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Extending the field: parent-toddler psychotherapy inspired by mother-infant work

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Extending the field: parent–toddler psychotherapy inspired by mother–infant work

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Many psychotherapists working with infants and parents have extended their practice to toddler–parent therapy. This paper presents such work, developed from a psychoanalytic mother–infant therapy mode. Like other published therapy techniques, it invites both parent and toddler to take part in treatment. Similarly, it also takes into account the specific challenges facing the developing toddler and his/her parents. Here, however, focus is placed more clearly on the therapist's interaction with the child, in the presence of the parent. This involves addressing the child about what the therapist intuits are the unconscious motivations behind his behaviour in the session. It also implies speaking about the child's feelings towards the therapist. In parallel, the parents' emotional attitudes towards the therapist are viewed as vehicles that may further the therapeutic process, once they are spoken about. A suitable metaphor is couple therapy, provided one bears in mind the differences between parent and child regarding developmental levels and motivations for therapeutic work. The paper contains a detailed account of a psychotherapeutic treatment with a two-and-a-half-year-old boy and his mother. Based on this presentation, the author compares his work with that of other authors.

Keywords: parent–toddler psychotherapy; mother–infant psychoanalytic treatment; parent–child interaction; containment

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Introduction

This paper describes a therapy mode with toddlers of between two and four years and their parent(s), which was developed from experiences with psychoanalytic mother–infant therapy. This extension of the field is not self-evident. An infant does not speak or understand words. In joint therapy with his parent, whether we address the parent about his/her 'ghosts' (Fraiberg, 1980) or the baby to contain his anxieties, he cannot respond verbally. Our impressions and interpretations of his reactions will be based on intuitions, however accurate they may prove to be later on. A toddler, in contrast, allows us to enter into a verbal dialogue that is, at least to a certain extent, mutually comprehensible.

Another shibboleth is that babies are dependent on the parent's physical presence. Thus, individual therapy with a baby is unthinkable. A toddler, in contrast, might play by himself at length and even be alone with a stranger. However, being alone with a therapist for more than a few seconds will elicit anxiety. The situation will resemble the Strange Situation Inventory (Ainsworth *et al.*, 1978), especially that part when the parent leaves the child to be alone with the stranger. Since the toddlers we meet as

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therapists are most likely to be insecurely attached, it would be counterproductive for us to work with them alone.

Yet the toddler's need for the parent's immediate presence, as well as his anxiety evoked by the therapist's participation, may be turned into an advantage. Once we offer parent and child a safe and well-contained therapeutic setting, they may enact individual and shared fantasies lying at the root of their disorder. The therapist may explain to the parent the developmental struggle beneath the child's behaviour. Or, s/he may describe the child's attachment anxieties. Finally, s/he may interpret the parent's 'ghosts' (Fraiberg, 1980) and the ensuing projective identifications onto the child. As seen in the literature survey, variations of these techniques have been suggested.

The therapy mode presented here sprang from experiences with psychoanalytic parent–infant therapies. Here, the infant is seen as a subject (Salo, 2007) likely to develop a specific relationship with the therapist (Salomonsson, 2013) and be responsive to analytic containment (Norman, 2001). In the baby's struggle with fear, longing, sadness, rage, confusion and despair, he has tried to interact with his parents to get containment. If this proves to be of no avail, he might erect primitive defences, such as gaze avoidance *vis-à-vis* the parent (Fraiberg, 1982; Salomonsson, 2014a). Their aim is to ward off internal distress, while they inevitably affect the parents as well. Hence, a vicious interactive circle gets started. Once the therapist directs his attention to these strivings of the baby, he may notice that the child seeks to involve him as well for containment. Interactive patterns similar, though seldom identical, to those between parent and child might commence between the two. This phenomenon forms an important leverage for therapeutic work.

Having made such observations of infants and mothers, and how they interacted with each other and with me, I hypothesised that this technique could be extended to toddlers and parents. An assignment as a consultant psychoanalyst at a Child Health Centre (CHC) enabled me to test the hypothesis. In Sweden, these are government-funded clinics where parents bring their babies for check-ups including inoculations, weighing and measuring, as well as getting advice on nutrition and other aspects of childcare. Visits follow a schedule: weekly the first month, monthly up to four months, and every second month during the rest of the first year followed by check-ups at 18 months, three, four and five years. The CHC where I work consists of 10 health visitors, a paediatrician and a general practitioner.

My task is to supervise the health visitor team and provide brief family consultations. The supervisions aim at promoting the health visitors' ability to detect emotional problems and inspiring them to broach these issues with the parents. Many parents have 'baby worries', which they vent with the CHC health visitor. If she feels it is appropriate, she may recommend a few consultations with me. My office is adjacent to a health visitor's office, which allows parents to take up the offer fairly easily. If a lengthy therapy is needed and feasible for the family and myself, I have a valuable opportunity to investigate how a disturbed behaviour in a child may be rooted in her internal world. The paper describes one such therapy, discusses the rationale for the technique and compares it with other authors' techniques.

Background to the case

Health visitor Danielle has been told by a mother, Bridget, that she feels depressed. Danielle suggests a consultation with me. I meet a grey-hued and slightly worn-out woman who, I conjecture, had once looked happier in her life. Emotions pass swiftly

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across her face: despair, joy, concern, fear, sadness and exhaustion. She doesn't sleep well and has a hard time managing her boys. When she only had Walter, it was OK. He is now two and a half years old. But since Bruno was born nine months ago, she has no energy left.

She expresses herself cautiously and doesn't like 'poking about' in her worries. But there is her gastritis, her stress, her feeling worn out … She works as a gym teacher and describes herself as dutiful and a bit stern towards herself. Ron, her husband, is her colleague with whom she has many things in common. "But I have no go nowadays, so marriage isn't much fun. That goes for my Mum-feelings too." She adds that she has never seen a psychiatrist or a therapist.

