

**Video Feedback With A Depressed Mother and Her Infant:  
A Collaborative Individual Psychoanalytic and Mother-Infant Treatment**

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## **Video Feedback With A Depressed Mother and Her Infant:**

### **A Collaborative Individual Psychoanalytic and Mother-Infant Treatment**

Abstract. A collaboration between two analysts is presented, one in the role of primary therapist of a severely depressed young woman, and the other in the role of consultant for a concurrent mother-infant treatment. We report on the treatment during the child's first three years of life, during which time seven videotaped feedback intervention sessions occurred. These sessions were used as an adjunct to the mother's individual therapy.

We present a model of collaboration between two analysts, one in the role of primary therapist (Phyllis Cohen) of a severely depressed young woman, and the other (Beatrice Beebe) in the role of consultant for a concurrent mother-infant treatment. The psychoanalytically informed treatment of Linda, mother of a three year old and an infant, was conducted on a three times weekly basis. We report on the treatment during the child's first three years of life, during which time seven videotaped feedback intervention sessions with Dr. Beebe occurred. These sessions were used as an adjunct to the mother's individual therapy with Dr. Cohen.

#### **The Beginning of Linda's Treatment**

Linda was referred to me (Phyllis Cohen) one month after the birth of her second son, Dan. She was feeling increasingly "depressed, nervous, scared, dizzy and lightheaded." These feelings had begun toward the end of her pregnancy, which was medically normal. She was afraid she had a brain tumor that would not be detected. She did not want to get out of bed. On the day that her sister first contacted me, Linda had called her older sister, weakly crying, "Please help me. I can't go on any more. Please help me end it all." Although her husband had been generally supportive of her, recently he had become impatient.

The sister brought Linda to her first session. Linda was in a very regressed state. She needed assistance to walk. She was lethargic and despondent, but she was able to ask, "Can you help

me?" In lieu of hospitalization, the sister, Linda and I together decided to try three-times-per-week individual therapy sessions. A psychiatric consultation yielded diagnoses of panic disorder and severe post-partum depression. Zoloft, zanax, and valium were prescribed. An M.R.I. ruled out any physical causes.

Linda began her sessions explaining that she was the youngest of four children. She had been very close to her mother, who had died of colon cancer six years earlier, three years prior to the birth of her first child. I later learned that it had been the anniversary of her mother's death the day that Linda had called her sister saying she could not go on. Linda explained that she was afraid she had a terminal illness, and she did not trust the medical profession that had failed to cure her mother. She had recently been clashing with her mother-in-law, whom she experienced as intrusive and controlling. She was anticipating a major loss because her older sister planned to move her family 60 miles away. She held onto the fantasy that if she were sick, weak and incapacitated enough, her older sister would not abandon her the way her mother had. Linda described holding onto her three-year-old son's security blanket: "I smell his blanket to comfort myself. But he comes over and pulls it away, and I feel stabbed." She lamented, "How could I have a baby without my mother here? I want to be the baby. I feel cheated."

Although her husband worked long hours, several sessions were held together with him, in an effort to help him understand what Linda was going through, and the importance of her treatment. I tried to help him support her capacity for, and interest in, being a mother to her baby and her three year old. It was also important for him to ensure that enough help was in place to keep the family afloat. A full-time baby nurse took care of Dan, which was facilitated by the fact that Linda was not nursing Dan. A nanny took care of her three-year-old son. Yet she felt there was no one to take care of her.

### **The Introduction of Dan at Four and One-Half Months**

Not until the second month of her therapy did Linda begin to talk about Dan. In retrospect, she had been preoccupied with her own survival, and I (P.C.) had also been so involved in her survival that

I failed to ask, “How is your baby?” It was her pediatrician who jolted Linda into a greater awareness of Dan. At a well-baby visit when Dan was 4 1/2-months, the pediatrician noticed that the baby was delayed, not smiling, “inside himself.” When Linda told me about the pediatrician’s concern, for the first time she offered her own concerns: “Dan doesn’t smile without lifting him up in the air and jiggling him, and I’m not strong enough to keep lifting him.”

That very week, I recommended that Linda bring Dan into the next session. I suggested that we videotape the session, and she agreed. She did not “set the stage” to orient the baby toward her; instead, she placed the baby on her lap, oriented away from her. She strained her neck around as she attempted to speak to him. Her repertoire of play was quite limited. Only when she repeatedly lifted him up and down would Dan would smile, but she kept saying, “You’re so heavy. I can’t do this.” Then she patted his hands, touched his face, and smelled him while speaking to him in a sing-song voice. She explained to me, “He lets me do these things, but he shows no reaction. I guess he has a serious nature.”

Linda then complained, “Dan doesn’t even play with toys; he’s not interested in anything. Other kids his age smile all the time, but not him.” I tried to test out Linda’s statement that her baby was “unable to do anything”. I held a candy dish in Dan’s reach. Dan reached for the candy and then dropped the pieces on the floor. I said to him, “You can do something. You can reach for the candy if you want to.” Linda responded, “You think he wants to? I think he’s just flailing his arms by accident.”

In another attempt to assess the baby’s capacity, I asked Linda if I could play with him. I held him on my lap, face-to-face. I began to talk to him, but only when he looked at me. He, in turn, focused longer and longer. When my voice rose, he became more animated, and we moved higher and higher together, until Dan and I were both smiling and giggling. Through this interaction, I determined that this baby was capable of positive engagement.

Linda was watching our interaction, and she was giggling on the couch next to me, like a baby herself. She did this until she became self-conscious and said, “He never did that with me. He’ll never laugh with me, even if I stand on my head.” I joined her in her feeling that it was so painful to see that Dan laughed with me, but she felt he would never laugh with her. I told her that she needs

to remember that the stranger, as a new person, usually has an advantage over the mother in interesting a baby at this age. We also discussed how painful it is to let someone else play with your baby, and how natural it is, but how painful, to feel inadequate.

I asked her if she'd like to try to do what I did. For the first time, as I coached her to wait for his cues, Dan responded to her. Her expectation of rejection seemed to be so strong, and she had been so sure that this could never happen, that as he was responding to her, Linda said, "He just wants to show me up to be a liar." This assumption of negative intent was a salient aspect of her view of Dan.

At another moment when Dan became fussy, Linda offered him a pacifier. When he took the pacifier out of his mouth, she said she was thinking of cutting off the handle because "...he uses it too much to pull it out of his mouth." She did not understand her infant's need to be able to regulate his own arousal, by putting the pacifier in and out of his own mouth by himself.

Following this first joint session, Linda was different. Unlike all her previous sessions, she had little to talk about. I wondered to myself if she might be feeling embarrassed about having exposed herself with her baby to me. I worried that she might be feeling jealous of my interaction with Dan. I felt it was important not to push her to speak about the session with Dan until she was ready. Instead, I needed to be sensitive to her feelings of depression and vulnerability. We spoke about Linda feeling incompetent in many areas of her life, and then she expressed anger at Dan for making her feel so inadequate. I raised with her the possibility that she might be feeling angry with me as well, since it was so painful to see Dan laugh with me, when she felt she could not get this response from him. Linda said, "No, you were trying to teach me." She could not bear to experience any negative feelings toward me at this point in the treatment.

Her depression was so strong at times that she completely relied on her household help to care for her children. She alternated between feeling anxious and totally hopeless. In sessions she often cried about her feelings of abandonment. She felt that no one was there for her, and that her husband, her mother-in-law and her sister were all critical of her.

We did not focus on her baby again until a few weeks later, when Linda told me she was absolutely convinced that there was something wrong with Dan. She said, "He's not doing anything. He's not trying to get anywhere. He doesn't seem sharp or with it. It feels like he's somewhere else." When asked to describe more of what had been going on, she responded, "I'm trying not to be critical. But I think it's all in the name. He's named after my father, and he's serious, just like him." She added, "My other child was perfect at that age, but Dan has turned into a big fat blob, and I'm not cut out to be his mother. I'm just not strong enough." I asked her to bring Dan into my office for another joint session which we would videotape. Once again, I attempted to interact with Dan. Unlike the previous session, on this day he was totally uninterested in me. Although it was possible that his bad cold had played a role, at this point I began to be seriously worried about Dan. I told Linda that I knew someone who would be able to help us. With her permission, I asked Dr. Beebe, a psychoanalyst and infant researcher, to see the mother and baby together. I told her that I would come with her to the session with Dr. Beebe. I reassured her that our consulting with Dr. Beebe would not in any way replace our own relationship.

In order to more fully evaluate Dan, an early intervention evaluation was recommended by the pediatrician, and a neurological evaluation was recommended both by the early intervention services and by Dr. Beebe. Interestingly, neither of these evaluations emphasized the social difficulty, nor was mother-infant treatment recommended. Instead, both the Early Intervention Services and the neurological evaluations recommended intervention strategies which addressed the *infant*, rather than the *dyad* and the potential interactive mismatch in the dyad.

## **Evaluations of Dan at 5 ½ Months**

The Early Intervention Services evaluated Dan with the Bayley Scales, the Denver II, the Vineland Adaptive Behavior Scale, and the Early Learning Accomplishment Profile (E-LAP). Their diagnosis emphasized physical and motor delays. Although he was now almost 6 months, these tests all assessed Dan as functioning at a three month level of development. Moderate to severe delays were seen in fine and gross motor development, borderline functioning was observed in language and communication skills, and a moderate to high muscle tone in extremities and trunk were observed to prevent free movement of extremities for exploration and interaction. Affect was considered “low to normal”. The evaluation noted that no score could be obtained in the social/emotional sections of the tests, and interestingly, this dimension of Dan’s functioning was not explored or pursued. Therapy with a special educator, an occupational therapist, and a physical therapist were recommended.

Within the same few weeks, Dan was evaluated by a pediatric neurologist. Concerns related to hypertonia (constricted muscles in his upper body), delays in his gross motor ability, problems in socialization, and “peculiar affect and other abnormalities”, placed him “at risk for subsequent developmental or behavioral impairments.” Physical stimulation was recommended, confirming a similar conclusion from the Early Intervention Services. Thus physical and occupational therapy services were organized for Dan. Although mother-infant treatment was not mentioned in either of the above evaluations, we decided to address the social/emotional aspect of his development in a collaborative treatment with Drs. Beebe and Cohen.

## **First Face- to-Face Video Feedback Consultation with Dr. Beebe - Dan at 5 ½ Months**

When Dr. Cohen requested a consultation with Dr. Beebe for a mother-infant evaluation, Dr. Beebe recommended that the roles be separated in the following way: Dr. Beebe would do the split-screen videotaping and initial evaluations of the interactions in the filming lab, with brief feedback to the parents. She would teach Dr. Cohen how to view the videotapes and do the actual

mother-infant treatment using video feedback, while simultaneously continuing the individual treatment of Linda. Dr. Beebe recommended that Dr. Cohen work with the mother around the video feedback, rather than Dr. Beebe, because the trusting relationship the mother had already established with Dr. Cohen would facilitate her ability to share all her feelings, both negative and positive.

Preparing the way to include a consultant in a psychoanalytic treatment is a delicate process. Linda needed to be reassured that I (Phyllis Cohen) was not going to abandon her, and that she would not be criticized by yet another “expert.” The consultation was presented as something that would help her “find a way to reach and connect with her son.” It was important for her to see that I was still competent to help her, but that someone else specially trained in mother-infant interaction could enlighten us further about Dan. She had recently started with the early intervention services, which included three sessions per week of physical therapy for Dan’s hypertonia. Linda had been asked to push, pull and twist her screaming baby in the name of exercising his muscles, and she was worried about what would be asked of her by yet another consultant.

When Dan was 5 ½ months, Linda, her husband, Dan, and the housekeeper, together with Dr. Cohen, visited Dr. Beebe’s research videotape lab. After a brief welcome, Linda was given the standard instructions for face-to-face interaction: “Play with your baby as you would at home”. With the baby seated in an infant seat on a table, and the mother seated opposite in the same plane, two cameras (one on each partner’s face and upper torso) videotaped the mother/ infant dyad. The video yields a split screen view, so that it is possible to observe each partner simultaneously. The baby was videotaped for approximately 5 minutes each with his mother, father, Dr. Beebe, and with his Nanny.

As we will see from the videotape microanalysis, Dan did not look at his mother much during the face-to-face play. All infants at various points in the interaction look away, and then look back. Field (1981) has shown that one of the functions of looking away is to reduce arousal, and we infer that this was one of the central reasons why Dan looked away so much. Our goal, however, was to try to track the tiny, fleeting interactive events that seemed to precipitate a moment of Dan’s gaze aversion, or which facilitated his ability to look. We also began to detect other patterns. A central one was maternal “pursuit”, that is, attempts to stimulate Dan, or call to him, when he was not

available, looking away or oriented away. In another important pattern, at moments in which Dan was “self-soothing” by fingering his own clothing, or by fingering his mother’s hands, Linda frequently disturbed his self-soothing. We detected a very unusual pattern of self-soothing in Dan, in which he soothed himself on his mother’s hand, even if he were looking away. We termed this pattern “reach/self soothe”. Still another pattern was one of “affective errors”, a term coined by Lyons-Ruth (Bronfman, Parsons & Lyons-Ruth, 1999), in which despite the infant’s negative affect (frown, grimace), or gaze aversion, mother is positive, smiling, seeming not to notice the infant’s distress or aversion.

### **First Face-to-Face Videotaped Intervention: Dan at 5 ½ months**

To facilitate coding the interaction, numbers appear in the lower corner of the video screen, indicating hours, minutes, and seconds. The coded section runs 49 seconds, from 11:27:00 - 11:27:49. Although some seconds are not coded, the transcript below is for the most part a second-by-second description.

