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**Talking to the Infant in Psychoanalytic Parent-Infant Psychotherapy: An  
exploration of therapy process**

Literature Review

Empirical Research Project

Reflective Commentary

Candidate number: XXXXXXXXXX

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Anna Freud National Centre for Children and Families)

## DECLARATION

I declare that the material submitted for examination is my own work. The ideas and findings of others have been referenced in accordance with the guidelines provided and any work by others has been acknowledged.

I understand that anti-plagiarism software may be used to check for appropriate use of referencing.

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Signature: 

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## Abstract

This study examines how the aims and principles of psychoanalytic parent-infant psychotherapy (PIIP) are translated into the words used by the therapist to address the infant in the specific modality of parent-infant psychotherapy treatment (PIPT) developed at the Anna Freud Centre. **Literature Review.** The literature review appraises different modalities of PIIP. It looks at the similarities in their theoretical and treatment frameworks and shows how the way in which the infant is understood in these different frameworks produces a differences in theory and technique.

**Empirical Paper.** The empirical study is a naturalistic observational study of the therapist's talk when in direct communication with the infant. The aim is to deepen our understanding of the what the therapist actually says and does in a therapy session. The results show that the therapist talks for a significant amount of time directly to the baby, and on a specific number of themes. Even though this is small single case study the findings contribute to our understanding of what therapists do in therapy. **Reflective Commentary.** The reflective commentary considers the process of engaging with doctoral research around a pre-verbal infant in treatment. It reflects on the personal experience of doing the research and considers how this experience has contributed to my development as a researcher and a child and adolescent psychotherapist.

Keywords:

Psychoanalytic parent-infant psychotherapy, therapists talk, infant participation, agency, discourse, therapy process

## **Impact Statement**

### **Impact on clinical theory and practice.**

Whilst there is a large body of research on the outcomes of psychotherapy and to a lesser extent on therapy process, psychoanalytic parent infant psychotherapy (PPIP) is a relatively under-researched area. Furthermore, in-session process research in PPIP is scant. This study focuses on what the therapist actually says and does when addressing the infant in one successful treatment of PPIP for relational trauma. By studying in detail how therapy gets done in practice, this study illuminates clinical process and can contribute to better understanding mechanisms of change in parent-infant psychotherapy, contribute to theory regarding the infant's participation in PPIP, and promote clinical reflexivity with implications for the improvement of services provided to distressed parents and their infants.

### **Impact on Service Development.**

Although this is a small scale study, it can contribute to service development by presenting in detail an example of psychoanalytic parent-infant psychotherapy, thus making psychoanalytic psychotherapy more accessible to service commissioners.

### **Impacting on Research.**

This is very much an exploratory study which, however, identifies the need to further explore language-in-use in parent-infant psychotherapy and the relationship between language and change in psychotherapy. In terms of method, a coding scheme for studying therapist's talk has been developed that can be used in future research in the field.

**Impact on literature.** The review of the literature used in this study will hopefully map the theoretical ground out of which PPIP has emerged enabling further discussion and exploration. It is hoped that the links between theory and research can be strengthened through further interrogation and examination.

All names and identifying features of the participants in the treatment under discussion in the empirical paper have been concealed and changed. The child subject in research and therapy is referred to 'he' or 'infant' to distinguish him from the psychotherapist in therapy and research whom is called 'she' or 'therapist'. The parent-infant couple under discussion in the empirical paper are referred to as Baby and Mother.

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Part 1: Literature Review

Title: Psychoanalytic Parent Infant Psychotherapy: the infant's participation

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## **Abstract**

This review sets out to map the theoretical ideas and practices that have informed different modalities of Psychoanalytic Parent-Infant Psychotherapy (PPIP). In brief, PPIP is shown to draw upon a theoretical framework based on psychoanalytic theory, ideas from developmental research and attachment theory. The review examines themes that are shared across different approaches to PPIP including; good enough holding and containment to describe the infant's early environment, flexibility in the understanding of the therapy setting and how different modalities of PPIP work reflectively within a transference matrix, in which close observation of unhelpful patterns of relating are made. The review also found that different approaches of PPIP conceptualise the infant as capable of using defences, as object seeking and as primed to form attachments from an early age. In addition, different modalities of PPIP accept the importance of the development of the capacity to mentalise in both parents and infants. Finally it was found that though the different approaches shared a conceptual framework, they defined the patient in different ways; namely the patient as parents and their past, the infant or the parent-infant relationship. With the different understandings resulting in differences in theory and technique.

## **Introduction**

Psychoanalytical Parent-Infant Psychotherapy (PIIP) is a modality of psychoanalytic relational-based psychotherapy that seeks to address, through therapeutic intervention, distressed parent-infant dyads where the attachment relationship is at risk and there is a threat to the infant's development.

## **Key concepts in Psychoanalytic Parent-infant Psychotherapy**

Different models of PIIP exist, which focus on different aspects of the parent-infant relationship. In brief, some models tend to focus on the parent-infant relationship, others emphasise the role of parental fantasies evoked by the infant, and others focus mainly on the infant. Through a discussion of the ideas and assumptions that underpin different models of PIIP, this literature review examines the similarities that inform them but also reviews how specific historical moments, cultural and regional differences, and the demands of specific settings have shaped the particular approaches.

Initially, through a discussion of how psychoanalysis has historically understood the place of the parents in work with infants, key psychoanalytical ideas that have informed PIIP are identified and discussed; next, different modalities of PIIP are discussed in light of their theoretical emphasis.

PIIP is a relatively recent development in psychoanalytical theory and practice, even though there has been - from the earliest days of psychoanalysis - a curiosity about and engagement with, the relationship between parents and children. For example, Sigmund Freud's (1856-1939) analysis of Little Hans (Freud, 1909) took place through detailed consultations with Hans' father following the father's

close observation of the latter's son. Hermine von Hellmuth (1871-1924) predated Anna Freud (1895-1982) with her insistence on working with the parents when analysing children, not least because of her observation that without the parents bringing the child, therapy cannot take place (Grinstein, 1994; Hug-Hellmuth, 1921, 1986; Plastow 2011). Sandor Ferenczi (1873-1933) examined the role and responsibility of the parents in the developing child's personality in the early parent-infant relationship in essays such as "The Unwelcome Child and his Death-Instinct" (1929).

In the early 1920's Anna Freud and her colleagues from the University of Vienna observed the importance of the parent-child relationship to the child's development. She developed these ideas in her lectures on *The Psycho-Analytical Treatment of Children* (Freud, 1946), in her work and observations in the War Nurseries and then later, her involvement in the parent-toddler groups that developed from the Well Baby Clinics that were part of the Hampstead Child Therapy Course and Clinic (Zaphiriou, Woods & Pretorius, 2016).

Melanie Klein's (1882-1960) play technique (1927; 1929; 1955) designed to analyse very young children, conversely rejects attempts to bring parents into the analytical frame (Klein, 1948; 1975). Holmes (1995), cites Joan Riviere, a keen proponent of Klein's ideas, who insists "Psychoanalysis is Freud's discovery of what goes on in the imagination...It has no concern with anything else, it is not concerned with the real world...It is concerned simply and solely with the imaginings of the childish mind" (cited in Holmes, 1995, p. 23).

These theoretical and procedural differences, once thought seemingly insurmountable, (Likierman, 1995; Viner, 1996) perhaps, can be more usefully understood as differences in perspective and emphasis. Donald Winnicott (1896-

1972), an example of someone thinking and working in the dialectical space between the “ideas and personalities of Klein and Freud” (Ogden p. 346) places the parent-infant relationship at the centre of his understanding of any disturbance or psychopathology in infancy (Winnicott, 1960, 1970; Ogden, 1985;).

In PPIP psychoanalytic theories are utilised for their usefulness, rather than on the basis of adherence to one school rather than another, what Baradon (2016) calls a tool-kit approach. Although there are different modalities of PPIP, all share general principles of psychoanalytic thought which include similar ideas about the environment, setting, transference relationship, observation, defences, object relating, attachment and mentalising. These will be briefly discussed below.

**Environment.** Winnicott summarises the different aspects of the maternal function and role in relation to her infant in terms of the environment. Central for Winnicott, is the idea that the quality of the infant’s early environment is part of a psychological matrix that includes both infant and parents. Winnicott argued-against the thrust of Kleinian thought-that the mother-infant is a psychological unit, insisting that “there is no such thing as a baby” (Winnicott, 1947/1957, p.137). He argues that the quality of the early environment offered by the mother determines whether she protects her infant from impingements which the infant cannot understand, and whether the infant will be successful in their attempts to self-integrate or gather up the different “bits” of themselves (1945). He states that around the time of the birth the mother enters a “state of heightened sensitivity, almost an illness” (Winnicott 1956/1975. p.302 ) in which the mother is, in an ordinary way, obsessed with her new-born infant. This leads to a constant holding and handling of the infant that provides protection and support (Winnicott, 1956/1992a) allowing the healthy infant to establish a sense of self and a sense of “going-on being” (1956/1975 p. 304)

which is integral to supporting the infant's developing ego in his task of integration and developing towards separation and relative independence.

Winnicott describes how the good enough environment provided by the mother adapts itself to the developing needs of the infant. Through a gradual process, the mother disillusiones the infant and introduces him to the reality of physical and mental separateness. At the same time the infant needs the support and holding of this environment less and less until in due course it becomes redundant (Winnicott, 1965). Winnicott describes the role of the father at this time as equally important as it is his function to contain and hold the mother as she loses herself to maternal preoccupation. Furthermore, as Abram (2007) points out, he is vital in dealing with the antisocial elements of the infant and child.

Bion's (1897-1979) view of the psychic development of infants is similar to that of Winnicott's, however he draws on Klein's understanding of early ego development. Bion conceptualises early maternal functioning as one of containment (1962). Developing from Klein's (1946) notion of projective identification, that process by which the infant rids themselves of unpleasure by projecting the intolerable fragments of sensory and bodily experiences into the mother's mind or body, Bion argues that the mother through her unconscious thinking or reverie (1962b), takes on these intolerable fragments and in a process of detoxification (akin to digestion), gives them shape and mentalises them. As the mother sensitively adapts to these projections, she functions as a dynamic container for them, a process he terms container/contained. It represents a capacity for unconscious psychological thinking and work (Ogden, 2004). In a healthy relationship the mother is able to return the transformed intolerable projections to the infant in a safe form stripped of their harmful unbearable elements.

These two concepts are both used by PPIP. They overlap but represent different positions on the development of infants and their relationship to their early environments. Ogden (2004) summaries the differences by describing Winnicott's notion of holding as being something that occurs across time whilst Bion's idea of the container/containment is more focused on the processing of thoughts that arise from experience. Bion conceptualises the infant as having an awareness of his mother beyond or outside himself, whereas Winnicott views the baby as needing to feel that the mother is, initially, not separate but an extension of himself (Parry, 2010).

Ogden thus characterises the early infant environment as a dynamic one which is central in shaping how the infant understands his mind body matrix. Closely related to the maternal environment is the setting within which therapy takes place.

**Setting.** In PPIP the therapeutic setting functions in the same way as the maternal holding environment in that it operates both externally and internally. Following Winnicott's (1955) assertion that the role of the therapist is a facilitating one, analogous to the good enough mother who provides good enough holding which in turn allows the patient to correct the original failures and move to relative independence, the therapeutic space represents a potential space in which a creative alliance can be made.

The therapist must be ready to receive, in a state akin to reverie, the undigested, unpleasant projections of both mother and infant. Bion termed this capacity "negative capability" after Keats (Green, 1973) and defined it as the facility to tolerate the discomfort, confusion and pain of not understanding and then reflect upon it. Bion argues that the therapist's engagement with this reverie, allows for mutual growth as the therapist is as changed by the encounter as the patient is.

Consistency in the setting is important to the establishment of a safe holding and containing environment. It also informs Winnicott's idea of the "potential space" (1971), that area located outside of and between therapist, parent and infant in which creative change can emerge. The boundaries of this space include time (length and frequency of session), interruptions, location and the of physical holding and touching of the infant (Baradon et al 2016).

The boundary and setting in psychotherapy delimit the interface between the patient's inner and external world and can therefore represent the most primitive parts of their relationships (Mahler, Pine, & Bergman, 1975). In therapy, the patient is required to revisit their most defenceless and dependent states (Bull, 1985; Barratt, 2015;). The establishment, maintenance and awareness of consistent boundaries and frames in psychotherapy is essential to allow for the anxieties generated to be contained and detoxified and then change can be safely experienced.

In addition, PPIP therapists highlight the need for flexibility as work with infants often occurs in settings other than the therapy room, for example, the home, kitchen table or hospital and does not rely on the rigid time frame of traditional therapy. Reliability and consistency then, comes from the thinking space offered by the therapist and her complete emotional and mental availability during therapy (Baradon et al. 2016).

What must also be considered are the specific socio-economic, cultural and power matrices in which therapy takes place. People of colour and those economically and socially disadvantaged are over represented as patients in mental health statistics (Peter Fonagy et al., 2016), whereas therapists are overwhelmingly white, socio-economically and culturally privileged. Psychoanalysis has been

criticised for neglecting issues of social identity and contexts in which identities are constructed in favour of an examination of the inner world (Botticelli, 2007; Dewing, 2010; Frosh, 2016; Ryan 2017; Meyer & Zane, 2013). Psychoanalysis has also been attacked for normalising a psychoanalytic subject that is male, white and Western (Oliver, 2017; Suchet, 2004). Transference experiences shaped by difference of race or class can become barriers within the therapy if they are not sensitively and directly addressed (Aggarwal, 2011; Holmes, 1999; Leary, 1995; Tang, 1999).

PPIP aims to explicitly address difference. It is proactive in its work with vulnerable parent-infant dyads and seeks out difficult to reach populations of disadvantaged mothers and babies. (See for example Baradon et al., 2016; Lieberman, Silverman & Pawl 2000; Belt et al 2012; Sled et al 2013). Also, PPIP's understanding of the intersubjective space between the therapist and the patient, termed the analytic third by Ogden (2004) and the potential space by Winnicott (1971), designates a place separate from, but constituted by the patient and the therapist, which draws on the subjectivities and experiences of both. This therapeutic holding space allows for the safe exploration of extant cultural and religious differences and reflection on how they shape how meaning is ascribed in the therapeutic interaction. This enables alternative experiences and meanings to be created (Baradon et al. 2016).

The setting within the different approaches of PPIP is more flexible than classical psychoanalysis has traditionally allowed with the frames and boundaries of time, frequency and place, more loosely interpreted. The containment and emotional availability of the therapist is privileged over a reliance on external boundaries and settings. Also the modalities of PPIP actively engage with the asymmetries that cut

through the therapeutic and relationship. This engagement often occurs through the transference countertransference relationship.

**Transference/countertransference.** PPIP is informed by ideas about the nature and function of the relationship between the infant and their key attachment figures. PPIP also draws on the assumption that during a therapeutic interaction, conscious and unconscious parts of both the patient's and the therapist's mind will communicate and interact with each other in a process of transference and countertransference (Orr, 1954). The relationship with the parent and infant in PPIP is a constantly shifting relationship of intersubjectivities made up of the present relationships of the participants in the room and their wider environments. Winnicott (1958) describes this as a matrix of transference, that is an early infant/mother environment of ego-relatedness from which the infant can emerge and live creatively. Ogden (1991) developed this understanding in order to describe the inter-subjective spaces of the therapy setting. The transference matrix becomes the place where the patient and the therapist collaborate to understand the communications in therapy.