I ask how the troubles started. She mentions insomnia again – this time not hers but Walter's. He cannot fall asleep on his own and often wakes up. A light sleeping drug has been of little help. One of his parents must sit with him for hours, otherwise he lies awake. "Something seems to worry him," she says. Bridget adds that the troubles started "when Walter returned from the hospital". During her pregnancy, a routine ultrasound showed an intestinal malformation. The doctors explained that an operation after delivery was crucial to enable the passage of food. Delivery went well and the operation was performed instantly without any complications. "Walter and I returned home after two weeks. Since then he has never slept normally." They were not recommended any psychological support and did not feel it was necessary. "Everything was OK, I was breast-feeding, and he gained weight and developed normally except for his sleep." At one year, a CAMHS psychologist suggested that the parents should sit close to Walter until he fell asleep and then cautiously move their chairs towards the exit of the room. "It worked so-so."

Bridget continues, "Then Bruno was born and the second problem arose." Bridget refers to Walter's violence towards his little brother and her feelings about it. The parents must watch them constantly, otherwise Walter hits Bruno. "I show Walter love and attention. But he's jealous anyway. So, I feel guilty about Bruno and upset with Walter." Mother is weighed down by her failure to solve the problem. When I suggest she come next week and bring both boys with her, she willingly accepts.

Comment

Bridget's postnatal depression is apparent; there is a lack of zest and joy, feelings of guilt, anxiety and stress, symptoms of gastritis and insomnia, and finally, a connection with Bruno's birth. Accordingly, one might recommend antidepressant medication. In addition, associations have been demonstrated between prenatal stress and sleep disturbances in newborn children (Field *et al.*, 2007; Glover *et al.*, 2008; Marcus *et al.*, 2011). According to a biological explanatory model, the child's stress tolerance is decreased because mother's perinatal stress has affected the hypothalamic–pituitary–adrenal (HPA) axis and secondarily, the child's cortisol levels. I might explain this to Bridget and tell her that things will probably be better in the future.

The interview also invites psychodynamic speculations: Bridget's worries about the foetal malformation, the anxiety about the operation, Walter's insomnia and her exasperation, anger and guilt that she cannot protect Bruno from his brother's attacks. Not only do I ponder on how the parents' fantasies about their future child were affected by the message about the malformation, I also wonder about the impact of

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Walter's operation. His insomnia might indicate that anxieties – in him, in the parents and/or in their relationship – were never properly allayed. If so, this might cast a shadow – though the mechanism is yet unclear – on his present relationship with Bruno. This tentative model seems important to investigate in psychodynamic therapy. I prefer this approach to pursuing a biological model, which aims at adjusting her brain biochemistry or a pedagogical model that involves explaining research findings about prenatal stress. Such measures may be necessary but not in this case, since Bridget asks neither for drugs nor for explanations. She asks for help and seems interested in pursuing this path with me.

Meeting with the two brothers

Next week, I find Bridget playing with her two sons in the waiting room.

Unabashed, Walter runs into my office while Mum is tidying up after the boys. During the one minute I am alone with him, he exhibits fierce jealousy and possessiveness, seeing a box of crayons and yelling, "It's MY box!" He asks me to open it and then howls, "MY crayons!" He sees another box, "MY box too," and tears it open. He is sitting, triumphant, with 30 crayons, "MY crayons!" Meanwhile, I am reflecting on my feelings of repugnance and provocation.

Mum and Bruno enter the room. Walter exclaims, "MY crayons!" and kicks Bruno. Mum looks aggrieved and I feel even more ill at ease with Walter's violence. Bruno seems accustomed to it and keeps smiling. Mother exhorts Walter in vain to share the crayons with Bruno. I start addressing Walter with two aims. One is to convey, through my interpretations, how I think his behaviour is ruled by affects that he seems to ward off. A parallel aim is to create a setting where these affects can be investigated, rather than being acted out in the form of violent behaviour.

Analyst to Walter: *You want all the crayons. Bruno shouldn't have any. I guess you're mad at him.*
Walter: *MY crayons!*
Analyst: *Well, actually, they're my crayons. But you may borrow them. You want them all for yourself. Now I'd also like Bruno to borrow some.*

Walter looks petulant as I give Bruno some crayons. Unexpectedly, a truck is heard outside. He looks at the window to see what is humming. I lift him up so that he can have a look. Suddenly, he weeps and panics.

Walter: *I go away. Away!*
Mother: *I don't recognise this …*
Analyst: *Walter, you got scared and want to run away. I think it's better if you stay and we try to find out what is so scary.*

Comment

When Bridget reflects that she is unfamiliar with his behaviour, she is already an interested participant in therapy. I might therefore share with her my speculations about Walter's behaviour. However, at this point, I want to enlist Walter as an active participant by clarifying to him the setting and following up on the emotions that my stance elicits. The rules and the logic of the setting are as follows: we will remain in my office, violence is not accepted, Bruno's rights will be attended to, the crayons are mine but I willingly lend them to Walter as tools of our joint investigation, which aims

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to comprehend the emotions behind his unruly behaviour. I thus preside over the transference (Meltzer, 1967). Clarifying the setting kindles a negative transference, as evidenced by his sulkiness and, I speculate, by the truck incident. The next interchange indicates that a parallel positive transference is nascent as well.

Analyst to Walter: *You wanted all the crayons. Then you kicked Bruno. Mum and I saw it. Then the car came. You got scared ... Now you're scared of my room. It's spooky in here ... But it's better you stay, then we can talk about it.*

Walter listens attentively. Mum gives him the pacifier and he calms down. She suggests, "If you take out the dummy you can tell us what's scaring you." But Walter wants to keep it in his mouth.