### **Videotape microanalysis of Mother and Dan at 5 ½ months**

11:27:00 The session begins with Dan looking away, head averted. Nevertheless mother smiles. Her smile has a frozen quality. *This discrepancy between the mother’s positive affect and the infant’s gaze aversion would be considered an “affective error.”*

11:27:04 Mother then pursues, leaning in, wiggling his foot, saying “hi Dan”. As he orients to the vis-a-vis, Dan frowns. Then he puts his hands to his mouth (self-soothe).

11:27:06 Mother disturbs this self-soothing by touching Dan’s hands, then pulling her hands back. Immediately Dan’s hand and feet fly out, as if Dan is over-aroused. He orients away with a strong movement. *Evidently mother disturbed Dan’s self-regulation by touching the hand that is in his mouth.*

11:27:10 Mother pursues, putting her hands on his stomach, saying “Say hi, mama”. Dan reaches for mother and fingers her hand (“reach/self-soothe”), while simultaneously orienting away. *Reaching for mother’s hand and fingering it, as a form of self-soothing, while*

*simultaneously remaining averted, is a remarkable “coping” capacity of this infant. He continues to reach for her in this way, despite being visually or posturally averted, a fascinating example of a compromise between engagement and disengagement (see Beebe & Stern, 1977).*

11: 27: 12 Mother smiles, while moving her hand under his, disturbing Dan’s self-soothing. Now she removes her hand, and his hand drops. Dan frowns, then averts his head further away from the vis-a-vis. *Mother’s smile while Dan is averted, frowning and unavailable is an “affective error.”*

11: 27: 13 Mother takes his hand and moves it, disturbing his self-soothing again, and immediately Dan pulls his hand free from hers. But then, still averted and frowning, Dan moves his hand back to mother’s in a “reach/self-soothe”. *Mother’s disturbance of Dan’s self-soothing seems to precipitate further averting, frowning, or actually pulling his hand free from hers. But he keeps “coming back” through his hands. Mother seems oblivious to Dan’s “reaching” for her in this way.*

11: 27: 14 Mother, still smiling, goes into Dan’s body, while Dan is still oriented away and frowning. *Another instance of “affective error” and pursuit.*

11: 27: 15 Dan again does a “reach/self-soothe”, fingering mother’s hands. Mother pursues again, moving her body in toward Dan (not quite a “loom”).

11: 27: 16 Then, as mother moves her body back and upright, Dan orients back to her and looks (for 2 seconds). *Mother moves back, as Dan simultaneously returns to the vis-a-vis and looks at her. It is as if Dan needs this “space” in order to look.*

11: 27: 17 Mother says “hi, hi”, but blinks and slightly grimaces. Dan frowns.

11: 27: 18: Mother makes a mock surprise face, and Dan increases his frown. Mother moves the hand that Dan has been self-soothing, and Dan then looks away. Mother moves back. *Here it seems that mother’s blink and grimace precipitated Dan’s frown; Dan’s frown precipitated mother’s mock-surprise expression (which would be coded failure of maternal facial empathy: Malatesta et al. (1988) found that maternal surprise in response to infant distress predicted a disturbance in toddler self-regulation, in which the toddlers showed more “holding in” negative affect through “bite-lip” and*

*“compressed lips”); and mother’s mock surprise precipitated Dan’s further frown. Dan finally looks away after mother disturbs his self-soothing. Mother seems to sense the difficulty and moves back.*

11: 27: 19 As mother moves back, simultaneously Dan averts, but he holds on to her finger, and with his other hand he fingers her hand (“reach/self-soothe”), as he completes his head turn away to a full 90 degree aversion, with a strong kick (11: 27: 20). *This is another remarkable instance of a compromise between engagement and disengagement: a strong postural-visual disengagement, but an engagement by reaching for her hand and fingering it.*

11: 27: 21 Mother now has a partial grimace, but remains with her body back, and says “Dan?” Dan orients to her but does not look; nevertheless he continues to hold onto her finger. *The initiative and perseverance of this infant are impressive. He continues to reach for her to self-soothe, despite the many disturbances of the engagement, and despite her lack of awareness of his efforts at self-regulation.*

11: 27: 22 Dan looks, with a partial frown. Mother says “hi, gorgeous boy!” and begins to smile. 11: 27: 23 Then mother strokes Dan’s cheek. Dan looks away with a strong kick, but he is still fingering her hand. Mother’s smile reaches full display (*a moment of affective error*). *Stroking Dan’s cheek may have been too much of an intrusion into Dan’s “face-space”.*

11: 27: 26 Mother pulls Dan’s hand down, still smiling, and Dan’s foot goes up with a big kick.

11: 27: 27 Mother starts to sober. She pulls Dan’s hand back up.

11: 27: 28 Mother sobers fully, and moves her body back. Simultaneously Dan orients and looks for 5 seconds, with a sober expression. *This is another example of Dan orienting and looking simultaneously as mother moves back, as if he needs this much “space” to visually engage.*

11: 27: 29 As Dan looks, mother says “Clap hands? Clap hands, til Daddy comes home”, smiling broadly. Dan frowns during this refrain.

11: 27: 31 Mother then moves forward and takes Dan’s hands.

11: 27: 33 Dan averts his head and gaze. Mother continues to smile (*affective error*). Mother then sobers (*as if sensing something is wrong*).

11: 27: 34 As mother sobers, Dan orients back to the vis-a-vis.

11: 27: 35 As mother's sober deepens, Dan looks (again for 5 seconds), also sober-faced. *This time Dan's looking seems to have been facilitated by mother 'joining' Dan's more sober affective range.*

11: 27: 36 Mother says, "You don't want to play that game now? Ok. Ok." As mother says this, Dan pulls his hands free, but then immediately (11: 27: 37) reaches to self-soothe on mother's hand, continuing to hold the gaze while sober-faced.

11: 27: 38 Mother begins to smile broadly, then blinks.

11: 27: 40 Dan frowns, still looking, and self-soothes (with his right hand) by fingering his own clothing. Mother opens her eyes, smiling broadly.

11: 27: 41 Immediately Dan looks down with a big frown, then a strong head avert.

Mother moves her hands all over Dan's stomach, saying "gooda, gooda, gooda". Dan reaches to finger her hand in a "reach/self-soothe".

11:27:42 Mother disturbs this self-regulation by moving her hand and pulling it slightly away. Dan moves his head down and away sharply, with tight lips.

11:27:43 Dan pulls his hands free. *This is another example of how Dan seems to be distressed when mother disturbs his self-regulation.*

11:27:44 Mother pursues, going into Dan's tummy, saying "gooda, gooda, gooda". Remaining averted, Dan does a "reach/self-soothe".

11:27:45 Mother again pursues, moving her hands into his face. Dan does a sharp head-avert.

11:27:46 Mother pulls her hand back from his face, smiling.

11:27:47 Dan now orients and looks for a moment, sober-faced, as mother says "like that one?"

*Reaching into Dan's "face-space" seems to have disturbed him, and moving out of his face seems to have facilitated his return to the vis-a-vis.*

11:27:48 Dan immediately looks away. Mother pursues, with her hands into his tummy. Dan does a "reach/self-soothe", and then pulls his hands free (11:27:49). Mother sobers, but pursues, moving her hands into his tummy, saying "give mommy a kiss". "Give mommy a kiss" carries the implication that he is the one to give his mother affection. This would be coded as "role-reversal" by Bronfman et al (1999). Linda asks Dan to give her a kiss several times in this first session.

Comment: In general, Linda played relatively high-intensity games, frequently going into Dan's stomach with a tickle game, or pulling him to play "clap hands" with her. She had a steady stream of stimulation, without pausing much to give the infant a chance to initiate. She attempted to stimulate him without respect to whether he was visually available for engagement. The interaction had characteristic "chase and dodge" features (Beebe & Stern, 1977) in which Linda pursued with voice, body and hands as Dan was avoidant. Linda escalated her level of stimulation each time Dan did not respond. Quite frequently, Linda had a positive face while Dan was averted or had a negative face, a mismatch of affect. For the most part, Dan was visually and often posturally avoidant. He frowned frequently, with an unusually deep furrow, which was very striking. While looking away, Linda would say, "Look at mommy," "Are you having a good time?" and "Are you happy?" Dan engaged in some form of self-soothing, usually fingering his mother's hand, almost continuously. When Linda disturbed his efforts at self-soothing, he would frown, avert, kick, or pull his hands free, and resume his efforts at self-soothing. Dan's extensive self-soothing was seen as a positive coping capacity, that at times facilitated his ability to briefly engage. Although he did not smile at all, our overall impression was that he was interested, even though his capacity to respond was minimal .

**Videotape Microanalysis of Father and Dan at 5 ½ months**

The father had a somewhat quieter approach. He generally waited for Dan to initiate, and only responded when Dan seemed ready, facilitating a turntaking structure. Dan was less fussy and more interested. Nevertheless, Dan still did not relax, nor did he smile. The transcript below is not as detailed as the one of Dan and his Mother, and the specific seconds are not included.

Dan: Looks with a frown

Father: Leans in (not a loom)

Dan: Looks away and self soothes with his hand.

Father: Tickles leg.

Dan: Looks, frowns, then eyebrows up

Father: Game of rolling his hands

Dan: Frowns - looks away.

Father: You don't want to play? Oh you want to look up? (Stops game and waits)

Dan: Looks with big frown

Father: Resumes game of rolling Dan's hands, slow and rhythmic

Dan: Looks away with big frown.

Father: Goes into Dan's face.

Dan: Orients away, pulls hands free

Father: (in low voice) You're shaking my hand?

Dan: Big frown - looks, then looks away.

Looks back with partial smile.

Father: Tickle game into Dan's tummy

Dan: Frowns

Father: What?

Dan: Kicks his feet, looks away, big frown

Father: Blows bubbles

Dan: Looks, partial smile, then strong frown

Father: Rapid hand movements and tummy tickle [*intrusive* ]

Dan: Looks away, head averts.

Father: Stops

Blows bubbles

Dan: Looks, self-soothes

Father: Clap hands game.

*Comment: Father can be a bit intrusive but he **stops** when Dan indicates he does not like it. When Dan frowns, father can ask “what?” Thus the father was overall more sensitive to Dan’s moment-by-moment signals. His rhythms were slow and gentle. Most important, he was able to read negative facial expressions and gaze aversions as indications that something was amiss for Dan.*

### **Videotape Microanalysis of Dr. Beebe and Dan at 5 ½ months**

Dan: Looks with thumb in mouth

Kicking

Frowns and moves thumb in mouth

Sucks on thumb

Looks - frowning

Looks away - intermittent frown - on - off - on-off

Long frown.

BB: When Dan looks, BB opens and closes mouth with slight movements raising eyebrows

Dan: Looks with a lot of self soothing

Continuing frown

One hand fingering clothes - one hand is clenched

Long looks with intermittent frown

Surprise expression- Looks away

Self-soothes with two hands

Thumb over BB's other hand and fingers

Long looking with a frown

Self soothe

Long looks with frown

Self soothe.

BB: "Woe" face and woe sounds when he frowns

Dan: Fussy vocalizing; first pre-cry face

BB: Woe face and woe sounds

Dan: Sustained fussing and looking

BB.: Puts hand on Dan's tummy

Dan: Self-soothes using B's hand .

His foot kicks - there's fussing - pre cry sounds

BB: Matches fussing sounds

Dan: Lets BB help regulate himself

Pre cry face - fussy - looking - fussy

Looks away and arches -

Looks - cries while looking - arches again - fusses

BB: Puts hand on tummy - Making matching “woe” sounds; Picks him up

Dan: Cries on BB’s shoulder

*Comment: There were stretches of the interaction in which I (BB) waited quietly until Dan indicated that he was ready for engagement. When he did look, I matched and elaborated his facial expressions. When he was vocally or facially distressed, I “joined” the distress with a “woe-face” expression or “woe” sounds. When he became more fussy and aroused, I put my hand on his tummy in an effort to facilitate his self-regulation of dampening down his arousal. As he continued having difficulty and then began to cry, I picked him up. With slow, careful partnering, Dan could visually engage. Nevertheless he was continuously moderately distressed. Thus even this sensitive and careful partnering did not result in a positive engagement. My assessment was that Dan was not capable of a positive engagement at this point.*

At that first filming, we (Dr. Beebe and Dr. Cohen) divided up our roles. Dr. Beebe maintained the position of the one who could pinpoint specific moments and behaviors that could improve the parents’s ability to engage Dan. Dr. Cohen acted as the couple’s support squad, encouraging them, admiring positive moments. Following the taping, we all sat down to talk. Dr. Beebe first reassured the parents that they had a normal baby. Then she described what the difficulties were, and addressed the parents’ concerns.

I (BB) explained that Dan was a very sensitive child who seemed to be struggling with

exceptionally high levels of arousal. His legs had been kicking, his head was turning away, and it was very difficult for him to sustain any visual engagement. He frowned and averted from visual contact. He resorted to many self-soothing actions in an attempt to regulate himself. The parents meanwhile were, understandably, attempting to engage Dan. But, the more he turned away, the more active the parents' stimulation became, and the more they pursued him. Particularly the mother played very stimulating games. I noted that this pattern of interaction is not at all unusual when the infant has some difficulty engaging. I emphasized that there was nothing "wrong" per se with the way the parents interacted with Dan. With another baby, who might have a different temperament, a different ability to regulate his states of arousal, all of this might be fine. But it was not well matched to *Dan*, and what *he* needed. I suggested that, with Dan, "less is more." They needed to follow his lead more, to give him more control over the level of stimulation. I explained that infants look away when they are over-stimulated, and look back after their arousal has calmed down (Field, 1981). Stimulating Dan when he is looking away will only contribute to his feeling of over-arousal. If they could wait until he looks back, he will be more able to welcome their stimulation. Overall, I recommended decreasing the amount of stimulation, going slower, trying to "do less".