In PPIP, the therapist must carefully attend to the communications of the parent, the infant and the dyad as well as reflecting on their own histories and counter-transferential feelings. She must also be aware of the projections and "ghosts" and "angels" that are being generated by the therapy, especially the powerful projections of the infant which may represent un-analysed preverbal parts of the therapist (Money-Kyrle, 1956). These moments give a clue to the defences and obstacles to change in the therapy.

In all modalities of PPIP the therapists work reflectively within a transference matrix. They employ an understanding that during therapeutic interaction, conscious

and unconscious parts of patients and the therapists mind will communicate and interact with each other in a process of transference and countertransference. The therapist draws on techniques and skills of close observation in order to notice the projections and transferences.

**Observation.** Both Freud and Klein agree on the central importance of observing children within specific contexts, and child psychotherapists have drawn explicitly on the infant observation work developed by Freud (Freud, 1951, 1970; Colonna, 1996; Miller, 1996) Klein (1944; 1952; Sherwin-White 2017), and Esther Bick (Bick, 1964, 1968; Klauber, 2012; Watillon-Naveau & Coulson, 2010) to inform their understanding of infant development. Infant observation allows the therapist to develop skills and negative capabilities including a capacity to tolerate intense anxiety and not knowing whilst not resorting to defences, as well as patience, reverie, and empathy (Sternberg, 2006). Through observation, the PPIP therapist can detect these phenomena and help the infant and parent develop an awareness of their internal spaces and the operation of unhelpful defences.

All modalities of PPIP share an understanding about the importance of observation and a capacity to tolerate great anxiety and not knowing. The skilled observant therapist is able to spot unhelpful patterns of relating, or defences that cause dysfunction within the parent-infant relationship.

**Defences:** PPIP makes the assumption that from an early age the infant is capable of using defences, although there is disagreement as to whether these are ad hoc defences or an organised defence mechanism (Salomonsson, 2016). An infant is utterly vulnerable not least because of their immature psychic apparatus (Klein, 1997; Bion, 1962) and the total dependency on others (Winnicott, 1960, 1963, 1965). When there is inadequate maternal care and the protective holding and

containing function is lacking, the infant can be exposed to overwhelming feelings of anxiety that can threaten to annihilate the immature ego. These early infantile anxieties can be provoked as much from feelings generated from within the infant as from impingements from the environment.

Defences may function to protect but they can become internal obstacles to accessing the support they need. Defences can manifest themselves within the mother-infant dyad, the infant, the parent or the therapist themselves. Primitive anxieties within the parents may be evoked by the distress of the infant, causing them to withdraw from their infant in an attempt to protect them from the more destructive and aggressive parts of their personality (Lyons-Ruth, 2003; Lyons-Ruth & Spielman, 2004). Unpredictable, insensitive, distant or aggressive parenting may cause the infant to withdraw or adapt their behaviours (Baradon, 2005; Crittenden, 1992; 2008). Observable defensive behaviours in infants can include gaze avoidance, freezing, holding himself very stiff or conversely becoming very floppy, or an inhibition of attachment needs so that the infant demands very little from the caregivers and a precocious capacity to self soothe (Baradon et al. 2016). Defences can be co-constructed as the parent and infant attempt to regulate their distress and discomfort, not necessarily equally or symmetrically, in a “complex dance” (Stern, 1977) of mutual regulation. (Beebe, 2000; Beebe, Jaffe, & Lachmann, 1992; Beebe & Lachmann, 1998; Gianino & Tronick, 1988; Tronick, 1989; Lyons-Ruth, Bronfman, & Parsons, 1999; Main & Hesse, 1990).

PPIP accepts that the infant is capable of using defences at an early age and the process of therapy is to sensitively engage with them, in the knowledge that defences are protectively in place. Defences in therapy can be used by the parent or infant and are often co-constructed in complex systems of regulation between the self

and other.

**Object-relating and attachment.** At the heart of PPIP is an understanding that the infant develops its psyche in a dynamic relationship with internal mental representations and their early environment.

John Bowlby (1907-1990) argues that infants are born predisposed to form attachments and engage in social relationships. (Bowlby, 1958; Holmes, 1993, 1995a). Also acknowledging the importance of the infant's early environment and quality of the relationships, Bowlby contends that mothers and babies have a biological need to be together, and the mother's responsiveness and availability determined the type of attachment bond. He further argues that impairment in their relationship can be addressed through understanding the quality of their attachment (1980; 1997; 1998).

Bowlby's colleague Mary Ainsworth identifies different styles of attachment between infants and their care-givers through the "Strange Situation" test (1970). This structured observation procedure (applied to children between the age of nine and eighteen months), assesses the attachment between the parent and child in the presence and absence of the stranger. Ainsworth identifies three main patterns of attachment: secure, avoidant-insecure and ambivalent-insecure. Further research added a fourth attachment type - disorganised. Crittenden (Crittenden & Claussen, 2003; Crittenden, 2008) developed this idea further by arguing that attachment is a dynamic relationship with caregivers and can change in different environments and with different styles of caregiving. Her model the Dynamic-Maturational Model of Attachment and Adaption (DMM), demonstrates how the infant strategically uses different styles of attachment in response to the cues of their caregivers (Crittenden, 2008).

Bowlby's emphasis on the attachment between infant and caregiver and the environmental has been taken up by developmental psychology and research. By focussing on the infant-parent dyad this research studies the myriad complex and implicit ways the baby communicates with its mother, including the utilization of whole and part body movement, eye-tracking and contact, avoidance, facial expression, mimicry, and prosody.

There is a dynamic tension within PPIP between different conceptualisations of early infancy. On the one hand, different theoretical standpoints such as those of Winnicott (1945; 1960, 1963;) and Mahler (1971, 1972; 1974a, 1974b;) have argued that the new-born infant is originally merged in a symbiotic union with the mother and intersubjective awareness is gradually achieved when older and once relative independence from the mother had been accomplished. On the other hand, Klein (Bion 1962; Sherwin-White, 2017) and child development research including Bowlby, argues that the infant has a personhood or subjectivity from birth that can be addressed either directly or through the mother-parent dyad. Intersubjectivity has been understood as the processes through which infants begin to understand the thoughts and emotions of other people, in particular their immediate caregivers (Rochat, 2009). This view presupposes that the parent and infant have some sort of access to, and interest in each other's mind (Meltzoff & Moore, 1977, 1998; Trevarthen, 1998), which Stern (1985) argues is both innate and necessary.

Developmental research has demonstrated how neonatal behaviour such as imitation and mirroring illustrates a mutuality in which each partner in the infant-parent dyad mirror the motivations of each other. They engage in conversational type negotiations of purposes, emotions, experiences and meaning (Stern, 1995;

Trevarthen, 1993; 1998; Trevarthen & Aitken, 2001; Trevarthen, Aitken, Vandekerckhove, Delafield-Butt, & Nagy, 2006).

In this view, the newborn infant possesses emergent abilities and capacities for physical and mental organisation across the different modalities of hearing, seeing touch and taste. Through a very basic, body-based developing sense of self and within a social context, the infant can use its innate abilities to begin to make sense of and organise its experience of others right from the start. From birth the infant has developed a form of procedural (non-symbolic, non-verbal and non-conscious) knowledge of how to be with other people. Experiences relating to behaviours, emotions and images became hard-wired in the brain from birth and are quickly rendered unconscious allowing the infant to implicitly anticipate and respond to others (Lyons-Ruth et al., 1998; Stern et al., 1998; Stern, 1995; Stern, 2004).

The different modalities of PPIP all assume that the infant is object seeking and primed to form attachments to maternal and care giving objects from the very beginning of life. From this view the infant is capable of deploying and adapting mechanisms of relating. A key part in this ability to mentalise, that is the capacity to think about reflect on and imagine other people's minds and inner worlds.

**Mentalising:** All PPIP interventions aim to encourage the imaginative capacity and ability to reflect upon, understand and think about other people's minds, emotional states and intentions well as their own (Bateman et al., 2007; Fonagy & Bateman, 2007; Fonagy, Sled, & Baradon, 2016). This idea can be traced through different strands of psychoanalytical thought.

For Bion, thinking and mentalising arise out of absence (Holmes, 2006) and occupation of the depressive position, that state of thoughtful reflection and awareness of the hurt and sufferings of others, as well as self (1935, 1940). Bion

argues that primitive thoughts (pre-conceptions) are analogous to the new born's expectation of the mouth's union with the nipple (Bion, 1967) and give rise to states of satisfaction (or conception). This contrasts with thought which arises when the pre-conception is met with an absence, causing frustration in the infant. For Bion, the dynamic tension between satisfaction (conception) and frustration (thought) results in the development of thinking apparatus in the infant. Importantly for Bion, the mother performs a containing function which transforms the frustrated toxic (beta) elements which the infant projects out of themselves in into the willing receptive mother who transforms them through her processes of thinking into tolerable experiences (alpha functioning) (Bion 1962). This also establishes a "contact barrier" between conscious and unconscious thinking which allows for the differentiation between fantasy and reality (Holmes, 2006)

For Winnicott the development of thinking states is dependent upon the mirroring function of the mother. The infant seeks in the mother's face an experience of having been truly seen and cherished, which in turn leads to the development of an authentic sense of self because the infant perceives themselves through the mind of another (1967). However, if the infant repeatedly fails to find their emotional state reflected in the other's mind or on their face, the infant internalizes the alien state and struggles to develop the ability to understand mental states in the self and others, in other words to mentalise.

Attachment theory and development research have both sought to understand how the infant's earliest intersubjective experiences are connected to their ability to mentalise. Fonagy and colleagues (Fonagy & Bateman, 2007; Fonagy, Slead, & Baradon, 2016; Fonagy & Target, 1998) describe how the ability to mentalise is closely linked to the quality of parenting and attachment. In secure attachments, the

caregiver will be able to insightfully understand a child's experience and to give thoughtful feedback about their experience. This interaction can provide a useful model for the child and enable their developing understanding of their own and others' mind. However, when caregivers are unable to reflect on the infant's mind, or provide inaccurate feedback or no feedback, the child is unable to develop the capacity to mentalise; they cannot understand their own thoughts, feelings or motivations (Fonagy & Campbell, 2015). All modalities of PPIP accept that one of the aims of any therapeutic intervention is the development of the capacity of mentalisation in both the parent and the infant.

Whilst all modalities of PPIP use these theoretical arguments to inform their practice, they accord them different weights, with some modalities more psychoanalytically driven than others.

### **Different approaches to Psychoanalytic Parent-infant Psychotherapy**

The various models of PPIP could be labelled in terms of three broad categories depending on their emphasis. Approaches that focus primarily on parental fantasies and representations of the infant; those that regard the parent-infant dyad as the patient; and those that regard the infant as the patient. The earliest and arguably the most influential dyadic intervention into the parent infant relationship has been developed by Selma Fraiberg who innovatively brought the baby in to the therapy room alongside the parents, to address how the parents' past can adversely affect the baby.

**Approaches that focus on parental fantasies.** Through her image of "ghosts in the nursery" Fraiberg powerfully evokes the ways in which the childhood of the parent can influence their view of their child therefore their behaviour towards

the child (Fraiberg, 1976; Fraiberg, Adelson, & Shapiro, 1975). Fraiberg, by addressing the parents as the main agents of change in the parent-infant dyad, highlights how a parent's reaction to their child is often mediated by forgotten and unresolved issues from their own past relationships and have in turn, negatively impacted and restricted their the ability to effectively and sensitively parent. These forgotten, cut-off unconscious memories or 'ghosts in the nursery' affect the parent's interaction with their infant.

Fraiberg argues that the baby can be influenced by the parent's unconscious experiences, suggesting that responses in infants as young as three months, such as avoiding their of mother's gaze, can be regarded as "pathological defences" against perceived pain and distress. However, she didn't believe that these responses constituted a defence mechanism as the infant's ego is too immature (Fraiberg, 1982). For Fraiberg, the infant is only indirectly involved in the mother's distress and a healthy attachment between the mother and baby can be promoted by encouraging the mother to talk about how she had felt during her troubled past (1980).

The presence of the infant in therapy however, is vital. Fraiberg and her colleagues (1980) suggest that an infant can function as a catalyst for change, and as a participant who intensifies the emotional drama who at times engages in "eloquent dialogue" (Fraiberg, 1989) with family members and the therapist.

Fraiberg regards the mode of classic psychoanalytic practice as irrelevant to the populations of hard to reach disadvantaged mothers and babies whom she worked with. She advocates changing the parameters of the therapy setting to include home visits, practical and emotional support and guidance on child

development (Fraiberg, 1989; Fraiberg, 1976; Fraiberg, Adelson, Shapiro, & Fraiberg, 1980).

Serge Lebovici (1915-2000) works within a more explicit Freudian framework which highlights the role of the mother's unconscious infantile sexual fantasies in affecting her relationship with the baby (Moro, 2000; Salomonsson, 2014). Even though Lebovici viewed the baby as an equal partner with his mother and believed that the therapist can have a direct effect on the baby in the therapeutic process, like Fraiberg, Lebovici argued that it is the mother's internal reality and unconscious that ultimately constitutes the infant's world (Lebovici, 1995).

Lebovici is particularly interested in the creative relationship between the infant and the therapist (Lebovici, 1995) which he encapsulated in his dual ideas of enactment and metaphor. Lebovici argues that the therapist can enact and experience bodily sensations which represent unacknowledged affect in the mother or child. The language the therapist uses to describe these countertransference experiences reveal for Lebovici what is actually going on for the mother and the child (Cramer, 1995).

Parental representations are also the focus of the brief work with under-five's at the Tavistock Clinic's Under-Fives Counselling Services. This service is based on the work of Miller, Hopkins and the work of Cramer and his team in Geneva (Rustin & Emanuel, 2010). The aim of this therapeutic intervention is not to necessarily to change parental representations, rather to disconnect parental representations from the infant and reconnect them with their original source (Barrows, 1999). The therapist's focus is the relational aspects of the parent-infant dyad in which the infant serves as the stimulus for parental representations and misrepresentations.

The service offers up to 5 sessions, which may be spread out over a number of weeks, to parents who are anxious about their child (Miller, 1992). What is not of concern is the individual pathology of either member of the dyad. Barrows (1997), summarises Cramer's argument for brief intervention as it relates to the "specific characteristics of post-partum psychic functioning" (p.256) in which the new born baby becomes the "living effigy" of the mother's internal objects. The problems posed in the relationship are seen as new creations independent of previous functioning, albeit linked. As such they are regarded as treatable in their own right. It is important that the intervention is brief, with parents encouraged to re-present as and when they feel they need to so as to allow "working-through" to take place over time.

