

Family Therapy and Infant Mental Health: Natural Partners

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As science identifies the importance of interplay between an infant's innate potential and the experiences of the first two years of life for life-long brain development, infant mental health as a discipline in its own right is burgeoning. Family therapists with their knowledge of systems theory are well-placed to become specialised in this field. In this article, following discussion of definitions and 'territories', brief descriptions of the history of attachment theory and attachment behaviours lead to summaries of current work where family therapy and infant mental health overlap. Although definitive evidence of effectiveness of family interventions remains sparse, the vital benefits of ensuring appropriate home and cultural environments for our infants through family and community interventions is likely to be demonstrated in the next decades. Earliest intervention and preventive interventions are likely to be the most rapid and the most potent.

There is a frequently used aphorism in Infant Mental Health: 'It takes a village to raise a baby'. It may seem more self-evident that it takes a *family* to raise a baby, but very little has been written on the topic of Family Therapy and Infant Mental Health (IMH). In fact, an article on the interface between these topics must begin by defining what the topics may mean — clearly, there is much debate not only about what constitutes a family but about what family therapy is, let alone IMH. This article will review the field of infant mental health, highlighting the work of those relatively few theorists and clinicians who have attempted to integrate their family systems training in the most appropriate way for families with very young children.

As I struggled in my past life (professional of course) with out-of-control teenagers whose parents should have obtained the skill of limit-setting a decade earlier, I realised my time could be better spent prospectively with newer parents, maybe doing the 'stitch in time' (or helping seedlings towards optimal growth). So I began to work with families of infants and discovered the strengths and limitations of early interventions and prevention with this group, the motivation of the patients and the rapidity of changes when interventions were made. Family therapists have many of the necessary skills to work in this field, and so there is pleasure in sharing pathways to the relevant current knowledge. 'Must read'

texts are highlighted in the reference list as well as in the paper itself.

During the growth phases of family therapy in the mid-twentieth century, the family was usually envisaged as 'Mom, Dad and the kids', one of whom might have anorexia or schizophrenia (remember the schizophrenogenic mother, poor soul), and all of whom should have a voice in this systemic therapy. This contrasted to the previous child guidance model where the child was seen alone by the therapist and the parents separately by the social worker (!). As infants were thought to have no voice to speak for themselves, the classic family therapy model did not generally extend to infants. Family paradigms have changed dramatically of course, and so have conceptualisations of infants and their abilities (Schore, 1994; Murray & Andrews, 2001). In this article, I will take family therapy to mean a systemic therapy where two or more persons in a family meet together with a therapist in order to change action, thoughts, feelings, or beliefs either in or between these people. As this article is about IMH, at least one of those participants will be less than three years old, although some IMH workers extend their range to children perhaps up to six years. As will be seen, basically all IMH therapies are therefore family therapies, although of course the reverse is not true.

What is Infant Mental Health?

Infant mental health involves all aspects of an infant's world which are fundamental to the development of sound psychological functioning. In order for infants to attain the latter, attention must be given to the physical, nutritional, psychological and developmental health of the infants



Editors' Note: This article updates Neil Wigg's paper (1984), 'The Life Cycle: 0–3 Years, *AJFT*, 5, 4: 293–296.

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themselves, the psychological well-being of their parents and extended families, and numerous bio-sociocultural issues which may impact on them.

Selma Fraiberg, an American social worker, is considered the mother of mother–infant therapy, that section of IMH work where clinical changes are sought. Her seminal article, ‘Ghosts in the Nursery’, was published in 1980. A substantial discipline has developed since that time, whose proponents are generally trained in psychiatry or an allied health field. Sometimes infants are referred who have problems in their own right, e.g. sleep, feeding, and behaviour problems. Infants can also be referred when the mother has problems such as depression, other mental health difficulties, or issues around her feelings (or perhaps lack of them) for her infant.

In Australia, most Child and Adolescent Mental Health Services have few referrals of children under five years, with this trend perhaps changing a little recently as more workers acquire skills and knowledge in IMH. Families wishing help or advice with babies or toddlers generally seek this through Child and Youth Health or Maternal–Infant Health Services. Excellent knowledge about infants has been made available for more than a century, generally by nurses working in these services, with

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a concentration on feeding, sleeping, and general developmental guidance. Whilst support for a struggling mother (and yes, of course it was *always* a mother until very recently) was recognised as essential to the work, these agencies have traditionally not offered more intense psychological therapies.