I (BB) directly addressed the parents' fear that they had a damaged and possibly autistic child. This infant *was* responding to every overture, but by frowning, averting, and dampening his arousal. Because he maintained a micro-momentary responsiveness, even though it was in the withdrawal direction, I was convinced that the infant was not autistic. His responses were those of a physiologically intact infant dealing with extremely high, aversive levels of stimulation. He was reacting in a "normal" way to being over-stimulated. The parents heaved a huge sigh of relief. This was the first and most pivotal intervention. At that point the whole system shifted, from pathologizing the baby, and a near state of panic in the parents, to a more hopeful and constructive stance. We believed that the baby would be "ok"; we just had to work very hard to figure out a way of interacting with him that both he and his parents could enjoy.

I (PC) emphasized that it was hopeful that Dan had not given up. His struggling was a way of holding himself together. I complimented the parents for having the courage to come to the lab. I felt that my own physical presence at the lab was a powerful statement to the parents that I was in

this *with* them, I was going to be participate in their journey. I had not just “deposited” them at Dr. Beebe’s doorstep.

### **Processing of First Videotaped Interview, Dan at 5 ½ Months**

Prior to viewing the videotape with the parents, Dr. Cohen met with Dr. Beebe to discuss her microanalysis of this first videotaping. We spent an hour and a half viewing and re-viewing sections of the videotape. It was extremely important that Dr. Cohen be able to *see* what Dr. Beebe saw. Despite a therapist having some knowledge of infant development, becoming a “baby-watcher” would require an immersion in the details of the nonverbal process which are fleeting, rapid, and usually out of awareness. The second step was to think through the translation of the details of the interaction into terms that Linda could understand, and which would not leave her feeling criticized. It was essential that her fragile self-esteem not be further eroded in this delicate process.

I (BB) coached Dr. Cohen to pay particular attention to the following aspects of the interaction: Help Linda slow it down. Give her permission to not try as hard: “less is more.” Gently suggest to her not to go into Dan’s face. Explain that for now, if he can just look at her, even if he does not smile, that will be a lot: that he needs to learn her face, that he needs her face. Smiling is not the only evidence of “success”; smiling will come later. Suggest that she try to engage Dan with her face and voice, but for now, not with her hands so much. Right now, stimulating Dan with hand games is just too much for him. Teach her to play when he is looking at her, but to “cool it” when he looks away. Teach her vocal rhythm matching.

Dr. Cohen explained to Dr. Beebe that Linda felt she was “no good, poison, with nothing to give.” Furthermore, Linda felt that Dan was not interested in her. In those few instances in which Dan *did* seem interested in Linda, she felt that he was “showing me up to be a liar”. She saw herself as defective, and the baby as accusing her of it. She felt angry at Dan for “making” her feel this way. At this stage, Dr. Beebe suggested that Dr. Cohen tell Linda that although these ideas about the baby are very painful, and we can understand where they came from in her own life. But this is not

what the baby is feeling. Dr. Beebe recommended fostering the idea that the baby needs her and wants her. All this would need to happen before mother and baby could make an attachment to each other.

We discussed the dilemma of the treatment, that the mother's needs are at times in conflict with those of the infant, and that Dr. Cohen had to try to find a way to be there for both of them, in different ways at different times. We were aware of the mother's feelings of rejection of the baby, as well as the mother's wish to be a good mother, and her wish that her infant would respond to her. Dr. Cohen decided to model the treatment after the method of "simultaneous analysis of mother and child," first described by Dorothy Burlingham (1951). During the mother's, or the child's, own sessions, the therapy proceeds in the standard way: the therapist attempts to stay within the individual's experience. However, during "collateral" sessions, when both mother and child were seen together, Burlingham encouraged the mother to observe herself as a mother, and to observe the needs of her child. Burlingham might make specific suggestions to the mother, or bring either patient's experience to the attention of the other.

Following each visit to the lab, within two weeks, Dr. Cohen and Linda would schedule an additional "collateral" session specifically for the purpose of reviewing the videotape, separate from her own ongoing individual sessions. During Dan's first year, Linda's husband was invited to some of these collateral sessions. The strategy of collateral sessions was an attempt to preserve the integrity of the individual treatment and was modeled after Burlingham. Since the goal was to watch the whole videotape, including the portions of Dan with mother, father, and Dr. Beebe, often more than one session was required for the videofeedback. During the course of Linda's own treatment sessions, Dr. Cohen would not herself introduce the topic of the videotape, or lead Linda to explore any agenda other than her own. However, in the course of her own individual treatment, Linda would frequently refer to the issues raised in the videofeedback sessions.

In the collateral sessions, Dr. Cohen gave the remote control to Linda, who then had control over the videotape. The videotape was used associatively, rather than directly. Wherever Linda stopped the tape, together Dr. Cohen and Linda would try to say, what do we see, what is going on for both mother and infant, what is each feeling, and does this remind Linda of anything from her own life? However, if after reviewing the entire tape, the primary segments of concern to Dr.

Beebe had not been discussed, Dr. Cohen might return to these segments, commenting on Dr. Beebe's feedback. If Linda was not ready to discuss it, Dr. Cohen would let the matter drop. This aspect of the collateral session did have a "directive" component. Dr. Cohen decided that this mother needed this additional support of her wish to be a mother. In essence, she was saying to Linda: these are issues we need to pay attention to if you wish to be a mother. However, Dr. Cohen was careful to pay attention to any comments representing the other side of the dilemma, her wish not to be a mother. In essence, Dr. Cohen attempted to stay allied with Linda. Dr. Beebe was outside this dyad, and the one making specific behavioral suggestions.

With this mother, it was the opinion of Dr. Cohen and Dr. Beebe that the advantage of shifting the behavioral interactions between infant and mother, facilitating the mother's ability to create the space necessary for this infant to engage with her, outweighed the disadvantages of this one "directive" component. Any increased ability of the infant to engage would immediately gratify the mother and decrease the intensity of her anger and disappointment. With other parents, with different dynamics, the boundaries between the roles of the primary therapist and the mother-infant consultant might shift.

I (PC) arranged follow-up sessions with Linda alone, and then with the couple together, to discuss the videotape and their reactions to the session with Dr. Beebe. Linda and I spent a number of sessions watching the tape together, viewing and re-viewing, and discussing what each of the participants had been feeling. With Linda in charge of the remote control, we paused the videotape each time either of us noticed something unusual or had a question or comment. Linda was encouraged to become a "baby watcher," to try to guess what Dan might be communicating from moment to moment. At the same time, she was encouraged to become more aware of herself, what she had felt at various moments as she had tried to reach Dan.

Each time Dan looked away, I (PC) asked Linda what she was feeling. At first, Linda said, "Not only does Dan make me *look* like a bad mother, but I *feel* like a bad mother too". I was concerned about her self-criticism. I wanted to help her with her own feelings of rejection and anxiety, as well as to help her see her baby's behavior as a *communication* rather than a rejection. Slowly, Linda

began to be able to say that she felt anxious and worried and rejected when Dan didn't look at her. She felt it meant that he did not love her and did not accept her as his mother. She did not think he even *knew* that she was his mother. At times she said that she did not like Dan, she wished she did not have him as her baby, she wished he had never been born. I stayed close to her feelings, saying that I understood how hard it was for her to be Dan's mother.

Although Linda felt that Dan did not respond, in fact he was responding continuously, but in a distressed way. Each time his mother looked at him, he looked away from her. Linda would then feel completely disheartened and deflated. Then she would say that he didn't love her. She did not give him any time to recover from any of her overtures. She asked me, "Why does he look away?" I explained, "He needs to decide for himself how much he can take in." She responded, "Does he have to? I don't like it when he does that."

I (PC) reiterated that Dan's looking away was an attempt to regulate his arousal in response to feeling over-stimulated, *rather than a rejection of her*. It was extremely important for Linda to understand this. If she could be more patient and accepting of Dan's need to regulate his arousal down, he might be more open to engagement. I reframed some of her pursuit of Dan as her interest in him and her wish to be close to him. This helped her feel less like a bad mother. I reminded her of Dr. Beebe's advice, to wait until Dan would be "ready", to wait until he came back and looked at her, before she tried something else. If she could allow him this initiation, then he could feel a sense of his own agency and ability to regulate himself more comfortably. Then he would be more available to engage with her.

At this point in the process, Dan's remarkable pattern of reaching for his mother and soothing himself on her hands, often despite visual/postural avoidance, had not been noticed by Dr. Beebe. This pattern was identified only after the treatment was over, when reviewing the description of the videotapes for publication. Therefore unfortunately this pattern was not included in the treatment. If noticed earlier, this pattern would have been extremely helpful as a way to demonstrate to Linda that Dan was "reaching" for her, "wanted" her, wanted her comfort.

Over time, as we continued to watch the videotape together, I attempted to stimulate Linda's curiosity about her baby's depressed mood. She began to wonder whether it was related to her

own depression. She hadn't realized that she had any effect on him at all, since she had believed that he was oblivious to her. At this early point in the therapy, Linda was still convinced not only that her baby did not love her, but that he wanted nothing to do with her.

The treatment plan was structured so that Linda would continue her individual sessions for herself three times weekly, and she would also bring her baby in for joint monthly sessions with Dr. Cohen. In addition, every few months both parents would go with Dr. Cohen to Dr. Beebe's filming lab. After each taping, Dr. Beebe would continue in her role as consultant to the parents and the therapist. Following each consultation, Dr. Cohen would first meet with Dr. Beebe, and then process the tapes with Linda individually, and with Linda and her husband jointly. Sessions in which the videotape was reviewed were "extra" ones; Linda's own treatment proceeded in its regular schedule.

### **Early Themes in Linda's Therapy**

In each of Stern's (1995) four themes of the "motherhood constellation," Linda had numerous difficulties. Regarding Stern's theme of the infant's "growth and survival", Linda had already relinquished control over Dan's feedings and physical care to the nurse she had hired, because she could not handle him herself. In regard to the theme of "primary relatedness," it was clear that she was having a difficult time loving her baby, and she did not feel that Dan loved her. Because of her mother's death, Linda was continuously longing for an "affirming support-matrix" for herself, Stern's third theme. When she reached toward her older sister as a mother-substitute, circumstances were such that she felt totally abandoned. Although her husband was emotionally available and supportive, his work schedule forced him to be away for long hours, which left her feeling alone and abandoned. When he did interact with Dan, the baby was more responsive to him, which left her feeling even more inadequate. Finally, her severe postpartum depression threw her into such a regressed state that she was in great need of a "reorganization of her own identity", Stern's fourth theme. Each of these four themes was explored in Linda's individual sessions.

After the first videotaped intervention with Dr. Beebe, Linda began to talk more about her feelings about herself as a mother, her images of her own mother and father, and what each of her children represented to her. Watching the videotape together provided a powerful catalyst in this exploration. I continually commented on parallels between what was going on in her interaction with her baby and what I knew of her own childhood experiences growing up. I pointed out that she had felt inadequate in the past, and that she now thought of herself as incapable and inadequate as a mother. Her mother had died before Dan was born, after Linda had been married for several years, but Linda had not completed her mourning. In addition, she viewed her baby in the light of her unresolved conflicts with her critical, punitive father, for whom the child was named.

In one session with the mother-infant dyad, Dan was seven months, noticeably more relaxed, and sitting up by himself. Linda was just beginning to shift her feelings about Dan, and to feel proud of his growth and progress. She put some toys down around him, and he reached for them. She had learned to match his sounds, and she was matching the boom-boom-boom rhythms that he made with the toys. At one point I asked if there were any songs that he liked, and she said that he didn't like any songs. I encouraged her to try, and she did. The first time he was somewhat disinterested. Then with coaxing she tried again, singing "itsy-bitsy-spider," simultaneously gesturing with her hands. This time Dan surprised us: he dropped his toy and imitated his mother with his hands. When I pointed this out to her, she cautiously admitted, "I guess he is coming out of his cocoon."

### **Second Face-to-Face Videotaped Intervention: Dan at 8 ½ Months**

Dan seemed to recognize the filming lab at the second session. His eyes widened, and he immediately looked to the door of the filming chamber. He looked around and seemed relaxed. This session will be described more globally, rather than through a microanalysis.

#### **Linda and Dan at 8 ½ months**

The most obvious change for Linda in this second face-to-face interaction was that she could *wait, and she was slower*. There was considerable pursuit behavior (going after Dan and calling for his attention while he was looking away), and asking for a kiss. Asking for a kiss would be coded by Murray (1992) and Kaminer (1999) as self-directed speech, a less optimal form of

maternal speech more associated with maternal depression. Asking for a kiss would be coded by Bronfman et al (1999) as a role-reversal, asking the child to provide the mother with affection. However, there were many instances in which Linda did not pursue. Usually Dan returned within a few seconds to the mutual gaze. But Linda accomplished her new self-regulation at a considerable cost. Particularly in the second half of the 8 minute session, Linda waited without pursuing when Dan looked away, but with a frown or grimace or pout. It was very difficult for her to tolerate his looking away, and to tolerate her own disappointment, without pursuing. This was the leading edge of Linda's development with Dan, a struggle to monitor her own behavior and self-regulate in a new way. Overall Linda's frozen smile had given way to a sadder quality in this session, which seemed to be a gradual re-owning of how she really felt. It was striking that Linda did not "light up" to "greet" Dan facially or vocally at the moments when he turned to look at her. One positive development in this session was Linda's beginning ability to join or acknowledge Dan's distress. Once when he whimpered, she also made a whimper sound; once when he looked away and arched, she said "no?"