Lieberman and her colleagues (Lieberman, 1992, 2004) work with parents and their toddlers in day care settings. They engage with the parental representations of the infants but with the added awareness of the need to accommodate individual relationships and transferences. Their aim is to release "projective distortions" and defensive processes that stem from parent's memories of their own attachment in order to free the infant from "precocious defensive manoeuvres" (1992 p.573) which they have adopted to protect themselves and get their needs met. The therapy creates a space in between the parent and toddler, in which their individual needs can be met. Lieberman calls for therapists to learn "toddlerease" to facilitate their guidance by the toddler in therapy. This approach also encourages a positive transference from the parents to the therapist as a helpful figure (Lieberman & Zeanah, 1999).

**Approaches that focus on the parent-infant relationship.** Still working within the framework established by Fraiberg there have been methodological shifts

in emphasis from parental fantasies towards focus on the individual participants in PPIP. Some of these approaches to PPIP are outlined below.

*Watch Wait Wonder (WWW)*: This approach (Cohen et al., 1999) centres on the parent infant relationship but shifts the focus onto the infant and requires the parent to follow their lead. Like Fraiberg's model it also focuses on attachment theory and the understanding that secure attachments develops if a mother notices and responds to her baby's signals, and an insecure attachment develops if she did not. *WWW* is an infant-led approach in which the mother is encouraged to observe her infant's spontaneous activity, play at the infant's eye level and simply to describe her observations and experiences of her child's play. The therapist does not give advice or interpret the play, rather, observations, thoughts and feelings are discussed in order to understand the internal working models of her experience with her infant and this is used to work through developmental and relational issues.

*PIP at the Anna Freud Centre*: The form of PPIP practiced at the Parent-Infant Project (PIP) at the Anna Freud Centre also focuses on the parent-infant relationship and regards the infant as an active partner in the therapeutic process with whom the therapist can directly engage. Through close observation of the infant and use of countertransference, the therapist interprets the therapeutic processes. By directly addressing unconscious material the therapist explores the conscious and unconscious factors that shape the parent's and infant's specific ways of being with each other. The therapist may also interpret the infant's state of mind where she feels his defences are interfering in the normal developmental thrust. The interpretations are voiced to the infant with words gestures and tone congruent to his development and experience. Baradon describes this as enactive interpretation (2016 p.57) as it matches the level of the infant's mental functioning and

development, with the words functioning to represent his experience to the parents. Change occurs as intrusive projective identification decreases, and parental sensitivity increases (Baradon, 2009; 2018; Baradon et al 2016).

Alongside a psychoanalytical framework, this treatment is informed by ideas from developmental psychology in particular the work of Beatrice Beebe (Beebe & Lachmann, 1988, 2015). Beebe's research highlights how infants develop a sense of agency and efficacy from birth through their ability to predict responses to theirs and others actions. Infants, she argues, have an implicit understanding of the relationship with their caregivers (Lyons-Ruth & Bruschiweiler-Stern, 1998; Lyons-Ruth, 2003; Lyons-Ruth, Bronfman, & Parsons, 1999). Drawing on ideas from Fogel (1993), Sander (1977) and Stern (1977) Beebe regards all behaviour in the infant as modifying and being modified by the changing behaviour of the interactive partner (the parent). In this way the parent-infant dyad generates complex and organised behaviours that are coordinated in a bi-directional and dynamic system of mutuality-mutual recognition, mutual regulation and shared relationship. ( Beebe, Jaffe, & Lachmann, 1992; Beebe, 2006; Beebe & Steele, 2013; Cohen & Beebe, 2002).

A principal concept of the method is the creation of a good enough facilitating environment for the therapy to take place. There should be an active and creative engagement with disruptions, repairs, defences and resistances in which the therapist works directly with the present, positive and negative transference matrix. Key to creating a facilitating environment is the complex role of the therapist, who is required to negotiate multiple transferences (the parent's, the infant's and her own) be aware of the "ghosts" and "angels" that are evoked (Lieberman et al., 2005) as well as tolerate and think about intense mental states including anxiety, fear, loss, love and hate.

To facilitate this it is recommended that the therapist sits with her face in clear sight to allow the infant to focus on her. The therapist also aims to mark, using words and a gentle amplification of the infant's own expression, the infant's state of mind. Through a process of mirroring, the therapist confirms the infant's state allowing the experience of "seeing himself in the eyes of the beholder" with the aim of helping him understand his own mental state (Feldman, 2015; Feldman et al., 2011; Fonagy, 2015).

It is also suggested that the therapist adopts a particular enquiring, reflective and mentalising stance to contain and hold the family as they construct new symbolic narratives of their infant, family and relationships. This allows the therapist to notice the different defences used by the infant and parents whilst being alive to the possibility of change within the relationship. The therapist is also required to be self-reflexive and mindful of counter-transferential feelings that might provide a clue to some of the more hidden or cut off emotions in the relationship. The aim of the work is to provide a new developmental object experience to each of the participants, so as to interrupt the repetition of negative intergenerational patterns of relating and diminish the traumatic impact on the infant.

**Approaches that focus on the infant.** Thomson-Salo and Paul (Paul & Thomson Salo, 1997) also argue that a dialogue with the infant as an equal partner can be established. Unlike the approaches discussed above, they focus primarily on the infant rather than the parent-infant relationship. Working in a hospital clinic with medically unwell infants, a team of paediatricians and therapists seek to understand the infants' experience from their point of view and then communicate this to the parents. Through this intervention they argue it is possible to increase the reflectiveness of the parents, and to change parental experience and understanding

of their baby to that of an intentional object seeking person, rather than the source of struggle and worry. This reconceptualisation of the baby is very powerful and they argue that many infants change after a single intervention (Thomson-Salo, 2012).

Drawing on the work of Trevarthen (1998, 2009) they regard the baby as being in possession of a number of cognitive and emotional capacities which they bring to the relationship. These include a sense of immediacy, emotions, moral feelings, a wish to truthfully know and be known, and a wish to be creatively alive (Thomson-Salo & Paul, 2010).

In a similar vein, but years earlier, Françoise Dolto (1908-1988) developed a system of therapeutic and educational drop-in centre for parents with young infants where mothers and their infants receive immediate brief psychotherapeutic interventions that work directly with the infant (Hall, Hivernel, & Morgan, 2009; Paglia, 2016). A contemporary of Lacan, she followed his privileging of language as the site on, and through which we are constituted as subjects. For Dolto the infant is formed and informed by language. Dolto contends that young infants possess the ability to communicate directly, as well as the ability to understand verbal input from their caretakers. Adopting a controversial position (Anthony, 1974) Dolto is convinced that an infant can understand the literal meaning of the therapist's words and that speaking to an infant can have important therapeutic effects. Dolto recommends to parents that they talk to their children about everything (Dolto, Hivernel, & Sinclair, 2013; Hall et al., 2009; Hall, 2009a).

Dolto believes that whatever remains unsaid can affect the autonomy of a child's desires and can engender both psychological and physiological problems (Hall, 2009). The role of the therapist is to directly re-establish the flow of communication between these different elements and Dolto instruct the therapist to

be very attentive to the aspects of what she calls the infants “archaic” or preverbal development especially their use of body and unconscious image (Hall 2009 p.10).

Dolto’s insistence that the new-born can understand her words has been refuted by research that has conclusively demonstrated that newborn infants have not developed the capacity to literally understand the spoken word (Salomonsson, 2007). However, others have argued (Hall, 2009) that her understanding of language is not confined to just verbal content alone, insisting that she takes account of “sounds, nonverbal communications, affects, turmoil, as well as internal and external perceptions that make up intrapsychic life.” (Hall 2009 p.12). The preverbal infant’s understanding of words lies more in a comprehension of the structures of feelings behind the word rather than the words themselves

Johan Norman (2001), also devised a method of working with mothers and their infants which focuses on the infant (*Mother-Infant Psychoanalysis MIP*). At the heart of Norman’s method, which draws on the work of Freud, Klein, Bion and Meltzer, is an insistence that a relationship can be established between the therapist and the infant. The infant for Norman possess a “primordial subjectivity and self” which is primed to search for containment from wherever or whomever it is offered. Before the ego fully develops the infant has the capacity to change and adapt to others as well as the ability to process certain aspects of language (Norman, 1991, 2001). Although he did not agree with Dolto’s assertion that infants can understand the lexical meaning of language, he also suggests directly addressing the infant. Norman accepts that because the infant is in possession of an immature ego he is exposed to emotional disturbances with the mother but he is also primed to look for containment from whomever offers it. For Norman, this presents an opportunity for the undoing of the effects of trauma. The key mechanism for this is the analyst–

baby “transference” (Norman, 2004). Although Norman worked with the infant-parent attachment, he questioned attachment theory as an explanation of the object of study in psychoanalytical treatments (Norman, 1991; 1999; Salomonsson, 2011, 2015). Instead he argues that the essential mechanisms of disturbance and distress are the same at any age, and thus the response of the therapist should be the containment of anxieties. Citing Bion (1962), Norman argues that the role of the therapist is to bring the baby’s (and the mother’s) disturbance into the room and, by receiving the communication allow reverie to take place. Through this process, the mother-infant dyad can be repaired and a positive attachment achieved (Norman, 2001).

More recently, Salomonsson has addressed the infant as patient making the important assumption that the baby is willing and able to communicate their distress and suffering (Salomonsson, 2007). Following Norman, Salomonsson believes it is useful to directly address the infant. He describes the relationship between the baby and the therapist in semiotic and musical terms arguing that while the infant cannot understand the lexical content of the word, he can respond to the signs (symbols of action and visual images) or “meaning-units” that emanate from the analyst (Salomonsson, 2011).

Salomonsson also argues that the infant is not only an intersubjective being who actively relates to his primary objects from the beginning of life (Salomonsson, 2007), but also actively seeks containment from them. He uses Trevarthen and Aitken’s (2001) concept of “communicative musicality” to describe the bridging effect of music in the interchange of information between the infant and mother. Music, for Salomonsson plays an important role in structuring the parent-infant relationship, as well as giving shape to emotion and affect.

The different models of PPIP outlined above have taken as their patient different aspects of the parent-infant dyad; parents and their past, the parent-infant relationship or the infant but all ultimately address distress within the parent-infant dyad. Research has sought to examine and evaluate different aspects of the processes and effectiveness of PPIP in its attempts to address this distress.

In a recent systematic review of RCTs in which PIP interventions were specified, Barlow et al. (2015) suggest that meta-analyses indicate an improvement in the attachment of infants who had received PIP treatment as compared to those who had not. However, positive findings across other outcome measures, such as maternal representations and parent-infant interactions, were more limited. Also, evidence of the effectiveness of PIP compared with other methods of parent-infant intervention was inconclusive. Other studies have evaluated the role of PPIP in improving maternal mental health; for example Fonagy, Sleed, & Baradon (2016) conducted a RCT of Parent-Infant Psychotherapy for parents with mental health issues who were also experiencing high levels of social adversity. The study showed a clear impact of PIP on mothers' self-reported emotional well-being and on narratives of mothers' representations of their child, feelings of warmth towards their babies, a decreased sense of parental stress and a decrease in parent-reported dysfunctional interactions. However, little to no change was found in measures of infant development and attachment, observed parent-infant interactions or maternal reflective functioning.

Other studies compared PPIP with a control group, such as Lieberman, Weston, Pawl (1991) who compared Fraiberg's modality of Infant-Parent Psychotherapy (IPP) with a control group that focused on reducing maternal anxiety. It demonstrated that IPP had a positive effect on measures of mother-infant

interactions and behaviour. Similarly, Salomonsson & Sandall (2011) assessed maternal distress, infant functional problems and relationship difficulties through a comparison of Mother-infant Psychoanalysis (MIP) with treatment as usual. They found that MIP interventions decreased maternal depression, dyadic relationship qualities and maternal sensitivity.

Cohen et.al (1999) compared two different modalities; IPP with Watch Wait and Wonder (WWW). IPP was shown to reduce mother reported stress and improved mother-infant relationships, although WWW was shown to be more effective in improving attachment, infant development and parental satisfaction from their role. Salomonsson & Sandall (2011) assessed maternal distress, infant functional problems and relationship difficulties through a comparison of Mother-infant Psychoanalysis (MIP) with treatment as usual. They found that MIP interventions decreased maternal depression, dyadic relationship qualities and maternal sensitivity.

Further studies have focussed on mothers' experience within parent-infant therapy. Salomonsson & Barimani (2017) for example investigated MIP and found that it can help foster a closer mother-infant relationship. Other research has sought to examine the on the quality of the alliance between the therapist and the patient. However until recently much of this research has been conducted with adults (see for example Horvath & Symonds 1991). Newer research has focused on the therapeutic alliance with children and infants to attempt to demonstrate that a strong therapeutic alliance is associated with positive outcomes (see Bordin 1979; Chatoor & Kurpnick 2001; Karver, Handelsman, Fields, Bickman 2006; Baylis 2009). Further research has sought to evaluate the role of the therapist in PPIP, including consideration of their training (see Åstrand & Sandell, 2019; Sternberg, 2006; Urwin

& Sternberg, 2012). Ideas from attachment theory and research have also been assessed to evaluate how effectively these have informed clinically based parent-infant interventions (Zeanah, Berlin, & Boris, (2011).

In summarizing the above, research on the effectiveness of PPIP is relatively limited. There is evidence of positive changes in maternal functioning, experience and sensitivity, although significant change in terms of infant development, infant attachment, parent-infant interaction, or reflective functioning has not been demonstrated (Barlow et al., 2015; Fonagy et al., 2016). Several possible methodological explanations for these inconclusive findings have been proposed, including the lack of blind testing and lack of sensitivity in clinical measures. As such, there remains a need for further research to clarify and confirm these findings. Moreover, further research on the process of PPIP is also needed, so that we can begin to better understand the mechanisms through which change is achieved.

## **Conclusion**

Through a discussion of the psychoanalytic and developmental research literature, this review has set out to map the theoretical ideas and practices that have informed different modalities of PPIP. PPIP uses a theoretical framework that draws from psychoanalytical theory, ideas from developmental research and attachment theory. The different modalities share key ideas which this literature review has defined.

This review has found that even though the initial patient at the point of entry to the treatment may be specified by the modality, the aim of all treatments is to repair the parent-infant relationship. The focus on the particular patient has often been in response to the different demands of the therapy setting and target clinical

populations; be it the clinic, hospital, front room, or difficult to reach disadvantaged populations, self-referrals or clinical referrals. PPIP can perhaps be described as representing a continuum of different technical approaches and that during a therapy session the focus can switch from parent, to infant or to the relationship and is dependent on the needs of the moment.

It is worth noting that this review has been limited to psychodynamic therapeutic interventions. There are a range of behavioural treatments that focus on changing the conduct of parents or infants which have not been considered but can also positively affect change within the parent infant relationship. This review has been concerned with establishing the theoretical and procedural similarities in PPIP rather than considering differences. This can potentially give a false image of PPIP as a unified practice. Also, what has not been addressed in this paper is how change is conceptualised across the different modalities and further studies are needed to give a fuller account of how theory and practice inform each other.