A recent Pubmed search (Pubmed is a computerised search and retrieval system which accesses multiple journal and book databases) revealed 30 articles with ‘family therapy’ and ‘infant mental health’ as keywords. Two hundred and twenty-six resulted from ‘family therapy’ and ‘infant’, the majority not relevant to this article, and 36 from ‘attachment theory and family therapy’. Where more classical modes of family therapy are highlighted, there seems little attempt in most to attune to the infant, and the infant is more a passive recipient of (often very useful) changes.

In contrast, the infant mental health literature in general is much more likely to focus on the infant as an active participant in therapy. One cannot conceptualise psychological therapy for the infant alone (and indeed most family therapists cannot conceptualise the worth of therapy for older children out of family context!). So almost all work with

infants, regarding their mental health, could be seen as family therapy, since many family therapists would define family therapy as an active awareness that all family members, both present and absent, are active members of the system.

Family therapy is not a term generally used by IMH experts. Alicia Lieberman, speaking at the Australian IMH Conference in Perth (2001) used the term parent–infant therapy when discussing therapy with one parent and one child (see her excellent article, Lieberman, 1992), and ‘family therapy’ when the case involved therapy for warring partners as well as active therapy for an abused infant offspring. Her unspoken implication is that they are different modes of therapy but this may not be so clear to others.

Attachment Theory

It will be useful to describe the theoretical underpinnings of IMH, which for most workers in the field, lie in attachment theory. John Bowlby (1969) developed attachment theory during the middle third of the twentieth century. Perhaps sensitised by his own boarding school experiences, his initial work led him to focus on what he began to see as the effects of early maternal deprivation (Bowlby, 1944). His associates James and Joyce Robertson observed the patterns elicited in children ‘abandoned’ (inadvertently in most cases and against the instincts of parent and child alike) in hospital where they rarely saw their parents, according to the practices of the times. Sunday afternoon visiting may have been the only contact for many weeks, when long hospitalisations were the norm.

In developing his observations much further, Bowlby came to understand that in the first two years of life, infants develop a secure, trusting relationship through the repetitive behaviours of parent to child, which allow the child to develop a ‘schema’ (Stern, 1985) about what to expect and how to behave. A child who is well parented and has developed a secure attachment (60–65%) will have a coherent strategy to obtain relief from distress: approach the parent, make the distress abundantly clear, gain physical proximity, eye contact, often skin contact and verbal reassurance — and then be on its way again. Appropriate parenting provides children with a secure base for physical and psychological needs and also a place from which to explore the world.

Patterns of anxious attachment (30%) as delineated by Ainsworth, Blehar, Waters & Wall (1978) and later Main (1990), are observably different by the time an infant is one year old. (Read all about attachment in Robert Karen’s excellent book (1994)). *Avoidant* toddlers have learned that their needs will not be met by ‘wasting’ time on approaching their parent when distressed. They have already developed a seeming indifference which is powerful to observe: they appear happy in their play when their parent re-enters the room after leaving them alone or with a stranger, but their heart and respiratory rates rise as high as those of traumatised infants. *La belle indifférence?* *Resistantly attached* children will not be calmed easily when

separated from their parents, and are therefore often more hesitant to explore their world in age-appropriate ways. *Disorganised attachment* is the description of the remaining 5–10% of infants, most of whom are likely to have been substantially traumatised. As the name suggests, these children do not have an organised strategy to meet their needs when distressed. Perhaps the same parent offers both security and trauma and therefore there is no clear answer about whether to approach or distance when this parent reappears in a room.

These attachment styles can usually be traced into adult life. They are not however necessarily consistently sustained, as various life events can change the early patterns, e.g. a family divorce can move a child from secure to insecure (Weinfeld, Sroufe & Egeland, 2000; Beckwith, 1999). It is less clear that therapies can change the attachment status in the other direction (van Ijzendoorn, Juffer & Duyvesteyn, 1995; Fonagy, 1998).

Behaviours in older children can clearly be identified by attachment style, which may influence the nature of peer and authority figure relationships. In family therapy with older children, attachment theory combined with systems theory is a powerful method of understanding both the internalised schemata, which underlie the child's behaviours in the here and now, and the interrelationships between family members which often sustain these patterns. Marta Fisch (2001) has given a very clear account of integrating attachment theory with family therapy, with a case description following her summary of the relevant theories.

