WHERE IS THE INFANT IN INFANT INTERVENTION?

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Infants often experience problems related to difficulties in their relationships with primary caregivers. These may be manifested as problems involving feeding, sleeping, and behaviour regulation, as well as vulnerabilities associated with environmental factors that impede infant care such as parental depression, problems in bonding with the infant, and stresses associated with child care or abuse. Early relationship difficulties place infants at risk for developing long-lasting emotional and behavioural problems. Because of the centrality of the infant-caregiver relationship to these problems, it stands to reason that interventions should focus on enhancing this relationship. However, few interventions work directly with the caregiver-infant dyad; most work with the more verbal partner, generally the mother, and only indirectly with the infant.

Attachment Theory

Attachment refers to a response pattern believed to ensure infant survival (Ainsworth et al., 1971; Bowlby, 1969). Infants have an affiliative tie to a small number of individuals (usually their parents) to whom the infant is preferentially responsive and from whom comfort is derived in times of stress. From early on, mothers and infants are predisposed to be sensitive and responsive to each other (Papousek & Papousek, 1987). Later, infants also seek emotional expressions from their mothers to guide their own behavior, especially in times of uncertainty (Emde, 1987). This mutual sensitivity and responsiveness forms the foundation for a secure attachment relationship. It is important to emphasize that the infant is actively involved in this process. Security of attachment in infants has been found to correlate with the quality of subsequent relationships as well as social, emotional, cognitive, and linguistic development beyond infancy. When infants are insecurely attached and raised in stressful environments, they are at risk for developing behavioural problems. Since attachment is a dynamic process, there is a possibility to influence attachment security through intervention. A critical component of intervention is increasing mutual sensitivity and responsiveness in the mother-infant relationship. Because both partners are actively involved in their relationship, both need to be included in treatment.

There is some evidence that patterns of attachment are repeated across generations. Therefore, interventions that enhance the mother-infant relationship hold the potential for breaking intergenerational transmission of relationship problems. While the mechanisms of transmission are unclear, it is likely that the mother’s internal working models of her attachment relationships with her own parents influence the way she relates with her infant. The term — internal working models — refers to perceptions, thoughts, feelings, beliefs, and assumptions the mother has about her attachment relationships. Being able to recall and come to accept early attachment experiences and the emotions associated with those experiences appears to free the mother to be more sensitive and responsive to her infant. Thus, an important therapeutic component may be to provide opportunities for the mother to explore how her internal working model of her relationship with her infant affects her behaviour toward the infant, and how this is influenced by her internal working models of her past attachment experiences. As attachment patterns repeat themselves in all close relationships, including the therapeutic relationship, those who work with parents and infants are in a unique position to function as a secure base for parents and to facilitate the emergence of the patient’s true self through empathy and support.

In summary, attachment theory and research emphasize the role of the caregiver-infant relationship in the infant’s socio-emotional development. On the basis of attachment theory, effective interventions aiming to enhance the mother-infant relationship should: 1) increase mutual sensitivity and responsiveness, 2) focus on the relationship between the infant and mother rather than on either infant or maternal characteristics, e.g., temperament, 3) use the infant’s capacity to play an active role in the mother-infant relationship and in his/her own development, 4) take into consideration the mother’s internal working model of her infant and their relationship, and how her own attachment experiences may be influencing her relationship difficulties with her infant, and 5) provide a secure base for the dyad. Interventions that meet these criteria hold the potential for increasing attachment security.

Models of Intervention

Four models of intervention that aim to change the quality of the relationship between mothers and their infants have been described in the literature. In some of these, this is done indirectly (e.g., support and psychotherapy), while others aim to influence the relationship directly (e.g., guidance and infant-led intervention).

1. Supportive interventions have their roots in nursing and social work. In this approach, mothers are assisted to access community resources, such as housing, work, or childcare, or to gain support through counseling, social skills training, or participation in a self-help group (Booth et al., 1987; Bustan &
Sagi, 1984; Fraiberg et al., 1987; Landy et al., 1984; Minde et al., 1983; Searight et al., 1989). The intervenor may also be available on an ad hoc basis to listen to and help the mother with problem solving. The intervenor serves as a resource and facilitator, but rarely as an expert. An important feature of this approach is that it is non-threatening. Support is almost always provided in conjunction with other interventions such as developmental and relational guidance (e.g., Minde et al., 1983).