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Part 2: Empirical Research Project

Doing things with words: A therapist's talk to the infant in a successful treatment of  
Parent-Infant Psychotherapy

Candidate number: XXXXXXXXXX

Word Count 8000

## **Abstract**

**Aim:** This paper concerns an naturalistic observational single case study of the therapist's talk when in direct communication with the infant. It examines how the aims and principles of PPIP are translated into the words used by the therapist to the infant in therapy. The therapist's speech turns when in direct communication with the infant, were examined. The aim of this research is to get a greater understanding of the what the therapist actually says and does in a therapy session.

**Method:** Video recordings of a 14 week treatment of a 9 week infant and her mother were studied. Transcriptions were made of the audio and analysed using DP.

**Results.** The therapist was found to talk for a significant amount of time directly to the baby and on a specific number of themes. The content, form and function of the therapist's turns are described in details and their role in therapy process discussed. Even though this is small single case study the findings contribute to our understanding of what the therapist says does in therapy.

## **Introduction**

The therapists' interaction with the baby is a key intervention in PPIP, however to date, there has not been an examination of what the therapist says or does. Research which has primarily focussed on psychotherapy with adults has examined verbal interaction and discourse use in psychotherapy (Avdi & Georgaca, 2007a, 2007b; Georgaca & Avdi, 2009). There remains a need for more process research, i.e. research looking at how therapy gets done in practice rather than simply outcome research. This study contributes to this under-researched field by examining the therapist's direct verbal communication with the infant in PPIP.

This 'naturalistic' (non-experimental) observational study examines the words used by the therapist in her talk to a Baby in a 14 week PPIP treatment conducted at the Anna Freud Centre (AFC) using a modality of PPIP called Parent-Infant Psychotherapy (PIP). The therapist regarded the treatment as successful based on a number of factors including consistent attendance by the mother, positive change across routine measures and her own clinical experience and judgment.

This study is concerned with the psychotherapeutic themes of the therapist's talk; it relies on the assumption that therapy is a co-constructed interaction between the parent, infant and the therapist. The principles of discursive psychology were used to inform the method and analysis (Edwards & Potter, 1992; Potter et al., 2001; Potter & Wetherell, 1987).

## **Parent-Infant Psychotherapy (PIP) at the Anna Freud Centre**

PIP with its roots in child development research and psychoanalysis, is a culturally sensitive psychodynamic intervention that aims to address problems within the parent-infant relationship. It focuses on the quality of attachment between infant

(defined by Baradon, et al, 2016, as being from birth to 18 months) and parents, and considers parental fantasies and internal working models, and seeks to uncover unconscious patterns of relating which may be impeding the healthy development of the infant.

Different conceptual and technical ideas have been brought together and developed by the PIP team at the AFC to inform a particular modality of parent-infant intervention. Referrals to the PIP team come from both professionals and self-referrals of pregnant women/families or infants. It has at its core concepts from psychoanalysis and object relations theory and incorporates ideas and practices from developmental research. As well as keeping the father in mind, PIP offers a nuanced response to the needs of the referred dyads and families resulting in a flexibility around the setting, length of therapy and an awareness of difference. The key concepts of this modality have been summarised in a handbook *The Practice of Psychoanalytic Parent-Infant Psychotherapy* (Baradon et.al. 2016), in which ideas about the role and function of the therapist, and the aims of the treatment are outlined alongside a discussion of the theoretical assumptions that have informed the modality.

Foremost in this method is an understanding that the patient is the relationship between the parent and their infant. The infant however, is regarded as an active participant and subject in their own right with whom direct work can be done to promote their effectiveness in engaging with parental care. Using age appropriate modes of communication, including motherese, repetition and play, the therapist engages the infant in face-to-face turn-taking conversation that attends to his readiness and willingness to interact (Bateson, 1975; Beebe, Jaffe, & Lachmann, 1992; Jaffe et al., 2001; Trevarthen, 2009, 2015).

A key concept of this method is the creation of a good enough facilitating environment for the therapy to take place and an active and creative engagement with disruptions, repairs, defences and resistances. The therapist also works directly with the current positive/negative transference matrix. Vital to the creation of a facilitating environment is the setting in which therapy takes place and the complex role of the therapist. She is required to be self-reflective and mindful of counter-transferential feelings that might signify the more hidden or cut off emotions in the relationship. Multiple transferences (the parent's, the infant's, the therapist's) can be mobilised in therapy and can manifest as "ghosts" and "angels" which evoke intense mental states including anxiety, fear, loss, love and hate (Lieberman et al., 2005) and need to be tolerated and thought about. To achieve this, it is suggested that the therapist adopts a particular enquiring, reflective and mentalising stance to contain and hold the family as they construct new narratives of their infant, family and relationships. The aim of the work is to provide a new developmental object experience for the participants in therapy so as to interrupt the repetition of negative intergenerational patterns of relating and diminish the traumatic impact on the infant (Baradon et al 2016).

An important medium of communication for the therapist is her talk to the infant.

### **The therapist's talk to the infant:**

Spoken language is the prime medium of communication in psychotherapy. It can also function as a methodological tool for investigating psychotherapy which provides knowledge and clues to the construction of subjectivity and relationships within therapy (Russell, 1989). The specific significance of the therapist's talk to the infant is summarized by Salomonsson, (2017) who, drawing upon semiotics, as well

as Dolto's insistence on *parler vrai* to infants, argued that the therapist's words help the infant become aware that he too has a place in the symbolic order distinct from his parents and that he is able to use language to express and manage his distress. Salomonsson also added that the particular register of the therapist supports the infant's developing brain.

The therapist, in this way is not simply reflecting an external reality, rather she can be said to be doing something active with her words in the therapy session.

The view of this enquiry is that the therapist's talk is constructive in consummating an action, and situates her talk within a discourse analysis insofar as it examines a particular aspect of social life through the study of language in its broadest sense: face-to-face talk, nonverbal interactions, and documents signs and symbols (Wetherell et al., 2001). In line with the approaches adopted in other discourse analytical studies, this enquiry takes a social constructionist and deconstructionist view that understands language as grounded in behaviour, as interactive between individuals and their cultural environment, as a process in which talk is performative rather than simply mirroring or reflecting an external reality. Reality and meaning are generated in specific contexts, in this case the therapy session. It also draws on Discursive Psychology (DP) which is interested in psychologically informed talk in naturalistic environments.

DP uses detailed transcripts of naturalistic conversation to identify patterns of language. The DP understanding of language as constitutive, productive, and performative makes it a fitting methodology for this research question. DP regards transcripts as selective renditions of an interaction between the raw material and the transcriber that aims for consistency rather than being representative of reality

(Braun & Clarke., 2013). This fits with this study's assumption that the researcher is constituting a reality as does the therapist and family in the study.

DP also assumes that psychology and knowledge are not solely located in individuals, rather they are produced externally in systems of the social world and in interactions outside of, and around the individual (Edwards & Potter, 1992; Potter, 1996; Potter & Edwards, 1999). Based on a framework of what Braun and Clarke (2013) term a 'critical realism', this position assumes that there exists some objective reality but that this can only be perceived through the different prisms of culture and history. At the heart of this position is an acknowledgment that research is a subjective process that involves a complex relationship between researchers located within specific histories, experiences and common senses, and the objects of research which have been produced to illustrate and demonstrate the research question (Molder, 2015). DP then, is concerned with naturally occurring language, the social and cultural contexts in which language is produced and used, and the dynamic interactive strategies that structure language. It is the place where, as Sally Wiggins argues, "psychology happens" (Wiggins & Potter, 2008). In this context the researcher is not separate from the material presented in this research but a constituent part of it.

With its interest in the processes through which particular knowledges are produced, DP is concerned with questions about how social practices are carried out. This focus on the utterances, turn-taking, tone and pauses makes it particularly useful to the purpose of this study which aims to examine the words the therapist uses with the infant in the practice of PIP. In the specific context of the therapy session, the words used by the therapist constitute identity and different subject positions, on both the denotative and connotative level. The therapist is not just

performing her own role as a therapist in a successful treatment of a traumatised parent-infant dyad, she is also enunciating and calling the infant into a useful subject position which allows for both the acknowledgement of the trauma, but also for the restoration of a normal developmental trajectory.

A DP approach highlights the way in which the setting in which talk takes place, frames the speech that is generated. The assumptions and limits of the languages and discourses around the specific context of PIP at the Anna Freud Centre - informed by its theoretical considerations of psychoanalysis, infant development, understanding of infant subjectivity and its understanding of the role of the therapist - need to be accounted for in any discussion of process change in therapy. It is the understanding of this research drawing from psychoanalytic theory, speech act theory and constructionism, that the therapist's talk is central is helping the parent-infant dyad to rethink and reconstruct meaning.

This study, with its focus on the therapist's talk to a Baby is situated in the search to gain more understanding of the specific context in which meaning is produced in therapy. It asks: what does the therapist say in therapy? The answer hopes to shed light on the often assumed relationship between theory, practice and process change in therapy.

## **Method**

**Design.** This is a naturalistic observational study of the talk (the words and sound utterances) made by a therapist when in direct communication with a Baby who was 6 weeks old when the 14 week treatment began. The treatment took place over the course of 8 months following the referral . The first-time Mother reported that following a very traumatic birth in which the Baby nearly died, she could not

connect with her Baby and noticed that her Baby avoided eye contact (for more information on this case see Baradon, 2018).

The complete treatment was video-taped after consent was obtained. Three sample sessions were taken from the treatment; one from the beginning of therapy (week 2), the middle (week 6) and the final session (week 14). There were two main criteria for selection. Firstly, videos were chosen from different points to represent the range of utterances the therapist might use to an infant in PIP therapy. The second a more practical concern, videos were chosen that were audibly and visibly clear.

The audio of the sessions was transcribed using a simplified version of the Jefferson method (Lapadat & Lindsay, 1999) which adheres to utterance detail (both word and non-word utterance) and cross-checked for consistency by other post-graduate researchers.

**Ethical considerations.** As this study was part of a wider research project, ethics had already been approved by the AFC and UCL. Consent to view the video tapes by third party researchers had already been obtained from the participants as part of their therapy agreement.

The videos were password-protected and kept on the secure section of the Anna Freud intranet and were only accessible at the AFC. The transcripts of the sessions were kept securely in a locked desk in my office and were password protected on my computer.

**Participants.** The participants in the study are a senior PIP therapist at the AFC, a Mother and her 6 week-old infant daughter (the age at which she and her parents first met the therapist).

**Routine outcome measures used in the treatment.** PIP allows for flexibility in the choice of outcome measures allowing for a case by case use which reflects extant issues in the parents, the infant and/or the relationship. These include questionnaires, semi structured interviews as well as video-recordings of parent-infant interactions typically taken at different points of the therapy to represent change across time (Fonagy et al., 2016c).

In this particular treatment the therapist used a number of different measures to chart change across the therapy process. The therapist began the therapy with the Adult Attachment Interview (AAI) to assess Mother's initial understanding of her attachment behaviours. The therapist also used Goal Based Outcomes (Law 2009) at different points in the treatment to show how the mother's initial goals for the therapy had been achieved. A rating of the parent-infant relationship was assessed using the Parent-Infant Relational Assessment Tool (PIRAT), (Broughton 2014) also at various time points, (private correspondence with Slead 2020) highlighting improvements in the parent-infant relationship. The therapist used other measures drawn from AMBIANCE (Atypical Maternal Behaviour Instrument for Assessment and Classification), (Lyons-Ruth, Bronfman, & Atwood, 1999,) and Frightening Behaviour (FR) (Main & Hesse 1992), to demonstrate the improvement in the quality of attachment from the initially coded clinically concerning "frightened maternal behaviours" and "communication errors" to an improved parent-infant relationship. The therapist also assessed the treatment using a microanalysis of the videoed sessions based on the framework of Beebe et al to observe maternal behaviours in detail such as grimacing, looming and the infant's avoidance (Baradon 2018). The focus on Mother's behaviour and feelings towards attachment with her Baby,

emphasize the therapist's initial assessment's that maternal fantasies and behaviours were adversely impacting the infant (Baradon 2018).

**Procedure.** At the AFC, PIP sessions are routinely videotaped. Videos are used for the reflective practice of the therapist, enabling them to notice communications that are not immediately evident or for reflection with the family. As a matter of course, permission to video and to use the videos for training and research is sought before treatment begins.

After an initial meeting with the treatments' therapist it was decided that I would analyse sessions from a successful treatment, that is, one where the Mother regularly attended and where the initial outcome goals were met. Sessions from the beginning, middle and end of the therapy were chosen with the aim of capturing the fullest range of what the therapist says to the Baby. Sessions 2, 6 and 14 were selected.

These videos were viewed multiple times, and were stopped and re-examined for clarification when either the recording quality or the audio quality was not clear. The language of and utterances of all the participants were transcribed using an agreed method and then cross-checked by other researchers. The utterances made by the therapist directly to the Baby were identified to generate the corpus of data for this study. The transcripts were then analysed using a DP approach which draws upon thematic analysis (Wiggins, 2009; Wiggins & Potter, 2008) to produce codes.

**Coding Method.** For the purpose of this study a coding system for the therapist's talk was developed. Both the session material and the key principles of PIP (outlined by Baradon et al in 2016) were identified through an iterative process. The transcripts were initially coded along four axes: content, (the actual utterances made by the therapist), form (which related to the structure of the sentence - was it a

statement or a question), tone (which sought to capture the character and sound quality of the utterance) and function (which sought to capture the therapist's intention) as outlined in the PIP by Baradon et al. (2016). Under these subheadings further codes were generated to capture in the language used by the therapist in greater detail. These codes were comprehensively checked and rechecked in discussion with my supervisor. Codes that were too similar, irrelevant or too vague were combined, deleted or clarified to eventually produce a modified set of codes (see appendix A).

These codes were then reviewed by an external graduate researcher, who was not part of the study, in a process of inter-rater reliability. A training session was provided during which the principles of the study, the methods used to arrive at the codes, and a brief explanation of the coding system were discussed. Examples from the transcripts were used to illustrate each of the codes, and points of uncertainty or lack of clarity were explained. The graduate was given a copy of the sixth session (the longest and most complex) along with a description of the codes and she coded the session independently, after which we met to discuss our respective results. Once we had gained consensus, the graduate independently coded the other two sessions (2 and 14). We discussed any inconsistencies until consensus was reached on all utterances and a final set of codes was produced (see appendix C). Unfortunately, because of restraints around confidentiality, time and technology, it was not possible to have the codes checked by an outside researcher for reliability. Future studies would benefit from having the codes blind checked at each stage from initial video analysis to the final set of codes to produce reliability.

## **Findings**

## **How much the therapist talks to the Baby**

First, the number of therapist turns of talk addressed directly to the Baby were identified and the percentage of infant-direct utterances across three sessions was calculated. The therapist talked directly to the Baby for a significant percentage of utterances, and the percentage of utterances the therapist directed to the Baby changed across the course of the treatment with less talk to the Baby in session 2 and more in session 6 and the final session. More specifically, during session 2 the therapist made 154 utterances of which 16 (9.8%) were directly addressed to Baby. This compared with 180 utterance in session 6, of which 40 (22.2%) were addressed to the Baby. In the final session 114 utterance were identified of which 26 (22.8%) were addressed to the Baby (see appendix B and D).