Dan looked at his mother more frequently than the first session, and his gazes were more sustained. The most obvious change in Dan was that he was able to communicate some positive engagement: there were several instances of partial smiles (although not yet the full smile display). Although Linda's stimulation was still rough (loud and intense 'clap-hands' games, pushing Dan's hand, gently hitting him on the head), Dan seemed to recognize and anticipate some of the moves. These expectancies of the sequences occurred in conjunction with his partial smiles. However, many of his vocalizations carried a whimper sound. This symptom became a central index of his distress and lasted over the course of the second year. Unlike the first session when Dan's hands were continuously fingering Linda's hands in self-soothing, for much of this session Dan held his hands back, with elbows flexed, often with the fists partially clenched. Thus although he was less involved in a continuous self-soothing pattern, he was also more pulled back from Linda. Frequently Dan looked away and strongly averted his head without any obvious provocation from Linda. We worried that Dan might be taking on this pattern as his own style of relating. Toward the end of the interaction, Dan became more distressed, and swatted at his own

face, in an agitated form of self-soothing. Then he folded in on himself, looking down and holding his body still in a contained movement, as if holding in his distress (rather than going limp), giving a strong impression of trying to manage his distress totally on his own. Overall, despite these continuing difficulties, both Linda and Dan were calmer, and somewhat more engaged. Overall, nevertheless, there was little joint positive affect. And Linda still felt rejected by Dan.

### **Father and Dan at 8 ½ months**

Dan was upset as his father sat down. Father waited until Dan looked, and then softly matched the sound of Dan's whimper. Father said, "Don't be sad," and then slowly began to sing "Eensie, Beensie spider." Dan smiled, recognizing it. Overall, the interaction was slow, and Dan was able to look frequently, with some smiles. The father was able to focus on Dan, rather than asking Dan to focus on him.

### **Discussion of the Second Face-to-Face Videotaped Intervention**

Following the filming, everyone sat down to discuss it. I (BB) drew schematic pictures of various infant research findings to help the parents understand more about how infants perceive and interact. The research findings help to take the focus off pathology, and instead draw attention simply to "how infants work". Although I had mentioned some of these ideas in the first visit, I did not go into detail at the time because the parents were too upset. Now they were calmer. First I drew a schematic of Field's (1981) finding which helps the parent understand why the infant looks away, and thus potentially softens the feeling of rejection. This research shows that five seconds before an infant looks away, his heart rate has begun to go up. About five seconds after he looks away, the heart rate returns to baseline. Then once the infant regulates himself, he will resume looking at the partner, provided that the mother has tolerated the baby's move away and patiently waited for his return. If a mother is anxious and desperately needs her baby to look at her, she may interfere with the infant's cycle of re-regulating his arousal, and instead begin to "chase" (Stern, 1971; 1977; Beebe & Stern, 1977). Then the infant may become preoccupied with attempting to regulate his state all on his own, by extensive gaze aversion, arching away, and extensive self-soothing (Beebe et al., 1997; Tronick, 1989). This is what happened with Dan, and this preoccupation limited his repertoire. When Dan pulled back into his self-touching, frowning,

jiggling, and long periods of gaze aversion, this limited his capacity to develop new behaviors. Characteristic of the way that Dr. Beebe and Dr. Cohen collaborated, once Dr. Beebe explained something, Dr. Cohen would elaborate on it and link it to something that the parents and Dr. Cohen had shared together.

I (BB) also explained the infant's need for "face-space". From birth, infants defend the immediate space in front of the face from an intruding object. If something is about to come into the face, infants duck their heads down and away, and put their hands up in front of the face (Bower, Broughton & Moore, 1970). I encouraged the parents not to go into the infant's face as a way of trying to get his attention. Instead, I suggested vocal rhythm matching (Beebe, Jaffe, Lachmann, Feldstein, Crown & Jasnow, 2000) as a way of making contact with Dan even when he was looking away.

After this second visit to the lab, Dr. Cohen's private evaluation was that, despite some small progress, the difficulties were still quite entrenched. It was clear that Linda had learned to inhibit herself somewhat. She was not as active in "going after" Dan, she was not quite as over-stimulating, and she was able to "wait" a little more when Dan turned away. But it seemed rather "rote" and mechanical. She had not internalized a positive sense of herself as a mother to her son Dan, nor had she been able gain any real flexibility with her baby. Even though she was now "waiting" for his return after looking away, she had not yet really learned how to be more patient with him, to allow him to initiate interaction with her, nor to be spontaneously playful in a more fitting way. Yet in spite of this, Dan was responding somewhat more positively. This is an example of how the interactive organization at the behavioral level often shifts before the mother can reorganize her representations of the infant. It also illustrates the fact that the infant can profit from any improvement in the parents' interactive capacity (see Beebe, 2001).

### **Processing the Second Videotaped Intervention in Linda's Therapy**

When Linda and I (PC) viewed this second videotape in a follow-up session, we observed that Dan often sighed and looked away, jiggling his foot, and nervously moving his hands. Linda asked what

it might mean. Once again, we talked about Dan's jiggling and self-soothing as indicators of a high level of arousal. He looked away to help himself regulate the amount of stimulation that he allowed in. I told Linda that Dan's self-regulatory behaviors were a positive sign that he was working hard to stay in touch with himself, and with her. In retrospect, this was an example of how I reframed Linda's negative perceptions of Dan into an appreciation of his struggle. Even though Dan was upset, frowning and fussing, Linda could now see that he did come back to her when she gave him time to regroup. Following Dr. Beebe's suggestion, I explained to her that his visual interest in her was positive in itself. Dan's looking at her showed that he needed her and loved her (even though he still did not smile much). These explanations helped to reassure Linda. As she continued watching the videotape, she began to try to understand his motivation, such as, "He was tired of looking at me just then." This constituted a major shift in Linda. She began to see Dan as having his own separate needs and motivations, rather than as "accusing" her of being a bad mother.

I (PC) continued to be an encouraging support for Linda. Gently, but firmly, I coached her to be more sensitive to her baby, to decrease stimulation, to pause more often, and to give him more control, letting him initiate, and not chasing when he looked away. Using the coaching of Dr. Beebe, I helped her understand that by waiting until he initiated an interaction, and by matching his movements and sounds, her baby would know that she was *with* him. Linda still didn't fully accept why Dan needed to pull back into himself. But she was beginning to realize that when she tried too hard to get him to be interested in her, it resulted in his pushing her further away.

**Here add something about the therapist's dilemma re m's need vs. infant's need.**

Linda was still preoccupied with her own immediate present feelings of neediness and loneliness. It was painful for her to tolerate her neediness sufficiently to be able to reflect on the past, and the patterns in her life. As her individual treatment deepened, Linda became more open to the idea that her early experience might be significant. In a major turning point in the treatment, Linda began to wonder about how much her own mother had really been able to give her. Since the mother's death a few years before the birth of Dan, Linda had idealized her. Gradually Linda began to be able to acknowledge that her mother did not protect her from her aggressive and

angry father. Linda had greatly feared him during her childhood years, and continued to fear him as an adult.

In her individual sessions, Linda began to be able to connect Dan's need to pull back from her with her own dilemmas. When she perceived intrusive overtures from her mother-in-law, Linda just wanted to push her away. She began to see an analogy between her own withdrawal with her mother-in-law, and Dan's withdrawal with her. Linda now spoke about the relationships she had formed with people in her own life, and how few choices she ever felt she really had. In contrast, she described herself as having been somewhat of a rebel as a child.

Each time that we viewed the videotape together, Linda became more open to thinking about her own impact on Dan, and his impact on her. She began to be able to notice and put into words that she had "gone after his attention," after she felt rejected when he looked away. To be able to notice her own behavior and to imagine her own motivation was another critical shift for Linda.

By the time Dan was approximately 10 months, as she watched the tape, Linda became able to predict the sequence of her pursuit and Dan's retreat (a form of "chase and dodge" as described by Beebe & Stern, 1977). This capacity to predict the sequence began to give her more of a sense of her own agency. She felt that she "got it", that she understood the pattern, so that it need not continue to shock her, to take her by surprise, and so painfully disappoint her. And as she continued to increase her awareness, she understood that Dan *needed her* to stand by and wait for him to return to her. She came to see that Dan did continue to look back to her. She began to see that maybe her baby would return to her on his own, rather than her having to force him to return.

### **A Joint Session with Linda & Dan at 10 months**

The monthly joint sessions provided a way to assess how Linda and Dan were doing together. When Dan was 10 months, Linda brought him in and offered him some cheerios. He took them one-by-one out of the container, without eating them. When Linda saw this, she began to speak about her own eating problems: "He's just like me. When we give him real food, he makes a face.

I have to shove the food into his mouth with my finger to get him to eat. I'm a very picky eater too." She had assumed that Dan's playing with the cheerios meant a rejection of her food, rather than his interest in exploration.

In this session, she coaxed Dan, "Show Dr. Cohen you know how to smile." She was not happy with him when he didn't respond. She then took out a Big Bird doll and she said, "Give him a kiss." When he did, she continued, "Now give mommy a kiss." It was a wonderful moment for the two of them when Dan made a kissing gesture toward his mother. They spontaneously smiled at each other. But at another moment soon after, when Dan said, "Ga ga goo goo," she answered, "Ga ga goo goo. Give mommy a kiss. Can I have a kiss?" When he didn't respond on cue, she looked at me and stated, "Sometimes I don't feel like Dan's mother when he treats me like a stranger." Unlike his five-month stage of development, now at ten months Dan was, at times, able to respond to her verbal request for a kiss. But Linda still did not realize that her request for a kiss could be so similar to the physical "chasing" she had been doing.

Although Dan had become a bit more relaxed and responsive, Linda still desperately needed him to make her feel validated and competent. The few unpredictable moments of connection were not enough to sustain her. At one point she put a toy just out of his reach and he struggled to move toward it. I remarked, "Now he's learning he can get something that he wants." She responded, "I should do it more, but it's easier to just give it to him." It was as if she thought that she needed to "supply" him with whatever he gestured for, rather than encourage his growing initiative and agency. Thus Linda seemed to vacillate between two extremes of intruding her own agenda by demanding something from Dan, or "giving in" or anticipating his needs. Both modes of interaction potentially disturbed Dan's sense of agency.

At the end of this session, Dan struggled with a toy that he had dropped. Linda empathically said to me, "I feel for him. It's so hard to be little. I want to help him," and to Dan she said, "Here's your toy. Don't drop it this time." I noticed that she could empathize with Dan as she spoke to me, but that she seemed irritated as she spoke to Dan. I began to model for her by saying to Dan, "I know it's hard for you Dan. I know you're trying so hard. We are so proud of you. We wish we could help you to make it easier. But we know we have to help you to do it for yourself." With Linda, I empathized with how hard it is to "stand by" (Furman, 1992); how much easier it is for any parent

to “do it for” the child, rather than to patiently tolerate watching the child struggle to do it for himself.

### **Themes of Linda’s Individual Treatment Toward the End of Dan’s First Year**

In Linda’s individual sessions one of the main goals was to help her feel that she was a person of worth who did not have to depend on her baby to validate herself. Much of her intrusive behavior involved desperate efforts to get Dan to help her feel competent. I tried to help Linda to stay with her experience in the moment, to allow her time to process her own thoughts and feelings, so that she could explore her sense of worthlessness (Alvarez, 1992).

One central difficulty was Linda’s tendency to project negative intentions into Dan. She continued to say to Dan, “You’re making me look like a liar...You’re making me look like a bad mother...”. We worked on Linda’s negative transference to her baby as a person who did not gratify her. Because of her own cultural traditions, Dan had been named for her father, whom she openly hated and feared for being self-centered, verbally abusive, and explosive. We explored her fear that Dan would turn out like her father, and her tendency literally to confuse her father’s personality with Dan’s. Dan seemed to have become a personification of her depriving father who could not love her.

We explored her growing awareness that both her parents had not been sensitive to her. She returned to her feeling that her own mother had been unhappy and needed her. She remembered times when her mother had begged her to stay home from school, not because she was sick, but to keep her mother company. She began to see that she herself might be like that with Dan, needing him to provide something that her mother had not. Her awareness of what her mother had not provided emerged in relation to her amazement about what her therapist provided. Linda’s own capacity to attach to her therapist, and to reorganize her expectation of insensitive parenting, was critical in this process. She would frequently say, “I can’t believe you understand me. You really understand.” Linda began to be able to use Dr. Cohen as the mother she had never had. This was a central achievement.

Around this time, Linda had two dreams, both of which had the theme that nothing is as it seems. Each of these dreams were discussed in the context of the many losses Linda had experienced and of her growing awareness that her childhood had not been as it had seemed. In the first dream, she said “I found a skeleton on the floor. When I went to look at it, I was frightened. I realized that it was a woman dead on the floor. I ran to get help”. In her associations, Linda felt that she was by herself, alone, not knowing what to do, as if she had just lost her own mother. This dream allowed Linda to revisit the events surrounding her mother’s death. She discussed how she had been abandoned by her family throughout her mother’s illness, because they felt that she was unable to cope with what was happening. Shortly after, she reported her second dream: “I was upset. People around me were asking why there was a man there. I did not know what he did. Then I realized that he was not the man I thought he was. It was someone in a costume. Then I learned that the man I thought he was had died”. In her associations, she felt very sad and confused. She did not know what to make of it. Who was this man? Why couldn’t she count on anyone? Although Linda was extremely upset and confused, these dreams reflected her increasing ability to reflect on her own internal process. She was struggling with her need to revise her view of her herself and her childhood. She began to mourn many of her losses and to feel a tremendous sense of sadness for what never was.

