism, power, oppression and the understandable adaptions that parents make when the world is not a safe place.

Ruptures & Repairs: The Parent

- Larger ruptures and disruptions can lead to greater need for parent-led repairs
- Typically the parent needs to take a lead in the repair, in essence, changing a dance step, leading a "new way" with their children
- In other words, the parent takes a lead to bring the infant back into the optimal range

Discussion

- Examples of disruptions and repairs between parents and babies

On your family culture genogram, add how ruptures and repairs are part of your family culture.

- How often do people cut each other off?
- What topics lead to ruptures?
- How do those cut-offs end?
- Who is usually responsible for repairing those ruptures?
- What happens after there is a repair?
- If there are minimal numbers of ruptures/cut-offs, what in your family culture lends itself to this?

Reflect

Write or think about:

- What do you notice in your family culture about rupture/repair?
- What does it feel like for you when there is a rupture in your family?
- How might this show up in your work with families and babies?

How do we see ruptures and repairs between therapist and client/s?

Ruptures & Repairs: Parallel Processes

- Examples of ruptures in therapeutic relationships: canceled appointments, not understanding the importance of a shared vulnerability
- Repairs provide the example and experience that relationships don’t need to remain broken

Examples of Lapses in Attunement in the Therapeutic Relationship

- These lapses in attunement can be felt as ruptures
- Out-Mothering the Mother
  - Examples: Being a “Better Parent,” timing errors- too quick to correct, failing to appreciate parental emotional constraints, giving unsolicited advice from a dominant perspective
- Lapses in keeping the baby in mind
  - Examples: Not “seeing” the baby, failing to recognize or address a parental distortion
- Both “directions” in lapse can be influenced by countertransference

Factors that Complicate Attunement in the Therapeutic Relationship

- Clinician's countertransference or secondary traumatic stress
- Clinician's bias/beliefs about the family or family's culture
- Systemic burdens, for example:
  - CPS involvement
  - Systemic barriers to service provision
    - Heavy case loads
    - Clinician isolation in a HV model
    - The weight of poverty; inability to meet concrete needs
    - Lack of consistent supervision

Repairing the Therapeutic Relationship

- Name the rupture
- Give space for the parent to discuss feelings
- Reflect on the rupture and the repair
- Respect your own thoughts and feelings
- Respect the thoughts, feelings and ideas of the other
- Acknowledge your part in the rupture
- Consider apologizing
- identify and acknowledge what might be different moving forward

"The process is the teacher." - Heller & Gilkerson, pg. 115

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Identification

- Identification itself is a neutral process– but can have positive or negative effects depending on the specific identification
- A central part of psychotherapy can be the rethinking of old and now problematic identifications that were entered into automatically (there is usually a reason it made sense at the time)
- Positive identifications/‘good memories’ may be protective– for example, identifying with the “angels”
- Projective identification with "ghosts" or problematic projections of others can be an important focus of treatment

Elements of Projective Identification

- Projection: Projections can be benevolent/positive or distorted/hostile/rejecting

- Identifications that might reflect distorted/hostile/rejecting:
  - identify with the aggressor and become scary, overwhelming, harsh
  - identify with the victim side and feel helpless in current situations with the baby, even though they aren't
  - identify with the bystander and not protect their infant
  - can inhabit all three stances at various points in time

- In projective identification a parent unconsciously disavows vulnerable or unwanted feelings and instead projects them onto the infant (can also occur with partners, co-workers, and therapist!) and behaves accordingly towards that person. Ultimately the infant (or other person), begins to identify with those projections

Process of Projective Identification

- The first stage of projective identification involves the parent using a defensive psychological action to get rid of aspects of their emotional experience that are unbearably painful or incompatible with consciously held views of the self. This unwanted experience is attributed (projected) to another person.
  - Ex.: Parent feels angry at infant, but feels uncomfortable and cannot consciously acknowledge this, and instead perceives infant as angry & demanding… that is, they project this onto the infant.
- "Baby as a blank slate" – the parent "projects" attributes onto the baby
  - Ex.: a mother who believes her fetus kicks her on purpose because the fetus is angry that the father has abandoned them

Projective Identification

- The next stage of projective identification is the "pressure to comply"-- where the projector (i.e., parent) pressures the recipient to behave in a way that is consistent with the content of the projection
- This is typically an unconscious process.
  - For ex: Parent may delay in responding to baby's distress– leading baby to become inconsolable and disorganized, thus confirming of sorts the parent's projection that he was demanding or "spoiled."

Projective Identification

- In the final stage of this process the recipient (e.g., baby) complies with the pressure exerted on him to fulfill the projector's expectation and behaves accordingly.
  - Example cont'd: The infant learns that there is no response when distressed, so becomes more demanding, cries more, and consequently has identified with the parent's projection. May eventually become a person who "needs too much" and doesn't trust relationships to be fulfilling.