The therapist spoke less to the Baby at the beginning of the treatment - directing only 9.8% of her talk to her. There are a number of possible reasons for this. During the second session the Baby was only 9 weeks old and her engagement in the therapeutic process was minimal. Developmentally, a nine-week old infant should be becoming more aware of her environment, hand to eye coordination will be improving and she should be looking around as her movements become focused, coordinated and integrated. Her visual awareness should be more acute and she should respond to her carer's voice with physical and audible signs such as by smiling, cooing and making eye contact. Moreover, she should be becoming more responsive to exaggerated facial movements (Robinson, 2003). However, this Baby avoided eye contact and resisted attempts by her Mother to engage her. Her musculature was weak and she lay flopped in her Mother's arms.

Baradon (2016) argues that at the beginning of therapy the therapist has a number of tasks. She needs to establish an early alliance with Mother as it has been

demonstrated that there is a positive relationship the creation of a good alliance and a positive therapeutic outcome (Horvath, Del Re, Flückiger, & Symonds, 2011; Horvath & Symonds, 1991). The therapist also needs to uncover the different elements of the narrative around the parent-infant dyad. In this process of fact-finding the therapist needs to test out and refine any hypotheses that have been formulated as a result of the referral process (Baradon et.al. 2016 p.34). It is possible that the therapist's main focus at the beginning of therapy, for these reasons, was on Mother. Rather than ignoring the Baby the therapist's words can be seen as early attempts to engage an anxious mother her infant.

Over the course of the treatment, the therapist directs more of her talk towards the Baby, possibly reflecting the changes that have occurred through the course of the treatment. By the sixth and final sessions, a therapeutic alliance has been established and increased talk to the Baby could indicate this. Direct talk to the Baby could also function to promote attachment and normal development. By the middle stage of the treatment the Baby is about 4 months old and about 6 months old when the treatment ends. During this stage the infant is developmentally more proactive and should be able to use a range of different forms of communication. Infants are more able to map their bodies to their minds, to recognise objects that are outside of themselves, and their vision has improved aiding their physical coordination (Robinson 2003). Importantly, the infant's brain is increasingly organising itself around words and language. Their capacity to differentiate and understand words is becoming sophisticated and they are able to take part in proto-conversations (see for example Bråten, 2007; Trevarthen & Reddy, 2017). It is possible that the therapist wishes to exploit these advances by using her language

and the prosody of her communication to engage and stimulate normal development in the Baby.

It could also be argued that the therapist is using the Baby as the “entry ticket to the therapy” (Baradon et al. 2016 p.44). Parents who may be the primary source of disorder, either because of the condition of the parental relationship or maternal mental health, are induced into attending therapy as they bring the infant. It is possible that the therapist directs talk to the Baby that is intended to for the Mother. This way, difficult material that if addressed directly could be experienced as deeply persecutory by the Mother, is distanced enabling her space to hear and incorporate what is being said.

### **How the therapist talks to the Baby**

The therapist talks to the Baby in different ways. The therapist’s utterances were examined for the use of motherese, a playful tone and repetitions. The therapist also used more statements than questions. Below, the main features of the therapist’s talk to the infant are briefly described.

**Use of motherese.** In all her talk to the Baby with the exception of one utterance, the therapist uses motherese. This characteristic register of rhythmical, undulating, exaggerated intonation that typifies infant-directed talk has been demonstrated to be the “preferred” form of talk as it elicits the greatest response from infants (Fernald, 1985; Papaeliou & Trevarthen, 2006). PIP uses this form of speech to build trust and create a warm, caring and safe environment for the therapy to take place. The therapist communicates to the infant using a register and style that matches her developmental level.

**The therapist is playful.** Evident in the therapist’s utterances is a sense of play and playfulness. Winnicott, (1971) highlighted the importance of play, arguing

that play not only provides a unique space which allows the developing child to creatively reach out to others, but is also a means of getting in touch with the authentic and creative part of the personality; a quality as important in the therapist as in the child. Coates, (2007) drew attention to the idea of talk as play, drawing on Bateson's, (1953) idea of a 'play frame' in conversation whereby the participants frame their talk with shared markers and cues. These could include examples of prosody, such as intonation, volume levels, pitch changes, phrasing, but also by the responses of the participants. This 'play frame' assumes and creates a collaboration between the participants (Sullivan & Wilson, 2015).

This is evident in the sessions. The therapist's 'play talk' can be observed in her high pitched, melodic and sometimes humorous use of motherese as well as in talk that reflects the Baby's response to her. For example, in the final session the therapist has been observing and commenting as the Baby cheerfully explores the room. At one point the Baby stumbles and the therapist playfully says, "Whoopsie daisy did you fall down hmm?... What are you going to do". The Baby responds with a smile directed at the therapist and then turns around and pulls herself up causing the therapist to comment, "Ahh that's a good solution". The therapist models for Mother and Baby a different way of responding to a disruption as the humour of the play diffuses any potential anxiety allowing the Baby to respond differently.

**The therapist uses repetition.** The therapist uses repetition when talking to the Baby. For example in session 6, she says: "Mmh I could feel your little body getting a little bit agitated, that little body of yours. What was that? Hmm? What was that about?". Repetition has been found to be the preferred method of attracting young infants' attention (Fernald, 1985; McRoberts, McDonough, & Lakusta, 2009; Stern, Spieker, & MacKain, 1982). Infants are sensitive to repeated patterns of

speech and sound and it is possible that the therapist was demonstrating her awareness of the Baby's cognitive development by deploying age-appropriate techniques to communicate with her.

She also uses phatic expressions to maintain rapport such as 'Hmm', 'Ahh' and 'Oh' (al-Qinai, 2011). A clear example of this can be seen in session 6, where, in an exchange with the Baby that lasts over sixty seconds, the therapist says "Mmh. Pa. Pa. Pa. Pa. Pa. Pa". It is as if the therapist is addressing the Baby's earlier nascent attempts at interaction with a developmentally appropriate verbal response with the aim of retaining the Baby's attention and drawing her into the relationship.

**Use of statements.** The therapist talks using mainly statements. These statements make up 60% of her utterance in session 2, 68% of her utterances in session and 64% of her utterances in the final session. Statements-as compared to questions-are declarative in that the subject comes before the verb. It is possible that this emphasis on the subject removes potentially persecutory questions and anxiety inducing emotion from the therapist's talk and unambiguously puts the Baby's experience into words. Noticeably, the therapist's use of statements contrasts with the Mother's use of questions to the Baby. It can be argued that statements in this context provide unequivocal linguistic moments which can function as support and scaffold both the Mother and the Baby and around which creative change can be organised.

Furthermore, in session 6, 26% of the utterances addressed to the Baby would be described as interpretations. These types of statement move beyond the descriptive and offer hypotheses and explanations regarding the possible meaning of the Baby's communications. Baradon et al. (2016) argue that by the middle phase of therapy the relationship has generally been set-up, trust has been established and a

rhythm and momentum achieved. During this phase, unstated assumptions and less conscious feelings tend to be acknowledged. It is possible that during this session, the therapist felt more able to talk directly about the anxieties and worries that were stirred up by the Baby's earliest experiences. For example, the utterance below was made after the therapist had been talking to the Baby about the anxieties around during her birth. The Baby was looking at the therapist but then wriggles and then cried. The therapist said,

“ Oh. What is going on? Did you get a lot of saliva in your mouth? Or was that a big idea to have to digest? Yeah. It is isn't it. How fragile you were but you survived, Yeah. And you are doing so well”.

Here, the therapist acknowledges, and validates the Baby's present physical experience of discomfort and reattaches it to traumatic events and feelings from the past. She also connects the physical process of digestion to the mental process of absorbing an idea and highlights the process of learning through experience. It is possible that such statements draw attention to defences, in operation in both Mother and Baby, that may have been impinging on the relationship. In this comment, for example, the therapist articulated parental anxieties that may have been disruptively operating in the background of the relationship. As the therapist names these anxieties the Mother is momentarily distanced from her defences allowing for a creative, thinking and feeling space to emerge in which they could be made sense of and discharged. The interpretation models a different way of “being-with-the-other” (Bollas, 1978) through which words transform the physical emotional experiences of the past.

This might account for the low figure of only 11% interpretative statements in the final session. By the end of the treatment, the therapist's role has changed to

one which now helps the Baby and Mother reflect and express new and perhaps complicated feelings around endings, loss and separation that may have been stirred by the completion of treatment. The conscious words of the therapist become an opportunity to work through previous unsatisfactory endings and also provide a resource for future endings (Baradon 2016). In the last session, statements which reiterate reality are used more frequently. For example, in the last session the therapist says “Can you imagine, Sasha, you are going to be the older one. Yes” and a little earlier she says “...you are very small but you are doing so well”. Such statements potentially help disperse regressive or defensive moves that might want to either obliterate the therapy or fantasise about the continuation of the therapeutic relationship rather than integrate it into experience. The end of therapy is an unstable time of loss which can be very provocative. Here the therapists words might function to secure the gains of maturation and self-reflection, and stabilise the new relationship between the parent-infant dyad (Holmes, 1997).

### **What the therapist talks about**

A number of different themes emerge in the content of the therapist’s talk. These are briefly described next.

**The therapist salutes the Baby.** The therapist greets the Baby in the second and final sessions, however she doesn’t do so in session 6. Salutations are an important part of boundary setting in therapy as they mark and preserve the therapeutic framework in which psychological work can take place. Also, salutations function to establish who is taking part in the therapy. Greeting the Baby establishes her as a subject who is present in her own right (Paul & Thomson Salo, 1997; Thomson Salo et al., 1999). The lack of salutation in session 6 might be an

example of the therapist's counter-transference as Mother and Baby's anxiety overtakes her causing her to momentarily lose sight of the Baby.

**The therapist talks to the Baby about her physical and mental state.**

More specifically in session 2: 44% of all therapist's utterances are of this nature, rising in session 6 and dropping to 43% in session 14.

Typical statements include the example below from session 2:

“Oh you were both tiny and big, yes...yes...yes that's a complicated thing to be isn't it. Yeah oh. You've done lots of growing, lots of eating and growing but you're also still very small. Yes. You're taking that seriously aren't you. Mmm yeah it's about you”.

Here, there therapist makes explicit links between the physical reality of the Baby and her emotional state. It is conceivable that the therapist here acknowledges that these states are inextricably linked, and the preverbal Baby communicates through her body. It can be also argued that the therapist can be said to be supporting the cognitive development of the Baby by being explicit about the sensorimotor links between the different systems of gestures, movements and communication in the Baby (Davies, 1989; Jaffe et al., 2001; Trevarthen, 2009).

By framing the Baby's experience with words uttered in a way that she is developmentally receptive to, the therapist aims to draw the Baby into communication. Such utterances possibly serve two purposes. By repeatedly, and directly communicating with the Baby, the therapist demonstrates to the Mother that the Baby is someone with whom one can communicate. Moreover, through her persistence, the therapist models for Mother a way of communicating with the Baby which helps them both tolerate anxiety and rejection.

It is also possible to conceptualise this talk in terms of the therapist's aim of helping the Baby recognise and reflect her own feeling states through marking and mirroring them. This process is an important one in psychotherapy as it allows the Baby to regulate herself but also enables the parents to regulate the Baby. By concretely naming physical and mental states it becomes more possible to differentiate states that belong to the Baby from those projected into her.

**The therapist talks about the here and now.** Overwhelmingly, (session 2, 79% of all utterances; session 6 78% of all utterances; final session 86% of all utterance;) the therapist makes comments about what is happening in the room, including talk about the Baby's observable physical and mental states, reference to the Mother and comments about observable relationships and behaviours. For example, in the final session she says "Is that amazing... can you run away and then come back?". It is possible that these comments reflect the therapist's stance and training in observation which enables her to be responsive to both the Mother's and infant's state of mind (Rustin, 2009). Observation is a way of accessing the emotional communications, and allows the therapist through her own countertransference to comment on the feelings in the therapy room. Psychoanalysis argues (see Money-Kyrle, [1956] and Orr's, [1954] discussion of Klein, Bion and Winnicott) that young infants communicate by projecting their feelings into others so that they can be contained, digested and made useful. It is plausible that the therapist, by observing events and feelings present in the room, is holding and containing the Baby through her awareness and reverie. Her comments make sense of the Baby's emergent extant feelings and behaviours whilst she contains the emotional unbearable and intolerable states in the room (Urwin & Sternberg, 2012).

It is also possible that the here and now statements enable the therapist to attune to or go alongside the Baby, which help her regulate and reframe her negative experience. For example, session 2, “Now you are ready. But you like to take things in first, don’t you”. Here the therapist seems to articulate the Baby’s caution but also her capacity to learn from experience.

**The therapist talks about the past.** The therapist understands how the past shapes how the present is understood. Contained in representations of the past are parental attachment patterns that are brought to bear in relationship with their own infants (Ainsworth, Blehar, Waters, & Wall, 2015; Bowlby, 1958; 1997; Bowlby, Ainsworth, & Bretherton, 1992; Crittenden, 1992). In the treatment, talk about the past is highly charged and potentially anxiety-provoking as it contains difficult and traumatic memories from the Mother’s past as well as frightening and overwhelming memories of the Baby’s birth.

The therapists’ awareness of this could account for the observation that she makes reference to the past sparingly. In both session 2 and 14 the past is only mentioned once. In session 6, five comments about the past are made in total. However, these comments are interspersed throughout the session. It is conceivable that the therapist, whilst drawing on Fraiberg’s understanding of the importance of encouraging parents to reflect on and work through their painful past experiences as a way of interrupting damaging patterns with their own children, is sensitively managing the anxiety that this would arouse (Fraiberg, Adelson, & Shapiro, 1975; Fraiberg, 1980). It is possible that she is gauging the receptivity of the Mother and Baby and their ability to tolerate difficult memories. For example, after talking about the trauma of the birth, the therapist goes on to say:

“Yeah and not only did you have you own anxiety when you were being born, yeah. You had to survive. Yeah. But you know your mummy and daddy were so worried. Now everybody is trying to be confident. Mmh.”

The Mother, unable to contain her anxiety, stands up and walks away from the therapist and the Baby as if to put a physical distance between her and the traumatic memories. After this the therapist’s talk focuses on present feelings and events rather than on the past.

In the final session the therapist makes only one reference to the past. In contrast to the anxiety filled talk during previous mentions of past, she makes reference to a shared event in which obstacles were overcome. It is as if the therapist now references a new set of experiences in the recent past which the Mother and Baby can draw upon. This talk possibly highlights a new stage of the parent-infant relationship in which the anxiety evoked by speaking of the past had been diffused.

### **What the therapist does with her talk**

The therapist uses her talk to carry out the recommended techniques and theories of PIP .

**The therapist makes alliances.** From the very beginning the therapist draws the Baby and Mother into a therapeutic alliance. She does this by “going alongside the patient” (Baradon et al. 2016) and demonstrating a willingness to understand the difficult experiences that are being presented. This approach is indicated by the utterances in which the therapist used “We”, such as in session 2 where she says, “We’ve come to ask you questions”. It is possible that such statements have a number of different functions. Apart from indicating an alliance with the Mother they

also invite or call the Baby into a relationship with another dyad and therefore to take part in a triadic relationship so as to fully represent a full family perspective (Barrows, 1999; Fivaz-Depeursinge, 2008; McHale, 2003, 2007).