### **Third Face-to-Face Videotaped Intervention: Dan at 12 months**

#### **Mother and Dan**

As this interaction opens, Linda pursues Dan while he is not visually engaged. She offers him toy after toy. Finally he looks for a moment and smiles, then orients away. While Dan is still turned away, she asks, “Can I have a kiss? Want to play with mommy?” Dan then takes a toy and begins to be absorbed playing with it. Linda says, “You want me to get away from the toy? You only have eyes for the toy? What about Mommy? Give Mommy the toy.” Linda then attempts to get Dan’s attention by playing peek-a-boo, while Dan is oriented away, playing with the toy. Finally Linda takes the toy from him. He flaps his arms angrily, and shakes his head from side-to-side. Linda says “No?” and gives the toy back.

Linda then says “Wubba, wubba, wubba?” as Dan is engaged with the toy. Dan vocalizes back,

but with a whimper. She tries to get his attention, calling “Dan!” (with a sinusoidal greeting contour). Dan stays absorbed in the toy. Linda again says, “Wubba, wubba wubba?” Dan does not respond. Linda then says, “Throw mommy a kiss.” She is now making kiss sounds with her mouth. Dan whimpers, orients away, then grimaces. Linda makes a “woe” sound, and Dan looks at her, but then grimaces and kicks, continuing to look. Linda says, “Hiii” (with a sinusoidal greeting contour). Dan makes a sound and she matches it. Linda then says, “You want to play with mommy? Wubba, wubba, wubba?” Dan frowns and looks away.

Linda asks, “Where is the toy?” and brings in a different toy. Dan looks with a partial smile. At this moment Linda mouths a kiss to Dan, then kisses the doll, and says, “Give mommy a kiss.” Dan shakes his head “No”. Linda says, “Give mommy a kiss.” Dan buries his head in the toy. Linda says, “You’re kissing the toy?” Dan orients away, makes a whimper sound, and shakes his head “no”. Linda says, “You want to play that game?”

*Comment: The interaction is still in trouble. Linda pursues a great deal when Dan is not available. She attempts to shift the focus from Dan’s play with the toy to a direct visual encounter with her. She seems to be jealous of the attention he gives the toy (“You only have eyes for the toy? What about Mommy”? ). Instead of joining his activity, she attempts to shift the focus to herself, needing his acknowledgment. She is also preoccupied with the longing that Dan would give her a kiss. This would be coded by Bronfman et al (1999) as “role-reversal:” the child is asked to do something that ordinarily the parent does, that is, provide overt displays of affection. Furthermore, the affection should be provided on mother’s request (rather than coming from the child spontaneously). The one point at which Linda joins Dan’s distress with a “woe” sound, Dan looks at her. She also kept his attention with vocal matching of his sounds.*

*For his part, Dan does not look at his mother much and his whimper is still disturbing. His interest in the toys is age-appropriate. Linda does not seem to know how to join his play, rather than shifting the focus back to herself. Dan is beginning to say a vigorous “no”. [Linda later explained that she had “taught” him to say “no” by shaking his head*

*from side to side, and because he learned it from her, she enjoys it]. At times she respects the “no”, for example by giving the toy back, and other times she seems to ignore it, for example in her last comment, “You want to play that game?” Dan does have a couple of positive moments with his mother.*

### **Father and Dan at 12 months**

The interaction with the father at 12 months was very successful. A global description of the seven minute session follows. As the interaction begins, Dan is sobbing. Father says, “What’s the matter? (Pause). Scared?” The timing of his words is slow, and he waits. Dan gradually calms down. After 20 seconds, father says, “Sing a song?” He waits, then begins to sing, “Twinkle, twinkle, little star”, very slowly. Dan smiles. Then he fusses. Father says, “What’s your name?” Dan fusses a little.

Father offers him a book with a monkey. Dan takes the book and puts it in his mouth. Father says, “Eat the book?” Dan vocalizes softly. Father says, “yeah”, matching the rhythm and cadence. Then Dan vocalizes with some distress. Father says, “Why sad?” He waits. Then, “Want me to show you the pictures?” Dan hands his father the book. Then Dan takes the book back. Dan drops the book. Father picks it up saying, “Look what I found!” and hands it to Dan.

Dan opens the book. Father says, “Look at that!” Dan turns a page. Father waits. Dan turns another page. Father says, “Look at this picture! See all the pictures?” Father waits, smiling. Dan looks at the book. Father says, “Do you want me to help you? Yeah?” Dan looks at his father. Father says, “Oh, boy, look at that! Yeah. Are you ready?” Both looking, they smile at each other with big grins. Father says, “The puppet says, hey I want to eat that book.” Both smile again broadly. Father says, “You love that book”.

*Comment : The father is slow, recognizes Dan’s distress, and does not disrupt Dan’s agenda. He slowly helps Dan repair his distressed state. As he interacts with Dan, the father is careful to respect Dan’s initiatives and agency.*

### **Processing the Third Videotaped Intervention, Dan at One Year**

In a follow-up session watching the videotape together I (PC) continued to reinforce any positive moments between Linda and Dan. For example, “Look how well you waited,” or “That was really nice when you told him you loved him.” Linda was now more relaxed with Dan. She had developed a repertoire of action songs to sing and play with him. She had learned to be more patient, her affect was more modulated, and her voice rose and fell more slowly, at a lower pitch. As we watched the video, she excitedly noticed moments when Dan was trying to communicate with her: “Look how he’s telling me what he wants!” I noted that Dan was now looking at her more, and he was talking to her. However, it was difficult for me (PC) to tolerate that Dan was still not smiling much. I felt Linda’s struggle, as she would say to me, “Why can’t he be more smiley like my friends’ babies; why can’t he be normal?”

I reminded Linda of Dr. Beebe’s discussion with us. For Dan, at this time, looking at his mother and talking to her were as important as smiling, which he could not do yet. We recalled together that Dan had been in so much distress when she first brought him to be videotaped. It would take him time to recover, but he was already starting to come out of it. I told Linda that one of the ways she could most help Dan was to wait for him to initiate a focus of interest, by joining what *he* was interested in instead of shifting it to her interest, and by responding to him at the same level of intensity that he showed. She could really help him now.

Linda was still aching for more of a response from Dan. She constantly repeated, “Can I have a kiss?”; “Give mommy a kiss.” In the early months, it was as if Linda actually believed that her baby *could* blow her a kiss. Now that he was one year old and did at times blow kisses, she needed him to do it at her every command. Sometimes he would. But unless he did it on every request, she felt devastated. It was hard for her to feel that he cared about her. Over and over, she still said, “You want that toy? You want mommy to get out of the way for the toy? You only have eyes for the toy? What about mommy?” Each time she picked up a puppet, she repeated, “Give the puppet a kiss. Give mommy a kiss.” On the other hand, there was evidence on the videotape that the baby did care. Linda and Dan were now making a facial/visual connection that had not occurred in the early months. As a result, she could no longer say with complete conviction that “my baby doesn’t like me”.

## **The 12 Months Attachment Test: Avoidant**

Following the face-to-face interactions at 12 months, Dan and Linda participated in the Ainsworth “Strange Situation” Attachment Test. As Mother left the room the first time, Dan did not protest her departure, although he watched her leave. After she left, Dan jiggled a toy in the direction of the door and immediately re-engaged with the stranger. When Mother returned, neither she nor Dan greeted the other. Mother walked straight to her chair and sat down. She did not try to engage him. Dan remained oriented to the stranger. When the stranger left, he banged his toy and kept mother in peripheral view. Then he oriented away from her and happily engaged with toys, occasionally checking mother visually through the periphery. He remained oriented fully away from her, ignoring her. His play involved taking everything out of the bucket and putting it all back in.

During the second separation, Dan watched mother leave without protest. After a delay, he made a soft whimper sound. Then the camera person made a noise, and he whimpered toward the camera. Gradually he began to cry, at first softly, then more strongly, then active protest, then an angry cry. Finally he tried to crawl toward the door on his belly. When the stranger entered, he calmed down. She put him on her lap, talking gently to him. He cried briefly, then calmed down as she introduced toys. He was receptive to the stranger.

In the second reunion, as Mother knocked on the door, Dan oriented to the door. Mother entered and said “Hi.” He looked at her, and she said “Hi” again. He did not respond. Once she was fully into the room, he looked down at a toy. She sat down on the floor, approaching him obliquely from the side. As she sat down, he oriented toward her. When she was finally on the floor, he looked toward the toys. As she sat, he oriented to the door, watching the stranger leave. While mother sat next to him, she put a toy inside his toys. He continued looking at his own toys, partially oriented away from her. She offered more toys, disturbing his focus. He did not respond, playing with his own toy. She tried to join the play by making noises with the toys, saying, “Do you like that?” He did not respond. She gave him another toy, he took it and put it in his mouth, and she pulled it out.

## **Themes in Linda’s Treatment When Dan Was Age One to One-and-a-Half**

Linda’s self-esteem as a mother was continuing to improve. She began to see her therapy as

something she was doing for herself. She also began asserting herself in many situations with her family. When Dan turned 13 months, she felt she was ready to take over the total care of her baby for the first time. She now felt sufficiently confident to terminate the services of the Nanny. Previously she had been full of anxiety when the weekends approached and she would have to take care of the children on her own. In the therapeutic relationship, she had had a chance to experience herself as the needy child (Fraiberg et al, 1975). She began to feel “fed and filled-up” in therapy (Winnicott, 1960). As a result, she was developing into a mother who felt she could now feed and fill-up her baby. She was no longer clinically depressed. Her neediness and feelings of abandonment were being channeled into her marital relationship. She made new friends. She looked better, she said she and her husband were getting along better, she was calmer, and she wasn’t calling her sister for help all the time.

In her individual therapy, Linda began to be interested in me (PC) as a separate person, with separate needs. For the first time, she asked me how my holidays were spent, and how many years I had been in school. Following this leap, despite some continuing difficulties, in the next videotaped intervention, when Dan was 17 months, there was further progress.

#### **Fourth Face-to-Face Videotaped Intervention: Dan at 17 Months**

It was now four months since Linda had taken over Dan’s care on a full-time basis, and a little over a year since the first video intervention. She was now clearly the mommy that he turned to. At 17 months, Dan had become an interactive and communicative little boy. He showed more capacity for a real ebullience: he smiled at his mother with a huge open “gape smile” and at times became playful with her. Dan’s ebullience was so powerful, and so welcome, that we initially did not perceive the degree of distress that he was still in. Only after we did the microanalysis was it clear that the interaction with his mother was still quite problematic. We present the microanalysis of the videotape of this session in more detail to look at how the maternal difficulty became centered on Linda’s superimposing her own agenda. This is a further elaboration of the initial

“pursuit” pattern. However, since Dan was now capable of indicating his own “agenda” (such as asking for a particular toy), his mother’s pursuit had become elaborated into over-riding Dan’s agenda and superimposing her own.

They had arrived a few minutes before I (BB) came in. As I got to the door I sensed Dan’s wariness. I stood at door and from a distance made a vocal contact with him. He seemed shy, cautiously looking at me and looking away, about a dozen times. His voice carried a whimper sound. Gradually I went into the room. After watching me exchanging warm greetings with his parents, Dan seemed more relaxed.

### **Microanalysis of Linda and Dan at 17 Months**

As the session begins, the video is at 11-46-02. They orient together in a moment of mutual gaze. Linda takes the puppet and goes into his belly. Dan looks to door and then back to her. They both laugh. Dan points to a toy. Linda gets the toy but continues with the puppet playfully biting him. *Although mother responds to Dan’s agenda of the toy, she superimposes her own agenda of the puppet.*

11-46-04 Dan looks at door and back *Dan seems to indicate his distress by looking at the door.*

11-46-06 As Mother makes sharp forward motion with puppet, Dan looks to door. Mother: “I’m going to get you!” As Dan looks at her, Mother makes gentle eating sounds with the puppet. *Mother does not acknowledge his looking to the door as a hesitation, or a mild distress, and instead continues with her high-arousal game.*

11-46-08 Dan bites his lip and looks toward door again. Mother sobers. He looks at her and gestures toward her with a frown. *Mother sobering is the first indication that she “reads” his distress.*

11-46-09 Mother makes sharp movement forward with puppet. *She continues, superimposing her own agenda of the game.* He sustains eye contact and says “no”. She says, “O.K.” *This is a powerful moment in which Dan openly holds his ground. He now expresses through*

*language what he expressed previously through looking away and orienting away. For her part, Linda's ability to accept the "no" is extremely important. Later on in the session, however, Dan reverts to more nonverbal ways of saying "no."*

11-46-12 Big smiles on both.

11-46-13 Dan's smile is immediately followed by an avert. *This is an unusual pattern of high positive followed by avert, described by Beebe & Sloate (1982) as "gape-smile-avert". Perhaps this combination of the smile and the avert carries Dan's complicated feelings about the intrusive puppet game, on the one hand, and his relief that mother accepts his "no," on the other.*

As Dan orients back, sober-faced, Mother says, "Hi"(sinusoidal greeting ) *Mother here seems to over-ride his sobering by changing the focus to her own agenda, asking for an engagement.*

11: 46:20 Dan points to a toy. Mother hands him the toy saying, "Do you want this one?"

11: 46:24 Mother: It's orange.

11:46:26 Mother now kisses the puppet. They laugh. But immediately he says "no." *Here mother changes the focus from his toy to her own agenda with the puppet. Again we see Dan in a pattern of high positive, followed by an immediate negative, "no".*

Mother says, "Okay."

11: 46:27 Both give big smiles - she shows him the toy he wanted.

