Observation, reflection and containment: a psychoanalytic approach to work with parents and children under five.

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What does psychoanalysis have to offer in understanding the development of children's early years? It offers a theory of mental development, combining contemporary psychoanalytic theory, infant and young child observation in naturalistic settings, and the expanding field of early clinical interventions. Ongoing research in infant and child development, including discoveries in the field of neurosciences, also contribute to our knowledge base.

In this chapter we will describe three contemporary models of intervention for working with under fives and their families, illustrating each with a brief vignette. These are: initial parent consultation and family assessment as part of longer term work with complex cases relating, for example, to 'looked after children'; quick response, brief psychoanalytically based interventions, which form the basis of the Tavistock Clinic's Under Fives Service; and consultations to professionals working with parents and their young children. We will then discuss the theory underpinning these ways of working which all arise from the application of psychoanalytic ideas about development.[1]

Consultation for a family in crisis

[1] The first case was seen by Margaret Rustin and the second case and telephone consultation were the work of Louise Emanuel.

A clinical vignette from a first consultation with distraught parents and an out-of-control toddler is a fitting starting point.

The couple in question were experienced and very thoughtful adoptive parents shocked to the core by the arrival of a second adoptive child. They approached the clinic asking for an urgent appointment. In the three months since the placement of this eighteen month old, they described vividly how their lives had been turned upside down. Their previously contented three and a half year old was frightened and deeply upset by the wild and aggressive behaviour of the newcomer, who threw anything he could lay his hands on and kicked and punched without warning. Both parents were exhausted and had fallen ill. Their distress focussed on the endless screaming of the toddler, his complete failure to respond to their parenting (a mixture of defiance and blankness, they felt), his overwhelming hyperactivity and unpredictable violence, his endless diarrhoea, and the complete disruption of their 3 year old's equanimity, in the face of which they felt guilty and helpless.

This 18 month old was not the ordinary toddler described to them by his social worker before his arrival, just beginning to pick up words and easy to manage, who had been in one stable foster placement since birth. Was he suffering from a childhood mental illness, they wondered. Autism? ADHD? Their home felt to them like a madhouse, Mother frequently reduced to tears and Father disturbed by how enraged this little boy made him feel and his consequent desire to restore the peace by throwing him out and rescuing his wife and 3 year old from the monster wreaking such emotional havoc. Their fears about a possible genetic component ran high since the child's birth history contained serious criminality, addiction and more.

When they brought the toddler to the second appointment it was astonishing to see both how small he was and then to watch as he turned himself into something like a fireball, hurtling around the consulting room at speed. He used the toys (both those brought by his parents and those provided by the therapist) as missiles and his own body was in perpetual motion. However, he responded to remarks about his interest in getting out of the door and into the cupboards by looking hard at the therapist with bright eyes, and his immediate comprehension seemed evident. Later when he became thirsty, he accepted lying on the floor across his Father's legs and drinking from his bottle. At this point the therapist thought it might be possible to attract his attention to the toys and to create a narrative line. She sat the soft baby-like doll on her lap and made the doll talk about how delicious that drink looked and how cosy he seemed to be on Daddy's lap. How lucky he was to have a Mummy who brought his bottle in her bag. He responded, to his parents' amazement, by getting up and making pretend tea with the doll's tea set the therapist had put on the small table between them, and carefully offering some to the doll who was sitting on the therapist's lap. They suddenly saw a boy who understood conversation and who was now playing a game, which they had almost ceased to believe was possible. It was a transformative moment. The creation of meaning had cut into a discourse between parents and child that had become devoid of symbolic possibility and reduced to a matter of survival all round. Terror, in different ways, had come to dominate their interaction – the toddler constantly making them fearful for his safety or someone else's. They all seemed to feel they were hurtling towards an inevitable catastrophic outcome in which the family of four could not be held together. The firm containment within the security of the consulting room offered a chance for this shared unconscious phantasy of

unstoppable destructiveness to be tested. The therapist could see not an all-powerful little monster but a child in a panic with whom it was possible to talk.