The therapist uses more (12%) of these types of statements in sessions 6. For example the therapist's introductory utterance, "We've learnt to wait, haven't we Sasha", quickly establishes the baby as an evolving subject capable of relationships. This session, from the middle phase of the therapy, experienced more disruptions and resistance than the other two sessions. Perhaps because the therapist, having established a safe alliance through the previous sessions, was more able to challenge the defences of participants in the room.

During this difficult session the therapist's use of 'we' seems to function more as a support or scaffolding for the participants as painful memories and disruptions in the relationship are addressed. For example, at one point in the session Mother, unable to bear the complex feelings and memories evoked by the therapy breaks away from the Baby. The therapist responds by directing her talk to the Baby; pulling her towards her with her words: "And I thought maybe we could have a little conversation" (utterance 23), and then physically picking her up. Possibly, the repetition across different modes of communication (words, tone, actions) soothes the Baby by responding to her in a developmentally congruent way making it more likely that she will understand and respond to what is being said to her.

In the final session there were fewer 'we' utterances (just 7%). Unlike the joint statements in which "we" could have appealed to the Mother as well as the Baby, in this last session "we" refers to the relationship between the therapist and the Baby, for example, the therapist's utterance, "We know each other quite well by now". It is as if this joint statement at the end of therapy signals the accomplishment of

facilitating the Baby's age-appropriate dependency and her movement towards separateness and individuation through a relationship with someone who is not her Mother.

**The therapist evokes the network of attachments around the Baby.**

Evident in the therapist's talk is keeping in mind the Baby's relationship with her parents and other members of her family. In Session 2 17% of the comments the therapist are about Mother, Father and Grandmother, in session 6 such comment make up 22% of the total utterances, and in session 14 only 2%. For example in session 2 the therapist's utterance "Sometimes we need mummy to translate you", can be seen to show the therapist making an alliance with Mother but also might demonstrate her awareness that the Baby's defences are co-created with her Mother and that the Mother is needed to dismantle them. It is also conceivable that the therapist is mitigating against possible envy by prioritising the Mother's relationship with Baby.

The importance of fathers is highlighted by the early reference to the Father in session 2, "Are you a little girl who looks like her daddy?". In session 6 the therapist comments again on the physical similarities between Baby and her Father but then uses the absent Father as a way of framing some of the monstrous feelings around the Baby. She says,

"I wonder if you're daddy's? Your daddy is a mini-monster. Is daddy a little monster?"

It is possible that here the therapist evokes the figure of the Father as a complex, symbolic, as well as live figure at a moment of tension in the therapy. The therapist and the Baby have been absorbed in an intense exchange in which the therapist has attempted to draw-out the Baby. Then the therapist abruptly terminates the

exchange with a comment that doesn't use motherese, saying "Enough" (utterance 11). It is possible that the therapist uses the absent father as a way of putting distance between Baby and her difficult transference feelings. It is also possible that the reference to important external figures in the Baby's life could reinforce her ability to relate as part of a group from a very early age, and encourage her to draw on other potentially supportive family figures.

## **Discussion**

Children and infants have traditionally been regarded as silent partners in the therapeutic process, and even when their participation was elicited in, for example family therapy or PPIPs, their access to the "conversational floor" is often restricted (O'Reilly, 2006, 2008). By focusing on the therapist's talk to the Baby this study not only acknowledges that this talk is part of an on-going process of interaction that is produced across the talk of the participants in the treatment (Lerner, 1991; Sacks, Schegloff, & Jefferson, 1978), but accepts that the infant is a primed and engaging subject. This is reflected in the significant amount of talk to the Baby.

What the therapist actually does in therapy sessions has been the object of inquiry. Several discursive studies have been conducted in adult individual psychotherapy as well as family therapy (e.g. see Avdi & Georgaca, 2007). However, there have not been any comparable studies within PPIP. This is, on the one hand, understandable. The discipline of PPIP is a relatively new modality and as the understanding of infant subjectivity and agency has developed-informed in part by the experimental outcomes of child development research - there has been a growing body of research within PPIP. It is within this developing field that this study can be located.

One of the key findings of this exploratory study was that the therapist spoke to the Baby for a significant amount of time during the therapy sessions; 10.3% of her utterances in session 2, 22.2% in session 6 and 22.8% of the talk in session 14. It can be argued that this reflects the theoretical understanding of PPIP that the infant is a subject in their own right and is capable of forming triadic relationships from a very early age. As this study does not account for the Baby's response to the therapist, it could be argued that talk to the Baby alone does not necessarily reflect the Baby's understanding or engagement with the therapist or the process.

Furthermore, the therapist used different types of talk to the Baby, and that this talk is framed by the methods and techniques recommend by Baradon et al (2016). More specifically, the therapist overwhelmingly used motherese with the Baby and her tone was playful at times. Moreover, the therapist often repeated her utterances, she sometimes repeated sounds to make rhythmical vocal patterns, whilst at other times she repeated her words. This type of talk could be said to reflect PIP's intention to involve the Baby in the therapy by communicating in ways that are developmentally appropriate. This readiness by the therapist to communicate with the Baby in an appropriate way could be said to illustrate the PIP principle of establishing a therapeutic alliance with all participants in therapy. In terms of the topics the therapist spoke to the Baby about, these are in line with suggestions in the PIP literature as helpful in accomplishing a successful treatment.

Most of the therapist's talk referred to the Baby's mental or physical state and a significant portion of the therapist's talk was about observable facts in the present moment. It is possible that this talk helped the Baby and Mother recognise and normalise the different emotional and physical states that actively occupied the Baby. It can be speculated that by talking about such difficult feelings in the present

the therapist both acknowledged the anxiety that absorbed the Baby and Mother, but also defused and regulated it.

Another important theme discussed by Baradon et al (2016) is the past, as it is the place where trauma has often happened and these memories can impinge on present functioning. The study found that the therapist only made reference to the past on a few occasions, possibly indicating the therapist's sensitivity around traumatic events and memories.

As well as weaving in aspects of psychoanalytical and child developmental theory with the particulars of PIP as practiced in this case, this study found that the therapist could be argued to be actively doing things with her words. The things she appeared to be doing included making alliances with the Baby and with the Mother through the Baby. She seemed to be scaffolding and supporting the Baby's development with her words. One way this was achieved was through her use of the word "we" and joint statements which implied support. The therapist also evokes the network around the Baby with her words, for example in the way she mentions other family members when she speaks of Daddy or Grandma. This evocation could also be argued to demonstrate how the words invite or call the Baby to see herself as part of a wider group.

The focus of the study-the words used by the therapist directly to the Baby-implies an active subject primed to engage with the therapist. This study assumes the therapist's words are only part of a conversation between the therapist and the Baby but also the Baby's Mother-the silent but ever-present partner in this study. It can be argued that as PIP takes the parent-infant relationship as its patient this study is adversely unbalanced and that a more useful study would consider the therapist words to the mother-infant dyad not the Baby alone. However the focus of this study

was deliberately narrow as its intention was to increase awareness of the infant in PIP through the words spoken to them. It is possible that a wider focus on the patient might unintentionally displace the Baby. Also the focus on the spoken words when examining the therapist's communication to the baby, potentially neglects the important elements of non-verbal communication, such as tempo, tone, gesture and expression which are arguably just as important, if not more so, elements of communication and understanding for infants and babies. The focus on words alone ignores embodied communication as a medium within PPIP which often operates at levels beneath awareness (Baradon 2018).

As this is an exploratory study in many ways it raises more questions than it answers. The focus on the therapist's words is perhaps too narrow, and it would be useful for other studies analyse PIP using discourse analysis the talk to the patient, or a microanalysis to study the infants communications to develop the idea of the infant being a co-creator and active participant in therapy processes.

Another limitation of the study is more technical. It would have been useful if the codes could have been verified rather than just inter-rater reliably checked. It is hoped that future studies would be able to develop codes that can be more effectively verified.

Even though the study is described as being informed by the themes of DP, it could be argued that the research is more ethnographic because it is concerned with the nature of the context (therapeutic environment), the therapist's prior assumptions and the goals of the participants (therapeutic outcomes) (Potter, 1997). It could be argued that DP does not use talk as the route to external cognitive phenomena, this study's focus on the therapist's words to the Baby means that the DP framework has been compromised. However, this claim can be challenged by

the idea that the study is more interested in the stake and interest of the therapist (Billig, 1997) and that in practice these are difficult concepts to separate out. More focused further research will be required to clarify these points.

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Part 3: Reflective Commentary

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## **Abstract**

The reflective commentary considers the process of engaging with a doctoral research project around a pre-verbal infant in a treatment of PIP. It is a reflection on the personal experience of carrying out research and considers how this experience has contributed to my development as a researcher and as a child and adolescent psychotherapist.

## **Introduction**

Aside from the practical considerations involved in data gathering, theoretical clarification and ethical approval this piece of work has also involved momentous shifts in my learning and personal development. Even though I have a background in academic research I was unprepared for the many levels of examination that a psychoanalytically informed doctorate demanded.

I was one of the first intake of students for the new Doctorate in Child and Adolescent Psychotherapy jointly awarded by IPCAPA at the bpf the Anna Freud Centre and UCL. This new course integrated the clinical training of Child and Adolescent Psychoanalytical Psychotherapists with research into child and adolescent psychotherapy. Our cohort was, in a way, the first child of a new couple who already had other grown up families. There was a sense of hope, excitement and a will to make the new relationship work but an uncertainty that it actually would. This commentary aims to outline the journey of my doctorate including the challenges and the important lessons learned.

## **Beginnings**

In the first year we had three main tasks. As well as reading the key texts of psychoanalytical literature, we were required to familiarise ourselves with the form, structure and content of research papers and undertake a service-related project. I was familiar with the key analytical texts and felt reassured by this. However, I was less comfortable with the research papers and the idea of a service-related project. Now, from my post-qualification position as a working psychotherapist I realise how all-compassing my anxiety was in beginning a new training and career at a relatively late stage in life. Practical concerns about juggling the new demands of work and

analysis mixed with established responsibilities as a mother and partner. The encounter with new ways of thinking stirred primitive insecurities. I felt overwhelmed and one of the ways this found expression was through an adolescent-like resistance to taking in new information. I found expressions like “boring”, and “what’s the point” pop into my head when I struggled with the statistics seminar as I tried to make sense of p-values.

As preparation for the rigors of the research project, we were expected to carry out a NHS placement service audit. This audit introduced different research methodologies, as well as the practical considerations and limitations of any research project. I felt self-conscious as I consulted with my service manager in order to locate an area of the service that the team wanted more information about. The language and systems of the NHS were alien to me. As in the statistics seminars I was required to attend, I felt out of my depth and acutely aware of my lack and limitations. On reflection these early encounters with new systems and new ways of thinking mirrored the fledgling efforts of a young child to construct their identity. Mirroring the experience of an infant’s arrival into its family, it was as if I had landed in to pre-existing adult structures and was expected to work out my place and role within them.

Unfortunately, the service supervisor with whom I had developed a very supportive relationship became ill and was unable to support the placement. At the end of the first year I had to leave and begin a new placement. Although I was able to complete the audit and submit it as part of the doctorate, I was unable to present it to the service. This initially felt like a relief as the team were suspicious of what my findings might be. However, I also felt that I had not completed the assignment, leaving me with feelings of insecurity about my competence.

I struggled to contain and process complicated feelings of disappointment, grief and anxiety about moving placement. as I entered my second year and the new placement. Although I used the structures of containment that were in place to discuss my concerns (analysis and supervision) I did so in an unintegrated way. I experienced my concerns and feelings as if they were separate and isolated from each other. It became clear that I had, to use a Kleinian description of the adolescent regression to earlier infantile states, revisited the anxieties, defences and splits that typify the paranoid-schizoid position (1946).

In this context I began my research project torn between competing subject positions (mother, trainee, NHS employee) and an inner world riven with cut off and often unacknowledged feelings and defences. At the time it was difficult to make sense of my feelings. As a new trainee I had not yet developed the knowledge to understand or use the supporting structures of thinking that were made available to me. On reflection, I wonder about the extent to which my anxieties were stirred by the environmental impingements (Winnicott, 1945; 1960; 1965) I experienced, including the new language I was acquiring, the loss of my first training placement and the lack of clarity around my academic performance. Like an un-held new born infant I resorted to splitting off bad and un-integrated parts to survive.

## **Research Process**

The research properly began at the start of the second year in a new placement with a new service-supervisor. In collaboration with a senior clinician from the Parent-Infant Project at the Anna Freud Centre I began to look in detail at video recordings of a successful treatment for trauma using Parent-Infant Psychotherapy (PIP). Focussing on particular aspects, I began by transcribing selected sessions.

Early into this process I became interested in the communication between the therapist and the distressed infant. I began to study the video recordings and noticed the words, body language, prosody and rhythms used by the therapist and the baby.

I became aware that I was responding deeply to the videos. I was drawn in to the drama and narratives being played out in front of me. In particular I noticed the Baby; her distress, her floppy body and her distance cut-off gaze. Curious about my response to the videos, I began reading around the topic of PPIP, non-verbal communication, and the infant as part of family systems. I was interested in the work of theorists who focused on early infant development and attachment and explicitly considered the infant as an independent subject from, if not the beginning of life, very soon after birth. I soon realised however, that the areas I was interested in did not easily knit together. Whereas there was plenty of material around infants in laboratory or semi laboratory settings (see for example Beebe, Fivaz-Depeursinge, Trevarthen), very little had been written about the way the infant communicated in naturalistic settings.

In the training I encountered psychoanalytic ideas about how the infant communicates through the tools of transference and projective identification. I wondered if through my own countertransference I was identifying with the infant I observed. I considered the idea that my observation, thoughts and feelings around the videos combined with my experiences of rupture and loss during the training to constitute a new problematic. It is possible that this drew me to PIP; a modality concerned with the repair of disturbances and impingements.

On reflection, I think the Baby powerfully and indiscriminately projected her intense anxiety, a result of her early experiences in order to find a way of

communicating her need for helpful objects and attachment. I, as a new student struggling to find my place in the language of psychotherapy research, to find an identity in a new profession whilst making sense of my own history, was particularly receptive to these projections. In a way, my unconscious was using the research material to make sense of my own experience.

I concentrated on transcribing not just the words uttered but also the actions of the infant. This involved a laborious process of repeatedly rewinding the videos so that I could capture the small movements made by the infant. I also began to notice the role of the therapist and the effect of her words on the Baby. Even though she entered therapy when she was only 9 weeks old, rather than a passive, non-responsive infant I noticed that the Baby made tiny movements when the therapists spoke to her. I became aware that I was not simply passively viewing the material, rather I was actively anticipating the therapist's response to the Baby, as if it provided me in my enmeshed anxious and identified state, relief too. I read the work of Dolto (Hivernel, & Sinclair, 2013; Hall et al., 2009), Lebovici (1995), Norman (2001, 2004) and Salomonsson (2007a, 2007b) with deep interest as they considered the therapists words has having an important effect on the infant on the infant. These authors albeit with different emphasis, argued that the infant could respond to the therapists presence and words; an idea that informed my reading.