11: 46:29 Immediately Dan looks away and down, sobering, and he glances at the door. Mother sobers. *Again we see the pattern of positive followed by immediate avert in Dan. Mother does read his distress, as evidenced by her sobering.*

11: 46:33 Dan orients back and they both smile.

11: 46: 35 Now they both laugh. Dan seems ebullient.

11: 46: 37 Now Dan points, but with a strong frown; he pouts and whimpers. *Again Dan shows the pattern of positive- > immediate negative. His own agenda, that is, pointing toward the toy, is communicated with distress.*

11: 46:39 Mother says, "What do you want? Do you want this one?"

11: 46:51 Mother says, "Oh you want this one?"

11: 46:54 Dan looks at it, sober. Mother sobers. *Here mother has read Dan's distress.*

11:46:56 Dan looks toward the door.

11: 46: 59 He looks back at her, shakes his head "no" with a whimper. Mother sobers. *Again mother reads his distress.*

11: 47: 03 Mother takes the doll and kisses it. Both smile broadly. Although *Mother reads his distress, she does not then **acknowledge** it with her next behavior; instead she again superimposes her own agenda, the doll.*

11:47: 05 Dan looks down. Mother bites her lip. Both are sober-faced. *Mother reads his distress.*

11:47: 08 Dan looks back with a big smile.

11:47:09 Mother smiles.

11: 47: 10 Dan smiles further: he's ebullient. *He does have a new capacity to respond to his mother in an intensely positive way.*

11:47:11 Immediately Dan sobers and points to a toy, with a whimper, grimace and frown. *Again we see the pattern of positive followed by an immediate negative. Dan indicates his own agenda, but he does so with distress.*

11:47:13 Mother: Is that it? As mother smiles, Dan shows a partial smile.

11: 47: 15 Dan gestures toward something else with a whimper and frown. *Again Dan indicates his own agenda with distress.*

11:47:19 Dan again gestures to the toy with a whimper and mother gives it to him.

11:47:22 Mother hands him the Curious George doll, saying, "Say 'Hi' George".

11:47:29 They smile together.

11:47:31 Dan now immediately sobers. *Another instance of the pattern of positive followed by immediate sobering. What was the problem here? Was it that she was "conducting" how he should interact with the doll, rather than letting him spontaneously initiate?*

Mother's face sobers as well She offers the toy: "Do you want George?" *Mother reads his distress and tries to repair.*

11: 47: 35 Dan looks away and sobers. He looks back, then looks down, and whimpers.

11: 47: 40 Mother says, "What?" *Mother reads his distress and seems confused*

11:47-45 Dan reaches for George. Mother gives it to him. He then looks away and down. She looks down.

11:47:47 They both look at George. Dan plays with George for a moment.

11:47:55 Dan again gestures with a whimper.

11: 47: 57 Mother says, "What?" *Here mother is reading Dan's distress and trying to see what he wants.*

11:48:02 Mother says, "Hi Dan!" *But now she superimposes her own agenda, asking for engagement from him.*

11: 48: 03 Dan smiles but immediately looks down, sober. He looks at another toy. *This is another example of the pattern of positive followed by immediate sobering.*

11:48: 04 Dan is sober. Mother smiles. *This is an example of "affective error."*

11:48: 06 Mother looks for something else [not the toy Dan had just looked at]. She gives a different toy to him and he lets it drop. They both look down. Mother retrieves the toy. *Letting the*

*toy drop is a passive form of “no.”*

11:48:15 Dan has a hint of a frown and an ambivalent mouth expression. Mother looks down with a partial grimace/ partial smile. *Mother reads Dan’s distress.*

11:48:19 Both look at the toy; both are sober. *Here mother seems to actually share Dan’s state.*

11:48:29 Dan looks down and plays with a toy in his left hand. Mother looks for a different toy [instead of trying to play with him with the toy that he has.]

11:48:38 Mother hands Dan the new toy and Dan lets it drop. *Another example of a passive form of “no”.* Mother says, “Oh my goodness!” She gets the toy and they have a moment of mutual gaze and brightening. Then they both sober. *Positive affect is not sustained.*

11:48: 48 Dan now puts the toy in his mouth with a whimper. *It’s hard to know what he wants. Is he distressed because he has complied with her agenda?*

11: 48: 51 Mother says “more?” [She gives him a new toy, the pop-it beads]. Dan takes it and lets it drop. *Another example of a passive “no.”*

11: 48: 54 Mother takes her own pop-it beads and moves hers up and down. *She seems oblivious to his “no” and just continues to pursue her own agenda.*

11: 48: 57 Dan loses tonus and slumps. *This is a further escalation of a passive form of saying “no”. Losing tonus is one of the infant’s most extreme coping mechanisms. It occurred once in the “chase and dodge” interaction (Beebe & Stern, 1977) toward the end of the interaction, after many rounds of maternal pursuit and infant dodging. It is also a frequent form of coping seen in four-month infants who will be classified as disorganized at 12 months (Beebe, 2000). These infants seem to resort to going limp, loss of tonus in response to continuing maternal inability to “read” and acknowledge infant distress. This seems to be the case at this moment with Dan and Linda.*

11: 49 : 00 Mother’s face takes on a partial grimace. *She reads his distress.*

11: 49: 03 Mother offers Dan more pop-it beads. *She goes back to her own agenda.*

Comment: There are beautiful ebullient mutual smiles punctuated by Dan looking toward the door, and by frowns and whimpering, particularly when he has an agenda separate from hers. They do connect at times, but they fluctuate over a wide positive to negative range. Mother has more capacity to wait, and more capacity to **read but not necessarily respond** to his nonverbal gestures of “no,” or of distress. She changed his focus and superimposed her own agenda many times. His engagement is at times positive, but his method of indicating a different focus of interest is negative, primarily involving a whimper. We had come to understand the whimper communication as Dan’s attempt to express his intentional state in the face of repeated experiences of not being seen or heard or acknowledged. This pattern began, as we saw at 5 ½ months, as Linda’s inability to notice whether Dan was available for engagement or not, and whether Dan was distressed or not. By 17 months this pattern had evolved into Linda’s tendency to superimpose her own agenda, over-riding Dan’s cues about his own focus of interest and initiative.

### **Father and Dan at 17 months**

Following the interaction with mother, Dan played with his father. Dan looks at his father and smiles quite a bit. Father follows Dan’s agenda. But Dan continues to whimper as he indicates his interest in various toys. For the first time he didn’t show any more positive affect with his father than with his mother. Toward the end of the interaction, Dan looked toward the door, pointing and calling “ma, ma, ma, ma.” When Linda reentered she was thrilled that he had called her, and Dan gave her a big smile.

### **Dr. Beebe and Dan at 17 months**

After Dan played with both his mother and his father, he played with Dr. Beebe. Since Dan did not want to be separated from his parents, they sat behind Dan, well out of his visual field. The interaction begins with an ebullient smile but quickly follows the pattern of immediate loss of

positive, and gesturing for what he wants with a whimper. He becomes interested in getting toys out of a doctor's bag, and he plays with several of them with BB, with several sequences of smiles and whimpers.

After a little over two minutes, Dan begins to show an odd pattern. His head is down, his body tonus is partially collapsed, and he becomes completely still. After a few seconds, with his head still down, he looks up from under his eyebrows at Dr. Beebe. Each time he looks, BB nods her head very slowly and says, "It's ok". He watches me for five to ten seconds, and then looks down, motionless, for five to ten seconds. This pattern goes on for two minutes.

When he comes out of it, he picks up the toy he was playing with before, and whimpers. He then cranes his body all the way around to glimpse at his parents [who had stayed absolutely quiet], and then hands the toy to BB with a whimper. He glances back to his parents, then flashes BB a big smile.

*Comment: In this sequence Dan shows a pattern of "stilling." (Main & Soloman, 1990). Dr. Beebe's response was to join the "still" state and give reassurance whenever he looked. At the end of the interaction with his mother, Dan had shown an instance of going limp and losing tonus. He now showed this pattern to Dr. Beebe, in a very prolonged way, with great intensity. He seems to be indicating his degree of continuing distress to Dr. Beebe. Despite this quite unusual display of distress, after a break for lunch, in the next part of the lab visit, the Ainsworth test, Dan and his mother showed a secure pattern of attachment.*

### **The 17 months - Attachment Test: Secure**

The Attachment Test at 17 months showed a secure attachment, in contrast to the avoidant attachment at 12 months. Dan showed wariness and distress with the stranger. But when the stranger gave him a toy he responded positively and played with it. He was clearly happy to see his mother when she returned. He looked at her, turned toward her, smiled, and then resumed his play. When she left the room again, he cried, and he oriented to the door, pointing at it, looking for his mother. On the second reunion, he immediately went to his mother, and was happy to see her

return. Linda, in turn, embraced her son warmly. Then Dan began giving her toys and blocks as he initiated a new game with her.

There is some clear progress at 17 months, seen in Dan's capacity for ebullience. Although the second attachment test yielded a secure classification, the pair are still in difficulty. Dan is whimpering extensively, particularly associated with his own separate initiative and agency. By the time we will see them at 22 months, it will be clear that the system has begun to shift in a positive direction. And by 26 months, we will see that the relationship is for the first time on a solid footing. The 38 and 48 month follow-ups continued to show excellent progress.

### **Summary of Themes in Linda's Treatment From 17 to 26 Months**

Because there was a major shift in a positive direction in the interaction between Linda and Dan, we (PC and BB) became very interested in what was going on in Linda's individual treatment between the 17 and 22 month visits, and between the 22 and 26 month visits. As we have already noted, Linda made her first powerful reorganization when she for the first time took over the care of Dan at 13 months. However, during the summer following Dan's first birthday, as in the previous summer, Linda was not able to leave her therapist to go on the family's usual two-month vacation. Therefore during the period in which Dan was 12 to 17 months, Linda was still extremely dependent on a primary relationship with Dr. Cohen.

In the period from 17 to 26 months, Linda began working intensively on her relationship to her family of origin. She was now dealing with a transformation of her "idealized" mother into a more realistic picture of her needy and disappointing mother who had asked Linda for the nurturance that Linda herself so desperately needed. Moreover she was dealing with her relationships with her older sister (who had previously carried maternal functions), as well as her other sister and her brother. Linda had developed a growing ability to see her siblings, and particularly her older sister, in a more realistic way, acknowledging their limitations. She worked on giving up her longing to make these relationships into something they never could be, that is, more nurturing.

A pivotal point in the treatment occurred two months prior to the 22 month visit to the lab. For the

first time, Linda requested a family session with her siblings and her father, when she learned (one week prior to the wedding) that her father planned to remarry. In this family session, Linda took on the role of the family facilitator, totally uncharacteristic of her. Linda confronted her father, asking him about his emotional allegiance to his children and grandchildren in light of the new marriage. She encouraged her siblings to join her in standing up for themselves. The brother was able to confront the father about having been physically beaten and verbally abused by the father. There was a growing awareness of a reversal of roles between Linda and the older sister: Linda began to take on the role of the one with clarity and initiative. During the course of the session the family began to view Linda in a new light, as someone who could stand on her own, in contrast to the image of Linda as the needy, family baby. Her father was enraged at her and asked, "What happened to you? You're not the Linda I knew. The father showed how disconnected and explosive he could be. This session informed Dr. Cohen in a vivid and dramatic way about the possibilities and serious limitations in Linda's family of origin. Sadly, a rift in the family ensued.

This family session had a profound impact on Linda. After a brief period of mourning, the rift seemed to empower her to emotionally separate from her family of origin. She began to stand on her own, to look outside herself and her problems. In the month following the family session Linda unexpectedly announced that she was going to do charity work, and she went to her first meeting. She expressed the wish to help other people in the way that she had been. She joined a program that would train her in finding resources for mothers of disabled infants and young children.

Linda continued to work on the impact of the family session. She was able to transform her fantasy that her father might actually be able to be emotionally available and loving into a more realistic picture of his limitations. She was able to hear Dr. Cohen's gentle but optimistic suggestion that Linda was now capable of creating some of the "mothering" that had been missing in her family her whole life. These steps toward separation allowed Linda increasingly to invest in her own marriage and children as the emotional "center" of her "family". With both her husband and Dan she began to be able to *see* their own separate needs. She was developing a more collaborative approach in her marriage, where she was able to plan and participate in decision-making. Within the following year she began to restructure the family holidays so that her own nuclear family took center stage.

A further consolidation of gains occurred for Linda between the 22-month and 26-month visits. A month following the 22-month visit Linda reported the third dream of the treatment, which had a very different tone from the other two dreams reported in the first year. In this dream, an old high-school boyfriend came to see her outside her current home. He smiled at her as she looked at him through the window. She debated whether or not to go out and speak to him. In her associations, she felt really good. She saw herself as someone desirable, someone who could do something good for other people. This surprised her. Once again she expressed tremendous appreciation to Dr. Cohen for the help she received in the therapy. She reiterated that she wanted to share this with other people.

That spring, between the 22 and 26-month visits, Linda began to plan to spend the coming summer vacation with her family and friends, as she had in past years, instead of staying in the city to be able to see her therapist. Thus, Linda was able to take a major step in her own individuation with Dr. Cohen as well. Within the following year, she began to be able to analyze her mother's relationship with her own mother (the maternal grandmother), who had been very withholding with her mother and herself. These themes in Linda's individual treatment set the stage for understanding the major shifts that Dan and Linda showed in the 22 and 26-month visits, to which we now turn.