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This was, of course, just a glimpse of a different way of relating, but it heartened the parents, and was a first step in helping to bring about change. The fundamental theory underlying the therapist's intervention was that containment had broken down in this family. She saw a frightened and omnipotent toddler who could neither be held physically nor feel understood by his parents, parents whose psychic and somatic solidity had given way. She could also vividly imagine the three and a half year old at home who felt he had lost all sense of basic security. A whirlwind of frantic projections between family members had taken over. The clinic consultation provided a safe space, and the possibility of the therapist observing the situation from a fresh perspective. She talked to both parents and toddler while sharing the chaos and yet able not to be taken over by it. The room was indeed reduced to a total mess and the therapist had to join with Father in coping with the toddler's dangerous exploration of the windows, and certainly could not simply sit and think!.

Brief intervention: the Under Fives Counselling Service

A clinical example of a brief family intervention will serve to bring out an important feature of any work with young children, namely the relative speed of change that is often possible as a consequence of the thrust of the developmental process.

This case illustrates the range and flexibility of interventions possible in brief work with under fives, and the way in which a 'selected fact' (Bion) emerges. Six sessions were offered over a period of three months: an initial parent meeting, followed by a meeting

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together with Rosa, aged 4; then two family sessions which included her 8 year old brother Marco, and finally, two parent meetings which helped us gain an understanding of how their own backgrounds may have contributed to their current parent and couple difficulties. By the final session the parents and Rosa's nursery felt that substantial improvements had been made and subsequent contact with the parents indicated that the changes were maintained.

Rosa was referred to the Under Fives Service at the Tavistock Clinic by her GP, because her disruptive, controlling behaviour at school and home was becoming unmanageable. I invited the parents to meet me to discuss their concerns about Rosa. In the event, only mother attended, and described the considerable difficulties they were facing. She painted a picture of a fiery tempered child who smashed her toys in frustration if thwarted, could not follow rules at nursery, and lashed out at other children. She recently locked out of the house two friends who came to play, and pelted them with toy bricks from her bedroom. I also heard that Rosa hated noise, could not cope with change and appeared to hate mess, tidying her things into boxes to ensure they were all in order. She found it difficult to be left at her 'noisy, messy' school, wailing bitterly at the gate.

As a baby she had been restless, scratched at her face, and had long screaming fits. Mother had breastfed Rosa and weaned her at 9 months, because she felt 'trapped'. It had been difficult for Rosa to relinquish the breast. When mother had recently told her that she would soon be returning to work, Rosa had flung water over her laptop computer, damaging it. Mother's plans seemed to have increased Rosa's clinginess and refusal to relinquish control. Perhaps, I hypothesised, she feared being dropped out of mind when mother turned to other preoccupations. I also wondered whether fears of

another baby displacing her might play a part in her separation difficulties . Mother was interested in this idea, saying that Rosa had been asking her about more babies in the family. My impression from our conversation was of a child who could be controlling and tyrannical, but who also sounded frightened and unhappy. We arranged for the parents to bring Rosa for the following session in a fortnight's time. Mother made brief mention of a debilitating illness she had been suffering from before conceiving Rosa, and a miscarriage which occurred during a visit to Italy (their country of origin),when Rosa was 15 months.

Meeting Rosa

Rosa, strikingly big for her age, led the way apparently confidently into my room and, after introductions, her parents launched into the difficulties at home with her demands to get things 'just right'. I heard about a furious tantrum that morning about her clothes, once she realised she would be missing school to come to the clinic. I turned to Rosa and asked: 'was it because her clothes hadn't done exactly what she had told them to?' She nodded, showing me how she wanted her jeans hem tucked down tightly inside her boots. It was as though, faced with a change of routine, Rosa needed to be tightly held in the 'skin' of her clothes.

As mother described Rosa's complaints about itchiness and discomfort, I found myself thinking of the 'restless, scratching' infant described in our first meeting.

Rosa had begun drawing what appeared to be a princess, with long dark hair like her own. I described how, in fact, *she* sounded like a princess, who commanded everyone to do her bidding, and she laughed, as did her parents, saying it was true. I heard that in the

