

Psychodynamic Therapies with Infants and Parents: A Review of RCTs on Mother–Infant Psychoanalytic Treatment and Other Techniques

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Abstract: This article critically examines the existent evidence base for Psychodynamic Therapy with Infants and Parents (PTIP), specifically focusing on the available RCTs (Randomized Controlled Trials) in the literature. The author also discusses how these studies influenced the design of an RCT of a related novel treatment method, Mother–Infant Psychoanalytic treatment (MIP). He found that certain types of mothers and infants may be more likely to benefit from MIP. In addition to providing guidance on therapeutic techniques, this article also effectively outlines ways in which PTIP, as well as psychotherapy for emotional issues during pregnancy, can be better integrated into the comprehensive health care system. Local health care units comprised of a nurse group and one therapist may be a better way of handling mother–infant interactional difficulties than centralized, specialized perinatal psychiatry centers.

META-ANALYSES OF PTIP

There are several well-known modes of psychodynamic therapy with infants and parents, or PTIP (Salomonsson, 2014a), which have been tested in randomized, clinical trials (RCTs). These studies have in turn influenced a subsequent RCT of mother–infant psychoanalytic treatment (MIP). This article critically reviews the literature on PTIP and MIP, focusing on methodological problems with design, measures,

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interpretation of results, and implementation of PTIP in general health care.

Two meta-analyses of PTIP have been published, one on “nonbiological interventions” for postpartum depression (Dennis, 2004) and one on Parent–Infant Interaction Interventions (PIII; Singleton, 2005). These studies have identified the problematic heterogeneity of therapeutic methods and the frequent low quality of study designs. A third meta-analysis by Barlow and co-workers (2010) did not aim at systematically evaluating such qualities, but rather at suggesting how to organize perinatal psychiatric health care. The latter issue is approached in this article’s discussion.

SPECIFIC RCTs

Mother–Infant Psychotherapy vs. Interaction Guidance

One Swiss RCT (Robert-Tissot et al., 1996) has compared mother–infant psychotherapy to Interaction Guidance (McDonough, 2004). The former method follows the technique of the “Geneva school” (Cramer & Palacio Espasa, 1993), and resembles Selma Fraiberg’s (1980) parent–infant psychotherapy mode. The focus of the treatment involves exploration of ways in which the mother’s unconscious projections onto the child can contribute to a disturbed parent–infant relationship. Interaction Guidance, in contrast, is a supportive method in which the therapist encourages the parents to indicate their treatment goals, emphasizes their existing strengths, and promotes their satisfaction and enjoyment from interaction with their infants. The therapist may use video recordings to demonstrate to the parent various aspects of salubrious and less optimal interactions with the baby.

In this study, participants in both treatment groups received, on average, six sessions of therapy. Follow-ups were made immediately post-treatment and then again at 6 and 12 months. The details of this procedure, however, are not clarified in the paper’s methodology other than to state that the follow-ups were “conducted by the same psychologists” (p. 103) who met with the dyads. The outcome measures were a questionnaire on infant symptoms, an interview with the mother assessing her representations of the baby, herself *qua* mother, and her partner. Video-recorded mother–baby interactions were used to assess the mother’s sensitivity and ways of playing with her baby, and to determine the range of the baby’s affects. Significant effects—*independent of therapy method*—were found at six months on maternal sensitivity, infant behavior, and symptoms. For maternal representations, individual items improved significantly but not their summary scores.

One significant problem with this study's design is the large age span of the infants (2–30 months), leading to evaluation of both nonverbal and verbal children in one large sample. Another methodological issue is the lack of intent-to-treat (ITT) analysis. This statistical method calculates outcomes on the basis of the subjects' initial assignments, regardless of whether they choose to commence these treatments or not. It is thus a method of avoiding bias in estimating the effects in an RCT (Chakraborty & Gu, 2009). Various statistical methods have been developed, for example, MLM or Multi-Level Modeling (for a summary of its application in psychotherapy research, see a paper by Adelson & Owen, 2012). Fifteen percent of the patients in this study were excluded during "pretreatment assignment" and an additional 13% dropped out at the six-month follow-up. Since the outcome statistics apply only to cases remaining in the study, we know nothing about one quarter of the sample. At the 12-month follow-up another quarter had dropped out.

Yet another methodological problem with this study is the fact that subgroup effects were reported. It is well known that the more measurements one performs within a "family" of phenomena, the higher the probability of a type I error (Tukey, 1991). Such "family-wise" or "experiment-wise" errors may lead to a false belief that a treatment effect exists (Olds, Sadler, & Kitzman, 2007; Sun, Briel, Walter, & Guyatt, 2010). Furthermore, the lack of a non-treatment control group makes it difficult to determine the relevance of the magnitude of improvements. Perhaps the number of sessions in both treatment modalities was too brief to show their full potential. This calls into question the differential effects reported in the study, namely that Interaction Guidance brought greater improvement on maternal sensitivity, while mother–infant therapy increased maternal self-esteem. It is easy to agree with the authors that these results are "consistent with expectations often expressed in psychotherapy outcome research: the effects common to both treatments are greater than their specific effects" (Robert-Tissot et al., 1996, p. 111).