### **Fifth Face-to-Face Videotaped Intervention: Dan at 22 Months**

Prior to the filming Linda spontaneously said, "I'm usually nervous but now I'm not." In this filming Linda has become less intense and a bit more related, while Dan is still whimpering when he signals his own interest in a toy, when he gives a toy to his mother, or when he points to something. However, there are now many moments of shared smiles, and some moments of real ebullience in Dan, where he giggles and laughs. Linda still has some difficulty joining Dan's agenda, for example, throwing him a kiss when he points to a toy with a whimper. For his part, Dan has more flexibility, able to shift from his own focus and go with his mother's agenda. For example, he pointed to a toy car, and Linda said, "want to play with a puppet?" He giggled and laughed as he joined mother's puppet game, in which Linda played at having the puppet go into

Dan's stomach, as she says "Don't eat Dan!" However, when he sobers at one point in this game, she does not seem to "read" it or acknowledge it nonverbally; instead she simply repeats the same gesture, going into his body with the puppet. Dan shows his increased flexibility by being able to recover and again "go with" his mother's agenda, laughing. But when mother finally pushes the puppet right into Dan's face, he squeals and pushes the puppet away. When she did it a second time, he pulled the puppet from his mother's hand, showing a good capacity to indicate 'no' when her intensity became too high. He showed a further flexibility in being able immediately to recover from this disruption and rejoin the game, laughing. In both the interactions with his father and with Dr. Beebe, Dan is capable of focused play, with frequent smiles, but he is still whimpering as he indicates his own agenda. At the end, as mother comes back in, Dan greets her joyfully.

### **Sixth Face-to-Face Videotaped Intervention: Dan at 26 Months**

As the team is setting up the microphones, Mother and Dan are enjoying an exchange: Dan says, "Dot, dot" and Mother repeats "Dot, dot; Dot, dot; toy?" Dan responds "toy." Then they are interrupted as mother is asked to count, to test the microphone.

Mother says, "Want to count? One..." (with a sinusoidal contour). Dan says, "Toy." Mother continues, "Two..." Dan again says, "Toy". Mother then says, "Three... Toy?" Dan says: "Toy!" Mother says "Four..." Dan says, "No, toy!" Mother says, "Toy? Which one?" Dan again says, "Toy." Mother: "Blue one?" Dan: "Okay!"(smiling). *This sequence shows a marked improvement in Linda. She was sufficiently flexible to let go of the counting sequence in the middle, and to join Dan's focus of interest.*

As Dr. Beebe leaves the dyad in the room, Dan gives mother a cute face with pursed lips, and Mother matches it. Then Mother makes a partial "mock surprise" face, just as the door is closed. Dan says, "Bye", and Mother says, "Bye-bye." *This sequence shows very nice facial and vocal tracking by Linda.*

Pointing to a toy, Mother says, "Want this one?"

Dan: "Where's Dad?"

Mother: "Dad is outside" (looking down with lip-in).

Dan frowns and grimaces. Then he looks to the door.

Mother looks down again, with lip-in.

Dan looks at the door, with a whimper sound.

Mother: "Daddy is outside and you'll see him in a few minutes."

Mother picks up a toy saying: "What color is this?"

Dan: "Blue"

They make eye contact -

Mother: "Yes, that's right. It's blue."

Dan smiles at Mother.

Mother responds with large happy smile.

*Dan seems to have had a separation reaction when the door was closed and his father was now outside the filming chamber. Linda seems to have felt disappointed or rejected. She tried to distract Dan with a toy, and he responded well. It was Dan's ability to tolerate being separated from his father, and his flexibility to come back to his mother, that essentially repaired the momentary disruption. For her part, Linda was very receptive to the repair. Later in the interaction a very similar sequence occurred, and it was resolved in the same way.*

In this session Dan is having trouble tolerating the microphone on his neck. Mother initiates a game to distract him from being upset about the microphone. It is again the game of moving the puppet in toward Dan's belly. Dan clearly knows the game, expects all the moves, and he likes it. He laughs and Mom says "Oh Wow!", smiling broadly.

*Comment:* *This is essentially a positive interaction between Dan and Linda. Linda is more flexible in her ability to join Dan, and she shows very nice facial and vocal*

*tracking. She is however having some difficulty with Dan's separation reaction with his father. Dan for his part disrupts their interaction by asking about his father, but he can flexibly re-join his mother. Dan makes only one whimper sound in this sequence.*

### **Processing of Sixth Videotaped Interview With the Parents**

Dr. Beebe (to the parents): "Where are you now? What is the same and what is different?"

Mother: "I changed because Dan changed. He's now responding better to me so our relationship is so much easier."

Father: "My relationship to Dan has changed. I feel closer to him. I feel I connect more with him. We have our own games. I know what he likes now."

Dr. Cohen: "How well he communicates what he wants now. He doesn't seem to be in that constant state of feeling misunderstood. There's a lovely give and take flow."

Mother: "I love this stage. His father got closer to Dan. Not that long ago, Dan didn't care if his Dad left. Now, he asks, where's Daddy? Aron gives him more attention now, stays with him longer, makes up games with him. And now Dan grabs his father's face and kisses him."

Father: "Linda is also closer to Dan. And with language, its easier. Now they are pals."

*In this sequence, each parent tells the success of the other. In the half dozen couples sessions held primarily in the first year of Linda's treatment, this ability to admire and support the other was one of the essential themes that Dr. Cohen had emphasized.*

Dr. Beebe: "Could you describe the changes from the beginning?"

Father: "Dan is like a different kid. Someone dropped off a new kid. And Linda too. The same person dropped off a new wife. It was a package deal! We're so much more together. Things just don't get Linda down the way they used to since she's been in treatment with Phyllis. Now we even handle big things together. It's unbelievable. It's like night and day, especially with Dan. I'm so happy that the thing with Dan did not destroy her. She did whatever she had to do. She made the appointments. She went to Phyllis. She came to Dr. Beebe.

Linda: "My husband made it possible. His coming with me made all the difference. And the way

Phyllis hears me. She never judges me. It's not something I'm used to. Phyllis lifts us up to where we could be. Phyllis never made us feel crazy. She made us feel good. Nothing was a problem; she kept me calm. When I met Phyllis, what a find! (During this conversation Dan is watching intently).

Both parents felt that they did not need more therapy with Dan. We agreed that Dan was now much better, and we would have a follow-up in a year.

### **Seventh Videotaped Intervention: Follow-up – Dan at 38 Months**

#### **Linda and Dan**

Dan has a wonderful concentration on the toys with directed symbolic play and a beautiful smile, excitement and pleasure in the play. He is verbal now. He actively plays with his mother. Mother is calm with sweet smiles. She knows the characters that he's involved with, actively participates in the drama, and shares his humor. Linda usually shares and elaborates Dan's focus. A few times she changes it.

The session begins with Linda and Dan seated at a table, Dan playing with a toy on the table.

Dan: No this goes over here. He stays home

Mother: He stays home? (matching his vocal contour).

*In this opening sequence Dan is very clear about what he wants*

Dan: What is he?

Mother: He's a doggie (they look at each other and smile).

(Both are using the toy figures:)

Dan: Bye

Mother: Bye

Dan: They're going to school

Mother: Okay

Dan: Bye

Mother: Bye

Dan: Bye school bus

*In this sequence mother follows Dan's lead.*

Dan: Let's go back in the car - (He puts the toy people in the car) - Get ready for the ride.

Mother: Wow! One of the people fell out.

Dan: Get in the car - let's go in the car now - ok?

Mother: Are they going to school?

[Dan arranges the people in the car]

Dan: Let's park the school bus

Mother: Hi children - Oh you're home from school now -

Dan: Good!

*In this sequence mother participates actively and elaborates Dan's storyline.*

Mother: Hi children. Did you have fun in school today? Who wants a snack?

Dan: I want a drink

Mother: What kind of drink do you want?

Dan: Juice.

Mother: Who else wants some?

Dan: Me! (He raises his hand enthusiastically, then pretends to drink the juice).

Mother: How was school today children? I love you! Are the other children wearing their seat belts?

Dan: They're scared.

Mother: Why?

Dan: Because they don't have their seat belts on.

Mother: Tell them not to be scared.

Dan: Don't be scared!

[They both laugh]

Dan: I yell at them.

Mother: No! (With a sinusoidal contour to her voice).

Dan: I have to park the bus here.

Mother: Oh! Ok

[He goes to get another toy]

Mother: You can play with it.

Dan: What's this?

Mother: A puppet - It's a rooster

Dan: Cockadoodledoo!

[He bites the puppet - Mother plays at having the rooster puppet bite Dan]

Dan: He bites me. He's going to get punished now.

Mother: Oh no! What did he do?

Dan: He eats me.

Mother [to puppet]: Did you eat him?

Dan: Yeah. (he laughs)

*Comment: From 5 ½ to 38 months there is a remarkable transformation of Linda's game of going "into the belly," as she and Dan elaborated and changed it. At 5 ½ months Linda went into his Dan's belly with her hands, with high intensity, saying for example, "gooda, gooda, gooda." Dan would look away, turn away, and self-soothe. The game did not generate anything positive for Dan. At 17 months a variant of this game was played by mother moving a puppet into Dan's belly. In this version of the game, Dan responded by laughing, but he was also quite distressed by it. Mother "rode over" his distress several times, whereupon Dan finally asserted a strong "No!" Linda accepted the no. But as the 17-month session progressed and mother continued to insist on the puppet while Dan wanted another toy. Increasingly Dan's protests took on the form of whimpering, grimacing, frowning, and turning away.*

*At 22 months Dan had a great deal of flexibility, as well as increasing capacity to protest. Although Linda superimposed her own agenda with the puppet game, changing the focus from his interest in a toy, he was able to go with her agenda in a very flexible way, giggling and laughing. Each time as Linda moved into his belly with the puppet, Dan reached for it, integrating his own initiative into the game. When Dan finally sobered, mother would over-ride it, and escalate the puppet game, going into his stomach with the puppet while saying, "Don't eat Dan," with a squirreling/eating sound. Even so, Dan would laugh. But when mother finally took the puppet and pushed it right into his face, Dan squealed and said "No!," forcefully pushing the puppet away, pulling it right out of mother's hand, and he put it in the house. They both then laughed and squealed. Finally he oriented away and pursued his own toy. The game was well on its way to being transformed, and Dan did not have to go limp and turn away to set boundaries.*

*At 26 months Linda distracted Dan from the microphone with a puppet game of going*

*into his belly. He knew the game well, anticipating the moves, and he liked it. He laughed, and mother said, "Wow." At this point the game has been transformed into one of positive expectations. At 38 months we see some signs of identification with mother. Whereas earlier mother would say, "Don't eat Dan!" to the puppet, Dan now plays the part that mother played, of pretending that the puppet bit him and ate him. Dan complains, but laughs. The game is transformed into something fun, but he acknowledges something disturbing as well, since the puppet should get punished. Thus at 3 years Dan replays a game he has played with his mother since infancy: he reproduces the interaction of the puppet biting him, and saying no to it. He adds the idea that it should be punished. At this point the original game is transformed into verbal and symbolic play, and the aggressive component has been transformed into something playful and not really harmful. A hint of "playful" aggression remains.*

### **Dr. Beebe and Dan at 38 months**

BB: Is it a long drive?

Dan: It's far - Daddy's driving and I'm in the car seat and I'm sitting over here.

BB: What do they say?

Dan: They're singing Barney songs and Sesame - he sings it and smiles and looks at door.

[He makes eye contact with big smiles.] This is Daddy's car - Here's a window. We're going to Grandma - she's over here.

BB: Hi Grandma. Is she here?

Dan: No, that's Mommy.

BB: What does Grandma say?

Dan: I love you. Whish Whish Whish - Daddy's driving in the rain.

BB: Where are we going? [ he looks and smiles] What's that?

Dan: He puts the swing upside down and the baby falls out.

BB: Ooh!

*Here Dan seems to represent something of his own story in the idea that something bad happened to a baby. Dan immediately began to play another game with a doggie and BB followed his lead.*

Dan: Let's go home mother - we're tired... (he moves the bus around) The doggie bit me - it's going to bite his head Then he's going to pull his hair. Goodbye doggie - I'm throwing you in the garbage - we're putting him to sleep - (To BB) he does ruff ruff at you. Ruff ruff. He's biting you.

BB: He's biting me - but it doesn't hurt -

Dan: (Yells at the dog) - don't wake up - don't wake up [Now he gets other figures and begins to play a new game]. He sings a song, "How old are you now?" Then Dan checks the doggie]

BB: It's ok - he's in there.

[He listens and looks toward door] -

BB: you can hear Mommy and Daddy talking? Let's go find them.

*Here Dan again represents something threatening. It is interesting that the aggression is again "oral," similar to the biting of the puppet in his mother's game. The aggression is briefly turned against Dr. Beebe, something that he does not do with his mother.*

### **Processing of Seventh Videotaped Intervention With the Parents**

Father reports that Dan can be moody. It's hard to wake him up from sleep or a nap. He has a temper. But if he's moody he can usually get out of it quickly. Mother reports that he is afraid of things, like dogs: "He's very cautious - even more than I am!"

Dr. Cohen and Dr. Beebe commented that Dan was able to tell Dr. Beebe about his fear of the dog. He was able to throw the dog in the garbage - then he put the dog to sleep and was able to return to the play. We suggested that the fear of the dog was a way of verbalizing the distress, a way of working on it. We also commented on Dan's strong exuberance and rich imaginative, symbolic play.

## DISCUSSION

### The Individual Treatment.

The use of a consultant within an individually oriented psychoanalytic treatment is a delicate process. It requires considerable flexibility on the part of the therapist, the patient and the consultant. In this case, it was essential that Dr. Cohen and Dr. Beebe were united in their perception of the necessity to treat the mother-infant system, as well as the mother individually. Once the core of the mother-infant mismatch was on its way to being resolved, Linda was freed to pursue her own treatment in a more traditional fashion. After Dan was approximately two years old, he was no longer such a central issue in the treatment, and Linda's own identity expansion took center stage.