car on the way to the clinic Rosa had been poking a sharp pencil into the front passenger car seat, damaging the upholstery. I wondered aloud whether her mother had been sitting in the front together with her dad, to which they agreed. I said how difficult it seemed for Rosa to be a little girl in the back, allowing mum and dad to be together in the front. The parents said wearily how discouraged they were and mother described feeling 'flattened'. I suggested that Rosa could not hold onto her feelings of frustration and helplessness, but that they all spilt out, lodging in others, particularly her parents. Being on the 'receiving end' of Rosa's distress could leave them feeling doubly useless. They seemed relieved, and when I mentioned that Rosa seemed an anxious child, they were able to talk about her difficulty coping with transitions and change. Mother said they never knew when Rosa was going to erupt next. I said that this was an interesting communication, which might give us a clue. Perhaps mother's anxiety about Rosa's unpredictable behaviour, and the 'shock' she might give them was Rosa's way of conveying the nature of *her* anxiety; of things happening unpredictably, and giving *her* a shock. Her mother agreed, recalling that when the classroom had been painted without warning, Rosa had refused to enter it. I addressed Rosa, who had been listening as she drew, saying 'it sounded as if she hadn't been sure it was the same class and didn't know if it was safe in there,' and she nodded expressively. Father talked about her love of soft fabrics and furry toys and her need to be tucked up very tight in bed at night. I suggested that despite her 'tough' appearance, Rosa needed to be wrapped like a tiny baby at night to hold her together.

Rosa regularly interrupted, and drowned out our talk and father described how she covered her ears at home when she didn't want to hear. I said it seemed as if Rosa

seemed to operate on a sensory level, like a much younger child, and had little capacity to process these sensory experiences which quickly became overwhelming for her.

Family meetings

At this point I thought it would be helpful to meet the family and two sessions were set up at fortnightly intervals. Rosa dominated the first meeting, becoming increasingly physically intrusive towards the other members of the family. In the last 5 minutes Marco, who had remained largely silent, began to cry quietly and I took up his silent distress. In contrast to his sister's emotional outbursts, he had held onto his upset for the entire session.

The second family meeting included some transformative moments and signalled hope of change. The family looked relaxed, having recently returned from holiday. Mother mentioned Rosa's birthday, suggesting hopefully that she would behave more sensibly now she was five . I asked Rosa if she had had a birthday party, and she said 'yes', at which her parents exclaimed this wasn't true – it was due to take place that Saturday! Father commented on this sort of 'lying' which had been reported by a concerned teacher. I felt a little bewildered by this, as if this was an attack on my thinking, a way of muddling me. Mother described Rosa's furious tantrum and hours of sulking when asked to tidy her room. A baking activity had culminated in the cake mix being flung to the floor when things had not worked out perfectly. I talked about Rosa's difficulty tolerating someone else being in charge, or showing her something she may need help with. Rosa, who had been drawing and listening, exclaimed: ' yuck!', saying she had something nasty in her mouth (possibly a bit of pencil). I suggested she did not like what

I was saying about a grown up being the one in charge. She turned her back and began a loud conversation on the toy phone.

She then began to explore the room, returning to her seat with a baby's rattle which she flung across the room at her brother. I said that we had been talking about how Rosa feels easily mortified if asked to do something, as if being small is very humiliating, and she is showing us what she feels about babies, and being the youngest in the family. Rosa nodded at this, but several times she interjected: 'Nonsense!' as I talked. This became disconcerting and I spoke about her need to muddle me up. I thought I was to have an experience of what it feels like not to be able to think properly, to lose my capacity to function effectively and set firm limits for her, a common experience for her parents.

Rosa began leaping around wildly, flinging herself onto her parents' laps, roughly pulling at their ears and noses as I sat wondering what made it difficult for them to stop her. I talked about how habituated they had become to this manhandling. It seemed to me to be intolerable, a concrete imparting of her physical states of discomfort into them. Rosa jumped up and found a baby toy with different sized, coloured hoops. She threw the hoops over the central pole, missing out the large base one all in the wrong order. I had a thought that she might have experienced a moment's anxiety at realizing she had 'failed' the task, but in a second she was lunging at Marco. I wondered about the difficulty of saying no and Marco said: ' I let Rosa do it because it makes her feel happy'. Marco went on to say that if he didn't let Rosa do this, she would get angry. I said it sounded as if anything was better than an upset Rosa. I described how the family seemed to be living under siege, taken hostage by their daughter – and the parents agreed with some relief.