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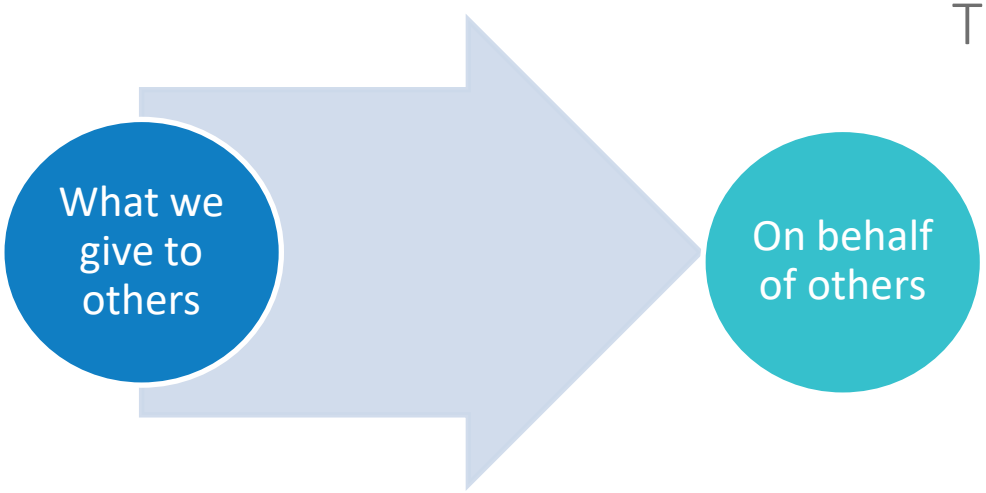
How Do We “Know” How another Feels?

Two Forms of Parallel Process

Do Unto Others



Induced Countertransference

- Induced Countertransference
  The way we comprehend the states of others

Platinum Rule

"Do unto others as you would have others do unto others."

~Jeree Pawl

Parallel Process

"Do unto others as you would have others do unto others."

- if we want a parent to listen more closely to infant cues, they also need the experience of being closely listened to…and in order to do this, you need the experience of being closely listened to, as well
- Use what you know, what you experience, to begin to understand what the parent may feel

Parallel Process and Reflective Supervision/Consultation

- We can use our observations, insight, empathic awareness, and induced feelings in helpful ways
- We need reflective supervision/consultation to understand, tolerate, and make sense of our own reactions in order to understand the client/dyad, and to create the potential for new meanings and experiences
- We will more fully cover reflective supervision/consultation another day

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Sequencing

1. Examine conflicted feelings
2. Create and exchange words for painful feelings
3. Identify or locate feelings rooted in past experiences
4. Support understanding why feelings exist, coping strategies and defenses that had function but may interfere with present
5. Recognize these defenses are no longer needed
6. Create healthier patterns of coping, relating
7. Create healthier patterns of coping, relating

Sequencing cont'd

- Start with building trust
- Create safety
- Scaffold and nurture insight and understanding
- The process is not simply linear- we circle back, and sometimes feel like there is a big 'leap'
  - Aha! moments - moments when we truly understand, and the client recognizes we understand them
  - Stern and the Process of Change group identified these as nodal moments when change occurs

Pacing

What factors affect decisions about timing?

How do you make these decisions?

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Historical/Cultural/Race/Ethnicity Memory & Experience

Historical trauma is not about what happened in the past. **It's about what's still happening.**

What is Cultural Healing?

Achieving racial justice requires that we understand racism. Not an understanding that emerges from intellectual exercise or even in the consumption or production of science—but rather a visceral understanding that connects to spirit and body as much as reason. What would it take for you to not just feel bad, or empathize, but to act and feel differently. **What** would it take?

– Courtney Cogburn

Immigration and Attachment

- **Beliefs, Values and Practices**
  - How do you see your role in feeding your child(ren)
  - How do you show love to your child(ren)
  - How do you comfort your child(ren)
  - Can also explore values around dependence, sleep, touch, play and teaching