Comment

Bridget's suggestion that Walter takes out the dummy to talk probably reflects her nascent identification with my perspective. As for his attentive listening, I interpret it as a burgeoning positive transference. I suggest to Bridget that Walter met with an 'ugly' feeling in my office, and the lorry turned into a kind of policeman roaring, 'I know your ugly thoughts about Bruno'. She listens but does not comment. A little later, she says it is difficult to think about the problems at home, where she must constantly make peace between the boys. In contrast, she says it is good to have a place here, where she can think. In this way, she does not immediately confirm my interpretations, which would have been astounding after our brief contact. Rather, she seems to appreciate that she is offered a place for reflection, and that this may lead to a different form of thinking than she and her husband have been using so far. Thus, on the one hand her son has suddenly become more difficult to understand; "I don't recognise this …" On the other hand, she has become interested in another mode of thinking and in another thinker; the containing therapist.

A new quarrel follows about a pencil that Bruno holds in his hand but which Walter wants. When he does not get it, he grabs eight soft cuddly toys and refuses to give any to Bruno.

Analyst to Walter: *You want everything for yourself. Nothing to Bruno! You're mad at him, that's why you kick him. Then you get afraid ... Now you put your dummy in your mouth, but actually you don't need it. Why don't you take it out again, so we can talk?*

To my surprise, Walter follows my advice. Later I add, "You think Bruno is silly. You wish there was no Bruno. But he is here. So, what should you do?"

Comment

My sentences are interspersed with Walter's silent and attentive nodding of his head. I take this to confirm not that he has understood my interpretations' verbal content literally but their crucial ingredients; he is angry with Bruno, I have noticed this, I take an interest in it, and I do not condemn him – though I want to prevent the violent consequences. In other words, Walter grasps not only that there is some disturbing feeling inside him, but also that I accept him as a very angry boy.

Following our dialogue, Walter lets go of his brother. He empties the toy box and puts it on like a hat. He looks happy and Mum is laughing. He holds a fish in his hand and Mum sings a song about a fish. Walter is happy and has forgotten, right now, his jealousy. He sees a pair of slippers and checks if he may play with them. I nod in consent. He exclaims, "Your shoes!" and tries to put them on me. We are both laughing that they are too small. He then puts them on himself and walks proudly across the room. I tell him, "Earlier, you wanted to be a little boy. Now you're feeling better. It feels good to be bigger, almost as big as me." Bridget smiles warmly.

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Comment

Walter seems to identify with aspects he perceives in me: being big and friendly, and having fun and sharing interesting thoughts. He is literally 'walking in my shoes'.

I now suggest to Bridget that she come with her husband Ron next week. I also suggest that she and Walter start a joint therapy with me once weekly. I point out that Walter has shared strong feelings with us; he seems to suffer from them and has noticed my interest in understanding them. She consents and tells me that the family will soon be moving to another faraway town.

I have several arguments for suggesting a therapy. Walter can only handle his jealousy and anger through fighting. His mood and ego-functioning change swiftly. His insomnia persists. I also assume he has a dictatorial superego who 'saw' when he was kicking his brother. I guessed this was why he wanted to run away when he heard the lorry. Cathy Urwin (2008) reminds us about the suggestion by Klein (1934) and Winnicott (1956) that a ruthless child may actually suffer from an intolerable guilt, induced by his violence. As a result, he tries to invite the parents to inflict punishment, 'which would at least be time-limited and tolerable' (ibid., 5387).

Walter's relentless superego parallels his unstable perception of psychic reality. Neither I, my room, nor the truck are objects with which he can engage in a pretend mode (Fonagy and Target, 1996). Instead, in terms of his psychic experience, he is unable to differentiate between external and internal reality. The truck is inside and outside him – and it is all very frightening. His unconscious internal monologue can be sketched: 'I'm mad at my brother. I kick him. He cries and I get scared. I'm a bad boy. My parents don't like me and I can't stand that. I'm not bad – the truck's bad and is haunting me! The truck is me as well.' His terrifying internal objects are reflected in his behaviour towards Bruno and his panic at the lorry's noise. Their harshness is perhaps not only nourished by his fraternal jealousy, but also from the operation in infancy and the anxious climate at the time. This latter idea remains as yet an unproven conjecture. These considerations make me assume that one or two consultations will be insufficient. I suggest we work for 14 weeks, until the family moves from town.

Crocodiles

When I meet with the parents, Ron, the father, is much angrier with Walter than Bridget. He feels sorry for her and Bruno when Walter behaves badly. He describes him as reckless and wild, and when I tell them that he seems scared of his rage, they are surprised. They have never thought about Walter in this way, probably because they are down in the trenches and find it hard to empathise with him.

For the first mother–toddler therapy session, I have arranged a toy box for Walter. The reasons are the same as in therapy with older children: to offer a space where he can express himself as freely as possible. There is a sketchbook, crayons, some little

dolls (a sailor boy, king, queen, witch, bumble-bee), a family of pigs and a German shepherd dog with open jaws. With this little collection, he may express fantasies that I assume centre on oral-aggression, tenderness, family life with its tensions, fears and aspirations, and himself as a cheerful sailor boy.

Walter steps right into my office greeting me with, "Hi Björn". I respond and show him the toys in the box. He picks out the dolls and throws them at me, one at a time, with a mixture of force and happiness. "Soft things," he says. Finally, I am holding all the dolls in my hands and he tells me to throw them at Mum, which I do. Then he orders her to throw them at him. This triangular play goes on for a while. He picks up the sketchbook saying, "Draw crocodile," which he does. He orders me and Mum to do the same and delights when we do it. Bridget seems to enjoy her son's exultant and intrepid attitude.

Comment

Ever since Freud (1905) and Abraham (1927), psychoanalytic theory has assumed that an infant tends to express curiosity, love and anger through the mouth – and that later in development, his relationship to the oral world will colour his personality. Two events in Walter's life were probably stressful and occurred when the oral zone still carried a major significance: his post-operative insomnia and his violent aggression after Bruno's birth. I imagine the crocodiles with their perilous teeth symbolise the accompanying emotions. I also intuit that there is a link between the reptiles in this session and the truck in the first interview. His anxiety about the vehicle appeared after he had been pitiless with his brother and I had explained that Bruno could use the crayons. I surmised that his petulance expressed his suppressed anger with me. This anger was then turned into an avenger towards himself – in the form of a roaring truck. The truck might therefore symbolise both his rage and his superego's austere penalty for his 'ugly' feeling. I formulate these hypotheses to myself while I address Walter.