### Parallel Dyads

There were many parallel dyads involved in this treatment: Linda and Dan; Linda and Dr. Cohen; Linda and her husband; Linda and Dr. Beebe; Dan and his father; Dr. Cohen and Dr. Beebe; Dan and Dr. Cohen; and Dan and Dr. Beebe. In the beginning of the treatment Dr. Cohen set the stage for the inclusion of a wider set of dyads by inviting Linda's husband to attend a few couples sessions, as a partner in the therapy process. She was influenced by a child therapy model of including parents as collaterals in the child's therapy. The parents are consulted and become allies, instead of feeling threatened and excluded, potentially sabotaging the treatment.

By inviting Linda to bring Dan to the individual therapy sessions, Dr. Cohen included another critical dyad, Linda and Dan. By bringing Dr. Beebe into the treatment as a consultant, the field was greatly widened, opening the possibility that Dr. Beebe would form bonds with Linda, her husband, and Dan.

The dyad of Dr. Cohen and Dr. Beebe became pivotal to the success of the mother-infant treatment. Each of us felt that the presence of the other greatly enhanced our ability to do this work. Dr. Cohen's flexibility in making an emotional "place" for Dr. Beebe to have a powerful bond with each of the members was critical to the success of the treatment. For her part, Dr. Beebe had to balance the dual roles of "expert," as well as a participant in the family's world, entering their

fears and their pain.

### The Dyadic Treatment of Linda and Dan: Theory of Interaction

The mother-infant treatment utilized a theory of interaction in which each partner simultaneously participates in self- and interactive regulation (see Beebe, 2001; Beebe, Jaffe, & Lachmann, 1992, Beebe, Lachmann & Jaffe, 1997). Each brings his or her own temperament, regulatory style, and modes of coping. At the same time, within an intimate face-to-face encounter, each affects and is affected by the other's behavior, moment-by-moment. On a split-second basis, each partner's gaze pattern, orientation, facial expression, touch, and vocal rhythm and cadence affects that of the other. Furthermore, the way that the self-regulation of each partner proceeds will affect the success of the interactive regulation, and vice-versa. At any point either party can change the interactional matrix, since the interaction is part of a reciprocal feedback loop (Bateson, 1972).

Both Dan and Linda brought difficulties to the relationship. Linda brought her own difficult childhood, including incomplete mourning of her mother, complicated by an idealization that had protected her from facing the extent to which her mother had failed to nurture, and had turned to Linda for nurturance instead. Linda also brought a very conflictual relationship with her aggressive father. In addition, Linda had various transferences to Dan, both in terms of the longing for the mothering she had never had, and in terms of imagining Dan's rejection of her, possibly based on her own father's rejections.

### Postpartum Depression

Linda also suffered from a severe postpartum depression. In the last decade, infant research has learned a great deal about the interactions between depressed mothers and their infants (see Field, 1995, for a review). Compared to control pairs, depressed mothers and their infants show fewer positive faces, more angry and sad faces, and tend to match negative states (rather than positive ones as controls do). Depressed mothers show more intrusive or more withdrawn behavior, and infants of depressed mothers show more gaze aversion and vocal protest (Field, 1995; Cohn et al, 1990). When depressed mothers disengage by looking away, their infants tend

to follow the mother into a disengaged state (Field et al, 1990). Some studies show a very low level of mutual contingencies in which each partner's behavior predicts that of the other (Cohn & Tronick, 1989). Maternal depression also predicts lowered infant cognitive scores and insecure infant attachment (Murray, 1992). Thus maternal depression calls for immediate intervention for a mother-infant dyad.

For his part, by the time we saw him at 5 ½ months, Dan brought a high arousal level (agitated foot kicking and nearly continuous self-touching) that was most likely exacerbated in his prenatal and neonatal environment with his depressed mother. Field (1995) has found that 6-month old infants of depressed mothers have high levels of stress hormones (cortisol) at six months. Dan also had some motoric impairment, including hypertonia (a tightness of the limbs) for which he was receiving physical therapy. His movement patterns were inhibited.

### Split-Screen Videotaping and Microanalysis of Face-to-Face Interaction

The use of the videotape and its microanalysis is a powerful method of assessing the exact nature of the difficulty in a derailed mother-infant relationship. Videotaping the infant with mother, father, and stranger provides a wider window on the infant's range of capacities with different partners. It is remarkable that just a few minutes of interaction can reveal the basic pattern of the relatedness. The initial evaluation revealed that Linda's style of engaging Dan was over-arousing for him, and intrusive. Dan was visually and posturally avoidant, and preoccupied with self-regulation through self-touching. They were in a downward spiral of a typical "chase and dodge" pattern (Beebe and Stern, 1977), in which the more the mother experienced Dan avoiding her, the more she went after him, and reciprocally the more he withdrew. Conflict around the moment of visual disengagement, and the mother's difficulty tolerating this moment is one of the most extensively documented problematic patterns in the infant literature (see Beebe & Stern, 1977; Field, 1981, Beebe 2001).

### The Rhythm of the Visits

In this paper we report on seven laboratory filming visits. The first two visits were spaced two months apart, the third visit after 3 ½ months, and the fourth, fifth and sixth visits were approximately five months apart, by which time Dan was 26 months. The seventh follow-up visit

occurred one year later, when Dan was three years old. The early visits were closer together during the time that the infant was at considerable risk. However, we felt that a two-month period between the early visits was necessary for Linda and Dr. Cohen to review the videotape, and for Linda to process the experience of being at the lab, and to digest it at her own pace. The fourth, fifth and sixth visits, at 17, 22 and 26 months respectively, were spaced somewhat further apart because Dan was progressing relatively well. By 26 months the parents felt, and we agreed, that Dan was doing well, and that we could wait a year for a follow-up. Subsequent to writing this report, another follow-up when Dan was four years old found him to be thriving well. Future follow-ups are planned.

### Video Feedback as an Intervention Technique

The specificity of microanalysis reveals the behavioral details of the interaction, which become a springboard for reflection, association and memories. The same sequence can be replayed, and the videotape can be viewed in slow motion, or even paused. The videotape is a concrete record that can be referred back to, rather than a memory which is always subject to distortion. The therapist and the parent together co-construct what they can see and represent, in a collaborative rather than didactic mode. The parent learns to observe both directions of the sequence of the interaction: how the parent affects the infant, and how the infant affects the parent. The parent's motivation to engage the infant overcomes the natural awkwardness at seeing oneself. The videotape itself operates as a "shock" to the unconscious (see Beebe, 2001), promoting a capacity to observe the difficulties, and unlocking distant memories. The parent gradually becomes able to "see". In this sense the videotape itself makes the "interpretation" of the difficulty. The therapist can take on the role of supporting, empathizing, pointing out the positive, and helping the parent make connections to associations and memories, translating procedural knowledge into declarative, facilitating a reorganization of representations of the self and the infant. This process preserves the parent's self-esteem.

"The video microanalysis and feedback method adds a depth and a specificity that would ordinarily be absent in a brief treatment. In fact, even in a lengthy individual treatment, it would still take a

long time (if ever) to identify the interactive organization so quickly identified through microanalysis. There is no time to waste in a mother-infant disturbance, and this method goes directly to the core interactional dynamic. On the other hand, the success of the video method depends on the therapist's sensitive capacity to "hold" the mother: to follow the mother's lead in the treatment and be her advocate; to sense the moment to suggest the video, and how many minutes of video to show; to maintain a collaborative rather than didactic stance; and to *stay with* the parent as the video is shown, alert to any signs of parental distress, particularly shame, humiliation, or feeling criticized, using these empathically to deepen our understanding of the parent's experience of the infant, and of her own inner world and history (Beebe, 2001)".

Through the videofeedback, Linda came to realize that the hungry need she had for Dan (give me a kiss, vigorously going into his body, calling for him when he turned away, asking him if he had eyes only for the toy) was a way of playing out with her baby unresolved need for her own mother. Although she began the treatment preoccupied with the loss of her own mother who had been idealized, in the process of the treatment she came to see that she had also been hungry with her own mother, that her own mother was also hungry, and her own mother had turned to her to fill her needs, at times keeping her home from school to keep her company. At times Linda had treated her baby as she remembered her mother had treated her, that is, too controlling and intrusive. At other times she had treated her baby as if the baby was like her mother who needed to be forced into paying attention to her and nurturing her. The demand that she be nurtured had been out of Linda's awareness. This was a dissociated trauma that she played out with Dan. It was through the videofeedback that this theme came into the treatment. In Dr. Cohen's opinion, it would have taken years to reach this theme in the ordinary progress of psychoanalytically oriented therapy.

In conclusion, therapists of women who are pregnant, or who have a baby, need to be aware of the possibility that some intervention might be indicated, and if so, the earlier the better. The therapist's tendency to see the baby as an intrusion into the individual adult treatment can interfere with a full awareness of the critical need of an infant to bond with the mother, and the mother's reciprocal need for her infant. A therapist might intervene by asking to see the mother and baby interact, or by introducing the idea of using an infant consultant. As adult therapists and psychoanalysts we must not ignore the mother-baby unit.

## References

Alvarez, A. (1992). Live Company. London: Routledge.

Bateson, G. (1972). Steps to an ecology of mind. N.Y.: Ballantine Books.

Beebe, B. (2001). Brief Mother-Infant Treatment Using Psychoanalytically Informed Video Microanalysis: Integrating Procedural and Declarative Processing. Infant Mental Health Journal, under review.

Beebe, B. (2000). Munich Lecture on Disorganized Attachment. Unpublished Presentation.

Beebe, B., Jaffe, J., Lachmann, F., Feldstein, S., Crown, C., & Jasnow, M. (2000). Systems models in development and psychoanalysis: The case of vocal rhythm and attachment. Infant Mental Health Journal, 21 (1-2), 99-122.

Beebe, B., Jaffe, J., & Lachmann, F. (1992). A dyadic systems view of communication. In N. Skolnick & S. Warshaw (Eds.), Relational perspectives in psychoanalysis (pp.61-81). Hillsdale, NJ: Analytic Press.

Beebe, B., Lachmann, F. & Jaffe, J. (1997). Mother-infant interaction structures and presymbolic self and object representations. Psychoanalytic Dialogues, 7 (2): 133-182.

Beebe, B. & Sloate, P. (1982). Assessment and treatment of difficulties in mother-infant attunement in the first three years of life: A case history. Psychoanalytic Inquiry, 1: (4), 601-623.

Beebe, B. & Stern, D. (1977). Engagement-disengagement and early object experiences. In N. Freedman and S. Grand (Eds.) Communicative structures and psychic structures. A psychoanalytic interpretation of communication. (pp.35-55). N.Y.: Plenum Press.

Bower, T., Broughton, J., & Moore, M. (1970). Infant response to approaching objects. Perception and Psychophysics. 9: 193 –196.

Bronfman, E., Parsons, E., & Lyons-Ruth, K. (1999). Atypical maternal behavior instrument for assessment and classification: Manual for coding disrupted affective communication. Version 2. Harvard Medical School.

Burlingham, D. (1951). Present trends in handling the mother-child relationship during the therapeutic process. In Psychoanalytic Study of the Child, 6: 31-37.

Cohn, J. & Tronick, E. (1989). Specificity of infants' response to mothers' affective behavior. J. Amer. Acad. Child & Adolescent Psychiat. 28, (2), 242-248.

Cohn, J., Campbell, S., Matias, R., Hopkins, J. (1990). Face to face interactions of post partum depressed and nondepressed mother infant pairs at 2 months. Developmental Psychology, 26, (1), 15-23.

Field, T. (1995). Infants of depressed mothers. Infant Behavior and Development. 18, 1-13.

Field, T. (1981). Infant gaze aversion and heart rate during face-to-face interactions. Infant Behavior and Development. 4, 307-315.

Field, T., Healy, B., Goldstein, S. & Guthertz, M. (1990). Behavior-state matching and synchrony in mother-infant interactions of nondepressed versus depressed dyads. Developmental Psychology, 26, 7-14.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. Journal of the American Academy of Child Psychiatry, 14, 387-421.

Furman, E. (1992). Toddlers and their mothers: A study in early personality development. Conn: International. University Press.

Kaminer, T., Beebe, B., Jaffe, J., Kelly, K. & Marquette, L. (2000). Maternal depression, maternal speech, and infant gaze at 4 months. International Conference Infant Studies, Brighton, England, July.

Main, M. & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. In M. Greenberg, D. Cicchetti, & E. Cummings, Attachment in the preschool years (pp. 121-160). Chicago: Univ. Chicago Press.

Malatesta, C. Culver, C., Tesman, J., & Shepard, B. (1989). The development of emotion expression during the first two years of life. Monographs of the Society for Research in Child Development 54: (1-2), Serial 219.

Morgan, A. C. (1997). The application of infant research to psychoanalytic theory and therapy. Psychoanalytic Psychology, 14: (3), 315-336.

Murray, L. (1992). The impact of postnatal depression on infant development. Journal of Child Psychology & Psychiatry 33 (3), 543-561.

Stern, D. (1971). A microanalysis of the mother-infant interaction. Journal of the American Academy of Child Psychiatry, 10: 501-507.

Stern, D. (1977). The first relationship: Infants and mothers. London: Fontana, Open Books.

Stern, D. (1995). The motherhood constellation. New York: Basic Books.

Tronick, 1989. Emotions and emotional communication in infants. American Psychologist,  
44: 112-119.

Winnicott, D. 1960. The theory of the parent-infant relationship. In The maturational processes and  
the facilitating environment, London: Hogarth (1965).