Mother–Infant Psychotherapy vs. Watch, Wait and Wonder

The Watch, Wait, and Wonder (WWW) method is based on attachment theory and encourages the mother's presence with the baby in the sessions. She is asked to get down on the floor, observe the baby, and interact with him at his initiative. She observes his activity, thus gaining insight into his inner world and relational needs. The therapist is watching, waiting, and wondering about the mother–infant interactions. During the second half of the session, the therapist and the

mother discuss what transpired during these interactions. This enables the mother to examine and modify her internal working models of her relationship with the baby.

A Canadian study (Cohen et al., 1999) compared WWW with mother-infant therapy (Fraiberg, 1980). Seventy-three dyads with a child mean age of 20 months took part in the study, but six dropped out "early in treatment" and were not analyzed. Quite a few cases were assigned to treatment according to the therapists' caseload, yet assignments were said to be "essentially random." Treatments consisted of about 14 once-weekly sessions. The outcome instruments were questionnaires on parental stress, sense of competence, and depression. The infants' cognitive behavior and development were assessed via the Bayley scales (1969), and video-recordings were used to assess the quality of mother-infant play (Chatoor, 1986).

Immediately post-treatment, WWW was more efficacious in improving attachments, development according to the Bayley mental scores, and mother-reported satisfaction, but not maternal sensitivity or responsiveness. Both therapy methods equally reduced mother-reported child problems and stress and also improved mother-child relationships. The authors hypothesize that the differential advantage of WWW was due to the fact that therapists in this modality advised the mother to follow the infant's lead, thereby utilizing the child's attachment and developmental strivings. This may in turn have led to improved maternal competence as compared with mother-infant therapy.

Follow-ups were made on the remaining 79% of cases after six months (Cohen, Lojkasek, Muir, Muir, & Parker, 2002). Most outcomes continued to improve, and some new improvements began to emerge for mother-infant therapy. The authors suggest that improvements may have appeared earlier in WWW because the infant was working through "developmental and relational struggles in the presence of his mother" (p. 377), while the mother was working through her own anxieties emerging with the infant. In contrast, the insight-oriented work which characterizes mother-infant therapy might have left the mother distressed for a longer period, thereby explaining its slower outcome development. We are reminded of the "sleeper" effect demonstrated for intensive and insight-oriented therapies, in which treatment effects are slow to emerge but may ultimately surpass those found for less intensive therapies (Knekt et al., 2011; Leichsenring, Rabung, & Leibing, 2004; Sandell, 2012).

Finally, this RCT also did not include an intent-to-treat analysis. As in the case of Robert-Tissot et al. (1996), Cohen et al.'s (1999) sample of infants was very developmentally heterogeneous, comprised of both

nonverbal and verbal children who probably took part in therapy in quite different ways.

Mother-Infant Psychotherapy in a High-Risk Sample

Both the Swiss and the Canadian samples discussed above examined a fairly low-risk socioeconomic population of mothers. There were few single parents, maternal mean age was above 30, and the educational level and incomes of the mothers studied were relatively high. In contrast, a Californian study (Lieberman, Weston, & Pawl, 1991) investigated a high-risk Latino immigrant sample in which three quarters of the families shared living quarters with others and an equal number of the mothers were unemployed. The mothers' mean age was only 25 years, but the number of single mothers was not reported. Outcome measures were video-recorded interactions to assess the mother's sensitivity and the child's range of affects. Home visitors also assessed the mothers' child-rearing attitudes and the impact of life events (Egeland, Deinard, & Brunquell, 1979). Since all the children were one year old at start, the researchers were able to use the Strange Situation procedure (SSI; Ainsworth, Blehar, Waters, & Wall, 1978) for both assignment and outcome evaluation. All children who appeared securely attached on the SSI formed the "secure control group." The insecure children were randomized to mother-infant psychotherapy or to the "anxious control group." The control group treatments were unspecified. The mother-infant therapies lasted one year, much longer than in the Swiss and Canadian studies.

The study found that at a child age of 24 months, the index group scored higher on most items of maternal and infant behavior and interaction. Outcomes were better if the mother was involved in the therapeutic process, displayed empathy, initiated interaction, and encouraged reciprocity with the baby. ITT analyses were not made on the 82% of subjects that remained at the follow-up assessments directly after treatment termination.

Depressed Mothers: Comparing Four Therapies

A group in Cambridge, U.K. (Cooper, Murray, Wilson, & Romaniuk, 2003; Murray, Cooper, Wilson, & Romaniuk, 2003) has investigated whether or not early improvement of maternal depression might improve dyadic relationships and child development. The population studied was a relatively low-risk sample of depressed first-time mothers who were randomized with their babies to either cognitive-behavioral therapy, psychodynamic mother-infant therapy, non-directive

counseling (Holden, Sagovsky, & Cox, 1989), or routine primary care. The three active treatment groups received 10 once-weekly sessions at home when the baby was 8–18 weeks, with 83% completing therapies. This study used ITT analyses, revealing improvements for all three active therapies on mother-reported relationship problems with the babies, but not on infant behavioral problems. Interestingly, mothers with high social adversity improved their interactive behavior with the infants only from non-directive counseling. This important finding adds to our understanding of therapeutic specificity: perhaps disadvantaged mothers may benefit more from a method that provides advice and support.