Analyst to Walter: *Yes, crocodiles are scary. You're afraid of them. You want to draw many crocodiles so they won't be scary. Mum and I should draw them, too.*

Walter: *Draw crocodiles!*

Mother: *We were at the Zoo last summer, he saw some crocodiles there. I guess that's why he's so fascinated by them.*

Analyst: *You may be right but I also think Walter wants to tell us something. We know he's angry. Maybe he wants to bite like a croc but doesn't dare to.*

Walter goes on drawing, his eyes becoming increasingly warm and enthusiastic. Bridget looks warmly at her son. I suggest, "You like that chap, don't you?" She smiles tenderly.

Comment

The practice of gathering Walter's desires and fears into the transference (Meltzer, 1967) already pays off. Before therapy, Walter had no phobias. He was just ruthless and sleepless. Therapy unsettles this balance: I set limits but do not punish, I take an interest in his violence but do not condone it and I am attentive to his emotions without impugning his right to harbour them. The setting provides a sanctuary (Britton, 1998) where he is held in a safe and boundaried place and it offers him an encounter in which I describe to him the underlying meanings of his experiences and behaviour.

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His fear of the truck and anxious fascination with the crocs reveal that anxieties underlie his violent behaviour. When they are met with containment and interpretations, Walter relaxes and his warmth and enthusiasm emerge. Up until now, such traits have been smothered under his temper tantrums. At the same time, my feelings for Walter are changing. At the start, I felt repulsed by his greed and violence. These issues are far from being solved, but I now feel that I also have a charming fellow in front of me. In other words, my countertransference has become more varied, with positive and negative feelings alternating.

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Walter whines again

In the next session, Walter enters protesting and whining, "Not go to Björn! Go home!" Mother tells him, "But Walter, when I picked you up at preschool you said you wanted to see Björn!" I assume his behaviour reflects a regressive retreat, as if Walter is declaring, 'No, I'm not an angry and violent chap. I am a sad little baby to be taken care of. I wanna go home and sleep!' He avoids looking at his toy box saying sulkily, "Have dummy". Bridget explains, "Walter wants a pacifier when he is tired." I suggest she wait a little, since we need to understand why Walter is afraid: "You're right that the pacifier will soothe him – but it can also function as a 'plug' for his thinking." Mother and son might feel I am cruel in not condoning the dummy, but I dare take this risk after having seen Bridget's positive reactions to Walter's progress during the last session. Meanwhile, Walter is glaring at me.

Analyst to Walter: *You got angry with me when I asked Mum to wait with your dummy. I understand that … I wonder why you didn't want to enter my room today. Did something scare you here?*

Walter casts a quick glance at his toy box. I suggest we open it. Another furtive glance ensues, this time at the crocodile drawings. Then he avoids them – and me. He seems baffled.

Analyst: *You drew crocodiles. You liked them. Now you're afraid of them.*
Walter: *Draw croc. You too! They must have eyes!*
Analyst: *So they can see if anyone has done some mischief?*

Walter does not answer but goes on drawing crocs.

Analyst: *When you arrived today you were whining and afraid. Now you're happier. Crocs are scary. They bite and their eyes see the silly things people have done. But they can be good, too! Vroom! (In a playful mood, I push my crocodile drawing towards him. He smiles and does the same to me.)*
Analyst: *When you're whining, a croc may help you to bite – in a pretend way. Earlier, you were scared. Not anymore … It's good not to be scared.*

Comment

My 'Vroom' game could be called an enactment ('*mise en acte';* Lebovici *et al.*, 2002: 181) of my feelings during the consultation. These authors suggest that the infant therapist need develop a new 'analytic self, with the attributes of empathy, an ability to construct metaphors ('*un self métaphorisante'*) or to observe them, and the capacity to allow himself or herself to 'become' (temporarily) the parent or the infant to experience – through ideation and somatic sensations – the 'knot' in which the family

is tied up' (p. 180). This often entails the use of humour and spontaneity, as evinced in DVD recordings of Lebovici's work (Casanova, 2000) and perhaps also by my 'Vroom'.

Walter's fear of my office is another offshoot of the gathering of the transference. These events follow the logic described by Meltzer (1967). Not only does the child project his fears and desires on the analyst's person, but also on his belongings. My things become clad with Walter's projections and the counter-projections, which he fantasises emanate from me. The illusory advantage to this phobic mechanism is that, as long as he avoids my room, everything will be fine. The disadvantages are that his interior dilemma remains and that the regression entailed in the temporary phobia damages his self-esteem. Soon however, the crocodile will come to his aid; not as a fearsome avenger but as a symbol of force, brute but tamed.

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A new verve in Walter

Some sessions later, Walter enters my office whining and protesting again.

> *He wants the dummy but this time Bridget says no, resolutely, yet in a friendly way. He opens the toy box, draws a croc, gets tired of it, and becomes interested in the pig family. He forms a group of all four and places the German shepherd a bit aside from them. I comment, "The dog is guarding the pigs so that nothing bad can happen to them." Walter moves the dog inside the pig family. I comment again, "Aha, now the dog is in the family. Earlier, the pigs were afraid of him. Now he's allowed to play with them. I guess they like the dog though he bites sometimes." Walter looks at me happily. Then he starts whining.*

Walter pleading to mother:	*Throw soft animals!*
Mother, while throwing the animals to him:	*It's been a long day today.*
Analyst to mother:	*You often have an excuse at hand when Walter is whining. You don't want to see the German shepherd inside of him.*
Mother with some vexation:	*But he IS tired you know!*
Analyst, while throwing a soft animal to her:	*And he IS angry, too, you know!*
Mother smiling, in a mixture of surprise, playfulness and irritation, as she throws the cuddly animal back at me:	*Hey, you there!*

Comment

Similarly to my 'Vroom' play with Walter, throwing the cuddly toy at Bridget is an enactment or a spontaneous gesture (Winnicott, 1960). It denotes my countertransference vexation with her resistance to seeing Walter's oral aggression, my

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display that anger is not a dangerous feeling, and my invitation to do 'psychotherapy [which] has to do with two people playing together' (Winnicott, 1971: 38). When playing is not possible, the therapist should seek to bring the patient 'from a state of not being able to play into a state of being able to play' (ibid.). This I do now with Bridget and, at other times, with her son.