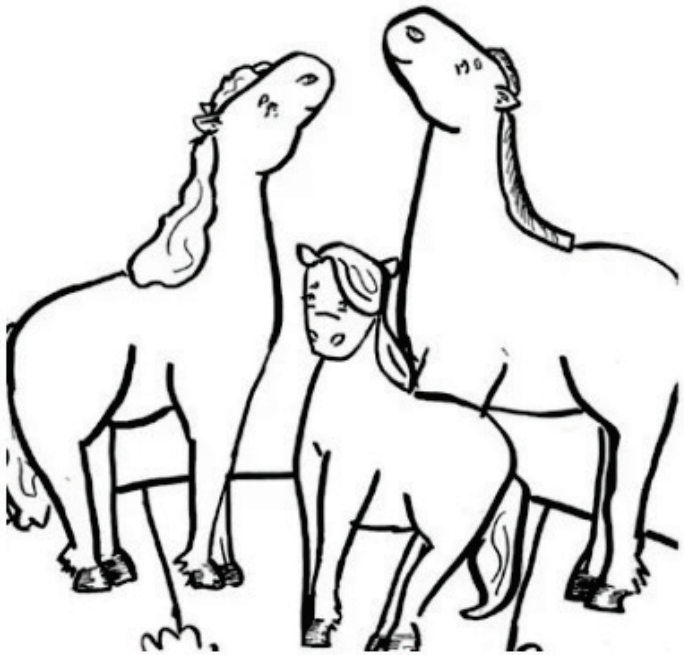
Immigration and Attachment Cont'd

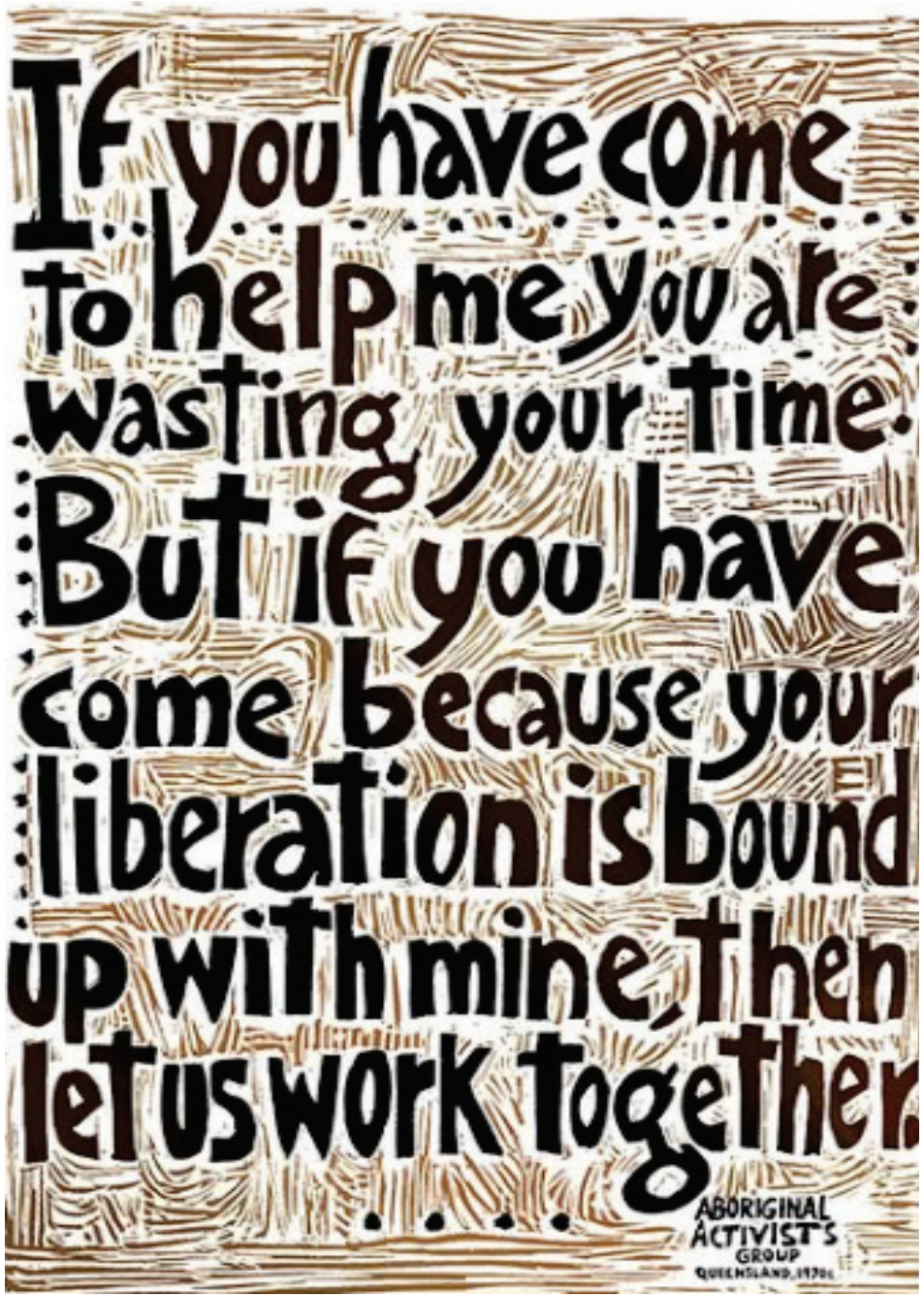
- **Impact of Immigration**
  - What does home mean to you?
  - How has your move to the US affected the way you show love to and respond to your child?
- **Maintaining Effective Parenting**
  - Do you feel your parenting practices are respected in the US?
  - What barriers do you face? What supports do you need?
  - What could we do to offer more support?