When the children were 18 months, only the mothers in the counseling group reported fewer baby problems. No between-group effects were found on measures of attachment and cognitive development. At the five-year follow-up point, no effects were found on mother- and teacher-reported child behavior problems or cognitive development. Thus, most child outcomes failed to show any benefit of the three active treatments, whereas maternal depression improved from all of them. The authors conclude that “more prolonged interventions may be required,” but that “such treatment may not require high-level psychological expertise” (p. 426). The latter conclusion is based on the positive findings on counseling. In her meta-analysis, Singleton (2005) reached a different conclusion, namely that therapist training moderated outcomes in a positive direction. Nevertheless, the Cambridge study has cast serious doubts on the long-term effects of PTIP.

Depressed Mothers: Group Therapy

In this study from the U.S. (Clark, Tluczek, & Wenzel, 2003), 39 mothers with babies of about nine months of age were recruited via clinical referrals and selected via a depression questionnaire. Though the target group was mothers with depression, the study also examined the effect on infants' development. The sample constituted an even lower social risk population than the Swiss and the WWW samples. The mothers were all Caucasian, well-educated with a good economic situation, and few of them were single parents. The dyads were randomized to mother–infant group therapy, interpersonal individual therapy for the mother (Klerman, Weismann, Rounsaville, & Chevron, 1984), or a waiting list. Treatments lasted 12 weeks and focused on the depression and the baby relationship. No drop-outs were reported. Outcome measurements were questionnaires on depression and parental stress, assessments of infant development (Bayley, 1969) and mother–infant interaction (Clark, 1985).

Follow-up at three months after treatment demonstrated that both active groups were superior in “reducing maternal depressive symptoms, improving mothers’ perceptions of their infants’ adaptability and reinforcement value, and increasing mothers’ positive affect and verbalization” (Clark et al., 2003, p. 441). As in the Swiss study, subscale effects were used to demonstrate general therapy effects, a procedure that does not take into account the possibility of making family-wise errors. Though both active treatments included the baby, effects were found only on the mother’s and not on the infant’s interactive contributions.

Many studies have been omitted from the above review, either because mothers were treated without their infants (O’Hara, Stuart, Gorman, & Wenzel, 2000), the studies were not RCTs (Suchman, DeCoste, Castiglioni, Legow, & Mayes, 2008), or the children were toddlers (Cicchetti, Rogosch, & Toth, 2000; Cicchetti, Toth, & Rogosch, 1999; Toth, Rogosch, Manly, & Cicchetti, 2006). As for the studies reviewed here, their findings may be summarized in one sentence: The active therapies yielded effects mostly on mothers’ well-being, while infant effects were not always thoroughly investigated and, if found, were weaker. We sought to discover whether or not a related, novel form of psychoanalytic treatment with mothers and infants might prove more effective in improving both maternal and infant well-being.

MOTHER-INFANT PSYCHOANALYTIC TREATMENT: A DETAILED DISCUSSION OF PROTOCOL AND FINDINGS OF AUTHOR’S RESEARCH

Our RCT (Salomonsson & Sandell, 2011a, 2011b) compared mother-infant psychoanalytic treatment (MIP; Norman, 2001; Salomonsson, 2014a, 2014b) with routine care at Child Health Centers (CHC) in Stockholm, Sweden. The design was informed by the RCTs reviewed above. However, there are some key methodological differences in our study that we feel makes it a uniquely rigorous contribution to the literature: these include study of only nonverbal infants, use of questionnaires covering not only maternal depression but also general distress and parental distress, use of intent-to-treat analyses, and use of a live interview in addition to externally rated videotaped interactions. We also made the decision to not report significances on single variables with the aim of supporting general treatment effects.

Study Design and Protocol

Comparison Treatment. In our study, MIP treatments were performed by members of the Mother–Infant Psychoanalysis Project of Stockholm (MIPPS), a group founded in 2001 by Norman (2001, 2004). While it would have been ideal to compare MIP with a therapeutic modality of similar standard and theoretical clarity, this was not practically feasible for our study. However, MIP is a new treatment method and therefore we found justification in comparing it with an ethical “treatment as usual.” Swedish CHC care is well established and utilized by an overwhelming majority of families. It is surveyed by healthcare authorities and it aims at also promoting the psychological well-being of mother and child. Thus, the authors felt that its use as a comparison treatment method was acceptable.

Subject Recruitment. One third of the mothers were recruited from CHCs in Stockholm and two thirds from advertisements on parental Internet sites and delivery wards. The advertisements on the internet sites and the delivery wards contained descriptions of common maternal–infant problems, or “baby worries” (e.g., difficulties with feeding or weaning, infant sleep, maternal–infant bonding, etc.). The text in the advertisements encouraged concerned mothers to contact the study coordinator. Mothers recruited from CHCs were invited by nurses to participate in the study if they expressed any concern regarding their baby’s functioning, their own parenting, or their relationship with their infant. The CHC nurses gave these women written information about the study. Common concerns among these mothers were related to poor infant sleep, difficulties with feeding or weaning, or an infant who appeared depressed or anxious. Other chief complaints included maternal anxiety, depression, or uncertainty and ambivalence about motherhood.