Walter is watching us closely. Then he starts whining again. With renewed energy mother addresses him.

Mother to Walter:	*But Walter, what do you want? Talking is better than whining!*
Analyst:	*I think you're whining when you're angry or afraid, Walter. You don't have to be afraid of being angry, you know. Someone who's angry may be liked anyway. The pigs liked the dog though he bites sometimes, didn't they?*
Mother:	*That's right!*

At this point, Walter walks up to me, looking straight into my eyes. He bangs the witch doll resolutely on my knee, while smiling warmly and fearlessly.

Analyst laughing:	*There! I got what I deserved, didn't I?*
Walter:	*Draw croc, Björn. Croc silly!*
Analyst:	*Why?*
Walter:	*'Cos it bites.*
Analyst to Walter:	*But crocs have to eat, don't they?*

Walter gets pensive and I address Bridget: Walter is probably using the crocs to show his anger with Bruno – and how scared he is of it.

Mother:	*Funny you mentioned Bruno. I was thinking they're getting along better now. When Bruno grabs one of his toys, Walter tells him not to do it – instead of giving him a beating. It works most of the time. And one day Bruno will be bigger and hit back!*

Comment

This section exemplifies some advantages of joint parent–toddler work. Our interchange about the pigs and the dog might have occurred in an individual child therapy but here, the mother's contributions are included in therapeutic work; mainly her defensive avoidance of her child's anger, a mechanism addressed by Parens (1991), Parker (1995) and Hoffman (2003). When I address her 'excuse', she gets annoyed. Indeed, these therapies are replete with transferences from toddler *and* parent. Authors like Miller and Wittenberg (in Emanuel and Bradley, 2008), and Lieberman and Van Horn (2008), advise against interpreting parental transferences since it may be 'unhelpful to encourage infantile dependency at a point in a couple's lives when they are being called upon to be at their most adult' (Wittenberg, 2008: 928). Parental transferences should only be interpreted when presenting 'an obstacle to the work' (ibid.).

I agree with these authors regarding treatments where parents seek advice and the child is not directly addressed. I take a different view on joint treatments such as the one presented here. I consider it a form of 'couple therapy', where both participants, though on different developmental levels and with different functions, put their conscious and unconscious urges 'on the table'. Walter fears his aggression – and

Bridget fears acknowledging and understanding it. Consequently, she develops a negative transference towards a therapist who keeps reminding her of this problem. Therefore, I see her transference as providing therapeutic leverage, which may help her *and* Walter come to terms with his internal 'German shepherd'.

When I throw the witch at Bridget, I am explicit only about her refusal to acknowledge Walter's anger, whereas I implicitly interpret her anger with me. I could have said, "I think you're angry with me, Bridget" but the witch game emerged spontaneously. She accepted it and showed that she had integrated my message when she told Walter, "Talking is better than whining!" He watched our interchange with interest. When he banged the witch on my knee, he confirmed that he was about to learn that anger is not a perilous feeling. He understood this, not only from his interchange with me, but also from the one between mother and me.

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A glimpse of the primordial trauma?

One of the arguments for a lengthy therapy was Walter's early operation, which I surmised constituted an emotional trauma. Essentially, however, our work dealt with his rage, jealousy, violence and his mother's ways of dealing with this. Now, as the session above is approaching the end, something occurs which perhaps points to the events after birth. I am pondering silently whether any traces of these primordial events remain in Walter. Meanwhile, he silently sits down on my desk chair. Slowly, he is sliding downwards, as if trying to glide under my writing desk.

Walter talking to himself:	*Into Mum. Into Mum! ... They took me away, they took me away.*

These two comments and his funny ballet on my chair make me wonder: is he enacting a fantasy of returning, back 'into Mum'? If so, is it a reaction against the fact that they 'took him away' for the operation? I say nothing, but I notice that mother is fascinated. I share my thoughts with her: "We've never spoken about Walter's operation ... " She starts telling me, visibly moved and pained, about the worries during pregnancy and before the operation, and how she missed him during the surgery.

Mother:	*When we returned home from the hospital, I was not sure I could trust the doctors' reports that everything would be OK. I thought something bad was going to happen anyway.*
Analyst:	*It must have been a very hard time. I was thinking of this period when Walter said, "Into Mum" and "They took me away".*
Mother:	*Yeah, I also noted his words. I've been talking with some mothers at the Child Health Centre about attachment. I wondered if the operation affected his attachment to me.*
Analyst:	*Maybe your attachment to him as well?*
Mother:	*I have always regarded him as a sensitive boy. Maybe I've been pampering him. Sure, it's related to his start in life. It was so taxing! And I felt so sorry for him ... Maybe I've let him have his way too much when is he fighting with Bruno.*
Analyst:	*That's why I don't think your excuses are of much use. It's easier when you tell Walter if what he is wanting or doing is OK with you or not. I know this is easier said than done, but take it as a suggestion!*
Mother:	*I'm working on it. Another thing, and this is no excuse, these things happened in the beginning of his life, and I guess that's why he is sensitive. We used to change lodging quite often before, but we've decided to cut that down now. He doesn't like changes. Such things we can respect of course, but not when he hits Bruno!*

Comment

Sometimes a child exhibits an enigmatic utterance or behaviour. For a therapist who has listened to parental reports of early trauma, it is tempting to link this behaviour with the past events. I had the fantasy that Walter's playing with my chair and his comments "Into mother" and "They took me away" were related to the operation. It is easy to refute this idea; if any memories should persist at all, they must be implicit and nebulous. I have cautioned (Salomonsson, 2014b) against imputing recollections of early memories. Walter has no explicit recall of these events. In contrast, Bridget's comments reveal that they have been, and still are, part of the family canon and colour the parents' relationships with him: how they view him, handle him, and what they expect of him. This is evidenced by Bridget's comment that Walter was always a sensitive boy, which she relates to the operation.