Rosa went and sat on a large chair, her legs spread out wide on each arm. Her parents told her to put them down and she did for a moment, then returned them, sitting spread-eagled and exposed. I said I thought that when they described Rosa as ‘happy’ it seemed to be more about how excited she could get. Everyone gets drawn into physical pushing and pulling, which ends up with hurt. Rosa farted loudly and I described how she seemed to be filled with sensations which overwhelmed her and which she needed to get rid of. As I was talking to father, Rosa told me firmly: 'His name is not Mr Gadi (how I had always addressed him), it is Mr Leonides’, repeating this assertion and stopping me in my tracks. I asked father about this, he shook his head, and it became clear to us all how Rosa had completely immobilised me. I described the growing undercurrent of confusion I had observed, and suggested that it would be anxiety provoking for Rosa if she felt she could muddle her parents in this way as she wouldn’t then be sure there was anyone to keep her safe. There was some laughter of recognition from Marco and father as I described this.

As I heard more about their daily routine, I enquired how much time Marco got to spend with his dad. His expression became sad. I said I thought Rosa might feel worried if she believed that she has been allowed to 'steal' others' share of attention in the family; her increasing sense of persecution might lead to keeping on the move, to hold her anxiety at bay. Her parents said they hadn't thought about it in these terms.

Rosa, who had been lying on the floor away from the family, got up, came into the centre of the room and said: ' That is true, I do like a muddle'. I said I thought she had just said something true without any muddle. She then completed the hoop toy correctly, from

base to top and I talked about the strong adult base needing to be the foundation, to look after the little ones. As the session ended and I insisted on Rosa leaving her drawings with me, she capitulated without a fuss.

I was aware of a need to explore what underlay the parents' difficulty in setting firm boundaries for Rosa, and arranged to see them on their own. In these meetings the parents were able to consider how mother's illness and miscarriage, had left her feeling weak, preoccupied and fraught during Rosa's infancy. The marriage had been going through difficulties and they had moved house several times. Father described a history of depression in his family, and his own difficulties with depression and explosive rage. Both parents had had an experience as children of a lack of containing parental figures, father's family being distant and disciplinarian, mother's mother unable to cope with negative emotions. They acknowledged they may have been lax in maintaining privacy around nudity and their sexuality, which we recognized might have contributed to Rosa's states of overwhelming excitement and intrusiveness. They worked hard to effect practical shifts in their parenting, 'sharing' their attention more between the two children, 'daring' to grant their older child certain privileges despite Rosa's protests, and setting firmer boundaries. In our final meeting they told us that they were selling their current house, which was 'open plan', and moving to a house with doors!

Discussion

This vignette illustrates the fluctuating shifts in attention and perspective required when undertaking brief work with young children and their families, as the focus moves between Rosa, the parent/couple and the family as a whole. We see how, despite her age and size, Rosa appears to resort to early infantile ways of coping with distress, by

projecting her states of discomfort into others, unable to process them herself. The recent transition to school and mother's plans to return to work, seem to precipitate a crisis which may have its roots in the early parent-infant relationship. Mother's preoccupation and father's depression around the time of her birth may have contributed to Rosa's anxiety about feeling abandoned or dropped from mind, and to the early development of 'second skin' phenomena as a means of holding her anxiety at bay. Her hyperactive, controlling behaviour during the day help her to evade awareness of anxiety and dependence on others, but have consequences for her learning and social development at school. Her need for tight swaddling at night, when faced with the task of 'falling' asleep, conveys a need for an external layer of protection, when constant movement and other distractions are not an option. Rosa appears to convey her feeling of inadequate containment at a somatic level, complaining about her 'itchy' clothing, reminding us of the restless, scratching infant described by mother. Interspersed with these infantile defences against catastrophic anxiety, we perceive Rosa's oedipal impulses emerging as she struggles to cope with the notion of her parents as a sexual couple.

Parents often express bewilderment at their inability to exert firm boundaries with their children, as if their parental capacities have been immobilised. It can be a relief when parents are helped to recognise that they may be the recipients of their child's unwanted feelings of infantile helplessness and confusion. A transformative moment occurs in the second family session when I am rendered incapable of thinking by Rosa's muddling her father's name. I am given first hand experience of the anxiety and confusion Rosa might feel when faced with uncertainty and change, and we are all able to recognise the paralysing effect this can have on the parental capacity for containment.

The experience of a ‘third’, the observing therapist, who offers a fresh perspective on the family situation, and can help the parents to recognise the anxiety that underlies Rosa’s controlling behaviour, provides great relief to the child. Once Rosa feels understood, she is more able to tolerate links being made between others, without resorting to her habitual ‘muddling’ of minds, including mine!