Support has also been used as a means of building a trusting therapist-patient relationship where psychotherapy was the main treatment (Fraiberg et al., 1987). This is the only model that deals with systems beyond the immediate family, including the extended family, employment, friends, and society at large.

Supportive interventions fit with attachment theory by providing mothers with an intervenor who functions as a secure base. A reduction in stress frees the mother to be sensitive and responsive to her infant, but mutual sensitivity and responsiveness in the relationship is not addressed directly. The primary focus is the mother, and sometimes the father. Any benefits to the infant come about indirectly. Because support is combined with other interventions its impact cannot be evaluated alone. There is one exception: Booth and colleagues (1987) found improvements in the mother-infant relationship when they helped mothers develop skills in obtaining social supports.

2. Developmental and Relational Guidance interventions have their roots in infant stimulation programs (Bricker & Veltman, 1990; Simeonsson et al., 1982), transactional theory (Sameroff & Chandler, 1975) and empirical research with medically compromised or disadvantaged populations (i.e., low socioeconomic groups, teen mothers). Programs were designed to prevent or ameliorate such vulnerabilities and were not developed for clinical populations seeking help primarily for relationship problems. The intervention was typically conducted in the newborn period or first year of life. Programs to enhance the infant’s functioning (i.e., infant stimulation) will not be discussed because they do not focus on the mother-infant relationship.

Two types of guidance models, developmental guidance and relational guidance, are described in the literature. Developmental guidance focuses on increasing maternal knowledge of the infant’s abilities, developmental milestones, and needs, as well as practical caretaking issues. Information may be provided individually (e.g., during a medical checkup), in a group format, through reading material (e.g., developmental charts), or through demonstration with the infant. The intervenor is seen as an information provider and expert on child development.

Relational guidance helps mothers to increase their knowledge of an experience with their infant in the context of spontaneous interactions. Here, mothers are guided to attend to their infant’s cues and to respond appropriately in the presence of a therapist who provides feedback and models behaviour. In some cases, sessions may be videotaped in order to stimulate discussion between mother and therapist as well as to facilitate observation and the learning of new skills (Cramer et al., 1990; McDonough, 1992). Mutual enjoyment is emphasized and new, more pleasurable interactions between the mother and infant are encouraged, which also help the mother build confidence in her parenting role. In this approach, the therapist acts as a consultant or facilitator, and rarely as an expert.

Consistent with attachment theory, both approaches aim to enhance maternal sensitivity and responsiveness toward the infant. However, both approaches involve the infant only indirectly. The goal is to help the mother, who, in turn, will help her infant. Because there are also opportunities for new and more pleasurable interactions for the dyad, the infant may benefit directly, although this is not central. The infant does not have the opportunity to express needs, feelings, and experiences spontaneously. Neither approach considers the mother’s inner working models of attachment relationships or addresses the role of the dyad’s relationship with the therapist in the intervention.

Although attachment theory has not explicitly formed the basis for these interventions, most studies using guidance have demonstrated significant improvements in the quality of the infant-mother relationship. Cognitive improvements, changes in maternal perception of the infant as more manageable and less difficult, normalized developmental expectations and childrearing attitudes, improved parenting skills, and increased father involvement in infant care when the father was involved in treatment have been reported. Developmental and relational guidance have been shown to effect positive changes in the mother-infant relationship and in some cases in infant functioning and maternal perception.

3. Psychotherapy for infant intervention has its roots in psychoanalytic and object relations theory. Psychotherapy is conducted either alone with the mother or with the infant present. These approaches assume that the mother’s dysfunctional beliefs and assumptions about her relationship with her parents influence the difficulties she has with the infant (Cramer & Stern, 1988; Fraiberg et al., 1983; Lieberman et al., 1989). Furthermore, parenting is influenced by current factors such as marital difficulties, general stress, and lack of support, and these must also be addressed in the course of therapy. Psychotherapy with the mother focuses on gaining access to repressed early experiences and insight into relational difficulties in the context of a secure relationship with the therapist. These insights are facilitated by the re-enactment or repetition of the mother’s past relationships in her relationship with the therapist (i.e., transference). Through this process the mother has an opportunity to resolve her past and present relational problems and to understand how they contribute to difficulties in her relationship with the infant. This understanding, in turn, — the mother to parent. The infant is not involved in the therapy because the problem is seen as residing in the mother. It is assumed that once the mother resolves her own difficulties, an improvement in the relationship with her infant will ensue. There are several problems in working this way. First, the infant is often already compromised emotionally and developmentally and requires immediate attention, which cannot wait until the mother gets better. Second, the mother’s issues influence her difficulties with her infant, and the actual nature of the relational problems may not be apparent until both are seen together. If both are present, the relationship can be observed directly and the mother
can discuss her perceptions, thoughts, and feelings about the problems. For these reasons, some clinicians involve the infant in the mother’s therapy (Fraiberg et al., 1987; Lieberman et al., 1991).