Inclusion and Exclusion Criteria. The primary inclusion criteria for the study was maternal “baby worries,” as described above. We chose this terminology as we felt it would be a sensitive means of detecting possible disturbances within any or both of the dyad’s participants, and/or between the two. Study participants were excluded if they did not live in Stockholm or were unable to speak or understand Swedish well enough to participate in psychotherapy. Mothers with psychosis or substance abuse were also excluded if there was any concern about their collaboration in the study. Since the MIP method was devised for nonverbal children, infants older than 18 months were also excluded from the study.

Assessment of Maternal–Infant Relationship. Prior RCTs studying mother–infant interactions have used external raters viewing videotaped sessions. Our study design is unique in its usage of a live interview in which the rater can actually probe more deeply into the dyadic relationships. It is true that an interviewer meeting face to face with a respondent may be less reliable than an external rater watching a video sequence. On the other hand, the interviewer can get a first-hand view of the relationship and the genesis of symptoms and also make more qualitative assessments. In our study, mothers and babies were interviewed by the writer (BS) at intake and again six months later. The therapists were interviewed post-treatment by BS with the aim of understanding more about the therapeutic specificity of MIP. Practical circumstances did not allow for interviews with the nurses.

Outcome Measures and Instruments. We devised a specific interview rating format that quantified the impact of the mother’s experiences, “ideal types” (Wachholz & Stuhr, 1999), that is, global characteristics of mothers and babies, and the mother’s suitability for psychoanalysis. Since many forms of maternal distress may negatively affect the mother–infant interaction, we measured maternal depression as well as parental stress and general psychopathology using the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987), the Swedish Parental Stress Questionnaire (SPSQ; Östberg, Hagekull, & Wettergren, 1997), and the General Stress Index (GSI) of the Symptom Check List-90 on general psychological distress (SCL-90; Derogatis, 2004; Fridell, Cesarec, Johansson, & Malling Thorsen (2002). These instruments have been well-validated and have satisfactory inter-rater reliability, as outlined in detail in our original paper.

Mothers also rated infant function using the Ages and Stages Questionnaire: Social-Emotional (ASQ:SE; Squires, Bricker, Heo, & Twombly, 2002). The quality of the mother–infant relationship was quantified using the Parent-Infant Relationship Global Assessment Scale (PIR-GAS). This is a component of the DC 0–3:R classification system (ZERO-TO-THREE, 2005), in which scores may range from 0 to 99, from “documented maltreatment” to “well-adapted.” The interviewer made ratings based on video-recordings of the interviews, and these were then checked for reliability with an external rater. To measure the qualities of maternal–infant interactions, two external clinicians assessed brief video-recordings according to the Emotional Availability Scales (EAS; Biringen, Robinson, & Emde, 1998). They rated maternal sensitivity, structuring, and non-intrusiveness, as well as infant responsiveness and involvement. The mother-baby interviewer also interviewed the study therapists after treatment termination and scored nine items

regarding their adherence to the MIP method. Some questions in the post-treatment interviews with the mothers focused on their experiences of therapy. The mothers assigned to MIP thus contributed to the adherence ratings, a procedure that was thought to increase their validity.

Two quantitative interview instruments were developed for the study. One measured maternal suitability for psychoanalysis on a 4-point scale from "dubious" to "excellent." The questions focused on the mother's interest in greater self-awareness and psychological understanding, as well as her ability to tolerate delayed gratification in obtaining psychotherapeutic results. The second instrument, the I-ME or the Interview of the Mother's Experiences, focused on how the mother experienced herself in her various roles as daughter, spouse, and mother. There were also questions exploring the mother's feelings about her child's emotions and behavior (for further details, see Salomonsson & Sandell, 2012). Twenty items were set up, each formulated as a positive statement, for example "The mother feels the baby's father supports her" and "The mother feels her baby is cheerful." The interviewer rated to what extent her responses cohered with each item. Four-point Likert scales were used, where 1 implied maximum disagreement with the statement and 4 total agreement. A mean score, "I-ME score," across all 20 items was calculated. Babies were kept present during the interviews. This allowed for some distress to emerge, which was thought to give a more varied and undisguised image of the mother-infant interaction. The interviewer could then compare his observations with the mother's account.

In addition to the quantitative measures described above, we also utilized a purely qualitative instrument to describe the mothers' personalities and their babies' characteristics, according to the model of "ideal types" (Wachholz & Stuhr, 1999). This method aims at collecting typical instances of phenomena in the world of ideas, and has been used in psychotherapy research (Leuzinger-Bohleber, Stuhr, Ruger, & Beutel, 2003; Lindner, 2006; Philips, Werbart, Wennberg, & Schubert, 2007).