Consultation to Early Years Professionals

The expansion of the Early Years workforce through the Sure Start initiative, the expansion of Children’s Centres and current government emphasis on nursery education has meant that young children are in the minds of a wide variety of professionals in the community. This new context provides both the need and the opportunity for discussion of emerging concerns between community-based workers and specialist clinicians. This can be a highly effective and satisfying exchange of thoughts: it simultaneously enriches the skills of a range of professionals and provides help to their clients.

An example of this approach involved responding to a phone call from a health visitor who telephoned for some advice because a mother had consulted her about 3 year old Ben who insisted on being given a nappy to defecate in the corner of his bedroom. There was at first rather scanty information and I discussed briefly with her how some children have anxieties about releasing their faeces, as if they fear their insides may fall out, which touches on early infantile terrors of falling or falling apart. The nappy provides a kind of ‘skin’ for holding the child together, possibly in the absence of emotional holding and attentiveness in the caregiver.

The health visitor phoned again a few weeks later with a clearer picture of the situation, describing a very neat house, where the children are given star charts for tidying and cleaning. Ben had been suffering from a recurring worm infection which caused itching. I suggested he may feel a sense of persecution, as if something horrible was inside him, and she agreed. I wondered whether there was some rigidity in the home and the health visitor described mother as a 'sensible and organised' professional woman, trying to run a home and business efficiently. I wondered whether mother might be running the home as a rather 'professional' undertaking, and be somewhat out of touch with her child's more messy, upset or frightened feelings. Perhaps she conveyed to the child an intolerance of both physical and emotional 'mess', whereas he needed some help, since he appeared fearful of his faeces, as well as his messy feelings, leaking out of him.

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The health visitor found this interesting and added that he always insists his mother checks his nappy to make sure there are no holes in it. I said this may confirm that he has a wish for a strong, safe receptacle for his evacuations. The health visitor then told me more about the family situation: mother separated from father when Ben was a baby, and her current partner, a well loved stepfather, stays for half the week at their home. I linked the fear of faeces falling into the toilet, with the loss of his father and the recurrent disappearance of step father half way through the week. We discussed how the fear of using the toilet can often be linked to states of anxiety relating to separation and loss. We discussed how the child might be helped if mother could be encouraged to prepare him for stepfather's weekly departure. She agreed and contacted me some time later to say that she had been able to do some work with mother along these lines, and the problem had been resolved.

Core features of these approaches

There are common elements in work of this kind that can be usefully summarized. The focus on the parent-child relationship, and in particular on processes of communication between family members, and breakdowns of understanding is central. To achieve conviction about the dominant anxieties interfering with containment and reciprocity in the family requires the study of the relationship the family makes with the clinician. Allied to this is the therapist's close attention to the child's play activities and behaviour, which provides clues to the unconscious hopes and fears which are shaping his developing personality and relationships.

The therapist's use of observation provides a model of receptiveness, respect and tolerant curiosity. This attitude is combined with maintaining clear boundaries, seeking to explore the meaning of behaviour and putting things into words in a way which is understandable by both children and adults. Finally, the therapist's conviction that some change may be effected quite quickly if both children's and parents' anxieties are gathered in can be an important source of renewing hopefulness.

This way of working is rooted in a number of core psychoanalytic ideas. The concept of containment initially developed by W.R.Bion, building on Klein's theory of projective identification, is a helpful way of conceptualizing the emotional heart of the parent-child relationship. The toddler described earlier was, of course, experiencing himself as something like a new-born baby in the totally unfamiliar world of his new family – as needy of being held together as most neonates, but with the physical strength of an 18 month old with which to express his feelings. His behaviour thrust extreme states of anxiety into his parents, and what was needed was some recognition of his fundamental

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fear that he would be too much for this new family and be given away as had already happened to him twice. His unconscious question was whether anyone wanted to hold on to him, and he was utilizing all the resources he had to fill his parents with doubt about whether they could manage, and at the same time hoping that they might be strong enough to do so.

Bion's exploration of the phenomena of containment allowed him to distinguish between projective identification used as a primitive pre-verbal method of communication ("I must make you feel what I need you to understand I am feeling and cannot bear" is the unconscious logic) and more perverse uses designed not for communication with another mind but rather to expel painful emotion, to get rid of intolerable aspects of the self's experience, to destroy links and to attack anyone's efforts to make contact. In work with young children, one is especially likely to observe projective identification of the first sort, since it is a normal mode of emotional communication in the pre-verbal period of our lives, and remains so when we are overwhelmed by intense anxiety.