Walter may have heard about the operation later and then created fantasies about getting 'into Mum' in order for 'them' not to 'take him away'. Or, he may never have heard about it but has observed Mum's frightened eyes when her old fears suddenly re-emerged. 'Into Mum' might then be his fantasy of getting into a safer place inside her, where he is unaffected by her anguish. Or, finally, the scene may be a mere insignificant whim. If so, it nevertheless sparked not only my but also Bridget's imagination and emotional response.

Clinical epilogue

Some months after the family had left Stockholm, I received a letter from Bridget. Walter had started pre-school and was enjoying it. Recently, his sleep pattern had improved. He now could announce when he was tired, 'and that has never happened before! So we stopped his sleeping drug and he sleeps through the night. Then he quit the diapers, without big problems. Walter is a big boy now.' Bridget went on writing that the move from Stockholm had upset him. He often had 'breakdowns' and was whining a lot. Now that he had started pre-school, he was getting more stimulation, which was helpful. Mother was about to resume working. She ended by saying, "I have more patience with Walter because I understand him better."

Not all problems have vanished. Walter is still an intensive chap. He is prone to stress in new surroundings – just as Bridget guessed towards the end of therapy. Important advantages are reported: Walter is a big boy who has let go of his diapers; when he feels sleepy, he announces it, and falls asleep. No mention is made of the brothers fighting. Finally, Bridget exudes greater safety and satisfaction in being a mother.

Comparative literature survey of toddler–parent psychotherapy

The technique presented above emphasises the dialogue with parent and toddler, as well as interpretations to both participants about the unconscious motivations beneath their behaviour and relationships with each other and the therapist. In contrast, interventions that support attachment and advise on child education and management, though existent, are less highlighted. This model will now be compared with other traditions, with the purpose of clarifying technical and theoretical similarities and differences. As an introduction, I emphasise that all therapists working with relationship-based interventions 'may be indistinguishable from one another when observed clinically even if they use different theoretical terms to describe their work'

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(Lieberman and Van Horn, 2008: 2104). We must thus read theoretical accounts and clinical vignettes – mine as well as others' – as personal distillates and not as objective accounts. The characterisations submitted below are derived from the authors' publications. Some of the differences noted may actually be greater in writing than in real practice. Nonetheless, it is important to chisel out and discuss these features.

Lieberman and Van Horn, San Francisco: attachment in focus

In an early paper, Lieberman (1992) describes therapy with the toddler mainly in developmental terms. She identifies three patterns of disturbance: inhibition of exploration, recklessness or accident proneness, and precocious competence in self-protection. The therapist should flexibly switch between parent–child sessions, parent-only sessions and/or hours with the child. The therapist speaks 'toddlerese' to explain to the child his feelings. In joint sessions, this will also reach the 'child … inside the parent' (p. 570). A parent may affect the child via projective identifications of disowned but ego-syntonic aspects of herself. He may then feel pushed to comply and identify with them. The vignettes evince some reluctance to address the child about how s/he is giving emotional heat to the dyad, though Lieberman emphasises that 'the child's contribution to the affective tone of the interaction is particularly salient in the second year of life' (p. 561).

A later volume (Lieberman and Van Horn, 2008) describes therapies predominantly with underprivileged families. The terminology relies on theories of attachment, psychoanalysis, developmental psychology and cognitive behavioural therapy. The child's attachment, defined as his 'primary emotional relationships with the parents', is the 'unifying theme' (ibid.: 303) in therapy.

> Attachment problems face parent and child with dilemmas about what is safe and what is dangerous, what is allowed and what is forbidden, that need to be resolved through interpersonal communication, internal accommodation, or a combination of both'.
>
> (Lieberman and Van Horn, 2008: 455)

The emphasis on danger reflects the authors' experiences of children exposed to physical threat and violence. They recommend a hands-on approach, such as giving practical advice for families living under imminent threat. In contrast, the meaning of the term 'internal accommodation' is less clear.

Interventions often have a supportive and encouraging quality. But the authors also enter into a dialogue with the child to understand what unconsciously drives him/her – an approach where the psychoanalytic heritage of Fraiberg (1980, 1982) becomes more evident. To exemplify, two-year-old Maria refuses to clean up her toys at the end of the session. Her mother gets annoyed and demands that the therapist stays out of the imminent mother–daughter power struggle. In response, the therapist acknowledges to Maria both Mum's good intentions and the girl's anxiety at separating from the therapist. She speaks 'slowly and quietly' to Maria, claps her hands when the girl finally picks up the toys and then 'answers [the mother] lightly' (Lieberman and Van Horn, 2008: 1742–54). No mention is made of any anger behind Maria's refusal to clean up. In my reading, a full use is not made of uncovering unconscious meaning, either to the child or to her mother. 'Internal accommodation' therefore takes on a more restricted meaning than in the work presented in this paper.

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One might argue that this reflects the authors' conscious efforts to adapt their technique according to the needs arising during the session. This is true, but the scarcity of uncovering the child's unconscious communications – as compared with my technique with Walter – should be noted. One might also deem the technique that I used with Walter as being unsuitable for Lieberman's and Van Horn's population. This raises questions about how to adapt technique according to a family's education, therapy motivation and socio-economic situation. Walter's family was middle-class with two committed parents. Certainly, the technique I have presented cannot be transferred unmodified to any other case. The therapist must keep a constant eye on whether the parent is following the interventions and making use of them. The important thing is not whether she immediately rejects or confirms them, but whether she seems to find them interesting.