Cecilia and the long walk

"A children's story - Cecilia and the Long Walk - meant to help children understand their recent experience of being separated from their parents/hearing about other children being separated from their parents, providing language to help organize internal confusion and terror. The story is presented as a coloring book, with version available in both English and Spanish. "

https://tenderpressbooks.com/cecilia-%26-the-long-walk





Anchoring our Work in Anti-Oppressive Practice – The Wisdom of Lilla Watson

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- **Balancing all relationships**
- Reflective supervision

Holding Multiple Relationships in Mind

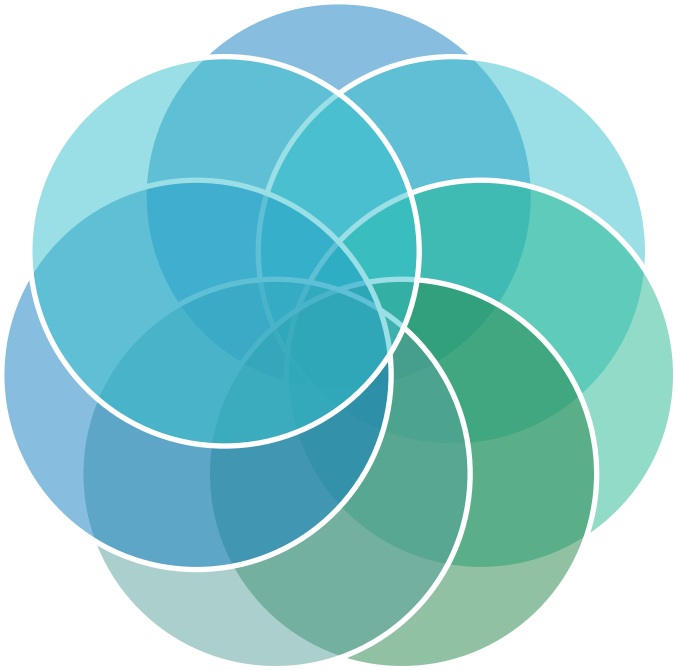
- What is it like to be this baby in relation to (parent)?
- What is it like to be this parent in relation to (baby/therapist)?
- **What is it like to be this person in relation to (extended family/community)?**
- **And more...**

Balancing All Relationships

Parent

Extended Family/Kin

Baby



Siblings

Parent

Gardians

Clinician

Relationships in Infant-Parent Psychotherapy

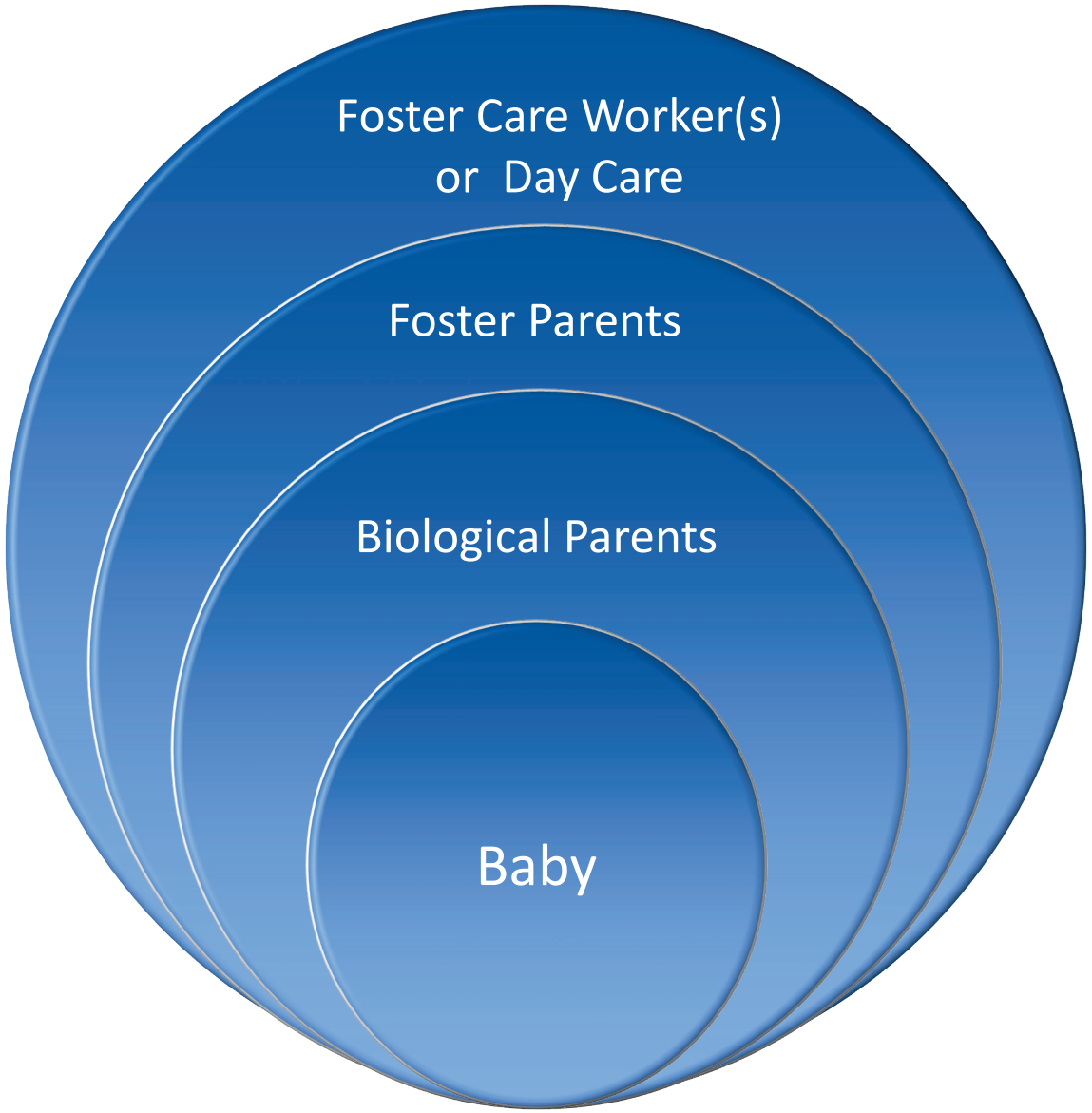
- Relationship-based practice– therapeutic alliance with parent and with the baby
- Therapist strives to balance attention to mulitple relational dynamics – and these include but are not limited to:
  - parent-infant
  - parent-therapist
  - baby-therapist
  - dyad-therapist
  - therapist –supervisor, etc.
- Relationships to systems matter, too!
  -