The infant's early emotional states are frequently too much for its immature psychic apparatus – they are like untamed forces of nature, waves of feeling which threaten to shake the baby to bits. Bion, (Bion, 1962) Klein (Klein 1959)and many other writers have described how responsive early maternal care provides shape and meaning to these elemental experiences. Mother's thoughtful response to the baby's primitive somatic communications – crying, restlessness, colicky pains and so on – provides gradual differentiation between the need for food, warmth, rest, comfort and cleanliness. Mothers do not know by magic what babies need, but can reach intuitive understanding by being open to receiving the impact of their baby's distress, allowing it to resonate

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within them and thinking about what would relieve it, what it means. Bion named this unconscious maternal thinking 'reverie'. This is the infant's first experience of containment – when mother's response fits the need, the container (mother's understanding expressed in her behaviour) has offered the baby what it sought and the baby feels contained.

Winnicott's (1971) theory of the early mother-child relationship is a similar one in terms of the primary maternal function, which he designated as 'holding', although his understanding of the level of psychic development in the infant is somewhat different. Whereas Bion draws on Klein's picture of very early ego development and experience of the anxieties of separateness and dependence, Winnicott describes an initial period of babies feeling undifferentiated from their mothers, and a gradual process of mothers disillusioning their babies and introducing them to the reality of physical and mental separateness. Contemporary work with parents and young children utilizes these overlapping theorizations of how development begins. "Mindfulness" is a current therapeutic nostrum, and is an everyday simplified description of aspects of Bion's concept of containment.

The recent history of academic research in child development has demonstrated that psychoanalytic assumptions about the quite sophisticated mental functioning of infants have proved to be much closer to the truth than the experimental scientists of earlier periods recognized (e.g. Stern 1985, Murray, 1988). The remarkable capacities for discrimination of tiny infants able to recognize their mothers from the start introduce us to babies as people with a sense of a place they belong (in their own mother's arms), not just a bundle of physiological needs to be met.

Psychoanalysis has developed its own specific methodology for the direct study of the mother/infant relationship, in addition to reconstructive theories based on clinical work with children and adults in which the patient/analyst transference relationship is the source of understandings about the early growth of mind. Psychoanalytically informed longitudinal observation allows us access to evidence of the mental state and communication processes of babies from birth to two in their family context. What has this added to our overall picture?

Esther Bick's (Bick, 1964) creation of Infant Observation as a core tool for the training of child psychotherapists embodied her own attentiveness to the profound psychological vulnerability of the new born and of new parents (Rustin, 2009). She described the baby's initial need to be held together and protected from fears of falling apart, of melting, of falling into a hole with no bottom. She noted the baby's search for a source of focus, most characteristically supplied by the experience of feeding in mother's arms – the hole of the mouth filled by the nipple, the lap and arms cradling the baby's body as a whole, and mother's eyes as a potent attractor for the baby's search for face and eyes. In her absence, a room light can function as a point of integration. She theorized that the new born infant lacks a sense of a body held together by a skin-container and instead is frequently assailed by experiences of unintegration which are mitigated by the mental and physical holding mother provides. Her overall care offers the baby repeated moments of contact with an integrative whole, which is absorbed alongside the milk that is building baby's body. This forms the core of an 'internal mother', conceived by Bick as first providing a psychic skin which the baby can gradually make his own.

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Bick was most sensitive to the strain that the new born's extreme vulnerability placed on mothers. They themselves are in great need of layers of containment for their own anxious response to the huge responsibility for sustaining a new life, which has to contend with their fears of failing in this task. The idea of the baby stopping breathing in the night, the panic that can be stirred by a baby who has difficulty feeding or who vomits up the milk – such everyday occurrences reveal that the mother has to bear both baby's fears and her own about his survival. To do so, she has to have access to practical and emotional support to help her to stay in touch with her adult self and experience. Life with a small infant in distress stirs intense emotions and a new closeness to the nearness of life and death, just as every birth feels that it is a sometimes hard-won victory for life.