Infant Brains and Infant Psychological Development

Most growth of brain tissue occurs in the first two years of life. Infants are born with a very primitive network of interconnecting neurones, which allow for completion of basic functions such as breathing, eating and evacuation. Many innate capabilities of neonates are currently being identified, highlighting an infant's predisposition to relate successfully to other human beings, in particular to their near and (hopefully) dear. In the next 20–30 months, an enormous growth of brain tissue is accompanied by the maturation of the higher function centres of the brain, enabling the development of language, moral development, and social connectedness. The type and quality of neurotransmitters are believed to be determined by the interactive style of the infant with her/his caregivers, as is the rate of growth of some of the connecting neurones. Thus appropriate caregiving is believed to promote optimal brain development — yes, back to the potential for mother-blaming again! (Schore's work (1994) provides an overview of all these issues, but it is not light reading.)

Trauma in these early years is believed to cause hyperarousal and dissociation, adaptations which protect the infant from information that is too difficult to integrate (Perry, Pollard & Blakely, 1995). If this happens often enough, the infant may learn to dissociate more readily when overstimulated, thus potentially interfering with con-

centration and learning. Such infants also learn maladaptive ways of feeling and expressing emotions, and may have difficulties in interpersonal relationships.

Thus good-enough parenting is believed to offer the developing child the possibility of making good interpersonal relationships which provide a secure base throughout life and optimise brain development and learning. Less appropriate parenting, particularly if accompanied by abuse and trauma, has the potential to produce insecure or disorganised attachment patterns, perhaps accompanied by interpersonal and learning difficulties which are extremely difficult to change once solidified by the end of infancy. However, parenting practices can be taught. Understanding the need for timely and appropriate interventions is a valuable clinical skill.

Parent–Infant Interventions

Parent–Infant Preventive Interventions

At-Risk Parents

Multiple risk factors in a woman such as low socioeconomic status, single parenthood, youth, and abuse as a child, place her infant at substantial risk. Targeted interventions for this group are certainly the province of IMH, and are successful on a range of measures (Olds, Henderson & Kitzman, 1994). The programs tend to be based around support and parent education for the mother, often through home visiting, and use a range of practitioners, from highly trained to volunteers. Such support may begin in pregnancy and continue for several years. Armstrong's Brisbane study showed highly encouraging early results although at follow-up there were fewer differences compared to the control group (Fraser, Armstrong, Morris & Dadds, 2000). Huston's (1999) article gives a very clear case description of one client from their project.

Early Interventions

Parents may often define a problem in themselves when no impact can yet be measured in their infants. Women are often highly tuned to dissatisfactions with themselves as parents. Interventions with this group, although preventive or early interventive for an at-risk infant, use the same techniques as those outlined in the next section.

The Parent–infant Therapies

In their very useful article, Lojkasek, Cohen & Muir (1994) define four main styles of parent–infant therapy. In the first two styles, the infant need not necessarily be present and training can be offered to workers from many of the health disciplines. (Daniel Stern [1995], a master in the infant mental health field, chooses a slightly different classification — his well-known book is a 'must' for those seriously entering the field.)

Support

Whilst support is seen as the cornerstone of all and any therapy, with all therapies succeeding on the basis of a con-

riding relationship with a trusted therapist (Frank, 1972), in infant therapies, the paradigm is a secure base, heightening even more the relevance of support. Many programs provide support as their mainstay, and do so with great success (Armstrong, Fraser, Dadds & Morris, 2000; Olds, & Kitzman, 1993; Olds et al., 1994).

Developmental Guidance

Giving information to parents in ways that help contain their anxieties normalises their situation and educates them about their infant's progress. These interventions would not be considered family therapies although a beneficial outcome for the infant is the aim.

In the other two modes, the infant is not only present but is an active participant. These modes usually involve more advanced training and a range of psychotherapeutic skills.

Psychodynamically-oriented Infant-Parent Psychotherapy

Selma Fraiberg (1975) initiated psychodynamically-oriented Infant-Parent Psychotherapy, which is now practised by a range of clinicians in similar or innovative formats. These include 'Watch, Wait and Wonder' (Muir, 1992; Cohen, Muir et al., 1999) and its adaptations, and infant-parent psychotherapy (Hopkins, 1994). Salo and Paul (2001) described the work of Ann Morgan, a Melbourne paediatrician with a life-long interest in working directly with infants and mothers. Her work is perhaps the most striking example of direct engagement between therapist and infant — the engagement allows the mother the opportunity to reflect about her own and her infant's powerful emotions, always 'bearing the infant in mind' and allowing a safe space for containment of emotions (the infant's by the parents, and the parents' by the therapist).