Hypotheses

Due to the double focus of MIP on the mothers' problems concerning maternity as well as the babies' functional symptoms, this therapeutic mode was hypothesized to yield better results than CHC treatment on all quantitative measures. In contrast, the qualitative classifications into ideal types did not contain any inherent assumptions of a ranking order and thus no quantitative hypotheses were set up. They were introduced for two other reasons; to investigate if they functioned as mod-

erators for the quantitative assessments and also if they might yield new hypotheses, for example, of which types of mothers and babies might be more or less suitable for MIP or CHC treatment.

Results

Two hundred and fourteen mothers responded to the study advertisements and were interviewed on the telephone. One hundred and thirty-four declined participation. Some women felt their concerns had abated after a few days of worry. Others had responded to the Internet ad because they wanted to "support research," but did not in fact consider themselves to be in need of help. This high rate of decline may reflect the often volatile nature of mother-infant relationship difficulties. No mothers were excluded. Eighty mothers with babies were interviewed. During the interview, mothers signed a document indicating their informed consent, and the interviewer signed another document indicating his ethical responsibilities. Thereupon, randomization followed. Four cases dropped out without providing data and one was in therapy at project termination. We could thus analyze 75 cases or 94% of the original sample.

The mothers' mean age was 33.2 years (SD or standard deviation = 4.2). A majority (64%) had a post-A level education, corresponding to an American college or university education, and was living (92%) with the child's father. The fathers' mean age was 34.6 years (SD = 5.2). This low level of social risk corresponded fairly well with the Swiss and the WWW samples reported above. In contrast, the psychiatric risk was higher. Though our study instruments did not focus on making psychiatric diagnoses in the mothers, we discovered in the interviews that half of them had had previous psychiatric contacts during childhood, adolescence, or adulthood. They reported prior diagnoses of eating disorders, depression, or anxiety disorders.

Seventy-nine percent of the mothers were primiparae. Most babies were delivered at full-term though deliveries complicated by Caesarean sections or vacuum extraction were frequent, exceeding one third of the sample. The mean age of the infants at intake was 5.1 (SD = 3.3) months. Only one baby had a diagnosed serious somatic illness. Since this child's prognosis was good and there were substantial mother-infant interaction difficulties, this case was included. *Pre-treatment* mean scores for depression, stress, psychological distress, infant behavioral and interaction problems reached clinical significance. For example, the mean score on the depression measure, the EPDS, was 11.9 (SD = 4.7). This is twice as high as scores among nonclinical Swedish mothers with babies (Seimyr, Edhborg, Lundh, & Sjögren, 2004; Wickberg &

Hwang, 1997). Similarly, the mean GSI scores on general psychic distress were two (Fridell et al., 2002) or three (Börjesson, Ruppert, & Bågedahl-Strindlund, 2005) times as high as nonclinical Swedish samples. The mothers' ratings of their babies' dysfunction on the ASQ:SE were also about twice as high compared with nonclinical American samples (Squires, Bricker, & Twombly, 2004). Maternal sensitivity to the baby's communications was at 60% of the optimal level, and the mean PIR-GAS score was 68.1 ($SD = 12.1$). These figures reflected the distress of mothers and babies alike. In terms of specific issues causing maternal distress, these included marital or family relationships, trauma or psychiatric disorders, feelings of sadness, indifference or anxiety about pregnancy, or concerns about the child's feeding, sleep, mood, or affection.

Post-treatment interviews were made six months later. Four mothers declined this interview, but their intake scores were included in the ITT analyses. The low attrition rate satisfied our ethical concerns (Kendall, Holmbeck, & Verduin, 2004) and increased the study's face validity. One third of the CHC mothers reported that they had had brief therapies in the interim, which were often recommended by the CHC staff. The MIP mothers continued with CHC care while also receiving a median of 23 MIP sessions two to three times weekly. The adherence score, with a mean value of 29 out of a maximum of 36, indicated that the therapists had adhered to MIP reasonably well. The interviews revealed that non-optimal scores often implied an insufficient working alliance or a failure by the therapist to perceive maternal negative transference.

To sum up the between-group outcome differences as illustrated in Table 1, *MIP effects were significantly more advantageous on the EPDS, the EAS sensitivity, the PIR-GAS, and nearly significant on the SPSQ*. Effect sizes as measured by Cohen's d were small to moderate. When measured by Becker's Δ (Becker, 1988), a standardized mean-change score that accounts for pre-treatment differences between groups, they were higher.

An important aim of the study was to learn which dyads seemed best suited for MIP or CHC care. We guessed that the mothers' suitability for psychoanalysis would indicate this, but this assumption was not actually borne out in our results. *Assessments of the parent's analytic suitability did not predict the results of dyadic therapy*. In contrast, the "ideal types" yielded more interesting results. Mothers were first classified into five types: (1) The Chaotic mother felt overwhelmed, often made incoherent comments, and demonstrated faltering ego function when strong feelings overpowered her. (2) The Depressed/Reserved mother felt unable to love her baby. Her low self-esteem and guilt were salient and sometimes combined with a reserved attitude toward the infant.