Data from observing babies and from the analysis of children has led to ongoing investigation of the consequences for the child when containment is inadequate. This may arise from internal or external difficulties of the mother or from constitutional impediments in the child's capacity to use what is available, including those situations when a baby is ill or has a disability. Bick (Bick, 1968) described what she termed 'second skin' phenomena in which the child finds substitutes from its own resources to replace a sense of safety based on dependable relationships. These include turning to its own muscular strength, like the toddler described earlier, hyperactive behaviour to hold anxiety at bay by filling the mind with a succession of sensations, thus creating a sensation dominated universe. Other babies can be seen to rely on the stimulation of objects rather than human contact, these objects not having the quality of 'transitional' phenomena (Winnicott, 1971) but a hard 'thingness' or flat brightness, reminiscent of the autistic child's use of small hard things held in preference to an adult hand or a soft

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comforting toy. This form of relating is with surfaces, and not based on a three-dimensional concept of person in which there is an inner space – in other words the child fails to develop either an awareness of either mother's or its own internal space, and instead clings to the outside.

Service Development

The clinical impact of the psychoanalytic understanding of infancy has grown in recent decades as a consequence of the greater integration of clinical and laboratory-based science and in the social context of pressures for the improvement of services to young families. 'Infant Mental Health' is now a preoccupation world-wide, and this new specialism would hardly have been recognized in earlier generations.

The specifically psychoanalytic contribution to this new field lies in the insight it offers into the unconscious dimensions of the mother/baby relationship and to the broader family dynamics in play which include the shift in the couple relationship when a baby is born, the impact of sibling relationships, and intergenerational family factors. The early contribution of Selma Fraiberg (1980) in her classic paper "The Ghost in the Nursery" provided a conceptualization of the interaction of the mother's internal world and her response to her baby which allowed clinicians to grasp the possible rivalry of mother and baby, the feelings of deprivation that could be stirred in mother, and the risk of traumatic re-enactments in the mother-baby relationship of the mother's unconscious relationship to her own mother.

In Britain, these ideas met up with the tradition of Infant Observation and the clinical skills it nurtured. Specialist services to provide consultation to parents troubled by their

babies and pre-school children were set up to add to the established community-based support of health visitors. The need for a quick and flexible response to the extreme anxieties generated by babies who do not feed well or sleep poorly or cry persistently was understood. The pioneering Under-Fives service at the Tavistock Clinic dealt with this sort of thing and drew on the expertise of child psychotherapists trained in individual analytic work with young children. Referrals focussed on parental conflict over how children should be treated, parents facing breakdown in their relationship, the problems of single mothers, the disturbance of older siblings, and developmental difficulties of all kinds in babies and young children – the child, for example, who could not cope with any separation from mother, who could not be toilet-trained, whose aggression was extreme. The model of brief and prompt intervention was attractive both to families and to NHS managers, and proved to be very exportable. There has been a plethora of relevant publication (e.g. Daws, 1989; Barrows, 1999; Pozzi, 2003; Bradley & Emanuel, 2008) and the International Journal of Infant Observation continues to publish significant clinical and research papers contributing to the field. A similar commitment to supporting vulnerable young families led to the subsequent development of the Parent Infant Project at the Anna Freud Centre. This work added a research dimension and new clinical approaches through the use of video recording of the mother-child interactions.

Alongside these usually brief interventions with young families, there is also a tradition of longer-term individual child psychotherapy for young children in serious difficulties, offered in parallel with support for parents. This is at present unevenly available due to the shortage of child psychotherapists in many parts of the UK, but is not only a life-line for very troubled young children but also a continuing source of psychoanalytic development. It is relevant to bear in mind that Klein, Anna Freud and also Winnicott,

who are rightly seen as major figures in British psychoanalysis of the mid 20th century, all had extensive experience of work with children. Their approach to psychoanalysis assumed the enormous importance of this work. What is also important to note is that relatively brief periods of intensive treatment with young children can quite often resolve apparently intractable difficulties, and free them to get on with their lives.

The under fives field has always been of particular interest to child psychotherapists because of the place of Infant and Child Observation in their professional training. Making use of what was learnt through close and disciplined observation had an important impact on clinical methodology. There was recognition of the value of holding back from premature therapeutic intervention and of allowing enough time to gather the details which will inform the understanding of any particular case. People began to consider the wider relevance of the observational approach and to explore a variety of educational and clinical initiatives. Training courses for people working in nurseries, in hospitals, and in health visiting and community paediatrics, and also more specialist training in Infant Mental Health, were one outcome. The use of Infant Observation as a direct clinical resource for the support of vulnerable families was pioneered, for example families where a toddler showed early signs of the risk of autistic trends or where mother's depression and isolation seemed to pose a serious risk. Sometimes such projects could be combined with research. A current example is a pilot project using Infant Observation in a Looked After Children CAMHS team to investigate the quality of the foster-care of babies, the nature of the support that foster carers need, and to contribute to social services decision making about long-term placement.