Interactional Guidance

Susan McDonough (1993) is generally credited as the initiator of this style although others such as Martha Erickson and K. Kurz-Riemer (1999) have also used video feedback in their therapy for a long time. Parents watch a video (several minutes in length) of themselves with their infant, with the therapist there to guide and help them reflect. Parents can rapidly change what they are doing with their infants, enhancing their positive behaviours and deleting intrusive or distancing behaviours. Little has been written about the inclusion of fathers, although at least two presentations at the 9th World Infant Mental Health Conference in Montreal, July 2000, revolved about this issue. A recent (Fall, 1999) edition of the *Infant Mental Health Journal* devoted to the topic of fathers and infants mainly described the role of the father in interactions with infants, rather than looking at therapeutic initiatives involving fathers.

As can be seen, the latter two modes of therapeutic intervention clearly involve family members and a therapist, although the therapeutic techniques are not those of classical family therapy. Other very useful articles include that of Dilys Daws (1999) who writes from a very practi-

cal point of view about her work with infants and their families in an under-fives counselling clinic, describing how she actually goes about assessing families and then promoting change.

The Integration of Family Therapy and Infant Mental Health

Foremost perhaps amongst those wishing to bring the skills and knowledge of family therapy to the infant field is John Byng-Hall, a British child psychiatrist. Byng-Hall worked with John Bowlby, and was profoundly influenced by attachment theory. His powerful book *Rewriting Family Scripts* (Byng-Hall, 1995), whilst not directed specifically towards younger children, begins by describing his intergenerational view of family life: children are inducted from the pre-verbal period onwards into family ways of talking, behaving, emoting, and generally being, by repeated contact with the repetitive patterns that make up the minutiae of daily family life. Parents are informed in turn by their own parents and the powerful influences of previous generations, and so children grow up 'knowing' how to be a member of that particular family, even down to the lines to speak at times of ritual or crisis. Byng-Hall then describes children's need for a secure base, brilliantly integrating the principal attachment theorists, Bowlby, Main and Ainsworth. The case examples in his book describe in detail how therapy unfolds, giving genograms over several generations. With transparent clarity, Byng-Hall brings to life therapeutic manoeuvres which induce change. He highlights his own dilemmas in these situations and how he uses them in the service of the family he is seeing. The book makes extensive use of vignettes, and a significant number of these describe work with families with small children as identified patients. In other articles, Byng-Hall (1990, 1991, 1995b) uses more clinical examples to explore the integration of systems and attachment theories.

The connection between family relationships and very small children has been explored in a number of ways by other authors. Heard (1978) was one of the earlier professionals attempting to put the theories into practice. Adams and Cotgrove (1995) have written succinct summaries of attachment and systems theory for nursing staff working with young families, and Golden (1977) was amongst the first to write for medical practitioners. Trad (1994) has tried integrating even more fully, using group, family and individual therapy techniques together, describing a group for mothers with infants which employs all these modalities. He states that enmeshment and triangulation are particularly responsive to this combination.

Family Assessment

A number of authors have described family assessment as an essential underpinning for better clinical work with infants.

Triadic and Family Group Interactions

McHale and Fivaz-Depeursinge (1999) studied triadic and family group interactions in infancy and toddlerhood. In an excellent paper, the authors first describe those personality characteristics of each parent which are likely to have a significant impact on their style as partner and parent, as well as those characteristics which are relatively universal for women as mothers and for men as fathers. They then delineate their findings as they develop a standardised tool, the Lausanne Triadic Play, for assessing the family's resources and vulnerabilities as the new parents learn to work together with their infant. They are able to show its reliability in comparison with other assessments, such as home-based observations of parents. They then discuss the potential effects on infants of appropriate cooperative behaviour and warmth between parents. They suggest that such microanalytic observations of developing family group dynamics may lead to prevention and early intervention for infant development, whilst recognising that the nuclear family paradigm does not apply to all families in all cultures.

Adolescent Mothers

Nathanson et al. (1986) used family therapy concepts to understand the characteristics of fifty pregnant adolescents in the context of their families. They rated these families antenatally and followed the young women into the post-natal period. Whilst the findings were more limited than expected, understanding enmeshment helped predict which teenager would remain with her family system, whilst the relationship between herself and the baby's father was adversely affected. The young parents also developed a troubled relationship in those families where conflict went unresolved, and in those with insufficient executive functioning. The authors recognised that more work was essential to turn these findings into clinically useful information, but that process has begun and is likely to provide worthwhile data in the longer term.