Another question concerns the effects on therapists working with severely traumatised families. Perhaps this leads them into focusing more on supportive and encouraging interventions and less on interpreting unconscious material. Cf. the notion that the therapist should convey to the family that 'experiences of love and support are important' (Lieberman and Van Horn, 2008: 2037). This might be mandatory with families living in abject circumstances and showing mistrust towards the therapist. Yet another rationale for an encouraging therapeutic stance is that many vignettes depict parental negative attributions (Silverman and Lieberman, 1999). Consequently, explaining to parents the possible meanings of their child's behaviour is often described as the main intervention. One caveat, however, is that such technique might miss the opportunity to use the child's communication to start his and the mother's therapeutic exploration. For example, when Walter was kicking his brother, I could have asked Bridget whether he did not also show signs of love *vis-à-vis* Bruno. I could also have explained the possible meanings of his kicking. Instead, I interpreted to Walter, in Bridget's presence, that he was acting out his possessive and angry feelings. This led to his panic at the sound of the truck, and to Bridget becoming thoughtful: "I don't recognise this behaviour".

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Harel and co-workers, Haifa: reflective functioning in focus

These authors (Harel *et al.*, 2006) recommend joint therapy to promote reflective functioning in parent and child. Parents may find it difficult to understand the child's behaviour because they cannot be guided by their own feelings or thoughts, which are too different from the child's (ibid.: 4786). The model is probably developed for families with less reflective functioning than Walter's. The vignettes exemplify the authors' efforts to promote 'facilitation of mental processes that generate representations' (ibid.: 4844), whereas I provided symbolic interpretations and made more consistent use of transference interpretations to Walter and Bridget. I refer to his fear of my room and her vexation when I pointed out her refusal to acknowledge Walter's anger. As in the book by Lieberman and Van Horn, the different emphasis on facilitating reflective processes and interpreting content, respectively, may partly be due to differences in the characteristics of the populations.

In the same volume, Arietta Slade (2006) describes therapy with a toddler and his mother. Here, too, we find a mother with inhibited reflective functioning. As with Harel, there is little mention of therapist–child dialogues. I am not convinced that it is only the different levels of ego-functioning and reflective functioning in our populations that lead to different techniques. There also seems to be a genuine

difference between my vision of therapy and the ones referred to here; I attribute more agency to the child in his relationship with the therapist. Consequently, I tend to think more of him as bringing a lively transference relationship to the work (Salomonsson, 2013).

Tavistock's Under Fives Service: a post-Kleinian approach

Louise Emanuel (2006, 2011), Elizabeth Bradley (Emanuel and Bradley, 2008) and their colleagues offer a handful of consultations with parents and toddlers. In particular, Emanuel's conceptualisations comprise both the mother's and the child's experiences. In a similar way to me, she often interprets a topic brought up by the parents or a behaviour by the child as a symbolic expression of a wish, fear or conflict that the child is struggling with. Like me, she also uses Kleinian and post-Kleinian conceptual models. In contrast, she seldom enters into a dialogue with the child or a trialogue including the parent to describe what transpires in the session (see, however, a passage (Emanuel, 2011: 683) where she addresses a 13-month-old girl about her angry fantasies). She rather tends to address (Emanuel, 2006) the parents on how to understand the emotions beneath the child's behaviour.

One of Emanuel's patients, Douglas, is obsessed with the batteries in his toys. She suggests that 'Douglas himself was like a battery, getting charged up and running and running, until he collapsed' (Emanuel, 2006: 257). Further, that he might have felt as an infant the need 'to bring Mother to life, to charge her up, so to speak, with his lively activity' and that his wrenching out the batteries from his toys symbolises 'the effect that his disruptive behaviour was having on his mother' (ibid.). Her guesses seem credible to me. I would also consider addressing the boy directly – and it is quite possible that Emanuel would agree with me on this point – to help him grasp his behaviour and its emotional background. I might tell him, "You like batteries, Douglas. Batteries make cars run quickly". Having waited for his response I would continue, "It's like having a battery inside. It makes you run about all the time. Mum gets mad at you, and then you get scared of her. I wonder why you run about so much." This interpretation focuses on the batteries as a symbol, the emotional climate surrounding his obsession, and some possible meanings beneath it. Douglas would only understand a fraction of the literal content. But he would probably grasp that I was struggling to understand why he is obsessed with batteries – and attempting to draw his attention to this enigma. Emanuel (2011) and I would agree that an understanding of Douglas's battery fixation is largely based on countertransference, and that neglecting negative *parental* transference would imply risking the entire therapeutic work. In addition, I would focus on the *child's* negative transference (Salomonsson, 2013) and convey that such frightening things can be talked about. I consider this aspect of containment indispensable.

To compare the Tavistock clinicians' views and mine further, I mention Isca Wittenberg's 'conviction that it is helpful to name [the underlying anxiety] and face it openly with the client' (Wittenberg, 2008: 1034). She refers to the parent's, not the child's, anxiety: 'We can best help the baby by the help we offer to the infantile aspects of *mother and father*, thus setting a model for them of being interested in thinking about and containing infantile feelings' (ibid., italics added). My argument for a dialogue with the child is that his responses will help convince the parents about the unconscious intentions beneath his behaviour. One clinician, Meira Likierman, comes close to this view. She picks up the child's behaviour as an intention to communicate

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with her and replies with verbal comments. Sixteen-month-old Rajeev gets fearful when people other than his parents touch him. When Likierman moves towards him, he stops his game and freezes. 'I said Rajeev did not like me to come too near him. He did not appear to grasp what I said … fluent speech was still somewhat beyond him' (Likierman, 2008: 76–83). Rajeev turns in tears to his mother and the therapist tells him, 'Look, I am moving *back*', as she moves her chair. Both Likierman and I are convinced that Rajeev, though unable to grasp her sentences fully, understands other aspects embedded in her interventions, such as her interest in understanding his fears. Perhaps, he might also be receptive to an interpretation of the affective quality of his relationship with the therapist, for example, "Rajeev, I think you want to get to know me but you're also scared of me. I wonder what scares you."