Balancing Many Relationships

Consider what happens if you only attend to one of these "nests"?

For example, only attending to biological parents, when the baby is in foster care?

Or not attending to the biological parents?



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- **Reflective supervision**

Reflective Supervision

- Is addressed at length in future Learning Gatherings
- We encourage personal reflective practice
- Deep engagement in reflective supervision supports better outcomes for families
- If you receive reflective supervision from your agency supervisor, seek outside reflective supervision if there is discomfort in delving deeply into your inner world in that setting.

Summing it Up: The Practice of IPP

1. Examine conflicted feelings
2. Create and exchange words for painful feelings
3. Identify or locate feelings rooted in past experiences
4. Support understanding why feelings exist, coping strategies and defenses that had function but may interfere with present
5. Recognize these defenses are no longer needed
6. Create healthier patterns of coping, relating
7. Create healthier patterns of coping, relating

Infant-Parent Psychotherapy

Parent/Childhood Experiences

Parent brings with them the parenting skills they have inherited from their own childhood experiences.

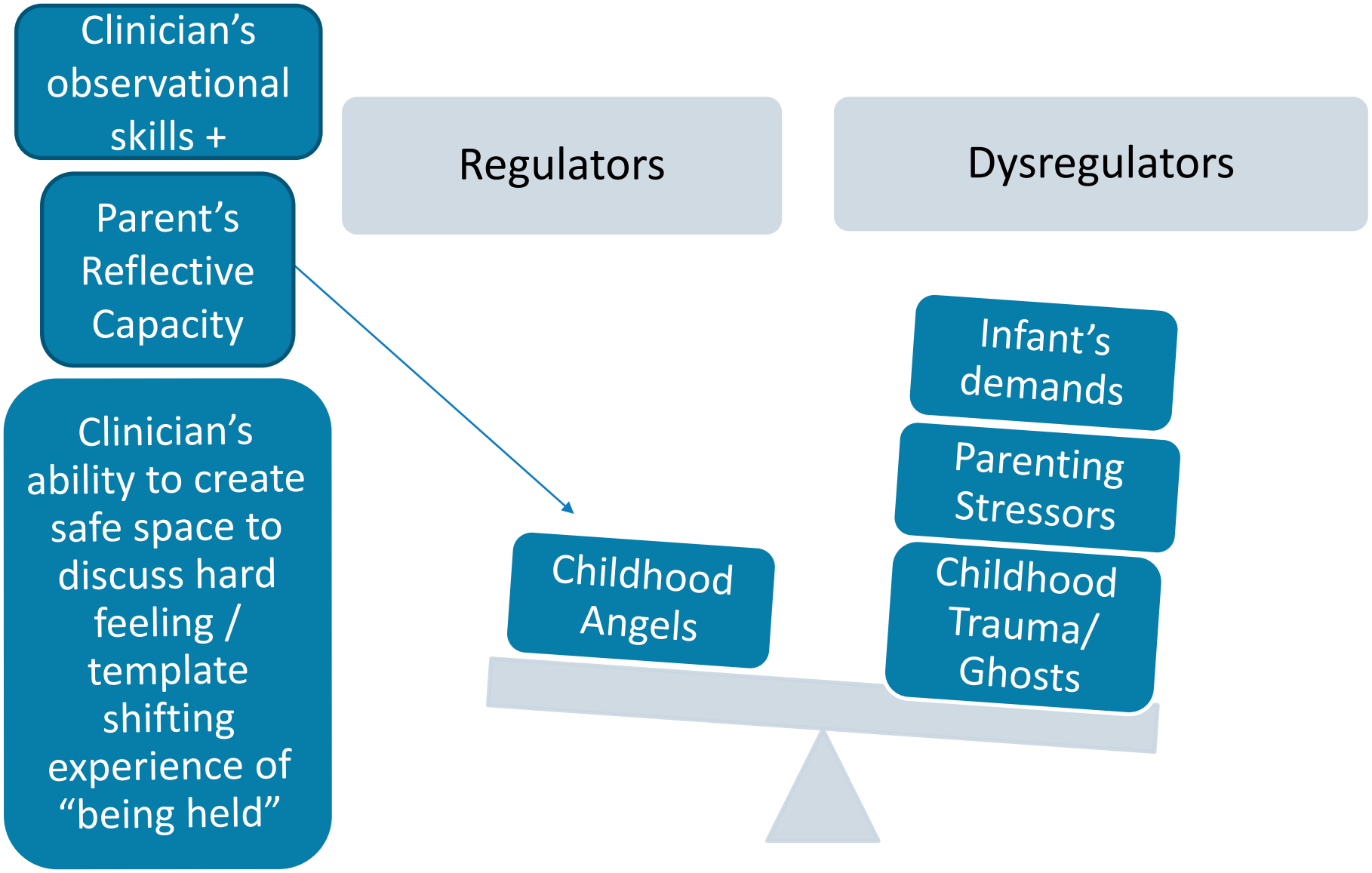
Parent/Infant

Infant evokes feelings in parent that may trigger unresolved trauma from experience of caregivers. Clinician uses infant as a tool to discusses these experiences with parent so that the parent may reflect and see the way experiences influence their own care giving experience.