Table 1. Mixed-Model Analyses Comparing Treatment Effects of MIP and CHC Care

Instrument	F	<i>p</i>	Cohen's <i>d</i>	Becker's Δ
EPDS	5.894	.018	0.39	0.57
ASQ:SE	1.255	.266	0.20	0.25
PIR-GAS	8.210	.006	0.58	0.84
SPSQ	3.901	.052	0.14	0.37
SCL-90	2.038	.158	0.25	0.11
EAS dimensions				
Mother: Sensitivity	4.872	.031	0.42	0.67
Mother: Structuring	1.718	.195	0.15	0.36
Mother: Non-intrusiveness	0.039	.844	0.27	0.02
Infant: Responsiveness	2.701	.105	0.17	0.47
Infant: Involvement	0.444	.508	0.10	0.22

Note. ASQ:SE = the Ages and Stages Questionnaire: Social-Emotional. Becker's Δ = effect size according to Becker's criteria. CHC = Child Health Center. Cohen's *d* = effect size according to Cohen's criteria. EAS = the Emotional Availability Scales. EPDS = the Edinburgh Postnatal Depression Scale. SCL-90 = the mean score (General Severity Index) of the Symptom Check List-90. MIP = Mother-Infant Psychoanalytic treatment. PIR-GAS = the Parent-Infant Relationship Global Assessment Scale. SPSQ = the Swedish Parental Stress Questionnaire.

(3) The mother with an Uncertain Maternal Identity had invested self-esteem in her professional career and now felt lost as a mother. Common to types 1–3 were maternal concerns about somehow contributing in an unknown way to the “baby worries.” These mothers were keen on finding out more about this in therapy. They were grouped together under the overarching type of the “Participator” mother. (4) The Anxious/Unready mother seemed unprepared for motherhood because her wish to be taken care of herself competed with those of caring for the baby. Her panic at any baby symptom was interpreted by the interviewer to express this inner conflict. (5) The mother Conflicting with her Partner had been abandoned by the child's father. She now wanted to understand her relationship with the father rather than with the baby. The interviewer grouped 4–5 under the overarching type of the “Abandoned” mother. The two types were evenly distributed across the two treatment groups; 2/3 Participators and 1/3 Abandoned in each group. We were interested in determining whether or not the two treatment modes would yield different results for these two groups. Indeed, MIP “Participators” became more sensitive to the child's signals (EAS) than did their peers in CHC care. No significant moderator effects were found for the Abandoned mothers.

The infants were also classified into “ideal types” during the interviews: (1) The Affected baby reacted negatively when the mother spoke

of distressing topics. Older babies indicated an avoidant or disorganized attachment. (2) In contrast, the Unaffected baby was calm even if the mother was addressing painful topics. The infant might look gently and curiously at her or just go on playing. Mothers with Affected babies reported more baby problems and stress on the ASQ:SE and the SPSQ, respectively. They had less optimal PIR-GAS relationships, maternal EAS sensitivity and structuring, and their babies also interacted less optimally on the EAS. The two baby types thus corresponded well with many quantitative measures at intake. Compared with CHC care, *MIP proved superior in improving maternal sensitivity and PIR-GAS scores among the dyads with Affected infants.*

To analyze the predictive qualities of the instrument “the Interview of Mother’s Experiences” (I-ME), we focused on cases that had received no psychological treatment at all. The I-ME score predicted the mother’s emotional availability, whereas the GSI score of the SCL-90 predicted the infant’s availability. In brief, *the mother’s load of experiences predicted her behavior with the child six months later—whereas her general level of psychic distress predicted how her infant would interact with her.*

DISCUSSION

Some of our findings coincided with the prior PTIP studies referred above. These included maternal improvement on ratings of depression, stress, and sensitivity after MIP. Our results demonstrated nonsignificant effects on the infants, as reported by mothers and rated on video interactions. This, too, replicates findings of earlier studies.

A novel finding of our study was the fact that our measure of the mother–infant relationship proved sensitive to the effects of MIP. On this measure, the infants seemed to benefit from MIP more than from CHC care. Another key finding was the fact that suitability for psychoanalysis was poorly associated with the outcomes. Ordinary considerations of what is a “good psychotherapy case” functioned badly as an outcome predictor. Instead, we found that other maternal or infant characteristics predicted a better response to MIP compared with CHC. These factors included a maternal sense of being “part of the problem.” Babies with higher levels of dysfunction also seemed to benefit more from MIP compared with CHC. The elucidation of such factors that moderate outcome is important, since psychotherapy implies a substantial economic and emotional investment. Thus, our study provides new data that can guide the clinician in choosing referral cases for PTIP.

Our Stockholm study, like other previous PTIP studies, had certain limitations. Compared with most of the studies cited above, our com-

parison treatment was less well defined, potentially detracting from the validity of comparing the two methods' outcomes. On the other hand, compared with prior studies (Lieberman et al., 1991; Murray, Cooper, Wilson, & Romaniuk, 2003), the Stockholm CHC group was far from a "no-treatment" control group. Many nurses focused on psychological issues and one third of the mothers received additional psychological support. This must be taken into account when one compares MIP's effect sizes with those of the aforementioned studies.