Conclusion

Current preoccupations within CAMHS policy and practice include an understandable emphasis on brief interventions – limited professional resources help more people if they are deployed in an economic way. What seems also vital is a model of services which differentiates between those problems which can realistically be tackled in short-term work and those for which more substantial ongoing work is needed, for example, psychotherapy for children in the care system and for those with major developmental or mental health problems. The emphasis on attention to the evidence base (Kennedy 2004, Kennedy & Midgley 2007) and the current NHS focus on quality both imply that clarity in assessing need can substantially benefit public health. The potential application of IAPT models of standardized brief interventions to work with young children and their families will need to take into account the complexity of parent/child relationships if it is to meet the needs of families appropriately. The work described in this chapter could helpfully be framed as a contribution to the diversity of models now seen as so important.

The conjunction of a theory of the development of the infant's mind and of the vital part that the relationship with parents plays in this process summarizes the strength of psychoanalytic thinking about young children. It adds the depth of the study of unconscious emotion and unconscious mental processes to our everyday picture of the more familiar conscious elements. What is available to the conscious mind varies to some degree across time and cultural context. The acknowledgement of infantile sexuality so difficult for the early 20th century is less a feature of our hyper-sexual contemporary western culture; the awareness of ambivalence towards parental and other authority figures seems difficult to encompass in more traditional cultures like those of the Middle, Near and Far East. What seems inescapable, however, is the painful reality

of the conflict between the child's profound dependence and his infantile omnipotent impulses. Hot on the heels of this first great struggle between narcissistic and reality-based relationships comes the challenge of oedipal development. By the age of five, the fortunate child will have struggled with the psychological impact of becoming one of three (or more), with generational and sexual difference, and with facing loss. Much of these crucial psychoanalytic discoveries about personality development has entered the Zeitgeist, but its instantiation in each particular family and individual brings with it complex challenges. When these collide with vulnerabilities, external or internal, psychoanalytically informed interventions are an essential component of contemporary mental health services.

References

Barrows, P. (1999) Fathers in parent-infant psychotherapy. *Infant Mental Health Journal, 20(*3, p.333-345.

Bick, E. (1964) Notes on Infant Observation in psychoanalytic training. International Journal of Psychoanalysis, 45, p.558-566.

Bick, E. (1968) The experience of the skin in early object relations. International Journal of Psychoanalysis, 49. p.484-486.

Bion, W.R. (1962) A Theory of Thinking. International Journal of Psychoanalysis, 43, pts 4-5, p. 306-310. Republished in "Second Thoughts" (1967) London: Heinemann

Bradley, E. & Emanuel, L. (Eds) (2008) *What can the matter be?* London: Karnac.

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Daws, D. (1989) *Through the Night*. London: Free Association Books.

Fraiberg, S. (Ed) (1980) *Clinical Studies in Infant Mental Health*. London: Tavistock.

Kennedy, E. (2004) *Child and Adolescent Psychotherapy: A Systematic Review of psychoanalytic approaches*. London: North Central London SHA.

Klein, M. (1959) Our Adult World and its Roots in Infancy, Human Relations 12, reprinted in "Envy and Gratitude and Other Works, 1946-1965", London: Hogarth

Kennedy, E. & Midgley, N. (2007) *Process and Outcome Research in Child, Adolescent and Parent-Infant Psychotherapy: A thematic review*. London: NHS London.

Murray, L. (1988) Effects of post-natal depression on infant development. In K.Kumar & I.Brockington (Eds) *Motherhood and Mental Illness*, Vol 2. London: Wright.

Pozzi, M. (2003) *Psychic Hooks and Bolts: Psychoanalytic work with children under five and their families.* London: Karnac.

Rustin, M. (2009) Esther Bick's Legacy of Infant Observation at the Tavistock – some reflections 60 years on. *International Journal of Infant Observation, Vol. 12, No 1*. p.29-41

Stern, D. (1985) *The Interpersonal World of the Infant*. New York: Basic Books.

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Winnicott, D.W. (1971) *Playing and Reality*. London: Tavistock.