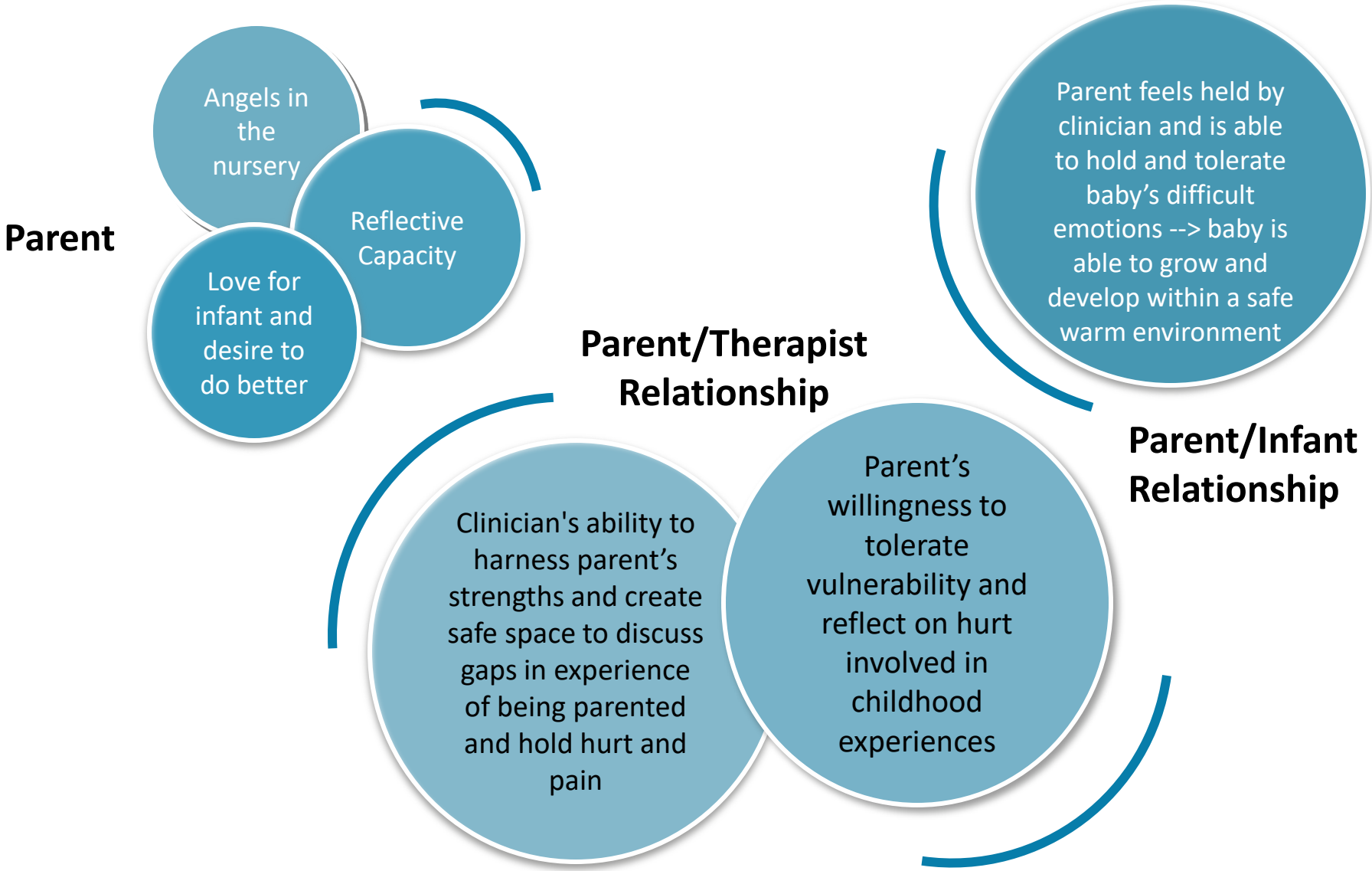
Therapist/Supervisor

Clinician (with aid from supervisor) gives parent the experience of being cared for in a way that the parent did not experience in childhood— “fills in the gaps” of missed caregiver experiences/ experience of being held so parent can in turn hold infant and have richer/warmer parenting skills