Since our design was naturalistic, therapists and mothers could decide on duration and frequency of treatment. In general, mothers with longer treatments had a history of more severe psychopathology. The free duration of treatment reflected clinical judgment but could also be criticized for a lack of standardization. If the MIP effects seemed more numerous than in other studies, this may be because these therapies were longer and not set at a fixed level in advance. This might have increased the chances of obtaining beneficial treatment effects. A separate covariate analysis, however, showed that the duration of therapy did not influence efficacy.

Another limitation of our study was the absence of paternal assessments. Considerations of feasibility and economic resources made us decide to focus primarily on those two individuals who participated in the MIP treatments: mother and baby. Evidently, though information was gathered from the mothers during the interviews, a direct contact with the fathers would have given a more reliable and comprehensive picture of their role in the family and its problems.

The interviewer's allegiance might of course have influenced the PIR-GAS assessments, though every effort was made to establish their reliability by comparing them with an external rater. Similarly, our study evolved out of a therapy center that had been instrumental in developing the index method. The therapists' allegiance to "their" method might have prompted them to do their utmost to prove its value. Therefore we do not know if the findings would apply to treatments of the population at large. Although therapist adherence to MIP technique was measured in our study, we cannot rule out the possibility that the therapists unwittingly might have changed technique according to the individual client's response (Stiles, 2009). Furthermore, the clients' ways of presenting and addressing problems might have varied according to their assignment to a certain treatment mode or therapist. It is thus uncertain if we actually evaluated the therapy we purported to study, though such limitations actually apply to most psychotherapy studies. Finally, in considering generalizability of our results, it is important to note that randomization procedures can never truly reflect typical clinical practice in which an individual is referred for a specific

treatment only after careful scrutiny. With these reservations, the MIP is approaching the status of "Evidence-Based Practice." We need more studies and lengthy follow-ups like the Cambridge study. Such a study is under way for the Stockholm sample and will be reported in the near future.

If we broaden our perspective to encompass all the referred PTIP studies, we note that they have combined explicit measures which evaluate "conscious attitudes and goal-directed behaviors" (i.e., questionnaires) with implicit measures that focus on "spontaneous behaviors that are exhibited 'mindlessly,' without conscious awareness" (Josephs & Bornstein, 2011, p. 423), such as ratings of video-recorded interactions. Though such combinations make for a comprehensive assessment, they may nevertheless fail to "differentiate between a psychological structure that is present but temporarily inactive and genuine change in that underlying structure" (p. 420). To exemplify, if a mother feels more harmonious during therapy and her baby stops crying, we do not know if this reflects a permanent or temporary change. If she reports a decrease of depressive symptoms, we are uncertain if this reflects "genuine" or "illusory" mental health (Shedler, Mayman, & Manis, 1993). Another measurement problem is that mothers' ratings of their children's functioning may be more closely associated with their ratings of personal distress than with external ratings of dyadic interaction or clinically assessed relationship qualities (Salomonsson & Sleded, 2010). The mothers' objectivity may thus be colored by their personal well-being.

Finally, the general problem of studying a diagnostically mixed sample (Sandell, 2012) is especially salient in mother-infant research, where we actually have three interdependent "patients": the mother, the baby, and their relationship. The problem is further increased by the fact that symptoms in these populations often come and go and change character quickly.

CONCLUSIONS

Our brief review of the design problems with the RCTs on PTIP highlights that certain conditions must be fulfilled in order to obtain meaningful results which may ultimately influence development of therapeutic techniques. Such studies must be performed under controlled conditions with carefully described quantitative measures. Qualitative assessments should be psychodynamically relevant and connected to the quantitative results. If these demands are met, the researcher's demands of scientific rigor can harmonize with the psychotherapist's de-

mands of a research that reflects, and is relevant to, his or her practice. For example, some of the therapists in the MIP study indicated to the interviewer that they had now reappraised former notions that a focus on the mother's well-being was less important than on establishing emotional contact with the baby.

To the individual PTIP therapist, the value of our RCT may not lie solely in findings that one method generally yields better outcomes than another one. What is of particular interest is the finding that certain groups of mothers with particular personality structure, psychological-mindedness, and motivation, may profit more from certain therapeutic techniques than from others. The issue of therapeutic specificity (Blatt & Shahar, 2004; Orlinsky, Rönnestad, & Willutzki, 2004) is thus central to the question of which types of parent-infant interaction are more accessible to dynamic interpretations. What roles, if any, do academic level, cultural background, and social status play in the parents' acceptance of such techniques, for example? Could one identify babies that are better cases for PTIP or supportive interventions, respectively? Our study is one of two (Lieberman et al., 1991; Salomonsson & Sandell, 2011b) which has addressed such specificity issues at depth. The findings concerning the mothers were similar in both studies; both mother-infant therapy *ad modum* Fraiberg and MIP yielded better results if the mother was emotionally involved in the therapeutic process. Interviews with the Stockholm sample indicated that its "Participator" mothers often found the analyst's probing and sometimes confronting attitude rewarding. In contrast, "Abandoned" mothers often requested the therapist's support and advice on child care. They sometimes spoke more warmly about CHC care than about MIP. The lesson to be learnt is that a therapist may need to adopt a more supportive, self-disclosing stance for such mothers.