Fraiberg and her colleagues (1983) suggest that something unique occurs in therapy when the infant is present because the infant — provides a powerful motive for a positive change in his parents. He represents their hopes and deepest longings; he stands for renewal of the self; his birth can be experienced as a psychological rebirth for his parents. — Thus, the infant can function as a catalyst for change.

Viewed through the perspective of attachment theory, in psychotherapy the primary focus is on how the mother’s relationship with her own parents or important others influences her relationship with her infant (i.e., internal working model). The importance of the therapeutic relationship also is emphasized. The therapist provides a secure base for the mother and also functions as a participant advocating for the infant. This approach, like support and guidance, assumes that changes in the infant will come about as a result of changes in the mother.

**4. Infant-Led Psychotherapy** is a relatively recent intervention for mothers and their infants. It involves setting aside a regular period in which the spontaneous and undirected activity of the infant is acknowledged by the mother in much the same way as the therapist does with an adult patient. The infant is directly involved in treatment and the goal is to enhance mutual sensitivity and responsiveness. Originally, mothers were instructed to practice this technique at home with their infant (Johnson et al., 1980) and then they met monthly with a therapist and other mothers to discuss their experience. More recently, Muir (1992) describes the use of this method within a clinical setting and combining it with a psychotherapeutic discussion of the mother’s observations of the infant’s play.

Specifically, the intervention requires the mother to get down on the floor with her infant, to observe and follow her infant’s lead and to respond to the infant’s initiations, but not initiate activity on her own. By learning to relax with the infant and realizing that she does not always have to intervene, the mother begins to observe and appreciate her infant’s individuality. As a result, she comes to read her infant’s signals more objectively and becomes more sensitive and responsive to the infant’s needs. In the process, within the context of a safe and accepting environment, the infant is allowed to express his/her inner life and to develop a sense of self through play, exploration, and interaction with the mother. Infant-led psychotherapy capitalizes on the importance of a biological thrust toward the formation of a positive relationship that fits with the unique capacities and temperamental styles of each partner. Unlike guidance, in infant-led psychotherapy the therapist does not choose the cues to which the mother is guided to attend and respond. The therapist is present throughout the session, providing a secure base for the mother-infant pair, and displaying an active interest in what is happening between the dyad but not directly intervening. The therapist also uses his/her knowledge about development and relationships to understand the mother-infant interaction in order to assist the mother during the discussion segment of the session.

Following the infant-led activity, the mother is asked to discuss her observations and experiences of the session. The therapist does not instruct, give advice, or interpret the infant’s play, but provides a safe, supportive environment, empowering the mother to give expression to her thoughts, feelings, and interpretations of the infant’s play and their relationship. This allows the mother to examine her internal working models of her relationship with her infant and to modify or revise them to be more in line with her new experiences. Although enhancing the mother’s observations and understanding of her relationship with her infant is the primary purpose of the discussion, opportunities are also provided for the mother and therapist to examine intergenerational influences on parenting behavior as well as transference issues that arise during the session.

At first glance this approach is deceptively simple. In practice, it is often difficult for mothers to adopt the observer role if they have been intrusive and directive. Similarly, it is often difficult for withdrawn mothers who have not attended to their infant’s activities to take on an active observer stance. The mother is active in this treatment in a nonintrusive manner rather than passive as the instructions might imply.

**Discussion and Conclusions**

Infant interventions that attempt to enhance the parent-infant relationship are still evolving. While a number of models are used, none are considered standard practice. Most interventions reviewed were multi-focused, the rationale being that high-risk groups have multiple needs and that each intervention adds something unique. However, the use of multi-focused treatments has interfered with establishing necessary and sufficient treatment components and made it difficult to assess the discrete contribution of each to the overall outcome.