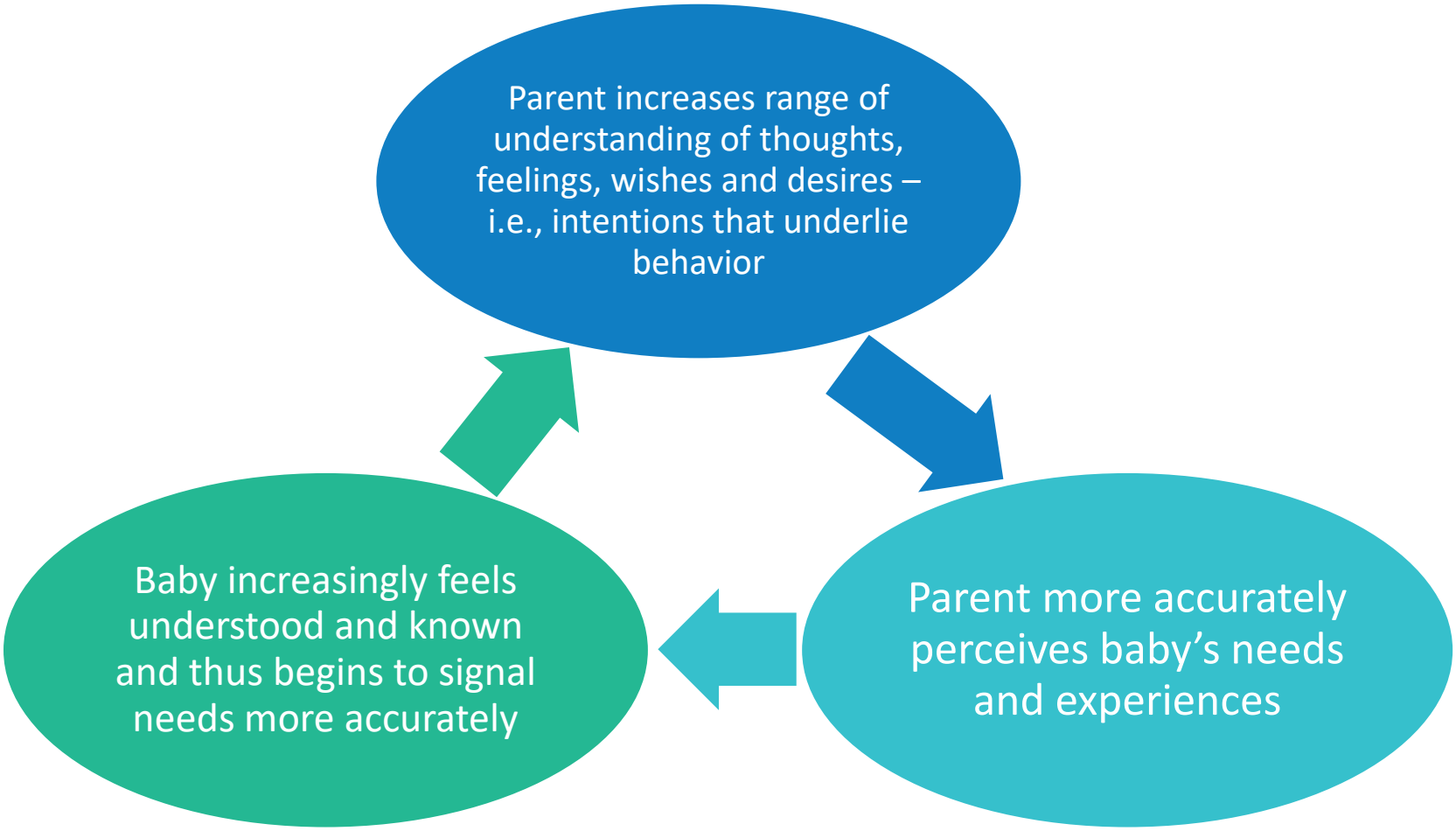
Infant-Parent Psychotherapy



Angels in Infant-Parent Psychotherapy



The Therapeutic Process

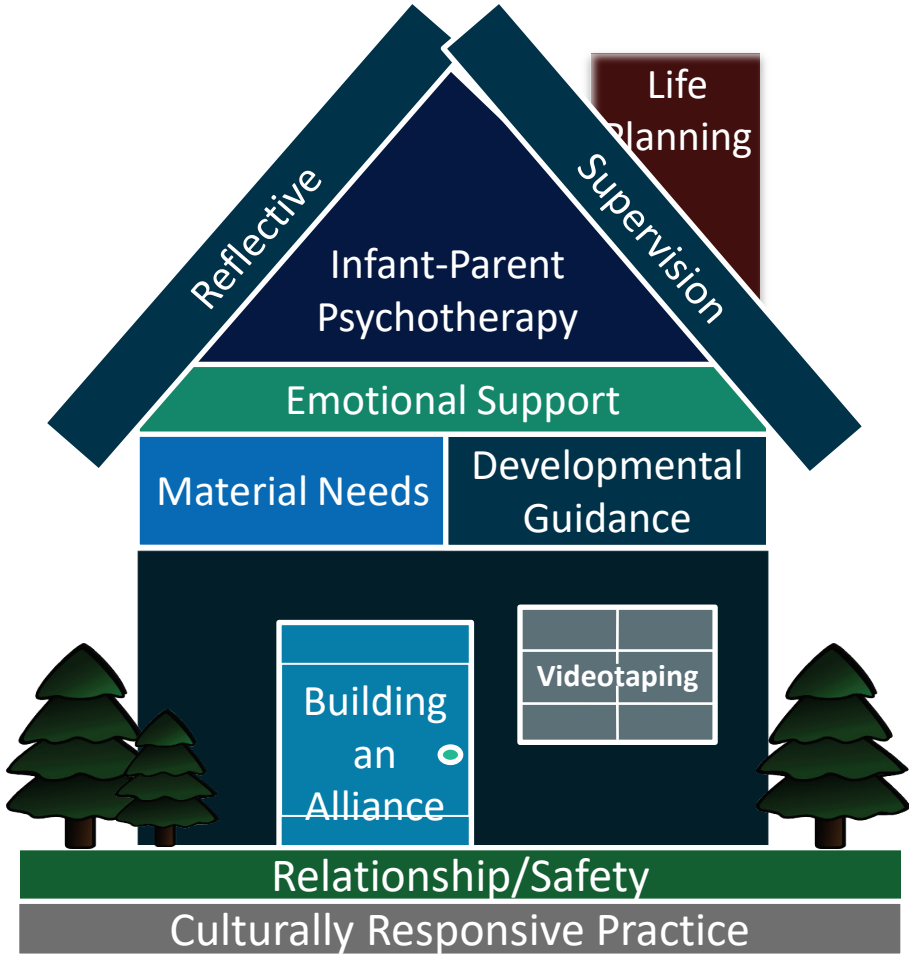


Vignette Practice Activity

1. Each person in a group should be assigned to consider how to 'craft' an IPP intervention that addresses the needs or experiences of ONE of the perspectives in the vignette (e.g., parent, child, 2nd parent, sibling, co-parent relationship, parent-therapist relationship, therapist-reflective supervisor relationship).
2. Read the vignette as a group, then consider what you might have done or said to address the perspective assigned in step 1. Share why you chose that approach for IPP.
3. After you have all shared your interventions, as a group craft an intervention that might hold the perspective of the parent AND child and that might strengthen the parent child relationship

Revisiting the Intentions of this Section

- Review the transition to parenthood and common mental health concerns in the early parenthood
- Identify how IPP with pregnant people differs from IPP with a baby present
- Increase participants' awareness and understanding of the concept of ghosts and angels in the nursery
- Develop participants' capacity to therapeutically address protective factors and barriers to parent-infant relational health



Questions?