I was particularly interested in the relationship between me the viewer of the videos and the material I was viewing. It seemed as if I was co-creating a new reality with my study of the videos. My research would be located somewhere between the videos, the actual treatment itself and my conscious and unconscious thoughts and processes. I began to annotate the videos and read extensively

development research papers. I immersed myself in this work, but it progressed very slowly. Permissions for accessing and viewing the videos, in compliance with the Anna Freud Centre's information governance guidelines, was restrictive. It was only possible to view them on site and in the library. The software on the computers was for general video viewing and did not allow me to stop and replay the videos. Without the means to pause, rewind and review small segments of video in order to make detailed notes about the small movements and utterances of the Baby, I began to fall behind my fellow students.

Attending the research seminars became uncomfortable. I was unable to formulate my ideas or frame my research aims as I had not yet established my data set. Even though I continued to discuss my ideas with my supervisor, they remained theoretically driven by my reading. Ideas from child development, systemic theory and research which looked in detail at how infants related in triads as well as dyads felt particularly important to me. I was drawn to psychoanalytic literature focussing on infants in psychotherapy, especially those writers who worked directly with the infant, rather than the infant reconstructed in adult psychoanalysis or therapy.

In this body of literature I found both questions and answers to barely formulated feelings and anxieties that were being provoked by my journey through the training. Continuing the analogy that the use of Kleinian language permits, I enjoyed feeding at the breast of this knowledge. As my mind chewed over and digested the new information I was taking in, I could indulge in the fantasy of being a whole and complete psychotherapy student and researcher. It was as if the process of reading allowed me to momentarily bring together the split off parts of myself. Through an inquiry into how infants develop their psychic identity I was able to find a

creative way of resolving the sense of loss and that marked my training experience and anxiety at having to start again.

However, occupying this fantasy position meant I was distracted from the reality of the growing need to firm up my data set, to describe my chosen methodology and to be more specific about my research question and aims. It became increasingly difficult to dismiss the impingement of reality into this fantasy.

### **Middle phase**

At the end of my second year I suffered another devastating loss. My analysis came to an abrupt end as a running dispute about how the analytic fee should be paid could not be resolved. I was, once again, plunged into an anxious infantile state with complicated thoughts and feelings dominating my thinking space. I received support from the training school, analysis and my supervisors who encouraged me to take time to recover. However, this meant that I lost even more time with the research and I fell even further behind. Progress with collecting my data set stalled. I became increasingly anxious as my research tutors demanded concrete answers to questions about the design and method of my project, which I was unable to provide.

It became evident as my third year of training progressed that I was unable to convert my initial interest in what infants do in PIP into a viable research project. In discussion with my supervisors it became clear that I was in an unsustainable position. At the time it felt humiliating to face what felt like another failure. However, I wonder if what I experienced at this time was the pain of relinquishing a delusion and having to face reality (Britton, 1995). Fortunately, I was given space to work out and articulate my more negative and complex feelings. I realised that an

unarticulated shadowy sense of resentment permeated both my research and training. This “ghost” silently prevented me from fully engaging in the research.

Baradon et al. (2016) argues that during the middle phase of therapy once the setting and relationship has been established, it becomes possible to begin work with the ruptures and unconscious processes within the parent-infant dynamic. On reflection it was as if by the third year, the fault-lines within my training experience were fully exposed and I had a full frontal encounter with difficult anxious feelings and defences. In a similar vein during the middle phase of the treatment the therapist named anxious feelings, the “ghosts”, that inhabited the Baby’s environment and body. She spoke directly about the traumatic feelings and memories that haunted the parent-infant relationship. Mirroring the PIP treatment I had been studying, the “ghosts” and traumas I had experienced were being exposed, so that they could gradually be put into words and thought about.

Just as therapists uncomfortable words during the middle phase of therapy arguably heralded a new phase in the treatment, the conversation with my supervisors, perhaps an example of Dolto’s insistence on *parler vrai*, resulted in a change in my attitude towards the research. A new reality principle best described by Klein (1940; 1975) as the depressive position came to the fore. I gradually swapped fantasies of identification with traumatised infants for an acceptance of a role as a good enough apprentice. In doing this I accepted that my initial idea for a research project was not viable and I reevaluated my research interests.

I became interested in the way that words seemed to accompany or cause transformation in the research process; words uttered to me by my supervisors and the words uttered by the therapist to the Baby. In a process that seemed to comparable to that experienced by the Mother and Baby, I experienced a change in

how I related to my research supervisor. We began to talk more. Her words kept alive the idea that there was a viable research project in an examination of the therapists talk in a PIP treatment. In this way, she became a fixed point around which I could organise myself, in the same way that Bick (1964, 1968) describes how a disintegrated infant will fix on an object outside of themselves to hold themselves together. I had gained enough understanding to be able to use my supervisor as a new developmental object. I wondered about how the Baby used the therapist and her words. I noticed how she often fixed intently on the therapist's mobile face as she spoke and I considered that the therapist's presence as well as her words functioned as new developmental object which the Baby could fix upon and use as a container and an auxiliary mind (Baradon, 1998).

It was as if change in my research process mirrored change in the therapy process. The Baby became more responsive to the therapist. She no longer stared into the distance but fixed her gaze on the therapist face. She also initiated more interactions with the therapist. The words of my supervisors triggered a transformation in attitude and orientation in me and, aware of my identification with the Baby in therapy I wondered about the effect of the therapist's words on her. Baradon (2018) highlights the importance of words in her role of therapist to address core anxieties in the therapy room. She quotes Nahum (2008 p.133) who argues that words are "pathways into direct embodied experiences that function implicitly". Words are utterances which bring together the different elements of communication, the verbal, non-verbal and implicit and function as focal points of interaction. The words uttered by the therapist brought together unspoken and implicit thoughts and feelings to be jointly examined and thought about. This seemed to result in a change in the Baby. She seemed alert and engaged as if she was actively listening with her

entire body, to the therapist. Her non-verbal communications directly corresponded to the therapist's utterances, often using her body to respond directly to comments.

My supervisor and I outlined a set of tasks beginning with coding the transcripts. At the same time I began a new post in a CAMHS clinic anxious that I would not have enough time to complete the research project. These new beginnings also represented an ending comparable to the final phase of a psychotherapy treatment where, once the ending is in sight a concentration and resolve to enact change is mobilised. With the realisation that I only had a year to complete, my research I gained a new determination and focus.

I then set about defining the codes. I used Baradon et al (2016) and focused on the chapters that discussed the aims in PIP and techniques of work with infants. This produced an initial list which I broke down into form (statements of questions), content (what the therapist talked about), function (why the therapist said what she said), and structure (how the therapist spoke – motherese).

Over the following months and in discussion with my supervisor, I tested, refined and combined the codes many times. Once I was satisfied they were meaningfully representative of the therapist's words, I had the codes reliably checked by a research student. The process of checking and rechecking was both anxiety making but also confirming as it was with relief that we agreed on the majority of each other's coding. During this process I learned to be less emotionally attached. It was as if the emotional work of internalising, processing and encountering difficulties had been done and now I could get on with the work.

In this new phase I dealt with mistakes and problems very differently than when I began the research and training. I no longer had the safety net of the training school to hold and contain me, and the onus was now on me to hold myself together

using the different techniques and skills I had learnt. In this post qualification year of finishing the research I occupied a place akin to Klein's depressive position. I was beginning to incorporate the unintegrated parts of trainee, researcher, mother, colleague, partner as I no longer felt the need to anxiously hold them separately as I encountered the painful reality of my fallibilities. Having said this however, I still relied heavily upon my supervisor. I unconsciously placed her in a parental-like position which held together a coherent image of a fully integrated post-doctoral researcher to which I could aspire. A parallel change was observed in the treatment. The Baby by the final session was confidently toddling around the therapy room. She babbled cheerfully to herself as she explored her environment using the therapist as helpful physical object as she manoeuvred around obstacles in her path. It was as if she has brought together the different parts of herself in a coherent way which allowed her to maintain her inner balance. She demonstrated her newly acquired skills of standing, rolling over and walking joyfully. She manipulated objects with a curiosity and confidently walked away from the adults. She also engaged in humorous non-verbal conversation, responding appropriately, with sounds, action and bodily movements, to the therapists comments. When she stumbled she was able to draw on helpful inner resources to turn a potentially distressing event in to an amusing one.

The next task was the completion of the findings. It was becoming evident that I did not have a lot of time to complete the doctorate before the deadline. Starting a new post was more time and energy consuming than I had imagined. Again, I found myself struggling but this time without the structures of the training school or analysis to help contain my anxieties and process my thoughts. Unsurprisingly tensions which could not be processed in my mind became lodged in

my body (Van der Kolk, 1994) and I developed debilitating back pain making it very difficult to sit.

My supervisor advised me to take time over the findings, and even though I was keen to just get on with it, her words were apposite. In a process akin to digestion I sat with information I had gathered and then discussed the findings and their implications with her. At this time I drew on the idea of staying with not knowing something that Bion termed negative capability (Green, 1973). I was required to tolerate the discomfort and confusion and not resort to my defences. I had to bear the physical and emotional pain lodged in my mind and body whilst I reflected on my struggle to incorporate the different bits of information I had gathered.

## **Conclusion**

The process of writing the empirical paper and the literature review has involved integrating the competing and split off parts of the doctoral training experience.

It has been a very painful and exacting process, one that mirrored the treatment I studied. It began, like the infant in therapy in a very cut off and immature state. My struggle to integrate the different “ghosts” and “angels” around me mirrored the way the therapist brings forgotten memories and feelings into the therapeutic frame with the aim of incorporating them so as to create new experiences. The research process, like therapy takes time to heal the ruptures, learn a new language and process new ways of being.

Just as the therapist’s words offered a new way of thinking about the parent-infant relationship, named and acknowledged the discomfort in the infant and the dyad, and scaffolded a new way of being for them, I felt that the words uttered to me by my supervisor at different points during the research process eased my journey to

becoming a researcher. I also found the demand that I learn and integrate a new language and a new way of thinking provided me with an important structure of support. Even though the topic I studied was not directly related to my work in CAMHS, the insights it provided into the early relationships, the subjectivity of the infant and the power of words to acts as a medium of change has added to my understanding of how these states are revisited at times of crisis.

The focus on the language of the therapist has demonstrated how transformative the considered words of others, including my supervisor, analysts and the therapist in PIP, uttered in a safe and trusted setting, can be. It can be said that the therapists words functioned as a vehicle of change as they drove the treatment to a successful conclusion. Similarly, the words I encountered helped articulate and transform the unarticulated shadowy sense of resentment that had dogged my relationship to this research project.

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## Appendix A

### Definition of codes

Figure 1

FORM CODE	DESCRIPTION
Q	The therapist asks a question that is either a direct inquiry or is more rhetorical and indirect.
S	The therapist makes a statement. The statement can be about the current situation, such as an introductory summary of the current situation (e.g. session 6 utterance 1). These statements often have an interpretive element to them as the therapist comments on her understanding of the situation and relationship before her
S2	These statements are explicitly more interpretive of the baby's or mothers inner state
JS	In these statements the therapist makes a statement which makes an alliance with either the mother or the baby indicated using we
JQ	The therapist asks a question on behalf of the parent/ the therapist models curiosity, framed as a question, for the parent.

Figure 2

CONTENT CODE	DESCRIPTION
BMS	When the therapist refers, either by question or statement to what she thinks is emotionally or mentally taking place for baby
BPS	When the therapist makes direct reference to the physical state of the baby.
RM	The therapist uses language which refers to mum, either what she is doing or what she might be thinking or feeling.
JMS	The therapist uses 'we' as a means of making a connection between her, the baby and mum. At times the link is between her and mum
G	The therapist provides a structure within which the session can be conducted with an introductory hello and closing goodbye.
I	The therapist gives or suggests an instruction, which although primarily directed to the baby may also be meant for mum.
D	The therapist outlines the extant reality in room by describing the relationships and behaviours that are evident to her.
P	There therapist makes direct reference to events, states and feelings from the past.
RDG	The therapist, referencing people outside of the therapy room and disrupts the mum baby dyad by introducing a third, but significant to the baby's life, person.

## **Appendix B**

### Results and examples

#### **RESULTS**

The total number of turns of talk made by all participants during each session was counted with talk being defined as utterances including words and non-lexical conversational sounds.

The total number of turns made by the therapist was also counted. Finally, the turns of talk made by the therapist directly (defined as motherese talk, talk performed face to face, talk addressing the baby and her concerns) were counted.

These utterances to the Baby were finally coded in to Form and Content. Form consisted of five codes two question codes (question and joint question) and three statement (statement, interpretive statement and joint statement. Content, the subject of the utterance was coded in to nine categories. Single utterances could contain more than one code

#### **Session 2**

During this session there were a total of 354 turns of talk made by the therapist, the Mother and the Baby. The therapist took 154 turns of talk of which 16 were directly addressed to Baby that is 9.8% of her utterances were made directly to the Baby.

**Form:** total 25 codes

40% of the utterances were in the form of questions such as utterance 3 “have you found your fist” (12% in the form of a joint questions for example (utterance 12 ‘We say...Sasha...Sasha what do you like looking at?’).

60% were in the form of statements, such as utterance 15 “ look at those eyes they’re so big” I including 16% of these were interpretive statements such as utterance 9 “doesn’t feel right for your teeny self”.

12% of these were joint statements such as utterance 13 “sometimes we need mummy to translate you.....she knows you best.....and if we call your name and if we say Sasha”.

**Content:** total 35 codes

**BPS** 31% of utterances made about the physical state of the baby for example utterance 7 “Oh so you were both tiny and big”.

**D** 23% in which the therapist describes the relationships and behaviours that are evident to her in the room with of utterance For example utterance 11“...what you looking at Sasha? Is it the light I can't see?”

**RM** 14% in which the therapist referred to what mum was thinking, feeling or doing as in utterance 13 “sometimes we need mummy to translate you”. Some utterances can be coded in a number of ways for example utterance 10 “well maybe mummy will put you down here in a little while”, is both an example of D and RM. The therapist spoke to the baby about her mental state,

**BMS**,11% of the time e.g. utterance 7 “...you're taking that seriously aren't you”. There are utterances that were coded both BPS and BMS such as utterance 9 “Doesn't feel right for your teeny self”.

**JMS** 6% The therapist makes two comments using ‘we’ as a means of making a connection between her, the baby and mum. For example utterance 12 “we've come to ask you questions,”

**G** 6% two utterance one at the beginning and one at the end of the session.

**P** 3% In this session the therapist made reference to the past on one occasion in utterance 8, in the middle part of the session when she spoke about Baby's past experience in an incubator.

**RDG** 3% She only made one reference to people outside of the therapy room RDG but who were closely involved in baby 's life utterance 1 "are you a little girl who looks like her daddy" at the beginning of the therapy establishing a connection in peoples mind with the absent father.