Our differential results for the "Abandoned" and the "Participator" mothers correspond well with prior studies on "anaclitic" and "introjective" patient categories (Blatt, 2006). Abandoned mothers seem akin to anaclitic individuals, who are "concerned about trust, closeness, and the dependability of others" (p. 507). They fear "being abandoned and left unprotected and uncared for" (p. 501) and are sensitive to "interpersonal or relational dimensions of the treatment process" (Blatt & Shahar, 2004, p. 429). Introjective individuals seek to "achieve separation, control, independence, and self-definition, and to be acknowledged, respected, and admired" (Blatt, 2006, p. 508). They change more readily and express improvement primarily in "a reduction of clinical symptoms and in an increase in level of cognitive functioning" (Blatt, 1992, p. 697). These individuals also tend to be more "ideational and concerned with establishing, protecting, and maintaining a viable self-concept"

(p. 696), which is particularly similar to our model of the "Participator" mothers. Blatt's group found that classical psychoanalysis especially helped introjective patients, whereas supportive therapy was better for the anaclitic patients. This is similar to our study's finding that the Participator mothers became more sensitive from MIP than CHC care. Vice versa, Abandoned mothers showed a nonsignificant trend toward becoming more sensitive from CHC.

Our study showed that babies who were particularly negatively affected by the relationship disturbance benefitted most from the MIP interventions. This seems logical, since the analyst focused on the baby's anxieties, as described in paper I. This finding suggests that MIP may be particularly helpful if a baby has functional symptoms like gaze avoidance, fretting, mood instability, sadness, insomnia, and feeding problems. If the symptoms seem to reflect the baby's internalization of the mother's projections, a focus on the baby is even more crucial. As concerns the mother, if she is depressed this is not necessarily linked with infant symptomatology. Excessive focus on her baby might detract from therapeutic work on her sadness, anger, shame, rivalry with the baby, etc. Thus, when the mother is in distress but her infant is relatively healthy, the therapist should be wary of damaging therapeutic alliance by an excessive focus on the infant.

Finally, our study has relevance to the more general question of how to effectively organize psychological care for dyads in general. Few prior studies on PTIP have approached this issue, though it is central to everyday clinical practice. There are several key problems that may lead to insufficiently developed or disorganized dyadic therapies in child health care (Barlow et al., 2010). For example, it is often difficult for dyads to pass smoothly from a low-level to a specialist-level care. Adult psychiatry does not always pay attention to its patients' needs as parents, and child psychiatry may often overlook that a youngster may have parents with mental health problems. Barlow et al. recommend that perinatal psychiatry be expanded, and that specialists should support "primary care and community professionals and involve consultation, joint assessment, direct clinical work, training, supervision, and the development of protocols and care pathways" (p. 183).

Our interest in the issue of subject recruitment emerged when the MIP study was terminated. It had been fairly easy to capture the interest of mothers and inspire them to take part in the study. After termination, the applications to the MIPPS group ceased, however. This is

reflective of a larger concern shared by many PTIP therapists, namely that perinatal psychiatry services are not sufficiently accessible. Our search revealed that mothers with "baby worries" were not adequately captured by the CHC nurses. Barlow et al. recommend centralized and specialized units for this population. We take another view, based on our post-study experiences as well as Stern's observation (1995) that mothers with baby worries seldom regard themselves as mentally ill. This fact, plus a lack of confidence among nurses to broach mental health issues with mothers, may explain the high threshold for mother-infant psychotherapy to get started. We speculate that if the mother is informed that such psychiatric services are available at a specialist clinic separated and perhaps far away from her CHC, this may diminish motivation for treatment.

In countries where perinatal healthcare services are well developed, another solution will probably better meet the mother's demands and the baby's needs: namely, embedded placement of appropriately trained therapists at each CHC or Well Baby Clinic. In this situation, the therapist can provide consultations for mothers and infants and supervise the nurses. Our MIP study found that it is important to gauge the mother's motivation for work on insight and her need for emotional support, as this may in turn influence outcomes. A therapist at a local CHC can gain the nurses' confidence more easily than if she or he is working at a multi-therapist mental health center far away from the CHC and the mother's living quarters. Once the nurse becomes interested in the therapist's approach, this is likely to extend to the parent(s), who in turn will find it easier to accept a consultation with the local psychotherapist. The nurses' relaxed and positive attitude toward the therapist's work may also contribute to increasing mothers' motivation for psychotherapeutic consultations. Today, it is often emphasized that mental health centers should provide a selection of evidence-based methods to be suggested according to the patient's diagnosis. According to the opinion of this author, this policy is ill-suited for the population of mother-infant dyads, in which psychotherapeutic motivation and self-esteem may be brittle and symptomatology may be volatile and difficult to pinpoint. This argument applies to pregnant women as well. In Sweden, as in many other countries, they are taken care of by midwives and gynecologists at specialized antenatal clinics. Just as this author suggests that medical and psychiatric care be integrated for parents with infants, he suggests a similar model also for pregnant couples.

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