Family Therapy Combined with IMH in Applied Clinical Settings *Grandparents Raising Grandchildren*

As some Western societies continue catastrophic disintegration, with the growing use of drugs among the young, more grandparents have become the primary carers for their grandchildren. US census statistics (1994) show that of the 1.4 million children living with caregiving grandparents, 46% are African American, 42% are Caucasian, and 12% are Hispanic. Brown-Standridge and Floyd (2000) 'revisit' contextual family therapy, developed initially by Boszormenyi-Nagy and Spark (1984), and suggest it is an appropriate technique for helping families living in this mode. They describe several case examples (as with Byng-Hall's work, some of the children are infants and work with older children is also described) and as the title implies,

attempt to alter long-standing interactional difficulties which may have been partially responsible for the development of the situation. Byng-Hall (1982) has also visited the topic of grandparents in family therapy, but in situations where they are not the primary caregivers. He describes the benefits of a multi-generational approach, where the genogram is in front of the therapist in its 'live' form.

Family Grief

Kissane and Bloch (1994) provide a scholarly overview of grief within the family setting, with a substantial section on the common clinical problems of grief and infant loss. They describe differing styles between mother and father in such situations and the almost inevitable effects on marital relationships, with further consequences for subsequent children. Systems therapists will value these writings.

Child Protection and Child Abuse

Child protection and family involvement is a very large topic in its own right. In the last three decades, as patterns of abuse in early childhood have been identified, and mandatory reporting schemes have generated intense efforts for early intervention, the patterns of intergenerational transfer of problems have become increasingly evident. There is a burgeoning need for therapists with systemic knowledge, who understand the needs of infants and children, and can intervene appropriately at this early stage, as family preservation holds the key for many infants. Substitute care, although better regulated, has many problems, including lack of availability of appropriate persons, lack of training, and lack of continuity of care for the children. IMH specialists are now beginning to intervene directly with infants in foster care (Zeanah, 1998) to ensure education of caregivers and integration of the many systems often involved. Again, those with family therapy training are well placed to understand the complexities, and help move these unfortunate children towards permanent placements and a meeting of their attachment needs.

Outcomes

There has been some attempt to evaluate parent-infant therapies, but none yet in a controlled trial. In an attempt to highlight the need for appropriate evaluation, 'Outcome' was chosen as the theme for the Sixth World Congress of the World Association of Infant Mental Health, and a subsequent issue of the *Infant Mental Health Journal* printed some of the findings (de Chateau, 1998). Some other authors have also attempted substantial evaluation. Robert-Tissot, Cramer, Stern, Serpa-Rusconi et al. (1996) have compared psychodynamic infant-parent therapy with interactional guidance, finding equivalent improvement in both groups. Preventive interventions have been better evaluated, and summarised (Fonagy, 1998), and there is growing evidence of the value of such programs for at-risk groups. Broberg (2000), in a helpful recent review of

attachment-based interventions, is able to conclude that interventions are clearly effective in enhancing maternal sensitivity to infants' attachment cues and quite possibly effective in enhancing infant attachment security. This outcome measure is clearly appropriate for these styles of intervention and highly significant in these children's lives, but differs from the measures used in family therapy (Lebow, 2000).

Sadly, quantitative evidence of effectiveness is still mostly lacking and gathering it remains an important task for researchers and clinicians. IMH therapists can show many clinical examples of rapid change in mother–infant work, using qualitative outcome measures. With greater demands for services and fewer resources, politicians and senior health administrators require better documentation than this.

Summary and Conclusion

Family therapy techniques have been successfully incorporated by some theoreticians and a number of clinicians into the IMH field, with excellent clinical results. The value of a secure base gained in infancy is evident in all aspects of life, and the potential to change parent–infant relationships rapidly can be seen clinically. IMH workers must master the challenge to show good outcome evidence that their interventions are effective.

Progress is being made on family assessments at this formative stage of family life. As more understanding develops of the infant's brain, and in particular, of how it develops at a cellular and biochemical level, the influence of parenting styles, family atmosphere and wider community support also becomes more evident. Family therapists understand systems, and systemic intervention. The exciting challenge for IMH and family therapists is to increase their knowledge

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of each other's strengths and capabilities, to ensure best use with this clinical population. As prevention and early intervention become increasingly seen as effective, time-efficient and appropriate, family therapists with an understanding of attachment theory, systems theory, brain development and intergenerational family problems will make successful and worthwhile clinical interventions. Working earlier in the life cycle has enormous advantages: infants are highly adaptable and learn rapidly. Appropriate nourishment for their 'root systems' allows each infant to grow straight and tall and strong. A forest with a whole ecosystem sustaining itself is an

outcome vision which family therapists and IMH can share, and are more likely to achieve by sharing their skills, knowledge and conceptualisations.

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