**I** 3 % as the therapist greets the baby utterance number 10 "well maybe mummy will put you down here"

### **Session 6**

During this session there were a total of 465 turns of talk made by the therapist, the Mother and the Baby. The therapist took 180 turns of talk of which 40 were directly addressed to Baby that is 22.2% of the utterances were made directly to the Baby.

**Form:** total 78 codes

32% of the therapist's talk was in the form of questions such as utterance 4 "what do you want to do?".

68% of the talk was in the form of statements with 26% interpretive statements (utterance 22 "how fragile you were, but you survived") and 10% joint statements such as utterance 21 "...your mummy and daddy were so worried....now everybody is trying to be confident"

**Content:** total 94 codes

**BMS** 27% The therapist made most utterances about Baby's mental state such as in utterance 6 "You do get very distressed. Yes you do". These comments were evenly dispersed throughout the session.

**BPS**, 15% The therapist made reference to Baby's physical state, for example in utterance 22 the therapist asks "Did you get a lot of saliva in your mouth?".

**RM** 18% of the therapist's comments made reference to Mother as in utterance 17  
"Did mummy want to protect you a little bit, maybe?"

**D** 18% of the comments related to the relationships and behaviours that were evident in the room including utterance 39 where the therapist spoke to Baby about what Mother was doing "...Mummy is going to?...oh I thought you were going to..."  
These comments appear throughout the session.

**JMS** 12% of the comments are made using 'we' as a means of making a connection between the baby and mum: For example the therapists first utterance 1 "We've learnt to wait, haven't we Sasha" . these utterances are clustered around the beginning of the session and two episodes in the middle of the session.

**P** 6% of the comments were made about the past. These occurred mainly at the beginning of the session such as utterance 5 "We heard you last time".

**RDG** 4% of the utterances reference people outside the therapy such as in utterance 5 "...And we expected to find you asleep but oh no , You were chatting with granny".  
These occur in a cluster in the middle of the session.

**I** 1% The therapist gives one instruction during the session when she terminates play with Baby by saying "enough".

**G** 0% No salutations

### **Final Session**

During this session there were a total of 301 turns of talk made by the therapist, the Mother and the Baby.

The therapist took 114 turns of talk of which 26, 22.8% were directly addressed to the Baby.

**Form:** total 36 codes

36% of the utterances were questions such as utterance 6 “can you run away and come back?” and only one joint questions utterance 12 “now what are we going to do?”.

64% of the utterances were statements such as utterance 18 “yes that’s you” with 11% interpretative statements such as utterance 19 “that was confusing wasn’t it”.

**Content:** total 44 codes

**D** 41% in The largest percentage of utterances in this category was in which the therapist commented on what was going on in the room.

**BPS** 25% such as the therapists introductory comment to Baby “Hello big girl”, followed by

**BMS** 18% for example utterance 9 “Are you enjoying your life now?” .

The remaining 16% of the therapist utterances were only coded amongst 4 categories.

**JMS** 7% were joint comments for example utterance 11 “We know each other quite well by now”.

**G**, 5% as the therapist greets and says goodbye to Baby.

**RM** 2% The therapist only mentions Mum once utterance 8 “Yes Mummy is talking about you”. and the past

**P**, 2% One utterance about the past “That’s what you were struggling with last time”.

**I** 0% No instructions

**Appendix C**  
Coder verification grid

Session 2				
Utterances	Content	Notes	Form	Notes
1	BPS, RDG,G	agree	S, Q	
2	RM,	agree	Q, S	
3	BPS, D	E adds D	Q	E error
4	BPS	agree	Q	
5	BMS, D	Discussion around what is baby's physical state of mental state. How can it be distinguished>. Decide on using D as a more general comment so delete BPS	Q	
6	BPS, D	agree	S	
7	BMS, BPS		S, JQ	G thinks JQ E agrees
8	RM, P, D		S, JQ	G adds JD E agrees
9	(edited 10 <sup>th</sup> July) BPS, BMS	agree	S2	
10	I, RM, D	E adds I	S2, (I have just edited this and removed Q	G adds S2 E agrees
11	D	G = RM	Q	
12	JMS, D, RM, BPS, BMS	agree	JQ, S2, S, JS	
13	JMS, BPS, RM, D	agree	JS, S, S2	
14	BPS	Not a question	Q	
15	BPS (D?)	Discussion around BPS or D in this case because directedly related to D BPS	S	
16	BPS,G		S	E error

Figure 1

Session 6				
Utterances	Content	Notes	Form	Notes
1	D, P, BMS, JMS, RM	agree	Q, S, JS, S2	
2	RM, BPS, D	Big discussion about DR - is it really necessary – take to supervision	Q, S, S2	
3	P, JMS, BMS, RM	G notes E's omission	Q, JS	
4	BMS	Both agree	Q	
5	P, JMS, RM, BMS, BPS	G notes E's omission Clarify codes discussion	S, S2, Q, JS	
6	BMS, RM, BPS	agree	S, S2, Q	
7	BMS, BPS	Discussion around difference between physical and mental state and how to code it	Q	
8	RM	Both agree	S2, S	E error corrected G not pick up on S
9	BMS, BPS, D, JMS, I	Clarify discussion around I	Q, S, S2, JS	E not pick up on JS
10	BMS	Both agree	Q, S2	
11	I	Both agree	S	
12	D, RDG, RM, BMS	Need to discuss as to whether BPS Agree in the end E's position for	S, S2,	Little monster G not pick up on S2

		BMS (little monster)		
13	RDG	agree	Q	
14	RDG	agree	Q, S	
15	D	agree	S	
16	RM	agree	S	
17	RM, BPS	Discussion G side	Q, S2	G not pick up on S2 - discussed
18	RM, JMS, BMS, (edited 11july remove DR)	Discussion	S, S2, Q	Finally agree
19	BMS, RM	Both agree	S, S2	
20	BMS	Both agree	JQ, S2	
21	BMS, RDG, P, RM	Both agree	S2, S, JS	G not pick up JS
22	BPS, BMS, P, D	Both agree	Q, S2, S	
23	RM, JMS, D	E corrects G G corrects E	Q, S	
24	RM	Both agree	Q	E error corrected Therapists makes sound not words to baby – not coded
25	RM, BPS, JMS, D	G clarifies E	S, Q, JS	
26	RM, D, BMS	Both agree	Q	
27	BPS, D	Both agree	S, Q	
28	BMS, BPS, D, JMS	G clarifies D	S, S2, JQ, Q	G not pick up S2 E not pick up on JQ E adds Q G not notice
29	BMS, BPS, D, JMS	agree	S, JS	

30	JMS,	Both agree	S, JS	
31	BPS	Both agree	Q, S2	E not notice S2
32	BMS, BPS, D		Q, S2	G thinks JQ – discussed corrected
33	BMS, D	G clarifies BPS 4 D	S	
34	BMS, D	agree	S2	
35	BMS, JMS, D		JQ	Discussion over whether this was a proper question – decided it as was over ‘I wonder’
36	BMS	G clarifies for E	S2	
37	BMS	G says D E disagrees Clarify D	S	
38	BMS	agree	S2	
39	RM, D	Both agree	S	
40	BPS, BMS	G not code	S	

Figure 2

Session 14 – Final Session				
Utterances	Content	Notes	Form	Notes
1	BPS G	E Error	S	
2	BMS	agree	Q, S	
3	BPS	E adds D after discussion it omitted	S	
4	D	agree	S	
5	D, P	agree	S	
6	BPS, D	agree	S, Q	
7	D, BPS. BMS	agree	S	
8	RM, D	G adds BPS after discussion adds D	S	
9	D, BMS	G says physical E says mental	Q S2	G not add S2 after discussion she agrees
10	B, BPS	E changes to BPS	Q, S	
11	JMS		JS Q	G sees Q E not pick it up – her error
12	D, JMS		JS, JQ(added 10 july)	
13	D	agree	S	
14	BPS, D	agree	S	
15	D, BPS		S	E sees Q after discussion agrees it not there
16	BMS	G physical state E disagree	Q	G sees S after discussion

				agrees it not there
17	BMS, BPS, D	Discussion over D difficult to decide	S,Q	G add Q E agrees E adds SE G disagrees and after discussion E agrees with he
18	D	G thinks BPS	S	G thinks Q E disagree, after discussion G agrees
19	D, BMS		S2, (jq removed 10 july)	
20	BMS	agree	S Q	
21	D		Q	G question thinks statement
22	D	agree	Q	
23	BMS, BPS, D	E adds D not G	S2 (jq removed 10 july)	G adds JQ after discussion E agrees
24	BPS, D	E adds D G agrees	Q	G thinks JQ E disagree
25	D, BPS	agree	S2, S	
26	JMS, G	agree	Q, JS	

Figure 3

**Appendix D**  
Results Pie charts

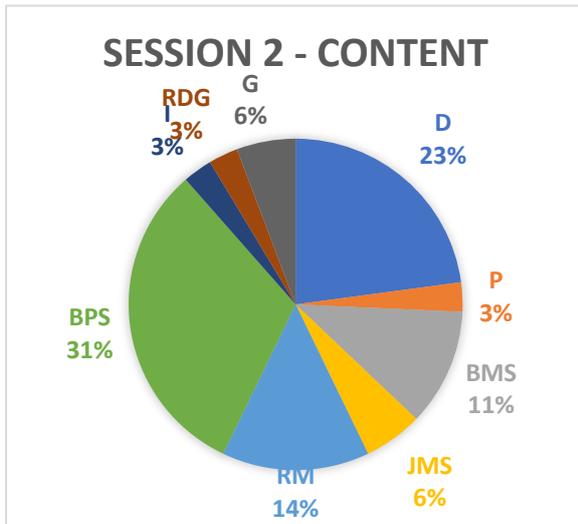


Figure 1. Session 2 - Content

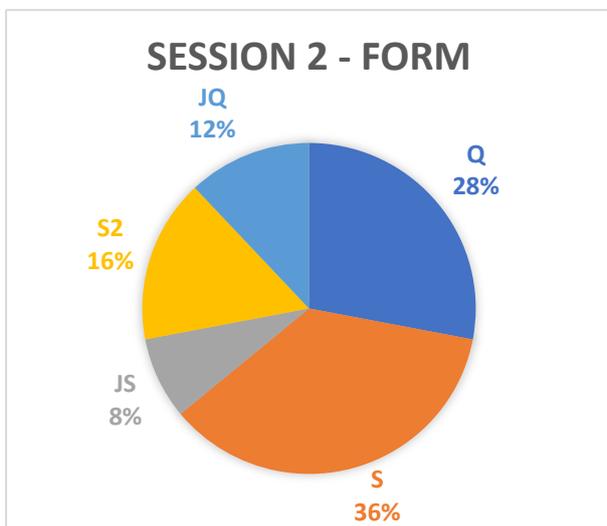


Figure 2. Session 2 - Form

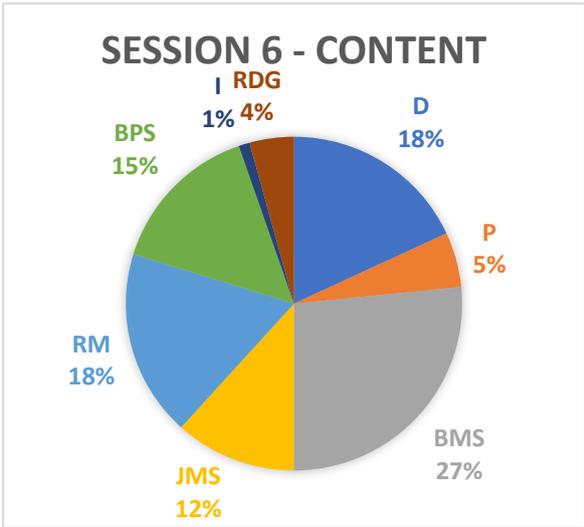


Figure 3. Session 6 - Content

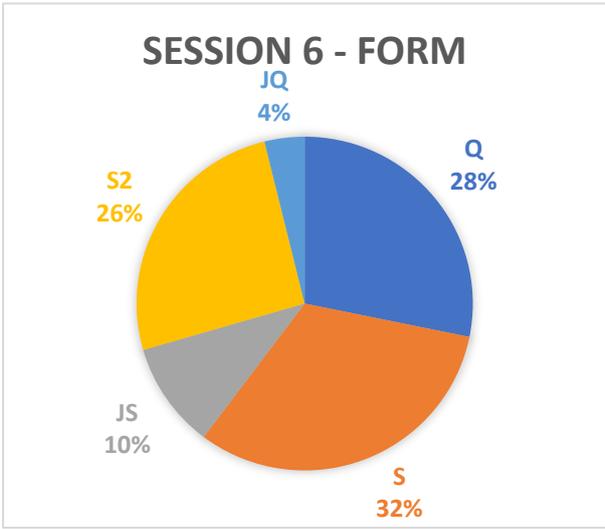


Figure 4. Session 6 - Form

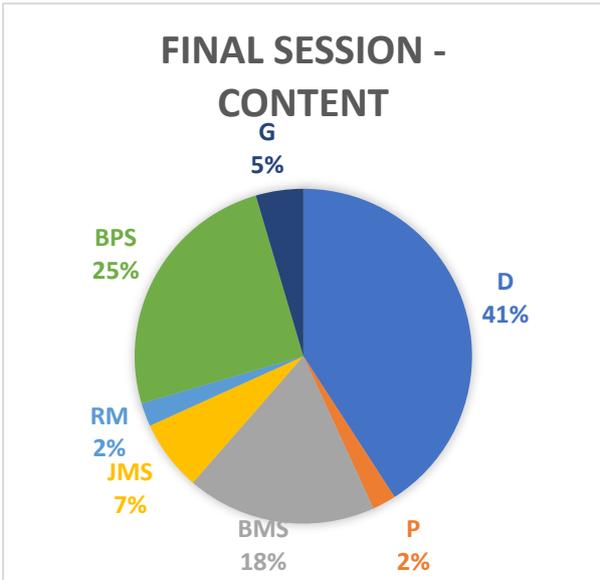


Figure 5. Final Session - Content

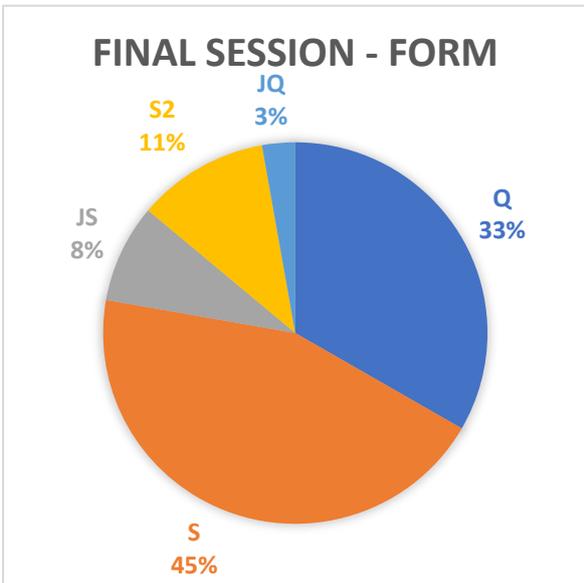


Figure 6. Final Session - Form