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Serge Lebovici, Centre Alfred Binet, Paris: a modified Freudian approach

Lebovici (Lebovici *et al.*, 2002) introduced researchers like Dan Stern and clinicians like Winnicott to French therapists, thus igniting their interest in parent–infant work. His Freudian affiliation was shown in an emphasis on interpreting drive impulses and resistances; that is, to the parents. However, he also considered 'the imaginary, fantasy, mythic, and narcissistic representations of the developing child' (de Mijolla, 2009). In his experience the parents, due to their 'fantasmatic interactions' (Lebovici and Stoléru, 2003: 269) with the child, often resist learning about the unconscious implications of his symptoms. He described the intertwining of their internal worlds as follows: 'The mother's internal reality, her unconscious, constitutes the first world offered to the baby' (p. 289).

Lebovoci recommended an active participation by the parent–child therapist, which should be informed by an understanding of the psychodynamics of the interactions and the situation. He disliked giving 'advice simply to satisfy the wishes of the parents' (Lebovici *et al.*, 2002: 170). Instead, he preferred to interpret how their unconscious sexuality coloured the relationship with the baby. This he did with a unique frankness and humour. As for a direct child address, he confirmed that the therapist 'can also have a direct therapeutic effect on the baby' (p. 180). Nevertheless, DVD recordings of his work (Casanova, 2000) suggest that he wanted primarily to inspire the *parents'* thinking about their child's feelings. Compare his advice that 'the presence of the baby gives the psychoanalyst an exceptional opportunity to ask the adult about the meaning of his behaviour' (Lebovoci and Stoléru, 2003: 270) with his observation that 'even young babies hear the affective value of words and organise their proto-representations in their interactions' (p. 363).

A most interesting contribution was Lebovici's exploration of the mind of the infant therapist, as indicated above by the concepts of enactment and metaphorising function. The two constitute the empathic function, which implies that the analyst opens up both to his/her parental function and creativity. Empathising with a child or parent consists not only of 'feeling into' but also in the therapist's 'forgetting about oneself' (Lebovici, 2000: 227) and allowing one's associations to interact with theirs. In my contribution, the 'Vroom' game and throwing the witch doll to Bridget represent such feeling and 'forgetting'; I was simultaneously a reflecting therapist and a child at play.

Summary of the technique and conclusion

The model exemplified in my work with Walter and Bridget did not come out of an attempt to modify existing published toddler work, but rather as an attempt to extend

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experiences from my *infant* work. Such development is reported by many other authors. Salient constituents of my technique are the emphasis on a dialogue with parent and child, and on interpretations relating to the unconscious motivations of each of them. The importance of containing the child's anxieties is inspired by Bion's work (Bion, 1962, 1970; O'Shaughnessy, 1988; Norman, 2001). The child address draws from Melanie Klein (1932, 1961, 1975) but with some crucial differences: (a) this mode opens up for a playful and less threatening atmosphere and enables the therapist to remain more relaxed, probing, and inquisitive when interpreting; (b) the interplay between external and internal objects becomes more visible to the therapist than in individual child therapy; (c) this gives him/her a more solid foundation for interpretations. Based on his observations of the parent–child interaction, he can explain and address it as an effect of the emotional interchange between the two; (d) it also enables child and parent to observe this interplay and to learn from it.

The main principles of the presented therapy mode can be summarised:

(1) It is an extension of psychoanalytically informed parent–infant psychotherapy.
(2) Parent and toddler are regarded as active therapy subjects. A suitable metaphor is 'couple therapy', provided one recalls the differences between parent and child regarding developmental levels and motivations for therapeutic work.
(3) Establishing a psychoanalytic framework should be done from the start. This will clarify what is and what is not allowed, and what is the aim of therapy; to explore conscious and unconscious urges that are at the root of the present disorder.
(4) These urges will manifest in the session as derivative expressions through play, words, body language, tone of voice, etc.
(5) Both parties seek containment for these urges and will involve the therapist to achieve this.
(6) They also try to defend against displaying and having them explored.
(7) These urges should preferably be interpreted from early on. This will lessen the anxiety of both parties. It will clarify to the child that therapy is not mere 'play-time' and to the parent that it implies something other than receiving guidance or advice.
(8) Interpretation sometimes implies addressing explicitly the emotions or conflicts that the therapist thinks motivate a certain behaviour. At other times, he enacts a pun or a game, which, though spontaneous, is built on a psychoanalytic understanding of the situation.
(9) The work presupposes the parent's motivation and interest to work in therapy. Should this be lacking from the start, alternative treatment should be considered. Should it decrease during therapy, any possibility of a negative transference burgeoning – in parent or child – should be explored and addressed
(10) Concerning which parent should participate, this is decided on the basis of which one of them is most involved in the relationship struggles. In my experience, this is most often the mother and thus I often suggest a mother–toddler therapy. Nothing prevents a father from participating if he is the one most entrenched in conflicts with the child. Triadic therapy could also be relevant, though I have less experience of such a setting that also implies a deep-reaching work with the toddler.

(11) This therapy mode seems most suitable when a child's disorder entails a concomitant disturbance in the parent–child relationship. Symptoms amenable to therapy include conduct problems, power-struggle with the parents, petulance, depression, fidgetiness and hyperactivity.

When external circumstances and the parent's motivations allow I suggest the interested therapist might apply it in his/her daily work, whether this takes place at a Child Health Centre or in private practice.

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