Empirical studies of individual or combined interventions report success in enhancing the mother-infant relationship as well as the infant’s socio-emotional development. However, there are limitations. Approaches that use guidance have usually addressed the difficulties of very young medically compromised or economically disadvantaged infants and it is not known whether infants and mothers referred primarily for relationship problems...
Consistent with attachment theory, most interventions aim to enhance the mother-infant relationship through influencing sensitivity and responsiveness whether working directly with the relationship or indirectly with the mother. However, interventions designed to change the mother-infant relationship often do not use interactions of the mother and infant or include the infant directly. This is surprising given the central importance of this relationship accorded by attachment theory and research to the quality of the infant’s life and as a mediator of infant development. This also appears to be at odds with our understanding of infants as active participants in their relationships with caregivers and in their development.

It is understandable that infants have not been more directly included in interventions because it is difficult to conceptualize working with mother-infant dyads and especially difficult to conceptualize working with a nonverbal infant. Fraiberg and her colleagues (1983), pioneers in the area of infant intervention, highlight this difficulty. — A baby has none of the conventional attributes of a psychiatric patient. He can’t talk about his problems. He can’t form a therapeutic alliance. He has no capacity for insight. Such patients are usually labeled ‘not suitable for treatment’ in the language of psychotherapy. — As a result, the mother has been the prime focus of therapy. Unfortunately, this may fail to address the immediate needs of the mother-infant dyad or the rapidly developing infant. In spite of these contradictions, most of the infant interventions reviewed report success in enhancing the mother-infant relationship.

Only psychotherapeutic and infant-led approaches consider maternal perceptions, thoughts, and feelings about the infant and their relationship, linking this to the mother’s experience in being parented. The supportive model while not dealing with interactions of the dyad to include fathers or extended family.

The finding that many forms of intervention enhance the mother-infant relationship also suggests that they may have in common certain factors that are not being systematically examined. Investigation of such factors requires greater emphasis on process rather than outcome. It is important to clarify what these models have in common that make them effective. Non-specific factors include the importance of the relationship with the therapist and the role of increasing positive relationship experiences of the mother as an expert on her infant. A number of investigations report that consistent attendance, rapport with the therapist, and enjoyment and interest in the therapeutic process, which can be seen as measures of the therapeutic relationship, are associated with better outcome whether the approach is support, guidance or psychotherapy.

The infant clinical literature also highlights the importance of new and positive relationship experiences for the mother and infant functioning as — corrective emotional experiences. — Fraiberg et al. (1987), for instance, stress the importance of having the infant in therapy with the mother so that she has the opportunity to express her newfound affection for the infant in the here-and-now, or to try new ways of interacting with the infant. Infant-led psychotherapy attempts to increase positive interactions between the mother and infant by directly reducing maternal intrusiveness and having the mother become more attentive and responsive to her infant. Some guidance models also emphasize the importance of pleasure and enjoyment between the mother and infant.

Finally, there has been an increasing emphasis in the literature on the therapist recognizing that the mother is the expert on her child and that, given support, she and her infant will discover their own way rather than learning to adopt some defined — right — way (Bromwich, 1990; Kendall et al., 1984). This is also consistent with research indicating that mothers and infants are predisposed to be sensitive and responsive to each other (Papousek and Papousek, 1987) and therefore have the potential for developing a relationship in their own way. Under these conditions the mother is more likely to develop confidence in her parenting and thus come to rely more on her own intuitive skills.

In summary, infant interventions that aim to ameliorate difficulties in the infant’s relationship with primary caregivers were reviewed and evaluated within the context of attachment theory. Four models were described including support, guidance, psychotherapy and infant-led psychotherapy. All of these models are consistent with attachment theory in that they aim to enhance maternal sensitivity and responsiveness. However, only infant-led psychotherapy focuses primarily on the mother-infant relationship and directly includes the infant in treatment instead of focusing and working primarily with the more verbal partner. Thus, of the four interventions, infant-led psychotherapy is most consistent with our current empirical and theoretical understanding of infants as active contributors to their relationships and development. The bulk of studies evaluate support and guidance. The majority of these studies report improvements in the mother-infant relationship and the infant’s developmental outcome, but they are conducted mainly with medically compromised infants and disadvantaged populations rather than clinical populations referred for relationship problems. Infant led therapy is currently being evaluated at the Hincks Institute (Cohen, Muir and Lojkasek).
REFERENCES


